Whittington Health NHS

TRUST BOARD

14.00 – 16.30
Wednesday 7 December 2016

Whittington Education Centre Room 7

NHS
Whittington Health
NHS Trust

Meeting	**Trust Board – Public**
Date & time	**7 December 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
16/151	**Declaration of Conflicts of Interests** *Steve Hitchins, Chair*	*Verbal*	*Declare* 1420hrs
16/152	**Apologies & Welcome** *Steve Hitchins, Chair*	*Verbal*	*Note* 1420hrs
16/153	**Draft Minutes, Action Log & Matters Arising 2 November** *Steve Hitchins, Chair*	1	*Approve* 1425hrs
16/154	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Note* 1430hrs
16/155	**Chief Executive's Report** *Simon Pleydell, Chief Executive*	2	*Approve* 1440hrs
Patient Safety & Quality			
16/156	**Quarterly Patient Safety Report Q2 (July - Sept)** *Richard Jennings, Medical Director*	3	*Approve* 1500hrs

16/157	**Serious Incident Report Month 7** *Philippa Davies, Director of Nursing & Patient Experience*	4	*Approve* 1510hrs
16/158	**Safer Staffing Report Month 7** *Philippa Davies, Director of Nursing & Patient Experience*	5	*Approve* 1520hrs
Strategy			
16/159	**Draft Sustainability and Transformation Plan (STP)** *Simon Pleydell, Chief Executive Officer*	6	*Approve* 1530hrs
Performance			
16/160	**Financial Performance Month 7** *Stephen Bloomer, Chief Finance Officer*	7	*Approve* 1540hrs
16/161	**Performance Dashboard Month 7** *Carol Gillen, Chief Operating Officer*	8	*Approve* 1550hrs
16/162	**Winter Plan** *Carol Gillen, Chief Operating Officer*	9	*Approve* 1600hrs
Governance			
16/163	**Workforce Assurance Committee draft minutes** *Steve Hitchins, Chairman*	10	*Approve* 1610hrs
16/164	**Finance & Business Committee draft minutes** *Tony Rice, Non Executive Chairman*	11	*Approve* 1615hrs
16/165	**Audit & Risk Committee Part 1 draft minutes** *David Holt, Non Executive Chairman*	12	*Approve* 1620hrs
16/166	**Quality Committee draft minutes** *Anu Singh, Non Executive Chairman*	13	*Approve* *1625hrs*
16/167	**Charitable Funds Committee draft minutes** *Tony Rice, Non Executive Chairman*	14	*Approve* *1630hrs*
Any other urgent business and questions from the public			
	No items		
Date of next Trust Board Meeting			
	04 January 2017 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: 16/153
Doc: 1

The draft minutes of the meeting of the Trust Board of Whittington Health held in public at 1400hrs on Wednesday 2nd November 2016 in the Whittington Education Centre

Present:	Stephen Bloomer	Chief Finance Officer
	Philippa Davies	Director of Nursing and Patient Experience
	Siobhan Harrington	Director of Strategy/Deputy CEO
	Deborah Harris-Ugbomah	Non-Executive Director
	Graham Hart	Non-Executive Director
	Steve Hitchins	Chairman
	David Holt	Non-Executive Director
	Richard Jennings	Medical Director
	Simon Pleydell	Chief Executive
	Tony Rice	Non-Executive Director
	Yua Haw Yoe	Non-Executive Director
In attendance:	Greg Battle	Medical Director, Integrated Care
	Janet Burgess	London Borough of Islington
	Norma French	Director of Workforce
	Kate Green	Minute Taker
	Fiona Isacsson	Director of Operations/Deputy COO
	Lynne Spencer	Director of Communications & Corporate Affairs

Patient Story

Philippa Davies introduced ex-patient Krishna and Clinical Psychologist Pippa Hendry from Simmonds House and thanked them for coming to the Board. Krishna had left Simmonds House two years ago, having been an in-patient there for fourteen months. She had agreed with Pippa that her patient story would take the form of an interview, focusing on her entry to the service, the mid-point of her treatment, then the end and her discharge.

Starting with her first impressions of Simmons House, Krishna recounted how she had enjoyed meeting her care manager and key worker, and how impressed she had been by the classroom where she had been able to work towards her GCSEs. Remembering the mid-point of her treatment, Krishna said that most of the patients had found night-times hard because most of the staff on duty had been bank staff and therefore not people they knew. A very important aspect of her departure from Simmons House had been the advance planning – this had begun two months prior to her discharge. Krishna was now in college studying for her 'A' levels and hoping to go to university.

When asked what changes might be made to improve her stay at Simmons House, Krishna replied that she and her friends would have liked to be more involved in ward rounds. On the whole, however, she described Simmons House as 'a place where everyone wants to help you', and said she would not be thinking in terms of university applications without her treatment there. The ethos of the place was, she said, encouraging without being pressurised. Two years on, friendships she made there have remained in place. It was also noted that every effort is now made to ensure more than one permanent member of staff is on duty at night.

Lower Urinary Tract Syndrome (LUTS)

On behalf of a group of patients from the LUTS clinic, Francesca read a prepared statement. In summary, patients welcomed the Royal College report and would continue to work with the Trust to ensure the successful implementation of its recommendations.

16/140 Declaration of Conflicts of Interest

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

16/141 Apologies and welcome

141.01 Steve Hitchins welcomed everyone to the meeting, in particular Fiona Isacsson, standing in for Carol Gillen who was on leave. Apologies for absence were received from Carol and from Anu Singh.

16/142 Minutes, Action Log and Matters Arising

142.01 The minutes of the Trust Board held on 5th October were approved. There were no matters arising other than those already scheduled for discussion.

Actions

142.02 110.03 IM&T Strategy: This was now due to be discussed at the Board Seminar in November, then would be brought to the Trust Board in the New Year.

142.03 All other action points either remained as set out in the October Board minutes or had been closed.

16/143 Chairman's Report

143.01 Steve Hitchins alerted Board colleagues to a number of forthcoming events he planned to attend, namely:

- Diwali celebrations the following day
- the recruitment event for AHPs the following Saturday
- the open day within maternity services also that Saturday
- the launch of the children and young people's forum on 9th November
- the memorial service for Paula Mattin on 29th November
- the switching on of the Christmas lights on 1st December.

143.02 Last month Steve had attended an event for Black History month, and he wished it to be noted that this event had been organised entirely and voluntarily by Eddie Kent from Security. Board members had also taken part in the Change Day; both Greg Battle and Anu Singh volunteering to make beds on the wards. Steve had also attended Haringey's voluntary sector forum, and the junior doctors' party.

16.144 Chief Executive's Report

144.01 Simon was pleased to begin his report with the announcement that Whittington Health had been chosen as one of 11 test sites to develop the nursing associate role. Continuing the theme of staff development, Simon said that he believed that within the Trust there was enormous potential for development and for adding value to jobs and thus encourage the retention of staff.

144.02 56% of staff had now been given the 'flu vaccination, meaning that the Trust was in a better position on its trajectory than at the same time the previous year. There was a CQUIN payment associated with the take-up of the vaccination, the target being 75% by the end of December. The message to stress was that even those who are carrying the virus in an asymptomatic way can still pass it on to patients.

144.03 The Trust had reported one case of MRSA, which was currently being investigated. The target was nil; this was therefore clearly disappointing. 5 cases of C. Difficile had been reported against a target of declaring no more than 17 cases and Simon said that this figure reflected extremely positively on the quality of the Trust's nursing care. All cancer targets had been met in August; MSK however had fallen to 45% largely

because of long waiters. The service target is 95% target, but should be set to around a realistic mid-60s. The IAPT service had exceeded both its targets.

144.04 Updating the Board on the Sustainability & Transformation Plan (STP) Simon said that the first draft had now been submitted to NHS England. Local Authority colleagues had published the narrative on their websites. Simon felt that a key aspect of this work for Whittington Health was the need to ensure that plans fitted with those of the Islington & Haringey Health & Wellbeing Partnership. There was also much to be done on governance arrangements. Richard Jennings added that from his experience of co-chairing the clinical cabinet there had been a very positive coming together of local leaders and a great deal of support for an agenda based on population health, integrated care and prevention, all of which underpinned everything the Trust stood for.

144.05 Steve Hitchins expressed some concerns about the process, and in particular the public engagement aspect – Whittington Health was keen to engage with local people, and to work alongside the local authorities. Simon agreed the principle of this, but felt it better to wait until there was a more complete understanding of how on the ground delivery of services would be affected. To engage prior to this ran the risk of inviting questions there were as yet no clear answers to. Janet Burgess saw the wisdom of this whilst expressing the view that the local authority always believed in publishing where possible; she believed the plan to be strong on prevention, and would also like to see how working with social services was envisaged.

144.05 As well as prioritising the Health & Wellbeing Partnership agenda, there was also scope for joint working with other hospitals – the LUTS clinic was a prime example of this. Another key issue, however, was how to manage demand, not just service provision. It was hoped that more detailed information would be available before the Trust Board meeting in December.

144.06 Simon informed the Board that NHS Improvement had recently developed a new Single Oversight Framework which mirrors the CQC standards but adds a further dimension around finance and use of resources. Trusts are rated according to the level of support they require to improve under a new process called 'segmentation', and for the first time there was no distinction between those Trusts with Foundation Trust status and those without; which gave a clear indication of the future of the FT agenda. Whittington Health had been rated Segment 2, largely because of its financial deficit and issues with the 95% A&E target. Only a handful of Trusts were rated at the top Segment 1, and others rated Segment 2 included UCL, the Royal Free and Salford so this was a real achievement.

144.07 A planning event had been held the previous day, at which all the Integrated Clinical Service Units (ICSUs) had presented their plans for the following year. Simon felt the day had gone well, with a great many encouraging discussions about collaboration. For the present, winter had arrived, and services were consequently struggling – ED had been at 88% the previous day, and had for the last few weeks been within achieving within the 80s rather than the 90s. There had also been an increase in length of stay, exacerbated by a number of patients from Barnet where there were difficulties in making effective discharge arrangements – this was in part because of the additional numbers admitted via blue light to ED, but also because the London Ambulance Service viewed Whittington Health as better at rapid and effective ED admissions than some other local providers. There was a need to speak to the CCGs and the local authorities to make sure that discharge issues were properly addressed.

144.08 Simon briefly drew attention to some of the other areas in his report, as follows:

- the importance of encouraging staff in all areas to complete the staff survey

- the standardising of staff bank rates which would bring the Trust in line with neighbouring organisations and improve rates for some of the lowest paid staff
- the financial position, which would be covered in more detail by Stephen Bloomer in his report
- many congratulations to Caroline Fertleman on her winning the prestigious President's Medal from the Academy of Medical Education
- the appointment of a substantive ED consultant.

144.09 In response to a question from David Holt about progress on the staff survey, Norma replied that the Trust had achieved a response rate of 30% the previous year; to date this year the response rate stood at 18%. The first set of (hand delivered) reminders had recently been issued, and there was a prize of a mini iPad. A random sample of 1250 staff had been surveyed, some on-line and others by paper, and every effort was being made to encourage completion. Simon explained that some staff were concerned about confidentiality and confirmed that the Picker Institute ran the survey independently on behalf of the Trust. He emphasised the correlation between a highly engaged workforce and quality of care.

16/145 Lower Urinary Tract Service

145.01 Richard Jennings explained that this was the first opportunity to look at the full report submitted by the Royal College of Physicians. Reviewers had been on site in early May, given their initial recommendations later that month and additional ones in August, then submitted their final report in October. Richard thanked all those who had been involved in the review, patients, staff and panel members, and expressed the view that the report would really help to move things forward. There was, he said, a great deal to do, but progress was being made and service users were being involved at every stage in the process.

145.02 Siobhan Harrington added that there was now a detailed action plan which she planned to share with the user group in December. The succession plan was a critical part of this, and Siobhan emphasised the importance of the service not being dependent on any one consultant. As well as involvement from service users, Siobhan had also met with MPs and Councillors, and she and Simon had attended meetings of the Joint Overview & Scrutiny Committee. Deborah Harris asked how confident the executive team was about the achievement of the succession plan, and Siobhan replied that many of the arrangements had already been completed, what was important now was to have a clear timeline with UCL and she was aiming for all issues to be complete by the end of March.

145.03 Simon Pleydell pointed out that the nature of this novel service meant there would inevitably be those who did not view it the same way as its patients; what was important was to have a cohort of clinicians dedicated to providing the best possible service in a way which met the recommendations of the Royal College report, and this would include the gathering of evidence for NICE which would support appropriate clinical practice.

16/146 Serious Incident Report

146.01 Philippa Davies informed the Board that six serious incidents (SIs) had been declared in September, bringing the total for the year to twenty-five. The six declared comprised:

- two intrauterine deaths, one at 32 weeks and the second at 38 weeks
- an information governance breach involving a patient list found off site
- an unexpected death of a patient with pulmonary embolism
- a delayed diagnosis of an active bleed
- a retained PICC line.

All were being investigated, and the Board would receive the results in a future report.

146.02 David Holt asked, since it was now just over half-way through the year, whether any trends had been identified, or whether each incident was unique. Richard Jennings replied that trends could be identified through the Quality Account; all SIs presented their own challenges, but if pressed he would say that this year had seen a trend of information governance breaches, and that echoed criticisms that had been made by the CQC during their inspection. Richard also mentioned sepsis cases, explaining that this was why the treatment of sepsis had been chosen as one of the Trust's 'sign up to safety' pledges.

146.03 David also commented on the lack of slips trips and falls declared which he found surprising given the level of acuity of the patients treated. Richard Jennings explained that a great deal of work had been carried out on falls prevention, particularly in respect of patients suffering from dementia. It was also noted, in respect of the most recent information governance breach, that the staff member responsible had declared the incident; had they not, it would have remained undiscovered.

16/147 Safe Staffing Report

147.01 Philippa Davies informed the Board that the monthly safe staffing report gave details of actual versus planned staffing for September. There had been some increase in the amount of special shifts required due to a high number of vulnerable patients on the wards, and it had remained necessary to use bank and agency staff to ensure safe staffing levels. Following a successful recruitment campaign in Greece and Portugal nursing staff from these two countries had now started work, but were currently filling HCA posts pending arrival of their NMC PIN numbers.

147.02 Asked whether the conversion of staff from agency to the staff bank was proving successful, Norma replied that the work to standardise bank rates was now complete, with dates for its implementation, she had also introduced a Christmas bonus scheme to encourage bank working. Overall, there had been a reduction in the use of agency staff since April and an increase in bank staff.

16/148 Nursing and Midwifery Revalidation Report

148.01 Philippa Davies reported on the Nursing & Midwifery Council (NMC) requirement for the revalidation of all registered nurses and midwives, which had been mandatory since April 2016. A number of briefing sessions had been held which had received very positive feedback, and the Trust was fully compliant. In due course there would be a similar process for AHP staff.

16/149 Financial Report

149.01 Introducing the financial report for Month 6, Stephen Bloomer said that the Trust had declared a £3.9m surplus in September, giving a year to date deficit position of £2.9m, in line with the planned position. This had been caused by a better than average run rate and a decrease in agency spend, and had meant that the Trust was now able to access its STP funding. There had also been a reduction in non-pay expenditure, which was largely due to the resolution of disputes with debtors. It should be noted that this latter was non-recurrent. The centre would be looking for evidence that the Trust was able to reach a sustainable position, and progress on this would be reported to the Finance & Business Development Committee.

149.02 The graph on page 4 illustrated what improvements needed to be made in order to reach that sustainable position, primarily comprising planned activities run through the PMO, but also through the ICSUs' CIPs. Most of these were already detailed on the PMO's 'roadmaps', but not all were yet generating the required level of savings.

149.03 Referring back to the earlier conversation about patients from Barnet and delayed discharges, Tony Rice enquired whether the Trust was receiving funding for this out of area cohort; Stephen confirmed the Trust was in receipt of the funding. David Holt asked about how the Board could be sure the Trust would meet its control totals, and Stephen assured him that projections were based on forecasts from the ICSUs, and his team worked extremely closely with them at every stage. David commented on the fact that some areas appeared to have achieved considerably more financial stability than others, and Stephen replied that those areas that had done well tended to be areas where there been improvements to income and not just reductions in spending.

16/150 Performance Report

150.01 Fiona Isacsson said that the Board had already discussed many of the key issues in the performance report such as ED performance, cancer targets, infection control and MSK. Moving on to theatre utilisation, Fiona reported some improvement, although there would need to be a shift in culture and ways of working before radical change could be effected. Usage was higher this week, and she hoped to be able to report further improvement in December. She also drew the Board's attention to the improvements within the urology service. Fiona was making good progress with job planning in surgery, and this would help to address this as staff became even clearer about what was expected of them.

150.01 In answer to a question about whether the CCGs fully understood and were sympathetic to the Trust's position on the MSK service and Siobhan confirmed that discussions were ongoing and she was aware more dates for meetings had already been set. Yua Haw Yoe enquired how cancer targets had been achieved, and Fiona replied that initially much time had been spent ensuring that people fully understood the current standard, and then learning from those areas where performance was best. There had also been considerable positive collaborative working with UCL.

150.02 Steve Hitchins commented on the amount of red areas within the workforce information section. Norma French replied that these areas had been discussed in some detail at the recent round of performance management reviews, and all ICSUs had presented detailed plans showing how improvements were to be made. Moving on to the quality of the appraisal paperwork, Norma informed the Board that an audit had just been completed on appraisals, and the results of this would be brought to the Audit & Risk Committee.

This information was also key to the staff survey. Richard Jennings added that for doctors' appraisals, appraisees are invited to give feedback to appraisers on the quality of the appraisals they had conducted.

16/151 Any other business

151.01 It was suggested the Board include within its series of patient stories the experiences of one of the users of the LUTS service. Philippa Davies would follow this up directly with the service users' group.

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Action Notes Summary

144.05	Draft STP to be available before the Trust Board meeting in December	On December Agenda	Closed
150.02	Appraisal audit results to Audit & Risk Committee	On forward planner for Audit & Risk Committee	Closed
151.01	LUTs for a future patient story to the Board	On TB forward planner	Closed

Whittington Health Trust Board

7 December 2016

Title:	Chief Executive Officer's Report to the Board		
Agenda item:	**16/155**	**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 November 2016		

Author name and title:		**Lynne Spencer, Director of Communications & Corporate Affairs**		**Director name and title:**		**Simon Pleydell, Chief Executive**	
Date paper seen by EC n/a	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

CHIEF EXECUTIVE OFFICER REPORT

The purpose of this report is to highlight issues and key priorities to the Trust Board.

1. QUALITY AND PATIENT SAFETY

Flu Campaign 2016

We have made a good start for our 2016 uptake of the flu vaccine. To date 77% of our staff received a flu jab against a target of 75%; last year's uptake was 62%. This is excellent news as it means our high profile campaign ensured as much protection for ourselves, our families and our patients against the flu virus. Thank you for helping us to save lives and protect the vulnerable.

MRSA Bacteraemia

We have reported 1 case of hospital acquired MRSA bacteraemia (October). Last year we did not have any cases reported. We will continue to manage our high profile infectious control campaign across the community and hospital to ensure that this remains a single MRSA incident for the year.

Clostridium Difficile

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

Cancer Waiting Time Targets

All targets met except the 62 days from referral to treatment. *Reported in arrears in line with the national cancer data validation process*.

- 31 days to first treatment 100% against target of 96%
- 31 days to subsequent treatment (surgery)100% against target of 96%
- 31 days to subsequent treatment (drugs)100% against a target of 98%
- 62 days from referral to treatment 74.5% against a target of 85%
- 14 days cancer to be first seen 96.6% against a target of 93%
- 14 days to be first seen for breast symptomatic 100% against a target of 93%

Community Access Targets

We reported up to end of September:

- MSK waiting time – non consultant led patients seen 50.66% - target 95%
- MSK waiting time – consultant led patients seen 99% - target 95%

We are pleased to have exceeded our Improving Access to Psychological Therapies (IAPT)

- IAPT – patients moving to recovery – 52.3% - target 50%
- IAPT – patients waiting for treatment <6 weeks – 94.6% - target 75%

2. STRATEGIC

Name Change

We are consulting on changing our name so that we can be known and referred to officially as 'Whittington Health NHS Trust'.

You may be aware that when we became an Integrated Care Organisation in 2011 we chose to use the working name 'Whittington Health NHS Trust' rather than the legacy name on our NHS establishment order which is 'Whittington Hospital NHS Trust'. This has caused confusion for stakeholders, staff and the public because we are trading as an Integrated Care Organisation and promoting our community and hospital services, whilst our official establishment name is often posted on websites and regulatory documents as a hospital/acute provider.

We believe the change of name is important because it better reflects both our community and hospital services and hope you agree that it makes complete sense.

Please forward any views you have to lynne.spencer1@nhs.net who will be liaising with the Department of Health to enable the official change to take place in 2017 by a minister who will lay the statutory instrument before parliament.

Operational Plan 2017/18

We have agreed our draft operational plan for 2017/18 and this will be shared with our Trust Finance and Business Committee in December and the Trust Board in January. Our November Business Planning day informed the Operational Plan and each Executive Directorate and Integrated Clinical Service Unit contributed to ensure we meet our strategic goals that are set out in our clinical strategy.

Strategic Estates Partner (SEP)

We have begun to hold a series of competitive dialogues with interested parties to identify a Strategic Estates Partner to support the delivery of our estates strategy. We expect to have chosen a partner by June 2017.

It is important to note that our work establishing a SEP is distinct from the North Central London Sustainability and Transformation Plan (NCL STP); although it will support the objectives of the NCL STP.

The aim of the SEP is to improve our working environments for our staff and our patients. Details are set out in our estate strategy at http://bit.ly/2gTnovX.

3. OPERATIONAL

Extreme pressures within the emergency care pathway continue and this resulted in our 4hr performance for November at 88.1% against a target of 95%. As we face winter we will continue to change the way we manage our patient flows. Some of these changes include focusing on improving pre noon senior clinical reviews, rolling

out a minimum data set for all white boards and continuing to operate our 24 winter escalation beds on Cavell ward.

4. WORKFORCE

London Healthy Workplace Charter

We are delighted to have been awarded an 'Excellence' rating by the London Healthy Workplace Charter; 1 of only 7 organisations, out of the 77 applications. The Charter is an initiative by the Mayor of London and recognises organisations that are taking positive steps to create workplaces that have healthy environments for staff.

Staff Engagement

I am continuing to get out and about meeting different staff groups as part of an extensive programme of staff engagement events. These sessions are proving invaluable to hearing views and ideas from staff. Last month I shadowed a district nurse in the community on a morning shift and found the experience to be extremely rewarding and insightful.

Annual Staff Survey

We have concluded our 2016 staff survey and the uptake was 32% (400 staff from a random sample of 1,250). An analysis of the results will now take place to help us to take forward an action plan to tackle the top issues raised by staff.

5. FINANCE – APRIL TO OCTOBER MONTH 7

Our financial position continues to remain very concerning and we have significant challenges ahead to meet our planned targets.

We reported a £0.8m deficit in October and a year to date deficit of £3.8m, which is £0.4m adverse against our planned year to date position. Pay expenditure was £0.3m adverse in month and £1m adverse year to date.

We improved on 2 key targets; increasing permanently employed staff and utilisation of bank staff. The nursing agency % reduced from 10% to 9% in October but the AHP and medical agency utilisation increased. We have not reduced agency sufficiently to meet our CIP target and the national cap. We will be focusing urgent actions for the rest of the financial year to recover the position.

The income position in Month 7 was the key driver for our variance showing an adverse position of £0.5m compared to planned income; year to date £2.5m adverse. The main variances for the income position include under performance on clinical income (day cases and endoscopy), assessment of sustainability and transformation funding income (unlikely A&E funding will be received), partial achievement of income efficiencies (CIP) and timing of donation from charitable funds for maternity redevelopment.

The cash position is £1.1m over plan, due to a large receipt from Health Education England in October and increased receipts from London Borough of Haringey following a review of debtors.

The capital programme is in progress with £2.1m of the budget committed year to date; £1.2m has been incurred. The Capital Management Group is monitoring the progress of the individual capital schemes.

5. AWARDS

Congratulations and well done to

Our library team who won a poster competition at the London, South East NHS and HE Libraries Conference. The team submitted a poster outlining their successful 'Reflective Reading Club' for revalidating nurses. They won first prize beating 9 other submissions from healthcare libraries across London, Kent, Surrey and Sussex.

Graham Smith, receptionist for Level 3B, who won the October monthly excellence award for his professional work managing the busy reception. Graham always puts patients first and his colleagues nominated him for being such a great asset to the Trust.

Lesley Platts, Head of Paediatric Therapy and Specialist School Nursing, who won the November monthly excellence award for her outstanding leadership. Lesley always demonstrates great respect in the way she values her team and her patients.

Simon Pleydell
Chief Executive

Nursing and Patient Experience
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Whittington Health

December 2016

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	**16/157**	**Paper**	**04**
Action requested:	For Information		
Executive Summary:	This report provides an overview of serious incidents (SI) submitted externally via StEIS (Strategic Executive Information System) as of the end of October 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. • NHS England 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:	25th November 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 October 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 9 serious incidents during October bringing the total of reportable serious incidents to 34 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.
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.
Intrauterine Death Ref: 23372	Sept 16	Intrauterine death at 32 weeks diagnosed by ultrasound scan.
Information Governance Breach Ref: 23932	Sept 16	A patient list was found off hospital grounds by another staff member.

Intrauterine Death Ref: 23903	Sept 16	Intrauterine death at 38+1 weeks diagnosed by ultrasound scan.
Unexpected death Ref: 25397	Sept 16	Unexpected death of patient with bilateral pulmonary embolism.
Delayed Diagnosis Ref: 25413	Sept 16	A delayed ultrasound scan resulting in delayed diagnosis of an active bleed.
Retained PICC Line. Ref: 25401	Sept 16	Patient discharged with a PICC line in situ.
Never Event - Nasogastric tube Ref: 2016.26486	Oct 16	Patient deterioration during NG feeding.
Maternal Death Ref: 2016.26963	Oct 16	Patient deterioration 10 days post delivery resulting in cardiac arrest .
Delayed diagnosis. Ref: 2016.27113	Oct 16	Delayed diagnosis due to failure to follow up investigation result.
12 hour Trolley breach. Ref: 2016.27253	Oct 16	A patient had a prolonged wait in the Emergency Department due to lack of bed availabilty in appropriate setting.
Discharge Planning failure. Ref: 2016.27258	Oct 16	Patient discharged from hospital without appropriate discharge plans in place.
Unexpected death Ref: 2016.27591	Oct 16	Unxepected death in the community as a result of suicide
Unexpected Admission to NICU Death. Ref: 2016.25786	Oct 16	Baby was born in poor condition and was transferred to the Neonatal Intensive Care Unit.
Missing Swabs - Near miss. Ref: 2016.28068	Oct 16	Failure to locate two swabs following instrumental delivery and suturing tear.
Sub Optimal Care of Patient Ref: 2016.28091	Oct 16	A patient developed pressure ulcers due to pressure relieving equipment not being provided.

The table below details serious incidents by category reported to the NEL CSU. The Trust reported 9 serious incidents during October 2016.

STEIS 2016-17 Category	Apr	May	June	July	Aug	Sept	Oct	Total
Safeguarding	0	1	1	0	1	0	1	4
Confidential information leak/loss/Information governance breach	1	2	1	0	1	1	0	6
Diagnostic Incident including delay	2	1	0	0	0	1	1	5
Failure to source a tier 4 bed for a child	0	0	0	1	0	0	0	1
Failure to meet expected target (12 hr trolley breach)	0	0	0	0	0	0	1	1
Maternity/Obstetric incident mother and baby (includes foetus	1	1	1	0	0	2	1	6
Maternity/Obstetric incident mother only	0	0	0	0	1	0	1	2
Medical disposables incident meeting SI criteria	0	0	0	0	0	0	1	1
Nasogastric tube	0	0	0	0	0	0	1	1
Slip/Trips/Falls	0	0	0	1	0	0	0	1
Sub optimal Care	0	0	0	0	0	0	1	1
Treatment Delay	0	0	0	0	0	0	1	1
Unexpected death	0	1	0	1	0	1	0	3
Retained foreign object	0	0	0	0	0	1	0	1
Total	4	6	3	3	3	6	9	**34**

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 occurrences.

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 October 2016.

Lessons learnt 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 3 reports to NELCSU during October 2016.**

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

Summary	Actions taken as result of lessons learnt
• **Ref.19498**	**Unwitnessed patient falls resulting in a fractured right and left shoulder.** • A falls risk assessment is now available on Anglia Ice which can be monitored to make sure this is being used effectively. • The Trust delirium policy is being updated to ensure clear guidance on appropriate use of sedation • The Trust bed management policy is being reviewed with respect to closer liaison with individual wards re: patient acuity and dependency.
• **Ref:19479**	**Lack of Tier 4 bed availability.** • The Trust is liaising with NHS England to develop a more systematic approach to sourcing Tier 4 beds. • A specific mental health pathway for children and young people is being developed. • The Childrens ICSU is developing an observation protocol for use by agency nurses when providing 1-1 'specialing' of young people presenting with psychiatric disorders.

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.

Whittington Health NHS

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Whittington Health Trust Board

7 December 2016

Title:	Safe Staffing - Nursing and Midwifery – October data		
Agenda item:	**16/158**	**Paper**	**05**
Action requested:	For information		
Executive Summary:	This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in October 2016. Key issues to note include: 1. A reduced fill rate for Registered Nurses displayed in the UNIFY report 2. Decrease use of special shifts used to support vulnerable patients October (115) vs September (215) 3. Slight increase in the number of Red Shifts reported in October (4) compared to September (3) 4. The number of RMN 'specials' used to care for patients with a mental health conditions was lower in October (2) compared to September (46). 5. CHPPD measure during the month was reduced from Sept (8.84) compared to October (8.64) 6. The continued use of agency and bank staff to support safe staffing		
Summary of recommendations:	Trust Board members are asked to note the October 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:	November 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 October 2016.

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

1.3 To provide assurance of the constant review of nursing/midwifery resource using Healthroster.

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 HealthRoster (Allocate) with its 'SafeCare' 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 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 September 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 October 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 - 93.8% Night - 95.8%
	Care hours per Patient Day - CHPPD	Overall 8.64 CHPPD was for October and is lower than last month but the RN delivered care continues to be consistent
Staff are supported in their decision making by effective reporting.	% of Red triggered shifts	4 shifts triggered red in October 2016 this was a slight increase from that of September 2016 (0.3%)
	% of shifts that remained partially mitigated (Amber shifts)	153 shift's i.e. 10.9% of all shifts in month. This was an increase on September's figure (68). These consisted of shifts mainly during the day distributed between early and

3.0 Fill rate indicator return

3.1 The 'actual' number of staffing hours planned is taken directly from the 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 the 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 93.8% for registered staff and 111.2% for care staff during the day and 95.8% for registered staff and 128.4% for care staff during the night.

3.3 On the day shift, six wards reported below 90% fill rates for qualified nurses. Eleven wards had above 100% fill rate for care staff and ten wards had above 100% fill rate for qualified nurses.

3.4 The UNIFY report shows some wards with unusually high percentage fill rates; for example, Nightingale ward at (HCA) 230%. This is due to the managed process of ensuring all wards are staffed to a safe and effective level for the acuity of the patients and the availability of staff on different days. Where the percentages are low for Registered Nurses they are correspondingly high for Healthcare Assistants and vice versa. This is a professional decision which is taken by the Matron depending on the needs of the specific patient group.
It must be remembered if the establishment of the ward for HCA's is 1 wte and two staff work then it is 100% increase.

3.5 Some wards (Montouchi, Mary Seacole South and Nightingale) have high levels of Healthcare Assistants. This is due to the recent introduction of European nurses waiting for their PIN numbers before they are allowed to work as registered nurses and currently filling Registered nurse vacancies.

Day		Night	
Average fill rate registered Nurses /Midwives	Average fill rate Care Staff	Average fill rate registered Nurses/Midwives	Average fill rate Care Staff
93.8%	111.2%	95.8%	128.4%

4.0 Additional Staff (Specials 1:1)

4.1 When comparing October's total requirement for 1:1 'specials' with previous month, the figures demonstrate a decrease in the number of shifts required (Appendix 2). October saw 115 requests for 1:1 specials compared to 215 requests in September. 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 October (2) compared to September (46). 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 October 4 shifts triggering red.

Month	% shifts triggering red in month	Actual number of red shifts
October	0.3	4
September	0.2	3
August 16	0.7	10

5.4 Wards triggering red shift

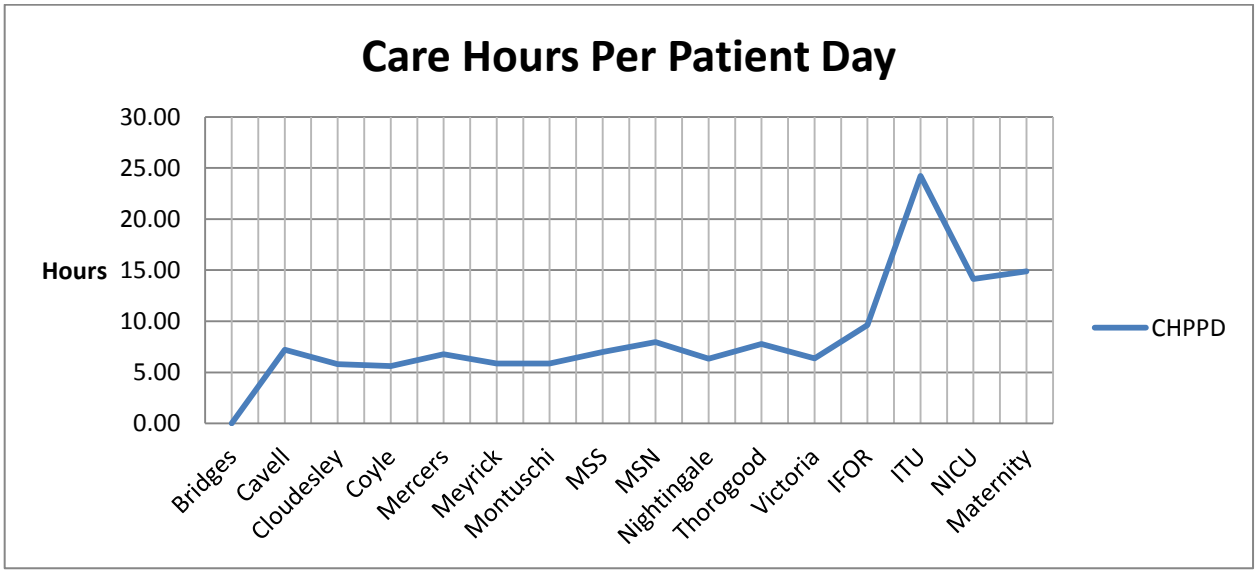
	Initial Red Shifts				
Wards	**Early**	**Late**	**Night**	**Number of shifts where staffing initially fell below agreed levels**	**% of shifts where staffing fell below agreed levels and triggered a red rating**
Mercers	1	1	0	2	**2.0**
Coyle	1	1	0	2	**2.0**

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 (24.23) and Coyle ward have the least (5.62).



6.2 The average number of hours of Registered Nurse time spent with patients was calculated at

6.45 hours and 2.19 hours for care staff. This provides an overall average of 8.64 hours of care per patient day.

	CHPPD
Registered Nurse	**6.45**
Care Staff	**2.19**
Overall hours	**8.64**

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 SaferCare module of Healthroster 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 five months has remained similar. Each ward maintained a high level of care hours delivery when comparing the total registered nurses hours available.

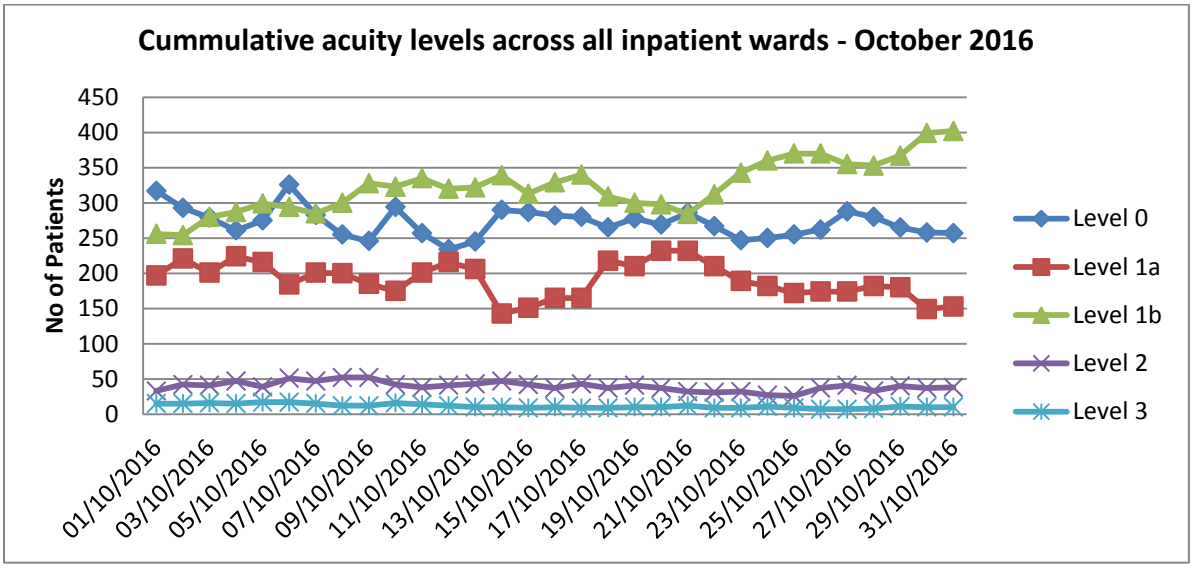
6.6 The table below shows the CHPPD hours for each in patient ward over the last four months and indicates the level of need remained stable overall. There is a slight decrease in hours of care delivered in October compared to September.

Ward Name	Oct	Sept	Aug	July
Bridges				
Cavell (bridges rehab)	7.20	8.66	7.74	7.78
Cloudesley	5.80	6.10	6.14	5.85
Coyle	5.62	5.88	5.88	6.46
Mercers	6.78	8.86	6.98	7.55
Meyrick	5.87	5.41	5.46	5.55
Montuschi	5.86	6.99	6.23	6.52
MSS	6.98	7.72	8.34	7.90
MSN	7.95	9.17	10.04	9.91
Nightingale	6.33	5.47	5.81	5.50
Thorogood	7.78	4.28	9.08	9.38
Victoria	6.35	6.15	6.56	6.14
IFOR	9.62	10.74	12.76	10.02
ITU	24.23	26.12	24.95	25.15
NICU	14.13	12.53	10.33	10.69
Maternity	14.90	13.95	16.19	11.73
Total	8.64	8.76	9.01	8.52

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 a patient is requiring a high level of nursing support. Many patients required total support with 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 October. 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 remains high. This increased number of dependant patients require a greater nursing support.



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.

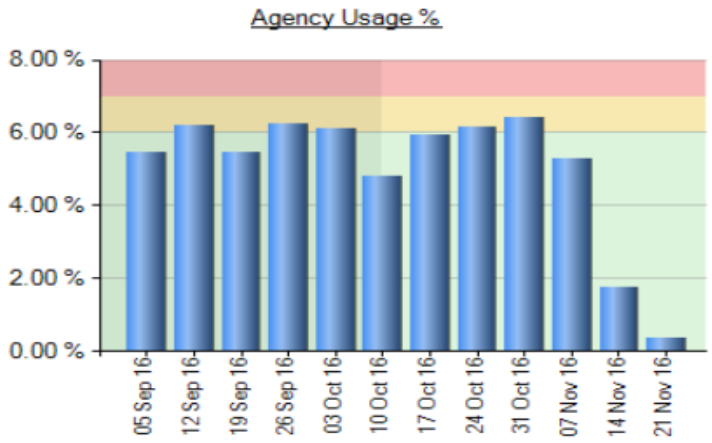
8.2 Monitoring the request for temporary staff in this way serves two purposes:

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 (September to date)

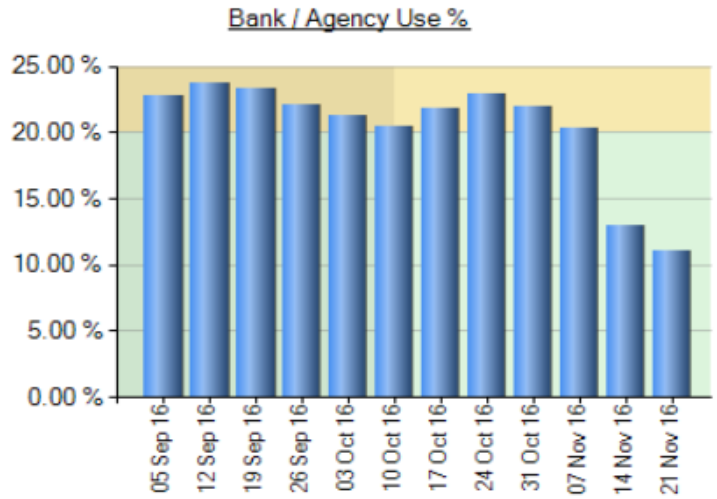
9.1 The utilisation of agency staff across all inpatient wards is monitored using the Healthroster system. The bar chart overleaf graphically represents total usage of agency staff on inpatient wards October to date (this is cumulative data captured from roster performance reports).



9.2 A key performance indicator (KPI) of less than 6% agency usage was set to coincide with the NHS England agency cap. The percentage continues to fluctuate close to the agreed 6% target

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

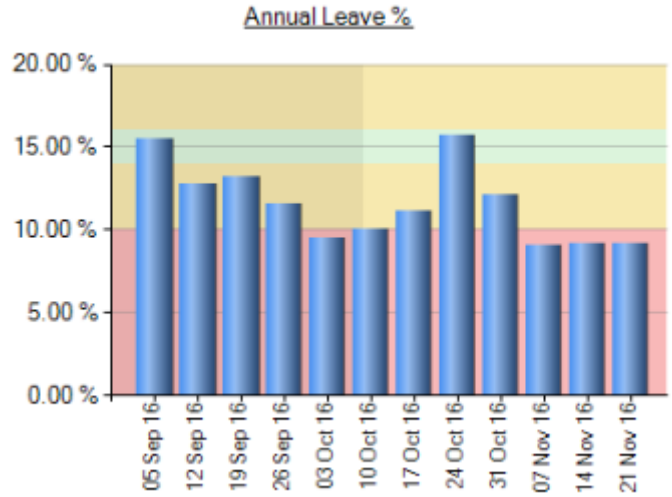
9.4 Temporary staffing usage (Bank and Agency) across inpatients wards remains high and fluctuates between 20 – 24%. Recruitment to reduce the current vacant posts is ongoing.



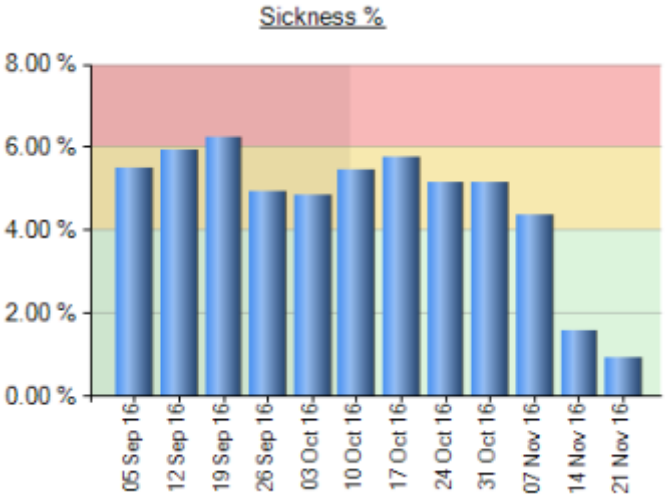
10.0 Managing Staff Resource

10.1 Annual leave taken from October to date is below the set tolerance of 14 -16%. This set tolerance level ensures all staff are allocated leave appropriately and ensures an even distribution of staff are available throughout the year.

10.2 Heads of Nursing are aware of the need to remind staff to request and take their full annual leave entitlement. This will be monitored closely over the next couple of months to ensure sufficient staff take annual leave in a more consistent way.



10.3 Sick leave reported in October was above the set parameter of less than 4%. Heads of Nursing ensure all individuals reporting back from sick leave undergo a sickness review. The data for sickness also includes 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 October UNIFY return position

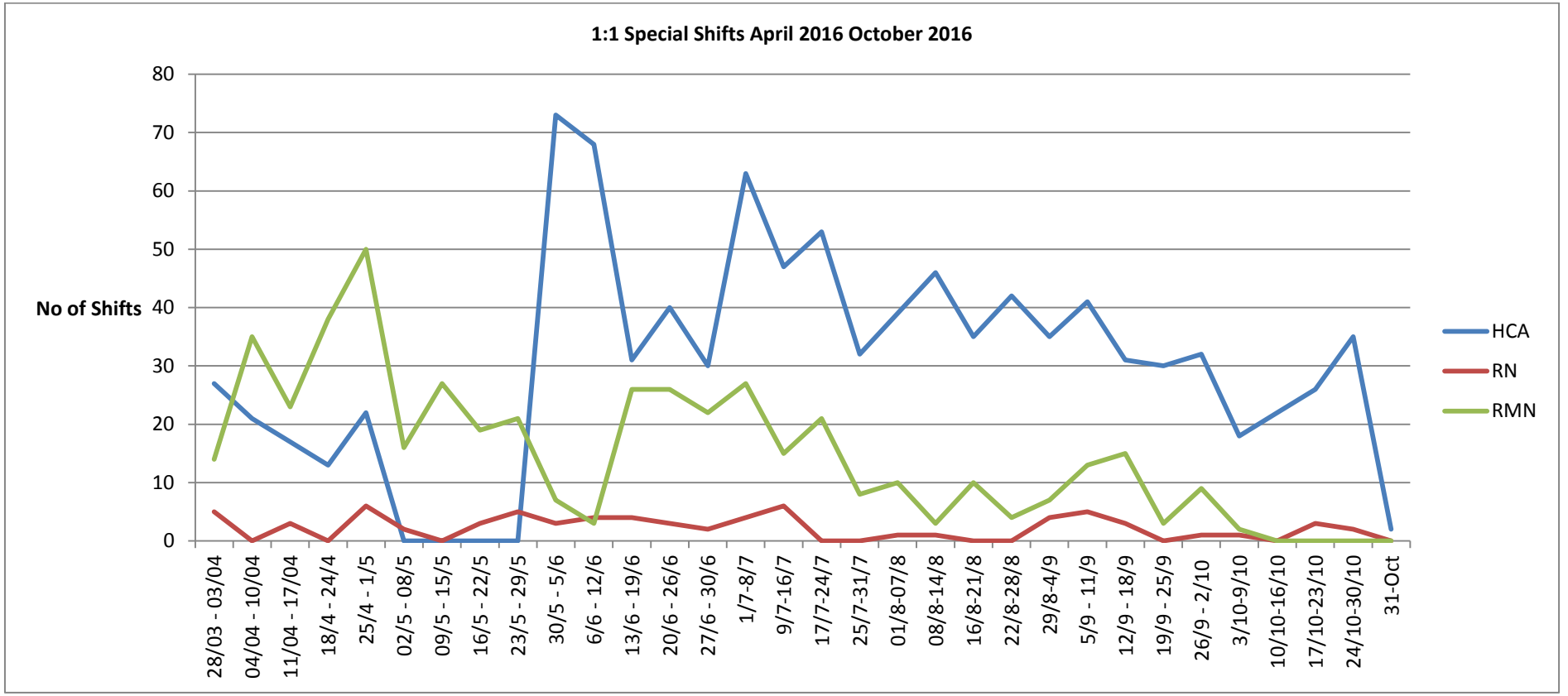
Updated tables

Fill rate data - summary
October 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)				
33622	31541	9714	10803	27540	26385	6873	8827	93.8%	111.2%	95.8%	128.4%

Care Hours per Patient Day
October 2016

Total Patients at Midnight/Month	CHPPD Registered staff	CHPPD Unregistered staff	Average CHPPD (all staff)
8978	6.45	2.19	8.64


1:1 Special Shifts April 2016 October 2016
No of Shifts
80
70
60
50
40
30
20
10
0
28/03 - 03/04
04/04 - 10/04
11/04 - 17/04
18/4 - 24/4
25/4 - 1/5
02/5 - 08/5
09/5 - 15/5
16/5 - 22/5
23/5 - 29/5
30/5 - 5/6
6/6 - 12/6
13/6 - 19/6
20/6 - 26/6
27/6 - 30/6
1/7-8/7
9/7-16/7
17/7-24/7
25/7-31/7
01/8-07/8
08/8-14/8
16/8-21/8
22/8-28/8
29/8-4/9
5/9 - 11/9
12/9 - 18/9
19/9 - 25/9
26/9 - 2/10
3/10-9/10
10/10-16/10
17/10-23/10
24/10-30/10
31-Oct
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	104.7%	82.5%	101.5%	117.7%
Cloudesley	96.0%	101.5%	107.8%	146.6%
Coyle	100.3%	76.6%	146.3%	105.9%
Mercers	84.4%	110.8%	100.4%	92.7%
Meyrick	95.5%	108.4%	106.8%	140.9%
Montuschi	79.0%	186.7%	108.3%	NA
MSS	86.8%	141.7%	85.9%	154.1%
MSN	84.2%	105.9%	98.3%	169.8%
Nightingale	77.8%	230.4%	83.5%	247.9%
Thorogood	99.9%	82.3%	99.6%	150.0%
Victoria	98.4%	118.5%	95.1%	134.4%
IFOR	98.6%	100.0%	91.9%	100.0%
ITU	100.0%	100.0%	100.0%	0.0%
NICU	85.4%	0.0%	80.6%	NA
Maternity	100.4%	111.8%	92.6%	94.8%
Average	93.8%	111.2%	95.8%	128.4%

Whittington Health NHS Trust

Trust Board Public

7 December 2016

Title:	North Central London Sustainability and Transformation Plan		
Agenda item:	**16/159**	**Paper**	**06**
Executive Summary:	This report provides an overview of the published North Central London (NCL) Sustainability and Transformation Plan (STP). The documents appended are: • The draft NCL STP strategic narrative submitted to NHS England on 21 October 2016 • The NCL STP summary document		
Summary of recommendations:	The Trust Board is asked to: • Note the North Central London Sustainability and Transformation Plan • Support the direction of travel and priorities for improving services and outcomes set out in the STP • Comment on next steps		
Fit with WH strategy:	Aligns with clinical strategy and population health approach		
Reference to related / other documents:	Aligns to NHSE 5 Year Forward View		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Trust BAF		
Date paper completed:	November 2016		

Author name and title:		**NCL central PMO SRO David Stout**		**Director name and title:**		**Simon Pleydell, Chief Executive Officer**	
Date paper seen by EC	**11/16**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Introduction
This report provides an overview of the published North Central London (NCL) Sustainability and Transformation Plan (STP).

The documents submitted are appended to this cover note and are:

- The draft NCL STP strategic narrative submitted to NHS England on 21 October 2016;
- NCL STP summary document

Sustainability and Transformation Plan
The draft Sustainability and Transformation Plan (STP) has been produced by all the main healthcare organisations and local authorities within North Central London. It sets out plans to meet the challenges faced locally and to deliver high quality and sustainable services in the years to come.

The vision for the STP is for North Central London to be a place with the best possible health and wellbeing, where no one gets left behind.

The clinical case for change within the STP describes the changing health and care needs of local people and the key issues facing health and care services in North Central London. It will be used to guide the transformation of local services over the next five years.

The clinical case for change in the STP is aligned to address the gaps identified in the Five Year Forward Plan for health and wellbeing, care and quality, and finance.

To support delivery of the vision for the STP and address the clinical case for change a programme of transformation has been designed with four fundamental aspects:

- **Prevention:** We will increase our efforts on prevention and early intervention to improve health and wellbeing outcomes for our whole population;
- **Service transformation:** To meet the changing needs of our population we will transform the way that we deliver services;
- **Productivity:** We will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies, including working together across organisations to identify opportunities to deliver better productivity at scale;
- **Enablers:** We will build capacity in digital, workforce, estates and new commissioning and delivery models to enable transformation.

Delivering these plans will result in improved outcomes and experience for the local population, increased quality of services and significant savings.

The STP is still work in progress. Despite the development of the plans for prevention, service transformation, productivity and enablers the draft STP submitted on 21 October 2016 showed an overall £75m deficit in 2020/21 across NHS organisations. A number of areas for further work have been identified between now and Christmas where additional savings can be found to address this residual gap.

To ensure overall delivery as a system, a robust governance structure is being developed to enable NHS and local government partners to work together in new ways to drive implementation.

It is crucial that the whole system is aligned around delivery of the STP and work is underway to ensure that the development of the two-year health contracts that are being put in place for 2017/18 - 2018/19 are consistent with the STP strategic framework.

There is more work to do to finalise the granular detail of our delivery plans and address the residual challenge forecast. Development of plans in more detail will involve full engagement of people who use services and the public to ensure those plans are reflective of their needs. There is a commitment to being radical in approach, to focusing on improving population health and delivering the best care in London. Our population deserves this, and we are confident that we can deliver it.

The draft North Central London Sustainability and Transformation Plan therefore articulates:

- The health and social care landscape, and its complexity;
- The collective understanding of the challenges faced through the clinical case for change;
- The vision for health and care in NCL in 2020/21;
- The plans to deliver the vision and address the challenges, and the delivery framework that will enable implementation of those plans;
- The impact expect to be achieved through the delivery of the plans;
- Supporting governance arrangements;
- Plans for securing broader public support and engagement with the STP proposals;
- Next steps for further developing proposals and responding to our residual financial gap.

Workstream delivery plans
Submission of the draft NCL Sustainability and Transformation Plan is supported by the development of workstream delivery plans.

The workstreams focus on identified priorities for joint working across North Central London and focus on:

1. **Prevention:** We will increase our efforts on prevention and early intervention to improve health and wellbeing outcomes for our whole population:
   - This includes a focus on population health, particularly in areas that will support improved outcomes and reduced costs within the five-year period of the STP – smoking, alcohol ,obesity, falls and sexual health (use of long-term contraception and earlier diagnosis of HIV);
   - A focus on a workforce for prevention including mental health first aid, dementia awareness, and the making every contact count programme;
   - A focus on healthier environments including workplace wellbeing and an environment to help reduce childhood obesity.

2. **Service transformation:** To meet the changing needs of our population we will transform the way that we deliver services:
   - A focus on developing out of hospital services and providing health and care closer to home. This includes the development of urgent care and primary care services;
   - Development of mental health services for adults and children;
   - Urgent and emergency care including an integrated urgent care system;
   - Optimising elective care pathways including outpatient activity;
   - Consolidation and/or networking of services following the previous template in London for stroke and trauma services;
   - Cancer pathways including earlier diagnosis and improving patient experience.

3. **Productivity:** We will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies, including working together across organisations to identify opportunities to deliver better productivity at scale through a focus on:
   - Workforce (skill-mix; shared recruitment and bank functions, increase retention);

- Reducing operational and clinical variation including a response to recommendations in the Carter Report;
- Procurement efficiencies by acting at scale;
- Sharing back office functions;
- Reducing contract and transaction costs including new commissioning and contract models;
- Cost improvement schemes including theatre productivity.

4. **Enablers:** We will build capacity in digital, workforce, estates and new commissioning and delivery models to enable transformation. This will be dome through workstreams for:
   - Workforce including the use of integrated employment models, developing new roles to support new models of care, and enabling productivity opportunities;
   - Digital maturity including interoperability across providers as envisaged with the "Care My Way" programme in Islington;
   - Estates including developing an overarching estates strategy, optimising the use and quality of estate across health and care services, supporting delivery of new models of care by delivering linked improvements to the health and care estate, and creating partnership working between commissioners and providers to align incentives for estate release and support delivery of devolved estates powers for the NHS and partners.

5. **Patient & public engagement:** We have a commitment to work in an open and transparent way. The STP summary has been produced to support further engagement, in recognition that the full STP is a technical planning document. All organisations involved in the STP are asked to publish the full strategic narrative and summary on their websites to stimulate feedback and engagement with patients, the public, staff and other stakeholders. We recognise that engagement on the overall STP to date has been limited to the stakeholder meetings held in each borough in September, although individual STP workstreams such as mental health have also engaged users of service in the development of their plans. We will now develop an STP workstream on communications and engagement to ensure we build active and effective engagement into the further development and delivery of the STP.

6. **Recommendations**

The Board is asked to

- Note the North Central London Sustainability and Transformation Plan
- Support the direction of travel and priorities for improving services and outcomes set out in the STP
- Comment on next steps

Appended

The documents appended to this report are
- NCL STP
- NCL STP summary document

North Central London Sustainability and Transformation Plan

North Central London Sustainability and Transformation Plan

21 October 2016

DRAFT

Key information
Name of footprint and number: North Central London, no. 28 **Nominated lead of the footprint:** David Sloman, Chief Executive, The Royal Free NHS FT **Organisations within footprint:** CCGs: Camden, Barnet, Islington, Haringey, Enfield LAs: Camden, Barnet, Islington, Haringey, Enfield Providers: Barnet, Enfield and Haringey Mental Health NHS Trust, Camden and Islington NHS FT, Central London Community Healthcare NHS Trust, Central and North West London NHS FT, Moorfields Eye Hospital NHS FT, North Middlesex University Hospital NHS Trust, Royal Free London NHS FT, Royal National Orthopaedic Hospital NHS Trust, Tavistock and Portman NHS FT, University College London Hospitals NHS FT, Whittington Health NHS Trust

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1 Foreword

Welcome to the Sustainability and Transformation Plan (STP) for the health and social care services that serve the population of North Central London (NCL). The aim of the STP is to ensure NCL is a place with the best possible health and wellbeing, where no one gets left behind.

This STP is a work in progress and we welcome your comments and input as we further develop the plans.

For the first time, we have come together as health and social care partners to plan how we will deliver excellent, future-proofed services for our local population over the next 5 years.

We know that the health and social care needs of our local people are changing, and that there are serious issues facing health and care services in NCL. People receive different care depending on where they go to obtain it: waiting times for services and health outcomes vary, and the quality of care and people's experience of health and social services is sometimes not as good as it could be.

On top of this, our financial situation remains challenging. Demand for health and social care continues to grow year on year and the growth in demand is running faster than the growth in funding. If we do nothing, we estimate that we would face an unprecedented financial gap in relation to health services alone of nearly £900m in NCL by 2020/21. In addition, as is well known, the trend is for people to live longer and in turn this is creating pressure on social care services and funding.

We believe the best approach to meeting these challenges is to work together to tackle them head on, working together to find solutions at scale and aligning as a system around the interests of local people rather than solely focusing on our individual organisations. It takes time to build relationships and trust in the context of a system that is fragmented and under increasing pressure, but we are committed to this joint endeavour across the whole partnership.

The STP sets out our commitment to transforming care to deliver the best possible health outcomes for our local population; shifting our model of care so that more people are cared for in out of hospital settings - through prevention, more proactive care, and new models of care delivery – and reducing reliance use of secondary care. We have made significant progress in developing our specific ideas for how we will achieve this. We have set up 13 different workstreams and have worked hard on these over the last few months to develop thinking, building on evidence and involving hundreds of members of staff drawn from every organisation in NCL. We have held public meetings in each of the boroughs to start to develop a dialogue with the local community, although we recognise there is much more to do on engagement in the months ahead.

The plan sets out a mixture of both radical service transformation and incremental improvements we believe we need to make in order to deliver real benefits for our population: increasing the emphasis on prevention; shifting care closer to home to reduce demand on hospitals; reducing variation in quality; improving productivity and reducing waste.

But the plan as it stands does not have all the answers. There are some parts of the plan which we have not had time to develop in detail that require significantly more work. We recognise the sheer scale of the changes that we set out currently in the plan will stretch our capacity to deliver, so we need to stress test the plan to ensure we focus on the most important improvement first. And fundamentally the plan does not yet balance the finances, either next year or by 2020/21. Unless we can do so, we will not be able to afford all of the investments and improvements we aspire to deliver. As a result we know that we may face some really tough decisions about where we can invest for improvement and where we will need to prioritise or make choices.

We need to resolve these questions between now and Christmas. We will ensure we are prioritising the areas which will add the most value (in terms of increasing health and wellbeing for people; improving the quality of care people receive; and ensuring value for tax payers' money) to focus our energies on achieving maximum benefit. This will include trying to attract as much investment into NCL as possible. We will continue to develop further ideas in the parts of the plan which are not fully developed. And we will review the phasing of our specific priorities for the first 2 years of our plan in the context of the significant financial challenge we face, seeking specifically to identify areas where we can go further and faster, and areas where we can defer our investment or effort.

We recognise there is much more work to do, and it is crucial that our local residents are involved in this. We are at the beginning of truly transforming care for our population, which will require significant input and contribution from the people who use services in NCL. We look forward to working with our local population to make designing and implementing the plan a success as it evolves.

2 Executive summary

There are some excellent health and care services in North Central London (NCL). However, services are not consistent and there are examples of poor practice. We also face significant challenges over the next five years and need to shift our model of care so that more people are cared for in out of hospital settings. This Sustainability and Transformation Plan (STP) has been produced by all the main healthcare organisations and local authorities within NCL. It sets out how we are planning to meet the challenges we face and deliver high quality and sustainable services in the years to come.

We know from our track record that we have the capability to deliver excellent services and to deliver significant change. However, we are not currently able to deliver services across NCL consistently to the standards we would like. We also face a number of significant challenges around the health and wellbeing of local people; and the care and quality of our services. Our current system is focussed on dealing with illness, rather than orientated to prevention and helping people to live well. There is a substantial financial challenge facing health organisations in NCL; the health system is already in deficit and, if nothing changes, this will worsen over the next 5 years meaning that by 2020/21 we estimate we will be c.£900m in deficit. Local authorities are also facing significant financial pressures due to demographic changes and policy inflation: by 2020/21 the combinations of pressures and continued loss of funding will result in a combined social care budget gap of c.£300m.

Our vision is for NCL to be a place with the best possible health and wellbeing, where no one gets left behind. To deliver on our vision, we have designed a programme of transformation with 4 fundamental aspects:

1. **Prevention:** We will increase our efforts on prevention and early intervention to improve health and wellbeing outcomes for our whole population.

2. **Service transformation:** To meet the changing needs of our population we will transform the way that we deliver services.

3. **Productivity:** We will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies, including working together across organisations to identify opportunities to deliver better productivity at scale.

4. **Enablers:** We will build capacity in digital, workforce, estates and new commissioning and delivery models to enable transformation.

Delivering these plans will result in improved outcomes and experience for our local population, increased quality of services and significant savings.

Despite this, we currently expect that the overall financial position of NHS organisations will be a £75m deficit in 2020/21. We have identified a number of areas for further work between now and Christmas where we believe there may be additional savings to be found that would address this residual gap.

To ensure we are able to deliver as a system, building on the progress we have made to date we will develop a robust governance structure which enables NHS and local government partners to work together in new ways to drive implementation. We will put in place dedicated resources to support delivery. It is crucial that whole system is aligned around delivery of the STP and we will ensure that the development of the 2 year health contracts that are being put in place for 2017/18 - 2018/19 are consistent with the STP strategic framework.

We recognise there is more work to do to finalise the granular detail of our delivery plans and address the residual challenge we are forecasting. To develop our plans in more detail we want to fully engage people who use services and the public in our thinking to ensure they are reflective of their needs. We are committed to being radical in our approach, focusing on improving population health and delivering the best care in London. Our population deserves this, and we are confident that we can deliver it.

3 Context

North Central London (NCL) comprises five Clinical Commissioning Groups (CCGs): Barnet, Camden, Enfield, Haringey and Islington, each of which is coterminous with the local London Boroughs. Approximately 1.45m[1] live in the 5 boroughs. We spend c.£2.5bn on health and c.£800m[2] on adult and children's social care and public health. The population is diverse and highly mobile, with a large number of people living in deprivation[3].

There are four acute trusts within NCL: The Royal Free London NHS Foundation Trust (sites include Barnet Hospital, Chase Farm Hospital and the Royal Free Hospital in Hampstead), University College London Hospitals NHS Foundation Trust, North Middlesex University Hospital NHS Trust, and Whittington Health NHS Trust. There are two single specialist hospitals: Moorfields Eye Hospital NHS Foundation Trust and the Royal National Orthopaedic Hospital NHS Trust. Great Ormond Street Hospital for Children NHS Foundation Trust is within the NCL geography, but currently out of the scope of the STP. Community services are provided by Central and North West London NHS Foundation Trust, the Whittington Health NHS Trust, and Central London Community Healthcare NHS Trust.

Mental health services are provided by the Tavistock and Portman NHS Foundation Trust, Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health NHS Trust. There are 220[4] GP practices, and the out-of-hours services contract was recently awarded to the London Central and West Unscheduled Care Collaborative. There are 497 active social care sites registered across NCL, including 273 registered care homes (47 of which provide nursing)[5]. Care homes are particularly high in numbers in the north of NCL, for example in Enfield where there are 97 registered care homes (in contrast to the 12 care homes registered in Camden)[6]. In addition, there are 214 registered domiciliary care providers[7].

The organisation of services in NCL makes the area quite unique and this has ramifications for planning: there is a particularly high concentration of specialised services across multiple providers covering a small geographic area. This means many of the patients treated in NCL do not live in NCL and consequentially, a large proportion of the income paid to our providers comes from commissioners outside of the area.

As individual organisations in NCL, we have a history of working together in different ways to meet the needs of our population, and there are numerous excellent examples of collaboration as a result. However, working collectively across all organisations remains a relatively new endeavour and we continue to build the trust required to enable us to do so.

[1] ONS, Mid-year population estimates, 2015
[2] 2015/16
[3] Office for national statistics, IMD 2015
[4] Latest figures from NHS England, updated since publication of the NCL case for change
[5] Local Authority Care Quality Commission reports, 2016
[6] Local Authority Care Quality Commission reports, 2016
[7] Local Authority Care Quality Commission reports, 2016

We are home to 4 national Vanguards: The Royal Free London NHS Foundation Trust is developing a provider chain model; University College London Hospitals NHS Foundation Trust Vanguard is focused on what can be done to improve the end-to-end experience for people with cancer; Moorfields Eye Hospital NHS Foundation Trust is developing an ophthalmology specialty chain; and, the Royal National Orthopaedic Hospital NHS Trust is one of 13 partners developing a UK-wide chain of orthopaedic providers. NCL is also home to two devolution pilots: one seeking to optimise the use of health and social care estate, and another focused on prevention in Haringey. In primary care, GP practices are already working together in a number of GP Federations to provide extended services to our residents.

In NCL, every borough has its own unique identity and local assets we can build on. Many people lead healthy lives, but if they do get sick we can offer some of the best care in the country. We have a reputation for world class performance in research and the application of innovation and best practice, and we can harness the intellectual capacity of our workforce to ensure the best outcomes are delivered. There are many examples of excellent practice across health and social care in our area, which we intend to use to help ensure that excellent practice can be offered to all our residents.

Our track record demonstrates that we have the capability to deliver excellent services and also to significantly change our services when needed. Our ambition is that everyone is able to get the care they need when they need it. This means ensuring people have the best start in life, and supporting them to live healthy lives. When people do need specialist care, we want them to be able to access it quickly and in the most appropriate setting, and to be fully supported to recover in the setting most suited to their needs.

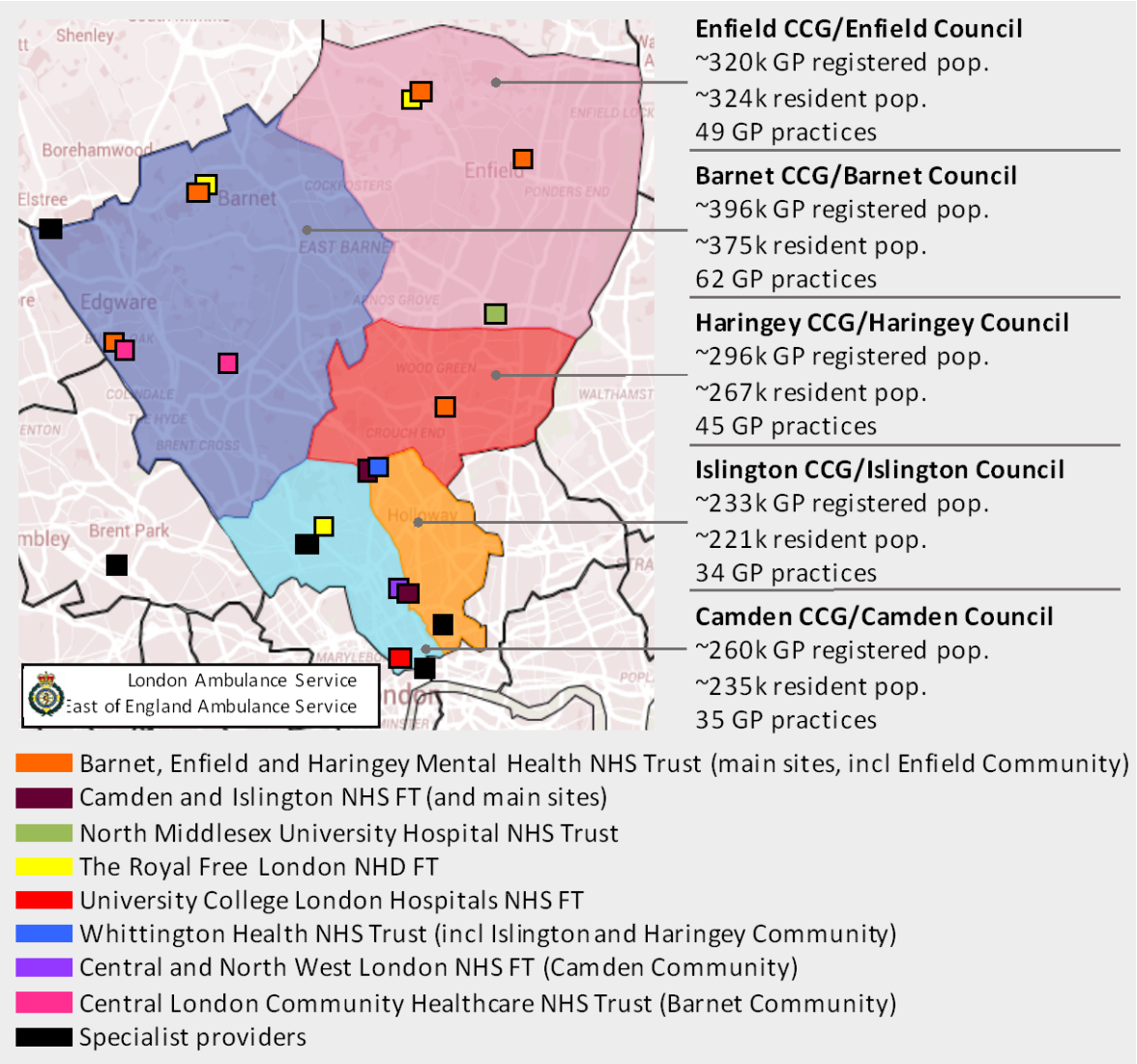
However, we are not consistently delivering our ambition to the standards we would like. We face significant challenges around the health and wellbeing outcomes for our population, the quality of our services and the financial sustainability of the health and care system. These are outlined in this document and set out in more detail in our case for change[8].

The national requirement to produce an STP is an opportunity for the NCL system to address these challenges together and widen the scope of our collaborative working. This document articulates:

- our collective understanding of the challenges we face
- our vision for health and care in NCL in 2020/21
- the plans to deliver on our vision and address the challenges
- the delivery framework which will enable us to implement our plan
- the impact we expect to achieve through the delivery of our plans
- our plans for securing broader public support and engagement with our proposals
- our next steps for further developing proposals and responding to our residual financial gap.

[8] https://www.uclh.nhs.uk/News/Documents/NCL%20case%20for%20change.September%202016.pdf

Exhibit 1: Overview of NCL



Source: Population figures from 2014 ONS data.

4 Case for change: our challenges and priorities

In NCL we share many of the same challenges faced by health and care organisations across the UK (and indeed internationally). We have undertaken significant work to identify, articulate and quantify the specific gaps in health and wellbeing; care and quality; and our baseline financial position. Across the system we have aligned behind this work and we all agree on the nature and scale of the challenge, which we have described in our case for change which was published in September 2016.

4.1 Health and wellbeing gap

We have a diverse and highly mobile population. There are people from a range of Black and Minority Ethnic (BME) groups: these groups have differing health needs and health risks. A quarter of our local people do not have English as their main language[9], which creates challenges for the effective delivery of health and care services. The mobility of our population, with 8% of local people moving into or out of NCL each year[10], has a significant impact on access to services and delivery.

Poverty is a crucial determinant of health, and is widespread among both adults and children living in the boroughs that make up NCL[11]. Significant inequalities exist, which need to be addressed; for example, men in the most deprived areas of Camden live on average 10 years fewer than those in the least deprived areas[12]. We face challenges in addressing other wider determinants of health, for example, there are high levels of homelessness and households in temporary housing with all five boroughs in the top 10% for number of households in temporary accommodation[13]. Social isolation also remains a critical issue across the sub-region.

The children of NCL do not always get the best start to life. 30% of children grow up in child poverty and 6% live in households where no one works. 60 children take up smoking every day[14]. Although there have been some improvements recently, London as a whole has the highest rates of obesity nationally: 1 in 3 children are obese in Year 6 (age 11) and we need to do more to tackle this, particularly working with the schools in NCL[15]. Although many of our residents are healthy and people are living for longer, good health does not always persist into old age. Our older people are living the last 20 years of their life in worse health than the England average[16].

Almost half of people in NCL have at least one lifestyle-related clinical problem (e.g. high blood pressure) that is putting their health at risk[17]. However, they have not yet developed

[9] NCL case for change, 2016
[10] ONS mid-year population estimates 2014
[11] Census 2011
[12] IMD 2015, ONS
[13] https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness
[14] CENSUS 2011
[15] Public health outcomes framework tool, 2015
[16] Office for National Statistics, HSCIC CCG Indicators, 2014-15
[17] Camden and Islington GP Linked Dataset projected to NCL level

a long term health condition. Many of these lifestyle-related clinical problems are risk factors for NCL's biggest killers - circulatory diseases and cancer. These diseases are also the biggest contributors to the differences which exist in life expectancy.

There are high rates of mental illness amongst both adults and children in NCL[18], and many conditions go undiagnosed[19]. 50% of all mental illness in adults begins before 14 years of age and 75% by 18[20]. Children with mothers with mental ill health are much more likely to develop mental health issues themselves. Three of our boroughs have the highest rates of child mental health admissions in London[21] There are high rates of early death amongst those with mental health conditions[22], particularly in Haringey and Islington, and the rate of inpatient admissions amongst this population is above the national average. A strong focus on mental health is central to our approach with a clear aim of treating mental and physical ill health in a joined up way and with "parity of esteem."

4.2 Care and quality gap

Currently, our system does not sufficiently invest in those people with a life-style related clinical problem, which would help stop them from developing the long term conditions which in aggregate are a huge burden on our health and care system. Only 3% of health and social care funding is spent on public health in NCL[23], and that is despite evidence showing that between 2012 and 2014 around 20% (4,628) of deaths in NCL could have been prevented[24]. There is a large opportunity in refocusing our efforts towards prevention and making every contact count. This focus should also address the wider determinants of health such as poverty, housing and employment, all of which have a significant impact on individuals' health and wellbeing.

Disease and illness could be detected and managed much earlier, and managed better in community. It is thought that there are around 20,000 people in NCL who do not know they have diabetes, while 13% of the population are thought to be living with hypertension[25]. It is likely that people are being treated in hospital for long term conditions (LTCs) when they could be better managed by individuals themselves with the support of professionals in the community. Many people with LTCs – over 40% in Barnet, Haringey and Enfield – do not feel supported to manage their condition[26]. This would help avoid the high levels of hospitalisation we experience for the elderly and those with chronic conditions.

One of the disease specific challenges we face is in the provision of cancer care. Late diagnosis of cancers is a particular issue, alongside low levels of screening for cancer and low awareness of the symptoms of cancer in some minority ethnic groups. Waiting times to

[18] QOF data 2014/15
[19] NHS England Dementia Diagnosis Monthly Workbook, April 2016
[20] Dunedin Multidisciplinary Health & Development Research Unit. Welcome to the Dunedin Multidisciplinary Health and Development Research Unit (DMHDRU).
[21] Fingertips, 2014/15
[22] Healthy Lives, Healthy People 2010
[23] Based on 2015/16 public health budget of each NCL council
[24] Public Health Profiles Data Tool, PHE, 2012-14
[25] QOF 2014/15
[26] Office for National Statistics, HSCIC CCG Indicators, 2014-15

see a specialist are long, and so are waiting times for diagnostics. Additionally, referrals to specialists have almost doubled in five years. There is a huge shortfall in diagnostic equipment and workforce, and a lack of services in the community, particularly at weekends. A further issue is that some hospitals are seeing small numbers of patients with some types of cancer, in some cases less than two per week.

There are some challenges in primary care provision, however, this is a mixed picture which creates inequity. There are too few GPs in Barnet, Enfield and Haringey, and low numbers of registered practice nurses per person across all areas, but particularly in Camden and Haringey.

There are high levels of A&E attendances across NCL compared to national and peer averages[27], and very high levels of first outpatient attendances[28], which indicate potential gaps in primary care provision. Acute providers are not consistently meeting emergency standards.

In the acute setting there are differences in the way that planned care is delivered and this needs to be addressed, with variation based on differences in clinical practice rather than patient need. The number of people seen as outpatients in NCL is high and there is variation in the number of referrals between consultants in the same hospital, the number of follow-up outpatient appointments and the proportion of planned care that is done as a day case.

We are using hospital beds for people who could be cared for at home, or in alternative care settings. 59% of acute bed days are used by people with stays over 10 days, and the majority of these people are elderly. 85% of the mental health bed days in NCL are from patients staying over 30 days. Delayed discharges are also high in some hospitals. Staying longer than necessary in hospital is not good for people's health, especially the elderly whose health and wellbeing can deteriorate rapidly in an acute environment.[29]

We face challenges in mental health provision. People do not always have easy access to information and community based support, and community mental health services are under huge pressure. There is also no high quality health-based place of safety in NCL. Many people receive their first diagnosis of mental illness in Emergency Departments. High numbers of people are admitted to hospital – many under the Mental Health Act. There is variable access to liaison psychiatry, perinatal psychiatry and child and adolescent mental health services (CAMHS) within urgent care: most of the liaison psychiatry and CAMHS services in hospitals in NCL do not see children within one hour at weekends and overnight[30]. There is limited perinatal community service in NCL, in the northern boroughs there is no specialist team and in the southern boroughs the service does not meet national standards[31].

[27] RightCare Atlas of Variation in Healthcare, September 2015
[28] NHS England Activity Data 2014-15
[29] Philip et al. (2013) Reducing hospital bed use by frail older people: results from a systematic review of the literature. International Journal of integrated care.
[30] Mental health crisis care ED audit, NHS England (London), 2015
[31] Maternal Mental Health Everyone's Business

Our use of information and technology does not currently support integrated health and social care across NCL. There is a variable level of digital maturity across providers and most being below the national average for digital capabilities, particularly their capability to share information with others.

Some of our buildings are not fit for purpose and there are opportunities to use our estates better. 11 sites in NCL have facilitites management costs at least 10% more than the Carter benchmark (£319 p sq. m), with a further 3 sites within 10% of the benchmark. 8 sites have a higher proportion of unutilised space than the 2.5% benchmark contained within the Carter report, and over half of the sites analysed were found to have a higher proportion of non-clinical space than the Carter benchmark (35%).

We have significant workforce challenges across health and social care, including a high turnover across a range of professions, an over reliance on agency staff and HR policies which are not transferable across organisations.

There is consensus across the system that the current approach to commissioning and providing health and social care services across NCL could be better aligned to support the implementation of our emerging vision for the STP. In particular, the delivery of a population health approach and genuinely integrated care is significantly constrained by:

- the rigid separation of commissioning and providing responsibilities within the NHS
- the limited existing integration between health and social care
- the fragmentation of providers of health and care into many sovereign organisations
- increased financial risks across CCGs and providers
- stretched capacity and capability in the current organisational form.

We need to design new commissioning and delivery models that enable us to deliver transformed care in a way that is sustainable.

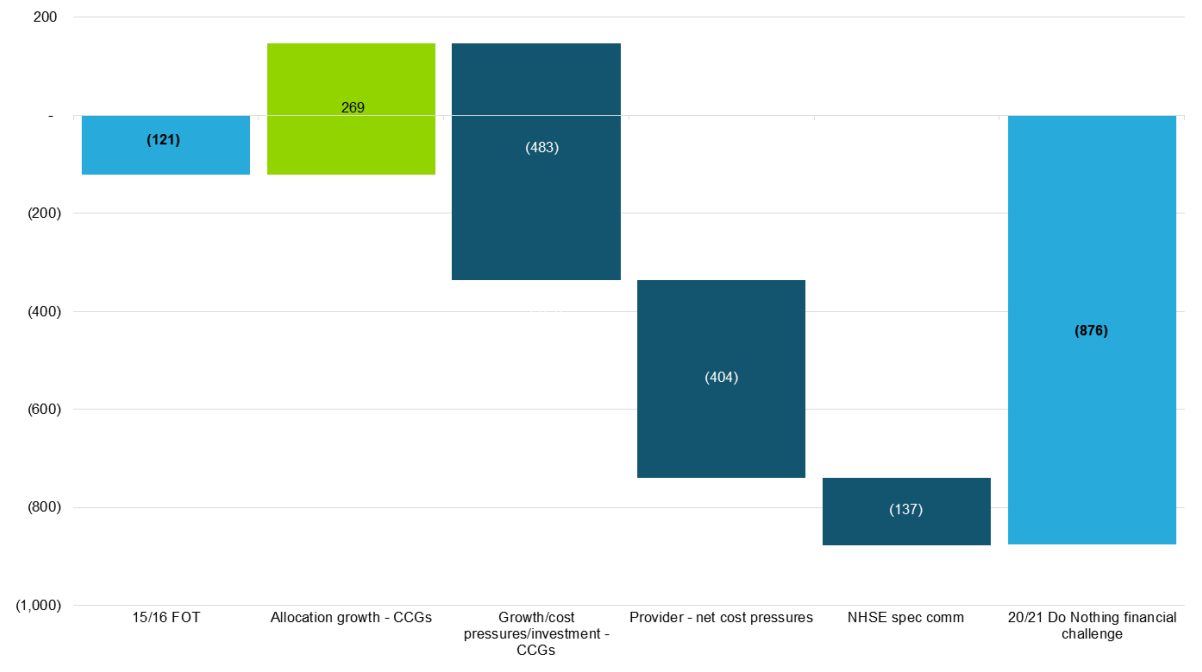
4.3 Baseline financial gap

Our population is growing and demand is rising: people access health care more often, and are – positively – living longer, but often with one or more long term conditions. Meanwhile, the NHS's costs are rising more than inflation across the UK economy (to which allocations are linked). The upshot of this is that not only is the system responding to greater demand, but also that the sum cost of activity is growing faster than allocations.

Put simply, funding increases in NCL of £269m over the next 5 years will not meet the likely increases in numbers of local people and growth in demand for health services of c.£483m, plus increases in the cost of delivering health care of c.£404m.

This means that there is a substantial financial challenge facing health organisations in NCL. Health commissioners and providers were already £121m in deficit in 2015/16 and, if nothing changes, this will grow to £876m in deficit by 2020/21.

Exhibit 2: The 'do nothing' financial gap for NCL



The 'do nothing' specialised commissioning financial challenge is estimated at £137m (this estimate is currently being validated). This excludes Great Ormond Street Hospital NHS Trust and the Royal National Orthopaedic Hospital NHS Foundation Trust which would add a further £49m and £10m respectively. The specialised commissioning challenge is driven by advances in science; an increasingly ageing population with LTCs; and rising public expectation and choice for specialised treatment. In addition there are increasing financial pressures for specialised services, including the increasing volume of expensive new drugs. Spending on specialised services has increased at much greater a rate than other parts of the NHS, and this is expected to continue.

The current combined net budgets for the 5 boroughs in NCL is £760m for Adults and Children's Social Care (CSC) and Public Health services. However, we know that between 2010/11 and 2020/21 the average reduction in borough spending power will be 35%. Adult Social Care (ASC) budget reductions during this period will total at least £154.5m. This reduction in funding requires that a significant savings programme be delivered.

The collective 2016/17 forecast budget pressures for the 5 boroughs in ASC and CSC is £39m (£26m ASC, £13m CSC). Both ASC and CSC will continue face considerable pressures from demographic growth, inflation and increasingly complex care needs. By 2020/21 the combinations of pressures and continued loss of funding will result in a combined social care budget gap of c.£308m, which is equivalent to a 28% reduction on the current Councils' total budget. Councils may have the option to raise a 2% precept for social care in future years, but this will be subject to political agreement and will not come close to closing the gap.

5 Vision

Our vision is for North Central London to be a place with the best possible health and wellbeing, where no-one gets left behind.

Developing our vision in NCL has taken time, and we have harnessed our high quality clinical and practitioner leadership at every stage of the process. The vision for NCL initially drew on existing local work which was underway before the STP process started. Leaders across the system then iterated the vision at an event in September 2016. This process, alongside the series of borough-based public engagement events in September and October, has ensured that our vision is collectively owned across the system. We are committed to fulfilling our vision through this plan, and have identified a set of core principles to support our ambition.

Our core principles

- We will work in a new way as a whole system; sharing risk, resources and reward.
- Health and social care will be integrated as a critical enabler to the delivery of seamless, joined up care.
- We will move from pilots and projects to interventions for whole populations built around communities, people and their needs. This will be underpinned by research based delivery models that move innovation in laboratories to frontline delivery as quickly as possible.
- We will make the best the standard for everyone, by reducing variation across NCL.
- In terms of health we will give children the best start in life, and work with people to help them remain independent and manage their own health and wellbeing.
- In terms of care we will work together to improve outcomes, provide care closer to home, and people will only need to go to hospital when it is clinically essential or economically sensible.
- We will ensure value for tax payers' money through increasing efficiency and productivity, and consolidating services where appropriate.
- To do all of this we will do things radically differently through optimising the use of technology.
- This will be delivered by a unified, high quality workforce for NCL.

6 Strategic framework

To deliver on our vision and achieve the triple aim as set out in the Five Year Forward View (to increase health and wellbeing; meet the highest standards of care and quality; and improve productivity and efficiency), we have designed a programme of transformation with 4 aspects:

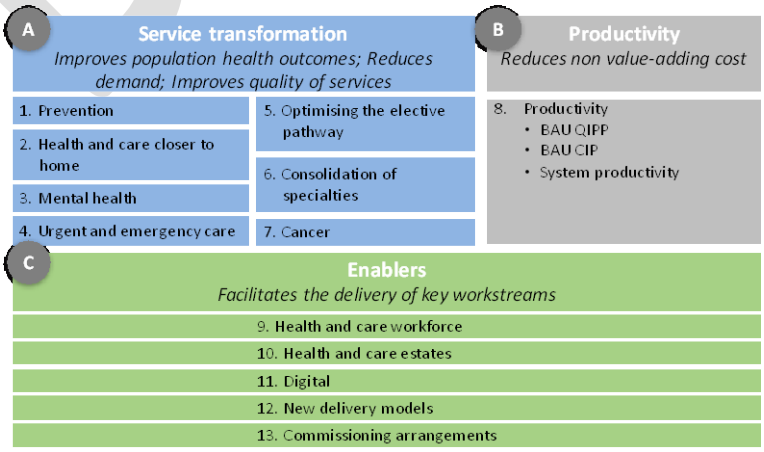
1. **Prevention:** Much of the burden of ill health, poor quality of life and health inequalities in NCL is preventable. We will increase our efforts on prevention and early intervention to improve health and wellbeing outcomes for our whole population, which will reduce health inequalities, and help prevent demand for more expensive health and care services in the longer term.

2. **Service transformation:** To meet the changing needs of our population we will transform the way that we deliver services. This involves taking a "population health" approach: giving children the best possible start in life; strengthening the offers and provision in the local community to ensure that where possible care can be provided out of hospital and closer to home – reducing pressure on hospital services; rethinking the relationships between physical and mental health to ensure that mental health care is holistic and person-centred; and, reducing variation in services provided in hospital. Social care plays a key role in service transformation.

3. **Productivity:** In order to ensure sustainability, we will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies. For providers, this includes implementing recommendations from the Carter Review and working together across organisations to identify opportunities to deliver better productivity at scale.

4. **Enablers:** We will focus on delivering capacity in key areas that will support the delivery of transformed care across NCL. This includes digital, workforce, estates, and new commissioning and delivery models.

Exhibit 3: The NCL STP strategic framework



6.1 Prevention

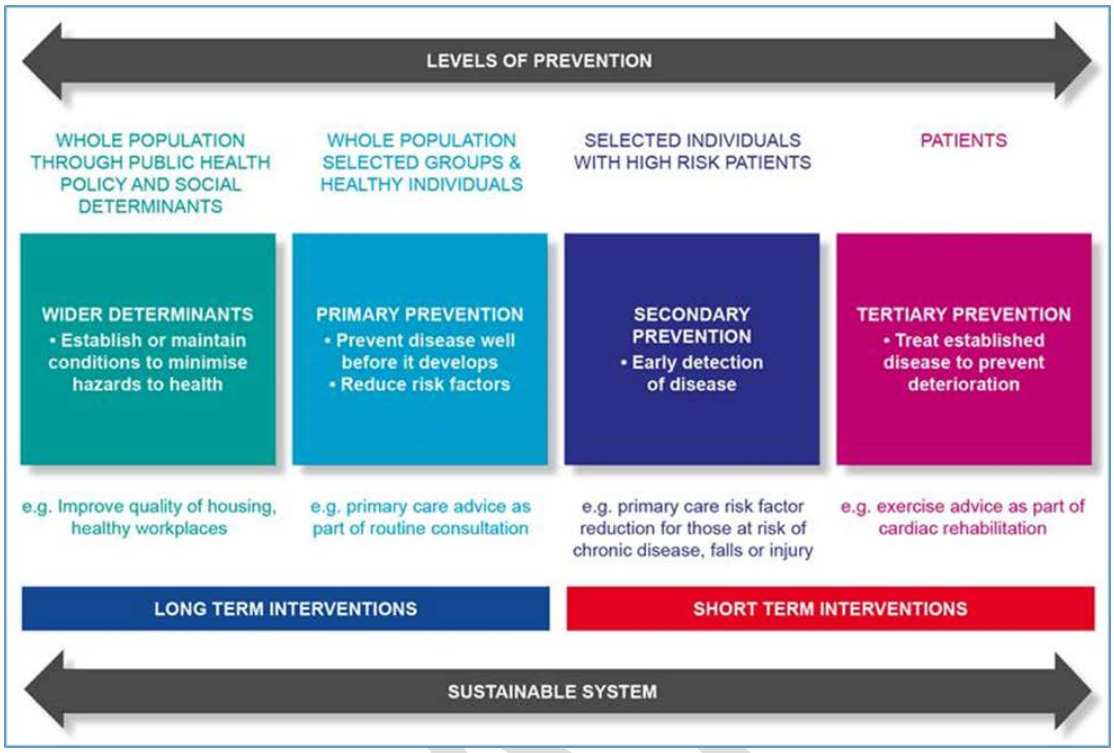
We will embed prevention and early intervention across the whole health and care system and deliver effective preventative interventions at scale. As a result, we will improve population health outcomes and reduce health inequalities by harnessing assets within and across communities for example, from Council services, including social care and the voluntary and community sector. This will positively impacting on the lives of residents, their families, and our communities.

Afrin lives in hostel accommodation and is dependent on alcohol. He experiences seizures almost daily. Afrin has in the past, with support from treatment, managed to gain abstinence but had a relapse which is due to depression brought on by unstable housing and economic circumstances. Afrin has had many unscheduled hospital admissions in the last 6 months. In future, on admission to hospital Afrin will be referred to an alcohol assertive outreach worker (AAOT) by the hospital alcohol liaison worker. This support will enable him to put in place foundations that will help him towards abstinence and recovery. Afrin will be supported to give up drinking, with input from an addictions doctor at a community alcohol service. A slow reduction plan, that is achievable and minimises the risk of seizures which in the past have led to hospital admission, will be put in place. Afrin will have regular 1-2-1 appointments with his AAOT, which will include psychological help.

Our prevention plans focus on interventions and system change across the whole spectrum of prevention (exhibit 4), where there is strong evidence of effectiveness and return on investment within the 5 year period of the STP[32]. In addition, we have identified opportunities where we could rapidly build upon successful local initiatives across NCL to achieve economies of scale.

[32] Interventions have been identified from the Public Health England (PHE) Supporting Pack for STPs and the return on investment work undertaken for Healthy London Partnerships by Optimity.

Exhibit 4: Approach to prevention



We will concentrate our efforts on:

- **Creating a 'workforce for prevention'** so that every member of the local public sector workforce in NCL is a champion for prevention.
  Specific interventions: Making Every Contact Count (MECC); Mental Health First Aid (MHFA); dementia awareness
- **Ensuring that the places where residents and employees live and work promote good health.** This will include: reversing the upwards trend in childhood obesity; supporting people with mental ill health and other long term conditions to stay in work; pioneering new approaches to tackling gambling, alcohol misuse and smoking; and supporting the workforce across NCL (including our own staff) to become healthier.
  Specific interventions: Haringey Devolution Pilot; improving employment opportunities for people with mental ill health through individual placement support (IPS); Healthy Workplace Charter; Healthy Early Years / Healthy Schools accreditation
- **Supporting residents, families and communities to look after their health: smoking and drinking less, eating more healthily, and being more active, as well as looking after their sexual health and mental health wellbeing.** This will all reduce hospital admissions from preventable causes such as smoking, alcohol, and falls, and reductions in associated ill health and early deaths. We will protect and ensure high quality universal services for vulnerable families by starting direct conversations with schools to proactively identify who these families are, and collaborating to map across primary care, social care, early years, therapies, paediatrics and secondary care. We will ensure that smoking cessation programmes are embedded across

maternity services and services for children and young people, targeting parents and older children. Drawing on the experience of our local authorities in running large scale campaigns, we will design and deliver a campaign across NCL to address a variety of wellbeing or long term conditions through a single preventative message with common NCL branding.
Specific interventions: smoking cessation; alcohol screening, liaison and outreach teams; weight management programmes; diabetes prevention programme; multifactorial falls intervention; long-acting reversible contraception; community resilience; increased access to mental health services for children and new mothers; London's digital mental health programme.

- **Diagnosing residents with clinical risk factors and long term conditions much earlier to increase life expectancy.** Once diagnosed, empowering them to manage their own condition(s) alongside proactive management by health professionals to prevent the development of further conditions and complications.
Specific interventions: increasing awareness and case finding (including national cancer screening and HIV testing) and appropriate medications to control conditions for people with high blood pressure, diabetes, atrial fibrillation; self-care and structured self-management for long term conditions; reablement offers in social care and care navigation.

We will build upon on the individual strengths that each part of the public sector in NCL can bring to preventing disease and ill health. As well as traditional 'health professionals' this also means working with local authority housing officers and the London Fire Brigade in, for example, preventing falls. We also recognise the key contribution that voluntary and community sector organisations can make in achieving disproportionately greater improvements in health for residents with mental ill health and learning disabilities, specific BME groups, and those in the most deprived communities, and we are committed to working more collaboratively with these organisations.

6.2 Service transformation

To meet the changing needs of our population we will transform the way that we deliver services, shifting the balance of care from reactive to proactive. This will be through ensuring people achieve the best start in life, developing our care closer to home model, creating a holistic approach to mental health services, improving urgent and emergency care, optimising the elective pathway, consolidating of specialties where appropriate and transforming cancer services to improve the end-to-end experience. Social care plays a key role in all aspects of service transformation.

6.2.1 Achieving the best start in life

Children make up between 25% and 30% of the population across the NCL footprint which means that service transformation must include a specific focus on our children and young people. We recognise that providing children with the best start in life is critical for their development and health long term. We have identified interventions across the pathway,

from prevention to acute care, that are focussed specifically on improving health and outcomes for children and young people.

In the context of a considerable body of research suggesting that fetal exposure to an adverse environment in-utero sets the trajectory for child and adult health in terms of congenital malformations, obesity, diabetes and cardiovascular disease, we will explore ways to link primary care, public health and maternity services to optimise maternal health before, during and after pregnancy. In particular, smoking cessation, weight reduction, optimisation of blood sugar control in diabetics and improvement of diet in women of reproductive age has the potential to reduce the health needs of children. We will leverage the work of our NCL Maternity Network to ensure that our local maternity system implements the findings of the national Maternity review: Better Births. We are keen to take part in the National Maternity Transformation programme as an Early Adopter.

We will promote active travel, sport and play for children in schools, for example involving schools to deliver the *Take 10, Active 15, Walk a daily mile* initiatives that other parts of the country have adopted to support this. By 2020/21, our aim is that 4 out of 5 early years' settings and schools in NCL will be accredited as part of the healthy schools, healthy early years or similarly accredited programme for promoting healthy lives.

Tai, 14, suffers from severe depression. With the involvement of Tai, his family, and his CAMHS practitioners, Tai has been admitted into a Tier 4 unit on a planner basis. Previously, it was likely that Tai would have been placed far from home. In future, with the local commissioning of Tier 4 he will be able to be placed close to home. This will enable better linkage with the local CAMHS community team, which will have also been enhanced. Together, these factors will mean Tai has a better experience of care and stays in hospital for a shorter length of time. When Tai is discharged back into the community, he will have an enhanced care plan to support him to keep well.

We will address mental ill health in children as early as possible: developing antenatal and postnatal interventions for mothers with mental ill health; improving services for parenting support, health visiting, and signposting; and creating targeted services that focus on vulnerable high risk families. We will capitalise on the universal services of MIND, Place2Be and voluntary sector initiatives like *Hope Tottenham* that are already established and working directly with families and young people. As part of our Child and Adolescent Mental Health Services (CAMHS) and perinatal initiative led through the mental health workstream, we will:

1. **Develop a shared dataset for CAMHS** to enable comparison and shared learning across the 5 boroughs
2. **Tackle eating disorders** by establishing dedicated eating disorder teams in line with the waiting time standard, service model and guidance
3. **Upskill our workforce** to meet the mental health and psychological wellbeing needs of children and young people, including developing a children and young people's IAPT workforce capability programme

4. **Build on our Transforming Care initiative** by supporting children and young people with challenging behaviour in the community in order to prevent the need for residential admission
5. **Improve perinatal mental health services** by developing a specialist community perinatal mental health team that serves the NCL population and the physical health acute trusts within NCL
6. **Implement a Child House model** following best practice to support abused children
7. **Create a 24/7 crisis pathway for children and young people**, including local commissioning of Tier 4 CAMHS to eliminate out of area placements for non-specialist acute care by 2020/21; and review of S136
8. **Develop a co-commissioning model for youth justice** working with NHS England.

The principles of THRIVE will be used as an overarching approach to our CAMHS work, with the aim that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019 as set out in the Mental Health Taskforce.

6.2.2 Health and care closer to home

Health and care will be available closer to home for all, ensuring that people receive care in the best possible setting at a local level and with local accountability. We already have many high quality services outside acute settings across NCL, but our health and care closer to home model will focus on scaling these services up, reducing variation and making this the default approach to care. Social care will play a key role in the design, development and expansion of the future model.

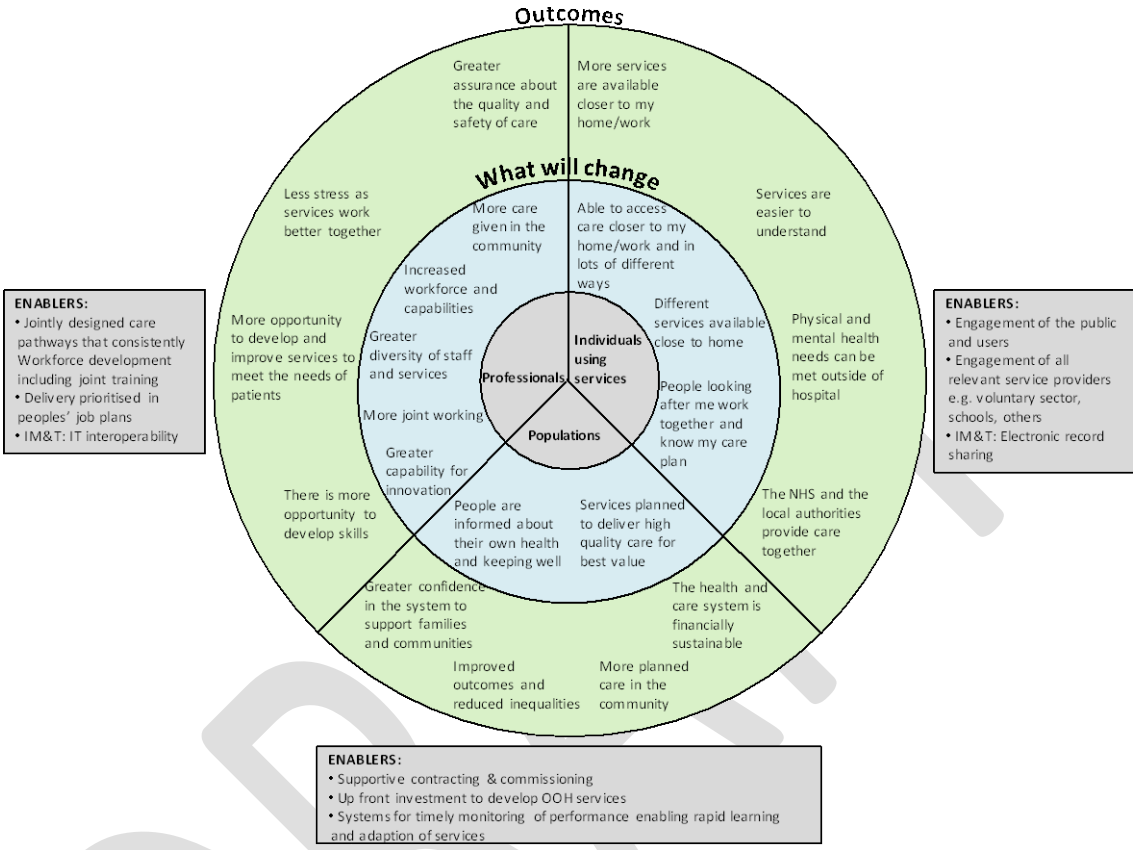
> Ms Sahni is 87 and has four chronic health problems. Previously, she had to book separate appointments with different primary care professionals to have all of the relevant check-ups and appointments that she required. In future, Ms Sahni will be in a special "stream" of patients who will have all of their care co-ordinated by a very experienced GP. This will allow her to see the specialist heart or diabetic nurses at the Integrated Care Centre located at her GP surgery. There will also be a care navigator in the team who can help to sort things out for her at home, including community support when she needs it.

We will address the sustainability and quality of general practice, including workforce and workload issues. It is recognised that for some people, health and care being delivered closer to their home is not always the best choice, and therefore high quality hospital-based and care home services will continue to be available when needed.

At the heart of the care closer to home model is a 'place-based' population health system of care delivery which draws together social, community, primary and specialist services. This will be underpinned by a systematic focus on prevention and supported self-care, with the aim of reducing demand on the system over time. We will deliver the right care at the right time to the whole population. The care closer to home model is one of the key vehicles by

which we will contribute towards the overall delivery of the Better Health for London outcomes.

Exhibit 5: Delivery of the Better Health for London outcomes through the health and care closer to home model



Specific interventions that make up the scope of the care closer to home model include:

- **Developing 'Care Closer to Home Integrated Networks' (CHINs):** CHINs may be virtual or physical, and will most likely cover a population of c.50,000 people. They will be home to a number of services including the voluntary and community sector to provide a more integrated and holistic, person-centred community model, including health and social care integrated multi-disciplinary teams (MDTs), care planning and care coordination for identified patients. Interventions focussed on the strengths of residents, families and communities; improving quality in primary care; and reducing unwarranted variation will also operate from CHINs, including Quality Improvement Support Teams (QIST) to provide hands-on practical help for individual GP practices to ensure a consistent quality standard and offer to all patients. This will include support for case finding and proactive management of high blood pressure, atrial fibrillation and diabetes. We have already piloted CHINs, for example the Barnet Integrated Local Team (BILT)[33] hub which provides coordinated care for older residents with complex medical and social care needs, as well as providing support

[33] Barnet integrated Care Locality Team, 2016

to carers. The BILT hub has been open since April 2016 and is a joint funded health and social care pilot.

- **Extending access to primary care:** patients will be able to access consultations with GPs or other primary care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm 7 days a week.
- **Supporting healthier choices:** in line with our prevention agenda, the care closer to home model will include upscaling our smoking cessation activities by 9-fold to reduce prevalence and hospital admissions; increasing alcohol screening and the capacity of alcohol liaison services and alcohol assertive outreach teams across NCL; scaling up weight management programmes with integrated physical and wellbeing activities; and reducing unplanned pregnancies by increasing the offer and uptake of long acting reversible contraception.
- **Improving access through technology and pathways:** telephone triage, virtual consultations and online booking systems will be available for all patients.
- **Supporting patients through social prescribing and patient education:** the care closer to home model will include a greater emphasis on social prescribing and patient education. Support will be available for patients, carers and professionals to be confident users of information and IT solutions that enable self-management and care, as well as care navigation support to direct patients to the right services.
- **24/7 access to specialist opinion in primary care:** primary care will be able to provide more complex patients with a number of options for specialist opinion outside of the hospital itself. These range from: 1) advice only 2) an urgent 'hot clinic' appointment in an out-patient clinic 3) assessment in an ambulatory emergency care facility and 4) admission to an acute assessment unit. In addition, consultant-led clinical assessment and treatment services offered in CHINs will enable more patients to be managed in the primary care setting. Specialties to be considered include gynaecology; ENT; urology; dermatology; musculo-skeletal; and ophthalmology.
- **GP front door model in Emergency Departments:** we will review the existing provision across NCL of GP led triage, treatment and streaming for all ambulatory patients will be provided at the front door of Emergency Departments. GPs and nurses on the door make decisions about where the patient is best treated – which could be in the urgent care centre or emergency department, or redirection to alternative services.
- **Falls emergency response team and multifactorial intervention:** multifactorial interventions combining regular exercise, modifications to people's homes and regular review of medications will prevent people from falling in the first place. If they do fall, falls partnership ambulance vehicles will be available with advanced, multi-disciplinary practitioners. In addition, a specific falls service will support patients to remain at home after a fall.
- **Enhanced rapid response (ERR):** a rapid response team will prevent an admission to hospital for those in crisis, providing enhanced therapy, nursing and social work support to support people to stay in their own home.

- **Acute care at home:** where there is a medical need, acute clinical care will be provided at home by a MDT to provide the best possible patient experience and outcomes, and enable the patient to benefit from holistic integrated care.
- **Frailty units:** a dedicated service, such as that already in place at the Whittington, that will be focussed on rapid assessment, treatment and rapid discharge of frail older people that could potentially be co-located within the Emergency Department. This will enable ambulatory care for people aged over 65. These would be rolled out across NCL.
- **Enhanced care home support:** provided to stabilise and / or treat residents in the care home where appropriate thereby reducing the level of conveyances, unplanned attendances and admissions to secondary care. The care closer to home model will prevent emergency readmissions from care homes through development of a care home bundle, including a proactive approach to prevention and early identification of complications.
- **End of life care:** we will support people at the end of life to receive the care that they need to enable them to die in their place of choice via rolling out the Co-ordinate My Care (CMC) care planning programme, and ensuring the new Integrated Urgent Care service (see section 6.2.4) has access to CMC plans.

Acheiving care closer to home will need to be underpinned by strong resilient communities that are able to support residents live independently at home, where that support is needed. The support may be needed from families, carers, neighbours or from voluntary and community groups all of whom have central roles to play.

We plan to bring together the funding currently used for Locally Commissioned Services (LCS) and the premium spent on Personal Medical Services (over and above GMS) and establish one LCS contract framework for the whole of NCL. This LCS contract will have agreed outcomes which are shared with the Health And Care Closer to Home Networks (CHINs) and the Quality Improvement Support Teams (QISTs) so that all local GPs are provided with the necessary funding and incentives to fully engage with these vital components of the health and care closer to home work. Delivery of this whole system alignment is partly dependent on NHS England (London) delegating commissioning of the PMS premium to the CCGs which is currently under discussion with all key parties.

In support of delivering our health and care closer to home model, Islington CCG has expressed an interest in becoming an Integrated Personal Commissioning (IPC) site in order to improve health and wellbeing outcomes through personalised commissioning, improved care and support planning and developing an asset based approach to support solutions.

The IPC site will:

- improve outcomes for patients with care delivered closer to home, and aim to reduce unplanned admissions
- realign service provision in light of new service developments related to IPC and Personal Health Budgets
- review existing contracts to assess impact and identify opportunities for realignment based on a number of other developments such as New Care Models and IPC.

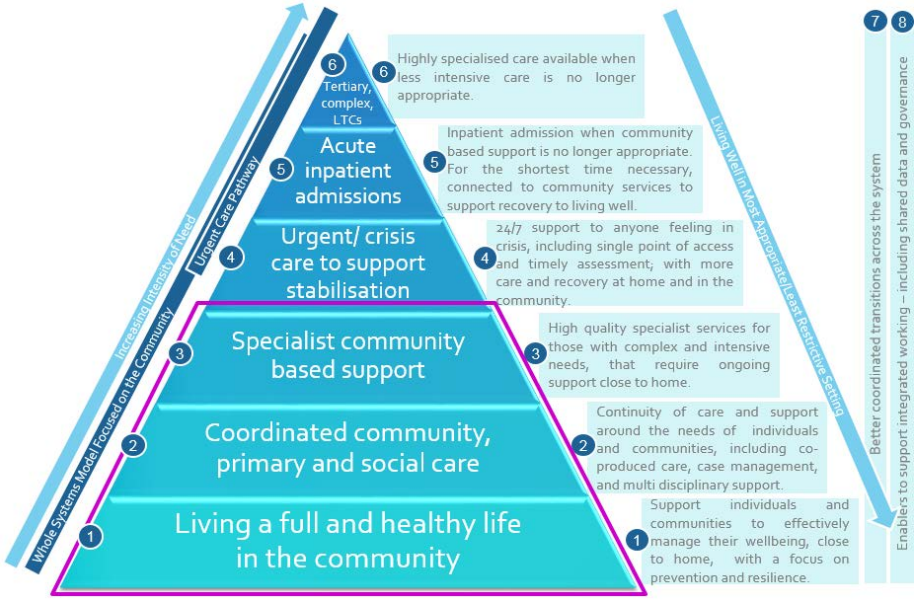
Improving outcomes will be the crucial measure of success of the care closer to home model. Using national and international evidence, we have estimated that some of the outcomes that our health and care closer to home model could potentially deliver are:

- 70% of people at the end of their life will have a care plan to support them to die in their place of choice
- 4% decrease in unplanned pregnancies
- a reduction in alcohol consumption with 10% fewer alcohol-related hospital admissions
- up to 150,000 fewer emergency department attendances
- 63,000 fewer non-elective admissions
- 35,000 fewer outpatient attendances
- 10% reduction in falls-related hospital admissions
- a halving of the numbers of late HIV diagnoses
- 50,000 weight management referrals leading to a reduction in excess weight
- 66% of people with high blood pressure have it diagnosed and controlled
- 55% of people with atrial fibrillation are receiving anti-coagulants
- 69% of people with diabetes have controlled blood glucose.

6.2.3 Mental health

We will develop a 'stepped' model of care (see exhibit 6) supporting people with mental ill health to live well, enabling them to receive care in the least restrictive setting for their needs.[34] We recognise the key role and accountabilities of social care for people with long-standing mental ill health and drawing on this will be central to the success of the stepped model.

Exhibit 6: The mental health 'stepped' model of care



[34] As identified in the Mental Health Taskforce Report

We aim to reduce demand on the acute sector and mitigate the need for additional mental health inpatient beds. This will improve overall mental health outcomes across NCL, reduce inequalities for those with mental ill health, enable more people to live well and receive services closer to home and ensure that we are treating both physical and mental ill health equally. We will achieve the key mental health access standards:

- more than 50% of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within 2 weeks of referral
- 75% of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within 6 weeks of referral, with 95% treated within 18 weeks.

Maisie suffers from dementia, and is cared for by her husband Albert. Previously, after falling at home, Maisie was admitted to hospital. Due to the accident and change of surroundings, Maisie was agitated and more confused than normal. In future, the hospital will have Core 24 liasion psychiatry meaning that the liaison team will be able to help the hospital support both Maisie's physical and mental health needs. As Maisie will receive holistic care it will mean that she is ready to be discharged sooner than if only her physical health needs were supported. Maisie's husband Albert will also be supported by the dementia service, allowing him to continue to care for Maisie at home.

Initiatives will cover mental health support for all age groups and include:

- **Improving community resilience:** both for the general population, and those at risk of developing mental ill health or of it becoming more severe. For the general population this includes a promotional drive aimed at increasing basic mental health awareness including self-awareness, normalising mental health needs and reducing stigma. For the at risk population focus will be given to improving access and support through training of non-mental health specialists to recognise mental ill health symptoms, improving service navigation, development of open resources, and provision of individual and group therapies; employment support to help people to maintain and get back into work including through Individual Placement Support[35]; and suicide prevention work to strengthen referral pathways for those in crisis, linked to the local multiagency suicide prevention strategies.[36] This will be delivered in conjunction with other regional and national schemes such as the London digital wellbeing platform. We will continue to build upon current work; for example Barnet CCG and local authority are already working towards a dementia friendly borough by providing lunch clubs, reminiscent therapy and engaging with local shops to raise awareness.
- **Increasing access to primary care mental health services:** ensuring more accessible mental health support is delivered locally within primary care services, developed as part of the CHINs; enabling both physical health and mental health needs to be

[35] Five Year Forward View - 29,000 more people living with mental ill health should be supported to find or stay in work (~725 within NCL)
[36] Five Year Forward View - Reduce suicide by 10%

supported together[37]. We will offer support directly to patients and support to GPs and other professionals; enabling more people to access evidenced based mental health services[38], and more care to be offered through CHINs rather than requiring referral to secondary care mental health services. Services will include increasing the IAPT offer to reach 25% of need.[39]

- **Improving the acute mental health pathway:** building community capacity to enable people to stay well and reduce acute presentations. This includes developing alternatives to admission by strengthening crisis and home treatment teams; reviewing Health Based Place of Safety (HBPoS) provision with the view to reduce the number of units and to have a sector wide provision that meets all requirements; and investing in longer term supported living arrangements to ensure effective discharge, enabling more people to live well in the community.
- **Developing a Female Psychiatric Intensive Care Unit (PICU):** we will ensure local provision of inpatient services to female patients requiring psychiatric intensive care, where currently there is none. This will enable patients to remain close to their communities, with a more streamlined and effective pathway ensuring a focus on recovery.[40]
- **Investing in mental health liaison services:** scaling up 24/7 all-age comprehensive liaison to more wards and Emergency Departments, ensuring that more people in Emergency Departments and on inpatient wards with physical health problems have their mental health needs assessed and supported.
- **CAMHS and perinatal:** initiatives as set out in section 6.2.1.
- **Investing in a dementia friendly NCL:** looking at prevention and early intervention, supporting people to remain at home longer and supporting carers to ensure that we meet national standards around dementia, including a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.

An important enabler of a number our initiatives is the redevelopment of both the Barnet, Enfield and Haringey Mental Health Trust St Ann's site and the Camden and Islington Foundation Trust St Pancras site (in conjunction with the proposed relocation of Moorfields Eye Hospital Foundation Trust to the St Pancras site).

The proposed developments of the St Ann's and St Pancras sites would:

- transform the current inadequate acute mental health inpatient environments on both sites
- provide more therapeutic and recovery focussed surroundings for patients and staff
- improve clinical efficiency and greater integration of physical and mental health care
- release estate across the trusts, to enable development of community-based integrated physical and mental health facilities
- develop world class research facilities for mental health and ophthalmology enabling practice to reflect the best evidence

[37] FYFV – at least 280,000 people with severe mental ill health have their physical health needs met (~7,000 within NCL)
[38] Five Year Forward View - more adults with anxiety and depression have access to evidence based psychological therapies (~15,000 within NCL)
[39] Five Year Forward View
[40] Five Year Forward View - inappropriate out of area treatments for acute mental health care should be eliminated in all areas by 2020/21.

- provide land for both private and affordable housing, as well as supported housing for service users and housing for key workers.

6.2.4 Urgent and emergency care[41]

Over the next five years, we will deliver urgent and emergency care (UEC) services that are reliable, work well together and are easily understood. Our services will be consistent and inspire confidence in patients and professionals; supported by the use of an integrated digital care record that can be accessed across organisations. The first 2 years will focus on reducing variation in our services and the latter years will focus on transformation of the urgent and emergency care system, aligning closely with the care closer to home model.

Mary is 83 years old and lives at home with her husband. Mary had a fall at home and injured her ankle. Her husband was unable to help her get up so he called 999 for an ambulance. Mary was taken to the nearest A&E and admitted to hospital, where she is diagnosed with a urinary tract infection (UTI). She was reviewed by the consultant: a plan was put in place for treatment of her UTI and physiotherapy was recommended for her ankle. Over the weekend, Mary's UTI improved, but there was no consultant to review her condition or physiotherapist to provide her care, so Mary was unable to go home. When going to the toilet in the night, Mary fell again and stayed in hospital for a further 2 weeks. Mary became increasingly less mobile and more frail and dependent.

In future when Mary falls, her husband will dial 999, and a paramedic will be dispatched. When the clinical assessment does not suggest any fractures, the crew will access the local directory of services whilst on scene and electronically refer Mary to the Acute Care at Home service with request for a 12 hour response. Mary will then be visited at home by the falls team the next day who will design a package of care for Mary including reablement, allowing Mary to stay at home. The falls team will be able to detect if there is anything unusual about Mary's behaviour, and make a rapid appointment with her GP if they suspect a UTI. Mary will then get the antibiotics she needs to resolve this at an early stage.

Our aims are to:

- **Create a consistent UEC service across NCL:** all UEC services in NCL will meet National and London-wide quality standards[42] which will promote consistency in clinical assessment and the adoption of best practice. Patients will be seen by the most appropriate professional for their needs, which may include directing them to an alternative emergency or urgent care service.
- **Develop and implement a high quality integrated UEC service:** all urgent care services across NCL (including NHS 111, GP out of hours, Urgent Care Centres) will work together to offer consistent care. These services will be renamed 'Integrated

[41] This workstream includes all aspects of Urgent and Emergency Care provision delivered in the acute setting, including support for people to leave hospital. Also in scope is the development of a high quality, integrated urgent care system.
[42] As defined by the NHS E UEC designation process

Urgent Care'. We have commissioned a joined up new Integrated Urgent Care service provided by one provider, LCW, which goes live in October 2016. This service combines the NHS 111 and GP Out-of-Hours (OOH) services, and allows patients to access a wider skill mix of specialised clinicians in a new NHS 111 clinical hub.

- **Develop high quality, responsive 7-day hospital UEC services:** people will be supported to leave hospital as quickly as possible through building close links between acute care providers and social care. We will support shorter hospital stays by operating a simplified discharge or integrated 'discharge to assess' model: planning post-acute care in the community, as soon as the acute episode is complete, rather than in hospital before discharge. This will be the default pathway, with non-acute bedded alternatives for the very few patients who cannot manage this.
- **Develop high quality, responsive 7-day community services:** where possible, people will be supported and treated at home by community and ambulance services. For those people who do require ambulance transfer, the ambulance services will be able to use any UEC services that meets the patient's need.
- **Develop high quality ambulatory care services across NCL:** we will develop a service that reduces avoidable, unplanned admissions to hospital, such as that already in place at the Whittington. All UEC services will create consistent ambulatory care pathways that support people to have their care on a planned basis, wherever possible. This will provide same day emergency care to support patients to be assessed, diagnosed, treated and able to go home the same day without an overnight admission. This model will be rolled out across NCL.

The focus on urgent and emergency care services will reduce the number of unplanned admissions to hospital and support people to go home from hospital as soon as possible. This will improve patient experience, improve outcomes and make sure that people have their care on a planned basis wherever possible.

6.2.5 Social care

Social care is a crucial part of many of our workstreams, particularly care closer to home, Transforming Care, and mental health, as well as children's and public health interventions. We are considering how local authorities can work with the workforce leads across NCL to design and develop proposals specifically for social care, including a focus on the sustainability of provider workforce, the sustainability of the registered workforce and stimulating the personal assistant workforce. We will ensure that our plans factor in practical steps that we can take as partners to address provider failure and the huge risks around capacity and quality in the domiciliary market.

The role of social workers will be essential to delivering on our model for health and care closer to home, in addition to the role of home care workers, personal assistants, blended role between district nurses and care workers. The workforce workstream will consider these career pathways, making careers in these areas more attractive to support increased sustainability of the workforce. We will quantify any investment that might be needed in workforce from a social care point of view e.g. increasing numbers of domiciliary care

workers and, drawing on learning from elsewhere, we will quantify the return on investment.

Social care is also built into our mental health model, including a broader dimension of public service support such as employment support workers. Learning disabilities is a key area of focus given that half of social care spend is on this group, and that children with special educational needs and learning disabilities have worse long term outcomes in both health and education. We need to start supporting those with learning disabilities from early childhood to ensure early detection and appropriate intervention. Many of our interventions, including health visiting, early years, community paediatrics, CAMHS, and working directly with schools will ensure that we better support these children. We plan to scale up our Transforming Care work to implement enhanced community provision; reduce inpatient capacity; upgrade accommodation and support for those with learning disabilities; and roll out care and treatment reviews in line with published policy to reduce long lengths of stay in hospitals and improve independence.

As part of our STP we will explore collaboration and consolidation opportunities between local authorities in areas such as the hospital discharge pathway and the mental health enablement process. We will consider what can be commissioned differently and/or at scale - particularly across health and social care, for example nursing homes. We will focus on ramping up the use of data analysis and risk stratification; working cohesively with public health across the patch; leveraging telecare; and sharing of ideas and learning about best practice in terms of health and social care integration. Our pan-NCL bed state analysis will consider non-health beds, including the 6,440 care home beds in NCL, so that we gain an in-depth understanding of why people end up in these beds and how best their needs could be met elsewhere (as well as the resources it would take to do this).

We recognise the co-dependencies between health and social care: any change in either sector may have a significant impact on the other. As we continue to develop our plans, we will ensure local authorities are involved throughout so that we can mitigate any risks around this together, and transform the system so that it is truly integrated.

6.2.6 Optimising the elective (planned care) pathway

Building on the opportunities identified through RightCare, we will reduce unwarranted variation in elective (planned) care across providers in NCL. This will include reducing variation in the length of stay in hospital and the number of outpatient appointments received by patients with similar needs. Optimised pathways will ensure patient safety, quality and outcomes, and efficient care delivery.

Previously, John (who is 75 and has pain in his knee) made an appointment with his GP. The GP referred him to the hospital where he was seen in outpatients and sent for an MRI scan. A consultant established that John needed a knee replacement. John was about to go on a trip to visit family in the USA for 2 months, so the consultant sent him back to his GP. When he returned John saw the GP again as well as the consultant, who sent him to preoperative assessment. He was found to have high blood pressure, and was sent back to the GP for treatment. Once his blood pressure was under control, John was listed and then admitted for surgery. He spent about 5 days in hospital, and then returned home.

In the future, John will see an extended scope physiotherapist at the GP surgery for his knee pain. The physio will arrange the MRI, and discuss the results with John. The physio will identify that John has raised blood pressure while completing his electronic referral template to the consultant at the hospital, and liaise with the GP to make sure this is treated before he is referred. John will have his hospital appointment and pre-operative assessment on the same day, and will be given all the information he needs to prepare for after the operation.

We will draw on local examples of best practice, such as the South West London Elective Orthopaedic Centre; and international best practice, such as Intermountain's hip replacement pathway redesign, which reduced the cost of total hip replacement by a quarter.[43] Building on the evidence, we will redesign pathways with local clinicians, responding to local needs and opportunities. We will initially focus on areas with high volume or high variability, where there is opportunity to achieve high impact by making changes, such as orthopaedics.

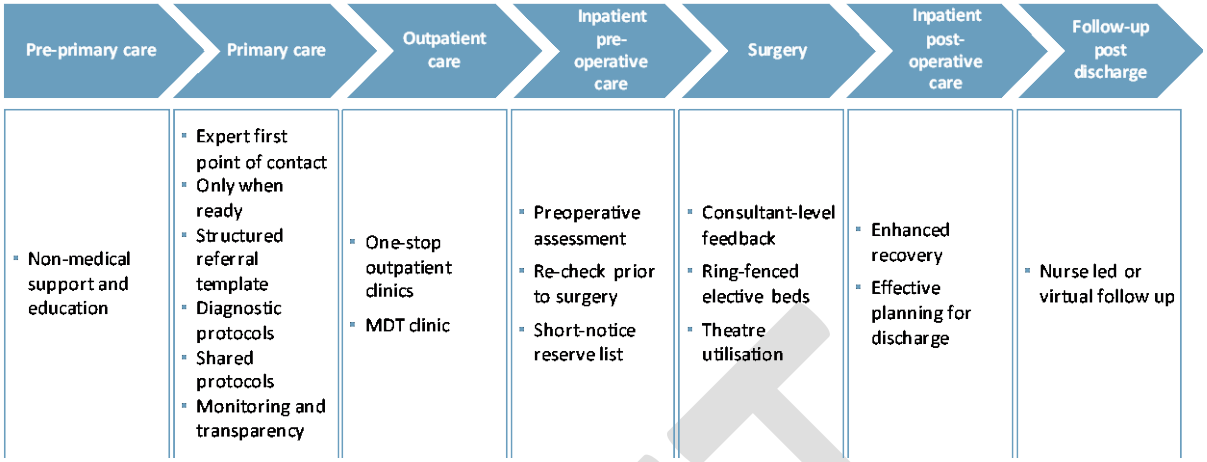
We will leverage the following opportunities for improvement to elective pathways:

- expert first point of contact: making sure people have access to the right expertise from their first appointment in primary care
- one-stop services: so that people do not need to attend multiple outpatient appointments before their procedure
- efficient surgical pathways: to ensure maximum use of staff and theatres
- timely discharge planning: to reduce unnecessary time in hospital.

To deliver on the above, a series of interventions will be put in place at each stage of the elective pathway. These are illustrated in exhibit 7.

[43] James and Savitz (2011). How Intermountain Trimmed Health Care Costs Through Robust Quality Improvement Efforts . Health Affairs

Exhibit 7: Interventions that support optimised elective pathways



For orthopaedics, implementation of these high level interventions includes: interventions includes:

- **Better use of non-medical support and education:** promoting non-medical support staff as the first line for minor concerns (e.g. at gyms), greater use of pharmacists, and giving patients access to more information online.
- **Expert first point of contact:** the first person the patient comes into contact with would be a GP with special interest or experienced physiotherapist, who would know the full range of treatment options available. As a consequence of this, more outpatient referrals would have diagnostics already performed and patients would be supported by the right information when they are making decisions about onward treatment.
- **Use of a structured referral template:** allowing all information to be available at the first clinic appointment. Ideally, this would be an electronic form which would reduce the risk of unnecessary follow up appointments as all relevant diagnostics and information are readily available to clinicans at the initial appointment. Structured referral templates are currently used by some providers and commissoners in NCL to good effect, but would be used more widely as part of the optimised elective pathway.
- **Improved diagnostic protocols:** administrative protocols would be ordered to ensure that the appropriate tests are being conducted to diagnose patients. This would limit repetitive tests being ordered, which is better for patients and optimises resource use.
- **Use of NCL-wide shared protocols:** would ensure that patients are being managed in a consistent way. It would build relationships and teams across the whole system, fostering trust and reducing duplication in tests, appointments and treatements as a result.
- **Only when ready:** patients are only referred when they are ready and available for treatment. This avoids a second GP appointment and re-referral.
- **Better monitoring and transparency:** peer review and support would be established to ensure referrals are appropriate, enabling clinicians to have an open dialogue

regarding the quality of referrals and continuously improve their own referral practices.

- **One-stop outpatient clinics:** access to simultaneous pre-assessment and additional diagnostics in a single place, reducing the need for unnecessary follow ups.
- **Multi-disciplinary team (MDT) clinics:** clinics which consist of multiple different people working together to triage to the most appropriate clinician. Consultants, extended scope physios and GPs with special interests would all working together in a single setting to form the MDT.
- **Pre-operative assessments conducted at the first outpatient appointment:** if patients are not found to be fit, then their plan is reviewed the same day. This would be supported by greater use of e-self assessment by patients in their home. Rehab and post-operative packages of care would be arranged prior to referral, enabling patients who are at risk of staying for long lengths of time in hospital to be proactively identified.
- **Re-check prior to surgery:** patients will be contacted 48-72 hours before their surgery to reduce the risk of late cancellations. This check will ensure patients are still well enough for surgery, and want to go ahead with the planned procedure.
- **Short-notice reserve list:** to ensure that gaps caused by late cancellation can be filled by patients who are ready for treatment which allows theatres to be used most efficiently.
- **Consultant-level feedback:** transparency of list utilisation and case volumes per list. This allows for peer challenge to take place between consultants, to ensure the highest quality and most efficient practices are being maintained.
- **More effective planning for discharge:** discharge planning services will be offered earlier in the process, before patients are admitted to hospital. This will give greater access to community support services, and reduce delays in discharge.
- **Enhanced recovery pathways will be consistently applied**: patients will have a greater understanding of their expected length of stay when they are admitted, and be advised on the best course of action to avoid staying for longer.
- **Ring fenced elective beds will be available:** to reduce wasted theatre time, and diminish the risk of infection for elective patients.
- **Theatre utilisation will be optimised:** by scheduling cases and ensuring that critical equipment is properly scheduled to maintain the order and running of lists.

In addition to the improvements being worked through for orthopaedics, further specialties have been identified for focused pathway design. These are:

- Urology
- General surgery
- Colorectal surgery
- Hepatobiliary and pancreatic surgery
- Upper gastrointestinal surgery
- Gynaecology
- Gynaecological oncology
- Ear, Nose and Throat (ENT)

- Vascular surgery
- Breast surgery
- Musculoskeletal (MSK)
- Ophthalmology
- General medicine
- Gastroenterology
- Endocrinology

As well as delivering efficiency savings, reducing variation in planned care will improve patient outcomes and experience through:

- improved access to information and support to help people manage conditions without surgical intervention
- support for people to access to the right professional expertise the first time, rather than being referred between several different professionals
- improved access to surgical interventions as capacity will be freed up
- patients receive a single outpatient appointment rather than needing to make several attendances
- less time spent in hospital, meaning less chance of acquiring infections and reducing the risk of lost independence
- ensuring access to the right post-operative support, helping patients get back to normal life more quickly.

Reducing variation will also improve staff experience, including ensuring access to the right professional expertise when needed, better access to high quality diagnostics, improved relationships between professionals in different care settings and increasing sharing and learning from best practice across the local professional communities.

6.2.7 Consolidation of specialties

We will identify clinical areas that might benefit from being organised differently (e.g. managing multiple services as a single service), networking across providers, or providers collaborating and / or configuring in a new way in order to deliver high impact changes to major services. While changes of this sort can be challenging to implement and controversial with the public, we should not shy away from considering making changes

In London, two thirds of early deaths in people under 75 are from cancer and heart disease, there is a high risk of heart disease among the local population and the number of people diagnosed with cancer is growing. Specialists, technology and research are spread across too many hospitals to provide the best round-the-clock care to all patients. If we were to improve local survival rates for heart disease and all cancers in line with at least the rate for England, over 1,200 lives could be saved each year. (Source: UCLH news, 14 March 2014)

UCLH, Barts Health, the Royal Free and a number of other north London trusts implemented a significant service reconfiguration to address these issues. Cardiovascular care services provided at The Heart Hospital, The London Chest Hospital and St Bartholomew's Hospital were combined to create an integrated cardiovascular centre in the new building at St Bartholomew's. For 5 complex or rare cancers, specialist treatment is provided in centres of excellence across the area. Services for other types of cancer and general cancer services, such as most diagnostics and chemotherapy, continued to be provided locally.

where we are sure that significant improvements in the quality of care can be achieved.

We are not starting from scratch in this area: considerable service consolidation and specialisation has already taken place in NCL. Recent examples where we have successfully done this include:

- Cardiac / cancer (see case example box)
- Neurosurgery
- Pathology Joint Venture
- Renal medicine
- Hepatology and hepatobiliary surgery
- Neurosurgery
- Vascular surgery
- Ear, Nose and Throat (ENT)
- Bone Marrow transplantation
- Upper gastrointestinal
- Malignant gynaecology
- Cardiology
- Major trauma services
- Stroke services
- Plastic surgery
- Respiratory sub-specialties
- Cancer services including: pancreatic cancer, renal cancer, skin cancer, prostate cancer, head and neck cancer

However, we recognise that there may be other service areas which are or will become vulnerable in the future. There are many reasons why consolidation of services might be considered as a possible opportunity for improvement. First and foremost, we agree that improving quality should be the key driver for exploring consolidation, particularly where there is clear evidence of patients achieving better outcomes. Where there is a 'burning platform' and it is widely accepted that a service needs urgent attention (for example, in addressing issues of workforce sustainability), consolidation will be explored as an option. Releasing cost savings to support overall system sustainability is another driver for exploring potential consolidation opportunities.

This work is at an early stage. No decisions have been made, but we have identified services where we will review whether some form of consolidation may be worth consideration. It is recognised that fundamental, large scale reorganisation may take longer than the 5 year strategic horizon of the STP. As such, we have made no assumptions of financial benefit from this work.

To understand where we should focus further work, senior clinicians have systematically assessed services based on whether consolidation or alternative networking is required and / or could be beneficial. This has enabled us to identify a long list of services potentially in scope for further work over the 5 year period, for example:

- Emergency surgery (out of hours)
- Maternity services, in the context of the Better Births initiative (see section 6.2.1)

- Elective orthopaedics
- Mental health crisis care and place of safety
- Mental health acute inpatient services
- Histopathology
- General dermatology services

Over the next year each of these services will be reviewed in light of whether they would benefit from consolidation or networking. We are in the process of developing proposals to bring together some mental health inpatient services in order to drive significant improvements in quality and patient experience as set out in the mental health workstream (see section 6.2.3). In addition, work is under way to understand potential opportunities for consolidation of mental health places of safety.

6.2.8 Cancer

We will save lives and improve patient experience for those with cancer in NCL and beyond. Commissioners and providers across NCL joined together to form our Cancer Vanguard, in partnership with Manchester Cancer and Royal Marsden Partners, with the aim of achieving earlier cancer diagnosis, ensuring effective use of cancer outcomes information and adoption of recognised best practice across the full spectrum of cancer pathways.

Previously Margaret, aged 60, went to see her GP with persistent epigastric pain for several weeks. She was otherwise well, and did not have reflux, diarrhoea, vomiting or weight loss. Over the course of next 3 weeks, Margaret's GP organised tests and ruled out any inflammation, heart problem, or gallstones that could cause the pain. He also started Margaret on a tablet (lansoprazole) to try to reduce inflammation from the acid on her stomach lining. However, Margaret's pain was more persistent this time and she was still worried.

In the new system, Margaret's GP will be able to refer her to the Multidisciplinary Diagnostic Centre at UCLH despite the fact that her symptoms are not considered "red flag". Here, Margaret will be assessed for vague abdominal symptoms. A clinical nurse specialist will see her 4 days after referral. The team will identify that Margaret has early stage pancreatic cancer and because it is picked up early she will be able to access potentially curative keyhole surgery.

Our cancer workstream is derived from the Vanguard agenda and encompasses a range of improvements to current practice. The key areas of focus include:

- **Early diagnosis:** to address impact of late diagnosis on survival outcomes across NCL, we will target specific causes of late diagnosis and poor detection rates. Targeting colorectal and lung pathways are a particular focus given the high percentage of patients receiving late stage diagnoses, often in Emergency Departments. We will roll out the Multi-disciplinary Diagnostic Clinic model for vague abdominal symptoms, promote adoption of straight to test models and deliver a programme to improve awareness of cancer symptoms in primary care.
- **New models of care:** we are developing the case for a single provider model for

radiotherapy in NCL, to help achieve financial sustainability, reduce variation in clinical protocols and improve patient access to research and clinical innovations. This is being explored between the North Middlesex University Hospitals NHS Trust, the Royal Free NHS Foundation Trust and University College London Hospitals NHS Foundation Trust and also links with the hospital chains Vanguard led by the Royal Free. We will increase provision of chemotherapy closer to home, establishing a quality kitemark for chemotherapy and supporting self-management. The first patient treatment in the home for breast cancer will be available by the end of September 2016.

- **Centre for Cancer Outcomes (CCO):** to deliver robust outcomes data, improve pathway intelligence and address important population health research questions we will produce balanced scorecards which can made available to MDTs, providers and commissioners through a free to access web based platform.
- **Research and commercialisation:** we will leverage our unique position nationally in cancer to improve care for people with cancer, generate additional revenues across the system, and generate efficiencies by avoiding unnecessary interventions.

6.2.9 Specialised commissioning

Specialised services are those provided in relatively few hospitals / providers, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. These services tend to be located in specialised hospital trusts that can recruit a team of staff with the appropriate expertise and enable them to develop their skills. In NCL, the main providers of specialised acute services are University College London Hospitals NHS Foundation Trust (with income totaling £317m) and the Royal Free London NHS Foundation Trust (with income totaling £273m). A further 10 providers receive an additional £128m in income for the delivery of specialised services. This includes three specialist hospitals: Royal National Orthopaedic Hospital NHS Trust, Moorfields Eye Hospital NHS Foundation Trust, and Great Ormond Street Hospital NHS Trust. Barnet, Enfield and Haringey Mental Health NHS Trust and the Tavistock and Portman NHS Foundation Trust provides specialised mental health services. As well as caring for the local population, the specialised services provided by hospitals in north central London are also accessed by a population from outside of NCL.

We recognise that planning for specialised services can have an impact across the region (and potentially nationally), and are therefore working closely with NHS England, London region to develop plans in this area. At a pan-London level, 11 priority transformation initiatives for specialised services have been identified. These are:

- Paediatrics
- Cardiovascular
- Neuroscience and stroke
- Renal
- Cancer
- Adult mental health
- Child and Adolescent Mental Health Services (CAMHS)
- Trauma

- Women and children
- Blood and infection
- Medicines optimisation

On review of these pan-London initiatives, our clinical leadership identified 5 areas which resonated strongly as opportunities where we could lead the way in transforming specialised services. We are in the process of progressing plans in the following 5 areas:

- **High cost drugs:** this involves reviewing and strengthening adherence to starting and stopping rules for all high cost drugs. There is already work ongoing in NCL in this area, which has revealed that clinicians are good at starting people on these drugs but poor at stopping them. We will set clear criteria around the use of high cost drugs at an NCL level. In addition, we will reduce the spend on cancer drugs through the Cancer Vanguard Pharma Challenge process, which includes programmes on biosimilars, home administration and system intelligence.
- **Elective spinal surgery:** we will rapidly progress work on assessment, pre-surgical pathways and stratification to ensure patients are directed to the best possible place. This will help us balance demand and capacity more effectively.
- **End of life chemotherapy:** we will undertake a comprehensive review of chemotherapy usage close to the end of life. Using the evidence on when to stop end of life chemotherapy, we will develop protocols around this. We will work across the whole pathway on this issue, and link stopping acute chemotherapy to end of life discussions in primary care, working closely with the Cancer Vanguard to deliver this.
- **Imaging:** we will contain growth in imaging costs by eliminating the need for re-acquisition due to inadequate or unavailable scans. For patients, this will increase the speed of diagnosis and result in a reduction in duplicated contrast or radiation exposure. Implementing a networking approach to imaging will help us to deliver on this, as well as use of information management and technology to enable providers to share information on the scans which have already taken place.
- **Spinal cord injury:** we will redesign the pathway locally to address patients are currently waiting in Intensive Care Unit (ICU) beds to access specialist spinal cord injury rehabilitation services. Waiting in ICU beds can cause the onset of other symptoms leading to worse outcomes for patients and high costs for the system.

We recognise that our planning on specialised services is less developed than many other parts of the STP. We will continue to work with the specialised commissioning team in NHS England, London Region to develop more detailed plans in this area.

6.3 Productivity

6.3.1 Commissioner productivity (BAU QIPP)

We will continue to deliver significant “business as usual” efficiencies throughout the 5 year period. Business as usual (BAU) QIPP (Quality, Innovation, Productivity and Prevention) comprises savings commissioners expect to deliver as part of their normal activities. These are efficiencies in areas of CCG spend not covered by our other workstreams and include opportunities in the following areas:

- **Mental health:** this includes ongoing non-transformational efficiencies, consistent with parity of esteem requirements. Examples of mental health QIPP are the management of out of sector placements and streamlining the pathways with specialist commissioning across forensic and mental health services.
- **Community:** spend on community services was c.£133m in 2015/16. There is an assumption of increased efficiency equivalent to 1.5% per annum supported by benchmarking work and transition to new models of care.
- **Continuing care:** spend on continuing care was c.£90m in 2015/16. There is an assumption of increased efficiency equivalent to 2.1% per annum supported by existing framework agreements.
- **Primary care prescribing:** spend on primary care prescribing was c.£205m in 15/16. There is an assumption of increased efficiency equivalent to 2.5% per annum including the adoption of generic drugs where possible, the adoption of local quality schemes to improve consistency and effectiveness. This is in the context of assumed growth of 5-7% per annum.
- **Programme costs (including estates):** this includes measures to reduce void costs and better alignment of health and care services to reduce the overall estate footprint whilst maintaining and improving service quality.

6.3.2 Provider productivity (BAU CIP) and system productivity

Significantly improving provider productivity is an essential part of the work to address our financial challenge. Our plans assume significant delivery of CIP (Cost Improvement Programmes), improving provider productivity.

We have identified opportunities for system productivity (defined as those areas where CIP delivery is dependent on trusts working together) to deliver financial savings whilst maintaining or improving quality. Our plans also assume savings from improvements to contracting between CCGs and trusts which will be realised system wide.

Specific initiatives to improve productivity include:

- **Workforce:** we will establish a shared recruitment and bank function across providers meaning that staff can be deployed between providers in the system; as well as improving retention of current staff and upskilling the health and social care workforce to enable delivery of new models of care. We commit to complying with the maximum total agency spend and hourly rates set out by NHS Improvement.
- **Procurement:** we will reduce purchasing unit costs with increased volume and scale across all providers by reducing clinical variation in product choice and undertaking joint action on drugs and medicines management.
- **Back office:** we will create centralised functions for payroll and pensions, finance and estates in order to reduce our overheads and improve service resilience. In addition we will:
    - Consolidate IT services to reduce costs whilst improving the resilience and quality of services

  - Enhance the existing share procurement arrangements to reduce non-pay costs
  - Pool our legal budgets and resources, considering options to consolidate outsourced resources or appoint an in-house legal team.
- **Operational and clinical variation:** we will collectively reduce average length of stay, maximise theatre utilisation and streamline clinical processes, in addition to the changes proposed through the elective workstream.
- **Contract and transaction costs:** Releasing savings from streamlining transactions and contracting. This will be delivered through implementing new commissioning arrangements (which may facilitate joint procurement of services from the Commissioning Support Unit (CSU), for example) and leveraging the opportunities associated with joint commissioning between local authorities and CCGs.
- **Other:** Additional existing provider productivity schemes: estates, clinical admin redesign, service transformation, income etc.

6.4 Enablers

6.4.1 Digital

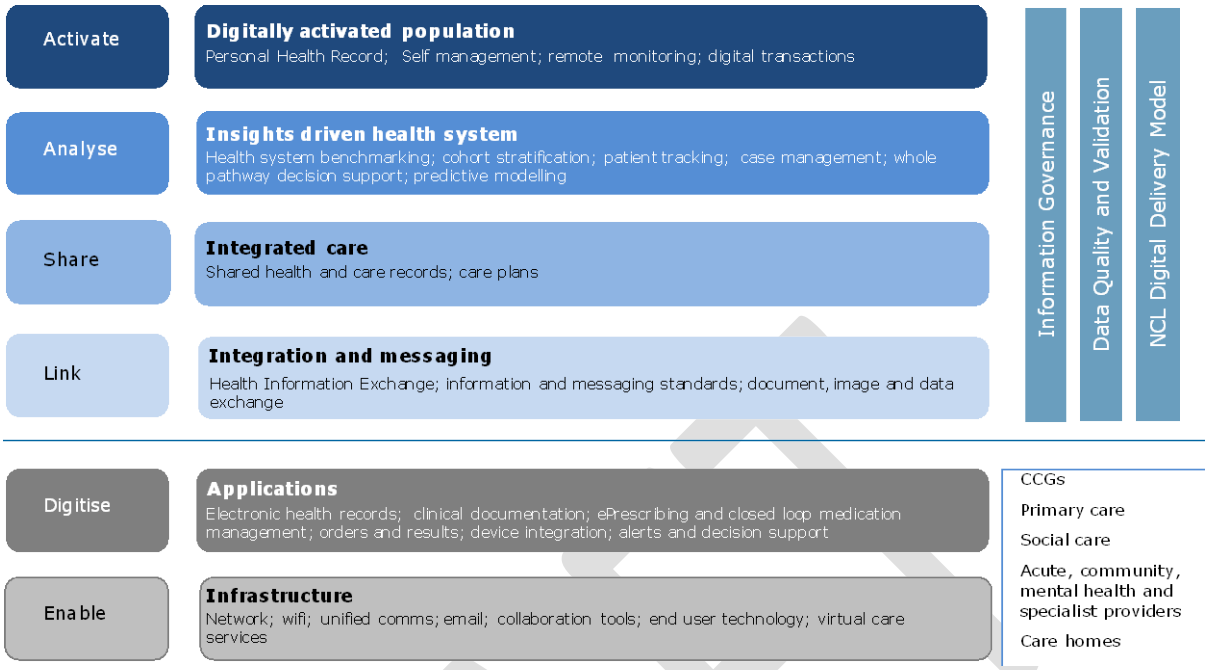
We will use digital technologies and information to move from our current models of care to deliver proactive, predictive, participatory, person-centred care for the population we serve.

There is significant and immediate opportunity for digital to transform our current delivery models and seed completely new, integrated models of health and social care. We recognise the strength of both the clinical and financial case for digital and its potential impact in strengthening productivity, providing ease of access to our services, minimising waste and improving care. Our ambition is to become a national leader in population health management enabled by informatics, to reduce variation and cost and improve care.

We will prioritise and increase pace of appropriate digital technology adoption within our organisations, realigning the demand on our services by reducing the emphasis on traditional face to face care models. In addition, we will explore new digital alternatives that will transform our services, with the aim of moving care closer to home, enabling virtual consultations and providing our patients with the information and resources to self-manage effectively, facilitating co-ordinated and effective out of hospital care. We will utilise opportunities for real-time, fully interoperable information exchanges to provide new, flexible and responsive digital services that deliver integrated, proactive care that improves outcomes for our patients.

Our digital programme proposes the creation of an NCL Population Health Management System (exhibit 8), which supports prevention, service transformation and productivity, and would enable us to meet the national mandate of operating paper free at the point of care by 2020. Through this system we will move from a landscape of diversity and variation to one of shared principles, consolidation and joint working for the benefit of the population.

Exhibit 8: NCL Population Health System Management



The 6 workstreams that make up our digital strategy are:

- **Activate**: We will provide our citizens with the ability to transact with healthcare services digitally, giving them access to their personal health and care information and equipping them with tools which enable them to actively manage their own health and wellbeing.
- **Analyse**: We will use data collected at the point of care to identify populations at risk, monitor the effectiveness of interventions on patients with established disease and deliver whole systems intelligence so that the needs of our entire population can be predicted and met.
- **Link**: We will enable information to be shared across the health and care systems seamlessly.
- **Share**: We will create and share care records and plans that enable integrated care delivery across organisations.
- **Digitise:** We will support our providers to move away from paper to fully digital care processes; including documentation, ordering, prescribing and decision support tools that help to make care safer.
- **Enable**: We will provide infrastructure which enables our care professionals to work and communicate effectively, anywhere at any time, and facilitate new and enhanced models of care closer to home.

To deliver on our digital strategy we will need to invest £159m, with a further £21m in 2020/21 (see section 8.3).

6.4.2 Estates

Our vision is to provide a fit for purpose, cost-effective, integrated, accessible estate which enables the delivery of high quality health and social care services for our local population. The priorities for development of our estates strategy are:

- to respond to clinical requirements and changes in demand by putting in place a fit for purpose estate
- to increase the operational efficiency of the estate
- to enhance delivery capability
- to enable the delivery of a portfolio of estates transformation projects.

There a number of barriers to achieving this, including:

- the complexity of the estates system in NCL, including the number of organisations and the differences in governance, objectives and incentives between each organisation, which often results in organisations working in silos
- misaligned incentives, which do not encourage optimal behaviour
- lack of affordability, specifically the inability for trusts to retain capital receipts, budget "annuality" and the difficulty of accessing capital investment for re-provision
- the complexity of developing business cases in terms of getting the right balance of speed and rigour, and the different approvals processes facing different organisation types (for example, there are different capital approval regimes operating across the NHS and local government).

We are working as part of the London devolution programme to pilot devolved powers in relation to the health and care estate. As part of this, we are asking for:

- local prioritisation and investment of capital receipts, including those that would otherwise be retained nationally
- NHS capital business case approval to be accelerated and consolidated through the implementation of a jointly owned and collaborative NCL / national process (or devolved to sub-regional or London-level)
- development of enhanced and revised definitions of value for money, which consider social value, wider community benefit and system sustainability at the sub-regional level
- new approaches for the accounting treatment of multi-year projects for non-foundation trust providers, in support of our plans
- developing local flexibilities in terms and conditions for the primary and community health estate to improve quality and utilisation
- support to agree the London-level and NCL delivery options to enhance our work
- ability to pay off PFIs using money raised from capital sales and/or a commitment by national partners to renegotiation of such agreements, where they have been identified as a significant barrier to financial sustainability and/or the facility is less than 50% utilised and no other utilisation solution will address the issue.

We anticipate the following benefits:

- a whole system approach to estates development across NCL, with different partners working together on projects and developing a shared view of the required investment and development to support clinical change
- the ability to undertake better local health economy planning, including establishing estates requirements
- increased affordability of estates change across NCL
- greater incentives to dispose of surplus property, releasing land for housing
- focused action on the development of the estates requirements to deliver care closer to home
- greater efficiency and flexibility in the estate, reducing voids and improving utilisation and co-location which will support financial savings

Across the sites of Moorfields, St Pancras, St Ann's we are beginning to evidence qualitative benefits of working together to deliver estates value and improvement. The sector for a number of years has had unresolved estates issues relating to poor mental health inpatient accommodation and potentially saleable and high value estate at St Pancras Hospital. The 3 providers are working together on this strategic estates project which aligns estates priorities between all 3 trusts.

The proposed programme, which is still subject to consultation, would see sales proceeds from surplus assets used to deliver new purpose built mental health accommodation, and the eventual relocation of Moorfields Eye Hospital to the St Pancras site. Clinical improvements would be prioritised through the building of a new Institute of Mental Health and an integrated Eye Hospital and Institute of Ophthalmology at the current St Pancras Hospital site.

The three trusts are currently refining their outline business cases, with Board decisions due in late 2016 and early 2017. Subject to consultation, further testing of economic viability and planning permission, the specific benefits of the work will include:

- development of a new world class research, education and clinical care facility housing an integrated Moorfields Eye Hospital and UCLH's Institute of Ophthalmology, transforming ophthalmology facilities that are at present a constraint on continuous improvement
- improvements to the estate to meet CQC "must dos" including new mental health inpatients facilities for Camden and Islington NHS Foundation Trust (including the integration of physical and mental health and social care through an integrated practice unit at St Pancras). Also, new facilities for Barnet, Enfield & Haringey Mental Health Trust at St Ann's Hospital, Tottenham
- a world class UCLH Institute of Mental Health and associated patient care and educational facilities at St Pancras Hospital
- potential to deliver c.1,500 new housing units in London, significantly contributing to the NHS target for release of land for residential development
- improvements to environmental sustainability, as the new builds will deliver a balance between BREEAM ratings for 'green' initiatives, the cost of the capital build requirements to deliver them and the whole life cycle benefits in terms of costs and

a more sustainable future for our planet. We will design, build and operate in a manner that supports recycling and use of low carbon technology.

The schemes are planned at a total capital cost of c.£400m (see section 8.3) with joint provider engagement under the umbrella of the estates devolution pilot driving completion of the final scheme by 2023. It is planned that £326m of this is financed by sale proceeds with the remainder funded from a variety of sources, including philanthropy.

Progressing this scheme may lead to a platform for sector wide capital prioritisation and create an improved incentive framework for asset disposal and enhanced utilisation, which will give rise to a locally originated capital funding stream.

In line with the findings of Healthcare for London in 2014, our analysis shows that significant capital work is required across NCL to improve the primary care estate. The primary and community estate needs improvement in a number of areas:

- development of CHINs to enable the delivery of the care closer to home model
- expansion and development of primary care facilities to ensure registration for a significantly expanding population and extended hours access
- whilst some capital to enable delivery may be available through the estates technology and transformation fund (ETTF), it is unlikely that this will cover the full set of requirements of £111m. Devolved powers will enable us to secure capital to deliver these much needed improvements and reduce the running costs of this estate.

Exhibit 9: NCL CHIN estate planning

Estates requirements for Care Closer to Home and CHINs

NCL CCG CHIN current locational planning (NB Early stage and subject to full consultation)		
Barnet CCG	North East South West	Vale Drive Health Centre: The site identified is a LIFT building and hence it will improve utilisation Finchley Memorial Hospital: A LIFT building which is a natural hub and this will improve utilisation Grove Mead and/or new Colindale HC: A new health centre/CHIN is planned for Colindale (ETTF & S106) Edgware Community Hospital: ECH is another natural activity hub and also an underutilised site at present
Camden CCG	North North East South West	Hampstead Group: An extension to an existing practice is planned to create a health centre/CHIN (ETTF) Kentish Town Health Centre: A LIFT building which is a natural hub and this will improve utilisation Somers Town: An existing practice that is well placed to serve as a CHIN West Hampstead: An existing practice that is well placed to serve as a CHIN
Enfield CCG	North East South East South West North West	A number of potential GP practices require further consideration in order to deliver Care Closer to Home services (CHINS), in support of implementing the GPFV. We are engaging with our local GP Federation(s) and GP practices on emerging options in order to agree the future direction informed by their suitability, viability and location to deliver the service requirements for CHINS in the future.
Haringey CCG	North East South East South West North West	Somerset Gardens: An ETTF scheme aims to extend an existing practice in the White Hart Lane re-gen area Tynemouth: A well placed existing practice currently providing extended access Hornsey Central (Queenswood): A LIFT building which is a natural hub and this will improve utilisation Bounds Green: A well placed existing practice currently providing extended access
Islington CCG	North Central South	Archway: An ETTF scheme to develop a new build health centre/CHIN Islington Central: A well placed and effective existing practice which can serve as a CHIN Ritchie Street: A well placed and effective existing practice which is able to serve as a CHIN

1

6.4.3 Workforce

We aim to ensure that NCL becomes the place of choice to train, work and live healthy lives. This includes co-creating, communicating and collaboratively delivering a compelling offer to attract, develop retain and sustain a community of people who work in health and care in NCL. Our workforce needs to move further towards a person-centred approach and this means developing a whole range of new skills, training modalities and new roles.

Our vision is for staff to be part of the wider NCL workforce, not just part of a single organisation. Through this we will achieve efficiencies in employment by managing services collectively across the footprint. We will create sustainable career pathways to attract, develop and support a workforce fit for purpose in the changing health and care landscape. We will work with NCL organisations across all care settings (including social care) to support their collaborative efforts to be excellent employers – employers of choice, committed to looking after the wellbeing of staff whilst also preparing them to begin delivering the new care models. This will support NCL organisations to recruit and retain staff, particularly where employee turnover rates are high or where there are staff shortages. Career pathways will not be limited to a single care setting and will offer our staff opportunities to experience a wide range of different opportunities which fit their own aspirations. This process will allow us to work towards the development of an integrated employment model and a personal career passport for staff to develop their career over the long-term within NCL.

We aim to improve employee wellbeing and reduce avoidable sickness absence cost-effectively, therefore increasing lifetime productivity. We will focus on implementing the healthy workplace charter in NHS organisations, local authorities and in small and medium sized businesses.

Through equipping the existing workforce with new skills and ways of working, we will both ensure that our people are working to the best of their ability as well as adapting roles to meet the changing requirements of our services. We will support some of those people currently working in hospital settings with the skills and confidence to work across the care pathway, reaching out into community care settings and delivering the care closer to home model. We will similarly enhance the capabilities of those currently working in social, community and primary care. We will equip all our existing and future staff with motivational and coaching skills, competence in promoting self-care and prevention, and the enhancement of emotional resilience in themselves, their teams and their patients. All frontline NHS and local authority staff will be trained online in Making Every Contact Count (MECC), with key frontline staff also receiving face-to-face training. All non-medical frontline staff will receive training in Mental Health First Aid (MHFA). All NHS and social care staff will be trained in basic dementia awareness, with more advanced training for frontline staff who are more likely to encounter people living with dementia.

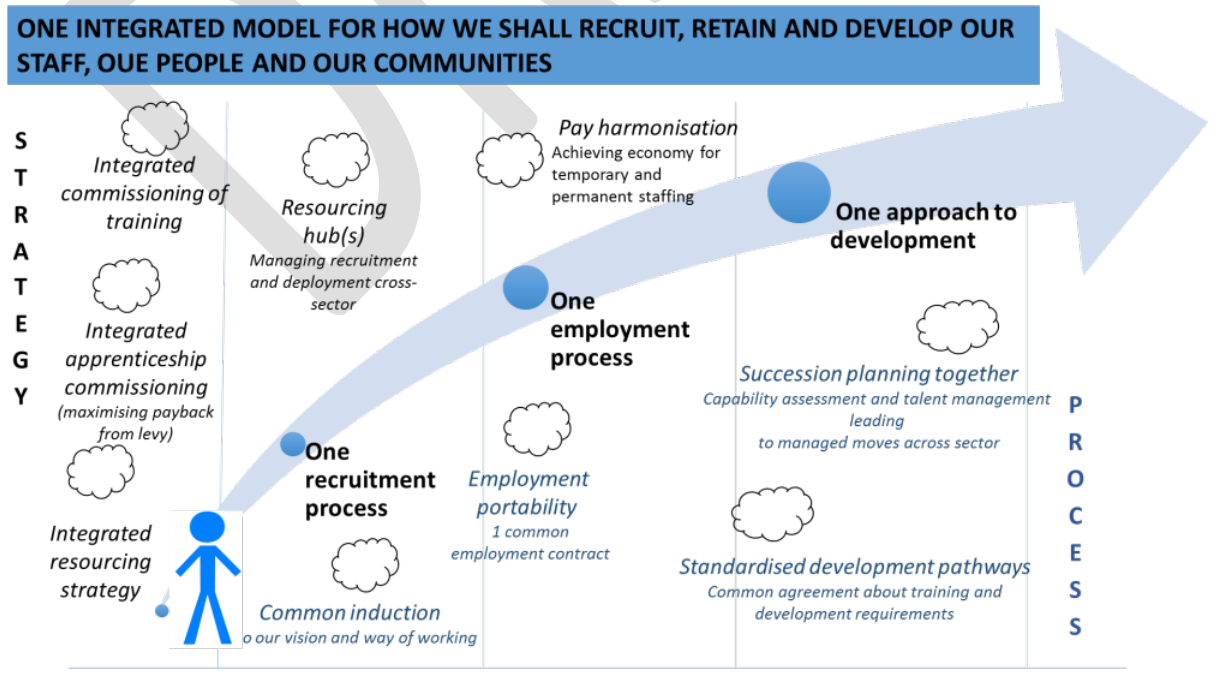
While most of the people who will be engaged in delivering the NCL vision are already with us, working in roles which will need to adapt or change in some way, we will also support the establishment of a small number of new roles, such as physician's associates, care

navigators and advanced clinical practitioners. We will undertake expert strategic workforce planning and redesign, and commission training for skill enhancement, role diversification and new role implementation.

To enable transformation, we will deliver system-level organisational development, supporting system leaders as individuals and as teams through the transformation journey to enable personal resilience and courageous action. In addition, we will train everyone in a single approach to continuous quality improvement to create a culture of continuous improvement to deliver clinical excellence and quality care.

Health, social care and public health delivery is not limited to employees of our traditional employers, and our notion of working with the 'wider workforce' extends to the numerous carers, volunteers and citizens who improve the life of our population. In order to improve the general wellbeing of our population and make use of the substantial social capital across our footprint, we will educate and support patients, carers and those in their communities in areas such as self-care, self-management, dementia and mental health awareness. Building on our 'wider workforce' vision and aligning with initiatives such as the Alzheimer's Society ambition for London to be a dementia friendly city by 2020, we will support the training of groups such as barbers, hairdressers, librarians and teachers to gather a better understanding of dementia and other long term conditions. Across NCL, we have already built five strong Community Education Provider Networks (CEPNs), and these will provide an effective vehicle for delivery of this aim. We will review the provision of learning and development across NCL to ensure we make the best use of existing assets to encompass the wider healthcare community including patients and carers. Our immediate aims will be to standardise and streamline statutory and mandatory training, align induction and share in-house learning and development capacity.

Exhibit 10: Integrated workforce model



6.4.4 New commissioning and delivery models

As part of the STP development process, and in response to the changing healthcare landscape in NCL, the 5 CCGs have been exploring ways of working more collaboratively together whilst also seeking to strengthen joint commissioning with local authorities. We have concluded that a more formalised degree of cooperation between the 5 CCGs will improve health commissioning, particularly in response to:

- the development of new models of care, including larger provider organisations such the Royal Free Vanguard.
- increasing financial risk
- stretched capability and capacity.

Our work has covered the development of a proposal for joint governance of strategic commissioning decisions (see section 9.2.1); the development of a common commissioning strategy and financial strategy; and, a review of CCG management arrangements, with a view to shaping new ways of commissioning. With a focus on population health systems and outcomes and the transition to new models to deliver these, our objective is to further strengthen strategic commissioning over the next 2 years. We have agreed that any new commissioning arrangements need to balance the importance of local relationships and existing programmes of work with the need to commission at scale.

The governing bodies of each of the CCGs have agreed to the need for new executive management arrangements including shared roles across the CCGs: an Accountable Officer; a Chief Finance Officer; a Director of Strategy; and, a Director of Performance. Additionally, in order to ensure the continued role of each CCG in respect to its local commissioning and joint work with local government, local Directors with responsibility for local functions and services have been proposed.

These new leadership positions will work with each of the CCGs, as well as the new shared governance structure described in section 9.2.1, to ensure that health commissioning in NCL delivers the best possible health and wellbeing for the local population whilst ensuring value for money. The arrangements will be further considered by governing bodies in November with the expectation that the new leadership will be in place no later than 1 April 2017.

In parallel, commissioners and providers across the system have been working together to define our direction of travel in terms of new delivery models. We already have significant work we can build on relating to this, including the Royal Free London's provider chain model; the UCLH Cancer Vanguard; the Moorfields Eye Hospital ophthalmology specialty chain; and, the Royal National Orthopaedic Hospital NHS Trust chain of orthopaedic providers.

We have consulted with the leaders of all organisations across the system to get views on the different options for new delivery models, and the broad consensus includes moving towards:

- whole system working with a population rather than individual organisational focus
- a deeper level of provider collaboration, including collaboration between primary care, community services, acute services, mental health services and social care services.
- the establishment of some form of 'new delivery vehicle' or 'new delivery system' to support this provider collaboration.
- a transfer over time of some elements of what we currently consider commissioning functions (for example, pathway redesign) into these new delivery vehicles.
- a move towards some sort of population based capitated budget for the new delivery vehicles.
- the retention of a strategic commissioning function responsible for holding the delivery vehicles to account, with accountability for outcomes rather than inputs based on principles of commissioning for value.

Further work needs to be done to resolve issues and differences of view around the following:

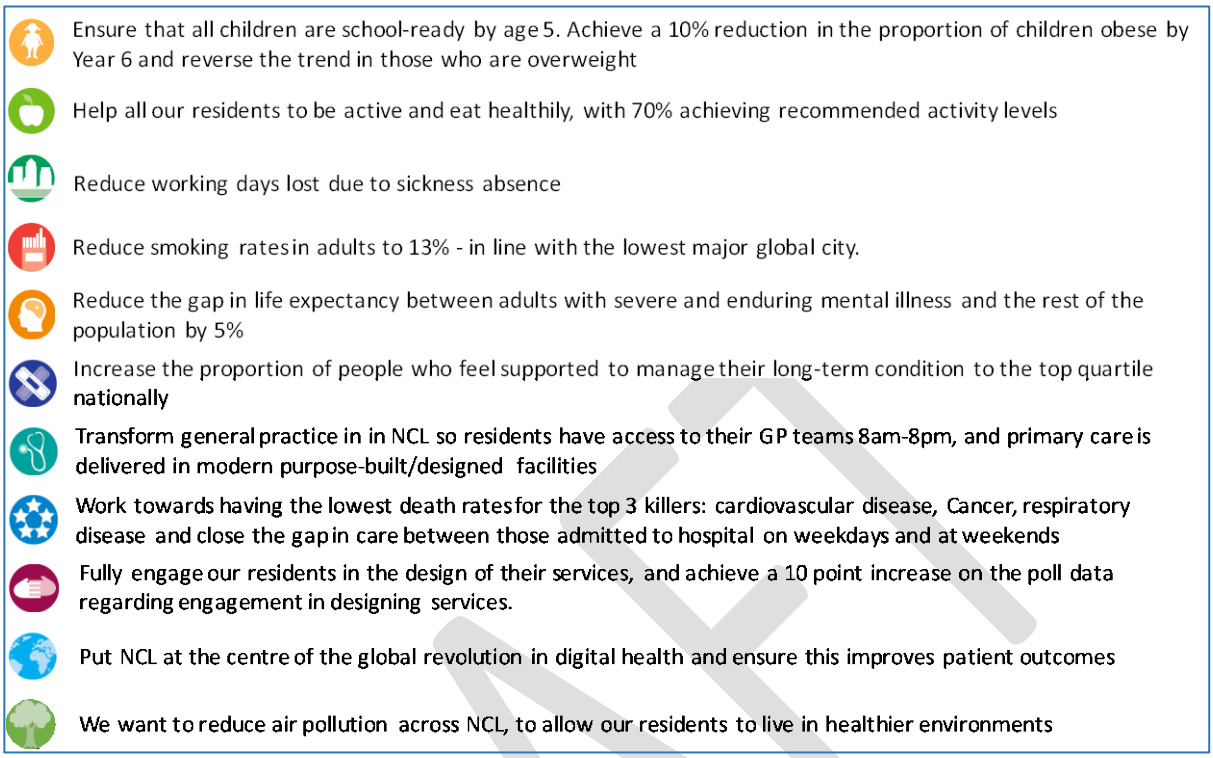
- the organisational form for the new delivery vehicles
- the optimal population size for population health management
- the geography over which new delivery vehicles should operate
- the form and governance of the strategic commissioning function
- which commissioning functions should remain with the strategic commissioning function and which should be undertaken through the new delivery vehicle.
- the scope of the new delivery vehicles
- unresolved issues such as how to manage patient choice, specialised services and other flows outside of the delivery vehicle and a full understanding of the legal framework which might impact on implementation
- speed of implementation.

Discussions continue across health and care commissioners and providers in NCL to establish agreement about the nature and scale of new delivery vehicles. Different care models are still being considered, and this work is being steered through the STP governance framework.

6.5 Measuring our success

We have established the anticipated impact of each of our workstreams to ensure we remain on track to close the key gaps as set out in our case for change. However, to ensure that the breadth of our workstreams collectively meet the scale of our ambition, 11 overarching outcomes have been developed by the London Health Commission for the Better Health for London strategy. These have been adapted for NCL and endorsed by the clinical cabinet for our STP. We will know if we have been successful by measuring impact against these outcomes over the next 4 years.

Exhibit 11: NCL STP outcomes



7 Delivery plans

A delivery plan has been developed for each of our workstreams, setting out the scope; objectives; financial and non-financial impact with trajectories; any investment requirements and the key risks to successful delivery. We will finalise the details of the delivery plans over the next few months as we agree the detailed phasing and investment timetables.

The delivery plans will be live documents and will continue to be iterated as the programme develops. In addition, each workstream is required to develop a full programme initiation document which will provide a reference point for every workstream to ensure planned delivery is on track, and to support the effective management of interdependencies between workstreams.

8 Bridging the financial gap

The financial analysis that we have undertaken (see exhibit 2) shows the significant gap between anticipated growth in demand (and therefore cost growth) for the NHS in NCL and the growth in funding that the NHS expects to receive over the 5 years of the STP. Without changing the way that we work together as a system to provide a more efficient, joined up service across organisations, this would leave us with an estimated £876m deficit in 2020/2021.

The STP in NCL has brought together organisations across health and social care to jointly discuss how we can address this financial challenge as well as making progress in improving the quality of, and access, to services. Based on the plans and analysis set out in this STP, which have been developed with and by local clinical experts, we will reduce the annual deficit over the next five years to £75m (exhibit 12) – whilst this addresses more than 90% of the financial gap, we recognise that further work is needed.

The key elements of the plan are set out in detail elsewhere in this document. Exhibit 12 shows how these contribute to the improvement in the annual financial position of the NCL system over 5 years. The key areas of work are:

- **Care closer to home:** savings of £114m have been estimated from improving access to primary care; proactively identifying need and early intervention to avoid crisis; rapid response to urgent needs to prevent hospital admissions; providing community-based and ambulatory-based care; and reducing delays to discharge.
- **Prevention and the support of healthier choices:** this is estimated to result in savings of £10m.
- **Mental health outreach and liaison:** this is estimated to result in savings of £6m.
- **Optimising the elective pathway**: savings of £55m have been estimated from benchmarking against best practice; working closely with clinicians; optimising flow through theatres (increasing throughput); and reducing length of stay - in addition to the excellent work that our hospitals and other providers do to improve productivity each year.
- Additional plans are being developed relating to the **UCLH Cancer Vanguard** scheme and **Royal Free Hospital Chain Vanguard** which are estimated to deliver £35m.
- **System level productivity** savings of £98m are planned to be achieved alongside the 'business as usual' cost improvements across providers in NCL of £218m and local commissioner business as usual efficiencies (QIPP) of £57m.
- We have identified a potential saving of £24m per year through 'buying out' a number of **Private Finance Initiative** hospitals, bringing management of these facilities back within the public sector. We will continue to work with the Department of Health and others to develop these plans, recognising that there are a number of constraints.
- Although detailed plans have not yet been developed, we have been advised by NHS England to assume that the NCL proportion of the **London Ambulance Service (LAS)** financial gap of £10m and the estimated **specialised commissioning** pressure of £137m will be fully addressed by LAS and NHS England respectively. NCL hospitals provide a very significant amount of specialist care and it is therefore essential that NHS England works together with the STP on how these services can flourish whilst

also addressing the financial pressures associated with the growth in specialist activity (which in most developed economies is higher than growth in other services due to new technologies, drugs and clinical interventions).

- Further work is ongoing in relation to developing a fuller understanding of the social care financial position and pressures. At present no financial values have been included as advised by NHS England, but this has not prevented the STP from working very closely across both health and social care. In particular the NHS within NCL is seeking to learn from local authority colleagues best practice in relation to reducing cost whilst improving the experience of people who use services and the public.

These improvements cannot be achieved without investment. The plan is based on investment of £64m in prevention and care closer to home, and £4m in elective care. We have also assumed that £31m of our indicative £105m share of the Sustainability and Transformation Fund will be required to fund national policy priorities over and above these investments, in addition to that already assumed within the 'do nothing' scenario.

The savings set out above are predicated strongly upon reducing significant activity in acute hospitals, in particular reducing demand for inpatient care. We know that realising such savings can be difficult in practice and are contingent upon removing or re-purposing capacity within acute hospitals. As such, through working with the clinical cabinet of clinical leaders within NCL we have assumed that the cost savings that will be realised from each avoided day of acute hospital care will be significantly lower than the average tariff that is currently paid to providers by commissioners for this care. This is reflected in a £53m 'risk adjustment' in the financial analysis.

8.1 Normalised forecast outturn by year

Each year there will be a number of one-off costs and income streams to the commissioners and providers within NCL. Our 5 year financial analysis is initially based upon the "normalised" (or underlying) financial position in 2016/17 which is then projected forward. We estimate that 2016/17 outturn will be a normalised deficit of £216m (£101m on an in-year basis). Significant one-off figures within this include UCLH's transitional funding that it is receiving to compensate for the financial impact of moving cardiac services to the new, world class centre at Barts hospital, and the Royal Free's transitional funding in relation to the merger with Barnet and Chase Farm. The underlying figure also includes a £40m adjustment which is an estimate of the combined risk to the NHS provider and commissioner forecast outturn. This has arisen as a result of potentially different assumptions between NHS commissioners and providers about the value of work undertaken by the end of 2016/17. We have reached an agreed view on forecast outturn activity and will continue to work urgently to ensure consistency of payment assumptions between different parts of the NHS within NCL. All parties have agreed a more 'open book' approach to contract agreements that will ensure a consistent, system-based approach.

The STP plan shows a gradual improvement in the financial position over the 5 years of the STP (exhibit 13). The normalised position improves year on year. This pattern is in part caused by the requirement for majority of the investment in the early years of the STP, with benefits accruing in the later years.

8.2 2017/18 forecast operating plan

In 2017/18 we estimate that our in-year position will be a £95m deficit for NCL against a draft system control total of £13m surplus (which we anticipate will change over the coming weeks due to a number of technical issues). This incorporates significant investment during the year on service transformation and delivery of the Five Year Forward View:

- investment in service transformation: £25m. This relates to the care closer to home (£23.5m), elective (£0.8m)and outpatient (£0.4m) workstreams
- other recurrent investment by CCGs and trusts – included within the CCG and trust cost movements it is estimated at £25m in 17/18 to deliver elements of the 5YFV priorities
- other non-recurrent costs (estimated at £20m in 17/18) for investment in Vanguard costs, IT digital costs, and STP programme costs.

In line with NHSE guidance we have also assumed that we will receive our 'fair share' of the national Sustainability and Transformation Fund (£105m) in 2017/18. This compares to the £52m currently notified to NHS providers, and additional a further £53m improves our revised forecast operating plan position to a deficit of £62m – see exhibit 14.

8.3 Capital expenditure

We recognise that the national capital budget for the NHS is highly constrained over the course of this parliament, and will continue to work hard to minimise the need for significant capital investment unless there is a strong return on investment. NCL also has a number of creative proposals that will seek to maximise disposal proceeds from sites no longer required, and use these to reinvest in the priority areas of the STP as well as the potential to provide additional, much-needed housing for the residents of NCL.

There are a number of large capital schemes that are already approved and underway within the STP and, whilst far from being 'business as usual' these are included in the 'do nothing' scenario as their approval pre-dates the STP work. Total capital, before specific STP-related investment, is £1.2bn over the 5 years. This includes:

- **UCLH new clinical facilities:** haematology-oncology and short stay surgery – (£137m); Proton-beam therapy (£130m), ENT and dental facility to consolidate two existing hospitals onto the main University College Hospital campus (£98m) and other more minor schemes. UCLH have approved DH funding of £278m (£51m public dividend capital (PDC) and £227m DH Loan) as well as anticipated, ring-fenced disposal proceeds to finance these developments
- **Royal Free - Chase Farm redevelopment:** (£183m), which includes £93m of approved DH funding (£80m PDC and £13m DH Loan).

In addition to these major developments there is of course significant business as usual capital investment such as equipment replacement and building maintenance, funded through depreciation, cash reserves and other sources of funding (including disposals).

The additional gross capital requirements to implement the transformation programme set out in the STP totals £542m, with a much smaller net investment requirement after taking into account disposals, donations and grants:

- **Estates redevelopment:** relating to our St Pancras/St Anns/Moorfields proposals: £404m, assumed to be funded through disposals £326m), DH loans (£39m) and Donations (£37m), of which **£272m** (including short term bridging loans and repayments) occur within the period covered by this STP (i.e. before 2020/21) and is included above. This scheme, including an assumption of DH loan funding, has yet to be agreed, and will be subject to normal Business Case processes through NHS Improvement.
- **Primary Care for Care Closer to Home and 5YFV investment: £111m** assumed to be funded predominantly through ETTF (£60m – all bids submitted), s106/CIL/GP contributions (£26m), grants and other sources.
- **IT investment: £159m** with a further £21m in 2021/22. All assumed to be funded by ETTF (circa £10m – bids submitted for the Person Held Record/IDCR) or through the central Digital Transformation Fund.

We recognise that further work is needed to develop full business cases for the above, and at present these figures are estimated - particularly in relation to primary care and digital investment. In developing these schemes we will seek to maximise the use of existing buildings and other assets, and minimise the need for new capital investment, together with applying a robust requirement for return on investment for each scheme. However, we fundamentally believe that investment in primary care and digital technology is central to the transformation of services that is needed in NCL to address the gaps in service quality, access and finance, and wholly consistent with the Five Year Forward View and requirement to be paper-free at the point of care by 2023. It would be wrong to assume that such investment is not required and will not deliver value simply because of the stage in development of these plans that NCL is currently in.

The estates redevelopment relating to St Pancras, St Ann's and Moorfields, and the estates devolution work, offers an exciting and compelling vision as to how existing assets, disposals, redevelopment and construction of new facilities can be financially efficient as well as delivering significant benefits to patients, service users and the wider population.

In addition, we will continue to engage as an STP with the work being led by Sir Robert Naylor in relation to property strategy across the NHS, to further understand how being a pilot area in this can help NCL make best use of its current assets to support the delivery of our STP vision.

8.4 Next steps to address the financial gap

We are very clear that we have more to do to close the financial gaps for the remainder of 2016/17 and across the next 4 years of the STP.

We will therefore undertake a period of further intensive work over the next 8 weeks both to improve confidence in delivery of current estimates, whilst concurrently working on other areas to further improve the position. As far as possible we will aim to do this by

Christmas, so that our operating plan submission improves on this submission. However, we do believe that there is a risk that the gap will not be fully closed in every year whilst ensuring that we continue to prioritise quality of and access to services, particularly as we balance the need to invest in the early years to deliver transformational benefits in later years. It is also essential that STPs and their constituent organisations and leadership are given the regulatory headroom to develop longer term plans, and that the 'new models of care' being developed give clarity of financial accountability to support the financial challenges that the STP faces.

We have identified a number of immediate actions to improve our current financial position, which include:

- early delivery of high impact care closer to home interventions
- accelerated delivery of stretch targets for high impact elective pathways
- increased effort in terms of delivering efficiencies through provider productivity schemes
- reducing any non-value added contracting costs
- implementation of pay harmonisation and shared principles around usage of bank and agency staff
- leveraging existing capacity in NHS providers to reduce outsourcing of activity to the independent sector
- other non-recurrent savings measures
- assessing and incorporating the impact of 2017/18 tariff changes.

There are also a number of areas that we will explore further as we believe there may be significant savings to be found. These include:

- maximising clinical productivity across providers, for example introducing shared clinical rotas
- developing alternative pathways for the London Ambulance Service to avoid conveyance to Emergency Departments
- rolling out standardised pathways to all specialities
- identifying opportunities to reduce the length of stay for patients receiving specialist services
- reviewing any plans that require capital and have not yet been agreed to establish the most cost effective way to deliver agreed outcomes
- rapid implementation of cancer initiatives, including early diagnosis, new models of care, end of life interventions and research and innovation
- re-providing cost effective services for the c.20% of people we estimate are currently in hospital beds but are medically fit to leave
- putting in place a peer review challenge approach across all areas of spend to identify further opportunities to reduce or avoid spend, and to aid collective delivery of plans.

Exhibit 12: Bridging the financial gap to 2020/21

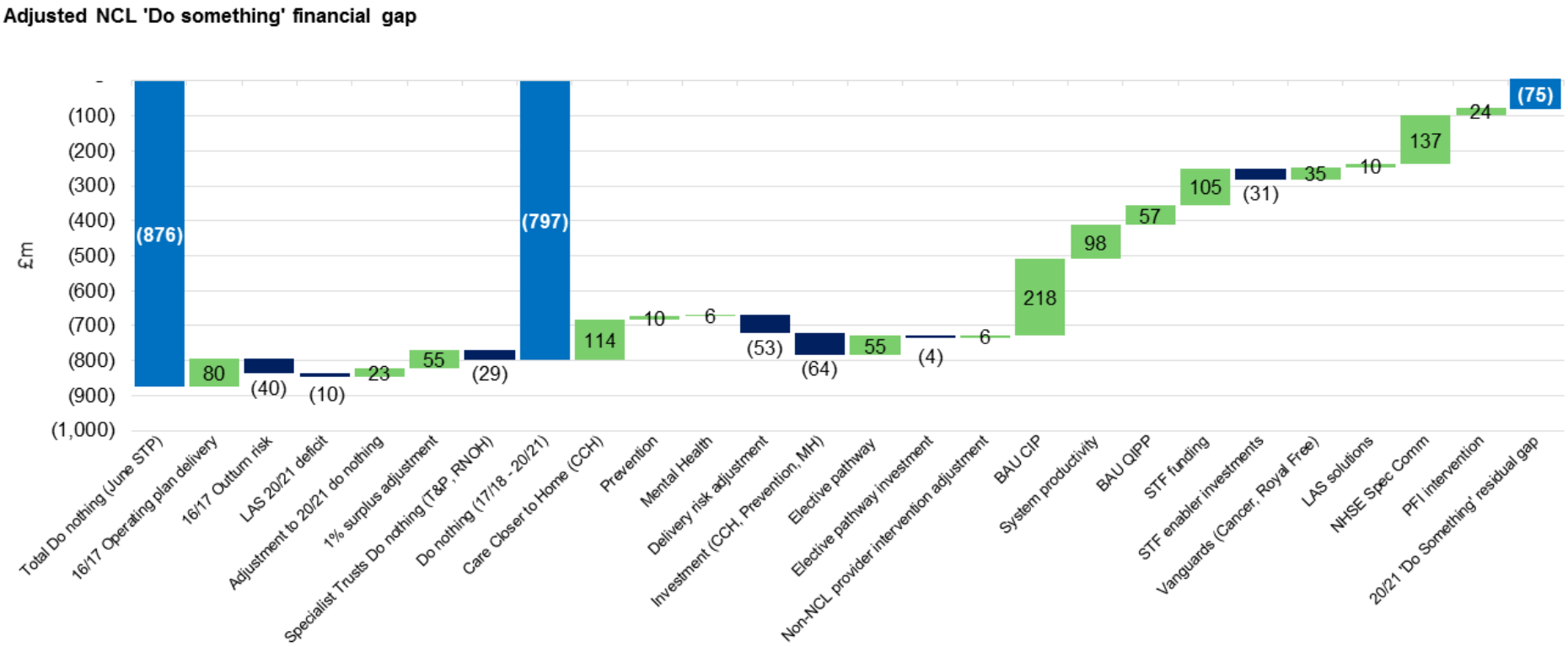


Exhibit 13: Normalised forecast outturn by year

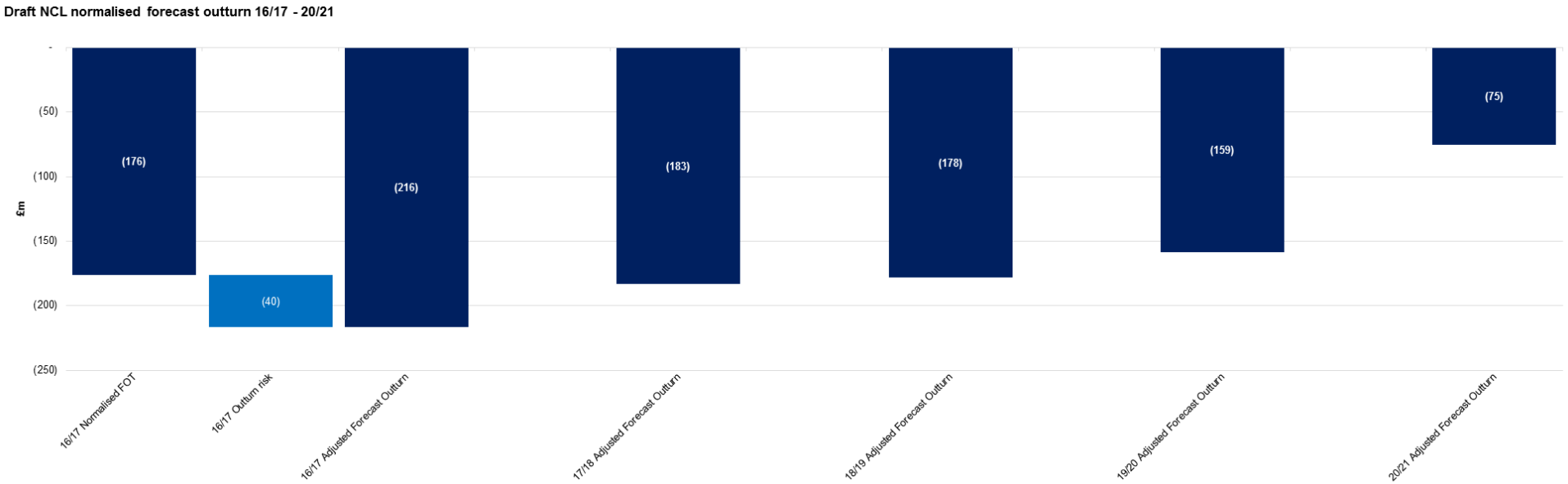
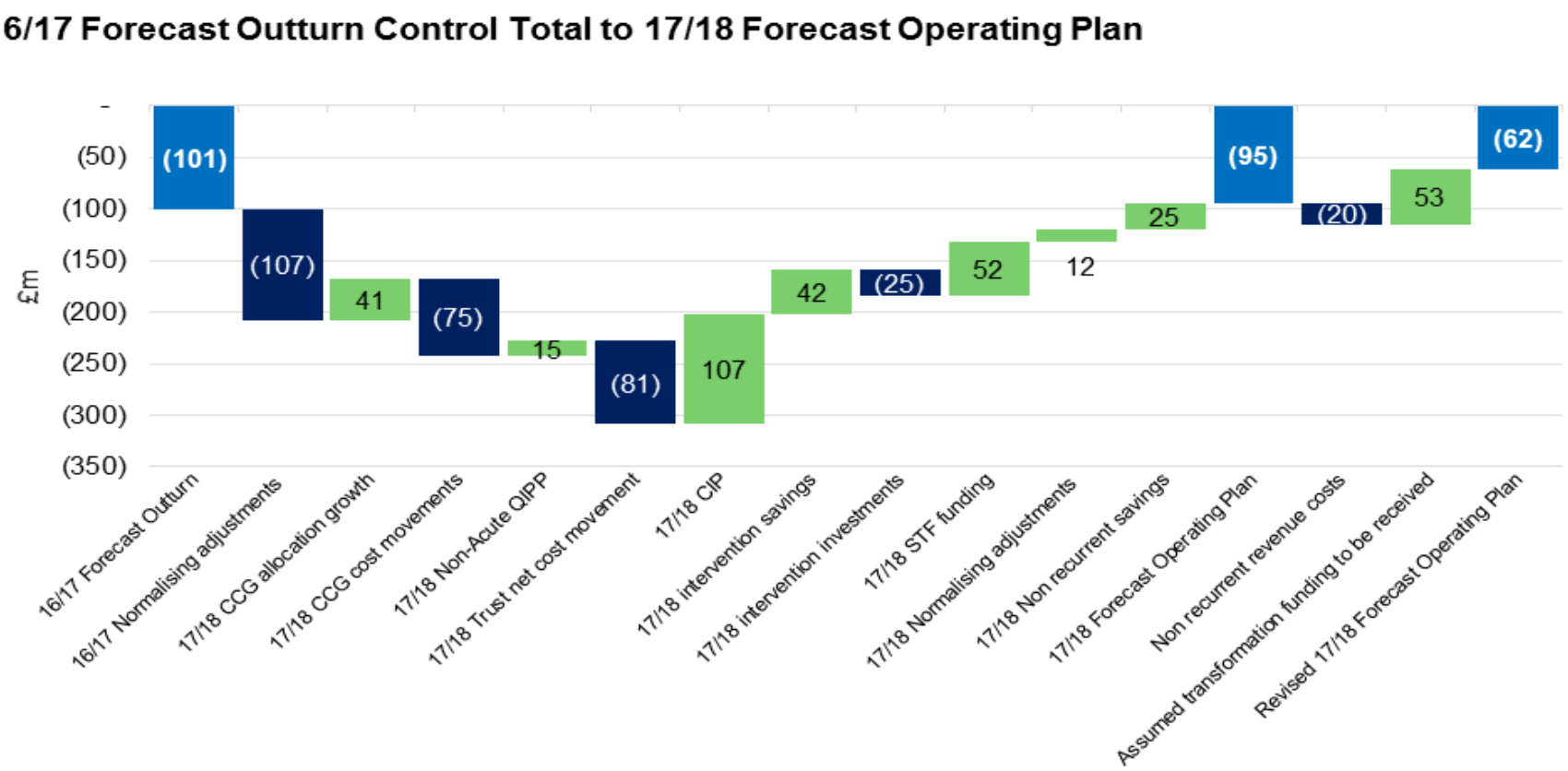


Exhibit 14: Forecast 2016/17 outturn control total to 2017/18 forecast operating plan



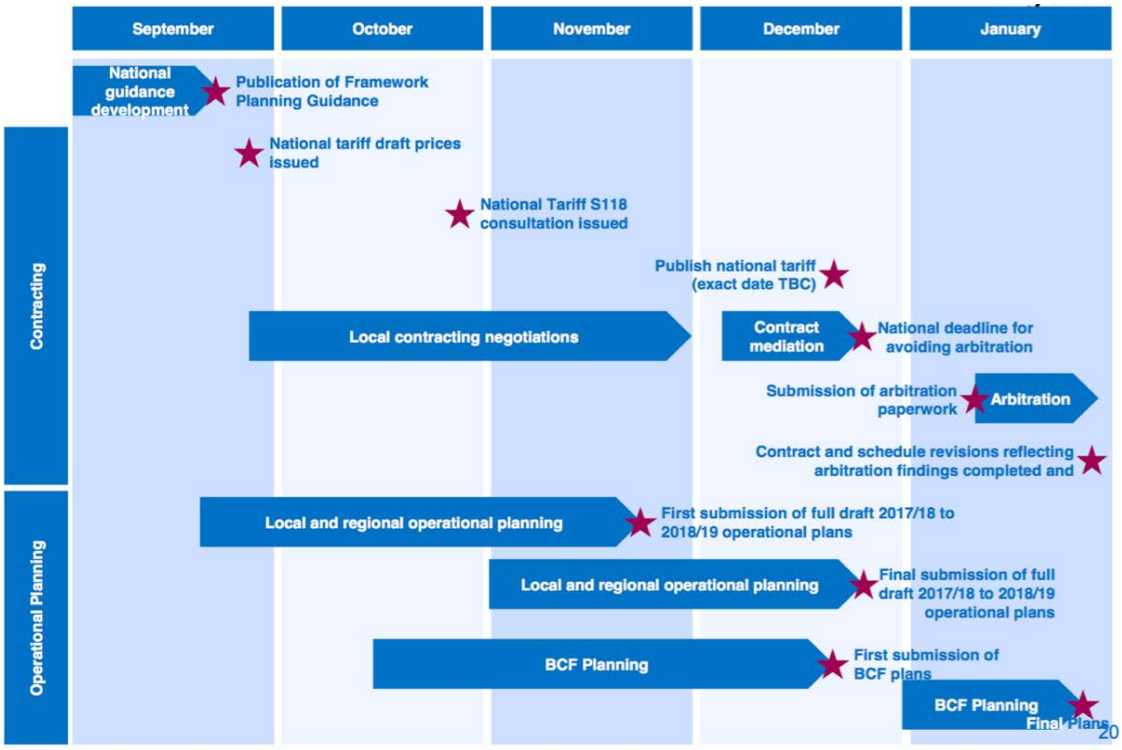
Note: The 16/17 in year FOT of £101m together with the £107m 16/17 normalizing adjustments represents the normalized 16/17 position excluding the specialist trusts (RNOH, T&P). Including the specialist trusts normalised 16/17 position (£8m) brings the combined 16/17 normalised deficit to £216m (shown in exhibit 13).

9 How we will deliver our plan

9.1 Delivery through 2 year contracts in NCL

Delivering the STP is a priority for health and care commissioners and providers in NCL - therefore it is essential that commissioning intentions and contracts reflect this. In line with national guidance, we are entering into a planning round for 2 year contracts covering 2017/18 and 2018/19. We will use this opportunity to ensure all contracts are strategically aligned to the STP, thus enabling its delivery. Whilst we recognise that implementation might look different in different local areas, we know that it will only be possible to deliver on the STP if we are all pulling in the same direction. Setting up 2 year contracts based around our STP delivery plans will both enable rapid implementation and support a longer term move to new relationships between commissioners and providers, reducing transactional costs and building the foundation for the development of new commissioning and delivery arrangements.

Exhibit 15: High level plan for 2 year planning round to support delivery of the STP



We have developed a proposed process and a set of draft principles for managing the contract negotiations that will take place over the next couple of months. Our leadership group will meet regularly (every 2 to 3 weeks) to ensure leadership alignment, assess progress on operating plans, and to ensure that the behaviours of teams reflect the agreed NCL approach.

We have agreed that operating plans and contracts will need to be strategically consistent with the STP. To achieve this, all finance and activity alignment will be overseen by the STP finance and activity modelling group, with overall plan alignment to be overseen by the NCL wide planning group led by the CCGs. All interim finance and activity submissions by CCGs and trusts between 21 October and 23 December should therefore be aligned across NCL

before submission. Whilst organisations will individually follow up queries with NHS England or NHS Improvement on 2017/18 control totals, no organisation will agree their individual target unless and until there is a pan-NCL plan agreed.

The risks of delivery of operating plans will be identified and jointly owned and managed, with the following principles:

- simplicity
- reducing transaction costs
- incentivising the changes in care delivery as set out in the STP
- incentivising the delivery in improved productivity as set out in the STP
- locating risk where it can best be managed
- an open book approach
- use of agreed sources of data.

In the current context of the financial position and management capacity across the system, we will ensure in the first 2 years of the STP that we are prioritising our efforts in the areas which will add the most value in terms of increasing health and wellbeing for people; improving the quality of care people receive; and ensuring value for tax payers' money. We will focus our energies on achieving maximum benefit and we will seek to identify areas where we can further and faster to build confidence and momentum.

We will identify resources to take forward areas of further potential benefit. In addition, we will set up a process for independent peer review challenge of all areas of discretionary spend in providers and CCGs to identify further opportunities to reduce or avoid spend and to aid the collective delivery of plans.

9.2 Decision making in the programme

The STP is a collaboration between a range of sovereign organisations in NCL, each with its own governance and decision-making structures. We have not to date introduced any collective decision-making structures. However we have worked together to produce both the Case for Change and the STP.

The STP is a work in progress and therefore has not been signed off by any of the organisations within the STP. We will take this STP through the public sessions of each of the NHS provider boards, CCG governing bodies and Local Authorities for their support and input into the next steps.

9.2.1 Collective governance arrangements for CCGs

Going forward, in order to support a more collaborative commissioning approach across NCL, the 5 CCGs will need a mechanism for collective decision making. Governing Bodies have recognised this requirement and have agreed the principle of establishing a joint NCL-wide governance structure for some elements of commissioning.

Further work is being done on the details of the proposed joint governance structure. Engagement on the design has been ongoing during October 2016 and will continue with further details to be presented at Governing Body meetings in November 2016.

9.3 Programme architecture

In coming together as an STP footprint, we have developed a governance structure, which enables NHS and local government STP partners to work together in new ways. The NCL STP Transformation Board brings together executives from all programme partners monthly to oversee the development of the programme. It has no formal decision making authority, but members are committed to steering decisions through their constituent boards and governing bodies. Three subgroups feed into the Transformation Board: the Clinical Cabinet, the Finance and Activity Modelling Group and the Transformation Group.

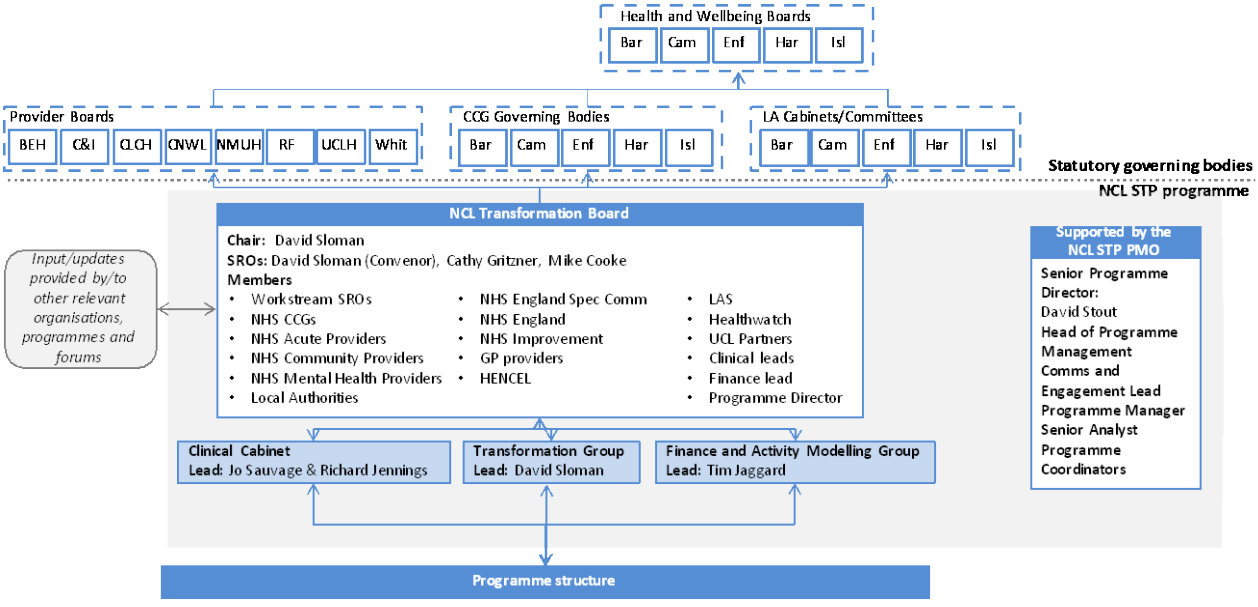
The Clinical Cabinet meets fortnightly to provide clinical and professional steer, input and challenge to all the workstreams as they develop. Membership consists of the 5 CCG Chairs, the 8 Medical Directors, clinical leads from across the workstreams, 3 nursing representatives from across the footprint, a representative for the Directors of Public Health and representatives for the Directors of Adult Social Services and the Directors of Children's Services respectively.

The Finance and Activity Modelling Group is attended by the Finance Directors from all organisations (commissioners and providers). This group also meets fortnightly, to oversee the finance and activity modelling of the workstream plans as they develop.

The Transformation Group is an executive steering group made up of a cross section of representatives from all organisations and roles. This group is specifically responsible for driving progress between meetings of the Transformation Board, and meets fortnightly to do so. Membership includes the SROs of all workstreams.

Additionally, the NCL STP has a full time PMO which facilitates and coordinates the meetings of the main governance groups, as well as delivering communications and engagement support to the programme.

Exhibit 16: NCL STP current governance structure



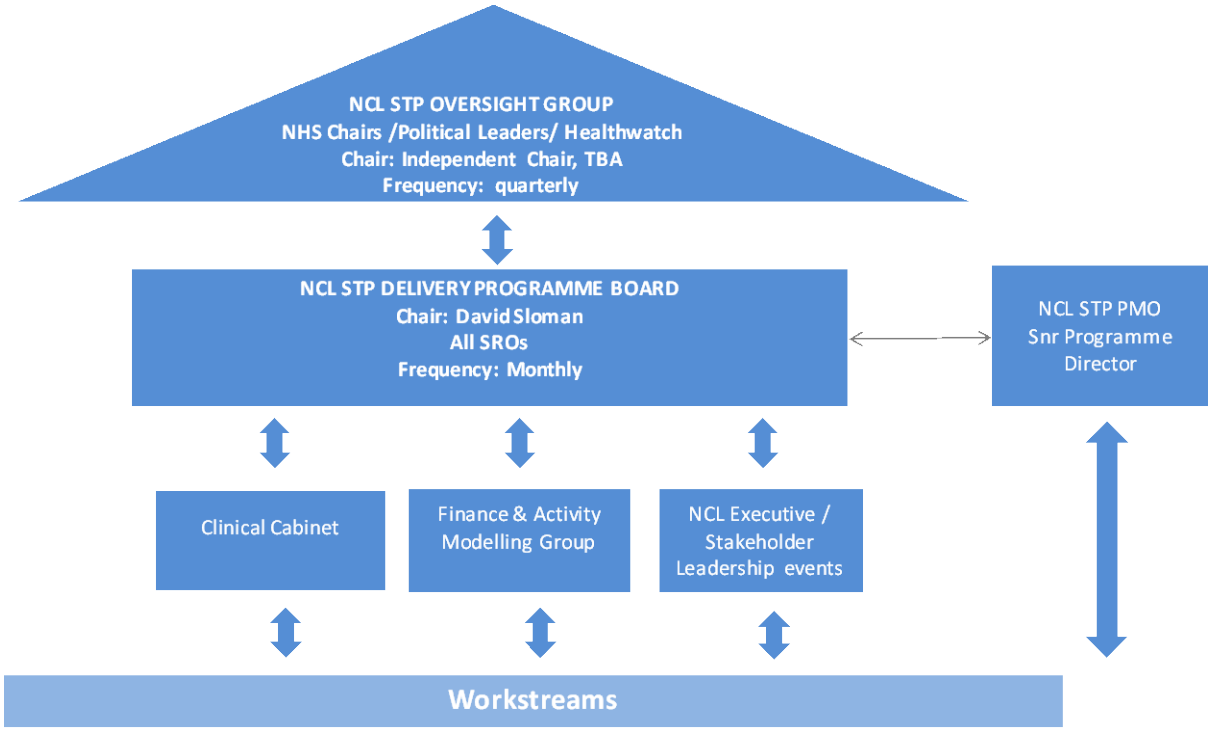
The component workstreams of the NCL STP feed into the overarching governance framework. The workstreams are responsible for developing proposals and delivery plans in the core priority areas. Every workstream has its own governance arrangements and meeting cycles which have been designed to meet their respective specific requirements, depending on the core stakeholders involved.

9.3.1 Future programme architecture

We recognise that as we move from planning to implementation that we will need to amend our programme architecture to ensure that it is fit for purpose. We will work with the Transformation Board to agree any required changes to the programme architecture so that we are ready to move forward with implementation from the new year.

Our initial proposal for discussion is set out in exhibit 17.

Exhibit 17: Proposed future programme architecture



This structure would comprise the following new groups:

- **STP Oversight Group:** This oversight group would be made up of Chairs and political leaders and would go some way to address the current 'democratic deficit' and representation of views of the local population. It is proposed that this group meet quarterly and might benefit from an appointed Independent Chair. Membership of this group would ensure scrutiny of the delivery of STP delivery and ensure a better connection with the NHS boards, governing bodies and local authority leadership.
- **STP Delivery Programme Board:** To drive and oversee the progression and delivery of the STP. It is proposed that the delivery board meet monthly. This would replace the Transformation Group.

- **Executive leadership events:** CEOs and other relevant executive directors and stakeholder representatives would meet periodically as requested by the Delivery Board in order to resolve delivery issues.

9.3.2 Health and wellbeing boards

CCGs are required to involve their local Health and Wellbeing Board (HWB) when preparing their commissioning plan so that HWBs can consider whether their draft plans take proper account of the local health and wellbeing strategy. As CCG commissioning plans will be set within the context of the STP, it will be important that we engage with HWBs as we develop the STP. Engagement of HWBs will also be an important means of ensuring engagement of local political leadership in the STP process.

9.3.3 Overview and scrutiny committees

Local authorities have a role in reviewing and scrutinising matters relating to the planning, provision and operation of health services in their local area. Commissioners and providers of NHS services (including NHS England, CCGs, NHS trusts, NHS foundation trusts and private providers) must consult the local authority where they are considering any proposal for a substantial development or variation of the health service in the area. Ordinarily, where the services in question are commissioned by NHS England or CCGs (as the case may be), the commissioners carry out this exercise on behalf of providers. Providers of public health services commissioned by the local authority are also required to consult the local authority in the same way as commissioners and providers of NHS services.

The local authority may scrutinise such proposals and make reports and recommendations to NHS England and the Secretary of State for Health. Legislation provides for exemptions from the duty to consult in certain circumstances, for example where the decision must be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff. As part of the overview and scrutiny process, the local authority will invite comment from interested parties and take into account relevant information available, including that from Healthwatch.

We have a Joint Health Overview and Scrutiny Committee (JHOSC) in place across NCL which has already put the STP on its agenda as a standing item. We will ensure that we liaise closely with the JHOSC as the STP plans develop so that we can plan ahead for any likely need for public consultation. In addition, we will discuss plans with any relevant local authority overview and scrutiny committees as we move towards local implementation.

9.4 Programme resourcing

We have dedicated resources in place to support the delivery of the STP, with an agreed overall programme budget of £5m in 2016/17. Each workstream has a Senior Responsible Officer (SRO). Some workstreams have shared leadership, where a mixed skillset is required. All of these individuals are senior Executive level - Chief Executives, Medical Directors or Finance Directors - ensuring leadership of the highest quality. Each SRO is supported by a dedicated programme manager, and in some cases a broader team of support. A programme budget for 2016/17 has been allocated to each of the workstreams based on

their proposed requirements. STP partner organisations are also giving in kind to each of the workstreams to ensure high quality plans can be delivered at pace.

We will review the requirements for 2017/18 and beyond as we finalise the delivery plans and phasing of implementation. A £10m resource requirement to deliver the plan has been factored into our financial modelling.

10 Engagement

We have come a long way since being asked to come together as 22 health and social care organisations with disparate views last December. It takes time to build trust and develop shared a shared vision of the future between people and organisations, and to get everyone working towards the same goals. We are now all aligned behind a collective agenda and are ready to share it more widely, seeking input and feedback on our draft plans to date.

The most important people we need to engage with are those who use our services – the residents of NCL. We have specifically created a shared core narrative for this purpose – ensuring it is in patient-focused and accessible in language to begin to involve people in the process. Now that we are in a position to communicate our collective thoughts effectively, our intention is to engage residents, local Councillors, our workforce and other key stakeholders to get feedback on our plans. We have held initial public meetings in each of the 5 boroughs to begin the process of co-design with patients, people who use services, carers, families and Healthwatch.

Our approach going forward will be to collaborate more extensively with people who use services and carers, local political stakeholders as well as members of the public, to ensure that our residents help inform our decisions. This approach is guided by the following core principles (often called the "Ladder of Citizen Participation"). We will undertake different types of engagement as set out on the ladder as appropriate:

1. 'inform' stakeholders
2. 'engage' with stakeholders in open discussions
3. 'co-design/ co-produce' services with stakeholders

Feedback from our local residents will be fundamental to our decision making and will help us shape the way the final plan is implemented.

10.1 Our future plans

We will now build on the success of our initial public engagement events by:

- holding a quarterly forum in each borough
- holding pan-NCL events on specific issues that may arise in support of the borough level events
- hosting meetings with the public on focussed topics such as urgent and emergency care, primary care, and mental health to get in-depth input from the community
- organising 'Tweet chats' on specific areas of interest
- developing a designated YouTube channel and populating it with relevant resources.
- using partner digital media channels – Twitter, Facebook, Instagram – to promote our public engagement programmes and information. We will also use these channels to test ideas and progress on local priorities which will help us develop our plans further.

To do this, we will:

- use Healthwatch, other patient representative groups and resident's associations, local authority engagement networks and the range of other networks available to reach out to the public and share our draft plans
- work in partnership with communications teams across NCL organisations and use their wide range of community channels to socialise the STP, for example Camden CCG's citizens' panel and Enfield's Patient Participation Groups Network.
- use existing online engagement tools that CCGs, local authorities and providers have to engage specific audiences and reach those who may be unable to attend our events.

We recognise it is crucial to ensure our local political stakeholders are actively involved in the oversight of the plans as they develop. We are planning on doing this by:

- planning regular face to face meetings between the STP leadership team and local councillors and MPs, along with Ministers in the Department for Health if required to seek their regular advice on all proposed changes
- continuing to share progress updates of the STP at all meetings at the Joint Health Overview and Scrutiny Committee (JHOSC)ensuring that all political channels through CCGs, local authorities and providers are kept fully briefed on the STP as it develops and any public concerns for the regular engagement they undertake with elected leaders
- logging all media stories and regularly updating the Transformation Board and those meeting with elected members on the STP as it develops, media development and any public concerns.

There is also a need to engage more of our own workforce in the planning process. We will do this via:

- the weekly STP newsletter that we have set up for those working within the organisations of the STP
- providing people working within our organisations with regular updates on progress through internal newsletters and bulletins, weekly / monthly updates from Chief Executives
- hosting sessions with a wider set of clinicians and social care practitioners to get their input into the priorities and delivery areas. This will include working with our GP Federations to engage primary care providers to ensure our workforce is a driver and owner of change
- running events within our membership organisations to showcase the range of work which is happening across NCL and to ensure staff understand the current plans, and how they may affect them as we progress into implementation.

We will continue to build our communications and engagement capabilities across the system. We are planning to host a workshop with communications leads from across sectors to co-design the future engagement strategy, having now identified the key audiences that we need to engage with across the 5 boroughs. The strategy will include the design of a programme of deliberative-style events which will bring together different groups to more

directly shape our plans. We will establish a designated communications and engagement workstream to oversee delivery of the strategy, with a Senior Responsible Officer for engagement.

10.2 Public consultation

A formal public consultation is not needed for every service change. However, it is likely to be needed should substantial changes to the configuration of health services in a local area be proposed as our plans develop and we are committed to ensuring we consult widely and effectively.

We are already beginning to develop a comprehensive picture of local views and concerns through our early engagement, building an extensive stakeholder and community database and contacts which will enable us to develop a detailed plan of those affected by any proposed changes.

We also have an existing relationship with both general and specialist media outlets (including digital). We are already working on STP stories with these stakeholders and will continue to do so whether formal consultation is required or not.

10.3 Equalities analysis and impact assessment

Under the Equality Act 2010, we are required to analyse the effect and impact of the NCL STP in relation to equality. We are committed to carrying out an equality impact assessment to ensure our plan does not discriminate against disadvantaged or vulnerable people, or other protected groups.

Our equality analysis will consider the effect on different groups protected from discrimination by the Equality Act to ensure any changes are fully effective for all target groups and mitigate against any unintended consequences for some groups. We are committed to undertaking an Equalities Impact Assessment as our plans become more fully developed.

We already have a good overview and analysis of equality information from across the NCL footprint through our existing and ongoing partnership work with the 5 local authorities, CCGs, providers and other representative organisations. We are building on local regular equality audits of residents, patients and staff to ensure good engagement with protected groups and others, so that we can better understand the actual or potential effect of changes to functions, policies or decisions through the STP. This will help us to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

Throughout our engagement to date, and building on the insight above, we have taken advice on best practice to ensure that all our public facing work is as fully accessible as possible, including sharing information in a variety of formats to ensure our we are able to engage all our residents, using interpreters or Easy Read material where required. We will continue to hold events and meetings in accessible locations (accessible for people with disabilities and easily reached on public transport, with adaptations made for attendees'

communication needs). Our aim is to enable different groups to be fully involved as the STP progresses.

11 Conclusion and next steps

The STP is work in progress and we recognise that we have much more work to do to deliver the vision we have set out.

The immediate next steps between now and Christmas are to:

- to take steps to stabilise our financial position, developing more detailed ideas in the areas we have not yet fully explored
- agree the priorities for implementation in the first 2 years of the STP to ensure that we focus initially on the improvements which will make the most impact on our triple aims most quickly.

At the same time, we are clear that we will not lose focus on the longer term transformation that will support sustainability.

There remain many issues to resolve and we know we do not have all the answers. But we are determined to succeed and will continue to work with people who use services, the public and our staff to find solutions in the months and years ahead.

North Central London

Sustainability and Transformation Plan

A summary

North Central London

Introduction

Hospitals, local authorities, GPs, commissioners, and mental health trusts across north central London have all come together to transform the care we deliver to our patients.

On a scale never seen before, health and social care services in the region are working on the 'North and Central London (NCL) Sustainability and Transformation Plan (STP)'.

Our work covers the five boroughs of Camden, Islington, Haringey, Barnet and Enfield – an area that is home to nearly 1.5 million people.

We know that the health and social care needs of our local people are changing, and that there are serious issues facing health and care services in NCL. People receive different standards of care depending on where they live: waiting times for services and health outcomes vary, and the quality of care and people's experience of health and social services is sometimes not as good as it should be.

We must improve and we can only do this if we all work closely together – with each other and with our local residents.

It does not 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. We want to ensure that everybody we care for has greater control of their health and wellbeing and receives the support they need to live longer, healthier lives. Many of these ambitions are not new, but are based on what local people have told us they want.

The plan is currently work in progress. We are looking to engage with as many people as possible over the next few months to develop our ideas further.

What is the Sustainability and Transformation Plan (STP)?

To make sure everybody receives the care they need when they need it, we have to change the way we do things.

Our draft plan sets out how we will work together to deliver high quality, sustainable services in the years to come and how we can meet the financial challenges and increasing pressures on our services over the next five years.

The North Central London area has a growing population and people are also living longer, often with long term health problems.

The growth in our funding over the next five years will not match the expected increases in population and the resulting growth in demand for health services. NHS services already have deficits and, if nothing changes, it is anticipated that the combined deficit of health services alone will be nearly £900million by 2020/21. Local authorities are also facing significant financial pressures on their social care budgets. We need to change how we provide services, reduce the amount of time and treatment spent in hospitals, boost prevention and offer more local people the care they need closer to home.

North Central London overview

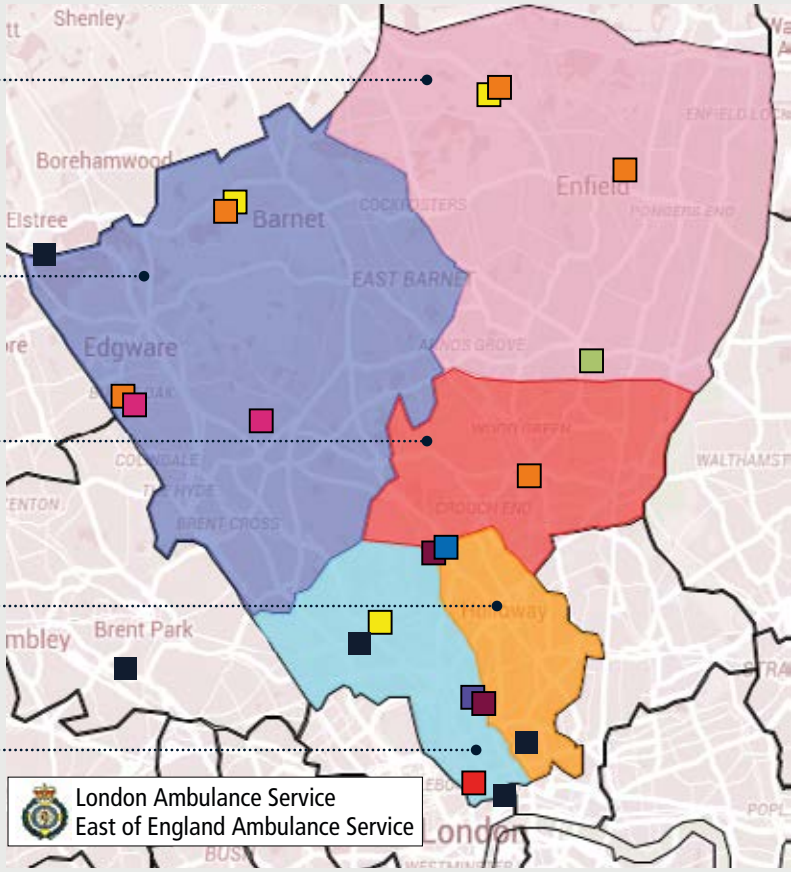
Enfield CCG / Enfield Council
~320,000 GP registered pop
~324,000 resident pop
49 GP practices

Barnet CCG / Barnet Council
~396,000 GP registered pop
~375,000 resident pop
62 GP practices

Haringey CCG / Haringey Council
~296,000 GP registered pop
~267,000 resident pop
45 GP practices

Islington CCG / Islington Council
~233,000 GP registered pop
~221,000 resident pop
34 GP practices

Camden CCG / Camden Council
~260,000 GP registered pop
~235,000 resident pop
35 GP practices



Total health spend £2.5bn

Total care spend £800m

NHS England

Primary care spend £~180m

Specialist commissioning spend £~730m

- Barnet Enfield and Haringey Mental Health NHS Trust (main sites, incl Enfield community)
- Camden and Islington NHS Foundation Trust (and main sites)
- North Middlesex University Hospital NHS Trust
- The Royal Free London NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust
- Whittington Health NHS Trust (incl Islington and Haringey Community)
- Central and North West London NHS Foundation Trust (Camden Community)
- Central London Community Healthcare NHS Trust (Barnet Community)
- Specialist providers

Other specialist providers out of scope:
Great Ormond Street Hospital, Moorfields Eye Hospital, Tavistock and Portman Foundation Trust, Royal National Orthopaedic Hospital

Note: registered pop data shows 2014 figures. Source: ONS

What are we going to do to?

There are a wide range of health problems in the region including high rates of childhood obesity and mental illness. Too many people are treated in hospital for long term conditions when they could be better cared for in the community. Waiting times to see a specialist and for diagnostic tests are long. Attendance levels at A&E departments are high and it's difficult to recruit staff. We want to create a health and social care system which delivers positive outcomes in all of these areas, no matter where you live.

To help us achieve this, over the next five years we aim to:

- Invest more in prevention to stop people getting ill
- Work with people to help them remain independent and manage their own health
- Give children the best possible start in life
- Provide care closer to home so that people will only need to go to hospital when it is clinically necessary
- Give mental health services equal priority to physical health services
- Improve cancer services
- Make the best standards available to all and reduce variation
- Make north central London an attractive place to work so that we have the right workforce to deliver high quality services
- Modernise our buildings and make greater use of digital technology
- Ensure value for tax payers' money through increasing efficiency and productivity, and consolidating and specialising where appropriate

Prevention

We aim to do more to promote and empower people to live healthy lives so we can stop the onset of disease, and keep people out of hospital. We want to increase investment in prevention and ensure that the places where people live and work promote good health.

We want to support residents, families and communities to look after their own health. We will work to diagnose residents with clinical risk factors and long term conditions much earlier to increase life expectancy.

What will be different for patients

Prevention and care closer to home

John, age 62 is a lifetime smoker who was recently diagnosed with chronic bronchitis. His GP advised him to stop smoking but John said he could not cope without his cigarettes and refused the offer of nicotine replacement therapy (NRT). John contracted a chest infection, went to A&E and was admitted. He stayed for several days and was given some NRT on the ward to cope with his cravings for cigarettes.

In future, when John is admitted to hospital his respiratory physician will discuss the importance of stopping smoking as a treatment for his bronchitis. He will be prescribed NRT to relieve his cravings and on discharge he will be offered a referral to specialist stop smoking support for heavily addicted smokers. John will then get a call the next day from the specialist stop smoking advisor who will arrange a home visit for the following day. John will be supported by the specialist advisor in weekly visits to help him to reduce or stop smoking altogether.

Care closer to home

We aim to deliver more health and care closer to home, so that people are treated in the best possible environment and do not have to go to hospital unless they really need to.

This would be achieved through local networks which bring different services together and improving access to GPs or other primary care professionals.

We aim to provide 24/7 access to specialist opinion in primary care, ranging from an advice only service to admission to an acute assessment unit. We will also review the existing provision across NCL of GP presence in emergency departments.

We will look to develop special falls emergency response services to help support older people to remain at home after a fall, as well as helping to educate them about the risks.

What will be different for patients

GP services

Ms Sahni is 87 and has four chronic health problems. She currently has to book separate appointments with different doctors to have all of the relevant check-ups and appointments that she needs.

In future, Ms Sahni will be in a special “stream” of patients who will have all of their care co-ordinated by a very experienced GP. This will allow her to see the specialist heart or diabetic nurses at the integrated care centre at her GPs surgery. There will also be a care navigator in the team who can help sort things out for her at home including community support.

Achieving the best start in life

Better education for children is crucial to our plan. We need to put health and wellbeing on the map at the earliest opportunity. We need to create healthy environments, promote active travel, sport and play in schools.

We have identified areas of focus – from prevention to acute care – which will improve health and outcomes for children and young people

This will include a focus on maternal health which evidence strongly suggests has an impact on child and adult health – for example obesity, diabetes and cardiovascular disease.

We want to address mental health in children as early as possible, supporting mothers with mental health problems both before and after birth. We also want to provide services for parenting support and health visiting which focus on vulnerable, high risk families.

Mental health

We will give equal priority to physical and mental illness and aim to reduce demand on hospital care and mental health inpatient beds.

Our plans include increasing access to primary care mental health services and improving how we manage acute mental health problems, building community capacity to enable people to stay well; and investing in mental health liaison services – for example ensuring that more people in hospitals have their mental health needs supported. We will also look to strengthen perinatal and child and adolescent mental health services (CAMHS).

What will be different for patients

Mental health liaison

Maisie suffers from dementia, and is cared for by her husband Albert. Previously, after falling at home Maisie was admitted to hospital. Due to the accident and change of surroundings, Maisie was agitated and more confused than normal.

In future, as the hospital will have Core 24 liaison psychiatry, the liaison team will be able to help the hospital support both Maisie's physical and mental health needs. As Maisie will receive holistic care it will mean that she is ready to be discharged sooner than if only her physical health needs were supported. Maisie's husband Albert will also be supported by the dementia service, allowing him to continue to care for Maisie at home.

Urgent and emergency care

Over the next five years, we aim to provide a consistent urgent and emergency care service. Patients should be seen by the most appropriate professional for their needs, which may include directing them to an alternative emergency or urgent care service. There is strong evidence that getting patients to the right specialist service, even if that might not be their local hospital, improves outcomes.

We want to develop high quality ambulatory care services across NCL – so patients can be assessed, diagnosed, treated and able to go home on the same day without needing a hospital admission.

For those patients who do need emergency treatment, we aim to have services in place that help them to leave hospital as quickly as possible and rehabilitate closer to their home if appropriate

Planned care

We want to reduce variation in the way that we deliver planned care across north central London. This includes some key areas for improvement, such as making sure patients can access the right expertise locally and that their experience of surgery is seamless, smooth and efficient.

We aim to have clear 'pathways' for patients across the region, with consistent approaches, so that we become more efficient and there is less variation in outcomes and experience.

We want to improve patients' access to information and help people manage conditions without surgical intervention where possible. We will ensure patients spend as little time as possible in hospital.

Cancer

Our aim is to save lives and improve patient experience for people who have cancer. The priority areas we have identified for improvement are getting earlier diagnosis and better provision of radiotherapy and chemotherapy.

Targeting colorectal and lung cancers are a particular focus given the high percentage of patients receiving late stage diagnosis, often in emergency departments.

We are also developing a case for a single provider model for radiotherapy in NCL.

We want to improve palliative care so that patients have a better quality of life in their final weeks.

What will be different for patients

Cancer

Previously Margaret, aged 60, went to see her GP with persistent gastric pain for several weeks. She was otherwise well, and did not have reflux, diarrhoea, vomiting or weight loss. Over the course of the next three weeks, Margaret's GP organised tests and ruled out any inflammation, heart problem, or gallstones that could cause the pain. He gave Margaret tablets to try to reduce inflammation from acid on her stomach lining. However, Margaret's pain was more persistent this time and she was still worried.

In the new system, Margaret's GP will be able to refer her to a Multidisciplinary Diagnostic Centre at UCLH despite the fact that her symptoms are not considered "red flag". Here, Margaret will be assessed for vague abdominal symptoms. A clinical nurse specialist will see her four days after referral. The team will identify that Margaret has early stage pancreatic cancer and because it was picked up early she can access potentially curative keyhole surgery.

Social care

Social care is a crucial part of many elements of our plan, in particular in delivering care closer to home and improving mental health services. We want to ensure that health and social care services work well together to deliver well-coordinated care for local people. We will improve collaboration between local authorities and hospitals – for example, focusing on earlier discharge of hospital patients where safe and appropriate. We will build on the experience and expertise of social care and public health in the development of new models of care.

We recognise that many social care providers of services such as residential, nursing home and home care services are under great pressure. We aim to focus on strengthening the supply of the workforce for these services to address risks around their staffing capacity.

The role of social workers will also be essential to delivering our model for health and care closer to home, in addition to the role of home care workers, personal assistants and the blended role between district nurses and care workers. We will focus on recruiting to these posts and developing career opportunities in these areas.

Bringing services together

We will work out where it makes sense to bring services together or create networks across organisations to improve the experience of our patients. We are already collaborating across the region with positive results in cardiac/cancer; pathology; neurosurgery; stroke; and many other services.

We can learn from our experience in these areas and more work is planned to identify areas where some form of consolidation may be worth considering.

Workforce

We want to attract the highest quality staff to deliver the best possible care we can for local people. Therefore as well as creating the most positive environment for our patients, we want NCL to be a place where we offer the best opportunities for people to develop their careers.

Our aim is to attract, develop and retain people who work in and support health and social care in north central London. We want to create attractive careers with a workforce fit for purpose in the changing healthcare landscape – so we have the right skills in the right place for patients.

Digital and estates

We want to use the power of digital communications and IT systems to share information and support the provision of better care and treatment for patients. We aim to promote changes so that patients can use technology to receive and share information, get treatment and prescriptions through e-referrals and e-consultations. Sharing high quality data between health and care professionals will mean people don't have to retell their stories. Digital technologies will help ensure care is delivered in the right place at the right time by the right person.

We also want to modernise the buildings we work from and our equipment to make sure they are fit for purpose. We already have major investments planned at University College Hospital and Chase Farm Hospital and would look to develop plans for investment to improve facilities so we can deliver more care closer to home and improve mental health services.

Reducing costs

We think the changes we have set out will help us reduce waste in the health and care system. **For example we can reduce cost of care by:**

- treating people right first time and improving the co-ordination of services.
- avoiding unnecessary admissions to hospital .
- speeding up discharge when people are ready to go home.
- being less reliant on agency and temporary staff.
- avoiding unnecessary duplication of services between organisations.

However our plans at the moment do not achieve financial balance over the next five years, so we will continue to look for other opportunities to improve our efficiency.

Engagement

We are committed to being open and transparent about our plan as it develops. We need engagement from all of our partners, patients and local residents if we are to succeed

This means:

- Early engagement on the issues before any decisions are made
- Stakeholders and the public help to devise the solution
- Ensuring decision-making is transparent and people know what to expect when
- Each stage of the process is informed by ongoing dialogue.

As we add more detail to our plans, we will ensure that we undertake formal public consultation where appropriate. We will work with the North Central London Joint Health Overview and Scrutiny Committee to agree when we need to do this and how we best do this.

Next steps

The draft Sustainability and Transformation Plan sets out our proposed approach to achieve sustainable health and care services in north central London. It is still work in progress. There is much more to do before we finalise the detail of these plans.

We want to fully engage patients and the public in our thinking to make sure we get this right. The various NHS organisations and local authorities will be looking at this draft plan over the next few months and they will arrange events to raise awareness of the proposals and get people's feedback.

In the meantime if you want to feed in ideas or comments please contact the NCL STP office at **nclstppmo@nhs.net**

Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board

7 December 2016

Title:	October (month 7) 2016/17 - Financial Performance		
Agenda item:	16/164	**Paper**	07
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 £0.8m deficit in October and a year to date position of £3.8m deficit. This is £0.4m adverse against the planned year to date (YTD) performance.		
Summary of recommendations:	To note the financial results relating to performance during October 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 November 2016		

Author name and title:		**Anis Choudhury Head of Financial Planning and Analysis**		**Director name and title:**		**Stephen Bloomer, Chief Financial Officer**	
Date paper seen by EC	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

Use of Resources Rating

The Use of Resources Metric has the replaced the Financial Sustainability Risk. Apart from measuring liquidity, capital and I&E metrics, it also measures the Trust's spend on agency staff as a proportion of the agency ceiling.

Use of Resource	Plan	Actual	Variance
Liquidity Ratio	4	4	0
Capital Servicing Capacity	4	4	0
I&E Margin	4	4	0
I&E Margin Variance from Plan		1	
Agency	2	3	1
Overall Use of Resources Metric		**3**	

Financial Overview

The Trust reported a £0.8m deficit in October and a year to date deficit of £3.8m, which is £0.4m adverse against the planned year to date (YTD) position.

Main issues of note:

- Pay expenditure was £0.3m adverse in month and £1m adverse year to date. Whilst the Trust showed improvement on two of its key targets by increasing the number of permanently employed staff and increasing the use of bank staff as a temporary resource there was not a corresponding reduction in agency. Although the nursing agency percentage from 10% to 9% in month AHP and medical agency rose sharply.

- A significant proportion of the Trust's CIP target is based on reducing agency spend. Whilst we are now seeing a reduced trend in agency spend, which links to an increase in both bank usage and permanent staffing expenditure, the rate of reduction is not sufficient at this stage to achieve the CIP. This coupled with the performance of other pay savings schemes means we will fail our CIP target unless urgent action is taken (by ICSUs) over the remaining 5 months of the year.

- The income position in Month 7 was the key driver for the Trust's adverse variance (in month) showing an adverse position, in total, of £0.5m compared to plan income (year to date £2.5m adverse). The main variances for the income position include:
    - Underperformance on clinical income which was primarily in day cases and endoscopy
    - Assessment of STF income receivable as it is unlikely that the A&E monies will be collected
    - Partial achievement of income efficiencies (CIP)
    - Timing of donation from charitable funds for maternity redevelopment

In order to recover the recurrent position and create the required exit run rate, the Trust needs to be achieving an average monthly deficit run rate of c. £0.5m. This will remain a key financial target for quarters 3 and 4.

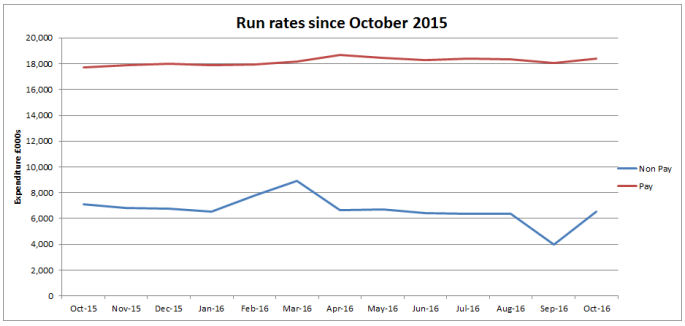
The cash position is £1.1m over plan, due to a large receipt from HEE (Health Education England) in October as well as increased receipts from London Borough of Haringey following a review of debtors.

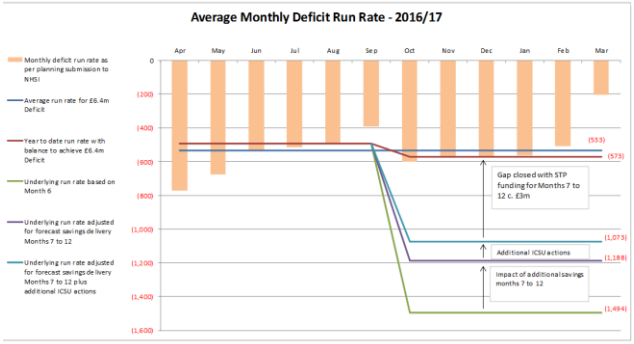
The capital programme is in progress with £2.1m of the budget committed YTD, of which £1.2m has been incurred. The Capital Management Group is monitoring progress of the individual capital schemes, with expenditure monitored closely to maintain the Trust's cash position.

Statement of Comprehensive Income

2016/17, Month 7 (October 2016)

Statement of Comprehensive Income	In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	YTD Budget (£000s)	Ytd Actuals (£000s)	Variance (£000s)	Full Year (£000s)
Nhs Clinical Income	21,462	20,887	(575)	151,083	148,628	(2,455)	258,366
Non-Nhs Clinical Income	1,899	2,177	278	13,291	13,696	405	22,784
Other Non-Patient Income	2,501	2,304	(197)	15,088	14,593	(495)	26,538
Total Income	**25,862**	**25,368**	**(494)**	**179,462**	**176,917**	**(2,545)**	**307,688**
Non-Pay	6,718	6,531	187	45,969	43,011	2,958	79,594
Pay	18,156	18,416	(260)	127,761	128,745	(984)	217,855
Total Operating Expenditure	**24,874**	**24,947**	**(73)**	**173,730**	**171,756**	**1,974**	**297,449**
EBITDA	**988**	**421**	**(567)**	**5,732**	**5,161**	**(571)**	**10,239**
Depreciation	690	656	34	4,830	4,746	84	8,280
Dividends Payable	355	354	1	2,475	2,475	0	4,243
Interest Payable	274	257	17	1,852	1,791	61	3,238
Interest Receivable	(3)	(1)	(2)	(21)	(14)	(7)	(36)
Total	**1,316**	**1,266**	**50**	**9,136**	**8,998**	**138**	**15,725**
Net Surplus / (Deficit) - before IFRIC 12 adjustment	**(328)**	**(845)**	**(517)**	**(3,404)**	**(3,837)**	**(433)**	**(5,486)**
Add back impairments and adjust for IFRS & Donate	5	3	2	30	30	0	(914)
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**(323)**	**(842)**	**(515)**	**(3,374)**	**(3,807)**	**(433)**	**(6,400)**





As reported last month, the Trust is increasing the use of monthly run rates to enhance monthly monitoring, improve forecasts and better assess trends in performance.

The chart above shows that the run rate for both pay and non-pay expenditure increased in October compared to September. This together with actual income performance led to a deficit run rate of £0.8m for the month of October. As stated above, in order to recover the recurrent position and create the required exit run rate the Trust needs to achieve an average monthly deficit run rate of c. £0.5m for the second half of the financial year (Months 7 to 12), and so this will remain a key financial target for quarters 3 and 4.

All ICSU's and overspending corporate areas are agreeing revised trajectories and action plans with the Chief Operating Officer and Chief Finance Officer to correct income, activity and expenditure positions and ensure the control target is achieved.

Cost Improvement Programme

Year to date, £3.2m has been delivered against a target of £4.4m. This equates to a 73% achievement. The Trust CIP profile requires a material increase in the rate of cost improvement during the final five months of the financial year to March 2017 in order to achieve the CIP target.

A review of the classifications of the CIP schemes was undertaken in month and is now reflected in the table below. There are two ICSUs ahead of target Emergency & Urgent Care and Medicine, Frailty & Network Services.

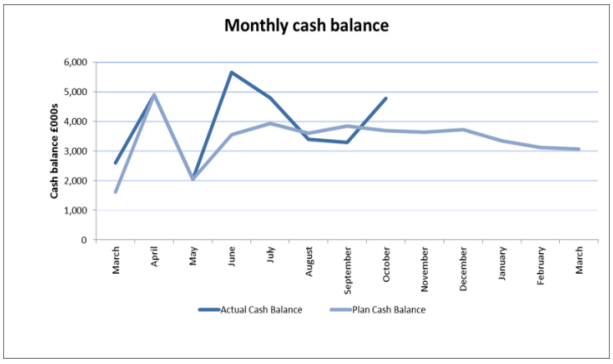
The PMO is working with ICSU's with weekly update meetings and monthly deep dives to work on roadmap progress and to move blocks to achievement of cash releasing savings. Where ICSUs are falling short of their YTD target it is principally on pay and non-pay schemes. The PMO is forecasting CIP achievement of £7.5m and is working to accelerate future schemes and replace those which will not achieve. It is recognised that the schemes will deliver greater financial benefit than the recorded CIP but budgetary overspends mean that CIP cannot be recognised.

Integrated Clincial Service Unit	Annual Plan £'000	YTD Plan £'000	YTD Actual £'000	YTD % achieved	YTD Variance £'000
Children's services	602	190	69	36.4%	-121
Clinical Support Services	1,019	406	283	69.8%	-123
Emergency & Urgent Care	786	232	483	208.3%	251
Medicine, Frailty & Network Services	1,673	568	685	120.6%	117
Outpatients Prevention & LTC	526	201	48	23.9%	-153
Surgery	2,613	1,032	515	49.9%	-517
Women's services	1,189	434	311	71.7%	-123
Corporate	2,307	1,372	585	42.6%	-787
Trustwide non-pay	0		250		250
Performance against operating plan	**10,715**	**4,434**	**3,229**	**72.8%**	**-1,205**

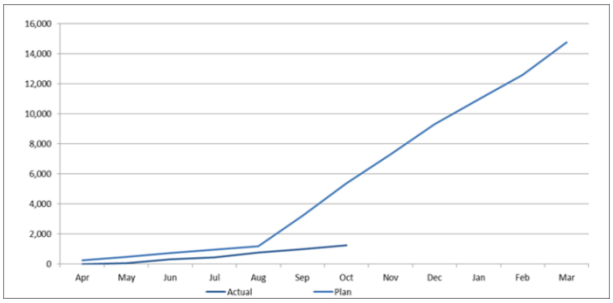
The PMO is continuing to work with all areas to finalise the £15.5m of cost reducing schemes required in 2017/18. There are a number of these in place with an agreed roadmap and progress, the unidentified value will form a key focus in the remainder of Q3 and in to Q4.

Statement of Financial Position

	As at 1 April 2016 £000	Plan 31 March 2017 £000	Year to Date Plan YTD 30 October 2016 £000	Year to Date As at 30 October 2016 £000	Year to Date Variance YTD 30 October 2016 £000
Property, plant and equipment	194,785	203,023	196,680	191,751	4,929
Intangible assets	4,583	2,831	3,569	4,113	(544)
Trade and other receivables	693	851	826	629	197
Total Non Current Assets	**200,061**	**206,705**	**201,075**	**196,493**	**4,582**
Inventories	1,403	1,500	1,500	1,646	(146)
Trade and other receivables	23,535	25,393	20,504	28,329	(7,825)
Cash and cash equivalents	2,598	3,060	3,689	4,767	(1,078)
Total Current Assets	**27,536**	**29,953**	**25,693**	**34,742**	**(9,049)**
Total Assets	**227,597**	**236,658**	**226,768**	**231,235**	**(4,467)**
Trade and other payables	39,112	43,391	(35,339)	(40,437)	5,098
Borrowings	376	2,455	0	0	0
Provisions	795	756	(774)	(481)	(293)
Total Current Liabilities	**40,283**	**46,602**	**(36,113)**	**(40,918)**	**4,805**
Net Current Assets (Liabilities)	**(12,747)**	**(16,649)**	**61,806**	**75,660**	**(13,854)**
Total Assets less Current Liabilities	**187,314**	**190,056**	**262,881**	**272,153**	**(9,272)**
Borrowings	52,934	61,419	0	0	0
Provisions	1,773	1,513	(1,047)	(1,773)	726
Total Non Current Liabilities	**54,707**	**62,932**	**(1,047)**	**(1,773)**	**726**
Total Assets Employed	**132,607**	**127,124**	**263,928**	**273,926**	**(9,998)**
Public dividend capital	62,404	62,404	62,404	62,404	0
Retained earnings	(7,873)	(13,356)	(11,297)	(11,805)	508
Revaluation reserve	78,076	78,076	78,076	77,868	208
Total Taxpayers' Equity	**132,607**	**127,124**	**129,183**	**128,467**	**716**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**	**3.5%**	**3.5%**



Capital Programme



Property, Plant & Equipment (incl. Intangible Assets): As reported in previous board reports the YTD underspend is a result of on-going negotiations with a managed services provider. A revised plan has been agreed and this is being put in to the revised model with purchases expected in Q4.

Trade Receivables: The adverse variance of £7.8m is mainly due to delayed settlement of outstanding activity invoices for 2015/16 and 2016/17. Discussions are on-going but very slow as they are linked with the issues in Accounts Payable.

Payables: The Trust is in the process of approving and paying significant creditor balances and furthermore the Trust is in discussions with local providers to reduce outstanding balances. The Trust will not achieve the Better Payments Target in 2016/17 as liquidity remains an issue.

Cash: The annual cash plan assumes that the Trust would receive £8.9m cash support. The trust has drawn down £6.9m of this amount as at month 7. The cash position at the close of month 7 was £4.8m.

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

Whittington Health Trust Board
7th December 2016

Title:	Trust Board Report November 2016 (October 2016 data)		
Agenda item:	**16/161**	**Paper**	**8**
Action requested:	For discussion and decision making		
Executive Summary:	The Trust Performance report has changed to reflect the five CQC Domains. It is underpinned by Qlikview and automated. The majority of targets on this dashboard are the mandated national targets. The next phase is to develop community targets. Community activity will be developed in line with the to-be-agreed contracts. Outcome based measures will be developed in line with the to-be-agreed commissioning metrics. **Highlights** **Emergency and Urgent Care** Performance has dropped to 88.1%. Continued focus on improvement plan. **Cancer** The 14 day cancer target has been consistently achieved this financial year. Although the year to date target for 62 days from referral to treatment is still achieved, this month it is under achieving. **Emergency Re-Admission within 30 days** This indicator is just above the target of 14.2% at 14.7% **Delayed Transfer of Care** This indicator has been underperforming since June 2016, although showing slight improving trend. **Out Patients Friend and Family Test** This indicator has been under the threshold of 90% for the last 2 months. **Theatre Utilisation** This indicator is not included in the current dashboard, but will be included next month. Update: Theatre Utilisation has improved this month to 83% from 81%. To note, Urology for October is 80% up from		

	September 68%. Gynaecology is at 73% down from 76%. All other specialities are above 80% **RTT Incomplete** This target has been consistently achieved to date. **Community FFT and Staff FFT** Both indicators have been achieved to date. **Staff sickness absence** This indicator is below the national threshold of 3.5% at 3.3%
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:	1st December 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?**	

Whittington Health NHS

Integrated Performance Report

November

Month 7 (2016 – 2017)

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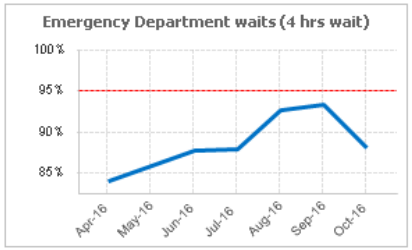
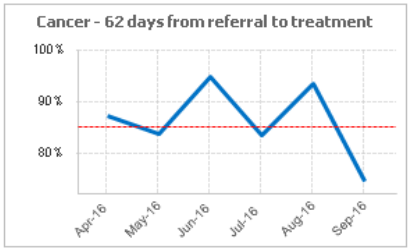
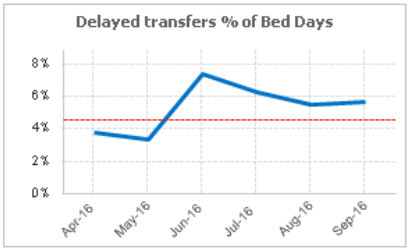
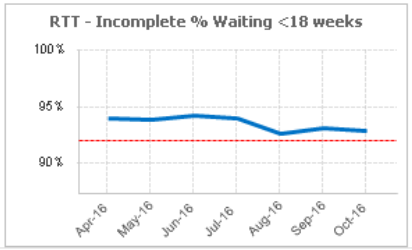
Summary Page - Indicators

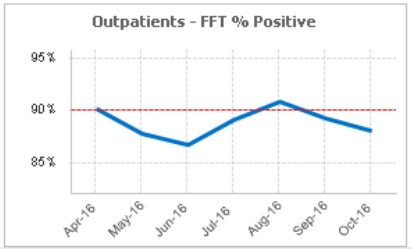
Category	Indicator	16_17 Target	Q1 Apr-16	Q1 May-16	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	2016-2017
ED	Emergency Department waits (4 hrs wait)	>95%	84.1%	85.9%	87.7%	87.9%	92.7%	93.4%	88.1%	88.5%
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	88	88	85	87	60	62	75	77
Cancer	Cancer - 14 days to first seen	>93%	97.4%	96.4%	96.4%	97.3%	97.7%	96.6%		97.0%
Cancer	Cancer - 62 days from referral to treatment	>85%	87.2%	83.6%	94.9%	83.3%	93.5%	74.5%		86.0%
Admitted	Emergency Re-admissions within 30 days	<14.2 %	11.5%	12.7%	16.3%	15.2%	14.1%	13.6%	14.7%	14.0%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	3.8%	3.3%	7.3%	6.3%	5.5%	5.7%		4.6%
Access	RTT - Incomplete % Waiting <18 weeks	>92%	93.9%	93.8%	94.2%	93.9%	92.7%	93.1%	92.9%	93.5%
Outpatients	Outpatients - FFT % Positive	>90%	90.2%	87.7%	86.7%	89.1%	90.8%	89.2%	88.0%	88.8%
Community	Community - FFT % Positive	>90%	97.3%	97.5%	97.5%	97.9%	97.5%	98.4%	98.1%	97.7%
Staff	Staff - FFT % Recommend Care	>70%			80.1%			76.2%		77.9%

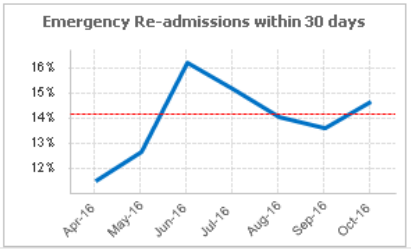












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Safe Services - Indicators and Performance

Category	Indicator	16_17 Target	Q3 Nov-15	Q3 Dec-15	Q4 Jan-16	Q4 Feb-16	Q4 Mar-16	Q1 Apr-16	Q1 May-16	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	2016-2017	Performance
Admitted	Admissions to Adult Facilities of pts under 16 yrs of age	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Admitted	HCAI C Difficile	<17	0	1	0	0	0	2	1	1	1	0	0	0	5	
All Areas	CAS Alerts Outstanding	0			0	0	0	0	0	0	0	0	0	0	0	
All Areas	Actual Falls	400	44	42	36	29	26	24	26	36	26	31	38	45	226	
Admitted	Avoidable Grade 3 or 4 Pressure Ulcers	0						4	2	1	3	5	5	5	25	
All Areas	Harm Free Care %	>95%	93.1%	93.2%	93.7%	93.6%	93.6%	92.2%	92.6%	93.5%	93.8%	91.9%	90.8%	93.3%	92.6%	
Maternity	Non Elective C-Section % Rate	>15%	20.5%	20.0%	18.1%	18.0%	18.1%	13.6%	18.9%	17.7%	16.4%	17.4%	20.2%	17.7%	17.4%	
Admitted	Medication Errors causing serious harm	0	1	0	0	0	0	1	0	0	0	0	0	0	1	
Admitted	MRSA Bacteraemia Incidences	0	0	0	1	0	0	0	0	0	0	0	0	1	1	
Admitted	Never Events	0	0	0	0	0	0	0	0	0	0	1	0	1	2	
All Areas	Proportion of reported Patient Safety Incidents Causing Harm	N/A								20.8%	22.6%	21.6%	21.8%	19.9%	21.4%	
All Areas	Serious Incidents	0	6	7	4	8	2	3	6	3	3	4	6	9	34	
Admitted	VTE Risk Assessment %	>95%	95.5%	95.4%	95.3%	95.3%	95.1%	95.0%	96.0%	96.3%	98.0%	96.2%	96.6%		96.4%	

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Safe Services - Commentary

This is the first dashboard in this format. This dashboard is taken as a snapshot from Qlikview. Some of the indicators have changed as requested by Whittington Health board. A list of definitions is attached to this dashboard.

New indicators:
Actual falls, now reported as number of actual falls. Avoidable grade 3 and 4 pressure ulcers, reported as number.
Key: Boxes in grey
The grey boxes pre May 2016 indicate there is no data in Qlikview available. The grey boxes after May 2016 indicate data is reported in arrears.

Falls
Falls rates in the Trust are continuing to increase. In October 2016 there were 45 falls compared to 30 in the same month last year. There were no deaths or serious harm and only 2 reports of moderate short term harm (One wrist fracture declared as SI and one heard injury severity to be confirmed). The new falls risk assessments and care plans are being rolled out with support from Heads of Nursing. Integrated Medicine ICSU is working on plan to recruit a specialist nurse in care of older people who will lead on Frailty, Falls & Dementia.

Avoidable Pressure Ulcers
The avoidable 5 pressure ulcers in October where; 1 - Grade 4 and 4 Grade 3 of which all occurred within the community setting.
The theme for avoidable pressure ulcers:
Two occurred as a result of faulty/broken equipment which had not been identified by the visiting District Nursing Team, therefore the equipment could not be repaired or replaced. One had no care plan or turning regime identified with the patient and 2 did not have assessments as per policy.
On International 'Stop pressure ulcer' day 17th November several documents were launched for patients, health professionals and carer's these included;
New pressure ulcer factsheet
New generic care prevention care plan
Pressure ulcer made easy guide for all areas.
We have again continued to raise awareness with our 'react to red skin' poster distributed throughout the hospital and all community teams, having attended the DN forum to raise awareness and remind of expectations.

Safe Services - Commentary

Harm Free Care
Not achieved, but improved compared to last month. It includes all avoidable and unavoidable harm. Unavoidable harm now reported separately in this report.

Non-Elective C-Section % rate
Although reduced this month compared to last month little progress was made. In July 2016 a pilot exploring alternative methods of induction commenced lead by the Gynaecology and Obstetric team and will shortly be evaluated.

MRSA Bacteraemia incidences
There was one MRSA bacteraemia reported in the CDU ward of EUC ICSU. All protocols were followed.

Serious Incidents
One **Never Event** concerning a possible misplaced Nasogastric tube was reported in October 2016. Initial investigation suggests that the tube was displaced after the patient vomited instead of misplaced during insertion.
A further 8 incidents were reported including; a failed discharge from Victoria Ward, delayed diagnosis of low grade lymphoma, 12 hour trolley breach, delay in treatment in IAPT services, pressure ulcers developing in a child, a maternal death, unexpected admission to NICU and a near miss of retained swabs after an instrumental assisted delivery. All SIs are being investigated and early learning has been shared within the services.

Caring Services - Indicators and Performance

Category	Indicator	16_17 Target	Q3 Nov-15	Q3 Dec-15	Q4 Jan-16	Q4 Feb-16	Q4 Mar-16	Q1 Apr-16	Q1 May-16	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	2016-2017	Performance
ED	ED - FFT % Positive	>90%	94.9%	93.1%	94.2%	91.6%	85.4%	89.9%	92.0%	87.7%	89.4%	92.4%	95.6%	89.9%	90.9%	
ED	ED - FFT Response Rate	>15%	1.5%	5.1%	3.9%	6.1%	4.0%	4.6%	4.8%	5.1%	4.5%	3.4%	4.1%	4.1%	4.4%	
Admitted	Inpatients - FFT % Positive	>90%	95.5%	93.9%	94.5%	89.5%	94.2%	96.6%	93.6%	95.7%	96.7%	96.0%	95.1%	95.8%	95.7%	
Admitted	Inpatients - FFT Response Rate	>25%	15.4%	13.5%	11.9%	12.6%	14.0%	19.4%	15.5%	15.5%	19.3%	15.4%	20.4%	18.3%	17.7%	
Maternity	Maternity - FFT % Positive	>90%	94.6%	93.6%	95.3%	87.7%	87.9%	94.6%	92.1%	94.6%	91.6%	93.2%	91.1%	91.6%	92.6%	
Maternity	Maternity - FFT Response Rate	>15%	4.4%	18.8%	14.2%	19.4%	19.2%	19.3%	16.1%	18.3%	10.5%	18.9%	24.2%	23.1%	18.5%	
Outpatients	Outpatients - FFT % Positive	>90%	91.2%	93.0%	94.3%	82.2%	84.7%	90.2%	87.7%	86.7%	89.1%	90.8%	89.2%	88.0%	88.8%	
Outpatients	Outpatients - FFT Responses	400	215	158	141	73	144	133	171	166	229	229	305	408	1641	
Community	Community - FFT % Positive	>90%	98.1%	97.0%	98.0%	96.3%	98.5%	97.3%	97.5%	97.5%	97.9%	97.5%	98.4%	98.1%	97.7%	
Community	Community - FFT Responses	1500	901	873	812	983	753	778	752	628	563	609	621	645	4596	
Staff	Staff - FFT % Recommend Care	>70%					82.3%			80.1%			76.2%		77.9%	
All Areas	Complaints responded to within 25 working day	>80%							90.5%	82.1%	95.5%	85.3%	85.7%	100.0%	89.0%	
All Areas	Complaints (including complaints against Corporate division)	N/A	22	22	34	21	48	23	23	31	26	38	32	25	198	

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Caring Services - Commentary

This commentary provides feedback on the clinical areas' performance against the FFT KPI targets. All clinical positive response rates are set at 90%. The response rates vary and are dependent upon number of expected patients.

ED: Six out of the past seven months ED's FFT positive response rates were 90% or above. The number of responses has averaged only 4.5%, against a KPI of 15%. In response, the Patient Experience Team (PET) recently implemented a new approach to help collect FFT feedback. This is the SMS (Short Message Service) and IVR (Interactive Voice Recorder) model. Patients now receive the FFT by text within 24 hours of discharge. In 17 days, the response rates doubled the number received for the months of August, September and October. The present trajectory indicates a response rate of over 15%.

Inpatients & Day-cases: During the past two quarters, the positive response rates average 95% per month. The response rates averages 20%, against the target of 25%. The response rate main issue is with day-cases. PET is looking to implement the SMS pilot for day-cases.

Outpatients: This is the most improved clinical area for FFT returns. In April 2016, Outpatients had 133 returns this has now increased to 408 by October. The main reasons for these improvements are: Reception staff reminding patients about the FFT feedback cards and the kiosks: Volunteers engaging with patients about the importance of FFT and patient feedback.

Community Services: Since April 2016, the positive response average has been 97.5% the highest across all services. The response rate of 645 was 855 lower than the KPI target 1500. There are two reasons for this.

1. Some services were still using the old Survey Monkey system to collect FFT and not Meridian. In other words the FFT was collected but results were not appropriately recorded; this has been rectified.
2. Some community services remain unsure about the best way to offer their clients the FFT. In response, PET are looking to implement a different approach where some services' clients will receive FFT email asking the patient to complete feedback

Maternity: Maternity has ensured that the FFT is and has remained part of the service's routine and commitment to patient experience. Both the positive responses of 90% and the FFT KPI of 15% are consistently achieved.

Effective Services - Indicators and Performance

Category	Indicator	16_17 Target	Q3 Nov-15	Q3 Dec-15	Q4 Jan-16	Q4 Feb-16	Q4 Mar-16	Q1 Apr-16	Q1 May-16	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	2016-2017	Performance
Maternity	Breastfeeding Initiated	>90%	91.9%	87.4%	91.3%	92.3%	93.3%	90.2%	92.1%	86.9%	94.9%	90.8%	87.9%	91.3%	90.6%	
Maternity	Smoking at Delivery	<6%	4.0%	6.0%	3.0%	7.4%	4.1%	4.4%	6.6%	6.2%	3.9%	4.4%	4.8%	3.2%	4.8%	
Admitted	Emergency Re-admissions within 30 days	<14.2 %	13.5%	12.7%	13.0%	13.6%	13.2%	11.5%	12.6%	16.3%	15.2%	14.1%	13.5%	14.6%	14.0%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	95.6	70.2	111.3	82.7	93.7	74.7	75.7	68.9	100.5				79.4	
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	115.8	85.9	88.2	68.8	54.6	42.0	117.1	60.1	76.7				74.1	
Trust	Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 mont...	1.14		0.67			0.68									
Admitted	Mortality rate per 1000 admissions in-months	14.4	6.5	6.9	8.2	6.7	7.5	6.7	4.7	6.1	5.8	5.8	4.2	6.5	5.7	

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Effective Services - Commentary

Emergency re-admission rate within 30 days

This target is now shown as a percentage instead of actual number.

Definition: The percentage of the number of Non Elective readmissions following a previous admission (Non Elective or Elective) within 30 days.

This indicator is just above target.

In the last two quarters this indicator has been missed one month out of 3 months although the year to date figure is still within target.

Responsive Services - Indicators and Performance

Category	Indicator	16_17 Target	Q3 Nov-15	Q3 Dec-15	Q4 Jan-16	Q4 Feb-16	Q4 Mar-16	Q1 Apr-16	Q1 May-16	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	2016-2017	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	92.5%	91.5%	84.6%	84.0%	81.6%	84.1%	85.9%	87.7%	87.9%	92.7%	93.4%	88.1%	88.5%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	74	81	85	94	103	88	88	85	87	60	62	75	77	
ED	Ambulance handovers waiting more than 30 mins	0	3	5	5	3	21	23	20	28	31		16		118	
ED	Ambulance handovers waiting more than 60 mins	0	0	0	0	0	0	0	2	9	0		0		11	
ED	12 hour trolley waits in A&E	0	2	0	0	1	0	0	2	1	1	0	0	1	5	
Cancer	Cancer - 14 days to first seen	>93%	89.9%	88.0%	93.2%	99.5%	98.9%	97.4%	96.4%	96.4%	97.3%	97.7%	96.6%		97.0%	
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	87.4%	90.8%	92.7%	98.3%	99.4%	98.1%	95.4%	99.2%	100.0%	100.0%	100.0%		98.5%	
Cancer	Cancer - 62 days from referral to treatment	>85%	88.9%	91.7%	93.8%	81.6%	91.4%	87.2%	83.6%	94.9%	83.3%	93.5%	74.5%		86.0%	
Cancer	Cancer - 31 days to first treatment	>96%	96.8%	100.0%	100.0%	100.0%	97.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Cancer	Cancer - 31 days to subsequent treatment - surgery	>98%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Cancer	Cancer - 31 days to subsequent treatment - drugs	>93%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%			100.0%	100.0%		100.0%	
Access	DM01 - Diagnostic Waits (<6 weeks)	>99%	99.63%	98.36%	99.10%	98.77%	99.38%	99.55%	99.43%	99.89%	99.32%	99.51%	99.72%	99.52%	99.56%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.3%	92.1%	92.3%	92.1%	92.7%	93.9%	93.8%	94.2%	93.9%	92.7%	93.1%	92.9%	93.5%	
Access	Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

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ED four hour waits

The ED four hour wait indicator declined in October 2016 following improvements seen in August 2016 into September 2016. This was compounded by increase in out of borough DTOCs (Delay Transfer of Care), probably as result of continued North Middlesex blue light divert. It also impacted negatively on the median wait for treatment due to increased blue light activity over night between 10pm and 6am. There was increased pressure on beds over October due DTOC and increase in number of patients with lengths of stay over 7 days.
44 % of breaches were due to bed management up from 24% in September.
29% of breaches were due to ED assessment down from 33% in September.
Actions -focus on time ED time to treatment & improved streaming.
Focus on flow: SAFER bundle, pre11am discharges & heightened focus (whole systems) on DTOCs. The organisation is also working with ENST (Enhanced Nursing Support Team) to look at the whole front of house flow. The first visit was on 24th November and the second visit is planned for 8th December 2016

Ambulance handover time

The data for August and October 2016 is currently being investigated by London Ambulance Services, who notified us that they have found issues with the data. Data will be added as soon as it becomes available.

12 hour trolley waits in A&E

There was one 12 hour trolley breach in October 2016.There was a further one patient waiting for a mental health bed for over 12 hours. Internal investigations have taken place for both and appropriate action put in place to mitigate risk going forward.

Cancer – 62 days from referral to treatment

Note: When boxes are grey in this section is means that there were no patients in this category for the month.

The indicator was non-compliant for the month of September at 73.6% against the standard of 85%. There were 6.5 breaches, 2 in Lung Services and 4.5 in Urology.
Issues: Lung, capacity within the service and delays are now resolving. Performance has improved for November 2016.
Urology, most delays due to patient choice and medical reasons. Of the remaining patients one was complex and one patient cancelled.
All patients now reviewed daily to avoid breaching.

Responsive Services - Indicators and Performance

Category	Indicator	16_17 Target	Q3 Nov-15	Q3 Dec-15	Q4 Jan-16	Q4 Feb-16	Q4 Mar-16	Q1 Apr-16	Q1 May-16	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	2016-2017	Performance
Theatres	Hospital Cancelled Operations	0	1	1	16	3	3	19	4	7	1	6	1	5	43	
Theatres	Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Theatres	Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Admitted	Delayed Transfers Of Care - Days Lost	N/A	109	218	143	102	183	148	129	273	240	191	199		1180	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	2.9%	5.3%	4.3%	2.4%	4.1%	3.8%	3.3%	7.3%	6.3%	5.5%	5.7%		4.6%	
Maternity	Women seen by HCP / midwife within 10 weeks	>50%			31.2%	38.7%	33.9%	40.4%	43.8%	63.7%	74.5%	69.1%	72.8%	69.4%	61.4%	
Community	IAPT Moving to Recovery	>50%				47.1%		47.4%	51.6%	48.0%	50.0%	51.7%	52.3%		50.2%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%						95.7%	95.0%	90.5%	95.1%	93.8%	94.6%		94.1%	
Community	GUM - Appointment Offered within 2 days	>98%	96.8%	99.0%	98.1%	99.4%	98.9%	98.7%	98.5%	99.7%	95.6%	97.8%	99.2%	99.9%	98.5%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	84.7%	80.8%	87.7%	83.8%	85.7%	88.6%	89.8%	87.9%	93.2%	94.6%	94.2%		91.3%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	95.0%	91.5%	94.5%	92.8%	94.7%	95.1%	96.1%	94.4%	94.9%	93.7%	88.3%		93.7%	

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Responsive Services - Commentary

Hospital Cancelled Operations
The data in the dashboard is un-validated and after validation only 4 cancelled operations on the day were confirmed. Three were due to trauma pressures, therefore elective procedure were cancelled. One breast operation was cancelled due to the appropriate staff not being available.

Delayed Transfer of Care % of Occupied Bed days
This indicator has been above the threshold of 4.5% since June 2016.
Action: Whole system focus on DTOCs with daily monitoring of medically optimised patients & DTOCs
Improved escalation processes with weekly calls with Social Services (London Borough of Islington)
Discharge to assess now in place with London Borough of Haringey & London Borough of Islington (reduce beds days for patients waiting for Reablement packages)

New Birth Visits September 2016
Haringey continue on upward trajectory due to close monitoring at team level and increase in HV FTE. Would have achieved 96% had those in hospital been excluded from the data.
Islington fall due to increase in HV vacancies along with high number of babies in hospital and parental refusals (see below); would have achieved 95.7% had these been excluded from the data. First time in 2 years % has fallen below 90%
Islington: 28 (11.7%) late (North locality achieved 98.7%)
11x in hospital; 7x parental refusals (all in South locality and said to be due to parents who receive private health care & support - to be explored more as this does not occur elsewhere in Islington or in Haringey); 4x transfer in - new birth completed elsewhere; remainder due to late notification or unable to access families within timeframe.
Haringey: 19 (5.8%) late
6x in hospital; remainder - late notifications / unable to access families

Well Led Services - Indicators and Performance

Category	Indicator	16_17 Target	Q3 Dec-15	Q4 Jan-16	Q4 Feb-16	Q4 Mar-16	Q1 Apr-16	Q1 May-16	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Performance
HR	Appraisals % Rate	>90%	76%	74%	74%	72%	71%	69%	68%	67%	66%	63%	66%	
HR	Mandatory Training % Rate	>90%	83%	82%	82%	82%	81%	81%	81%	81%	81%	80%	81%	
HR	Permanent Staffing WTEs Utilised	>90%					87.1%	87.7%	87.8%	86.2%	87.1%	87.0%	88.1%	
HR	Staff FFT % recommended work	>50%				69.6%			65.1%			59.7%		
HR	Staff FFT response rate	>20%				14.7%			19.6%			24.9%		
HR	Staff sickness absence %	<3.5%	3.0%	3.1%	2.9%	3.2%	3.0%	3.3%	3.2%	2.9%	2.9%	2.9%	3.3%	
HR	Staff turnover %	<10%					14.9%	14.9%	15.8%	15.7%	15.5%	15.7%	15.4%	
HR	Vacancy % Rate against Establishment	<10%					12.9%	12.3%	12.2%	13.8%	12.9%	13.0%	11.9%	

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Well Led Services - Commentary

Human Resources

The workforce KPIs are discussed at ICSU-level on a monthly basis led by the HR Business Partners. There is further scrutiny and assurance sought at the quarterly Performance Management meetings. Each ICSU now has a trajectory to achieve appraisal and mandatory training compliance.

Whittington Health NHS

Winter 2016/17

Resilience

Winter Plan: Aims

Whittington Health NHS

- ***Keep patients safe and provide high quality care during the winter months within Whittington Health***
- ***Patients looked after by the right team in the right place***

We aim to:

Whittington Health NHS

- Ensure appropriate capacity is available during winter period
- Ensure patient flow is maximised
- Ensure command and control is consistent 24/7
- Coordinate operations efficiently and effectively within and between ICSU teams
- Provide timely communications to all stakeholders via *Page One* and proven communications tools
- Escalate and prioritise actions in relation to demands of service

Additional Capacity

Whittington Health NHS

Scheme	Description
Cavell Ward	**Winter Pressures Ward** 24 beds open from 1st November 2016 - The ward will be clinical managed by the Care of Older People (COOP) team. Criteria for beds to be the same as other COOP wards.
Coyle Ward	Extra 7 beds open from 1st November 2016 . Cover and supported by AAU Consultant cover (0.5 WTE) AAU SpR, 1 x F2 (previous bridges post). Cross cover SHO post with Victoria SHO posts
Virtual Ward Team and Frailty unit support	Provide an Acute Frailty Service available 12 hours per day, 7 days per week. Trust plan to introduce in December on 5 day per week basis. Following December launch develop proof of concept to extend to 7 day per week. Extra therapy and pharmacy staff to support virtual ward
Additional ED Consultant/GP Support/Acute support	The additional funds will be used to provide additional senior support in the evenings and weekends that can be flexed across all areas of the department.
Discharge Medical Registrar	Discharge Medical Registrar. Ensure sufficient support is available during the weekend to facilitate timely discharge of patients identified by site team.
Enhanced pathway delivery	Increasing the CORE team by 2 x band 7 member of staff. To facilitate daily presence in the Emergency Department /AMU/Ambulatory Care with the aim to navigate 50% of patients

Improvement plan – Streaming & Redirect

Whittington Health NHS

- **Streaming at the front door**
  - Redirection to the Ambulatory Care Unit (ACU)
  - Increase ED Consultant establishment and key decision making capability
  - Productivity & reduce variation
  - RAT (*rapid assessment & treatment*)
  - Mental Health Liaison in emergency department
  - Monitor Specialty Response Times to A&E
  - *I- Hub pilot -*

Improvement plan :Flow & Discharge

Whittington Health NHS

- **Internal Plans**
  - Perfect week 2 -week beginning **9th January 2017**
  - Continue to drive criteria led discharges -
  - Pre-11am discharge
  - Senior review by midday/board round standardisation/EDD (SAFER BUNDLE)
  - MDT Review of patients with a Length of Stay (LOS) over 7 days in place –**weekly**
  - Standardised enhanced recovery protocols for core procedures
  - Supporting Choice at Discharge- revised protocol agreed
  - Optimising Virtual Ward and Rapid Response
  - Acute Assessment Flow/Streaming launched **28th November**
  - Frailty Pilot/Enhanced Pathway to launch **5th December**

Improvement plan : Flow & Discharge

Whittington Health NHS

- **External Plans**
  - Discharge to assess - Rapid discharge of reablement patients. Islington to start with non-complex patients end of November 2016. *Haringey planning on taking patients on the same day reablement commenced October*
  - E-confirmation of package of care pilot on Coyle ward with roll out to all wards upon successful trial- ***December***
  - Trusted assessor agreed for Intermediate care, (Mild may and St Anne's)

Winter Capacity: Nov 1st

Whittington Health NHS

Adult Acute beds		Adult Community Beds	
Current	197 (211)	**Current - Islington** St Pancras Stroke/Neuro Rehab General Rehab Mildmay St Ann's **Current Haringey** Bridges Rehab	 18 37 10 12 14
Winter beds (Cavell/Coyle)	23	**New** – Step down bed Haringey (Protheroe House)	10
Total	**234**	**Total**	**101**

Red to Green
Flow Meetings

Mandatory representation

Whittington Health NHS

Site Team Lead

Members

MH | Infection Control | Transport | Imaging | Therapies | Pharmacy | Complex D/C | HONs | Director Ops | Matrons | D/C Coord's | Consultant

08:30
(15 Mins)

Review and actions from previous day/ Red and Green Day Status recording by ward

Site Team
Director of Ops
Infection Control
HONs
+/- COO
Discharge list to be circulated to:
Transport
Imaging
Therapies
Pharmacy

10:15
(40 Mins)

Commence allocation of pre 11am beds
Patient level update from the wards for today and tomorrow's D/C and planning for patients with complex/ social/ care needs

Site Team
+/- Director of Ops
D/C Coordinators
Complex Care Nurse
Social Work (virtual access)
Matrons (10 mins slots each)

14:00
(20 Mins)

Progress on actions and unblocking of problems and confirmation of pre 11a.m DC recording by ward

Site Team
D/C Coordinators
Lead Drs for Med & Surgery
Transport
Imaging
Therapies
Pharmacy

16:00
(15 Mins)

Ensure all actions completed, planning for next day D/Cs and email cascade of information sent to all Members i.e. issues log for next day discharges to include Transport, Diagnostics, Therapies, Pharmacy

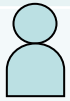
Site Team
D/C Coordinators
Silver "on call"

Version 2.0 dated 10th October 2016

Roles & Responsibilities

Site Manager/ Team (7 days/ week)

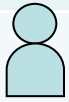
- Overall responsibility for patient flow and bed management
- Holds and updates list of all patients due for discharge within next 24 hours, those known to complex care team and all DTOCs
- Establish and updates daily D/C tracker i.e. No's per ward/ day
- Establish and updates discharge planner for proceeding 24 hours e.g. Thursday and Friday (planned, confirmed, suitable)
- Cascade of daily 8.30 am and 4p.m. D/C email



Discharge Coordinator(s)

- Active D/C ward liaison and management
- Provide update of:
- discharge for same day D/Cs
- discharges in proceeding 24 hours
- complex discharge patients
- Highlight:
- patients who may require complex D/C or SW input
- Survey monkey recording for respective wards:
- Red to Green status for previous day
- Outstanding issues at 4pm
- Pre 11a.m. D/C status
- Confirm senior review carried out before midday

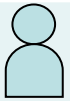
Infection Control Confirm any issues which effect flow. Communicate any special precautions required to keep patients safe and contain infection



Transport/ Therapies/ Imaging/ Pharmacy

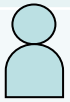
- Review 8.30 and 4pm lists within 30 mins of distribution
- Address issues and take action accordingly to ensure agreed standards are met
- Update next meeting

Role & Responsibilities



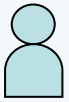
Director Operations/ HoN / Site Manager

- Escalation of internal and external issues using the PageOne communication system with standardised messaging. Message from WHIT1 to WHIT2
- Collaborative co-ordination of Business Continuity Issues that require external support.
- Standardised communication messaging
- Monitoring of NCL using the SHREWD resilience system



Complex Discharge C Nurse

- Update on progress for relevant patients/ next steps
- Social Work requests and escalation
- Allocation of D/C coordinator tasks

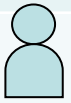


Matrons

- Take back actions to ensure agreed standards are met
- Including Criteria Led Discharge

Consultants

- Ensure senior review is completed by noon
- Enable TTA readiness for 8.30am and 2p.m.



Social Work/ MH

- To be available for actions arising at 10.15 meetings.
- Take back actions to ensure coordinated and timely D/C is managed

Emergency Department Flow and Escalation

Whittington Health NHS

Escalate Early
Clear Team Coordination
Standardised Communication
System Wide Response

BLACK OPEL 4

- The Emergency Department is under critical pressure - there is increased potential for patient care and safety to be compromised
- The ED is BLACK if ≥ 2 triggers are BLACK or any FULL CAPACITY trigger is BLACK
- ED Senior Team to complete actions against indicator that has triggered BLACK
- Additional Trustwide coordination to improve patient flow
- Consider activation of the FULL CAPACITY PROTOCOL

RED OPEL 3

- The Emergency Department is experiencing major pressures compromising patient flow
- The ED is RED if ≥ 3 triggers are RED or any FULL CAPACITY trigger is RED
- ED Senior Team to complete actions against indicator that has triggered RED
- Trustwide response to complete actions to support Emergency Department

AMBER OPEL 2

- The Emergency Department is starting to show signs of pressure
- The ED is AMBER if ≥ 3 triggers are AMBER
- ED Senior Team to complete actions against indicators that have triggered AMBER
- When actions are complete review the situation and update the ED Manager / Site Manager

GREEN OPEL 1

- Business as usual - the Emergency Department is able to maintain flow and meet demand
- Emergency Department Status is monitored continuously by SHREWD and a regular SITREP at board rounds at 0900, 1200, 1500 (ED Manager), and 1900, 2300 (Site Team supported by ED Cons / Reg)
- Concerns about flow, capacity or demand should prompt an earlier check
- If individual indicators are at AMBER or RED, complete actions against those triggers
- If individual patients are experiencing delays in assessment or treatment this should be escalated immediately to the ED Cons / Reg

Summary

- Bed capacity to respond to increased demand in winter
- Integrated flow, escalation and discharge planning within and between ICSU's
- Standardised communication, command, control and coordination to provide safe quality care
- Senior Clinical & Operational oversight of EUC & IM improvement plans
- Flu vaccination – currently at 75%

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DRAFT

Whittington Health NHS

WORKFORCE ASSURANCE COMMITTEE

Minutes of meeting held on Tuesday 25th October 2016

Present:	Stephen Bloomer	Chief Finance Officer
	Philippa Davies	Director of Nursing & Patient Experience
	Norma French	Director of Workforce
	Helen Gordon	Deputy Director of Workforce
	Kate Green	PA to Director of Workforce (notes)
	Steve Hitchins	Trust Chairman (in the Chair)
	Jana Kristienova	AD, Integrated Care Education
	Yua Haw Yoe	Non-Executive Director

16/24 Welcome and Introductions

24.01 Chairman Steve Hitchins welcomed everyone to the meeting. Apologies for absence were received from Graham Hart, Ian Bates, Carol Gillen and Siobhan Harrington.

16/25 Minutes of the meeting held on 31st August

25.01 The following amendments to the minutes of the meeting held on 31st August were agreed:

- Under 'present' on page 1, change 'Occupation' to 'Occupational@
- Minutes 17.05 should be divided into two sentences to reflect the fact that Facilities employs a fairly large number of staff
- 23.04 The spelling of Myra Stern's name needed to be corrected.

25.02 Other than the above amendments, the minutes of the Workforce Assurance Committee held on 31st August 2016 were approved.

16/26 Matters arising

26.01 There were no matters arising from the minutes of the previous meeting other than those already scheduled on the agenda for discussion.

16/27 Quarter 2 Workforce Report

27.01 Introducing this item, Helen Gordon acknowledged that staff turnover figures appeared high when set against the pan-London context, however consideration needed to be given to a technical point about the method by which figures were calculated, e.g. some organisations included their junior doctors whereas others did not. Helen would speak to Amelia about the best way to address these anomalies in future.

27.02 Moving on to the exit interviews section of the report, Helen emphasised that the key point was to ensure that the areas mentioned were being examined and addressed.

27.03 Discussions continued over the use and associated cost of agency staff. Norma French reported a significant reduction in agency usage in September, particularly within the Integrated Medicine and Emergency & Urgent Care ICSUs. She expanded on the controls that had been put into place to reduce such spending, saying that Philippa Davies or Doug Charlton personally signed off all requests for agency nurses and Richard Jennings did likewise for medical agency staff. From November, Beverleigh Senior would be asked to approve requests for AHP staff. Every effort was also being made to recruit permanent staff and to encourage staff to sign up to the Trust's Bank.

27.04 Philippa Davies informed the committee that a considerable number of shifts are being run on amber at present, with the acuity tool (part of the nursing roster) being used to gauge where there were highly dependent patients or specialling requirements and ensuring those shifts were run as green. She acknowledged that staff were unhappy about the workload, but wished to assure the committee that at no time was patient safety being compromised. Ward sisters would continue to request agency staff and heads of nursing would continue to issue challenges. Asked about when controls might be relaxed, Philippa replied that she suspected they would be required for the foreseeable future. Revised guidance from the centre, including the requirement for board level self-certification, was expected imminently.

27.05 Philippa reported that the Trust had successfully participated in the national Change Day, which Anu Singh had attended on behalf of the Board. She added that the Trust was planning to introduce pharmacy technicians who would be carrying out drug rounds; also that the Trust had been successful in securing funding for 40 associate nurses.

27.06 In answer to a question about the turnover in the Prevention & Planned Care ICSU, Helen Gordon replied that the HR Business Partners were in possession of the detail of this, however she believed this was in part due to the proportion of low-grade A&C staff within that ICSU, combined with the organisational change taking place around the introduction of Dictate 2. Norma French had recently attended the latest round of ICSU performance review meetings, saying that for the first time staff exit interview data had been made available to them.

27.07 There appeared to be a rise in nursing vacancies, however this could be attributed to routine seasonal variation. Stephen Bloomer enquired about posts which had been vacant for more than six months, and Norma replied that this was in no way due to the Trust's recruitment processes; rather Whittington Health's recruitment processes were the fastest within the London streamlining sector. She acknowledged that some posts were hard to recruit to, and some were purposely held as vacant posts as part of a cost saving initiative. A more meaningful exercise would be to look at posts which the Trust was actively trying to fill rather than just counting vacant posts. Vacancy Scrutiny Panel processes were not currently tracked.

27.08 Norma had received a letter from the centre the previous week setting out the requirement for Trusts to declare how many agency staff had been in place for more than six months. The meeting looked at the figures for the finance directorate, and Stephen explained that for most posts, appointments were in the pipeline, although it had been necessary to use Hays Recruitment services to assist with securing some people into posts. He believed that offers were now out for all finance posts.

27.09 In answer to a question from Yua Haw Yoe about whether all agencies used by the Trust were on the approved framework, Norma French replied that all NHS organisations were required to submit a weekly return to the centre detailing the use of any off-framework agency, and Helen Gordon added that new framework guidance from the centre was expected shortly.

27.10 Referring to page 18, it was noted that sickness figures for the Medical Director's area were potentially misleading given the small number of people employed within that team. Within the facilities directorate there were some cases of long-term sickness. Overall, there was a reduction in short-term sickness, but a slight increase in those on long-term sick leave. Long term sickness within the Trust is being actively managed through case conferences, the involvement of occupational health and close co-operation between line management and HR business partners. Return to work interviews were also now routine.

27.11 Moving on to appraisals, it was noted that the Trust's new pay progression policy had been implemented in September, this meant that in order to receive their pay increment staff needed to have completed their mandatory training and had an appraisal. Some had expressed concern about not having the time available to schedule appraisals, and Norma would be reinforcing the message to managers that allowing adequate time for appraisals was imperative. The quality indicator for this area was the staff survey results.

27.12 One issue that had arisen, Siobhan had heard anecdotally, was that the personal development (PDP) aspect of appraisals was either being omitted or, if agreed, not followed up on. In response, Philippa Davies referred back to the earlier discussion (minute 27.04) about wards running on amber, saying that where this was the case, it was sometimes necessary to call staff away from training sessions etc. Yua Haw Yoe asked whether PDPs were reviewed after six months, and Helen Gordon replied that such reviews should form an integral part of regular 1:1 sessions with line managers.

27.13 Turning to the section of the report on exit interviews, it was noted that the number of exit interviews completed was included, however it was not known how many of those staff who had left the Trust had either chosen not to complete an exit interview questionnaire or not been allowed the opportunity to do so. It was agreed this should be followed up outside the meeting. Helen Gordon made the correlation between high turnover and low appraisal rates.

27.14 The meeting discussed the extent to which some of this data (sickness and vacancies for example) was taken into account by the ICSUs when writing their business plans. Helen Gordon added that the challenge, as well as taking all these factors into account, was ensuring that staff felt valued and that Whittington Health remained a popular and valued employer.

27.15 It was noted that this report was routinely shared with all seven integrated clinical service units and with the Trust's Partnership Group.

16/28 <u>Employee Relations Activity</u>

28.01 Helen Gordon introduced this item by explaining to the committee that it was still necessary to compile the data used to create this report manually, although consideration was being given to purchasing a casework tracker which would analyse data. One of the key objectives for the team was to improve the time taken to resolve cases; this would both reduce costs and improve

staff morale – Helen confirmed that at present, compliance was not as good as it might be. Plans were underway to introduce some joint training sessions for management and staff side later in the year; this work was being led by Kristen Cluer.

28.02 Moving on to staff sickness, it was stressed that the management of sickness was about support rather than punishment. In answer to a question from Siobhan Harrington about length of time taken to resolve live cases, Norma explained that this was in part due to the complexity of some of those cases and the fact that there had in the past been a failure to tackle some of the admittedly very difficult issues. She herself had several ongoing cases which she estimated were taking up around 75% of her time, but her personal involvement with the work meant that cases which had been stalled, and which were 2-3 years old, were now moving forward. HR Business Partners were also still dealing with some case work pending the strengthening of the Employee Relations Team.

28.03 Philippa Davies asked whether future reports might be broken down into the different staff groups. It was also suggested that dates and costs to the Trust be included. In answer to a question about whether all six suspensions had taken place during Quarter 2, Norma said that she believed this to be the case but would check for certain.

16/29 Staff Survey 2016

29.01 Norma French informed the committee that the Trust was now part of the way through the conducting of the staff survey for 2016. This year, she had chosen to survey a random sample of 1,250 staff, through a combination of on-line and paper-based questionnaires. To date the response rate had been disappointing at 14%, however the first set of reminders had not yet been issued and a second set would be issued before the survey closed.

16/30 Leadership & Management Programme 2016

30.01 Norma French drew attention to the papers produced by Rai Gallo, Leadership Coach, which set out details of the programmes for 2016 and gave an overview of evaluations from them. The programmes had been well received, and the evaluations were positive. Rai had said, however, that he needed to give further thought to how best to deal with the attrition rate , as people are specifically nominated to participate in these programmes and they represent a significant financial and time commitment. It was noted that Rai always invited one or two executive directors to attend the feedback sessions.

30.02 Norma paid tribute to the success of the Stepping Stones Programme, saying that both she and Carol Gillen had acted as mentors for participants in that programme.

16/31 External Inspection – GMC Trainee Survey

31.01 Introducing this item, Postgraduate Medical Education Manager Graeme Muir said that the report of the most recent GMC Trainee Survey contained some key messages which he wished to highlight for the committee:

- The best performing medical training programme across London
- Green flags for nine of the 15 domains

- The particularly excellent score for paediatric training
- The recognition of the huge amount of work carried out in obstetrics and gynaecology.

31.02 Referring to the last area, it was suggested this be drawn attention to in some way at the forthcoming maternity services open day. Reference might also be made to the results of the survey in the Chairman's monthly report to the Trust Board.

31.03 Graham warned committee members that in some areas percentage scores might be misleading; for example in an area where there were only four trainees and one had expressed dissatisfaction that would come across as a disproportionately high percentage. He also pointed out that the survey was carried out in March – although the results are not received until July – so many improvements had already been made.

31.04 Graham acknowledged that it was of concern when areas were flagged as red in more than one consecutive year, but such issues were included and prioritised in the accompanying action plan, which was sent back to the GMC to illustrate what was being done to make improvements. In answer to a question from Yua Haw Yoe about how the success of the action plan was measured, Graeme replied that it was monitored by the Postgraduate Medical Education Board. Jana Kristienova added that the Trust had retained data from previous years so it was easy to see where real progress was being made.

16.32 <u>Workforce Risk Register</u>

32.01 Much work had been undertaken in this area prior to the CQC inspection last December. Norma drew attention to the top risk, that of ESR processes, saying that it needed now to be amended to show oversight. In answer to whether the risk register was produced collectively by the team, Helen replied that it was, and names were included so that it was easy to check progress against action plans.

32.02 Steve Hitchins enquired why the problems with ESR could not be corrected. Norma replied that ESR was a national system and therefore not one the Trust could amend or correct. It was not however at the top of every organisation's list of concerns since as well as the generic problems within the system Whittington health had also had to deal with a particular set of legacy issues around resources and staffing which had contributed to its difficulties. The most pressing piece of work required was the uploading of information from the ledger to ESR, and Norma was in discussion with finance colleagues about how best to achieve this.

32.02 Philippa Davies pointed out that the reference to this committee needed to be updated. In answer to a question from Steve Hitchins about Risk 3 (long term bank employment) Helen Gordon replied that she was minded to downgrade this, saying that for her, the key issue was always to have a pipeline and a plan. Some of the staff so categorized might in any case have retired and chosen to come back to work on the bank – this group was highly unlikely now to be seeking permanent employment.

32.03 Norma stressed that the workforce risk register was exactly that, it did not try to capture any risks touching on workforce for the entire Trust. It was agreed the wording of Risk 4 should be amended.

Whittington Health NHS

Draft Minutes of the

Audit & Risk Committee – Part I

14.00 - 17.00 on Wednesday 12 October 2016, WEC 6

Present:	David Holt	Non-Executive Director, Chair
	Stephen Bloomer	Chief Finance Officer
	Vivien Bucke	Business Manager, Finance (minutes)
	Carol Gillen	Chief Operating Officer
	Paul Grady	Director, TIAA
	Siobhan Harrington	Deputy CEO & Director of Strategy
	Neil Hewitson	KPMG Director
	Deborah Harris-Ugbomah	Non-Executive Director
	Tony Rice	Non-Executive Director
	Johnathan Shortall	Local Counter Fraud Specialist, BDO
	Adam Spires	Internal Auditor, BDO
	Glenn Winteringham	Director of IM&T

Item	Discussion	Action
16/029	**Welcome, Apologies & Declarations of Interest**	
29.1	Apologies were received from James Carroll, Ursula Grueger, Simon Pleydell, Philippa Davies & Norma French. There were no declarations of interest.	
16/30	**Minutes of the Audit & Risk Committee 1 June 2016**	
30.1	The minutes were agreed as an accurate record with the following amendments: Lynne Spencer to be added to the present list Paragraph 25.6 on unsigned leases: *'SMH said this would be a priority within the directorate and she would make sure this is delivered'* replace 'make sure this is delivered' with 'she would work towards this but it would be a challenge'.	
16/031	**Action Notes & Implementation Tracker**	
31.1	SB stated the actions related to the BAF were showing as completed as they were discussed and approved at Trust Board last week. DH suggested another session at Trust Board on the BAF and alignment with the Trust Strategy in February. TR asked about the BAF and Whittington Health's appetite for risk. DH responded that in his other audit committee roles he had seen an increasing discussion on risk appetite, particularly on financial risk and related commercial activity. . The current SEP process was a good example of this in our own Trust. DHU offered to send round an article on considering risk to the Committee. AS said he had recently facilitated a board session on risk and could do the same for the Whittington if required.	
31.2	DH asked if the Executives were comfortable with the progress being made on signed leases or is there any risk? SMH said the aim was to get all leases completed and signed. However leases with NHS property services have been difficult and a decision was taken to sign the Heads of Terms and not leases until all terms and end dates were agreed. DH asked for an update at a future	

	committee to determine if there is any risk from not having leases in place and SMH agreed it would be good to have another session at a future Audit Committee.	**AP1**
16/032	**Risk Deep Dive: IM&T Infrastructure Risks**	
32.1	GW spoke to the presentation and highlighted that in the self-scored IM&T readiness survey last year the Trust was below average nationally for infrastructure readiness. Red risk highlighted were: Thoroughgood & Jenner Data Centres not fit for purpose, lack of disk storage and obsolete backup. However all red risks were addressed in the capital plan for 2016/17 which improved the position. The risk was now that as the use of IT in front-line healthcare increases then the infrastructure would require a step change in investment.	
32.2	GW described the storage risk to the Network but he felt the Trust is in a much better place than previously.. GW gave assurance that the Trust is using the best industry infrastructure products on the market. However, 66% of the PC estate is older than 6 years. This is linked but not tied in to STP monies. DH recognised this is an area of increasing pressure on staff and a cause of frustration.	
32.3	GW described the increasing Cyber Security risk. The Trust was in the same position as other NHS organisations and does not have intrusion detection tools; it has standard defences but does not know if someone is trying to hack into the network. KPMG had run a Cyber Audit, which had informed the Trust of the assurance gaps, knowledge and product gaps. It will enable the Trust to move beyond standard NHS protection within a constrained budget. It will receive a high risk score and priority for investment.	
32.4	GW spoke of the national security conference and ransome ware software which could be in place. Sophos, one of the Trusts main suppliers, have just released ransome ware. DHU also felt there is something about providing information for frontline staff to be smarter and she asked what can all the CIOs do and can we get something in place quite quickly. DHU felt this is a business not an IT issue now. GW agreed an education piece is needed and IT will need to think of a programme of work with IG.	**AP2**
32.5	GW/CG left the meeting. DHU felt that the Trust is probably further along than other Trusts but DH was keen to keep on top of this item. DH asked that this be revisited regularly as part of the Committee as well as going to a Trust Board Seminar. TR described the revised data protection and new GDPR regulations, highlighting there are big penalties for a breach. SMH confirmed she received quite a lot of SAR requests and agreed with DH an update on this and SAR requests to come to the March Committee.	**AP3** **AP4**
16/033	**Review Committee's Terms of Reference**	
33.1	SB stated the Terms of Reference have been refreshed and they have been benchmarked with a number of organisations. Some standard items had been added on the role of the committee. In 2.1 Accounting Officer was amended to Accountable.. It was agreed that any amendments to the TOR, particularly relating to membership and substitutes, should be consistent with other committees. Subject to this, it was also agreed to delete paragraphs 6.3 and 11.1.5.3. **The TOR will now go to the Trust Board for approval.**	**AP5**
16/034	**TIAA Final Progress Report**	
34.1	PG reported that the work completed in this report would not cause TIAA to change the assurance given at year end, retrospectively. Within the report were	

	one substantial, six reasonable and one limited assurance reviews. There were a number of completed actions. PG explained that within the closing position for audit actions there are twenty five actions but quite a few had an action date that was only just passed. DH queried whether, with fifteen outstanding priority one actions, the Committee should assume these haven't been actioned? If so he asked that taking these forward the onus should be on the management team to ensure agreed actions are completed on time. PG confirmed the actions had been handed over to the new IA.	
34.2	PG took the Committee through the completed reports : Data quality 18 weeks RTT - This is at the upper tier of Reasonable Assurance. DHU asked PG did TIAA look at the systems on regulatory updates when testing. PG stated there were changes in how RTT was calculated, but that was some time ago and he was assured that the way the calculations were done as up to date as possible. Data quality Cancer - PG confirmed Reasonable Assurance Lone working arrangements - Reasonable Assurance; PG felt that generally there was a need to be more consistent on the good work and a bit more rigour on documentation. Financial Reporting & Budgetary Control - Reasonable Assurance; PG stated the report reflected a position in time and that a lot of progress has been made in the last year and there were plans in progress to go further which could be seen in the detailed responses. DH said that in the changes he had seen, he felt it was the start of the journey and with regard to the day to day relationship with Operations he recognised the responses. DHU asked PG if he was comfortable with the speed of progress. PG said the detail of SLR was not looked at again as IA had undertaken audits in the past; the report focussed on the basis of budgetary control and the trajectory on this is of reasonable speed. For SLR/PLICS area, DH said he could see good high level work but he felt when drilling further down Executives are reliant on staff. DHU asked SB/CG to comment on how they felt. SB said he was frustrated as the improvement programme was making progress but not as quickly as he would have liked. The finance programme covers all the points IA had made. Success would be in getting the team out into the organisation, more so improving the basic processing and reprocessing, which currently takes a lot longer than should when closing month end was a vital first step. When improved this would allow for two tiers of staff out with Operations. Business Managers are currently meeting with Directors but the next tier down should be with service managers and there is currently a mix of staff at 8a and that reflects the situation. CG felt the ICSUs are building better relationships with their service managers but agreed the next layer to be meeting with are ward managers who really need this relationship. CIP: Reasonable Assurance; While short of the plan for last year, CIPs were reasonably consistent, there are many process improvements although there was quite a high non-recurrent as reported to the Trust Board. The same issues with regard to joint working were echoed. Patient Transport: - Limited assurance. SMH said there was some movement with six or seven actions completed already. LAS had given notice but Adrien Cooper, the new Director of Environment had now started and was undertaking work with the Directors of Operations work around eligibility criteria. Mortality: Reasonable Assurance - PG said this was at the lower end of reasonable assurance. Improvements were required on documentation and inconsistencies with dates recorded but DH said it looked like most actions were being addressed. UCLPPS: – This was a follow up review from the original systems report and IA were able to close off the majority of actions. One was dependent on the	

	appointment of a permanent director and that position has just been filled. Benefits tracking had a revised action date.	
	Annual Plan 2016/17	
34.3	AS outlined how the report had been formulated with meetings with Execs and a review of the BAF. There is a need to complete on key financial systems and assess risk management functionality and AS stated he will benchmark the Trust. The plan is flexible and so has the ability to flex accordingly and AS asked for any queries on the plan to be addressed to himself.	
34.4	DH said he had no comments at this stage as he already discussed the plan with AS. SB confirmed the plan would be shared with TMG. AS said the plan had been seen at individual meetings and SB said this is because of timing as it is critical for BDO to undertake 12 month's work in 6 months. AS said that CIPs is something so critical it would be covered on a fairly regular basis. SB confirmed the Procurement and contracting review was originally based on the risk of hosting PPS but this would be based on the commercial rigour and the work PPS has done for the Trust.	
34.5	SB said that whilst the SEP is in the plan, it is unlikely there will be anything to review in the short term, the Trust may bring something forward from the following quarter. DHU suggested Pharmacy as an option and she would be interested to hear management team input to future reviews. DH said he was optimisticabout the skill sets to be introduced to the reviews and the Committee would have a chance to revisit this plan later in the year.	
34.6	In response to a question from DH, AS gave assurance that at the end of the year sufficient work will have been undertaken to give the Head of Internal Audit Opinion. He had listed possible additional audits that have seen limited assurance at other clients as food for thought for the Committee. This year he had put the emphasis on erostering for the Trust. DH said that any advice on agency cap would be important without necessarily using 20 days on this issue.	
34.7	Around December AS would meet again with Execs to bring the provisional plan for April 2017. DH asked that a full reconciliation list come to the Committee in March and that was agreed. AS asked the Committee if the plan was aligned to requirements. SMH asked about recruitment and retention and AS said that it was felt bullying and retention was more desirable. CQC and risk maturity would be completed by the next Committee and erostering would have started. AS said he would be prepared to do a Board Seminar on risk maturity. DHU asked NH if he felt this was a good plan and he said this ticks the finance, risk management and data quality boxes and has a sound balance and is a significant step in the right direction.	**AP6** **AP7**
16/035	**Local Counter Fraud Progress Report**	
35.1	JS emphasised he wanted to avoid duplication of work done by the previous LCFS. However, he wanted to ensure compliance and tailor as much as possible and then return in the new year to the Committee with a tailored programme addressing the key risks.	
35.2	With regard to the UCLPPS investigation JS stated he would continue to chase the NHS Protect investigator for an update. Cases reported to him were with regard to a fraudulent petty cash slip and a suspected staff member working elsewhere whilst sick. Enquiries were ongoing and he would keep the CFO up to	

	date. DH asked JS to also focus on the timeliness of information and progressing of internal investigations by Trust staff and to give the Committee information on this each time. JS said that so far responses have been good.	
35.3	The Fraud risks assessment will be completed for the next committee. JS reported he will be holding a roadshow for staff both in the hospital and in the community. He stated he was now registered for the National Fraud Initiative for the Trust.	
16/036	**External Audit Progress Report & Annual Audit letter 2015/16**	
36.1	NH reported that KPMG had debriefed on the 2015/16 audit and had completed the cyber security audit, which he would bring to the Committee or the Trust Board as Executives decided. The Charitable Fund audit was being finalised and there was nothing significant coming out of this. KPMG were ahead of planning on the 2016/17 plan.	
36.2	For the Annual audit letter NH said there was nothing new to report, however, he stated the Trust have a requirement to publish this on the website.	**AP8**
36.3	It was agreed the Audit plan to come to the January Committee and then again in March.	**AP9**
16/037	**Final Accounts Timetable and plan**	
37.1	SB reported that he had talked to KPMG and had looked at last year's process and by and large he felt it could have been smoother and had picked out areas to look at. More difficulties had been around the quality accounts and therefore suggested dates were listed in the Timetable. The plan is to pull together a steering group as one of the difficulties was the annual report wasn't easily aligned to the final accounts. The Head of Financial Services had discussed the plan with the teams that pull the information together. At present there is no confirmation of dates to submit the final accounts so this the best estimate based on last year's dates. The dates may change and the plan will then have to be modified. However, SB emphasised the Trust wants to be audited as soon as possible in the audit cycle. NH agreed the quality accounts production did get finalised very late in the day. He emphasised the most time consuming part for the Trust is getting stakeholder feedback. NH stated the Group Accounting Manual is published and it tends to be the annual report and the Communications team that have an issue not financial accounts. NH felt it would be good to ask Communications to run through the 2015/16 manual so it will be known in advance which areas have to updated. DH asked for drafts to relevant future meetings. SMH felt it was helpful to have dates and deadlines and agreed with DH that drafts need to go to management meetings. DH encouraged rolling over last year's documents and to start to populate and bring to the January/March Committee meetings.	**AP10**
16/038	**Losses and Special Payments** **Bad Debts Settlement**	
38.1	SB stated there is a formal write off of bad debts of £33k and he highlighted overseas visitors. There were a couple of salary overpayments that the Trust had been advised by the debt collection agency they will not be able to recover. DHU asked around the systems and controls assuming that ideally there would be no overpayments. SB reported that the issue is generally late completion of forms, particularly with reduced hours or leavers. The Trust makes use of the self-service element of ESR which, he said, to be fair is quite difficult and clunky to	

	use. Nearly all overpayments are because of late forms but he was aware of one that came into payroll that wasn't actioned. There needs to be continued focus on completing basic administration on time in ICSUs with support from HR and Payroll.	
38.2	The committee approved the write-offs.	
	Debtors Report	
38.3	SB stated that a lot of the local Trust debt is down to small agreements where the Trust had bought a service and it had not been signed off as received by the relevant ICSU. There was a combination of some disputes on both sides and this is not an unusual situation. In terms of process, the Head of Financial Accounting had met with UCLH and made some progress and it was now with both organisations to finalise sign off. DH said he could not see from the report what the view is on aged debt and recovery perspective. DH asked NH if there was anything more on Trust procedures that could be done. NH responded that every year the External Auditors give a judgment and he felt the Whittington is pretty balanced and he hadn't come across anything unusual and as a percentage of the NHSE balance it is pretty good. SB confirmed the Trust is trying to undertake the agreement of balances within the Quarters, while it is difficult with some organisations.	
16/039	**Tender Waiver Report and Breaches Report**	
39.1	SB stated the report covered a long period of time from February and therefore there were quite a few listed. Staff had tried to show the reasons a waiver had been sought. DH asked if there were any areas of the organisation which were consistently breaching tender waiver requirements and SB responded there were still some issues around timing and the need to go through the process and raise an order beforehand. This issue had been addressed with IT staff however, there was a need to revisit whether roll some systems over and there were some issues with breaches that SB was not happy with. TR asked about the £5k limit as he felt this was pretty low and SB said that is standard. DH said if this becomes administratively burdensome then there may be a need to name and shame staff/departments. SB stated that as part of UCLPPS the Whittington was the best in the group and are in the top quarter of NHS. SB had done quite a lot of work with PPS to make the process a little smoother.	
39.2	DHU asked about the breach report and all being IM&T & Keystream. SB stated there is an overall contract with Keystream and there was a misunderstanding that these were under that contract.	
16/040	**Any Other Business**	
40.1	No other business was discussed.	

Future Meeting Dates:
25th January, 9.30 - 12.30
2nd March, 9.30 - 12.30
24th May, Final Accounts 8-10.15 a.m.
11th October, 1.30 – 4.30 p.m.

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Whittington Health NHS

Whittington Health Trust Board
November 2016

Title:	Quality Committee Meeting November 2016 Draft Minutes cleared by Chair and Executive Lead						
Agenda item:	**16/165**		**Paper**		**13**		
Action requested:	For the Board to note the business of the November Quality Committee Meeting and its effective decision making						
Executive Summary:	This paper presents the draft November 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:	November 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**

DRAFT Minutes
Quality Committee, Whittington Health

Date & time:	Wednesday 9th November, 2 – 4
Venue:	Room 6 Whittington Education Centre, Whittington Hospital
Chair:	Yua Haw Yoe, Non-Executive Director
Members Present:	Philippa Davies, Director of Nursing and Patient Experience Richard Jennings, Medical Director
In attendance	Steve Hitchins, Chairman (representing NED member) Lynne Spencer (LS), Director of Communications & Corporate Affairs Daniela Petre (DP), Head of Risk Gillian Lewis (GL), Compliance and Quality Improvement Manager (minutes) Doug Charlton (DC), Deputy Director of nursing & Patient Experience Deborah Clatworthy (DCl), Head of Nursing, Surgery and Cancer Fiona Isacsson, Director of Operations S&C (deputising for Carol Gillen) Manjit Roseghini (MR), Head of Midwifery Mark Madams, Head of Nursing, Children's Services Rachel Landau, Clinical Director EUC
Apologies:	Anu Singh (AS) Non-Executive Director Deborah Harris-Ugbomah, Non-Executive Director Carol Gillen, Chief Operating Officer Julie Andrews, Associate Director for Patient Safety Sarah Hayes, Clinical Director PPP Helen Taylor (HT), Clinical Director CSS Clarissa Murdoch (SM), Clinical Director MFNS Beverleigh Senior (BS), Director of Operations, OPLTC Russell Nightingale (RN), Director of Operations, CYN Gurjit Mahil, Director of Operations, WFS Alison Kett, Head of Nursing Danielle Morrell, Director of Operations EUC

Agenda items

1.1	**Welcome & Apologies**	Chair
	Apologies noted above	

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

1.2	**Minutes of the previous meeting (September 2016)**	Chair
	The minutes of the last meeting were approved with no changes.	

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

1.3	**Action Log**	Chair
	The Action Log was approved and updates recorded. SI provided an update on the Trust community forum; the expanding email membership will form the base for consultation and engagement with STP planning.	

Actions	**Deadline**	**Owner**
See action tracker		

2.	**Nursing Associate Pilot**	
	DC provided an update on the status of the Nursing Associate Pilot; Whittington Health was successful with two bids – adult and children. • DC explained that nurse associates will work under supervision of qualified nurses and will support in the delivery of care, but not with diagnosis or prescribing. It is an 18 month programme. • PD noted the Nursing Associate Pilot provided opportunities for people who may not get places on a nursing academic qualification course. • SH asked if there was preferential treatment for HCAs already working at the Trust. DC responded that HCAs will be given the opportunity to apply first any remaining places will then be opened up to wider recruitment. The Quality Committee thanked Lisa Smith for the successful bid.	

Actions	**Deadline**	**Owner**

3	**Quality Performance Reports**	**ICSU Leads**
3.1	The CYP **Quality Report** was approved by the Quality Committee. MM presented the report. Key points were highlighted as follows: • Significant increase in reporting since new DATIX introduced. Staff feedback that revised DATIX is easier to use; there has been an increase in timely closure of incidents but MM recognised that more work was need to improve the grading of incidents, which has implications for duty of candour • Improvement in appraisals • Mandatory training declined • Safeguarding Level 3 training increased • CQC action plan reviewed. MM noted the mock abduction simulation, which will be carried out in conjunction with the police, needed to be re-rescheduled • Mock CQC inspections (Peer Reviews) completed in Simmons House and Northern Health Centre. Simmons House staff positive about peer review process and the feedback. Findings confirmed that aspects of ligature risk highlighted by CQC have been addressed. • Patient safety huddle on NICU identified areas for improvement in relation to the environment which are being discussed with Estates • Discussed serious incidents and high risk incidents. • CYP safety thermometer will show number of days since harm and duty of candour in future reports • YHH queried the progress against the observation policy for children. MM updated that this was currently being piloted, Simmons House provide staff to allow 2:1 observations on ward	
3.2	**The S&C Quality Report** was approved by the Quality Committee. DCl and FI presented the report. Key points were highlighted as follows: • Positive feedback from patients • Pioneer pharmacy role on Coyle Ward • Sustained improvement in complaints responses and action plans, and a decline in the number of complaints • Sustained improvement on infection control • Development of nurse-led services, including PICC lines • Recruitment of nursing in theatres and ITU ongoing, but vacancies remain on wards • Challenges remain around patient flow and outliers, particularly with delays in step-down from ICU • Improvements needed around compliance with WHO surgical safety checklist, monthly audit introduced from August which is reported to ICSU	

	Board and Patient Safety Committee. Issues identified with sign-out. RJ requested information on WHO audits and action plans. • Mixed sex breaches continue to be monitored • CQC action plan discussed; positive improvements noted with increase in incident reporting in ICU • Risk register reviewed for risks over 16 • CQC mock inspections held in 1B and ITU. Staff gave positive feedback around the process, findings generally positive and actions underway for improvement areas • DCl noted a summary of SI actions and learning would be brought to the next meeting. The Quality Committee discussed the 72 hour report process and FI noted difficulties in completing the reports within the 72 hour timeframe. DC noted that the 72hour report is a one-page document, and should be a quick summary of key information. RJ reiterated that the 72 hour report has one purpose; to provide sufficient information to the SI Panel to make an informed decision on the level of risk, investigation required and any immediate actions needed. FI noted that when clinicians are involved it can take longer than 72 hours to gather the key information and suggest holding an immediate huddle with key people involved for all serious incidents. The Quality Committee supported this approach and noted that this should be introduced in the ICSU and did not require corporate sign-off. DCl asked to reintroduce automatic emails to senior managers for high risk incidents on DATIX. DP noted that security groups were in place to send automatic emails which can be revised to meet needs of individual ICSUs. ICSU risk managers to liaise with Jonathan Rowe on requirements. RJ asked if the ICSU M&M meetings were minuted. FI responded that this process was being reviewed as part of job planning and would be completed by end November.
3.3	**The Emergency and Urgent Care Quality Report** was approved by the Quality Committee RL presented the report. Key points were highlighted as follows: • High activity in ED • Staff appraisal and mandatory training below standard. RL noted a lot of training expired at same time due to extra support for training provided around time of CQC inspection • Level 3 safeguarding highlighted as problem training area • Risk register reviewed at all ICSU Board meetings • CQC action plan progress – substantive consultant post in ED appointed and another to start in April and third expressed interest. On target with

expected timeframes.

- MRI delays – new phone for radiology to improve communication, better working with radiographers
- DATIX backlog reduced. RL noted new DATIX improved and good support provided by Risk Manager but still challenges at 'handler' side. RL felt culture of reporting improved but still time consuming task.
- Pressure ulcers, security incidents (violence and in supervision for mental health patients) and medication errors discussed
- Compliant with duty of candour
- Discussed open serious incidents and high risk incidents

SH asked if there were more changes to streamline the DATIX process possible. DP replied Whittington utilised the best practice available on the market currently. DATIX is a software package used widely across the NHS, not managed by IT. The new DATIX reduced workflows to streamline access but more work could be done to improve dashboards and reporting. FI noted the support provided in standardising dashboards and reports was very helpful.

RJ highlighted the learning identified from the recent serious incident of an unexpected death in the DN team. The incident related to a generic email list which was not actively managed. Immediate action taken to check all other patients who may have been affected by email error.

SH asked about staff morale in ED. RL noted staff felt under pressure when the department is overcrowded and they feel unable to provide good care. On an occasional basis this stress is manageable, but when it becomes the norm it is wearing on staff.

SH asked what more could be done to support pressures on ED. RL stressed that ED performance is a trustwide issue relating to bed flow throughout hospital and community pathways, not just an action for ED. PD noted pre-11 discharges is a key priority in this, and reflects a whole-organisation approach. RL felt it would be useful for staff across the hospital to see how ED operates and DCl noted new nurses will be spending time in ED to help improve understanding of patient flow and risk. RL also noted the ongoing work in NCL to review patient pathways to ED.

RJ noted importance of recognising success in ED and highlighted the improvements in sepsis as an example; 95% of patients with sepsis have received antimicrobials within 1 hour.

Actions	**Deadline**	**Owner**
• RJ and PD to be sent information on WHO audits and action plans	Jan 17	DCl
• FI and DCl to feedback on timeliness of 72 hour report to SI Panel following introduction of SI	Jan 17	DCl/ FI

'huddle' • DP to reintroduce automatic emails for senior managers on DATIX, as per ICSU requirements	Jan17	DP

4.1	**Nursing, Midwifery and AHP Education Q2 Report**	**DC**
	The Nursing, Midwifery and AHP Education Q2 Report was approved by the Quality Committee DC presented the report. Key points were highlighted as follows: • £114,783 spent on continuing professional development courses and other learning opportunities • 1,263 undergraduate student placement weeks were supported. • 299 staff trained in dementia care • 92 staff attended leadership development courses • The library achieved 92.71% in the annual quality assurance review • 166 staff were trained in resuscitation. DC noted that the education budget had been cut, and it would be a challenge to continue to deliver education programmes in 2017/18. DCl noted a lot of staff recently joined and note education as reason for joining Whittington. MM thanked Lisa's team for the support provided to ICSUs.	

Actions	**Deadline**	**Owner**

4.2	**Quality Impact Assessment on CIPs**	RJ
	RJ noted that Quality Impact Assessments will continue to be carried out for all new Cost Improvement Plans agreed and work is ongoing to improve this process. No meetings were held in quarter 2, however the April and May meetings were included with papers for information. DCl noted that quality impact assessments are carried out at ICSU Boards before they are proposed as a CIP. RJ added this was reflected in the outcome of QIA meetings; very few CIPs not supported on quality grounds, instead advice given on how to monitor quality.	

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

4.3	**Quality and Safety Risk Register**	DP

	The Quality and Safety Risk Register was approved by the Quality Committee DC presented the updated risk register and provided an update to Quality Committee about the overlap between the Quality Committee Risk Register and finance. The plan going forward is to provide updates to the capital monitoring group on all risks from ICSUs relating to finance and medical devices to give a better trustwide oversight. DC summarised the key changes on the risk register. The Quality Committee discussed the risk relating to a serious incident where a patient was not discharged appropriately to the DN team, resulting in a patient not having any DN care for three days. The investigation is ongoing to identify learning.

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

4.4	**Nursing Quality Indicators**	DC
	The Nursing and Midwifery Quality Indicators report was approved by the Quality Committee DC noted the report format had been revised and by next month trends and themes will be introduced for all ICSUs. Key highlights included: • Safety Thermometer with no acquired harms 93.7% with an average of 88% over the year so far. • Patient Falls remains higher than expected at 36 (average 29) • 2 patient falls resulting in serious harm • Decrease in patients receiving the SKIN bundle in community this month down to 35.4% (average 53%) • Nutritional screening initiated in 48 hrs 93.8% (average 90%) • Mandatory training up to 81.8% (average 56%) • Surgery triggered 3 red shifts. SH asked why the number of falls had increased. DC noted that while no themes had been identified, the falls were largely in the community and this was likely attributable to the increase in patients with higher acuity managed at home.	

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

4.5	**Aggregated SI, complaints and claims (including Legal Services Q2)**	DP
	The Aggregated SI, complaints and claims report was approved by the Quality Committee.	

	DC presented the report, key points highlighted as follows: • RJ highlighted the increase in reporting in S&C as a positive improvement; ICU had been identified by CQC as a low reporter. • Across the trust the latest NRLS report shows improvement in reporting. MM noted that this report also showed an increase in harms reported, DP noted some of this related to the NRLS uploading system which have now been rectified. • DP noted high number of incidents coming from consultants, registrars and newly qualified staff. Julie Andrews congratulated for role in engaging clinicians with patient safety.

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

4.6	**Duty of Candour Q1 Report**	DP
	The Duty of Candour Q1 report was approved by the Quality Committee. DP presented the report, which was developed to illustrate compliance with the statutory duty to our commissioners. There are two KPIs; first stage of duty of candour on discussion with patient, second on providing final outcome of investigation to patient or NOK. Key points were highlighted as follows: • DC noted clinical judgement used where the 10 day target for duty of candour not appropriate (e.g. death of patient or maternity bereavement) • Duty of Candour champions developed at ICSU level • Fully compliant with step 1 KPI, late on 11 step 2 incidents – area for improvement for next quarter. • Positive feedback from patients/ families SH asked what the link was between incidents, complaints and PALS for duty of candour. DP responded that an open dialogue was maintained with patients and families, patients are invited to contribute to the Terms of Reference for the RCA investigation and to meet to discuss the report and findings. Patient friendly language is used in all reports. SH asked how Whittington compared with our Trusts on duty of candour compliance; no benchmarking data is currently available.	

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

4.7	**Clinical Audit and Effectiveness Report**	
	The Clinical Audit and Effectiveness Report was approved by the Quality Committee RJ presented the paper on behalf of Sarah Crook, Head of Clinical Governance and highlighted the volume of work carried out by the audit team and across the trust. RJ outlined the work in progress to link quality improvement more closely with audit and effectiveness, which is being led by Julie Andrews. DCl welcomed this work and noted the need to ensure continuous improvement. RJ noted that the successful projects (e.g. sepsis) required full MDT involvement. SH asked what role the Audit and Risk Committee played in clinical audit. LS to review.	

Actions	**Deadline**	**Owner**
LS to review and feedback on the role Audit and Risk Committee plays in clinical audit programme	Jan 2016	LS

4.8	**Quality Committee Annual Workplan**	
	The Quality Committee approved the revised annual workplan, which streamlined the reporting process.	

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

4.9	**Serious Incident Report**	**DP**
	The Serious Incident report was previously discussed at Trust Board on 2nd November 2016. DP summarised the key highlights and Quality Committee noted the report.	

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

4.10	**Trust Policies**	**GL**
	The Quality Committee approved the Trust Policy update report. The Quality Committee discussed the Medical Devices policy which was currently overdue.	

	RJ agreed to discuss the policy with Steve Bloomer, Director of Finance.

Actions	Deadline	Owner
RJ to discuss Medical Devices policy with Steve Bloomer and agree final version.	Jan 2017	RJ

4.11	Patient Experience Report	PD
	The Quality Committee approved the Patient Experience Report. DC noted the Patient Experience Committee was being reviewed and the report format would be revised as part of this process. Key issues included: • Piloting new mechanism for FFT using SMS and telephone surveys • Selection of positive and negative comments included in report YHH asked if positive comments were shared with staff. DCl confirmed positive comments were shared, either with individual staff (if specific name supplied) or via team meetings.	

Actions	Deadline	Owner
None		

5.	Minutes from reporting groups	Information only
	The Quality Committee noted the minutes from reporting groups; • Patient Safety Committee • Patient Experience Committee • ICSU Board meetings	

Actions	Deadline	Owner
None		

6.	AOB	Lead
	None	

Actions	Deadline	Owner

Next meeting: Wednesday 11 January 2017, Room 6, WEC

Whittington Health NHS

Draft minutes of

The Whittington Health Charitable Funds Committee held on 2nd November 2016

Present:	Tony Rice	TR	Non-Executive Director, Chair
	Graham Brogden	GB	Head of Fundraising
	Jason Burn	JB	Interim Deputy Director of Finance
	Joe Farnell	JF	External Auditor, KPMG
	Steve Hitchins	SH	Chairman
	Fiona Isacsson	FI	Director of Operations, Surgery & Cancer
	Simon Pleydell	SP	Chief Executive Officer
	Lynne Spencer	LS	Director of Communications
	Stephen Bloomer	SB	Chief Finance Officer
	Jonathan Ware	JW	Head of Financial Accounts
	Vivien Bucke	VB	Business Support Manager, Finance

16/026	**Welcome, Apologies for Absence & Declarations of Interest**	
26.1	Apologies were received from Philippa Davies and Siobhan Harrington. Fiona Isacsson stated she was representing Carol Gillen who was on annual leave. No Declarations of Interest were received	
16/027	**Approval of Minutes of the meeting held on 7th September 2016**	
27.1	The minutes were agreed as an accurate record.	
27.2	Action Notes Update: - The challenge at the previous Committee was, is it appropriate, given how low the return received and should we consider holding a higher proportion of funds in a high yield equity portfolio which has a slightly higher capital risk profile but a significantly higher running yield and over the medium/long term tend to produce a higher total return than bank deposits. TR confirmed an agreement wasn't reached at the previous Committee but he said this would be looked at. GB confirmed that at his previous Trust 23% of funds were cash and the rest was in a low risk portfolio. TR commented at the Whittington that is the reverse situation and there might be a case for a higher proportion going into a dividend fund. SB agreed that in January the Executives will bring a report to the Committee. SP agreed that we should look at investment of a greater proportion of the Whittington Charitable funds in higher yielding equity investments as long as such investments were at the lower end if the equity risk profile.	**SB/JW**
27.3	SB said there will be a review of the small funds balance but there is a short period before the new Charitable Funds accountant is in post and therefore this work will start in the next few months.	
16/029	**ISA 260 (Audit Report and Accounts for 2015/16)**	
29.1	JF explained that at the point of writing this report he had not received the draft Annual Report but he had now and would be finalising it this week. There were no errors in the report but the External Auditor had made some minor adjustments.	

29.2	JF stated that the accounts were true and fair and that KPMG had not asked for or suggested any changes. It highlighted the recommendations raised on tightening up the journals process. Whilst the External Auditor had found no errors there was a risk that journals are processed without the necessary authorisation and therefore a little work to firm up the process, more as an efficiency, was recommended. This was agreed by management.	
29.3	The Committee accepted the accounts and accepted the report from KPMG. TR congratulated everyone involved.	
16/030	**Fund Balances and Financial Report Month 6 2016/17**	
30.1	SB gave an update around income and expenditure stating this was reasonably consistent and there were no significant movements. The economist shares have now been sold. There is £1.7m in the Restricted Funds from Legacies and £78k Postgraduate Funds investments.	
16/031	**Applications for Funding**	
31.1	The Committee approved the two bids above £5k; Provision of furniture and Purchase of Accuvein AV400.	
31.2	There was a discussion on the main fundraising project which is likely to be around maternity services. It was concluded that this would be finalised once there is agreement to progress with the stage 1 project which is currently with NHSI and DOH for approval.	
31.3	TR asked for an update on the Kanitz fund. SB said staff are pulling together a summary and will circulate a paper. The number one issue is investment in IT capability that could deliver a transformation in patient experience that the Trust is planning to fund. Currently staff are negotiating with Phillips for a free piece of kit. There is a bigger scheme around lighting and again staff are working with suppliers to acquire elements for free (however, this item is not at the top of the Kanitz request list). In addition, the purchase of iPads had been discussed. SB said he hoped to finalise the main IT scheme and some others within the next few weeks and he would work with Professor Hugh Montgomery, who is coordinating the requests, to produce the final list. SB would like everything committed within the next few months.	
31.4	TR asked about funding noise reduction ear plugs for patients. SP said this needed to be discussed with a multi-disciplinary group and would include a discussion on things like floor cushioning and even the mental state of some patients. He felt it was an interesting idea and would need to be tested. SH agreed this is worth looking at. FI said the noise issue was highlighted as part of the Patient Survey and there is a group working on this and this idea could be tied in.	**FI**
16/032	**Fundraising Update Report**	
32.1	GB reported that all Gold bond places had been taken for the 2017 London Marathon and 40 people were already signed up to undertake the 10k race. There were staff who had said they would undertake the Tough Mudder course and the London to Brighton marathon ride. There are a new range of challenge events that staff can now sign up for.	
32.2	GB said that relationships with Arsenal and Tottenham football clubs were	

	continuing positively and a mailshot to local law firms had led to a local solicitor saying she will work with the Trust on legacies.	
32.3	There are still plans for an abseil challenge but GB said he might have to ask for funds from the Committee. The Deputy Director of Facilities & Estates was looking at the costs for enabling work which were originally quoted at £20k but he is looking at these again.	
32.4	GB suggested a Plan B if the maternity business case did not proceed. He suggested a complete refurbishment of the IFOR play terrace. Site visits had taken place with the charity arm of Bright Spaces Children's Nurseries, Bright Horizons Foundation, to refurbish the play terraces. This also involved The Toy Project, a charity based in Islington. The cost would be £100k to completely gut and rebuild the space. SP asked for reassurances that this space will be properly used and an understanding how functionally this will work. GB said that the Operational policy of IFOR ward shows this would be used. It was agreed that data from the ward is needed but SB agreed this would be good. GB to bring a paper to the next Committee.	**GB**
16/033	**Any Other Business**	
33.1	LS reminded the Committee of the Open Day on Saturday for Maternity and the AHP recruitment day in the WEC and asked the Committee to publicise.	