NHS
Whittington Health
NHS Trust

Meeting	**Trust Board – Public**
Date & time	**4 January 2017 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 393178

Agenda Item		Paper	Action and Timing
Patient Story			
	Patient Story *Philippa Davies, Director of Nursing & Patient Experience*	*Verbal*	*Note* 1400hrs
17/001	**Declaration of Conflicts of Interests** *Steve Hitchins, Chair*	*Verbal*	*Declare* 1420hrs
17/002	**Apologies & Welcome** *Steve Hitchins, Chair*	*Verbal*	*Note* 1420hrs
17/003	**Draft Minutes, Action Log & Matters Arising 7 December** *Steve Hitchins, Chair*	1	*Approve* 1425hrs
17/004	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Note* 1430hrs
17/005	**Chief Executive's Report** *Simon Pleydell, Chief Executive*	2	*Approve* 1440hrs
Patient Safety & Quality			

17/006	**Serious Incident Report Month 8** *Philippa Davies, Director of Nursing & Patient Experience*	3	*Approve* 1455hrs
17/007	**Safer Staffing Report Month 8** *Philippa Davies, Director of Nursing & Patient Experience*	4	*Approve* 1505hrs
Strategy			
17/008	**Operational Plan 2017/18** *Siobhan Harrington, Deputy Chief Executive/Director of Strategy*	5	*Approve* 1515hrs
Performance			
17/009	**Financial Performance Month 8** *Stephen Bloomer, Chief Finance Officer*	6	*Approve* 1525hrs
17/010	**Performance Dashboard Month 8** *Carol Gillen, Chief Operating Officer*	7	*Approve* 1535hrs
Governance			
17/011	**LUTs Action Plan and Progress Report** *Siobhan Harrington, Deputy Chief Executive/Director of Strategy*	8	*Approve* *1545hrs*
17/012	**EPPR Annual Report** *Carol Gillen, Chief Operating Officer*	9	*Approve* *1600hrs*
17/013	**IG Framework** *Siobhan Harrington, Deputy Chief Executive/Director of Strategy*	10	*Approve* *1610hrs*
Any other urgent business and questions from the public			
	No items		
Date of next Trust Board Meeting			
	07 February 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: 17/003
Doc: 01

The draft minutes of the meeting of the Trust Board of Whittington Health held in public at 1400hrs on Wednesday 7 December 2016 in the Whittington Education Centre

Present:	Stephen Bloomer	Chief Finance Officer
	Philippa Davies	Director of Nursing and Patient Experience
	Carol Gillen	Chief Operating Officer
	Siobhan Harrington	Director of Strategy/Deputy CEO
	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
	Anu Singh	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
	Lynne Spencer	Director of Communications & Corporate Affairs

Patient Story

Philippa Davies confirmed that patient stories will be sourced from service areas rather than Integrated Clinical Service Units from 2017 onward. She introduced Nefisa, a former client of the Michael Palin Centre, and Elaine Kelman, Head of the Centre. Elaine informed the Board that the Michael Palin Centre for stammering children actually runs a service from cradle to grave for clients in Islington and Camden, but its charitable status allows it to provide a service for national referrals. The Centre has an international reputation with thirteen specialists.

Nefisa attended the centre at the age of 17 (she is now 19) having had an extremely difficult time at school. She had been assigned a speech therapist at school but this had proved insufficient for her needs, and so she had been referred for intensive therapy at the Michael Palin Centre. There, she had been helped to develop strategies for coping with everyday life.

During discussion the following points were raised:

- there was no set follow-up treatment but Nefisa knew she was able to call the centre for advice and support as needed
- there was a difference between those who had suffered from stammering from problems later in life, sometimes, as in Nefisa's case, as a result of a traumatic situation
- there was scope for updating some of the strategies used and developing further interactive techniques
- the centre was viewed as the 'jewel in the crown' of Whittington Health
- Nefisa had made some lifelong friends, with whom she was in regular communication via social media
- the best thing Nefisa had gained from her time at the centre was the confidence to speak in public – she had spoken at an assembly in front of her entire school and had also spoken on LBC Radio.

Concluding, Nefisa said that in some ways she was grateful for having had a stammer since her treatment at the centre had opened so many doors for her and provided so many

opportunities, including having had a one to one session with Michael Palin himself. On behalf of the Board, Richard Jennings thanked Nefisa for attending and told her that she was a fantastic ambassador for the centre.

16/151 Declaration of Conflicts of Interest

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

16/152 Apologies and welcome

152.01 Steve Hitchins welcomed everyone to the meeting. Apologies for absence were received from Deborah Harris.

16/153 Minutes, Action Log and Matters Arising

153.01 Referring to minute 143.02, Yua Haw Yoe asked for it to be recorded that she had also assisted with tasks on the wards on Change Day.

153.01 Other than this the minutes of the Trust Board held on 2nd November were approved. There were no matters arising other than those already scheduled for discussion.

Actions

153.02 110.03 IM&T Strategy: This will be brought to the Trust Board early in the New Year.

16/154 Chairman's Report

154.01 Steve Hitchins began his report for thanking everyone who had helped to arrange the very special memorial service for Paula Mattin; he had met Paula's sister- in-law recently and she had said how much the family had valued the occasion.

154.02 Steve thanked those responsible for organising the switching on of the Christmas lights and accompanying singing of carols with Lesley Garrett and Harriet Thorpe.

154.03 During the month since the previous Board meeting Steve had attended the following:

- a Haringey voluntary sector exposition at which he had spoken
- an Islington 'keep our NHS public' campaign meeting
- the WH maternity services open day
- the successful launch of the young people's forum at the Arsenal stadium; this had been attended by 68 people, of whom 65 had volunteered to join
- a peer review event for children's service
- the research symposium organised by Rob Sherwin
- a Christmas party organised for the volunteers who helped to run the Chaplaincy.

154.04 Events to come included a staff Christmas prize drawer and mince pies, a concert on December 20th, and a speaking engagement on the Sustainability and Transformation Plan at the Highgate branch of the Labour Party.

16.155 Chief Executive's Report

155.01 Simon began his report by commenting on how well the Trust had performed in its 'flu campaign; 77% of staff had now been vaccinated, and as of this week this made Whittington Health the highest performing Trust in London. The team was 'fantastically committed', and Simon felt this particularly encouraging given the dip in performance the previous year. Continuing the theme of safety, no new cases of MRSA had been declared since the one case in October, and the Trust's performance on C. Difficile also remained well below the maximum set number; a real achievement given how busy services were at present.

155.02 Carol Gillen would be giving the performance report later in the meeting, but Simon wished to raise some key issues; these included the one area where performance had slipped, which was the 62 day cancer wait target. He had been assured that the position on this would be rectified the following month. The MSK service remained under review, and the IAPT service continued to perform well.

155.03 The Trust was to formally change its name to Whittington Health. This was a purely technical statutory procedure which should not be in any way controversial; the name change had been planned for some time and had only been postponed due to the then possibility of Whittington Health's achieving Foundation Trust status.

155.04 The Trust's Operational Plan would be brought to the Board in January. Underpinning this was the contracts the Trust held with its local CCGs, and negotiations over these were ongoing at present. The expectation was that two year contracts would be signed before Christmas. The Trust was out to advertisement for the Strategic Estates Partnership (SEP), and the following day the first dialogue with three of the interested teams was due to take place. Simon stressed the importance of differentiating what was taking place under the STP proposals from the SEP initiative, which was to address some of the major challenges the Trust faced regarding its estate. It would have to sit within the context of the patterns of service identified in the STP plan, but was not purely a response to that. Several meetings had been held with the Joint Overview & Scrutiny Committee (JOSC) and other interested local parties.

155.05 Trust services remained under pressure, and the hospital appeared to be receiving an ever-increasing number of ambulance contacts in comparison with other local providers; Carol was monitoring and addressing this. The Trust had been in receipt of some external advice from the ED national support team and from Dr Vince Connolly of the Emergency Care Improvement Programme, with the primary aim of reaching the ED performance target of 95%.

155.06 Simon was pleased to inform the Board that the Trust had been awarded the Mayor's Health Workplace Charter (excellence standard) and was one of only seven organisations in London to achieve this. This work had been led by Cathy Ferguson, Head of Occupational Health & Wellbeing, and Cathy and her team were developing a repertoire of initiatives to support staff wellbeing, including yoga sessions for staff. Very real progress was being made in this area, and this was good news for the recruitment and retention of staff.

155.07 The staff survey had now closed with a 32% response rate, a slight improvement in comparison to last year's figure. The results of the survey would be received by the Trust in mid-January. Retention remained a critical issue.

155.08 Simon was clear that a key objective was to meet the Trust control totals by the year end. Crucial to this was reaching agreement with the commissioners over the final figure to be paid for 2016/17, and this was against a background of the whole health community coming under increasing pressure. All of the ICSUs and key corporate functions knew what their year-end position would be.

155.09 On behalf of the Board Simon congratulated the Trust's library team, who recently won a poster competition at the London, South East NHS and HE Libraries Conference. He also congratulated Graham Smith, receptionist for Level 3B, who had won the October monthly staff excellence award. On a personal note, Simon had taken a turn serving teas and coffees in out-patient clinics, and this had led to some good and interesting conversations with patients and staff.

155.10 Early in the New Year the Trust Board would receive a strategy on improvement and how this is recognised by Whittington Health. Concluding the Chief Executive's report, Board members discussed the fact that there had been no mention of health in the Chancellor's autumn statement, noting that the president of the Royal College of Physicians (and former NED of Whittington Health) Jane Dacre had written to the Times expressing her concern about this.

16/156 Quarterly Patient Safety Report

156.01 Steve Hitchins informed Board members that the next patient safety report to the Board would comprise information from quarters 2 and 3 and would be brought to the Board in February 2017.

16/157 Serious Incident Report

157.01 Philippa Davies informed the Board that nine serious incidents (SIs) had been declared in October, bringing the total for the year to thirty-four since 1st April. They fell into a variety of different categories, and Philippa invited questions. Steve Hitchins replied that he would welcome more detail on how the Trust learned from its incidents; Philippa replied that a section on this would be included in the next patient safety report.

157.02 David Holt enquired about the classification of the 12 hour breach as a serious incident, and Philippa replied that this was correct, however the breach had only been one of four minutes' duration.

16/158 Safer Staffing Report for Month 7

158.01 Philippa Davies informed the Board that all wards were under significant pressure; they were operating at full capacity as well as coping with the challenges brought about by staff vacancies and sickness. There had however been a decrease in the number of specials required in-month, and a reduction in shifts categorised red, although the number of ambers had risen correspondingly. With the Chairman, Philippa had recently visited Cavell Ward, where a Band 6 nurse was currently acting up as ward manager and doing a 'fantastic' job.

158.02 Together with Norma French, Philippa was holding a series of meetings with overseas recruitment consultancies, since it had to be acknowledged that the more local recruitment processes had not been as successful as it was hoped they would be. She had also met with Islington and Haringey local authority colleagues to discuss plans for the nursing associate pilots and increasing apprenticeships. The annual establishment review would be going to Quality Committee in the future.

16/159 Draft Sustainability and Transformation Plan (STP)

159.01 Simon said that there had been a great deal of agreement between health, social care and the wider local authorities on the main workstreams as set out in the draft STP. From his perspective, the key issue was how the plan would collectively address some of its ambitions in the light of the ambitious savings plans to be realised and the need to meet an £876m funding gap over the next five years. Steve Hitchins added that there was also a need to factor in growth in demand due to longer life expectancy and new developments in treatment. He also spoke strongly in favour of public engagement, which he viewed as particularly important. A great deal of care also needed to be given to how any plans for back office functions were developed, and overall, there would need to be a robust governance system underpinning the plan.

159.02 Richard Jennings felt that the clinical values set out resonated well with Whittington Health's own clinical strategy. Janet Burgess, who began by explaining that Islington Council had felt that the time was right to publish the STP, said that there was a view that to date social services colleagues had not been as involved as they should have

been. There needed to be more recognition of the challenges faced by this sector, a main one of which was that care home owners were warning that if they did not receive additional funding there was a real danger they would be forced out of business, which would have a serious impact on other services. Simon Pleydell replied that this was why partnership working between health and social care was so important, particularly when looking at the care of frail elderly people, and he hoped the two sectors would be able to support one another in making services more cost effective.

159.03 Stephen Bloomer spoke of the split between cost pressures and growth assumptions, saying that this had been discussed with clinical cabinet colleagues and that the finance directors had been working with the CSUs to look at financial calculations and projections in more detail.

159.04 In answer to a question from Anu Singh about when staff would become engaged in the process of innovation, Simon replied that he was already talking to staff, but the time was not yet right for a full engagement piece since the full implications for Whittington Health were not clearly defined. Staff side representatives would be attending the Board seminar the following week, and there would be an opportunity for opening the dialogue at that point. Simon added that he was aware that some had expressed concerns over the future of ED and he was anxious to allay these concerns. Richard Jennings added that the ambulatory care centre had been cited as an example of excellence in the plan.

159.05 Steve Hitchins thanked the executive team for their efforts to date on the STP, and particularly for the way in which they had demonstrated Whittington health's excellent track record of working with local authorities. He believed that the plan, if properly worked up and implemented, should play to the Trust's strengths and become a vehicle for celebrating change and promoting integration.

16/160 Financial Report

160.01 Stephen Bloomer began his report by informing the Board that the risk rating previously used had now been replaced by a 'use of resources' metric, which supported the recently-developed oversight framework.

160.01 The Trust had declared a £30.8m deficit at the end of Month 7, giving it a year to date deficit of £3.8m, a 0.4m adverse variance against plan. Trends were similar to those described in previous reports; with activity in some areas having been lower than planned and a continued overspend on pay. There had however been a reduction in agency spend, particularly within nursing, although spend had risen on Allied Health Professionals (AHPs), and it needed to be remembered that many of the CIP plans were contingent on a reduction in agency spend.

160.02 Much work had been carried out with all the ICSUs and corporate areas to forecast year end projections, and these were currently being re-checked. There were also ongoing discussions with commissioners, with the aim being to reach a position whereby the Trust would meet its control total; Stephen acknowledged this would present a challenge, but he expected the November figures to show further signs of improvement. December was likely to present a less positive picture as activity would lessen due to the Christmas and New Year holiday period. In answer to a question from David Holt about detail, Stephen replied that there would be further opportunity to discuss this at the Finance & Business Development Committee on 20th December.

16/161 Performance Report

161.01 Carol Gillen informed the Board that the monthly performance dashboard had been changed to reflect the five Care Quality Commission domains. It remained a work in

progress and was fairly hospital-focused at present, but working on community benchmarks was a priority.

161.02 Carol said that the ED performance had dropped again in October, which had been a particularly challenged month. There had been a rise in blue light ambulances attendance. There have been some delayed transfers of care, particularly of Barnet residents, and a further rise of clients with mental health problems. The national support team had advised the Trust further review those patients who might be diverted to the ambulatory care service. It was noted that 44% of breaches were due to bed management as compared with 24% in September. As mentioned in the Chief Executive's report the Trust had failed to meet the 62 day cancer target, but Carol was confident this position would be rectified for November.

161.04 Steve Hitchins thanked Carol for the new-style report, which he described as a major improvement. In turn Carol expressed her thanks to Laura Bell and Rhiannon Horton who had worked so hard to achieve this.

16/162 Winter Plan

162.01 Carol had attended a meeting with colleagues in Islington the previous week to discuss the detail of how services were preparing for winter. She took Board members through a slide pack which set out the aims of the plan, the additional capacity required to ensure that patients were kept safe and provided with high quality care during the winter months, the measures that were to be taken and the roles and responsibilities of the different staff teams.

162.02 Of particular importance were to ensure that patient flow was maximised and enhanced recovery used to maximum effect, and that communications, command and control were efficient and effective. The maintenance of close links with social services and further exploration of home assessments was key.

162.03 Following a question from Greg Battle, the Board discussed what percentage of bed occupancy the hospital aimed for. Carol said that services were already running at winter levels and had been as high as 98%, and Richard suggested that what bore further scrutiny was the percentage of those patients currently in hospital who did not need to be. The challenge, he added, was ensuring that the patients were in the right beds as the Trust had a very tight bed base. Carol assured the Board however that the Trust had a very good and extremely committed bed management team.

162.03 Steve Hitchins asked for a further report to come to the March or April Board meeting so the Board could review the success of the plan.

16/163 Workforce Assurance Committee

163.01 The draft minutes of the Workforce Assurance Committee held on 25th October were received by the Board. Steve Hitchins congratulated Norma French on the quality of the quarterly workforce report, and also commented that it had been useful to see the risk register. Norma French added that the committee had received an encouraging presentation from Graeme Muir on the GMC Trainee Survey. She also thanked Yua Haw for chairing the meeting in Graham Hart's absence.

16/164 Finance & Business Development Committee

164.01 This item was deferred.

16/165 Audit & Risk Committee

165.01 The draft minutes of the Audit & Risk Committee held on 12th October were received by the Board. David Holt informed the Board that this meeting had given an opportunity for the internal auditors to present their plan; he felt positive about their approach and

hoped they would provide increased value for money. In answer to a request that audit reports be circulated to all NEDs, Simon Pleydell explained that there was a process which needed to be followed including commentary from the manager, going through committee stage etc, and Stephen Bloomer added that the reports which should be released were the ones which had already been to the Audit & Risk Committee. It was suggested the internal auditors might be invited to a Trust Board seminar.

16/166 Quality Committee

166.01 The draft minutes of the meeting held on 9th November were received by the Board. Yua Haw, who had chaired that meeting in Anu's absence, said that the meeting had been very positive. The committee had held a detailed discussion on the nursing associate pilot, and Yua Haw paid tribute to the work carried out by Lisa Smith to progress this. There had also been a useful and informative discussion on the nursing quality indicators.

16/167 Whittington Health Charitable Funds Committee

167.01 The draft minutes of the meeting held on 2nd November were received by the Board. Tony Rice reported that the committee was in administrative mode at present and waiting for a decision on the maternity and neonatal care redevelopment – some work was in hand on staff recognition. Ideas for both expenditure and fundraising were welcome.

16/168 Any other business

188.01 Steve Hitchins wished all present a very Happy Christmas, adding that he would be visiting the hospital on Christmas Day along with some of the non-executive directors.

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Action Notes Summary

155.04	Operational Plan to Board in January	On Agenda	SMH
156.01	Patient safety report for Q2&Q3 to Board in February 2017	On forward plan	RJ
158.02	Annual establishment review to Quality Committee in the future	Closed	PD
162.03	Report to March/April Board to review success of winter plan	On forward plan	CG
165.01	Internal auditors to be invited to Trust Board seminar	11 January	SB

Whittington Health Trust Board

4 January 2017

Title:	Chief Executive Officer's Report to the Board		
Agenda item:	**17/005**	**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:	28 December 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.

I would like to wish everyone a happy New Year and thank all staff and volunteers for their hard work throughout 2016 and during the busy New Year period.

1. QUALITY AND PATIENT SAFETY

Joint Advisory Group (JAG) Accreditation 2017

We have received JAG national accreditation from the Royal College of Physicians for our endoscopy unit. This accreditation is for excellent and safe care provided by our endoscopy team. The unit was assessed against a number of standards including quality of care, patient experience, training, the unit environment, cleaning standards, equipment and the length of wait between referral and diagnosis. The JAG on Gastrointestinal Endoscopy (JAG) operates within the Clinical Standards Department of the Royal College of Physicians.

We would like to congratulate the staff at the endoscopy unit for their continued hard work in achieving and maintaining JAG standards to keep our patients safe and free from harm.

Flu Campaign 2016

We have achieved the top score across London for our 2016 uptake of the flu vaccine. 79% 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 to the team leading the vaccination programme for helping us to save lives and protect the vulnerable.

MRSA Bacteraemia

We have done extremely well in keeping our patients safe and free from MRSA bacteraemia during 2016. We have reported only 1 case of hospital acquired MRSA bacteraemia in 2016 (October). The previous reporting year 2015/16 we did not have any cases reported. We will continue to manage our high profile infectious control campaign across the community and hospital to aim to ensure that no further MRSA incidents are reported for the year 2016/17.

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

We were pleased to exceed all but one of our national cancer targets for October**.** *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 98%
- 31 days to subsequent treatment (drugs)100% against a target of 93%

- 62 days from referral to treatment 84.4% against a target of 85%
- 14 days cancer to be first seen 98.7% against a target of 93%
- 14 days to be first seen for breast symptomatic 100% against a target of 93%

Community Access Targets

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

- IAPT – patients moving to recovery – 45.7% - target 50%
- IAPT – patients waiting for treatment <6 weeks – 94.4% - target 75%

2. STRATEGIC

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. This important process is going well and we expect to have chosen a partner by June 2017.

Pharmacy

We are in the process of setting up a new pharmacy service which will improve and expand this important community asset. The name of the new service will be Whittington Pharmacy and we aim to finalise the improvement works in 2017.

3. OPERATIONAL

Operational Plan 2017/18

We have agreed our draft operational plan for 2017/18 and this has been signed off by our Finance and Business Committee in December and is included in our Trust Board papers for 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.

Emergency Department

Extreme pressures within the emergency care pathway continue to be a challenge and our 4hr performance for November was 85.1% against a target of 95%.

We want to make sure our hospital is functioning as efficiently as possible, and to help us achieve this we will be running our Perfect Week initiative again this month from 9 to 13 January.

The Perfect Week programme aims to change the way patients are seen, treated and discharged from hospital, to improve safety, patient experience, and our performance.

To help support colleagues during the week, we are encouraging all staff to

- Reduce the number of non-essential emails sent
- Cancel non-essential meetings to release staff time
- Consultants to cancel non-clinical sessions in favour of additional ward rounds

During the Perfect Week II, we will

- Test increased levels of administration support and the Flow Liaison Officer role
- Refocus our Board Round Standards and peer review work
- Support pre-1100am discharge
- Test small, simple changes

We know that many staff have been facing immense pressures because of patient flow issues through our hospital, and whilst we know that many colleagues have been working hard to reduce these pressures – we want to do more to support our teams.

4. WORKFORCE

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 was pleased to see hundreds of staff throughout our Christmas programme of activities in both the community and hospital.

5. FINANCE – APRIL TO NOVEMBER MONTH 8

Although we reported a £0.7m deficit in November, with a year to date £4.5m deficit, in line with our forecast, our financial position continues to remain very concerning. We have significant challenges for the remaining 3 months of the financial year to meet our overall planned financial targets.

The pay expenditure was £0.5m off plan in November and is £1.5m off plan year to date. In total the pay bill for November was £18.6m; the highest monthly amount since April at £18.7m.

Total agency costs for November were £1.1m, an increase of £0.1m to October. Reducing agency spend is a critical priority for our cost improvement programme and we will continue to increase our efforts to employ permanent and bank staff to continue reduction of agency staff. Whilst the total of agency spend increased compared to October, nursing agency costs continue to reduce. We now need to tackle reducing medical agency spend.

Non Pay expenditure continues to be favourable against plan, £0.3m in month and £3.2m year to date.

Income showed a slight improvement compared to October. Clinical income exceeded plan in month linked to improvements in elective work and critical care. Day case and out patients continue to underperform.

The Trust has agreed a fixed outturn with North Central London and is finalising a fixed outturn with NHSE.

The current cash position of the Trust is £1.4m over-plan and this includes funding from our sustainability and transformation which has been received for the first 2 quarters of 2016 (April to October).

Capital spending commitments total £2.5m (October £2.1m), with £1.4m incurred to date.

Responsibility for monitoring progress against the capital programme is with the Capital Management Group who report to the Trust Management Group.

6. AWARDS

Congratulations to the clinical, occupational and communication team members who worked so hard together over the past 3 months to achieve the highest level of flu vaccine uptake for all of London NHS trusts. This means our staff and patients are being protected as much as they can from the spread of this life-threatening illness.

Thank you to clinicians Mike Coltman, Tracy Groarke, Gretta O'Toole, Logan Van Lessen, Martin Peache, Patricia Folan, Head of Occupational Health Cathy Ferguson and Communication Manager, Ozge Duzgun.

I would like to thank Robert Loton, Heather Ezekiel, Stephenie Duckworth-Porras, Nicola Brooms, Hayley Naim and Mark Baker (smoking cessation team members) for their kindness helping the homeless in December. They all volunteered on their journey to and from work, to collect warm winter clothing and then re-distribute these to homeless people living round the Angel and Islington area. This was a great act of kindness by these staff members and one which I know many other staff will have replicated in other ways throughout the festive period.

Simon Pleydell
Chief Executive

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Whittington Health

January 2017

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	**17/006**	**Paper**	**03**
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 November 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:	21/12/2016		

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 November 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 8 serious incidents during November bringing the total of reportable serious incidents to 42 since 1st April 2016.

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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.
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.

Category	Month Declared	Summary
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:26486	Oct 16	Patient deterioration during NG feeding.
Maternal Death Ref: 26963	Oct 16	Patient deterioration 10 days post delivery resulting in cardiac arrest.
Delayed diagnosis. Ref: 27113	Oct 16	Delayed diagnosis due to failure to follow up investigation result.
12 hour Trolley breach. Ref: 27253	Oct 16	A patient had a prolonged wait in the Emergency Department due to lack of bed availability in appropriate setting.
Discharge Planning failure. Ref: 27258	Oct 16	Patient discharged from hospital without appropriate discharge plans in place.
Unexpected death Ref: 27591	Oct 16	Unexpected death in the community as a result of suicide
Unexpected Admission to NICU Death. Ref: 25786	Oct 16	Baby was born in poor condition and was transferred to the Neonatal Intensive Care Unit.
Missing Swabs - Near Miss. Ref:28068	Oct 16	Failure to locate two swabs following instrumental delivery and suturing tear.
Sub Optimal Care of Patient Ref:28091	Oct 16	Patient developed pressure ulcers due to pressure relieving equipment not being provided.
Suboptimal Care of Deteriorating patient. Ref: 29018	Nov 16	Patient admitted to ITU with a type 2 respiratory failure and acute kidney injury.
Unexpected Death Ref: 30701	Nov 16	Inappropriate surgical referral and delayed diagnosis.
Unexpected Death Ref:30716	Nov 16	Delay in implementing DNAR / end of life care pathway/inappropriate pain management.
Unexpected Death Ref:30720	Nov 16	Inappropriate management of surgical patient.

Category	Month Declared	Summary
Unexpected Death Ref:30726	Nov 16	Patient left the Hospital while waiting to be transported to another unit and was later found unresponsive.
Unexpected Death Ref:29379	Nov 16	Patient assessed and discharged and was subsequently found unresponsive.
Attempted Self Harm Ref:29357	Nov 16	Patient whilst on agreed leave from tier 4 unit attempted self harm
Delayed Diagnosis - Colposcopy Ref:30095	Nov 16	A delay in reviewing biopsy results, led to delay in diagnosis.

The table below details serious incidents by category reported to the NEL CSU. The Trust reported 8 serious incidents during November 2016.

STEIS 2016-17 Category	Apr	May	June	July	Aug	Sept	Oct	Nov	Total
Safeguarding	0	1	1	0	1	0	1	0	4
Attempted self-harm	0	0	0	0	0	0	0	1	1
Confidential information leak/loss/Information governance breach	1	2	1	0	1	1	0	0	6
Diagnostic Incident including delay	2	1	0	0	0	1	1	1	6
Failure to source a tier 4 bed for a child	0	0	0	1	0	0	0	0	1
Failure to meet expected target (12 hr trolley breach)	0	0	0	0	0	0	1	0	1
Maternity/Obstetric incident mother and baby (includes foetus	1	1	1	0	0	2	1	0	6
Maternity/Obstetric incident mother only	0	0	0	0	1	0	1	0	2
Medical disposables incident meeting SI criteria	0	0	0	0	0	0	1	0	1
Nasogastric tube	0	0	0	0	0	0	1	0	1
Slip/Trips/Falls	0	0	0	1	0	0	0	0	1
Sub optimal Care	0	0	0	0	0	0	1	1	2
Treatment Delay	0	0	0	0	0	0	1	0	1
Unexpected death	0	1	0	1	0	1	0	5	8
Retained foreign object	0	0	0	0	0	1	0	0	1
Total	4	6	3	3	3	6	9	**8**	**42**

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 November 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 4 reports to NELCSU during November 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 November 2016.

Summary	Actions taken as result of lessons learnt
• **Ref:21646**	**Safe Guarding (Allegations not substantiated).** • Support for staff should be improved on during an internal investigation or external inquiry.
• **Ref:21713**	**Information Governance Breach** • A communication plan is being arranged to highlight informantion governance risks in relation to paper copies of handover sheets and how these risks can be mitigated. • The Trust is reviewing whether an alternative method of sharing patient sensitive information can be identified and mitigate the risks of utilising paper copies of the handover sheets. • The Trust is working closely with partner organisation to ensure that all locum staff are aware of the responsibilities of handling patient identifiable information.
• **Ref:22867**	**Never Event. Retained foreign object post-procedure** • Swab checking is now included on the prompt skills station. • Swab counting will be included in live drills. • A live database is now maintained and regular refresher training sessions are being provided for swab counting.
• **Ref:23372**	**Intrauterine Death** • Updating and dissemination of reduced fetal movement guideline- this includes an informatic poster which will be given to women at booking; and a checklist on what to ask women at every antenatal encounter.

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

4 January 2016

Title:	Safe Staffing - Nursing and Midwifery – November data		
Agenda item:	**17/007**	**Paper**	**04**
Action requested:	For information		
Executive Summary:	This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in November 2016. Key issues to note include: 1. A reduced fill rate for Registered Nurses displayed in the UNIFY report 2. Increase use of special shifts used to support vulnerable patients November (235) vs October (115) 3. Same level of Red Shifts reported in November (4) compared to October (4) 4. The number of RMN 'specials' used to care for patients with a mental health conditions was higher in November (29) compared to October (2). 5. The continued use of agency and bank staff to support safe staffing		
Summary of recommendations:	Trust Board members are asked to note the November 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 November 2016.

1.2 To provide context for the Trust Board on the UNIFY safe staffing submission for the month of November 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 October 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 – 30th November 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 – 95.7% Night – 98.9%
	Care hours per Patient Day - CHPPD	Overall CHPPD was 8.58 for November 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.	0.3% of Red triggered shifts	4 shifts triggered red in November 2016 this was the same as October 2016
	30% of shifts remained partially mitigated (Amber shifts)	448 shifts i.e. 30% of all shifts in month. This was an increase on October's figure. These consisted of shifts mainly during the day distributed between early and late.

3.0 Fill rate indicator return

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

3.2 Appendix 1 details a summary of fill rates 'actual' versus 'planned'. The average fill rate was 95.7% for registered staff and 115% for care staff during the day and 98.9% for registered staff and 129.1% for care staff during the night.

3.3 On the day shift, eight wards reported below 90% fill rates for qualified nurses. Eleven wards had above 100% fill rate for unqualified nurse and five wards had above 100% fill rate for qualified nurses.

3.4 The UNIFY report show some wards with unusually high percentage fill rates; for example, Nightingale ward at (HCA) 201.6%. 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 a 100% increase.

3.5 A number of wards (Montouchi, Mary Seacole South, Mary Seacole North 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.

Day		Night	
Average fill rate registered Nurses /Midwives	Average fill rate Care Staff	Average fill rate registered Nurses/Midwives	Average fill rate Care Staff
95.7%	**115.0%**	**98.9%**	**129.1%**

4.0 Additional Staff (Specials 1:1)

4.1 When comparing November's total requirement for 1:1 'specials' with previous month, the figures demonstrate an increase in the number of shifts required (Appendix 2). November saw 235 requests for 1:1 specials compared to 115 requests in October. 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 higher in November (29) compared to October (2). 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 November 4 shifts triggering red.

Month	% shifts triggering red in month	Actual number of red shifts
November	0.3	4
October	0.3	4
September	0.2	3

5.4 Wards triggering red shift

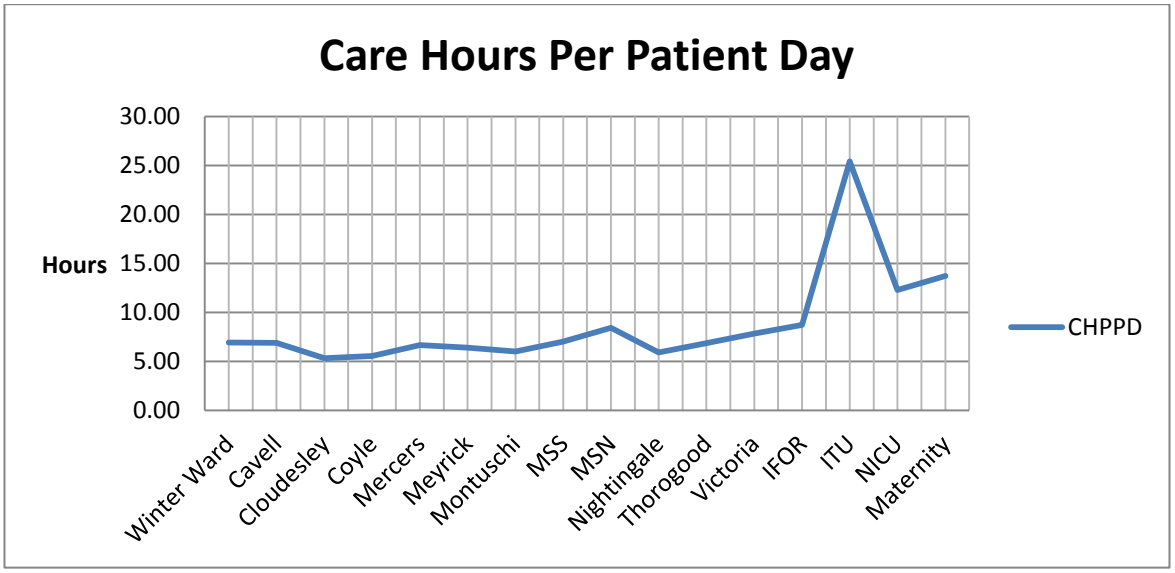
	Initial Red Shifts				
Wards	**Early**	**Late**	**Night**	**Number of shifts where staffing initially fell below agreed levels**	**% of shifts where staffing fell below agreed levels and triggered a red rating**
Cloudesley			1	1	**1**
Cavell Rehab Ward	0	1	0	1	**1**
Maternity	1	1	0	2	**2**

5.5 Summary of factors affecting red triggering shifts

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

6.0 Care Hours per Patient Day (CHPPD)

6.1 Care hours per patient day is calculated using the patient count on each ward at midnight (23.59hrs). CHPPD is calculated taking the actual hours worked (split by registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight. The graph below shows the average individual care hours per patient for each clinical area. ITU have the most care hours (25.43) and Cloudesley ward have the least (5.32)



6.2 The average number of hours of Registered Nurse time spent with patients was calculated at 6.34 hours and 2.24 hours for care staff. This provides an overall average of 8.58 hours of care per patient day.

	CHPPD
Registered Nurse	**6.34**
Care Staff	**2.24**
Overall hours	**8.58**

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

6.4 The new SaferCare module of the 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 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 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 November compared to October.

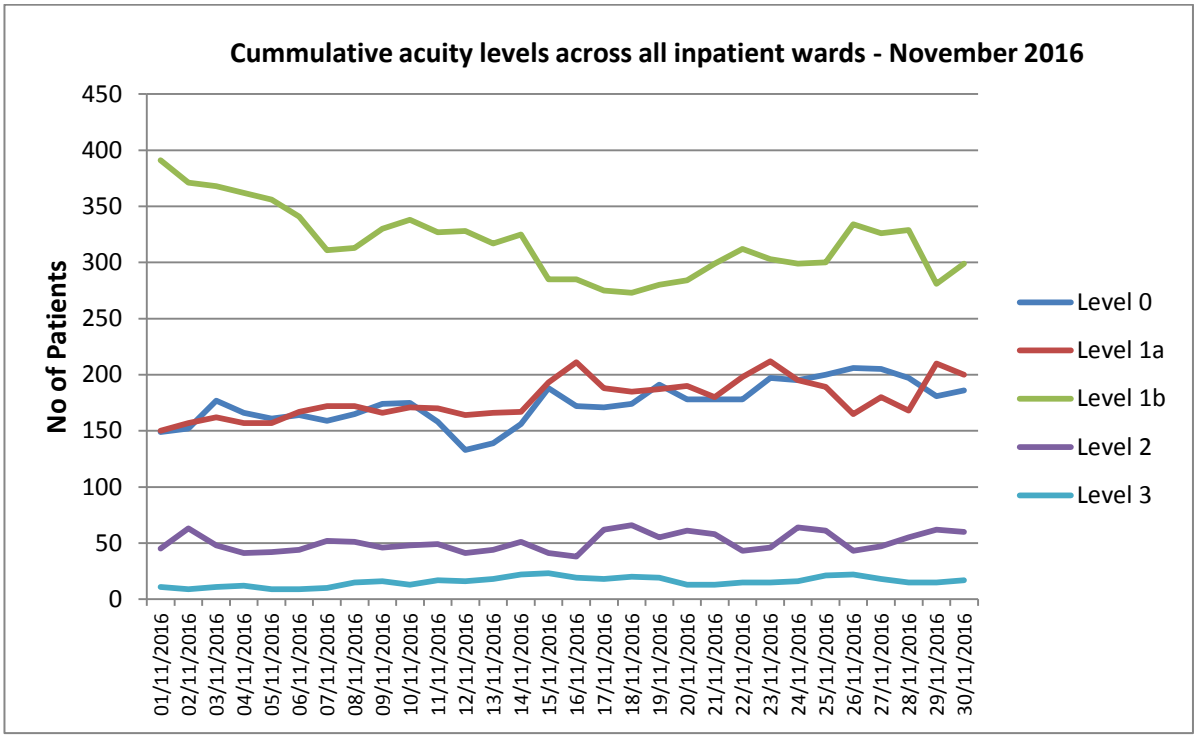
Ward Name	Nov	Oct	Sept	Aug
Bridges				
Cavell Winter Ward	6.93			
Cavell Rehab	6.89	7.20	8.66	7.74
Cloudesley	5.32	5.80	6.10	6.14
Coyle	5.57	5.62	5.88	5.88
Mercers	6.65	6.78	8.86	6.98
Meyrick	6.39	5.87	5.41	5.46
Montuschi	6.02	5.86	6.99	6.23
MSS	7.04	6.98	7.72	8.34
MSN	8.42	7.95	9.17	10.04
Nightingale	5.91	6.33	5.47	5.81
Thorogood	6.85	7.78	4.28	9.08
Victoria	7.84	6.35	6.15	6.56
IFOR	8.71	9.62	10.74	12.76
ITU	25.43	24.23	26.12	24.95
NICU	12.30	14.13	12.53	10.33
Maternity	13.71	14.90	13.95	16.19
Total	8.58	8.64	8.76	9.01

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 November. 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 requires 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.

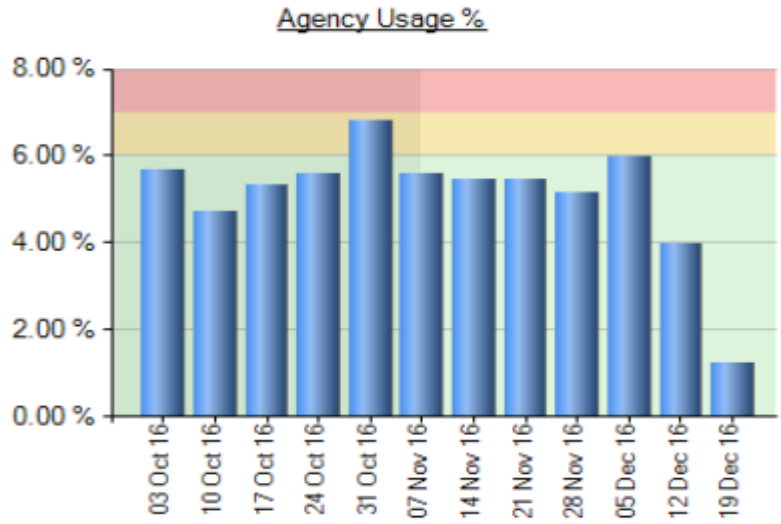
b) The process allows for an overview of the total number of temporary staff (agency) used in different clinical ward areas and provides a monitoring mechanism for the delivery of safe quality care.

9.0 Agency Usage Inpatient Wards (October to date)

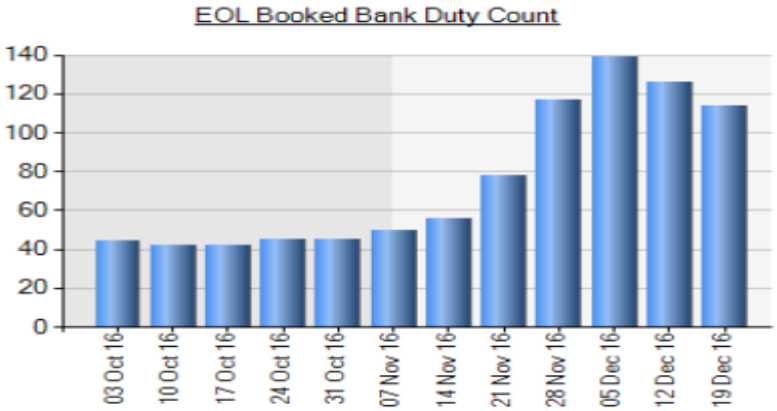
9.1 The utilisation of agency staff across all inpatient wards is monitored using the Healthroster system. The bar chart below graphically represents total usage of agency staff on inpatient

wards 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

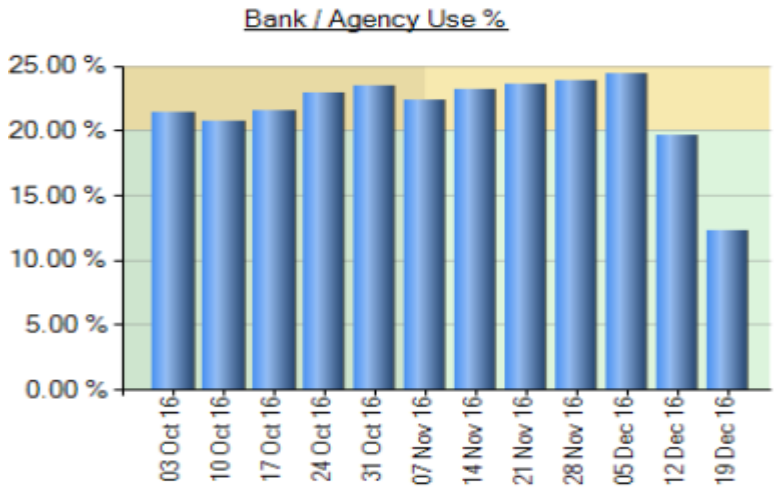


The introduction of the incentive bonus and the ability for staff to directly book themselves into bank shifts via their Employee on line accounts (EOL), has impacted on the continued reduction in to Agency usage.



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.

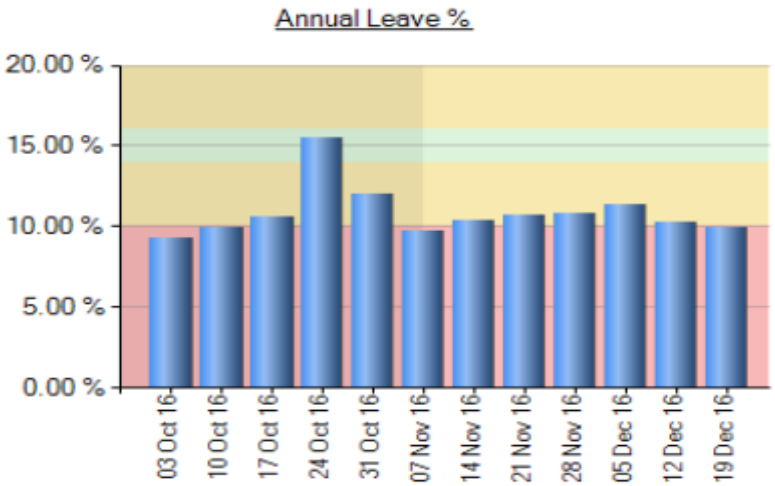
9.4 Temporary staffing usage (Bank and Agency) across inpatients wards remains high and fluctuates between 20 – 24%. Recruitment to reduce the current vacant posts is ongoing.



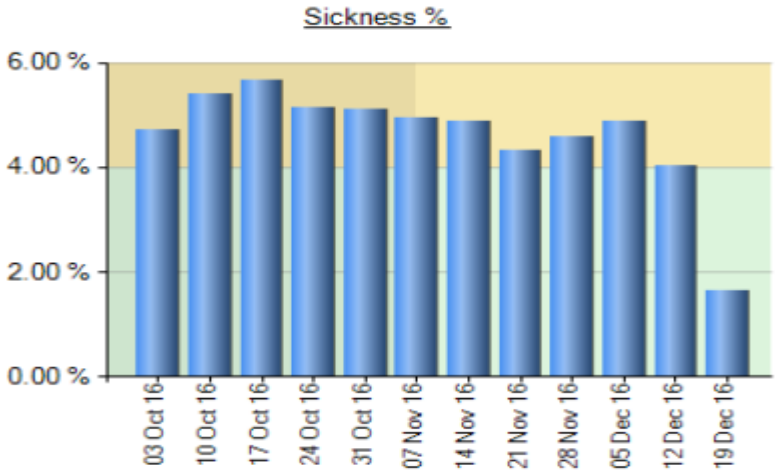
10.0 Managing Staff Resource

10.1 Annual leave taken from November to date is below the set tolerance of 14 -16%. This tolerance level ensures all staff is 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 holiday. This will monitor this 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 November was above the set parameter of less than 4%. Heads of Nursing ensure all individuals reporting back from sick leave undergo a sickness review.



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 hospital and the November UNIFY return position

Updated tables

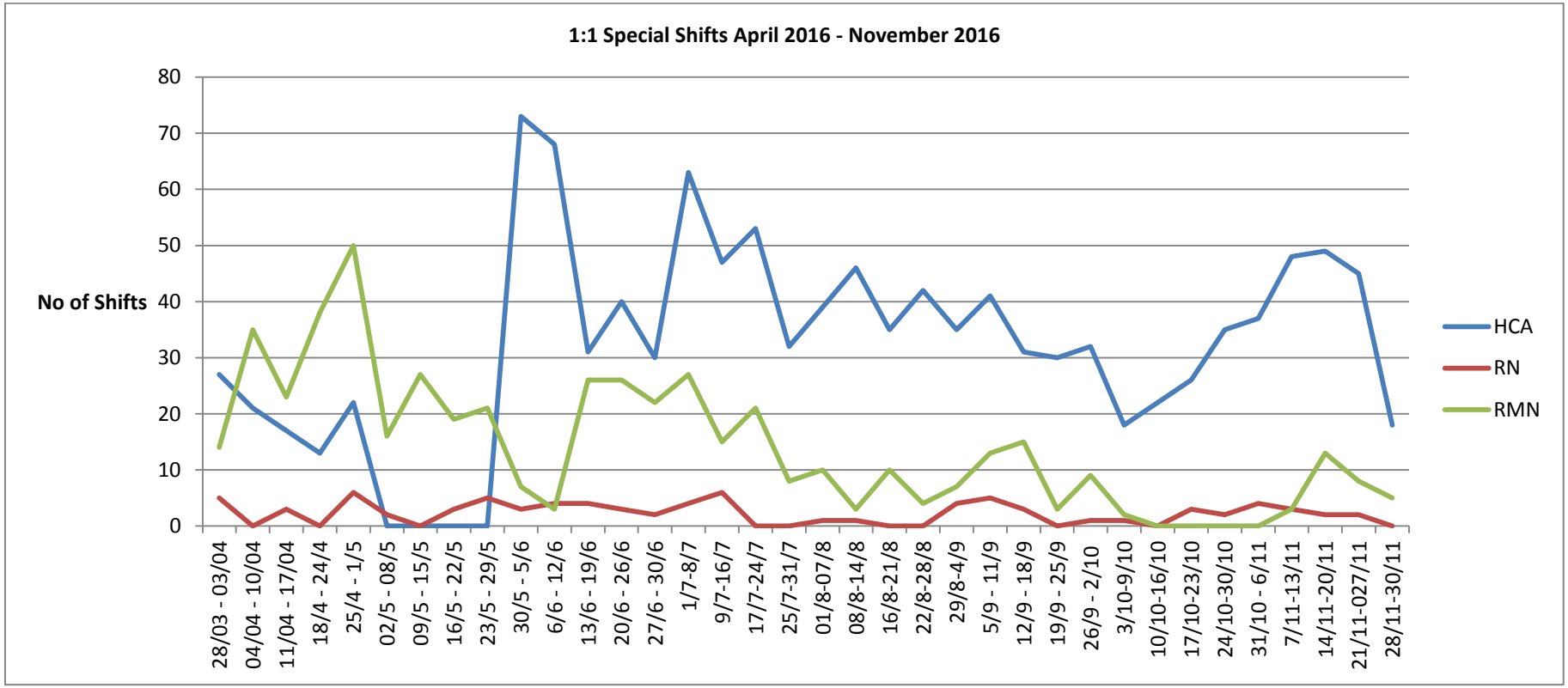
Fill rate data - summary
November 2016

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)				
34261	**32781**	**10146**	**11673**	**27776**	**27469**	**7443**	**9609**	**95.7%**	**115.0%**	**98.9%**	**129.1%**

Care Hours per Patient Day
November 2016

Total Patients at Midnight/Month	CHPPD Registered staff	CHPPD Unregistered staff	Average CHPPD (all staff)
9502	6.34	2.24	8.58

November 2016



Average fill rate for Registered and Unregistered staff day and night

	Day		Night	
	Nurses	Care Staff	Nurses	Care Staff
Ward Name	%	%	%	
Winter Ward	95.4%	79.4%	94.0%	101.7%
Cavell	106.2%	87.5%	99.0%	145.7%
Cloudesley	93.8%	89.9%	112.5%	106.5%
Coyle	108.3%	77.6%	153.5%	95.9%
Mercers	86.4%	112.5%	100.8%	92.3%
Meyrick	93.7%	125.7%	109.3%	169.6%
Montuschi	81.8%	182.2%	108.6%	NA
MSS	77.3%	185.2%	77.8%	198.6%
MSN	81.5%	114.2%	106.1%	205.5%
Nightingale	75.5%	201.6%	80.8%	210.1%
Thorogood	103.9%	89.9%	99.9%	40.0%
Victoria	100.6%	155.3%	113.1%	154.5%
IFOR	98.3%	100.0%	90.0%	100.0%
ITU	100.0%		100.0%	
NICU	94.0%		89.7%	
Maternity	105.4%	113.8%	98.0%	96.8%
Total	**95.7%**	**115.0%**	**98.9%**	**129.1%**

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Whittington Health Trust Board

4 January 2017

Title:	Whittington Health Operational Plan 2017/18		
Agenda item:	**17/008**	**Paper**	**05**
Action requested:	To approve		
Executive Summary:	The Operational Plan was submitted to NHSI on the deadline of 23 December. This paper covers the narrative plan that was submitted. Alongside the narrative, activity, financial and workforce templates were completed and submitted. The plan was written in the prescribed format based on outputs from the business plans from the ICSUs. The detail was discussed at Finance and Business Development Committee in December prior to submission. An internal document will be produced based on this plan to support the organisation in setting corporate and ICSU objectives from April.		
Summary of recommendations:	To approve		
Fit with WH strategy:	In line with the clinical strategy and NCL STP		
Reference to related / other documents:	Aligns with WH standing orders and NHSI Oversight Framework		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	All risks captured on relevant registers		
Date paper completed:	28 December 2016		

Author name and title:		**Helen Taylor, Clinical Director**		**Director name and title:**		**Siobhan Harrington, Deputy Chief Executive & Director of Strategy**	
Date paper seen by EC	**Dec 16**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Whittington Health

Trust Operational Plan

2017/18 – 2018/2019

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1 Introduction

Whittington Health's vision is to be a national leader in delivering safe, personal, coordinated care to the local community. It is geographically placed in the centre of North Central London (NCL) with a portfolio of services covering the populations of Haringey and Islington but also with some community services in Camden, Enfield, Barnet and Hackney. The Trust is an Integrated Care Organisation (ICO) and delivers some of the most innovative models of ambulatory and integrated care in the region e.g. Integrated Respiratory Services, Integrated Care of the Ageing, Integrated Care Hubs and working closely with social care.

Over the last twelve months, the organisation has been working closely with the Haringey and Islington Clinical Commissioning Groups (CCGs), Local Health Authorities (LHAs) and local providers (including Mental Health) in developing the Haringey & Islington Health and Wellbeing Partnership. The objective of this partnership is to work in an integrated and collaborative way to provide high quality health and social care for our local population. This work has been recognised and supported by, and integrated into the North Central London (NCL) Sustainability and Transformation Plan (STP).

As an Integrated Care Organisation (ICO) with community and hospital services across Islington and Haringey, Whittington Health is in a unique and important position to deliver the strategic objectives of the STP. The Trust's mission, documented in our clinical strategy, is to 'help local people live longer, healthier lives'. A key strategic goal is to secure the best possible health and wellbeing for all our community, of which prevention and health promotion is a key objective. An example of this is our CQC rated 'outstanding' community dental services. A key priority next year is embedding our work in co-creating health and shared decision making across our geography and taking a population-based approach to prevention. In addition to prevention, the Trust has led on the development of important service transformation such as our 'outstanding' ambulatory care model, rapid response and frailty units, and integrated care networks, which align directly with intentions to deliver care closer to home.

Within this context, the Trust, like many providers nationally, faces significant financial challenges. The year-end revenue forecast for 2016/17 is a £6.4m deficit, which is in line with the Trust's control total for the year inclusive of Sustainability & Transformation Funding (STF). The underlying, recurrent, position without STF is estimated to be a £15.2m deficit. A central goal for Whittington Health is to reduce costs whilst continuing to deliver high quality care. The Trust identified the need to deliver £25m of improvements when producing its 2016/17 financial plan, which was supported by the development of a 2-year programme. However, as highlighted in this plan, there are risks and challenges associated with our financial position, such as securing a contract for clinical service provision with an income quantum that reflects the level of activity undertaken by the Trust.

This operational plan reflects both the opportunities and risks faced by the organisation.

2 Activity planning

The 2017/18 (extending to 2018/19) activity plans have been calculated in line with the relevant guidance and is consistent with the approach of our lead commissioners and the North Central London STP planning submission.

Demand and capacity have been assessed via the use of IST models which is in line with national practice and an approach supported by commissioners. Further, capacity takes into account the activity that can be provided within the funded establishment and will be adjusted for, where appropriate:

- Full year effect of new appointments
- Part year business cases taking into account an increased full year effect
- Any planned and agreed service changes for 2017/18
- Lessons learned from winter resilience planning. Particular examples of how this has been incorporated include the most appropriate location for the winter pressures ward, forming a better link for stepping down patients (intermediate and re-ablement care) and a focus on the care for the elderly.

The validation process for demand and capacity includes:

- Checking outpatient capacity against clinic slots
- Clinic templates to improve 'Did Not Attend' (DNA) rates
- 'New' to 'Follow up' ratios
- Lessons learned from the move to PbR. NB – the move to PbR arrangements became more prevalent for the Trust in 2016/17, moving away from historical block contract arrangements

The clinically led structure of the ICSUs within WH has meant that each ICSU has developed a business plan led by its Clinical Director. Key elements to these plans have been identifying areas of changing demand and the consequent impacts on capacity. This work was developed in collaboration with the finance and information teams and has informed the development of this plan.

A consequence of this work has identified the pressure areas for demand and capacity are most likely to include Endoscopy and Diagnostic Imaging, where the Trust has seen a significant increase in growth, and the Emergency Department (ED). Currently, based on the commissioned level of activity, the Endoscopy department can satisfy the level of demand, but it may be an area in future where consideration of the requirement for additional capacity is needed. Imaging is working with the National Capacity and Demand Fund to develop a new model of working to deliver more diagnostic capacity for the NCL STP footprint.

2.1 Cancer

The Trust Cancer Strategy is being reviewed; this will be linked to the National Cancer Strategy, the London Cancer agenda, the Cancer Vanguard work and aligned to the Trust's Clinical Strategy. We will participate in the Cancer Peer Review process.

The Trust is compliant with the two week wait target. There are some challenges with the 62 day target. We have been compliant with this target except in the last quarter. Inter-trust transfers significantly impact on WHs achievement of this target. To that end WH is meeting on a fortnightly basis with North Central and North East London commissioners. The commissioners are leading work to tackle these issues and the focus for 2017/18 will therefore be to ensure that shared care patients are sent to other Trusts by day 38 and treated within the 62 day target. Within the STP WH is working with UCLH and other specialist centres, through clinical collaboration to strengthen multidisciplinary team arrangements and cancer pathways for patients. Key pathways that are being strengthened include breast, colorectal and lung cancer.

2.2 Referral to Treatment

From October 2016 the only national standard is the Incomplete Standard and as a Trust we are compliant and sustainably delivering this standard.

There are a number of individual specialities that are not compliant and the Trust is working to achieve sustainable compliance in each of these areas. Please see below for the three specialities and the actions being taken to deliver the standard.

Table 1: Specialities that are non-compliant for incomplete standard

Speciality	Incomplete %	No. patients + 18 weeks	No. patients over tolerance
General Surgery	86.85%	332	130
Trauma& Orthopaedics	87.01%	313	121
Gastroenterology	91.29%	109	9

(Submitted October 2016 performance)

Actions to achieve compliance with the standards include:

- Maximising clinic capacity - reducing DNAs and cancellations by optimising 'Netcall' (*text call reminder)*
- Reducing clinical variation and improving productivity – *review demand and capacity on a regular basis.*
- Continuously improve theatre utilisation as part of the Surgical Improvement Plan.

2.3 Emergency Department

Performance has remained particularly challenging for the organisation during 2016/17, compounded by an increase in activity compared to the same period last year. This is consistent with neighbouring Trusts in North Central London. One of the key plans of the Trust for 2016/17, to address this has been to develop a new model for the medical workforce utilising a skills mix of consultants and nurse practitioners rather than middle grade posts. Implementation of this plan has begun; a number of these posts have been filled and recruitment is currently underway for the remaining posts.

One challenge has been outflow from the Emergency Department (ED) to in-patient wards. The Trust has a robust improvement plan in place which is outlined in the quality improvement section and is designed to optimise patient flow, allow the organisation to respond to the increase in demand for its services and to support achievement of the ED target.

As part of the ED Delivery Board the organisation is working closely with commissioners and other providers to explore system-wide quality improvement and further resilience measures.

2.4 Endoscopy Services

The service has delivered against its performance trajectory over the past year. The Demand and Capacity modelling using the NHS IAMS IST tool has been refreshed to further understand the capacity within the service.

A workforce review has been undertaken looking at the skill mix within the clinical team with the plan to further develop the nurse endoscopist role.

A direct access colonoscopy trial commenced in July 2016 and the intention when fully evaluated will be to extend to Islington GPs in 17/18.

2.5 Imaging

There has been increased activity in CT and MRI due to direct access requests from GPs and increased Out Patient (OP) demand as part of the drive for earlier diagnosis in cancer. This increased activity is expected to continue and has driven the diagnostics cancer vanguard bid with UCLH. In addition Whittington Health has been successful in their bid to the National Diagnostics Capacity Fund to support the Trust in delivering further capacity. This will begin in January 2017.

2.6 Outpatients

As a consequence of reviews of capacity, activity and productivity remodelling of outpatients will be undertaken over the next 12 months. The remodelling will be to support more efficient patient pathways, patient engagement and explore other models using technology.

3 Quality planning

3.1 Quality improvement governance

Whittington Health (WH) has a strong governance structure in place to promote and monitor quality at all levels throughout the Trust. This robust structure allows for effective management of quality from ward and community services to Board and provides assurance of progress and delivery against plans, whilst also enabling clear and appropriate escalation of issues.

The quality improvement function is jointly led by executives Dr Richard Jennings, Medical Director, and Philippa Davies, Director of Nursing and Patient Experience. Both Directors report to the Trust Board and sit at the Board's Quality Committee.

The Quality Committee, a sub-committee of the Board, provides assurance on behalf of the Board on all matters relating to quality and ensures the maintenance of effective risk management and quality governance systems. This includes reviewing reports from the Patient Safety Committee and Patient Experience Committee, and conducting two deep-dives per annum for each of the seven Integrated Clinical Service Units (ICSUs).

The Board also receives quarterly patient safety reports, monthly quality performance dashboards and patient experience metrics. Each Board meeting includes a patient story which generates insights into how quality improvement processes have operated in practice, and how lessons are learnt and disseminated.

In 2015/16, Whittington Health invested in creating and appointing two new Associate Medical Director (AMD) posts. The AMD for Patient Safety was appointed to continue to strengthen our patient safety culture, whilst the AMD for Revalidation focusses on promoting and improving medical revalidation and appraisal processes.

Feeding into the Quality Committee, the Director for Nursing and Patient Experience chairs the Patient Experience Committee and the AMD for Patient Safety chairs the Patient Safety Committee. These committees provide a forum to analyse safety and experience separately, and receive reports from sub-committees and standing updates on safety and experience initiatives (see Figure 1).

In addition to these committees, the Medical Director, Director for Nursing and Patient Experience, and AMD for Patient Safety sit at the Trust's decision making forum, the Trust Management Group (TMG). TMG meets once a fortnight with all clinical and corporate Directors represented. Reports on progress against the CQC action plan are heard here and investment decisions are approved collectively with oversight from the quality executives and the AMD for Patient Safety on quality impact.

At ICSU level, quarterly performance meetings are chaired by the Chief Executive with the executive team and ICSU senior management team, where quality and patient safety performance is triangulated alongside activity, workforce, and financial performance.

Within individual ICSUs, Clinical and Operational Directors and Heads of Nursing hold monthly ICSU Boards which have quality as a standing item on the agenda, including all quality monitoring systems, patient safety and safety huddles, patient experience walkabouts, NICE guidelines, auditing, serious incident reporting, and qualitative patient comments received as part of the NHS Friends and Family Test (FFT).

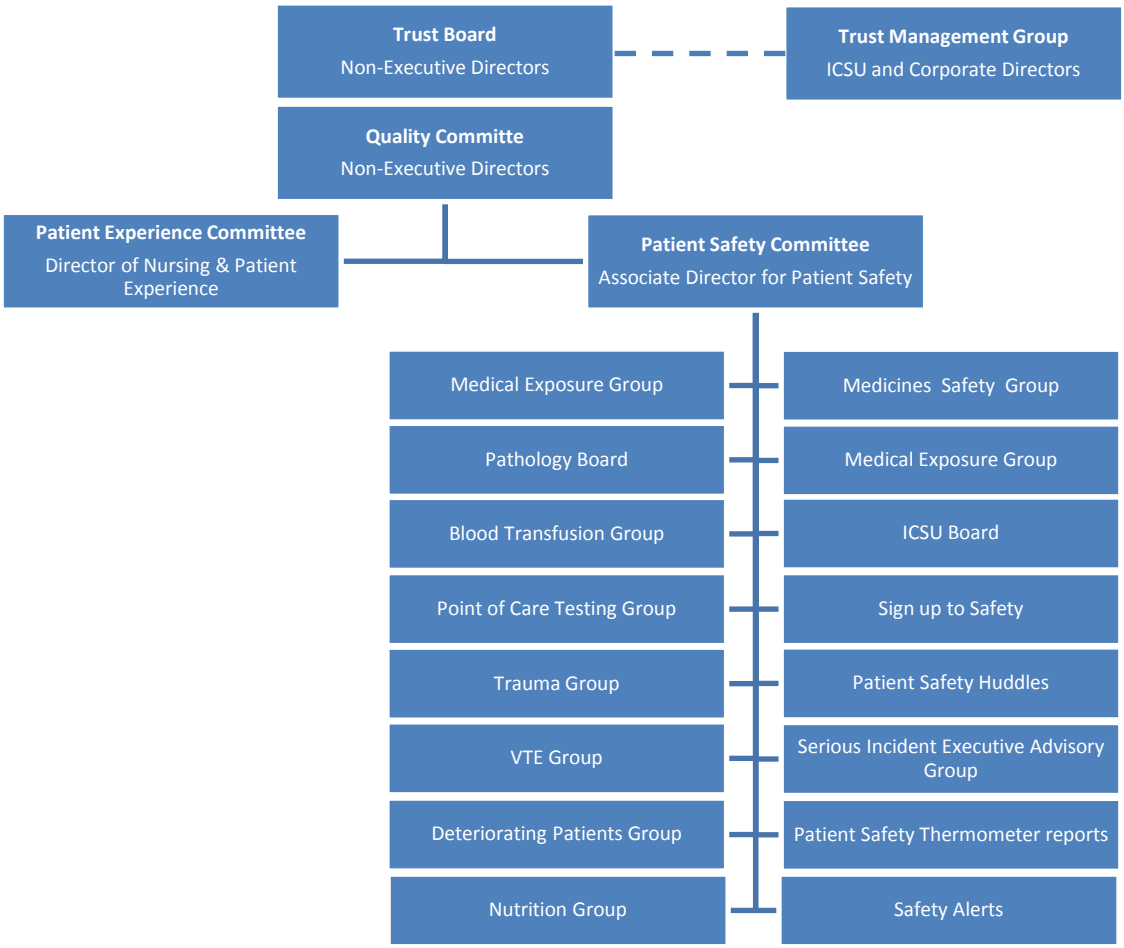
3.2 Quality improvement approach

The Trust's quality priorities are addressed through a number of strategies and initiatives:

Sign up to safety (SU2S) – This is a three-year programme established in July 2015 and led by the AMD for Patient Safety. SU2S frames the quality priorities of the Trust through measurable improvement initiatives focusing on reducing avoidable harm for the most vulnerable patients across our organisation. Specifically, these priorities focus on sepsis, Acute Kidney Injury (AKI), falls, pressure ulcers and learning disabilities. These priorities are described in more detail in our annual Quality Account.

Quality Account – Whittington Health publishes an annual Quality Account setting out a comprehensive description of the quality of care delivered to patients, progress against plan, areas requiring improvement, and detailed steps for how we will achieve improved outcomes.

Fig. 1: Quality Governance Structure



CQC Action Plan – In July 2016, Whittington Health was awarded a rating of 'good' by the CQC, with a rating of 'outstanding' for caring. The summary report highlighted many areas of good practice across the organisation, however the inspection team also identified areas for improvement and the Trust has developed an action plan based on the 'must do', 'should do' and 'could do' recommendations from the report. This action plan was shared with the CQC and commissioners at the Quality Summit and is monitored through the ICSU governance structure and reported by exception to the TMG. The Quality Committee is responsible for providing assurance to the Trust Board that actions are on target. Progress against this plan is also discussed with the commissioners at the monthly Care Quality Review Group (CQRG) meetings.

Mock CQC Inspections – The Trust runs a programme of peer review visits to support quality improvement across the Trust. The framework for these reviews is based on the CQC five key lines of enquiry with services given an overall rating in line with CQC criteria. Improvement actions are monitored through the ICSU governance structure and assurance reports to the Quality Committee.

The Junior Doctor Patient Safety Forum – Trainee doctors are a key staff group in the identification and dissemination of safety improvements and learning this monthly forum is chaired by Dr Julie Andrews, AMD for Patient Safety. It has been highly successful, highlighted externally as an example of good practice in safety learning. More recently, this forum has been opened to all professional groups in the Trust.

The Performance Dashboard – This provides at a glance performance against a number of key quality and safety indicators over a set period of time and is presented at ICSU level, at Quality Committee and Trust Board.

Serious Incident Executive Advisory Group – This group is held weekly and is co-chaired by the Medical Director and Director for Nursing and Patient Experience and has the Chief Operating Officer as a member. The group reviews 72 hour reports and Root Cause Analysis (RCA) reports. The group considers whether serious incident or never event criteria have been met. The group ensures the Trust's duties around Duty of Candour are discharged appropriately. The group also ensures that key learning is shared with staff through a dedicated page on the Trust intranet and through a monthly report to Trust Board.

PMO reporting – Whittington Health has a Programme Management Office (PMO) to oversee a £22m savings plan over two years. Each scheme has been subject to a Quality Impact Assessment before being signed off. Progress is tracked via weekly 'Roadmap calls' and monthly Deep Dives with each ICSU and Corporate department.

Patient Safety Huddle – This model provides an opportunity for 'board to ward' engagement and a framework for identifying patient safety risks and ensuring actions are addressed. It is particularly useful in identifying obstacles at service level, which can be driven forward with Executive level support. The Quality Improvement and Compliance Manager reports on Patient Safety Huddles and monitors compliance against actions via the Executive Team Meeting, Patient Safety Committee and ICSU governance structure.

Patient Stories – At the start of each Trust Board, a patient would have been invited to share their story and experiences of their care. These stories are followed by a description of the service action plan in response to any learning points, and provide an opportunity for Non-Executive Directors to question how lessons have been disseminated and learnt as well as providing a connection from ward to Board.

Nursing Quality Indicators – The Quality Nursing Indicators were developed by the senior nursing team by identifying those aspects of care which are directly or mainly under the control of the nursing staff. The indicators are in line with the five key lines of enquiry used by the CQC. The parameters are set for both community and hospital services with identified targets. The data is RAG rated to provide a visual picture of the quality. The Quality Nurse Indicators have recently been further developed to include trend lines which provide an ability to understand the trends of care quality over time. The indicators are used by each ISCU to monitor the quality of care and are discussed at the Nursing and Midwifery Committee.

Trust wide safety newsletter – Our 'Spotlight on Safety' is a new trust-wide e-newsletter that provides the Trust with a channel to disseminate information, news and policy relating to safety in a digestible format to all staff. The newsletter includes the use of infographics to maximise engagement with staff.

CQRG – This is a commissioner led monthly meeting where quality improvement leads report to commissioners on ad hoc items relating to quality and safety with a focus on quality. The group receives reports presented to Quality Committee for discussion.

Schwartz Rounds – The Trust will be resuming a programme of Schwartz Rounds from early 2017.

Quality Improvement plans for the Emergency Department – Our key objective for 2017/18 is to continue and to expand our programme of improvement. There are a number of plans in progress to recover both Emergency Department (ED) performance and flow across the acute admitted pathway, including but not exclusively:

- **Front-door streaming:** To ensure timely and appropriate care, in the right place by the right team and to maximise use of Ambulatory Care through appropriate diversion of acute medical assessment and paediatric patients, and transfer of medical clerking to the in-patient setting
- **Revision and recruitment of ED workforce in order to facilitate rapid assessment treatment (RAT) and reduction in median Time To Treat and meet the ED standards by:**
    - Increasing the number of consultants by 6 WTE over the next 18 months. This will mean we will have consultant cover form 8-10pm from August 2017 when three of the new posts will be filled and we will be working further toward meeting the London ED standards over the next 8 months as we recruit the additional three posts.
    - Developing the new Urgent Care Pharmacists roles with Health Education England
    - Developing enhanced roles for nurses and health care assistants within the ED department.
- **Improved speciality response/ agreements:** To prevent unnecessary delays in decision making and/ transfer of care
- **Development of Demand and Capacity tool/ Escalation Cards:** To allow early warning of approaching problems and implementation of escalation plan
- **Enhancement of Frailty Pathway:** To ensure early Frailty Team input to enable appropriate management/ discharge support, to achieve Length of Stay (LoS) and readmission reduction
- **Senior Clinician Review by noon**: To ensure appropriate management to progress recovery and discharge
- **Pre-11a.m. and Criteria Led Discharge:** Ongoing promotion and training
- **Advance Discharge to Assess model:** To ensure patients are discharged when medically fit
- **Enhanced Site Team and processes:** To proactively manage flow/ discharge planning and timely communication
- **Staff engagement:** enhanced recovery workshops to support the streamlining of discharge
- **Emergency Care Improvement Programme (**ECIP): implement the findings of the 2 day review lead by Vince Connolly of the front door, ED, clinical decision unit, ambulatory care and acute admission unit once published.
- **System wide improvement:** working with Haringey and Islington and the wider STP urgent care pathway to develop system wide processes to improve the performance of ED.

3.3 Summary of the quality improvement plan

Our quality improvement priorities for 2016/17 and 2017/18 are documented in our Sign up to Safety pledges, Quality Account, CQC Action Plan, and Clinical Strategy.

a. National clinical audits

We will continue to participate in 100% of the mandatory national audits.

b. The four priority standards for seven-day hospital services

We will meet the four priority standards for seven-day hospital services. (See above for the ED consultant standards)

c. Safe staffing / care hours per patient day

A safe staffing report is presented to each Trust Board and published on the Whittington Health website.

d. Mental health standards (Early Intervention in Psychosis and Improving Access to Psychological Therapies)

Maintaining the current high standards for our IAPT services, including:

- Delivering 50% clinical recovery for people who receive two or more sessions.
- Deliver treatment to 15% of those with common mental illnesses (estimated at 5,100).
- Ensure that 70% of those we treat wait less than six weeks.

e. Actions from the Better Births Review (BBR)

Whittington Health was one of the sites visited as part of the BBR. Our maternity service have reviewed the recommendations made by the Review and have developed an action plan in response to these. Whittington Health is a partner in the successful bid made by North Central London to be an early adopter site for the BBR recommendations.

f. Improving the quality of mortality review and Serious Incident investigation and subsequent learning and action

From 2017 we will review 100% of inpatient deaths through the mortality review process agreed with the Trust Board.

g. Anti-microbial resistance

We will focus further improvements around the NHS England Antimicrobial Resistance (AMR) local indicators. This includes minimising the consumption of antimicrobials, particularly highly restricted antimicrobials. We will also continue to monitor trends of antimicrobial prescribing. Quarterly point prevalence audit data will be collected to monitor that wards continue to achieve the 90% target for antimicrobial review within 72 hours.

h. Infection prevention and control

Significant improvement has already been made in reducing hospital acquired infections. Going forward we will further improve by focussing on the following priorities:

- Reducing the Trust attributable E.coli bloodstream infections by 50% by 1st April 2020.
- Continue to have zero tolerance around trust attributable MRSA bloodstream infections
- Ensuring we meet objectives around Trust attributable Clostridium difficile associated diarrhoea cases
- Ensuring we have below national benchmarks for surgical site infection rates in patients undergoing orthopaedics prosthetic hip and knee surgery
- Reviewing all deaths and severe harm cases associated with healthcare associated infections or any IPC issue using root cause analysis investigations.
- Ensuring more than 90% of staff received infection prevention and control training.

i. Falls

We will reduce the number of inpatient falls that result in severe/moderate harm by 25%.

j. Sepsis

We will achieve the target of the new and expanded national sepsis CQUIN in 2016/17.

k. Pressure ulcers

We have a zero tolerance to our patients developing 'avoidable' pressure ulcers and have developed the following priority targets for the next year:

- We will implement our 'React to Red' pressure ulcer prevention campaign
- We will have no avoidable grade four pressure ulcers.
- We will reduce the number of avoidable grade three pressure ulcers in the acute setting by 25%.
- We will reduce the number of avoidable grade three pressure ulcers in the community by 25%.

l. End of Life Care (EOLC)

The Quality improvement plan for EOLC is currently focused on three areas for Adults:

- Maintaining the current provision of Specialist Palliative Care following key retirements (December 2016).
- Within 2017-18, extending the Specialist Palliative Care on the acute site to a seven day service. We are working with other providers to deliver an affordable and sustainable model.
- Improving the use of the refreshed web based Co-ordinate My Care platform across the ICO and between providers.

Paediatric Palliative Care, which received a CQC rating of 'outstanding', will provide an annual report on EOLC and Specialist Palliative Care will be presented to the next Quality Committee and then to the Board in February.

m. Patient experience

The Trust is committed to improving patient experience, priorities in the next year include:

- Improving our FFT response rate by 20%. We will document and report our actions from patients' and carers' feedback within our Quarterly Patient Experience Report to the Quality Committee.
- Developing our Patient and Carer Experience Strategy.
- Revising our Communication and Engagement Strategy.
- Establishing a Community Forum which reflects the diverse community we serve.
- Hosting a minimum of four engagement events and report to our Board on how we have improved opportunities for our patients, carers, public and stakeholders to engage and inform our strategic plans to help local people live longer healthier lives.

n. National CQUINs

We will continue to aim to achieve and track progress against the following CQUINS:

- 1N Staff Health and Wellbeing
- 2N Sepsis
- 4N Antimicrobial Resistance (AMR)
- 1L Safe and Timely Discharge
- 2L Obesity
- 3L Domestic Abuse
- 4L Nutrition and Hydration
- CHIS – Child Health Information System
- CA2 – Cancer Dose Banding IV SACT
- MH4 – Improving CAMHS Care Pathway Journeys by Enhancing the Experience of the Family / Carer

o. Confirmation that the provider's quality priorities are consistent with STPs.

The Medical Director for Whittington Health is the co-clinical lead for the North Central London (NCL) Sustainability and Transformation Plan (STP) Clinical Cabinet and plays a key role in ensuring the alignment of the Trust and STP's priorities.

3.4 Summary of quality impact assessment process

Each individual ICSU use the QIA tool to assess the impact of any work or transformation projects. These quality and risk assessments of each approved Cost Improvement Plans (CIPs) are presented to the Medical Director and Director of nursing by the respective ICSU clinical and operational directors. At these meetings specific indicators of quality are agreed as part of the assessment process. These are then reviewed by the Medical and Nursing Directors with the respective teams every quarter or more frequently if felt necessary to identify any changes to risk and quality throughout the year. On the completion of each CIP programme there will be a formal to evaluation the risks and quality implications.

3.5 Summary of triangulation of quality with workforce and finance

Quarterly performance reviews for each ICSU are chaired by the Chief Executive and attended by the whole executive team. In order to provide the trust a holistic view of quality, workforce, performance and finance these performance reviews examine:

Safety, Quality Patient Experience and Risk	Performance	People Issues	Finance
• Infection Prevention and Control numbers • Safety thermometer indicators • Serious Untoward Incidents • Complaints (numbers trends and response rates) • Risk register/service	• Activity • Performance national standards and community waiting times	• Staff survey • Temporary staffing levels/spend • Recruitment issues • Sickness rates • Appraisal Rates • Mandatory training	• Divisional position cost pressures and hot spots • Financial plans and milestones for next year • Year-end projections • PbR and Coding issues • CIP progress

issues • Friends and Family test • CQC action plan			

3.6 Quality Improvement Methodology

Over the next three months the Trust will be refreshing its quality improvement strategy. The approach the strategy proposes is to further develop and improve the quality improvement capacity and capability of the organisation through:

- A structured tiered service improvement training programme for all WH staff
- Adopting co-design approach ensuring patients and residents inform service improvement
- Developing access of data for all staff to support the drive for improvement.
- Use the Whittington Health 'start ,stop' model to feedback and collect ideas from staff on a daily basis
- Celebrate good care and innovation in a way that shares service improvement initiatives

4 Workforce planning

Workforce planning is an integral part of our performance and management culture and strategic planning and is integrated into a number of the Trust's systems and processes. This section outlines our workforce planning strategy, methodology, and processes including productivity and transformation plans.

4.1 Workforce strategy

In 2016/17 we will continue implementation of our Workforce Strategy 2016-2021, focussing on: leadership; a flexible and responsive workforce; recruitment and retention; and education and training. This strategy was developed with wide engagement and consultation aligned with the Clinical Strategy.

4.2 Workforce planning methodology

The workforce planning process is aligned and integrated with the Trust's business planning process which is led by individual ICSUs. Throughout the process ICSUs Clinical and Operational Directors are supported by HR Business Partners who advise and challenge ICSUs on the workforce impact of their plans and ensure alignment with workforce and clinical strategy. This involves:

- Working with ICSUs to discuss workforce issues such as recruitment and retention, activity planning, education requirements and the delivery of key performance indicators;
- Analysing and monitoring workforce changes at a local level (which is aggregated to a Trust wide position);
- Ensuring current and future workforce needs are represented in business plans, consider growth, as well as options to develop new roles, new ways of working, and associated training implications.

Final ICSU plans are presented individually to the Trust's Board, Executives and all other Clinical, Operational and Corporate Directors in a peer-review and challenge session. Following this, amended plans are used to inform the Trust's Operational Plan.

In addition to the annual business planning process, the Director of Workforce is represented at the Investment Group which is responsible for approving business cases in-year and reviewing business plans during the planning process prior to proceeding to the Trust Management Group. Here the group triangulates between the workforce, finance, activity, IT and estates implications of all business cases and service changes.

4.3 Workforce planning governance and risk management

Workforce planning is an integral part of the ICSU Boards. These committees oversee local workforce strategies, including transformation and risk management and ensure the impact of proposed developments on existing and future workforce requirements are properly considered. In addition:

- All workforce risks are reviewed quarterly.
- Action plans for reducing amber and red rated risks are monitored on a quarterly basis by the Trust Management Group.
- High level risks are reported to Workforce Assurance Committee and subsequently added to the Board Assurance Framework.
- Workforce intelligence is used regularly to help the Trust make decisions. We are developing integrated workforce dashboards which triangulate workforce information, clinical quality and safety metrics:
- Safe nurse staffing levels are monitored continuously, supported by ongoing assessment of patient acuity. As part of 'Showing we care about speaking up' we encourage and support all staff to
- Nursing scorecards triangulate workforce information with other quality metrics.
- Workforce intelligence and Key Performance Indicators (KPIs) are reported at the Trust Board and are standing items on Performance Review Group meetings (PRGs). The Workforce Assurance Committee receives comprehensive corporate workforce information and analysis. Metrics include vacancy and sickness rates, turnover and appraisal compliance and temporary staffing.

4.4 Workforce efficiency, transformation and new initiatives

Service improvement is a key element of all our ICSU plans, which look at how delivery can be supported by existing workforce but also how the roles and workforce will transition to deliver programmes including seven day services and elimination of agency usage.

A number of workforce initiatives have been agreed locally and are integrated into our Trust plans and will deliver transformation and efficiency. These include:

- Developing new service delivery models, such as the use of pioneer pharmacists on wards and development of urology nurses' roles, to reducing reliance on agency staff and improve quality and safety.
- Prioritising clinical collaboration with NCL providers to ensure service productivity is maximised, services are lean and sustainable, and reducing costs and reliance on agency staff. In time, aligning this with broader NCL STP ambitions to pool resources.
- To further reduce agency spend develop initiatives to improve vacancy, attrition and agency rates such as reviewing bank pay rates, continue with director level scrutiny of agency and bank shifts, widen the roll out of e rostering and continue to monitor and challenge spend through the weekly agency tracker..
- Enhancing the health and wellbeing of staff through our health and Wellbeing Strategy, and linking this to the NCL STP ambition to implement a healthy workplace charter to improve employee wellbeing and reduce avoidable sickness absence.
- Recruitment delivering recruitment campaigns (internal and external), through open days, job fairs, develop sideways transfer schemes, continue with EU and overseas recruitment, develop rotational posts with other trust e.g. UCLH, increase local community campaign's, continue to be active partners in The Widening Participation initiative through the apprenticeship schemes and further education colleges.

In the following years, our workforce and operations will develop to focus on care closer to home, aligning with the NCL STP. Our aim is to identify the education and training needs of our current and future workforce, equipping them with the skills and flexibilities that are required in the changing health and social care environment. Our education and development plans are developed and updated through:

- Trust level analysis of organisation-wide educational and training needs analysis which is being developed through the re-structure of the Learning, Development and OD department/s.
- Analysis and discussion about training needs at ICSU Performance Review Meetings.

In line with the STP, we will roll out recommended training programmes where they are relevant and applicable, such Making Every Contact Count (MECC), Mental Health First Aid (MHFA), and dementia awareness.

4.5 Local workforce advisory boards and engagement with commissioners

The Director of Workforce is attends the Health Education North Central London (HENCL) forum, and the Trust's workforce planning submission to HENCL is dovetailed with our internal business planning cycle. This assesses workforce plans over five years supporting sector and national education commissioning and planning intentions. The HENCL plan is signed off by Trust professional leads and shared with commissioners.

5 Financial planning

The year-end revenue forecast for 2016/17 is a £6.4m deficit, which is in line with the Trust's control total for the year inclusive of Sustainability & Transformation Funding (STF). The underlying, recurrent, position without STF is estimated to be a £15.9m deficit.

The Whittington Health 2017/18 draft financial plan is a fully integrated component of the Trust's Operational Plan and builds on the planned outturn forecast for 2016/17, overlaid with key planning assumptions for the forthcoming financial year, as set out in the section 5.1 below.

The financial model is inclusive of a 5-year capital plan, for which the schemes are consistent with the Trust's clinical strategy, and clearly provide for the delivery of safe, productive services. Further detail in respect of capital planning is provided below.

Having completed the detailed planning the Trust has accepted its control total for 2017/18 of a £0.6m surplus and is planning to achieve the full STF available.

5.1 Financial forecasts and modelling

Using the 2016/17 forecast outturn (per the Month 7 TFMS submission) as a starting point, the Trust has reviewed the position, making iterative adjustments to take account of the planning assumptions outlined above. This has informed the initial 2017/18 plan position, before subsequent adjustments were made to account for local and specific national planning factors.

The Trust has agreed contracts with its main commissioners and these are based on activity plans which are both recognised and agreed by the contracting parties and included within the STP planning assumptions.

The agreed activity plan is based on performance for the first six months of 2016/17 and adjusted to take account of:

- Agreed service changes;
- Non-recurrent activity movements;
- STF funding;
- Assumed growth of 3% for acute contracts; and
- Proposed draft STP interventions which may vary in year.

The activity is priced at the latest national tariff and takes account of movements between national and local commissioners.

In agreeing the overall income envelope and contract, the Trust as part of the NCL STP has agreed to vary national tariff to recognise a marginal tariff rate as part of an overall risk share with local partners.

Expenditure plans are based on the recurrent outturn for the current financial year with the following planning adjustments:

- Application of standard national planning assumptions
- Identification of material non-recurrent income and expenditure
- Specific pay planning assumptions including the effect of the apprenticeship levy
- Pay award 1% (per national guidance)
- Incremental drift 1.1%
- Non-pay inflation 2%
- An allowance for specific non pay items that are over and above those funded by the national tariff inflation e.g. local business rates
- Financial efficiency (CIP plans for 2017/18 and 2018/19)
- STP QIPP
- Contingency and reserve requirements

Capital and cash plans reflect the key linkages between operational finance plan, strategic capital developments and high priority capital expenditure to support clinical service strategy

5.2 Efficiency savings 2017/18 & 2018/19

A central goal for Whittington Health is to reduce costs whilst continuing to deliver high quality care. The Trust identified the need to deliver £25m of improvements when producing its 2016/17 financial plan, which was supported by the development of a 2-year programme.

Within the 2-year programme c. £15m was to be delivered in 2017/18, predominately through cost reduction, to achieve a sustainable position. In drafting the current financial plan, covering the period 2017/18 to 2018/19, the Trust still needs to achieve a level of c. £25m in efficiencies/cost reductions across the 2 years, with £15.5m to be delivered in 2017/18. Clearly this will require significant transformation as the Trust needs to deliver major savings while also improving engagement and management of staff.

As stated above, the Trust has established a comprehensive programme to deliver this goal, with clear linkage to the Lord Carter provider productivity programme, and taking into account issues to date. The objectives of the programme are to:

- **Reduce costs whilst protecting quality:** Work with management and frontline staff to identify safe, sustainable savings
- **Establish integrated programme capabilities:** Put strong programme governance in place, supported by activist programme management to drive delivery
- **Build a sustainable approach to continuous improvement:** Empower the clinical and operational leads to develop and execute continuous improvement, and hold them accountable for it

A robust governance process has been established to ensure effective oversight:

- A Programme Management Office structure has been put in place, which is reaching a level of maturity having operated over the last 6 months.
- There is a bi- weekly CIP meeting chaired by the Chief Operating Officer and includes members of staff from a range of backgrounds covering clinical, operational and financial
- There are weekly project management calls chaired by the Chief Operating Officer to monitor progress against project plans and to escalate problems on the critical path
- There are quarterly deep dives in to every area chaired by the Chief Operating Officer and includes members of staff from a range of backgrounds covering clinical, operational and financial
- The Trust Management Group (TMG), receives monthly detailed CIP progress reports
- The Finance and Business Committee receive detailed PMO presentations at every meeting and also meet with two areas for deep dives
- The Trust Board receives monthly updates through the Financial Reporting

5.3 Capital Planning

The Trust's capital plan continues to be focused around the key strategic priority to improve and develop the current maternity care facilities. NHS Improvement (NHSI) is aware of the specific business case proposal and has been working with the Trust to conduct assurance of the case. More recently the Trust has been engaged with NHSI to explore potential funding structures for the proposed development, including additional funding which would supplement internally generated funds and charitable donations.

The planned capital programme for 2017/18 is set at an affordable level of c. £8.5million investment from internally generated sources of capital funding. This total takes account of meeting debt repayment liabilities to the Department of Health for existing capital loan facilities. At the time of producing the draft planning submission it is still anticipated that the externally requested funding sources in relation to the maternity and neonatal investment will be received in 2016/17.

Schemes contained within the capital programme reflect the high priority investments required by the Trust during 2017/18 to sustain safe and productive services, and are anchored to the Trust risk register to ensure that prior to investment commitments being finalised there is a collaborative assessment and agreement for schemes to proceed. Schemes can be broadly assigned to estates, IT and medical equipment areas.

5.4 Risks & Challenges

The Trust has confirmed that it would like to accept its notified control total for 2017/18 as outlined in the letter from NHS Improvement dated 1st November 2016. Accordingly the draft planning submission for 24th November is structured to deliver a £0.6m surplus on the receipt of £6.7m Sustainability & Transformation Funding.

As would be expected, there a number of challenges & risks the Trust will need to manage in both in the lead up to and during 2017/18 in order to deliver its control total, the most significant of which being the agreement of a contract for clinical service provision with local lead CCGs. The key risks and challenges currently identified through the planning process include:

- Delivery of the CIP programme together with a cost response to agreed QIPP
- Achievement of the agency expenditure ceiling balanced against safe care provision and the know challenges/barriers e.g. supply shortages for clinical staff across London
- Progress of the maternity and neonatal redevelopment

6 Links to the local STP

Whittington Health has played an important role in the development of the North Central London (NCL) Sustainability and Transformation Plan (STP). The Trust's Chief Executive is represented at the NCL STP Transformation Board and the Medical Director is clinical lead and co-chairs the NCL STP clinical cabinet. Furthermore, clinical and corporate leads are closely involved in the process.

The STP has four strategic aspects – prevention, service transformation, productivity and enablers – which will be delivered through eleven (draft) work streams – prevention, health and care closer to home, mental health, urgent and emergency care, optimising elective care, consolidation of services, cancer, productivity, workforce, digital and estates.

As an Integrated Care Organisation (ICO) with community and hospital services across Islington and Haringey, Whittington Health is in a unique and important position to deliver the strategic objectives of the STP. The following sections highlight just some of the work Whittington Health is doing in relation to the STP.

6.1 Service transformation

Whittington Health is on the forefront of delivering services that are crucially aligned with the objectives of the STP. The Trust has in place an 'outstanding' ambulatory care model, rapid response and frailty units, and integrated care networks, which align directly with intentions to deliver care closer to home and re-define urgent and emergency care in NCL. The Trust plays a key role in delivering community mental health services for adults, children and young people, as well as providing wider women's health and paediatrics services across NCL. In 2017-18, the Trust will continue to focus on networking services through clinical collaboration which will optimise achievement of cancer priorities and elective pathways.

Throughout 2017/18 the work to deliver an Accountable Care Partnership as a delivery vehicle in Islington and Haringey for the STP will continue, with the governance and operational arrangements to be agreed by April 2017. This work enables us to maintain momentum in delivering integrated care with colleagues from primary care, social care and mental health providers.

6.2 Prevention

As an ICO, the community reach of the Trust also enables us to deliver on the STPs increased emphasis on prevention. Our work on supporting patients with self-management and co-creating health, and 'making every contact count' will continue to be embedded in services across the organisation. The Trust delivers community services in smoking cessation, sexual health, dietetics, community nutrition, and we will seek to build and develop these services further. Our offer, coupled with our specialism in Paediatrics, Women's Health and CAMHS, will provide a crucial vehicle for delivering the STP's prevention strategy and 'achieving the best start in life'.

6.3 Enablers

Whittington Health has been actively engaged in the NCL estates work and considers estates to be a priority enabler. The Trust is in the process of procuring a Strategic Estates Partner (SEP) that will be in place in 2017/18 to deliver our Estates strategy. The SEP will act as a catalyst for new models of care, such as 'out of hospital' work streams including the 'Care Closer to Home Integrated Networks' (CHINs). This is a key enabler for the transformation outlined in the STP and the work across the Islington and Haringey Wellbeing partnership, which is closely aligned with the local devolution agenda.

The Trust will also be seeking to build its digital capacity further, building on the successes of existing schemes that have improved patient access through technology. Already these initiatives have had positive impact, such as through the use of iPads in our District Nursing Virtual Wards which have had significantly increased patient facing time. Specifically, in January we will commence use of the e-community tool which

will increase ability to effectively schedule work as well as providing continuity thus increasing productivity further. The use of store and forward RIO is now being rolled out and will mean the ability to have accurate and timely patient records in the home. We also plan to implement an e-referral service which will improve patient pathways, reduce DNAs and improve productivity. Renewed focus on digital as an enabler in the STP aligns fundamentally with the priorities of Whittington Health.

6.4 Productivity

Whittington Health will continue to prioritise productivity throughout 2017/18 through the delivery of its second year of Cost Improvement Programmes (CIPs) which will deliver total two year savings of £22m. Through this, we will complete work to consolidate our histopathology, cytology and pathology services and launch our new Pharmacy Wholly Owned Subsidy in 2017. We will also continue to work with others on improving back office functions in line with the Carter report and Model Hospital work. In 2017/18 our services will place emphasis on cross-NCL clinical collaboration to maximise services productively whilst also delivering improved patient outcomes and pathways and tackling agency spend. Tackling agency spend as a primary objective will remain a key priority of the Trust.

6.5 Summary

In summary, this Operational Plan outlines both the risks and opportunities presented to the Trust in the following two years.

Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board

4 January 2017

Title:	November (Month 8) 2016/17 - Financial Performance		
Agenda item:	17/009	**Paper**	6
Action requested:	To agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends.		
Executive Summary:	The Trust reported a £0.7m deficit in November and a year to date position of £4.5m deficit. This is in line with the planned year to date (YTD) performance. As a result the Trust continues to forecast delivery of its control total position i.e. a £6.4m deficit, by year end.		
Summary of recommendations:	To note the financial results relating to performance during November 2016		
Fit with WH strategy:	Delivering efficient, affordable and effective services. Meet statutory financial duties.		
Reference to related / other documents:	Previous monthly finance reports to the Trust Board. Operational Plan papers. Board Assurance Framework (Section 3).		
Date paper completed:	27 December 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 Metric

As reported last month, NHS Improvement (NHSI) has replaced the Financial Sustainability Risk Rating with a new 'Use of Resources Metric'. In addition to measuring liquidity, capital and I&E, this new metric 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**	

The table above shows the Trust's Use of Resources Metric for the year to date.

It should be noted that in introducing this new measure, to monitor Trusts, the scoring has also been changed. Previously, a high score under the Financial Sustainablity Risk Rating indicated the organisation was seen as low risk, however a high score is now the reverse i.e. idicates a higher risk organisation.

Under the Single Oversight Framework (published 30 September 2016) the Trust's score of 3, as shown in the table above, would trigger a 'potential support need' on review by NHSI.

Financial Overview

The Trust reported a £0.7m deficit in November and a year to date position of £4.5m deficit. This is in line with the planned year to date (YTD) performance.

Main issues of note:

- Pay expenditure was £0.5m adverse against plan in month, and is now £1.5m adverse year to date. In total the pay bill for November was £18.6m, which is the highest monthly amount since April (£18.7m) and £0.2m above the average for the year. Other key points that should be noted, include:
    - Total agency costs for November were £1.1m, an increase of c. £0.1m compared to October. As a significant proportion of the Trust's CIP target is based on reducing agency spend, which links to increasing both permanent and bank expenditure, failure to reduce agency spending over the remaining 4 months of the year, together with the performance of other pay savings schemes will see the Trust fail its CIP target.
    - Whilst total agency costs increased compared to October, Nursing agency costs reduced, linked in part to the closure of winter beds. Within this the cost of agency associated with qualified nursing also reduced, leading to an improved position of 6.55% of total qualified nursing spend (October – 9.01%) against the Trust's regulatory limit of 6%.

- Non Pay expenditure continues to be favourable against plan, £0.3m in month and £3.2m year to date.

- Income, while adverse in month, showed an improvement compared to October, £0.1m vs. £0.5m (adverse to plan). Particular points of note include:
    - Clinical income exceeded plan in month linked to improvements in elective work and critical care
    - Day case and out patients continue to underperform
    - The income position includes partial achievement of income efficiencies (CIP)
    - The Trust has now agreed a fixed outturn with NCL and is finalising a fixed outturn with NHSE (both in line with expectations)

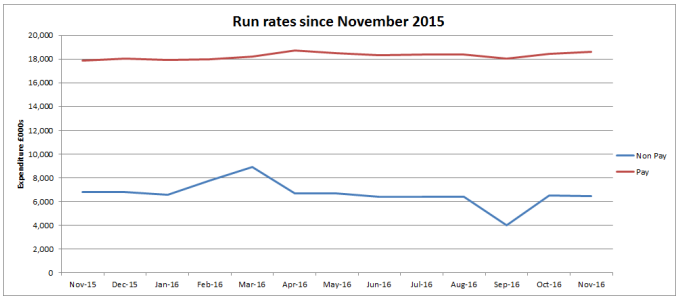
The in month position of a £0.7m deficit was an improvement compared to October. However, whilst the Trust is currently in line with its planned position, year to date, further actions are required to reduce the monthly run rate further in order to achieve the end of year control total and create a recurrent exit run rate that will be required to support the achievement of the Trust's planned position for 2017/18.

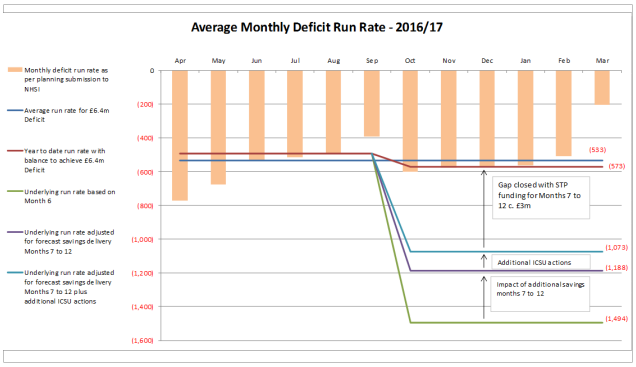
The current cash position of the Trust is £1.4m over plan. The improved position includes STP funding, for the first 2 quarters, that was received in month.

Capital sending commitments now total £2.5m (October £2.1m), with £1.4m actually incurred to date. Responsibility for monitoring progress against the capital programme is with the Capital Management Group.

Statement of Comprehensive Income

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	21,485	23	172,545	170,113	(2,432)	258,366
Non-Nhs Clinical Income	1,899	2,002	103	15,190	15,699	509	22,784
Other Non-Patient Income	2,501	2,265	(236)	17,589	16,858	(731)	26,538
Total Income	**25,862**	**25,752**	**(110)**	**205,324**	**202,670**	**(2,654)**	**307,688**
Non-Pay	6,722	6,460	262	52,713	49,471	3,242	79,594
Pay	18,107	18,632	(525)	145,868	147,377	(1,509)	217,855
Total Operating Expenditure	**24,829**	**25,092**	**(263)**	**198,581**	**196,848**	**1,733**	**297,449**
EBITDA	**1,033**	**660**	**(373)**	**6,743**	**5,822**	**(921)**	**10,239**
Depreciation	690	696	(6)	5,520	5,442	78	8,280
Dividends Payable	353	354	(1)	2,828	2,829	(1)	4,243
Interest Payable	275	261	14	2,127	2,052	75	3,238
Interest Receivable	(3)	(2)	(1)	(24)	(15)	(9)	(36)
Total	**1,315**	**1,309**	**6**	**10,451**	**10,308**	**143**	**15,725**
Net Surplus / (Deficit) - before IFRIC 12 adjustment	**(282)**	**(649)**	**(367)**	**(3,708)**	**(4,486)**	**(778)**	**(5,486)**
Add back impairments and adjust for IFRS & Donate	293	15	278	844	14	830	914
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**(575)**	**(664)**	**(89)**	**(4,552)**	**(4,500)**	**52**	**(6,400)**





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

As previously reported, the Trust needs to achieve an average monthly deficit run rate of c. £0.5m in order to achieve its control total for the year and create the necessary exit run rate to position the Trust to achieve its plan for 2017/18.

The deficit run rate in November, £0.7m, showed improvement compared to October, but still requires further actions to achieve the level required in order to meet the control total (£6.4m deficit) at year end. The section below provides details of the monthly run rate analysis for expenditure for clinical ICSUs.

Monthly Run Rates – Expenditure

The Trust has negotiated an end of year income figure with its local commissioners, which is beneficial for both parties as it provides a degree of 'certainty' when considering both the Trust's financial position and that associated with the wider STP for North Central London.

As an income position has been fixed, attention is now focused on achievement of expenditure and CIP positions in order to achieve the Trust's control total.

When analysing the Trust's financial position at Month 7, and considering the requirements for year-end, ICSUs were requested to provide their 'best' forecasts for outturn. These forecasts were discussed and accepted at the Trust Management Group (TMG) meeting at the start of December, and ICSUs were written to, pre-Christmas, confirming the forecast positions they were required to achieve.

As already highlighted above, the Trust has agreed an end of year income position with local commissioners, which is line with forecast projections, and therefore the focus is now on delivering expenditure positions (inclusive of CIPs) that are consistent with those forecast at Month 7. The tables below provide details of the expenditure forecasts by individual ICSU, the average monthly run rates for months 1 to 7 (actual) and months 1 to 8 (forecast), and a comparison of the actual Month 8 results compared to those expected based on the forecasts.

Pay

	Months 1 to 7 Actual	Months 8 to 12 Forecast	Full Year Forecast	Monthly Average				Monthly Average - Forecast			
				Months 1 to 7 Actual	Months 8 to 12 Forecast	Month 8 Actual		Month 9	Month 10	Month 11	Month 12
	£000s	£000s	£000s	£000s	£000s	£000s		£000s	£000s	£000s	£000s
Children's & Young People	27,649	19,596	47,245	3,950	3,919	3,963	↑	3,919	3,919	3,919	3,919
Clinical Support Services	9,156	6,393	15,549	1,308	1,279	1,383	↑	1,279	1,279	1,279	1,279
Emergency & Urgent Care	14,821	9,682	24,503	2,117	1,937	1,996	↑	1,937	1,937	1,937	1,937
Integrated Medicine	20,033	13,974	34,007	2,862	2,795	2,946	↑	2,795	2,795	2,795	2,795
Patient Access, Prevention & Planned Care	7,400	5,230	12,630	1,057	1,046	1,103	↑	1,046	1,046	1,046	1,046
Surgery & Cancer	21,225	14,589	35,814	3,032	2,918	3,111	↑	2,918	2,918	2,918	2,918
Women's Health	11,322	7,664	18,986	1,617	1,533	1,627	↑	1,533	1,533	1,533	1,533
Total Pay - Clinical ICSUs	111,606	77,128	188,734	15,943	15,427	16,129	↑	15,427	15,427	15,427	15,427

Non Pay

	Months 1 to 7 Actual	Months 8 to 12 Forecast	Full Year Forecast	Monthly Average				Monthly Average - Forecast			
				Months 1 to 7 Actual	Months 8 to 12 Forecast	Month 8 Actual		Month 9	Month 10	Month 11	Month 12
	£000s	£000s	£000s	£000s	£000s	£000s		£000s	£000s	£000s	£000s
Children's & Young People	1,424	952	2,376	203	190	220	↑	190	190	190	190
Clinical Support Services	9,870	6,743	16,613	1,410	1,348	1,337	↓	1,348	1,348	1,348	1,348
Emergency & Urgent Care	1,439	1,031	2,470	206	206	254	↑	206	206	206	206
Integrated Medicine	1,822	1,288	3,110	260	257	313	↑	257	257	257	257
Patient Access, Prevention & Planned Care	1,522	1,304	2,826	217	261	216	↓	261	261	261	261
Surgery & Cancer	5,275	3,856	9,131	754	771	796	↑	771	771	771	771
Women's Health	1,108	919	2,027	158	184	154	↓	184	184	184	184
Total Non Pay - Clinical ICSUs	22,460	16,093	38,553	3,208	3,217	3,290	↑	3,217	3,217	3,217	3,217

Combined Pay & Non Pay

	Months 1 to 7 Actual	Months 8 to 12 Forecast	Full Year Forecast	Monthly Average				Monthly Average - Forecast			
				Months 1 to 7 Actual	Months 8 to 12 Forecast	Month 8 Actual		Month 9	Month 10	Month 11	Month 12
	£000s	£000s	£000s	£000s	£000s	£000s		£000s	£000s	£000s	£000s
Children's & Young People	29,073	20,548	49,621	4,153	4,109	4,183	↑	4,109	4,109	4,109	4,109
Clinical Support Services	19,026	13,136	32,162	2,718	2,627	2,720	↑	2,627	2,627	2,627	2,627
Emergency & Urgent Care	16,260	10,713	26,973	2,323	2,143	2,250	↑	2,143	2,143	2,143	2,143
Integrated Medicine	21,855	15,262	37,117	3,122	3,052	3,259	↑	3,052	3,052	3,052	3,052
Patient Access, Prevention & Planned Care	8,922	6,534	15,456	1,274	1,307	1,319	↑	1,307	1,307	1,307	1,307
Surgery & Cancer	26,500	18,445	44,945	3,786	3,689	3,907	↑	3,689	3,689	3,689	3,689
Women's Health	12,430	8,583	21,013	1,775	1,717	1,781	↑	1,717	1,717	1,717	1,717
Total Expenditure - Clinical ICSUs	134,066	93,221	227,287	19,151	18,644	19,419	↑	18,644	18,644	18,644	18,644

Key: ↑ Actual spend higher than Month 7 Forecast - adverse performance
↔ Actual spend in line with Month 7 Forecast - expected performance
↓ Actual spend lower than Month 7 Forecast - favourable performance

Cost Improvement Programme

Year to date, £3.5m has been delivered against a target of £5.5m. This equates to a 64% achievement. The CIP profile requires a material increase in the rate of cost improvement during the final four months of the financial year in order to achieve the CIP target.

Integrated Clincial Service Unit	Annual Plan £'000	YTD Plan £'000	YTD Actual £'000	YTD % achieved	YTD Variance £'000
Children's services	602	272	92	33.8%	-180
Clinical Support Services	1,019	528	283	53.6%	-245
Emergency & Urgent Care	786	232	483	208.3%	251
Medicine, Frailty & Network Services	1,673	789	685	86.8%	-104
Outpatients Prevention & LTC	526	266	139	52.3%	-127
Surgery	2,613	1,348	628	46.6%	-720
Women's services	1,189	585	369	63.1%	-216
Corporate	2,307	1,483	610	41.1%	-873
Trustwide non-pay	0		250		250
Performance against operating plan	**10,715**	**5,504**	**3,539**	**64.3%**	**-1,965**

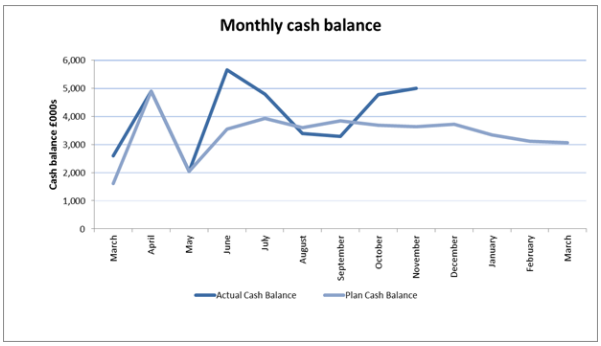
The table above shows actual performance against the original CIP plans, indicating a shortfall of c. £2m year to date. However, a number of non-recurrent benefits have been realised, which supports the Trust being on plan in overall terms year to date. These benefits are being validated further and will be included within the above table in Month 9.

Monitoring of performance against CIP plans continues to be undertaken by the PMO via weekly update meetings, together with monthly deep dives. Shortfalls are principally linked to pay and non-pay schemes and the PMO is working with ICSUs to accelerate future schemes and replace those that will now not achieve during the current financial year.

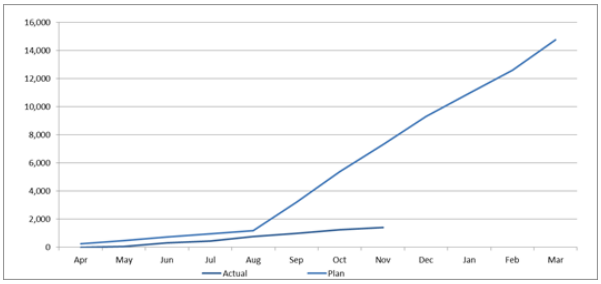
The latest planning submission for 2017/18 still requires a cost reduction target of £15.5m. A number of schemes have already been identified against this and the PMO is continuing to work with all areas to finalise programmes that will deliver a full £15.5m cost reduction in year.

Statement of Financial Position

	As at 1 April 2016 £000	Plan 31 March 2017 £000	Year to Date Plan YTD 30 November 2016 £000	Year to Date As at 30 November 2016 £000	Year to Date Variance YTD 30 November 2016 £000
Property, plant and equipment	194,785	203,023	198,382	191,391	6,991
Intangible assets	4,583	2,831	3,420	3,956	(536)
Trade and other receivables	693	851	831	627	204
Total Non Current Assets	**200,061**	**206,705**	**202,633**	**195,974**	**6,659**
Inventories	1,403	1,500	1,500	1,612	(112)
Trade and other receivables	23,535	25,393	20,362	26,177	(5,815)
Cash and cash equivalents	2,598	3,060	3,634	5,001	(1,367)
Total Current Assets	**27,536**	**29,953**	**25,496**	**32,790**	**(7,294)**
Total Assets	**227,597**	**236,658**	**228,129**	**228,764**	**(635)**
Trade and other payables	39,112	43,391	36,202	38,548	(2,346)
Borrowings	376	2,455	9,930	8,809	1,121
Provisions	795	756	771	256	515
Total Current Liabilities	**40,283**	**46,602**	**46,903**	**47,613**	**(710)**
Net Current Assets (Liabilities)	**(12,747)**	**(16,649)**	**(21,407)**	**(14,823)**	**(6,584)**
Total Assets less Current Liabilities	**187,314**	**190,056**	**181,226**	**181,151**	**75**
Borrowings	52,934	61,419	50,722	51,258	(536)
Provisions	1,773	1,513	1,604	1,773	(169)
Total Non Current Liabilities	**54,707**	**62,932**	**52,326**	**53,031**	**(705)**
Total Assets Employed	**132,607**	**127,124**	**128,900**	**128,120**	**780**
Public dividend capital	62,404	62,404	62,404	62,404	0
Retained earnings	(7,873)	(13,356)	(11,580)	(12,123)	543
Revaluation reserve	78,076	78,076	78,076	77,839	237
Total Taxpayers' Equity	**132,607**	**127,124**	**128,900**	**128,120**	**780**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**	**3.5%**	**3.5%**



Capital Programme



Property, Plant & Equipment (inc. Intangible Assets): As reported previously the YTD underspend is, in part, as a result of the on-going negotiations with a managed equipment services provider. It remains the case that a revised plan has been agreed, with purchases expected in Q4.

Trade Receivables: The adverse variance of £5.8m is mainly due to delayed settlement of outstanding activity invoices for 2015/16 and 2016/17. Discussions to clear the outstanding amounts remain on going, but progress has been slow due to the link with 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. As reported previously the Trust will not achieve the Better Payments Target in 2016/17, due its liquidity position.

Cash: The annual cash plan assumes that the Trust would receive £8.9m cash support. The trust drew down £6.9m as at month 8. The cash position at the close of month 8 was £5m.

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

Whittington Health Trust Board
4th January 2017

Title:	Trust Board Report December 2016 (November 2016 data)		
Agenda item:	**17/010**	**Paper**	**07**
Action requested:	For discussion and decision making		
Executive Summary:	This is the second time the Trust Performance report is presented in it new format. A slide on activity data has been added this month. **Highlights** **Emergency and Urgent Care** Performance has dropped to 85.1%. Continued focus on improvement plan which will include ECIP recommendations. **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. Early indication shows next month will be achieving. **Emergency Re-Admission within 30 days** Achieved **Delayed Transfer of Care** This indicator has gone up significantly from 5.7% to 10.1%. As a result of the LAS diversion from Barnet to Whittington Health more complex patients were admitted to the hospital affecting the DToC rate. **Out Patients Friend and Family Test** Achieved target after two months below target. **Theatre Utilisation** Improved from 81.5 % to 83.7% **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 dropped to 2.8% from 3.3% (threshold 3.5%) **Complaints** During November 2016 the Trust closed 19 complaints and, for the second consecutive month, achieved 100% in regard to response times exceeding the Trust target of 80% A review of the closed complaints during that period shows that the majority of the complaints 37% (7) related to 'attitude', with 43% (3) indicating that patients found staff to be 'rude and/or Disrespectful' 31% (6) of the complaints related to 'medical care' with 33% (2) indicating that patients felt that "inadequate treatment" had been provided. 16% (3) related to 'delay'. 84% (16) of the closed complaints were upheld
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:	23rd 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

December 2016

Month 8 (2016 – 2017)

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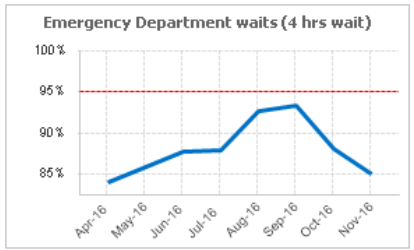
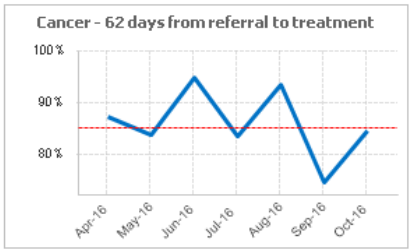
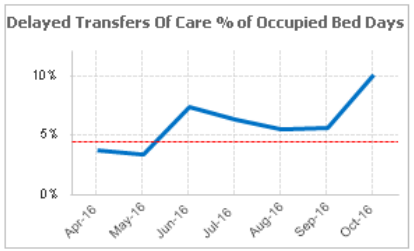
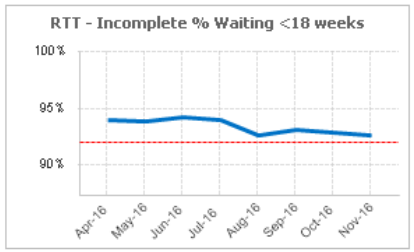
Summary Page - Indicators

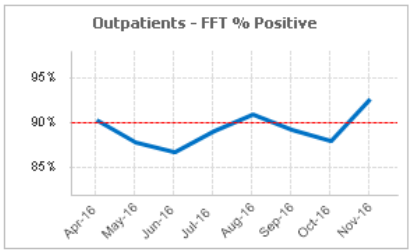
Category	Indicator	16_17 Target	Q1 Apr-16	Q1 May-16	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	2016-2017
ED	Emergency Department waits (4 hrs wait)	>95%	84.1%	85.9%	87.7%	87.9%	92.7%	93.4%	88.1%	85.1%	88.1%
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	88	88	85	87	60	62	75	88	78
Cancer	Cancer - 14 days to first seen	>93%	97.4%	96.4%	96.4%	97.3%	97.7%	96.6%	98.7%		97.2%
Cancer	Cancer - 62 days from referral to treatment	>85%	87.2%	83.6%	94.9%	83.3%	93.5%	74.5%	84.4%		85.8%
Admitted	Emergency Re-admissions within 30 days	<14.2 %	11.3%	12.8%	16.2%	15.2%	14.1%	13.6%	14.6%	14.0%	14.0%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	3.8%	3.3%	7.4%	6.3%	5.5%	5.7%	10.1%		5.1%
Access	RTT - Incomplete % Waiting <18 weeks	>92%	93.9%	93.8%	94.2%	93.9%	92.7%	93.1%	92.9%	92.6%	93.4%
Outpatients	Outpatients - FFT % Positive	>90%	90.2%	87.7%	86.7%	89.1%	90.8%	89.2%	88.0%	92.6%	89.7%
Community	Community - FFT % Positive	>90%	97.3%	97.5%	97.5%	97.9%	97.5%	98.4%	98.1%	98.2%	97.8%
Staff	Staff - FFT % Recommend Care	>70%			80.1%			76.2%			77.9%

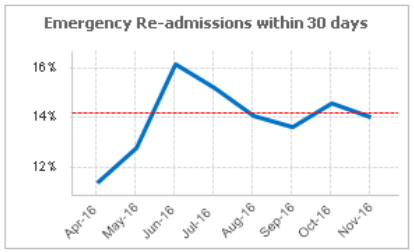












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Safe Services - Indicators and Performance

Category	Indicator	16_17 Target	Q3 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	Q3 Nov-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	1	0	0	0	2	1	1	1	0	0	0	0	5	
All Areas	CAS Alerts Outstanding	0		0	0	0	0	0	0	0	0	0	0	0	0	
All Areas	Actual Falls	400	42	36	29	26	24	26	36	26	31	38	45	30	256	
Admitted	Avoidable Grade 3 or 4 Pressure Ulcers	0					4	2	1	3	5	5	5	1	26	
All Areas	Harm Free Care %	>95%	93.2%	93.7%	93.6%	93.6%	92.2%	92.6%	93.5%	93.8%	91.9%	90.8%	93.3%	92.6%	92.6%	
Maternity	Non Elective C-Section % Rate	>15%	20.0%	18.1%	18.0%	18.1%	13.6%	18.9%	17.7%	16.4%	17.4%	20.2%	17.7%	21.6%	17.9%	
Admitted	Medication Errors causing serious harm	0	0	0	0	0	1	0	0	0	0	0	0	0	1	
Admitted	MRSA Bacteraemia Incidences	0	0	1	0	0	0	0	0	0	0	0	1	0	1	
Admitted	Never Events	0	0	0	0	0	0	0	0	0	1	0	1	0	2	
All Areas	Proportion of reported Patient Safety Incidents Causing Harm	N/A							20.8%	22.6%	21.6%	21.8%	19.9%	20.1%	21.2%	
All Areas	Serious Incidents	0	7	4	8	2	3	6	3	3	4	6	9	8	42	
Admitted	VTE Risk Assessment %	>95%	95.4%	95.3%	95.3%	95.1%	95.0%	96.0%	96.3%	98.0%	96.2%	96.6%	97.3%		96.5%	

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Safe Services - Commentary

Avoidable pressure ulcers
One avoidable Grade 3 pressure ulcer was reported on Victoria ward. The pressure ulcer occurred to the patient's heel.
The ward had not removed the compression bandages from admission and clinical assessment of the left heel was not completed in a timely manner. In discussion with the matron an action plan was developed.

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 percentage rate
The increase in the non-elective C-section rate may be due to the introduction of the new procedure for induction of labour (Cooks Balloon) now used at Whittington Hospital. The patients who are booked for the above mentioned procedure would normally have been booked for an elective section, however with this procedure they are able to commence the first stage of labour, which is beneficial for both the mother and baby. Some of these cases convert to non-elective C-section. We are still awaiting the data from the pilot study to confirm.
The trust is working with UCLH collaboratively, accepting women who are booked for C-section, which is increasing the number of births at Whittington Hospital, but which will lead to an increase in elective C-sections (2 patients in December).

Serious Incidents
Eight incidents were reported in November 2016, including; two un-expected deaths of patients with Mental Health issues, 3 un-expected deaths in surgery (one avoidable and two un-avoidable), one sub-optimal care following a total knee-replacement, one attempted suicide of young person from tier 4 unit and a Delayed Diagnosis - Screening Incident. 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 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	Q3 Nov-16	2016-2017	Performance
ED	ED - FFT % Positive	>90%	93.1%	94.2%	91.6%	85.4%	89.9%	92.0%	87.7%	89.4%	92.4%	95.6%	89.9%	82.1%	87.7%	
ED	ED - FFT Response Rate	>15%	5.1%	3.9%	6.1%	4.0%	4.6%	4.8%	5.1%	4.5%	3.4%	4.1%	4.1%	16.6%	5.9%	
Admitted	Inpatients - FFT % Positive	>90%	93.9%	94.5%	89.5%	94.2%	96.6%	93.6%	95.7%	96.7%	96.0%	95.1%	95.8%	92.7%	95.3%	
Admitted	Inpatients - FFT Response Rate	>25%	13.5%	11.9%	12.6%	14.0%	19.4%	15.5%	15.5%	19.3%	15.4%	20.4%	18.3%	18.0%	17.7%	
Maternity	Maternity - FFT % Positive	>90%	93.6%	95.3%	87.7%	87.9%	94.6%	92.1%	94.6%	91.6%	93.2%	91.1%	91.6%	93.8%	92.7%	
Maternity	Maternity - FFT Response Rate	>15%	18.8%	14.2%	19.4%	19.2%	19.3%	16.1%	18.3%	10.5%	18.9%	24.2%	23.1%	12.8%	17.8%	
Outpatients	Outpatients - FFT % Positive	>90%	93.0%	94.3%	82.2%	84.7%	90.2%	87.7%	86.7%	89.1%	90.8%	89.2%	88.0%	92.6%	89.7%	
Outpatients	Outpatients - FFT Responses	400	158	141	73	144	133	171	166	229	229	305	408	516	2157	
Community	Community - FFT % Positive	>90%	97.0%	98.0%	96.3%	98.5%	97.3%	97.5%	97.5%	97.9%	97.5%	98.4%	98.1%	98.2%	97.8%	
Community	Community - FFT Responses	1500	873	812	983	753	778	752	628	563	609	621	645	880	5476	
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%	100.0%	89.9%	
All Areas	Complaints (including complaints against Corporate division)	N/A	22	34	21	48	23	23	31	26	38	32	25	19	217	
Community	End of Life % of patients dying in Pref. Place of care - DN	>70%	59.1%	65.6%	76.0%	75.0%	95.5%	100.0%	96.0%	84.4%	85.7%	72.0%	71.4%	85.7%	86.7%	

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Caring Services - Commentary

FFT

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.
All underachieving areas have improvement actions in place.

Complaints

Achieved

Effective 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	Q3 Nov-16	2016-2017	Performance
Maternity	Breastfeeding Initiated	>90%	87.4%	91.7%	92.3%	93.3%	91.8%	93.4%	90.5%	95.2%	91.5%	90.6%	94.2%	90.2%	92.2%	
Maternity	Smoking at Delivery	<6%	6.0%	3.0%	7.4%	4.1%	4.4%	6.6%	6.2%	3.9%	4.4%	4.8%	3.2%	5.1%	4.8%	
Admitted	Emergency Re-admissions within 30 days	<14.2 %	12.7%	13.0%	13.6%	13.2%	11.4%	12.6%	16.3%	15.2%	14.1%	13.5%	14.6%	14.0%	14.0%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	70.2	111.3	82.8	94.0	75.8	79.0	70.4	104.8	83.0				82.1	
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	85.9	88.2	68.9	54.8	42.7	121.8	61.6	76.4	77.3				76.0	
Trust	Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 mont...	1.14	0.67			0.68			0.69						0.69	
Admitted	Mortality rate per 1000 admissions in-months	14.4	6.9	8.2	6.7	7.5	6.5	4.7	6.1	5.8	5.8	4.2	6.5	7.9	5.9	

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Effective Services - Commentary

All targets achieved this month.

Responsive 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	Q3 Nov-16	2016-2017	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	91.5%	84.6%	84.0%	81.6%	84.1%	85.9%	87.7%	87.9%	92.7%	93.4%	88.1%	85.1%	88.1%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	81	85	94	103	88	88	85	87	60	62	75	88	78	
ED	Ambulance handovers waiting more than 30 mins	0	5	5	3	21	23	20	28	31		16	26		144	
ED	Ambulance handovers waiting more than 60 mins	0	0	0	0	0	0	2	9	0		0	1		12	
ED	12 hour trolley waits in A&E	0	0	0	1	0	0	2	1	1	0	0	1	1	6	
Cancer	Cancer - 14 days to first seen	>93%	88.0%	93.2%	99.5%	98.9%	97.4%	96.4%	96.4%	97.3%	97.7%	96.6%	98.7%		97.2%	
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	90.8%	92.7%	98.3%	99.4%	98.1%	95.4%	99.2%	100.0%	100.0%	100.0%	100.0%		98.7%	
Cancer	Cancer - 62 days from referral to treatment	>85%	91.7%	93.8%	81.6%	91.4%	87.2%	83.6%	94.9%	83.3%	93.5%	74.5%	84.4%		85.8%	
Cancer	Cancer - 31 days to first treatment	>96%	100.0%	100.0%	100.0%	97.5%	100.0%	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%	98.4%	99.1%	98.8%	99.4%	99.6%	99.4%	99.9%	99.3%	99.5%	99.7%	99.5%	99.8%	99.6%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.1%	92.3%	92.1%	92.7%	93.9%	93.8%	94.2%	93.9%	92.7%	93.1%	92.9%	92.6%	93.4%	
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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Responsive Services - Commentary

ED four hour waits
The ED four hour wait indicator continued to decline in November 2016 following improvements seen in August 2016 into September 2016 as activity has increased. There was increased pressure on beds during November due DTOC's and increase in number of patients with lengths of stay over 7 days and ED have seen several shifts cancelled due to sickness. In order to focus on improving the performance the organisation have been working closely with the ECIP team who have undertaken 2 visits during November / December and are preparing a report with recommendation for improving.

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 patient waiting for a mental health bed for over 12 hours. Internal investigations have taken place and appropriate action put in place to mitigate risk going forward.

Cancer – 62 days from referral to treatment
The indicator was non-compliant for the month of October at 83.7% against the standard of 85%. There were 3.5 breaches, 2 in Urology, 1 in Lung & 0.5 in Upper GI.
Issues: Lung - complex & patient choice, Urology – delays in treatment at UCLH, Upper GI – diagnostic delay at RFH.
All cancer patients are being reviewed on a regular basis to avoid breaching.
Early indication for November data shows the indicator is achieved.

Responsive 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	Q3 Nov-16	2016-2017	Performance
Theatres	Hospital Cancelled Operations	0	1	16	3	3	19	4	7	1	6	1	5	6	49	
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	218	143	102	183	148	129	273	240	191	199	364		1544	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	5.3%	4.3%	2.4%	4.1%	3.8%	3.3%	7.4%	6.3%	5.5%	5.7%	10.1%		5.1%	
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%	67.2%	62.2%	
Community	IAPT Moving to Recovery	>50%			47.1%		47.4%	51.6%	48.0%	50.0%	51.7%	52.3%	45.7%		49.7%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%					95.7%	95.0%	90.5%	95.1%	93.8%	94.6%	94.4%		94.1%	
Community	GUM - Appointment Offered within 2 days	>98%	99.0%	98.1%	99.4%	98.9%	98.7%	98.5%	99.7%	95.6%	97.8%	99.2%	99.9%	99.6%	98.7%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	80.8%	87.7%	83.8%	85.7%	88.6%	89.8%	87.9%	93.2%	94.6%	94.2%	91.8%		91.4%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	91.5%	94.5%	92.8%	94.7%	95.1%	96.1%	94.4%	94.9%	93.7%	88.3%	93.3%		93.7%	

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Responsive Services - Commentary

Hospital Cancelled Operations

There were 6 cancelled operations in November 2016

Reasons

1 patient was cancelled as previous patient had a cardiac arrest which impacted on theatre time.

1 kit was ordered but not available on time.

1 wrong transport booked so patient could not be done due to recovery time.

3 procedures overran which impacted on theatre time.

Delayed Transfer of Care % of Occupied Bed days

Delayed Transfer of Care spiked in October and this is continuing into November for the following reason:

The number of complex patients with complex discharge pathways has increased as result of diverted ambulances from North Middlesex Hospital. An increased number of patients from the borough of Barnet impact on more bed occupancy therefore there is a reduction in bed availability affecting flow.

IAPT

The recovery rate has dropped to 45.7% this month. A deep dive into the data showed a higher dropout rate in October which equated to a lower average number of treatment sessions per patient. This directly affects recovery data. The changeover in 7 trainee staff may have played a part which happened between September and October. Many would have closed the cases in their caseload in bulk and this process change affects the data. Lastly due to the small sample size of people completing treatment per month, the recovery rates are highly volatile. If 8 more patients had moved to recovery in October, we would have had a 50% recovery rate.

This analysis suggests to us that this is an unusual monthly occurrence, but we have continued and stepped up our improving recovery rate CPD programme. Patient Satisfaction remained 99%.

New Birth Visits October 2016
Haringey new births within 10-14 days fell slightly this month but remain in line with yearly average.
Islington is back to yearly average from previous month's fall.
Health Visitor vacancies remain a significant issue for both boroughs as New Birth Visit's performance directly related to this.

Islington: 16 (6.72%) late visits
4x parental choice 4x in hospital 1x late notification 1x staying elsewhere (remainder moved out/were completed but not recorded as such)

Haringey: 28 (8.19%) late visits
Breakdown from 3x localities: 8 in hospital, 4x late notifications, 3x no access
Information not available for Stuart Crescent

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	Q3 Nov-16	Performance
HR	Appraisals % Rate	>90%	76%	74%	74%	72%	71%	69%	68%	67%	66%	63%	66%	66%	
HR	Mandatory Training % Rate	>90%	83%	82%	82%	82%	81%	81%	81%	81%	81%	80%	81%	81%	
HR	Permanent Staffing WTEs Utilised	>90%					87.1%	87.7%	87.8%	86.2%	87.1%	87.0%	88.1%	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%	2.8%	
HR	Staff turnover %	<10%					14.9%	14.9%	15.8%	15.7%	15.5%	15.7%	15.4%	14.9%	
HR	Vacancy % Rate against Establishment	<10%					12.9%	12.3%	12.2%	13.8%	12.9%	13.0%	11.9%	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.

Both appraisal and mandatory training compliance remain static at 66% and 81% respectively. Each ICSU and Directorate have developed action plans to achieve the target of 90% by year end.

Sickness absence overall has fallen slightly from 3.3% to 2.8% and remains below the target of 3.5%. Turnover has reduced slightly with vacancy rate remaining static.

Activity - Indicators and Performance

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	Q3 Nov-16	Activity
ED	ED Attendances	**8605**	7878	8540	7908	8277	7513	8020	8253	8271	
ED	ED Admission Rate %		17.6%	18.1%	17.8%	18.1%	17.8%	16.7%	16.2%	16.6%	
Community	Community DNA Rate %	**<10%**	5.6%	5.2%	5.3%	5.4%	5.3%	5.3%	5.0%	5.2%	
Community	Community Paediatrics (<16) DNA Rate %	**<10%**	6.3%	6.7%	6.8%	7.4%	7.6%	5.8%	5.9%	6.4%	
Community	Community Adults (>=16) DNA Rate %	**<10%**	5.3%	4.6%	4.7%	4.8%	4.8%	5.1%	4.7%	4.7%	
Community	Community Face to Face Contacts		58778	60545	61181	58082	54134	59567	58980	62493	
Admissions	Elective and Daycase		1861	1860	2082	2004	1769	1935	1946	1874	
Admissions	Emergency Inpatients		2129	2255	2175	2322	2117	2079	2036	2125	
Referrals	GP Referrals		6714	6179	6435	6144	5910	6352	5979	6275	
Maternity	Maternity Births	**333**	325	324	311	340	299	337	315	324	
Maternity	Maternity Bookings	**377**	331	383	403	354	299	301	353	365	
Outpatients	Outpatient DNA Rate % - New	**<10%**	12.3%	12.1%	11.7%	11.7%	11.9%	12.3%	11.1%	11.4%	
Outpatients	Outpatient DNA Rate % - FUp	**<10%**	11.4%	10.5%	10.2%	10.3%	9.8%	11.2%	10.1%	10.3%	
Outpatients	Outpatient New Attendances		12862	13711	14025	13085	12655	13316	12859	13898	
Outpatients	Outpatient FUp Attendances		29767	31552	32887	31113	30959	32001	31646	33131	
Outpatients	Outpatient Procedures	**1279**	5595	5869	6291	6173	6262	6013	6258	6111	
Theatres	Theatre Utilisation	**>95%**	78.1%	81.5%	80.7%	78.3%	78.2%	81.8%	81.5%	83.7%	

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Activity - Commentary

This is the first time the Activity slide has been included in the new style dashboard.

ED attendance is measured against the average number of expected attendances a month.

Community DNA
Achieved target

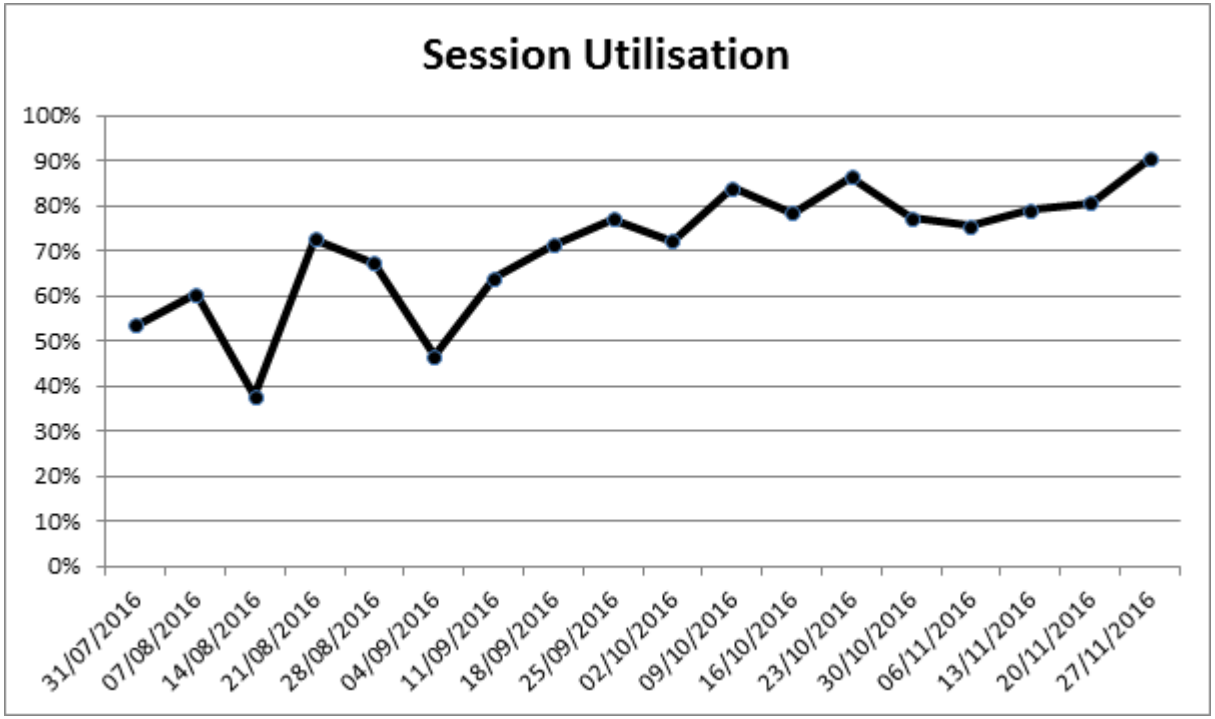
Hospital DNA
Just underachieving

Activity for Community, Hospital, Maternity and GP referrals
For information

Theatre utilisation
For November 2016 performance is 84%
All specialities managed performance over 80% apart from Urology with 79% however this is improving.
Actions:
New supervisor in booking team started to ensure processes are robust and adhered to ensuring high utilisation.
Reviewing organisation of urgent and trauma cases to ensure used properly thus not encroaching on elective lists.
Actions to reduce cancellations on the day are: checking booked equipment is available and the pre op assessment has been undertaken in a timely manner.

The table chart below shows the improvement in theatre utilisations over the last months.

Activity - Commentary



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Whittington Health Trust Board

4 January 2016

Title:	LUTS action plan and progress report		
Agenda item:	**17/011**	**Paper**	**8**
Action requested:	To note progress against action plan		
Executive Summary:	This paper consists of a progress report and the action plan produced in response to the recommendations from the RCP invited service review of the LUTS service, which was received by the Trust on 19 October 2016. The action plan will be discussed at Quality Committee and the CQRG.		
Summary of recommendations:	To agree the next steps		
Fit with WH strategy:			
Reference to related / other documents:	RCP invited service review May 2016.		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	BAF risk as corporate risk (reference BAF2)		
Date paper completed:	28 December 2016		

Author name and title:		**Siobhan Harrington Director of Strategy**		**Director name and title:**		**Siobhan Harrington Director of Strategy Richard Jennings Medical Director**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Risk assessment undertaken?**		**Legal advice received?**	

Trust Board Progress update regarding LUTS service

1. This paper updates the Board on progress made against the action plan in place to meet the recommendations of the RCP invited service review of the LUTS service. The review was conducted in May 2016 and the final report received in October 2016; an interim letter was received in May 2016 which enabled key actions to be progressed.

2. The action plan is attached as appendix 1.

Overall progress has been made although there are a key number of areas where work needs to be completed. As a team we are working to conclude the actions so that we can assure the Board with regard to the two criteria set:-

- A succession plan having been agreed
- Safety and governance concerns raised by the RCP review having been satisfactorily addressed from WH and commissioners' perspectives

The LUTS service will continue and will reopen to new patients once we have secured the detail of the succession plan with UCLH colleagues and commissioners, and when the commissioners and the Trust Board are assured that safety concerns have been addressed. We are aiming to conclude the final actions by the end of March 2017.

3. Key areas of progress

Since the last discussion at Trust Board in November the key areas that have progressed are

3.1 Integrating the Artemis IT with the Trust IT
3.2 Continuing to strengthen the MDT working jointly between WH and UCLH
3.3 Identifying a paediatrician from GOSH who will work on the paediatric pathways
3.4 Professor Malone Lee and his team continuing the clinic and strengthening the clinical governance arrangements
3.5 Ongoing communication with service users, Overview and Scrutiny colleagues and responding to MP letters
3.6 Agreeing the detail of the review regarding Nitrofurantoin prescribing

4. Key risks and mitigations

There remain a number of risks in securing the future arrangements

4.1 The agreement on a final succession plan and sustainable and viable model of care for the LUTs clinic. There has been progress with colleagues from UCLH however this will need a reviewed focus. Through January discussions will continue with the Trust and also commissioners to secure the future sustainable model.
4.2 The contracting and financial arrangements of the clinic will need to be agreed with commissioners and work progressed to secure a tertiary setting for the clinic.
4.3 In order to allay safety and governance concerns there are a number of aspects that need to be addressed. The review of patients prescribed Nitrofurantoin will be completed. A desktop review will be completed where the various policies, audit programme and clinical governance activities will be reviewed in January. This will enable any gaps to be addressed.
4.4 Communication with service users and ensuring that we continue to keep local councillors and MPs informed of progress.

5. Proposed next steps

Through January final agreement needs to be reached with colleagues from UCLH.
There are plans for a meeting with commissioners to discuss the detail of progress against the action plan and the future sustainable model for the clinic.
The review of Nitrofurantoin patients will commence and aim to conclude by the end of February.
A desktop review of the clinical governance arrangements will be conducted with the Medical and Nursing Director and ICSU so that any potential gaps can be addressed.
Further service user meetings will be held.
A final report will be brought to the March Trust Board on actions completed and an assessment of achievement of the criteria previously set to enable the clinic to reopen.

Appendix 1: Action Plan re RCP Review LUTS clinic. December 2016

Task No	Action	Timescale as per RCP report received 19 October	Progress
1.	At the conclusion of the review visit, the review team provided immediate feedback to the Trust regarding potential patient safety concerns that required intervention. This feedback was confirmed in a letter sent to the Trust by the medical director for Invited Service Reviews on the 19 May 2016. This was followed up by an additional letter highlighting potential concerns about further cases of pulmonary fibrosis associated with nitrofurantoin in LUTS patients.	**0-3 months** Review will be completed by March 2017.	• **RJ created draft action plan for this task and received feedback from key stakeholders.** • **James Malone-Lee reviewed the LUTS database on the 13 patients who also had a diagnosis of pulmonary fibrosis, and wrote a report, with additional information, on 28.08.2016.** • **RJ wrote to the Head of Medicines Management for Islington CCG and internal Trust experts for specific advice about thresholds for investigation.** • **RJ identified an independent respiratory physician to complete the review.** • **RJ wrote to the Head of Medicines Management for Islington CCG about an expert on pharmacovigilance, on 22.11.2016.** • **Review to be completed by March 2017.**
2.	The Trust must provide sufficient resource and focus to investigate these and other potential safety concerns raised by its own governance systems, our review and its principal commissioners.	**0-3 months** Resource identified.	• **Internal project resource identified.** • **IT resources to integrate Artemis (stand-alone LUTS clinic record system) with the central Trust patient record system and this will be done by 31.12.2016.** • **Clinical audit requirements for the LUTS clinic review complete and agreed:** o **Control Audit due in February 2017** o **Document and Consent Audit due in August 2017.** o **Patient Experience Audits to be confirmed.**
3.	The Trust should continue to provide access to the LUTS clinic for those patients already registered with it and until such a time that long term succession plans have been agree and implemented. It may be appropriate for some patients to subsequently be referred to other services but there are likely to be a significant number of patients who will need to continue to access the service.	**0-6 months** Continuity of service in place.	• **Continuity of service provision in place.** • **The MDT is now established at UCLH and arrangements continue to be strengthened.** • **Discussions continue to take place with UCLH, commissioners and service user to ensure a sustainable and viable safe tertiary service.**
4.	The management of these patients, including the medication prescribed, its doses and durations, should be reviewed,	**0-6 months**	• **MDT in place with WH and UCLH.** • **NH now chairing the MDT.**

	discussed and agreed at properly constituted and well managed MDT meetings with additional resources committed to it as required.	Joint UCLH/WH MDT in place	• **TOR's for UCLH/WH MDT to be formalised and approved by both Trusts.** • **First MDT meeting was held on 14.07.2016, 6 MDTs have been held so far. Each MDT is held on the second Thursday of every month.**
5.	The information provided by the LUTS clinic to its patients on the treatments and their associated risks should be reviewed to ensure its accuracy. It will be necessary to provide patients with updated information on the risks of their medications and discuss further their preference in terms of on-going treatment.	**0-6 months**	• **Information in place.** • **Desktop review to be conducted.**
6.	The existing restriction for a requirement of consultant paediatrician input for current paediatric patients should remain in place with oversight being provided by a consultant paediatrician. It would be beneficial to ensure these patients are discussed in the LUTS MDT meeting with input from the consultant paediatrician involved.	**0-3 months** In place	• **Progress has been made with colleagues from GOSH and JML. A Consultant Paediatric Nephrologist from GOSH has agreed to be involved in the Paediatric Pathway.** • **This has the support of the Medical Directors of both WH and GOSH.** • **The restriction around the treatment of patients by the LUTS clinic remains in place.** • **Detail on pathway with GOSH to be agreed in January.**
7.	The Trust should review the LUTS clinic's current use of telephone and virtual review appointments and prepare a clear policy on its expectations about how patients are reviewed.	**0-6 months**	• **Policies to be reviewed as part of desktop review in January.**
8.	The Trust should consider where the clinic should be housed in the short term until longer term succession plans have been agreed. It should seek to locate it more clearly within its own hospital premises to allow the Trust to better support and oversee the clinic.	**0-6 months** Complete	• **The Trust has consulted with the service user group and has agreed for the service to continue for now at Hornsey.**
9.	The clinic should undertake audits of patient outcomes and of consent to unlicensed treatments.	**6-24 months**	• **Audit programme being agreed.**
10.	To ensure that treatment is provided in a safe manner the	**0-6 months**	**In order to strengthen governance within the service, the**

	Trust should put in place robust clinical governance processes to monitor the outcomes, side effects and any adverse effects experienced by the clinic's patients. The Trust will need to resource these measures appropriately.	Resource in place Clinical Governance process IT access to records	**Trust expects the service to deliver within the policies and clinical governance processes of the Trust. The service requires:** • **Regular audit - Support has been offered and accepted in completing any national and Trust-wide audits for the service. Infection Control and Record Keeping Audits due February and August 2017 respectively.** • **Robust arrangements to gain and record informed patient consent to treatments** • **Incident reporting** • **Mandatory training – The clinic is up-to-date on all Mandatory and Statutory training** • **Patient safety** • **Protocols in place – protocol received 29 August** • **Information Governance training complete** • **Records Management** • **Trust I.T integrated Artemis, Datix etc – I.T systems will be in place by end of December**
11.	If any serious incidents, associated with the LUTS clinic, were to be identified by the Trust these should be appropriately escalated and investigated utilising the Trust's established clinical governance processes. The Trust would need to consider the outcome of any such investigations to determine if the continuation of the existing clinic is considered safe.	**0-6 months** Ongoing	• **There has been one logged Serious Incident– the investigation is complete but awaiting completion of actions.** • **The Serious Incident report has been completed – RCA report has been shared with the family.**

12.	The current corporate provision of serious incident investigations needs significant enhancement to provide timely and comprehensive investigation. Investment in the medical directorate structure is also required and robust processes put into place to ensure learning from clinical incidents is shared.	**0-6 months** Complete	• **Two Associate Medical Director posts were created in 2015/16. Mr Robert Sherwin was appointed to the role of Associate Medical Director (AMD) for Revalidation on 01.02.2016.** **Dr Julie Andrews was appointed to the role of AMD for Patient Safety on 01/02/2016.** • **The Trust Board receives Quarterly Safety and Patient reports; the last two reports were received by the Board on 01.06.2016 and 07.09.2016.**
13.	The Trust should conclude the serious incident investigation regarding nitrofurantoin toxicity and share the findings and recommended actions with the patient who was harmed and the clinic team ensuring lessons are learned. Similarly, the Trust should review patient admissions to secondary care during the period in which the LUTS clinic was "suspended", other potential harms with nitrofurantoin and the true incidence of *Clostridium difficile* should be completed.	**0-6 months** Complete	• **An SI involving Nitrofurantoin – this investigation has been completed and the RCA report has been shared with the family.** • **Review of emergency admissions during the suspension of the LUTS service complete.** • **If a C.Diff case was associated with a LUTS patient this would be highlighted by the Post Infection Review that is completed on each case, which would then be highlighted through the ICSU and clinical team associated with the patient.**
14.	A clear definition of the involvements of the Trust's microbiology services in the LUTS clinic's work should be put in place to include UKAS accreditable performance of the clinic's arrangements for urine microscopy.	**0-6 months** Complete	• **The microbiology laboratory will continue performing investigations on LUTS clinic patient using the standards outlined in the UK agreed standard document.** • **JML is currently in discussion with NICE regarding urine testing techniques.**
15.	A review of the LUTS clinic's method of prescribing should be carried out and a clear policy put in place as to how medications should be prescribed and dispensed.	**6-24 months**	• **Policy is in place.**
16.	The Trust should ensure that information held by the LUTS clinic about its patients is fed in to the Trust's central electronic patient records system and that there are clear	**6-24 months**	• **IT system integration will be completed by the end of December 2016.**

	flows of information in each direction.		
17.	The Trust should identify who can take over the management of the LUTS clinic in the short term, once Professor Malone-Lee retires later this year. The issue of oversight and development of independent practice for junior doctors and nurses in the clinic needs attention and should be encouraged in line with good medical and nursing practice.	**0-3 months** Plan from September for Clinical Leadership and Consultant input	• **JML has agreed to 4 clinical sessions a week. His contract has just been extended for a further 3 months from December 2016 to March 2017.**
18.	A succession plan should urgently be developed in direct dialogue between the Trust and Professor Malone-Lee. This should include direct high-level dialogue with neighbouring tertiary centres such as UCLH or other tertiary centres. Succession should focus on the development of multi-disciplinary team working to ensure resilience in the service, and to overcome the reliance on any one individual. The Trust should ensure they take steps to regularly update the patient representatives and service users on these plans as they develop.	**0-6 months** NOT YET COMPLETE Ongoing communication and engagement of JML and Patient Representatives	• **Clinical Collaboration meetings are being held with UCLH colleagues.** • **Final succession plan will require the approval of the CCG's.** • **Progress on the succession plan includes identification of some additional WH consultant support and UCLH consultant support.** • **The Trust is currently negotiating extra support from UCLH.** • **A letter was sent out to all LUTS clinic patients on 20th November 2016.** • **Service users group regularly meeting. Since May there have been 5 meetings with the last one in December 2016.** • **Communication with Overview and Scrutiny Committees and MPs continues.**
19.	The Trust should engage in direct, high-level dialogue with local clinical commissioning groups and with neighbouring tertiary centres to agree a strategy for the long-term future of the LUTS clinic. This should include a review of what treatments are likely to be commissioned, whether the clinic should open to new patients, which providers are best placed to offer them and whether the treatment to be offered would be part of the research framework.	**6-24 months** NOT YET COMPLETE	• **A meeting will be held in January 2017 with commissioners to discuss the strategy for the long-term future of the clinic.**
20.	The future of the clinic would be safer and better regulated with a fresh start in a tertiary centre such as UCLH that has a mix of appropriate specialties, and could offer true disciplinary working. Clinicians working in such an environment will safeguard care of patients by peer review, good teamwork	**6-24 months** NOT YET COMPLETE	**See box 18 and 19 above.**

	and integration with Trust governance processes.		
21.	Until the future of the service has been determined by the Trust and commissioners, no new patient referrals should be accepted into the LUTS clinic.	**0-6 months** NOT YET COMPLETE	• **On 02.11.2016 the Trust Board agreed that new referrals would only be accepted by the LUTS clinic if the following criteria were met:** - **Quality and safety concerns have been resolved** - **A clear succession plan in place**
22.	In view of the significant patient interest, reputational risk, and pressure on individuals, the Trust should invest in significant project management to provide additional capacity and capability to deliver both strategic and operational work including governance improvements for the LUTS service.	**0-6 months** Under review	• **Project management support has been in place and is currently being reviewed.**
23.	Support must be offered to Professor Malone-Lee during what will likely be a very difficult and stressful period of time for him personally prior to his retirement.	**0-3 months** Ongoing	• **The Trust has continually offered support during this period; this offer was reiterated during the last meeting of 15th November 2016 and also in December 2016.**
24.	UCL should be urgently reminded of their employer responsibility regarding provision of this clinic that is entirely focused around one individual they employ who has an honorary contract with the Trust.	**0-3 months** Complete	• **RJ shared the report with the Dean of UCL Faculty of Medical Sciences, on 21.10.2016.**
25.	UCL should be urgently engaged to fulfil its responsibilities regarding oversight of the LUTS clinic's research and the use of research data to make individual patient treatment decisions and how the research findings published by Professor Malone-Lee have been translated in to clinical practice in the LUTS clinic. Any new information should be utilised in conjunction with the Trust to plan the future of the service.	**0-3 months** Complete	• **See box 24 above.** • **Research governance arrangements have been confirmed with UCL and WH research teams in December 2016.**
26.	UCL should state its intentions regarding carrying out further research in the field of the lower urinary tract infection and the Trust should discuss with them what its intentions are for the future delivery of the clinic, including the acceptance of new patients.	**6-24 months** Complete	• **UCL's Vice-Dean for Research and UCL's Dean of the Faculty of Medical Sciences have responsibility for the research that is on-going in the LUTS clinic. UCL statement received.**
27.	When Professor Malone-Lee retires and if he then continues to practice privately, there would need to be formal discussion with his new Responsibly Officer or the regulator the GMC, to	**0-6 months**	• **Professor Malone-Lee has offered assurance to the Trust that all private sessions take place not on Whittington Health premises. JML is working at a**

	ensure any future private practice arrangements are safe.		**private clinic which is listed as a Designated Body and has an RO. However, JML's RO continues to be WH RO and his NHS practice is subject to arrangements with WH RO.**

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Whittington Health Trust Board

[4 January 2017]

Title:	This is an annual report of emergency preparedness, resilience and response (EPRR) arrangements for the Trust.		
Agenda item:	**17/012**	**Paper**	**09**
Action requested:	For information		
Executive Summary:	This paper outlines the progress that the Trust has made over the last 12 months in EPRR arrangements and an update on the plans in place that the Trust is required to prepare for and respond to a wide range of emergencies that could impact on health or patient care. The Trust continues to be represented at appropriate levels in the various London wide EPRR arrangements. The Trust undertakes various training & exercising initiatives relating to Emergency and Business Continuity and also participates in exercises run by partner organisations, and those on a larger scale run across sector.		
Summary of recommendations: For Information	On the 18th of October Whittington Health's EPRR systems were reviewed by the NHS England NENC Assurance Team. Whittington Health was scored as "Substantial" as part of the yearly review. The review outcome informs the action plan for the ensuing year.		
Fit with WH strategy:	Fulfil all relevant legal and contractual EPRR requirements including, the Civil Contingences Act 2004 and NHS England Emergency Preparedness Framework & core standards 2016		
Reference to related / other documents:	EPRR policy, Business Continuity Management Policy.		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Not applicable		
Date paper completed:	17/11/16		

Author name and title:		**Lee Smith Emergency Planning Officer**		**Director name and title:**		**Carol Gillen Chief Operating Officer**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE
2016/2017 ANNUAL REPORT

1.0 EXECUTIVE SUMMARY

All NHS Organisations are required to prepare for and respond to a wide range of incidents or emergencies that could impact on health or patient care. These could be anything from extreme weather events, infectious disease outbreaks, terrorist attacks to major transport accidents. Furthermore, NHS Organisations must be internally resilient and be able to respond safely to such incidents, or other internal disruptions, whilst maintaining its services to patients.

The Civil Contingencies Act (CCA) 2004 places a number of duties on both Category 1 and 2 responders to ensure they are adequately prepared to respond to an emergency. The Trust is defined as a Category 1 responder under the CCA 2004 and therefore has a legal obligation to comply with a number of statutory duties. The CCA 2004 brings together both Category 1 and 2 responders within a framework to ensure greater consistency and co-operation at the local level.

The Trust continues to be represented and involved at appropriate levels in the various London wide Emergency Preparedness, Resilience and Response (EPRR) arrangements. The Trust undertakes various training and exercising initiatives relating to Emergency and Business Continuity and also participates as appropriate in exercises run by partner organisations, and those on a larger scale run across sector.

2.0 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

The CCA 2004 places duties on all trusts to cooperate and share information with, and to coordinate efforts and work jointly with, partner organisations in Local Resilience Forums to ensure that emergency planning and preparedness is properly coordinated within each area, thus facilitating effective response to Major Incidents, and other emergencies or significant service interruptions.

The NHS England Emergency Preparedness Framework 2015, core standards and a number of significant guidance documents have informed the Trust's emergency planning. Some of these are specifically referred to below in the relevant sections of this report.

It is essential that the Trust Board be kept appropriately informed regarding EPRR, which includes planning for major incidents and emergencies, business continuity issues and any other scenarios with the potential to seriously disrupt the running of the Trust or the delivery of its services.

3.0 RESPONSIBILITY AND ACCOUNTABILITY

The Health and Social care Act 2012 places upon NHS-funded organisations the duty of Accountable Emergency Officer with regard to emergency preparedness, resilience, and response (EPRR) (Section 46.9). In line with NHS England guidance, Carol Gillen Chief Operating Officer (COO) has been designated to take responsibility for EPRR on behalf of the organisation known as the Accountable Emergency Officer (AEO) and the Emergency Planning Liaison Officer (EPLO). The COO is responsible for ensuring that the Trust has a Major Incident Plan in place based on the duties of the CCA i.e. risk assessment, cooperation with partners, emergency planning, business continuity management, communication with the public and information sharing. This is supported on a day to day management of emergency response by the Emergency and Business Continuity Planning Officer Lee Smith.

4.0 FRAMEWORK FOR EMERGENCY PREPAREDNESS WORK WITHIN WHITTINGTON HEALTH

The Emergency Management Steering Committee has met throughout the year in order to ensure that the emergency preparedness agenda continues to progress and to facilitate the increasingly requirement to have standardised Trust wide business continuity plans The group is chaired by Carol Gillen and includes senior representatives from each Directorate as well as a number of other key individuals from specific services.

The work of this group is critical to the Trust's ability to respond effectively to any emergency or major incident, and to its ability to continue to deliver agreed levels of services during any crisis. Directors are therefore expected to give the work and requirements of the group high priority, ensure they actively support it, and ensure all within 'their' services comply with its requirements and expectations. The committee reports through to Trust Operating Board (ToB) which in turn reports directly to the Executive Committee (EC).

An EPRR policy and Business Continuity Management (BCM) policy has been written to outline how emergency management will be implemented into the Trust to ensure we are meeting our legal obligations.

5.0 NHS ENGLAND EPRR AND CBRN CORE STANDARDS ANNUAL ASSURANCE

This year Whittington Health was reviewed on the 18th of October by the North East North Central NHS England Assurance Team. There was an intense review which focused on business continuity. Whittington Health was assessed for compliance against the EPRR Core Standards.

The EPRR Core Standards set out by NHS England enable the Trust to co-ordinate activities and provide a consistent cohesive framework for self-assessment, peer review and assurance processes. There is also core standards related to the response to chemical, biological, radiation, and nuclear (CBRN) incidents.

The core standards have gone through a national review and have changed from 2016 process, this includes less core standards and the process which NHS England (London) have taken to review the organisations is a fairer system across all organisations.

This document is V4.0. The following changes have been made 2016:

• Inclusion of Business Continuity questions to support the 'deep dive' for EPRR Assurance 2016-17, replacing the Pandemic Influenza tab

• Inclusion of the Hazardous Response Area Response Team (HART) service specification for ambulance service providers and the reference to this in the EPRR Core Standards

• Inclusion of the Marauding Terrorism Firearms Attack (MTFA) service specification for ambulance service providers and the reference to this in the EPRR Core Standards

• Updated the requirements for primary care to more accurately reflect where they sit in the health economy

• update the requirement for acute service providers to have Chemical Exposure Assessment Kits (ChEAKs) (via PHE) to reflect that not all acute service providers have been issued these by PHE and to clarify the expectations for acute service providers in relation to supporting PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, should this be required.

The Trust will go through annually an assurance review with NHS England (London) against the core standards, this year that has involved a self-assessment involving RAG rating using Red, Amber Green system – see below.

Red = Not compliant with core standard and no evidence of progress

Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.

Green = Fully compliant with core standard.

This was followed by a challenge and review session involving NHS England (London), Clinical Commissioning Group (CCG) and a peer reviewer (Emergency Planning Officer from another Acute Trust) where we went into more detail on each of the core standards and they asked for more evidence to support the RAG rating. This was also carried out in a similar way with the CBRN core standards but was attended by London Ambulance Service instead of the CCG.

The tables below show the results of the 2013, 2014 2015, 2016 EPRR and CBRN core standard assurance illustrating a significant improvement over the 12 months with work on EPRR. NHS England (London) also informed that the Trust that the overall score for this year is "**Substantial**" compliance. This indicates an improvement on last year. Areas of outstanding performance identified by NHS England include the Pandemic Flu Plan and Business Continuity Management

EPRR and CBRN **2016** assurance outcome

NHS England Core Standards	Core Standards total:	Assessment outcome Red	Assessment outcome Amber	Assessment outcome Green
EPRR	37	0	3	34
CBRN	14	0	2	12
Business Continuity	6	0	0	6

EPRR and CBRN **2015** assurance outcome

NHS England Core Standards	Core Standards total:	Assessment outcome Red	Assessment outcome Amber	Assessment outcome Green
EPRR	37	0	5	32
CBRN	14	0	4	10
Pandemic Flu	4	0	0	4

EPRR and CBRN **2014** assurance outcome

NHS England Core Standards	Core Standards total:	Assessment outcome Red	Assessment outcome Amber	Assessment outcome Green
EPRR	47	0	4	43
CBRN	14	0	4	10

EPRR and CBRN **2013** assurance outcome

NHS England Core Standards	Core Standards total:	Assessment outcome Red	Assessment outcome Amber	Assessment outcome Green
EPRR	109	3	46	60
CBRN	23	3	8	12

Assurance Review Team Summary 2016

- The Trust now has a permanent EPLO in place, which was based on the recommendations from the NHS Assurance Team in 2015.
- The Trust continues to demonstrate improvements to its preparedness and response since the 2015-16 Assurance process.
- It is recommended that the ELPO engage with the Community and Mental Health Learning Set. The current chair is Katy Tame katy.tame@nhs.net.

Pandemic Flu Feedback

Organization	Patch	Provider/ CCG/ CSU	2016 RAG	2016 Feedback
Whittington	NENC	P	G	A comprehensive plan with detail about actions during the UK response stages. The UK response tables would benefit from including details of who is responsible for the various actions to ensure delivery. You could delete NHS Direct from the table on p46.

Business Continuity Feedback

Organization	Patch	Provider/ CCG/ CSU	2016 RAG	2016 Feedback
Whittington *Deep Dive*	NENC	P	G	The Trust has maintained a robust business continuity management process within the Trust. Work is ongoing to implement formal BC checks as part of procurement/ commissioning processes.

CBRNe/ HAZMAT Assurance Visit

- The Trust has improved since the 2016 Assurance Process. We have reduced the Amber score from four to two this year.

Amber Scores 2016/Further Action

1) **Backfilling plan for the ED in the recovery phase of an CBRN event, Identify on Health Roster**
2) **Mass Counter Measures Plan for Mass Prophylaxis**
3) **Completion of the CBRN Major Incident Plan**
4) **Completion of the Evacuation Plan**
5) **A Mass Casualty Plan**

Action plans and governance

Within two weeks of the assurance review meeting being held, the Accountable Emergency Officer must submit the following documentation: NHS England (London) also informed that the Trust that the overall score for this year is “Substantial” compliance. This indicates an improvement on last year. Areas of outstanding performance identified by NHS England include the Pandemic Flu Plan and Business Continuity Management

EPRR and CBRN **2016** assurance outcome

- Results of the organisation’s final EPRR RAG scores, as agreed at the review meeting
- A resulting action/work plan providing clear actions, timescales and leads on areas where the organisation scored Amber which has been submitted
- A declaration of the Level of Compliance achieved (see below)

To enable a national-level overview of EPRR capability each organisation is asked to provide a single self-assessed Level of Compliance, approved by the AEO. This is intended to summarise whether organisations believe they are fully, substantially, partially or non-compliant against the core standards as a whole. The definitions of each term are detailed below:

Compliance Level	**Evaluation and Testing Conclusion**
Full	The plans and work programme in place appropriately address the entire core standards that the organisation is expected to achieve.
Substantial	The plans and work programme in place do not appropriately address one or more the core standard themes that the organisation is expected to achieve.
Partial	The plans and work programme in place do not adequately address several core standard themes that the organisation is expected to achieve.
Non-compliant	The plans and work programme in place do not appropriately address multiple core standard themes that the organisation is expected to achieve.

6.0 EMERGENCY PLANNING – MAJOR INCIDENT

On the 8th of February 2016, Whittington Health conducted Exercise Peripieo, which focused on a Marauding Terror Attack and Cyber disruption. We had representation across the sector with delegates from Local Authorities, Police, LFB, LAS and NHS England present.

On the 14th of April 2016 Whittington Health Participated in Exercise KANIKUL which tested the response of North Central London to a National Level 4 Heatwave. Whittington Health had operational, tactical and strategic representation at the exercise.

6.1 Pre planning - major events

Under emergency management there is also a process to plan for pre identified major events (internally or externally) or upgrades to critical systems. There is a standard template in place which covers:

- Operations
- Logistics
- Communications – internal & external
- Planning – response & recovery

This process has been used for the following events:

- Industrial Action – Health Unions; Junior Doctors; Fire Brigades Union & London Underground
- EPR PAS/ED & BI planned upgrade;
- Medway planned upgrades;
- PACS - imaging planned upgrades;
- Pathology system planned upgrade;
- Monthly generator tests;
- Vacuum plant changeover.
- Generator Upgrade
- Medical Gasses Maintenance
- SCBU environmental clean
- Road Works
- Evacuation Matt training on site and in community.

Following each event a debrief is carried out by the Emergency & Business Continuity Planning Officer with key leads to identify learning in preparation for future major events.

7.0 SERIOUS WEATHER RELATED DISRUPTIONS

There is now a heatwave and cold weather plan for the Trust which follows national guidance. As well as this the advance information and warnings available to the Trust has improved. The
Meteorological Office issues a range of warnings (detailing severity and levels of 'confidence'
In the forecast) which are sent to the Emergency Planning and Business Continuity Officer, Site Managers and silver and gold on call. Thus enabling services to receive (and respond as appropriate to) a range of severe weather related threats and potential service disruptions, without having the receipt of this information delayed by channelling it through one individual or office.

8.0 BUSINESS CONTINUITY MANAGEMENT

The Trust has undertaken initial work on Business Continuity Planning concentrating in the first instance on each Directorate attempting to prioritise services in terms of criticality, and considering the minimum staff levels (and to some extent, skill mix) required to continue delivering these services. However this is still work in progress as there is variation in the quality and standard of the individual service plan. A new Trust template has been agreed and good progress has been made in completion by the services.

Other significant improvements within this area relate to the following - implementation of:

- Business Continuity Management Policy
- Strategic Business Continuity Plan
- Service/Department Business Continuity Plans

9.0 CBRN RESPONSE PROCEDURES

The CBRN response procedure was updated this summer by the newly established CBRN subcommittee from the Emergency Management steering committee. Training and testing of key staff in the use of the decontamination equipment is carried out monthly lead by CBRN lead in ED and supported by Security. There are some changes with regards to methods of decontamination, the new guidance and DVDs are being produced by NHS England which will be distributed to provider Trusts in due course. The subcommittee will oversee the implementation of the changes by April 2015. The course content for CBRN has changed in 2016; we have increased resilience by adding Paul Abdey Resuscitation Lead to the Training Team, whom qualified in September 2016.

10.0 PANDEMIC INFLUENZA PLAN

The pandemic influenza plan has had a complete revision following new guidance and best practice. A new pandemic influenza subcommittee has been established from the Emergency Management Steering Committee to oversee this review. The plan is planned for sign off by the end of December 2014. The Plan was reviewed on the 30th of September and was fully compliant with national standards. The plan continues to receive positive feedback from NHS England in 2016.

10.1 Ebola virus disease

Through the pandemic influenza subcommittee there has been a review of the current guidance from Public Health England and NHS England and the Trust viral haemo fever policy to ensure we are following current guidance.

The Trust has been working closely with partners, including Public Health England and NHS England, to review existing preparedness against the following headings:

- Ensuring that updated viral haemorrhagic fever (VHF) algorithm and associated information is cascaded appropriately
- Engaging in multi-agency preparations
- Personal protective equipment (PPE) stock and resupply mechanisms
- Training of staff in the correct use of PPE and any processes in place
- The mechanism and process for identification and isolation of a suspected case

11.0 COOPERATING AND COLLABORATING WITH MUTLI AGENCY PARTNERS

The Accountable Emergency Officer will ensure there is attendance on behalf of the Trust to the Local Health Resilience Partnerships (LHRP). The Trust's Emergency Planning and Business Continuity Officer continued to maintain positive working relationships with NHS England (London). The Trust representatives regularly attend the North East and North Central London NHS EPRR Network Meeting and both the Borough Resilience Forum in London Borough of Islington and Haringey.

12.0 SUMMARY

The aim of the Trusts Emergency Preparedness arrangements, including its Emergency and
Major Incident Plan, and associated Business Continuity arrangements, is to mitigate loss once an incident occurs; to (as a minimum) maintain previously agreed essential levels of service; and to return to 'normal' service as soon as possible following an interruption. The work of the Emergency Management steering committee and its representatives over the last year has increased the level of engagement of senior managers around the Trust in these processes, leading to significant progress in some areas.

The Trust continues to update its arrangements and amend them in line with national guidance, external advice and experience. Other supporting arrangements i.e. Evacuation plan and rigorous review of the Business Continuity plans across services will be implemented and actioned accordingly throughout 2016.

13.0 ACTION PLAN 2016/2017

It is anticipated that much of the workload for the Trusts Emergency Management Steering Committee over the coming year 2016 to 2017 will related to the following areas that have been rated Amber in from NHS England in 2016

-

NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Cat 1		Cat 2	categoris		Suggested Minimum Level of Evidence to be submitted to review group	Commentary/ References to Evidence Supplied	Self Assessment	Review Team Comment	Time line
	Acute trusts	Ambulanc trusts	CCGs	Communit y	Mental health					
Establishment of a Mass Casualty Working Group	X	X	X	X	X	Development of Mass Casualty Work Group. To Meet every 2 weeks.	Action Tracker		Aim to complete and ratify plan before next NHS England assurance review	Sep-17
Establishment of a Mass Countermeasures/Prophylaxis Working Group	X	X	X	X	X	Work group to be established with members from LRF	Action Tracker		Aim to complete and ratify plan before next NHS England assurance review	Sep-17
Ratification of Evacuation Plan	X	X	X	X	X	Steve Primerose Chair for work group	Action Tracker. Has been reviewed by the Islington LRF 2016		Aim to ratify plan after final review of Draft	Jan-17
Review of skill mix that are CBRN trained on each shift in ED.	X	X	X	X	X	Lee Smith- Lead	Action Tracker. Engagement with Fiona Long establish CBRN identification on the Health Roster		Aim to complete action	Feb-17
Ratification of CBRN plan	X	X	X	X	X	Lee Smith- Lead	Action Tracker. Has been reviewed by the Islington LRF 2016. Has been reviewed bt NENC NHS England. Has been reviewed by LAS		Aim to ratify plan after final review of Draft	Mar-17

- Please refer to the full action plan 20/2017 in the attached link.

Whittington Health
EPRR Assurance.Acti

Carol Gillen
Chief Operating Officer
(Accountable Emergency Officer &
Emergency Planning Liaison Officer)

Lee Smith
Emergency and Business
Continuity Planning Officer

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Magdala Avenue
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Whittington Health Trust Board

4 January 2017

Title:	Information Governance Framework		
Agenda item:	**17/013**	**Paper**	**10**
Action requested:	For approval		
Executive Summary:	The paper lays out the detail of the Information Governance Framework for the organisation which forms part of the evidence for the Information Governance toolkit. It has been approved at the Information Governance Committee and Trust Management Group.		
Summary of recommendations:	To approve the Information Governance Framework		
Fit with WH strategy:	Aligns with governance framework and standing orders		
Reference to related / other documents:	Compliant with Information Commissioner requirements		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	BAF risk re meeting level 2 of the IG toolkit as an organisation		
Date paper completed:	28 December 2016		

Author name and title:		**Ali Kapasi Assistant Director of Information Governance**		**Director name and title:**		**Siobhan Harrington Director of Strategy. SIRO**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Risk assessment undertaken?**		**Legal advice received?**	

Whittington Health NHS

Information Governance Management Framework

Subject:	Information Governance
Approved By:	Information Governance Committee
Date Ratified:	May 2016
Version:	1.8
Policy Executive Owner:	Senior Information Risk Owner (SIRO)
Designation of Author:	Assistant Director of Information Governance
Name of Assurance Committee:	Audit and Risk Committee (ARC)
Ratified by:	Information Governance Committee
Date Issued:	July 2016
Review Date:	July 2017
Target Audience:	All Staff
Key Words:	Information Governance; Confidentiality, Information Security, Safe Haven, Information Sharing, Caldicott Guardian, Data Protection; IT security, Freedom of Information, Records Management, IG Toolkit; Records Management

Version Control Sheet

Version	Date	Author	Status	Comment
1.0	22.11.12	Asst. Dir. Info. Governance	Consultation	To Members of the Information Governance for consultation
1.1	26.11.12	Asst. Dir. Info. Governance	Approved	Information Governance Committee
1.1	March 2013	Asst. Dir. Info. Governance	Ratified	Executive Committee
1.2	June 2013	Asst. Dir. Info. Governance	March 2013 Review	Updated following Audit & Risk Committee approval (07.03.13) clarifying process for monitoring the performance of Trust attainment of IG toolkit Levels; Update following development of Information Risk Assessment Management Programme (IRAMP) & Information Risk Assessment Security Plan (IRASP); Change in SIRO (Richard Martin) 01.06.13; Policies and Procedures updated; ADIG role short term contract extended to Sept 2013
1.3	Feb 2014	Asst. Dir. Info. Governance	Review – draft	Amendments to named officers, new policies and Records Management governance structure
1.4	Feb 2014		Approved	Information Governance Committee
1.5	July 2015	AD of IG	Draft	For approval at Information Governance Committee (IGC)
1.6	July 2015	AD of IG	Approved	Information Governance Committee (IGC)
1.7	May 2016	IG Officer	Approved	For approval at Information Governance Committee (IGC)
1.7	May 2016	IG Officer	Approved	Information Governance Committee (IGC)

Contents

1 Introduction

This document sets out the approach taken by Whittington Health (Whittington Hospital NHS Trust: 'The Trust') to provide a robust Information Governance Management Framework (IGMF) for the current and future management and security of all confidential information (i.e. personal confidential data, commercially or corporate sensitive information).

Information Governance (IG) is as a part of overall governance within the Trust and as a vital component of both planning and healthcare. The IGMF is linked with other strategic initiatives to ensure integration with all aspects of the Trust's business activities.

The IGMF plays a key part in corporate governance, strategic risk, clinical governance, service planning, informatics, performance, the Board Assurance Framework and business management. Achieving Level 2 IG compliance with all IG Toolkit standards is a requisite of the Trust's application for Foundation Trust status.

2 Purpose

The IGMF provides an overview of how the Trust is addressing IG by detailing management and accountability structures, governance processes, documented policies and procedures, training and resources.

The IGMF provides assurance about the capacity and capability of the Trust to support the current and evolving IG agenda.

3 The Information Governance Management Framework

The headings below set out the components that demonstrate how the Trust manages current and future security of confidential information:

3.1 Information Governance Management and Accountability Structure

3.2 Information Governance Process

3.3 Policies and Procedures Associated with Information Governance

3.4 Information Governance Staffing

3.5 Information Governance Resources

3.1 Information Governance Management and Accountability Structure

Senior Roles

Senior roles and duties in the management of IG are as follows:

The Chief Executive Officer (CEO) is the Accounting Officer for ensuring that the organisation operates as an employer and as a user of confidential information in accordance with terms of the Data Protection Act (1998) and NHS Code of Practice on Confidentiality (2003)

The Senior Information Risk Owner (SIRO) is the Senior Management Board Member with overall ownership of the Organisation's Information Risk Policy. The SIRO is the champion for information risk at the Trust Board and provides written advice to the Accounting Officer (the CEO) on the content of the Organisation's Statement of Internal Control in regard to information risk. **The Current SIRO is named as Siobhan Harrington (Deputy CEO & Director of Strategy).**

The Board of Directors is responsible for managing IG risk as an organisation that is a user of confidential information. This includes the following:

- Management of the Trust's activities in accordance with laws and regulations
- Establishing and maintaining a system of internal control to give reasonable assurance that information assets are safeguarded, and that any impact on information security, confidentiality, data protection and information quality are minimised in line with the standards set out by the Health and Social Care Information Centre (HSCIC)

The Caldicott Guardian (CG) is responsible for providing guidance on all aspects of patient confidentiality, for promoting best practice and, in conjunction with the Board, SIRO and IG staff, for making decisions on information sharing to recipients outside the direct clinical care teams.

The Establishment of IG roles:

The IG roles required by the Trust in order to comply with Level 2 IGT are confirmed in place.

IG roles are appointed by the Accounting Officer for IG (the CEO of the Trust) and are at Board or the most senior leadership team level.

The IG lead and the SIRO are the same individual for Whittington Health. This is in line with best practice guidance from the HSCIC.

The Caldicott Guardian (CG) is distinct from other roles in an advisory capacity. The CG is a suitably qualified senior clinician.

Detailed descriptions of these roles are found in the Trust IG Policy.

These roles are summarised together with their responsibilities in the table below (sorted alphabetically):

Key Information Governance Roles		
Role (A-Z)	Filled By	Responsibility
Accountable Officer	Chief Executive Officer	Overall responsibility for all aspects of Information Governance
Caldicott Guardian	Senior Medical Consultant for Diabetes	Responsibility for safeguarding the confidentiality of, and access to, patient and service user information (advisory role)
Corporate Records Management Lead	Director of Communications & Corporate Affairs	Advice on, and monitoring compliance with, legal and best practice in records management ('records' means what the Trust records i.e. Financial, Estates, HR, Medical etc.)
Data Protection Lead	Assistant Director of Information Governance	Responsibility for assessing and monitoring compliance with Data Protection legislative requirements
Freedom of Information Lead	Director of Strategy (SIRO)	Responsibility to assessing and monitoring compliance with Freedom of Information legislative requirements
Health Records Lead	Director of Operations PPP	Management of the Trust's Health Records Library function
Information Governance Incident Management	Senior Information Risk Owner (SIRO)	Responsibility for the incident management process / chairing incident panels / investigations and

Key Information Governance Roles		
Role (A-Z)	Filled By	Responsibility
		investigation subject matter expertise
Information Governance Lead	Senior Information Risk Owner (SIRO)	Responsibility for assessing, monitoring and reporting compliance with emerging issues in Information Governance
Information Security Officer	Assistant Director of IM&T (Hardware)	Responsibility for ensuring compliance with Information Security Standards (ISO/IEC 27001:2005) and an appropriate Information Security framework is in place with adequate skills, knowledge and experience to successfully co-ordinate and implement the Information Security agenda
Information Quality Lead	Chief Operating Officer	Lead on the reporting of compliance against Information Quality requirements
Senior Information Risk Owner (SIRO)	Deputy CEO & Director of Strategy	Implement and lead the Information Governance risk assessment and management process
Trust Risk Management Lead	Director of Nursing	Leads the clinical risk assessment and incident management process

All Staff have a duty to manage IG in accordance with the relevant Trust IG polices and procedures.

Key Governance Bodies

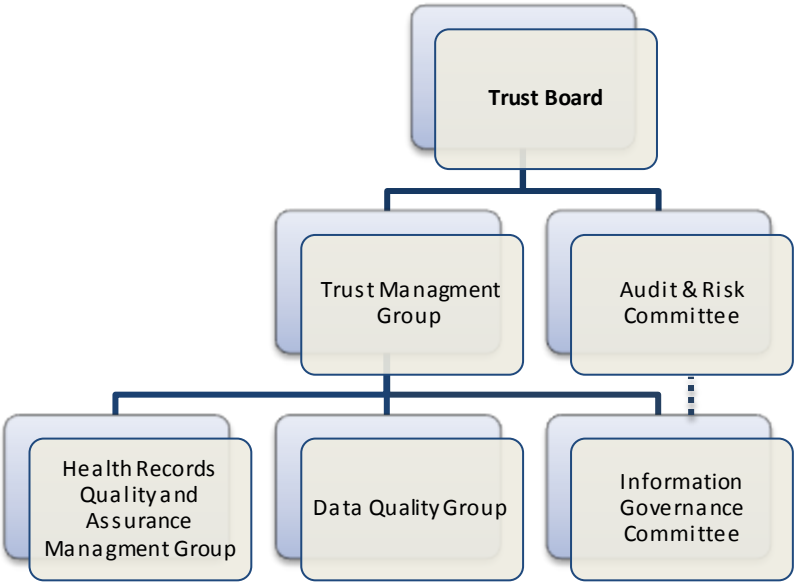
The details of the key bodies required by Level 3 IGT to manage the governance associated with IG are listed below in hierarchical order with senior committees below the Trust Board listed first and sub committees/ boards/ groups below these:

Key Governance Bodies		
Group / Committee	Accountability	Responsibility
Audit and Risk Committee	Trust Board	Parent committee of the IGC provides assurance to the Trust board of status in relation to Information Governance national standards, requirements and risks
Information Governance Committee	To the Audit and Risk Committee	Promotes effective Information Governance, maintains a framework to ensure legal compliance, promotes local-level responsibility and accountability. Identifies risks, plans and implements the Information Risk Agenda. Gives assurance to the ARC that IG national standards are in place. Reports IG risk to the Trust.
Data Quality Group	Trust Operational Meeting/TMG	Develops Data Quality Policy; develops audit for checking the accuracy of service user data , information on all systems and/or records that support the provision of care.

Key Governance Bodies		
Group / Committee	Accountability	Responsibility
Patient Safety Committee	Quality Committee	Manages compliance, monitoring and reporting risk, including IG at Divisional level
Health Records Quality and Assurance Management Board	Trust Operational Meeting/TMG	Provides assurance to the Trust Board on all matters relating to health records management. The RMB covers the management of clinical records across all areas of the trust.

Committee Duties and Reporting Structure

The **Audit & Risk Committee (ARC)** as a Standing Committee of the Trust Board oversees the IG assurance process to the Board through the Information Governance Committee (IGC). See structure chart below:



The Information Governance Committee (IGC) is constituted as a sub-committee of the ARC to provide assurance on the effectiveness of information risk management, to implement and lead the IG risk assessment and management processes within the Trust and ensure the IG Toolkit submission is managed to ensure continued compliance. The Data Quality Group (DQG) reports to the Trust Operational Meeting through to TMG in assuring that a Data Quality Audit Plan is managed within the Trust.

3.2 Information Governance Process

The Governance Framework

Guidance for the governance of information for the Trust is cascaded throughout the organisation through the guidance given to Directors, Managers and all staff (clinical and non-clinical) about their responsibility and accountability concerning the safeguarding of Personal Confidential Data (PCD) and commercially sensitive information. The key Trust policies are set out in section 3.3 below.

Responsibility and accountability is defined with assigned roles, such as Information Asset Owners (IOAs) and Information Asset Administrators (IAAs); included in staff contracts and highlighted as part of the recruitment and induction process.

Governance principles based on the Data Protection Act (1998) form part of contractual agreements for sharing information with third parties or other organisations with access to PCD for which the Trust is accountable as the Data Controller and are included in procurement and capital expenditure procedures.

IG Compliance with IG Toolkit Standards

Compliance with the IG Toolkit is monitored by the IGC under direction of the SIRO. The IGC reports Trust IG Toolkit performance as measured by attainment of evidence against the toolkit level sections to the IGC at each meeting (set out in the IGC Terms of Reference). Management of IG toolkit is undertaken by two IG posts (the 'IG staff') under the direction and guidance of the IGC, supporting and facilitating the divisions and departments that make up the Trust to provide evidence of IG compliance. The IG staff manage the programme for implementation and improvement of Information Governance standards for the Trust.

Departmental Duties

Management of the IG Framework is undertaken by IG staff under the direction and guidance of the IGC.

All Divisions and the departments that form the Trust have a duty to manage IG in accordance with the relevant Trust IG polices and procedures.

Incident Management

Guidance for managing incidents is disseminated throughout the Trust and available on the intranet in the Serious Incident Policy and Risk Management Strategy. Staff are made aware of the procedures for reporting and investigating incidents at induction and through regular communication concerning the management of risk. A digital reporting system called 'Datix' is the primary method for reporting, recording investigations and analysing risk. This is available on all Whittington Health computer desktops.

Information security

Information security is managed through the assessment and review schedule of the IGC and the Information Risk Assessment Management Programme (IRAMP) v1.3 May 2016. Scheduled security reviews include the following aspects of Trust information management systems: Information Assets and Information Flows; Data Sharing Agreements; The Information Risk Assessment and Security Plan; and, relevant policies listed in section 3.3 below.

3.3 Policies and Procedures Associated with Information Governance

Key Policies

Trust policies set out the scope, intent, best practice standards and guidance in the management of IG. The over-arching IG policy references three key supporting policies of IG Confidentiality, IG Security and Records Management. IG strategies and improvement plans are 'owned' and signed-off by the senior management team at the IGC and ratified by the Executive Team and Audit and Risk Committee.

All policies are distributed to Managers and to all Corporate Functions via the intranet, communications bulletins and information cascade at management meetings.

The main policies associated with the IGMF are listed below:

	Information Governance Management Framework Policies			
Policy Name (a-z) (NB Linked)	**Approval Date**	**Expiry Date**	**Responsible Manager**	**Approving Body**
Access to Health Records Policy	Jan 2016	Jan 2019	SIRO	IGC
Clinical Coding Strategy & Policy v4.2	Jan 2016	Feb 2019	Head of Coding	IGC
Confidentiality Audit Procedures	Mar 2015	Apr 2018	SIRO	IGC
Confidentiality Policy	Feb 2015	Mar 2018	SIRO	IGC
Data Quality Policy	Mar 2016	Mar 2017	COO	IGC
Email & Internet Acceptable Use Policy	Mar 2015	Mar 2016	Dir. IT	IGC
Freedom of Information Policy	Mar 2015	Mar 2018	SIRO	IGC
Information Asset Policy	Nov 2012	Apr 2016	SIRO	IGC
Information Governance Policy	Mar 2015	Mar 2018	SIRO	IGC
Information Governance Training Policy	July 2015	Nov 2018	SIRO	IGC
Information Lifecycle Management Policy	Mar 2015	Mar 2018	SIRO	IGC
Information Risk Assessment Management Programme	May 2016	May 2017	SIRO	IGC
Information Security Policy	Mar 2015	Mar 2016	Dir. IT	IGC
Information Sharing Policy	Feb 2015	Mar 2018	SIRO	IGC
Mobile Device Management Policy	Mar 2015	Mar 2016	Dir. IT	IGC
Network Security Policy	Mar 2015	March 2018	Dir. IT	IGC
De-identification & Pseudonymisation guidance	Apr 2013	N/A	SIRO	IGC
Records Management Policy	Dec 2015	Dec 2018	COO	IGC
Safe Haven Policy	Feb 2015	Mar 2018	SIRO	IGC
Serious Incident Management Policy	Dec 2015	Dec 2018	Dir. Nursing	Clinical Quality and Assurance and Governance Board
Staff Code of Conduct: Confidentiality	Mar 2015	Mar 2018	SIRO	IGC

Related Trust Policies and Procedures			
Policy Name (a-z) (NB Linked)	**Approval Date**	**Responsible Manager**	**Approving Body**
Clinical Audit Policy	Oct 2013	Executive Medical Director	Patient Safety Committee
EPR Standard Operating Procedures	2013	Dir. IT	EPR Implementation Board
Induction Policy	Jun 2015	Dir. of People	Executive Committee
Mandatory Training Policy	Sep 2015	Dir. of People	Education & Development Steering Group/ Executive Committee
Policy for the Development and Management of Procedural Documents	Mar 2015	Dir. Nursing	Trust Management Group
Registration Authority Policy & Procedures	Mar 2015	Dir. of HR	Workforce Development Group
Risk Management Strategy	Oct 2015	Dir. Nursing	Whittington Health Board

Staff Training and Awareness of Policies and Procedures

Staff are given guidance on expected working practices and on the consequences of failing to follow the policies and procedures listed in Section 3.3 above.

Polices and procedures are brought to the attention of staff members as part of the recruitment process and at induction through IG mandatory training provided either through an e-learning course, on-line training and test or face-to-face learning. Staff are also made aware of policies and procedures at local induction to departments and services.

Each department and service is responsible for training their staff to be able to manage IG issues as appropriate to their roles and in line with Trust policies and procedures, with the support of the IG department. IG guidance is tailored to particular staff groups or work areas through Training Needs Assessments.

All staff with specific IG roles are trained to the standards set out by HSCIC*.*

3.4 Information Governance Resources

Key Staff

The key staff involved in the IGMF and management of IG in the Trust are confirmed as holding budgets that allow for their role in IG and for those staff required to carry out the duties with respect to IG in the Trust (identified in Section 3.1 ‘Management and Accountability Structure’ above).

Roles such as the Data Protection Lead, Information Security Officer, Freedom of Information Lead, Information Quality Lead, Clinical Governance leads are incorporated into existing substantive roles in the Trust.

The staff directly employed in Information Governance roles consists of the following:

- 1.0 wte (8b) Assistant Director for Information Governance
- 1.0 wte (5) Information Governance Officer

The areas of responsibility covered by the Information Governance Department include:

IG Toolkit; SIRO Support; Support for the Caldicott Function; Data Protection Lead; Confidentiality; Information Security Officer; Business Continuity advice; Risk assessment and investigation leads; Data flows mapping; Secure data transfer advice; IAO and IAA Advice; Research support; Freedom of Information advice; Advice on Record Management; design, development and maintenance of the IG Intranet site; IGC administration; IG policy and procedure management; IG training programme leads; Data Sharing advisors; Data protection Act leads and advisors for Tendering and Contracts; Subject Access Request administrators and advisors.

Budgetary Resource:

The IGD has a pay and non-pay budget. The non-pay budget is adequate to support the department.

The Information Governance Officer is a substantive budgeted role.

The Assistant Director of Information Governance is a substantive budgeted role.

Resource review and recommendations will form part of the annual review and report of the IGC to the ARC.

4 Document Development and Approval Process

4.1 Approval of Policy

The SIRO and Caldicott Guardian are sponsors of the IGMF which is approved by the IGC.

4.2 Consultation and Communication with Stakeholders

The SIRO, Caldicott Guardian, Director of Information Technology, Director of Improvement, Performance and Information have been consulted as part of the development of the IGMF. The IGMF has also had input from the Assistant Director for Risk, Safety, Regulation and Compliance. Improvement plans against the standards set out in the IGT through internal auditors TIAA (summer 2016) have informed the development of the IGMF. The IGMF has been approved by the Trust Audit and Risk Committee and ratified by the Trust Executive Committee.

4.3 Responsibility for Document Development

The SIRO is the nominated Lead Director for the IGMF. The author is the Assistant Director of IG. Further development of the IGMF will be managed through the IGC.

4.4 Equality Impact Assessment

Under the Race Relations (Amendment) Act 2000 the Trust is required to undertake equality impact assessments on all policies/guidelines and practices. This obligation has been expanded to include equality and human rights with regard to disability, age, gender and religion.

An Equality Impact Assessment has been carried out with respect to the IGMF and this appears as an appendix.

4.5 Dissemination and Implementation

Dissemination and implementation of the IGMF will be managed by the IGC and documented as part of the IG Communications Plan. The IGMF is advertised in the Whittington Health Bulletin and available on the intranet for staff.

5 References

Requirement	Description
Statutory	Data Protection Act (1998) Copyright, Designs and Patents Act (1988) Computer Misuse Act (1990) Health and Safety at Work Act (1974) Human Rights Act (1998) Regulation of Investigatory Powers Act 2000 Freedom of Information Act (2000) Health and Social Care Act (2012) Health Service (Control of Patient Information) Regulations (2002)
NHS Policy\Guidance	NHS Information Governance : Guidance on Legal and Professional Obligations (2007) Information Security Management : NHS Code of Practice (2007) Confidentiality : NHS Code of Practice (2003) Records Management : NHS Code of Practice (2006) Information Governance Toolkit Caldicott Guidance

6 Definitions

HSCIC	Health & Social Care Information Centre
CG	Caldicott Guardian
IAA	Information Asset Administrator
IAO	Information Asset Owner
IG	Information Governance
IGC	IG Committee
IGMF	IG Management Framework
IGT	IG Toolkit
SIRO	Senior Information Risk Owner

7 Appendices

Appendix 1: Summary of Requirements for the management of IG

IGMF		
Heading	**Requirement**	**Notes**
Senior Roles	IG Lead (see below) Senior Information Risk Owner (SIRO) **(see IGT requirement 307)** *Caldicott Guardian* **(see IGT requirement 200)**	These roles should be at Board or the most senior leadership team level. The IG lead and the SIRO may be the same individual but the Caldicott Guardian should be distinct from both of the others and advisory rather than accountable.
Key Policies (see IGT requirement 105)	Over-arching IG Policy Data Protection Act 1998 Confidentiality Policy Organisation Security Policy Information Lifecycle Management Policy Corporate Governance Policy	Policies set out scope and intent. The over-arching IG policy should reference the three supporting confidentiality, security and records management policies and might be where the organisation's intended IG Management Framework is documented
Key Governance Bodies	IG Board/Forum/Steering Group (see below)	A group, or groups, with appropriate authority should have responsibility for the IG agenda. This might be one or more standalone groups or be part of an Integrated Governance Board or Risk Management group.
Resources	Details of key staff roles and dedicated budgets (see below)	The key staff involved in the IG agenda below those at Board or most senior levels should be identified with a description of their roles and responsibilities. This may include an IG officer, Data Protection Officer, Information Security Officer, Freedom of Information manager, Corporate and Clinical Governance leads or Data quality leads. Any dedicated budgets and high level plans for expenditure in-year should also be identified, including outsourcing to external resources or contractors.
Governance Framework	Details of how responsibility and accountability for IG is cascaded through the organisation. **(see IGT requirements 200 & 307)**	This should include staff contracts, contracts with third parties, Information Asset Owner arrangements, Departmental leads on aspects of IG etc.
Training & Guidance (see IGT requirement 112)	Staff Code of Conduct **(see IGT requirements 201, 202 & 203)** Training for all staff Organisation Security Policy Training for specialist IG roles	Staff need clear guidelines on expected working practices and on the consequences of failing to follow policies and procedures. The approach to ensuring that all staff receive training appropriate to their roles should be detailed.
Incident Management (see IGT requirements 307, 301 & 302)	Documented procedures and staff awareness	Clear guidance on incident management procedures should be documented and staff should be made aware of their existence, where to find them and how to implement them.

(Reference: IG Toolkit: Acute Trust, HSCIC)

Appendix 2: Equality Impact Assessment

An Equality Impact Assessment has been carried out with respect to the IGMF as follows:

		Yes/No	Comments
1.	**Does the procedural document affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the procedural document likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the procedural document without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

Appendix 3: Checklist for the Review and Approval of Procedural Document

To be completed and attached to any procedural document when submitted to the relevant committee for consideration and approval.

	Title of document being reviewed:	Yes/No	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is it clear that the relevant people/groups have been involved in the development of the document?	Yes	
	Are people involved in the development?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
5.	**Evidence Base**		
	Are key references cited in full?	N/A	
	Are supporting documents referenced?	N/A	
6.	**Approval**		
	Does the document identify which committee/ group will approve it?	Yes	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		

	Title of document being reviewed:	Yes/No	Comments
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	