NHS
Whittington Health
NHS Trust

Meeting	**Trust Board – Public**
Date & time	**1 February 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
17/015	**Declaration of Conflicts of Interests** *Steve Hitchins, Chair*	*Verbal*	*Declare* 1420hrs
17/016	**Apologies & Welcome** *Steve Hitchins, Chair*	*Verbal*	*Note* 1420hrs
17/017	**Draft Minutes, Action Log & Matters Arising 4 January 2017** *Steve Hitchins, Chair*	1	*Approve* 1425hrs
17/018	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Note* 1435hrs
17/019	**Chief Executive's Report** *Simon Pleydell, Chief Executive*	2	*Approve* 1445hrs
Patient Safety & Quality			

17/020	**Serious Incident Report Month 9** *Philippa Davies, Director of Nursing & Patient Experience*	3	*Approve* 1500hrs
17/021	**Safer Staffing Report Month 9** *Philippa Davies, Director of Nursing & Patient Experience*	4	*Approve* 1510hrs
17/022	**Patient Safety and 6 Monthly Report** *Dr Richard Jennings, Medical Director*	5	*Approve* 1520hrs
Performance			
17/023	**Financial Performance Month 9** *Stephen Bloomer, Chief Finance Officer*	6	*Approve* 1550hrs
17/024	**Performance Dashboard Month 9** *Carol Gillen, Chief Operating Officer*	7	*Approve* 1600hrs
Governance			
17/025	**Draft minutes of Quality Committee 11 January 2017** *Anu Singh, Non Executive Director*	8	*Approve* 1610hrs
17/026	**Draft minutes of Charity Committee 4 January 2017** *Tony Rice, Non Executive Director*	9	*Approve* *1620hrs*
Any other urgent business and questions from the public			
	No items		
Date of next Trust Board Meeting			
	01 March 2017 at 1400hrs to 1630hrs at the Whittington Education Centre Room 7, Magdala Avenue, N19 5NF		

Register of Conflicts of Interests:
The Register of Members' Conflicts of Interests is available for viewing during working hours from Lynne Spencer, Director of Communications & Corporate Affairs, at Trust Headquarters, Ground Floor, Jenner Building, Whittington Health, Magdala Avenue, London N19 5NF - communications.whitthealth@nhs.net.

Whittington Health NHS

ITEM: 01
Doc: 17/017

The draft minutes of the meeting of the Trust Board of Whittington Health held in public at 1400hrs on Wednesday 4th January 2017 in the Whittington Education Centre

Present:	Stephen Bloomer	Chief Finance Officer
	Philippa Davies	Director of Nursing and Patient Experience
	Siobhan Harrington	Director of Strategy/Deputy CEO
	Deborah Harris-Ugbomah	non-Executive Director
	Graham Hart	Non-Executive Director
	Steve Hitchins	Chairman
	David Holt	Non-Executive Director
	Richard Jennings	Medical Director
	Simon Pleydell	Chief Executive
	Tony Rice	Non-Executive Director
	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 introduced junior doctors' Vidushi Golash and Gillian Brown. The patient story presented to the Board had been investigated as a Serious Incident (SI). The story explained the experience of a drug and alcohol dependent patient and their physical and mental health needs and treatment during their admission to the hospital and contact with services from the mental health liaison team.

Vidushi and Gillian highlighted the learning from the patient story which included improvements to communication, documentation and handover arrangements. It was noted that the Trust implementation of CareCentrix would make a significant contribution to the rapid and efficient sharing of information amongst professionals.

Gillian and Vidushi confirmed the story had been shared in the Trust's Patient Safety Forum in November to disseminate the learning. They paid tribute to Julie Andrews, who leads the Forum and supports junior doctors with queries or concerns during the course of their work. Simon Pleydell echoed this, saying that Whittington Health had a vibrant culture in terms of patient safety which made an important contribution to the ethos of the organisation.

16/168 Declaration of Conflicts of Interest

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

16/169 Apologies and welcome

169.01 Steve Hitchins welcomed everyone to the meeting. Apologies for absence were received from Carol Gillen.

16/170 Minutes, Action Log and Matters Arising

170.01 Referring to minute 160.01, the Chairman pointed out that the figure in the first line should read £3.8m rather than £30.8.

170.02 The minutes of the Trust Board held on 7th December were approved. There were no matters arising other than those already scheduled for discussion.

Actions

170.03 Action 65.01: It was noted that the internal auditors had now been invited to attend the February Trust Board Seminar meeting. All other actions were either scheduled for discussion that afternoon, been placed on the forward plan, or had been completed.

16/171 Chairman's Report

171.01 Having first wished Board colleagues a very happy new year, Steve Hitchins began his report by highlighting the success of the Trust's 'flu vaccination programme; the take-up rate amongst staff had reached 79% the previous week making it the highest in London and second highest in the country, and NHS England had praised the Trust's underpinning communications plan for the winter uptake campaign. Steve formally thanked Sodexo for their generous gift of mince pies to all Trust sites over Christmas. The busy Christmas programme had been a great success, with too many individual events to list, but he mentioned the Chief Executive's free raffle for staff, and thanked Yua Haw Yoe and Siobhan Harrington for visiting the wards with him on Christmas Day.

171.02 The following week was to be a second 'perfect week', where non-essential meetings were cancelled and every attempt made to resolve issues which hampered the effective delivery of care (e.g. IM&T and maintenance problems). Also imminent was the Community Forum's launch of an art competition.

171.03 Steve thanked all those in the finance and contracting teams who had worked hard to ensure contracts were negotiated and signed in December.

16/172 Chief Executive's Report

172.01 Simon Pleydell informed the Board that the Endoscopy Unit had received Joint Advisory Group (JAG) accreditation for 2017; this was an important achievement. He thanked all those who had contributed to the success of the flu campaign, which reflected well on the safety culture of the Trust, as did the patient story. RTT performance remained good, and the Trust had exceeded all cancer targets with the exception of the 62 day target; 84.4% against the target of 85%.

172.02 The Trust had continued meeting potential strategic estates partners and will continue with the competitive dialogues over the coming months to identify the appropriate support for the Trust. The pharmacy project to create a wholly-owned subsidiary was progressing and the future name will be Whittington Pharmacy. In answer to a question from Deborah Harris about whether the aim remained to achieve this by April, Simon confirmed that this was the intention, and progress was being monitored by the Clinical Support Services Unit and the central Project Management Office. The Trust's Operational Plan, contained within the Board papers, had been submitted to NHS Improvement.

172.03 Simon explained that Carol Gillen was not at the Board meeting as she was overseeing the second 'Perfect Week' and supporting the Emergency Department, which was currently experiencing unprecedented demand. The whole sector was under immense

pressure and the high winter demand was expected to continue. He informed the Board that the next few months would be challenging, and that other key corporate priorities included embedding CIP plans and meeting the Trust agreed 2016/17 financial control total of £6.4m deficit.

16/173 Serious Incident Report

173.01 Philippa Davies informed the Board that eight serious incidents (SIs) had been declared in November, bringing the total for the year to forty-two since 1st April. It was noted that of these eight five related to unexpected deaths, all of which were the subject of current investigations which would be reported to the SI Panel.

173.02 Philippa reminded Board colleagues of the previous month's discussion about mental health services and the impact that pressure on those services was having on patient flow within Whittington Health. Together with Richard Jennings and Carol Gillen, she would be meeting with Directors (their counterparts) at Camden & Islington NHS Foundation Trust to discuss service provision. She referred back to the Patient Story presentation given at the start of the meeting which had provided useful lessons for both Trusts, and Greg Battle added that an important example of these was the need for earlier assessment by senior clinicians.

16/174 Safer Staffing Report for Month 8

174.01 Philippa Davies reported that during November 30% of shifts had been rated amber, an increase on last month's figures. There had been additional pressure on staff due to the opening of the winter pressures ward, there had also been a further increase in the number of special shifts required to care for patients with a mental health condition. Greg Battle expressed his congratulations at the efforts made within nursing to reduce the use of agency staffing.

16/175 Operational Plan 2017/18

175.01 Siobhan Harrington confirmed that the Trust's Operational Plan for 2017/18 had been submitted to NHS Improvement on 23rd December as required. This included a narrative piece set out on a prescribed template, as can be seen in the paper circulated. Siobhan confirmed that the Plan had been signed off by the Finance & Business Development Committee at its meeting in December. The next stage of this work would be to develop a summary version to explain the Trust's annual objectives.

175.02 Siobhan drew attention to the section covering quality, saying that this would form the basis of the Trust's Quality Account. Steve Hitchins thanked Siobhan for a succinct report, but added that the Trust had numerous targets, and it would be necessary to look at which were of most importance to the Trust for reporting from the plan.

175.03 David Holt raised the need to plan how best to monitor the financial targets facing the Trust since it seemed unlikely that not all would meet with 100% success, and Deborah Harris commented on how helpful she had found the discussion about this at the most recent Board seminar. Anu Singh commended the plan but was concerned that it had not fully captured the culture of the Trust. Siobhan replied that she would be taking a paper on the Quality Account to the Trust Management Group (TMG); this was likely to address Anu's point, and the paper could be circulated to the Board. Simon Pleydell reiterated the importance of producing a meaningful and clear document for Trust staff.

17/176 Financial Report

176.01 Stephen Bloomer reported that the Trust had declared a £0.7m deficit at the end of Month 8, giving it a year to date deficit of £4.5m, which was, he said, in line with the planned year to date performance. He drew attention to the pay bill, which at £18.6m was the highest since the start of the financial year. There had been an increase in both substantive and agency staff spend.

176.02 There had been a slight improvement in income, which had been in excess of plan, and the improved position also included some achievement of CIP plans. It was noted however that achievement of the control total was ultimately dependent on pay costs. ICSUs had been asked to supply their projections.

176.03 Moving on to CIP plans for next year, Stephen informed the Board that the Trust had plans which covered £12m of the required £15.5m savings, but there was a piece of work which needed to be taken forward by Finance, the PMO and Operations Directors which would include resurrecting those schemes which had been rejected this year. There were also some schemes which had been planned for this year but which had now slipped to the following year. Simon Pleydell spoke about the importance of consulting staff in affected areas once it was known that a scheme looked viable.

176.04 It was predicted that the Trust would be in a position to gain its STP funding at the end of Quarter Three, however December was traditionally a challenging month, with lower than usual activity levels due to the holiday period, so achievement of the planned position was likely to be challenging. Stephen stressed that Whittington Health was in no way an outlier, numerous NHS organisations were in a similar position.

17/177 Performance Dashboard

177.01 Referring to page 11 of the dashboard report, Simon Pleydell spoke of the risk inherent in performing well; the pressure on the Trust's ED was undoubtedly due in part to its good reputation with the London Ambulance Service (LAS). It was noted however that some of the data on ambulance handover timings was being reviewed by LAS as it appeared the data might contain some inaccuracies. The same page in the report also made reference to a patient who had waited over 12 hours for a mental health bed.

177.02 Board members held a brief discussion on staff turnover, which currently stood at c.18% within nursing and midwifery. Norma French informed colleagues that consideration was being given to international recruitment outside Europe and that a paper had been drafted for TMG setting out proposals; however even if a decision was made to begin a recruitment campaign as early as February it was unlikely that any new staff recruited would be in place much before next winter. Norma briefed the Board on the new legislation about apprenticeships.

177.03 Anu Singh paid tribute to the Trust's work on appraisals and mandatory training, saying that the fact that figures had remained broadly static was a credit to the teams. It was noted that the decision to stop the automatic progression to pay increment had contributed to the success. Simon Pleydell added that the draft figures from the staff survey gave some indication of improvement in staff feedback.

17/178 LUTS action plan and progress report

178.01 Siobhan Harrington outlined some of the work that would be required during January. This included finalising and gaining agreement for the succession plan and new model of service that needed to be in place by 1st April. A desktop review and stocktake were

planned. Work was in hand on communications; this included responding to letters received from MPs. A further paper on progress would come to the Board in March.

178.02 Janet Burgess confirmed that the LUTS clinic continued to be raised with local councillors, and she would ensure the paper was taken to the Joint Overview & Scrutiny Committee; Siobhan offered to attend this if it would be helpful. It was further noted that the patient group had been offered the opportunity to present a Patient Story at the February Board meeting.

178.03 The key issue remaining was that a final solution had not yet been reached, and Richard Jennings reminded the Board that the main challenge was that Professor Malone-Lee's practice was unique and so it was very hard to find a solution that provided the best possible care, met the requirements of the patients, yet still complied with clinical guidelines. In answer to a question from Greg Battle about the degree to which the patients recognised that the degree of accessibility they had had previously could not be exactly replicated, Richard replied that the message given by the Trust had been consistent throughout.

16/179 Emergency Preparedness, Resilience & Response 2016 Report

179.01 This report had been prepared in line with NHS England requirements and it was noted that the Trust's systems had been reviewed in October and given an overall score of 'substantial'. The report was circulated for information only; any questions to be directed to Carol Gillen.

16/180 Information Governance Framework

180.01 The information governance framework had been signed off at the Information Governance Committee and Trust Management Group and now required Trust Board ratification. The IG Committee was chaired by Siobhan Harrington (SIRO), who expressed confidence in the robustness of the framework. The framework was formally ratified by the Board, noting that references to the role of the Chief Executive should be changed from 'Accounting' to 'Accountable' Officer.

16.181 Any Other Business

181.01 The last set of minutes of the Finance & Business Development Committee would be circulated with the February Board papers.

181.02 On behalf of the Board, Dr Battle formally recorded his congratulations to Royal Free Chief Executive David Sloman on his recognition in the New Year's Honour's List.

181.03 Richard Jennings informed the Board that ED had been uniquely busy that day and the level of support received from colleagues had been greatly valued by Clinical Director Rachel Landau and her team.

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Action Notes Summary

175.03	Anu Singh commended the operational plan but was concerned that it had not fully captured the culture of the Trust. Siobhan replied that she would be taking a paper on the Quality Account to the Trust Management Group (TMG); this was likely to address Anu's point, and the paper could be circulated to the Board.	Closed – on forward action plan to circulate	SMH
178.01	A further LUTs paper on progress would come to the Board in March.	March Board	SMH
181.01	The last set of minutes of the Finance & Business Development Committee would be circulated with the February Board papers	March Board	SB

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Whittington Health

1 February 2017

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	**17/020**	**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 December 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:	20/01/2017		

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 December 2016.

The management of Serious Incident's (SIs) includes not only identification, reporting and investigation of each incident but also examples of recommendations following investigation and dissemination of learning to prevent recurrences.

2. Background

The Serious Incident Executive Approval Group (SIEAG) comprising the Executive Medical Director/Associate Medical Director, Director of Nursing and Patient Experience, Chief Operating Officer, the Head of Integrated Risk Management and SI Coordinator meet weekly to review Serious Incident investigation reports. In addition, high risk incidents are reviewed by the panel to ascertain whether these meet the reporting threshold of a serious incident (as described within the NHSE Serious Incident Framework (March 2015).

3. Serious Incidents

3.1 The Trust declared 3 serious incidents during December bringing the total of reportable serious incidents to 45 since 1st April 2016. Of the 3 reported,1 was subsequently de-escalated by NELCSU following a case review where expert opinion concluded the incident had not caused or contributed to the outcome.

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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.
Information Governance Breach Ref: 23932 (submitted on 5/1/2017)	Sept 16	A patient list was found off hospital grounds by another staff member.
Unexpected death Ref: 25397	Sept 16	Unexpected death of patient with bilateral pulmonary embolism.

Category	Month Declared	Summary
Never Event - Nasogastric tube Ref:26486 (submitted 5/1/2017)	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 (Submitted 12/01/2017)	Oct 16	Delayed diagnosis due to failure to follow up investigation result.
12 hour Trolley breach. Ref: 27253 9Submitted 13/01/2017)	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 (Submitted 13/01/2017)	Oct 16	Patient discharged from hospital without appropriate discharge plans in place.
Unexpected death Ref: 27591 (De-escalated) C&I	Oct 16	Unexpected death in the community as a result of suicide
Unexpected Admission to NICU Death. Ref: 27586	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.
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

Category	Month Declared	Summary
Delayed Diagnosis - Colposcopy Ref:30095	Nov 16	A delay in reviewing biopsy results, led to delay in diagnosis.
Unexpected Death Ref:31941	Dec16	Patient who was assessed and discharged was subsequently found unresponsive.
Patient Fall Ref: 33339	Dec 16	Patient fell from standing position resulting in a fractured skull and intra-cerebral bleed.

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

STEIS 2016-17 Category	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Safeguarding	0	1	1	0	1	0	1	0	0	4
Attempted self-harm	0	0	0	0	0	0	0	1	0	1
Confidential information leak/loss/Information governance breach	1	2	1	0	1	1	0	0	0	6
Diagnostic Incident including delay	2	1	0	0	0	1	1	1	0	6
Failure to source a tier 4 bed for a child	0	0	0	1	0	0	0	0	0	1
Failure to meet expected target (12 hr trolley breach)	0	0	0	0	0	0	1	0	0	1
Maternity/Obstetric incident mother and baby (includes foetus	1	1	1	0	0	2	1	0	0	6
Maternity/Obstetric incident mother only	0	0	0	0	1	0	1	0	0	2
Medical disposables incident meeting SI criteria	0	0	0	0	0	0	1	0	0	1
Nasogastric tube	0	0	0	0	0	0	1	0	0	1
Slip/Trips/Falls	0	0	0	1	0	0	0	0	2	3
Sub optimal Care	0	0	0	0	0	0	1	1	0	2
Treatment Delay	0	0	0	0	0	0	1	0	0	1
Unexpected death	0	1	0	1	0	1	0	5	1	9
Retained foreign object	0	0	0	0	0	1	0	0	0	1
Total	4	6	3	3	3	6	9	**8**	**3**	**45**

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 December 2016.

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

4.1 **The Trust submitted 3 reports to NELCSU during December 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 December 2016.

Summary	**Actions taken as result of lessons learnt**
• Ref: 25401	Retained peripherally inserted central catheter (PICC or PIC line). • A review of nurse competencies on the ward is currently being undertaken to ensure that all staff have key training in PICC Line care. An audit of PICC Line documentation is also being undertaken on all wards.
• Ref: 25413	Delayed Diagnosis of an ultrasound scan resulting in delayed diagnosis of an active bleed. • Clear guidelines are being developed for staff to ensure that all Obstetric patients over 18 weeks gestation attending Whittington Health Emergency Department should remain under direct lead of the Obstetric Teams even if they require specialist medical or surgical opinions. • To ensure on-call Surgical Teams are aware of speciality review times for patients in the Emergency Department. • A protocol agreed between the Clinical Lead for Surgery and the interventional Lead for Radiology for the management of patients with acute surgical abdominal presentation. • AHP skill mix review with the aim of identifying additional capacity.
• Ref.23903	Intra uterine Death • All clinicians providing care to pregnant women to have received training to correctly complete a the customised antenatal chart to plot fundal height and estimated fetal weight measurements throughout pregnancy. • Updating and dissemination of reduced fetal movement guideline- this includes information 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

1 February 2017

Title:	Safe Staffing - Nursing and Midwifery – December data		
Agenda item:	**17/021**	**Paper**	**04**
Action requested:	For information		
Executive Summary:	This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in December 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 December (252) vs November (235) 3. Same level of Red Shifts reported in December (4) compared to November (4) 4. The number of RMN 'specials' used to care for patients with a mental health conditions was higher in December (57) compared to November (29). 5. CHPPD measure during the month was increased from (8.76) in December compared to (8.58) on November 6. The continued use of agency and bank staff to support safe staffing		
Summary of recommendations:	Trust Board members are asked to note the December 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:	January 2017		

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 December 2016.

1.2 To provide context for the Trust Board on the UNIFY safe staffing submission for the month of December 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 November data by ward please see Appendix 1).

2.3 Staff fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st – 31st December 2016 for Whittington Hospital was uploaded and submitted on UNIFY, the online collection system used for collating, sharing and reporting NHS and social care data. Patients and the public are able to see how hospitals are performing on this indicator on the NHS Choices website.

2.4 Summary of Staffing Parameters

Standard	Measure	Summary
Patient safety is delivered though consistent, appropriate staffing levels for the service.	Unify RN fill rate	Day – 93.9% Night – 98.1%
	Care hours per Patient Day - CHPPD	Overall 8.76 CHPPD was recorded in December and is higher 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 December 2016 this was the same as November
	14% of shift remained partially mitigated (Amber shifts)	207 shifts i.e. 14% of all shifts in month. This was an increase on November'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 93.9% for registered staff and 117% for care staff during the day and 98.1% for registered staff and 119.9% for care staff during the night.

3.3 On the day shift, six wards reported below 90% fill rates for qualified nurses. Eleven wards had above 100% fill rate for unqualified nurse and four 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, Montuschi and Mary Seacole North wards at (HCA) above 200%. 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 HCAs is 1 wte and two staff work then this represents an 100% increase.

Day		Night	
Average fill rate registered Nurses /Midwives	Average fill rate Care Staff	Average fill rate registered Nurses/Midwives	Average fill rate Care Staff
93.9%	**117.0%**	**98.1%**	**119.9%**

4.0 Additional Staff (Specials 1:1)

4.1 When comparing December's total requirement for 1:1 'specials' with previous month, the figures demonstrate an increase in the number of shifts required (Appendix 2). December saw 252 requests for 1:1 specials compared to 235 requests in November. 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 December (57) compared to November (29). 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 December 4 shifts triggering red.

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

5.4 Wards triggering red shift

5.5

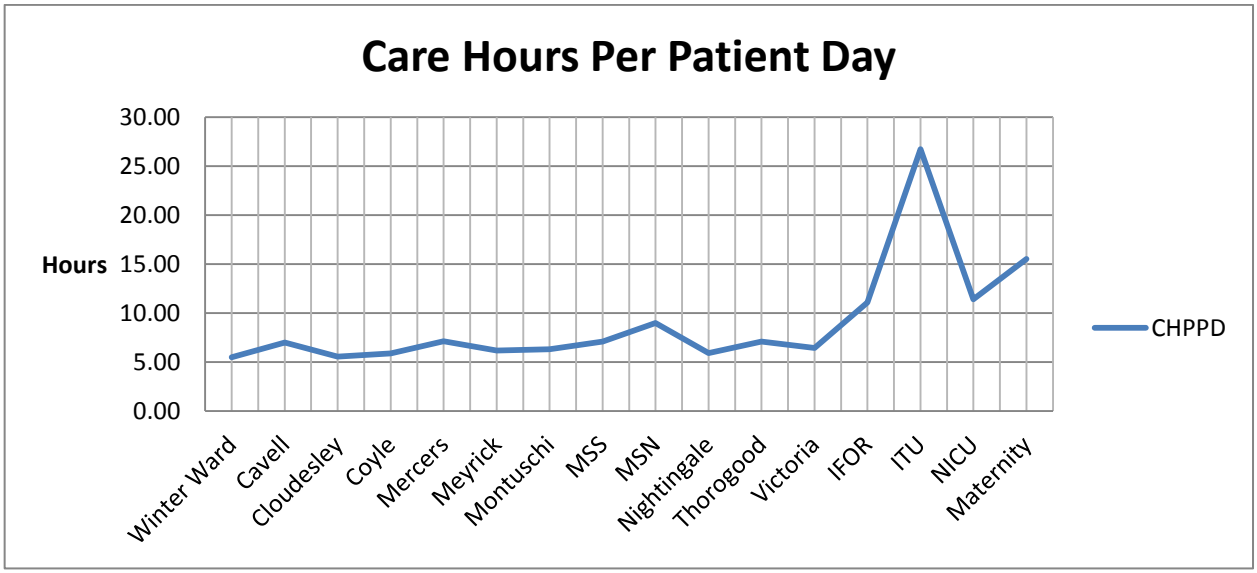
	Initial Red Shifts				
Wards	Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	% of shifts where staffing fell below agreed levels and triggered a red rating
Bridges	0	1	0	1	**1**
MSS	0	0	2	2	**2**
Coyle	0	0	1	1	**1**

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 (26.71) and Cavell Winter Ward have the least (5.51).



6.2 The average number of hours of Registered Nurse time spent with patients was calculated at 6.52 hours and 2.24 hours for care staff. This provides an overall average of 8.76 hours of care per patient day.

	CHPPD
Registered Nurse	**6.52**
Care Staff	**2.24**
Overall hours	**8.76**

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

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

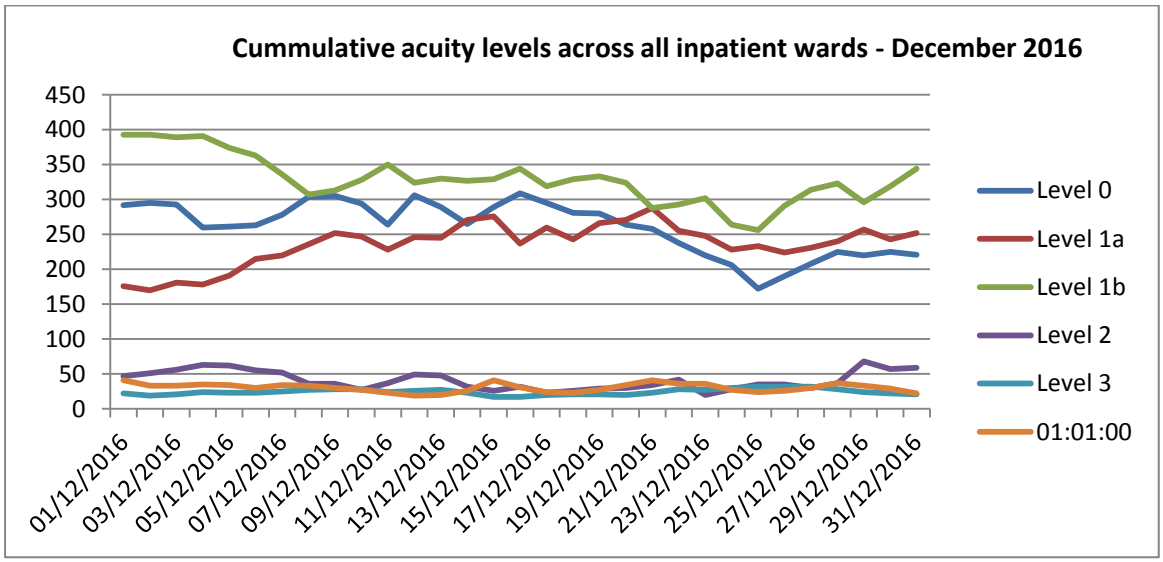
Ward Name	Dec	Nov	Oct	Sept
Bridges				
Cavell Winter Ward	5.51	6.93	N/A	N/A
Cavell Rehab	7.00	6.89	7.20	8.66
Cloudesley	5.57	5.32	5.80	6.10
Coyle	5.90	5.57	5.62	5.88
Mercers	7.13	6.65	6.78	8.86
Meyrick	6.20	6.39	5.87	5.41
Montuschi	6.31	6.02	5.86	6.99
MSS	7.10	7.04	6.98	7.72
MSN	8.98	8.42	7.95	9.17
Nightingale	5.93	5.91	6.33	5.47
Thorogood	7.09	6.85	7.78	4.28
Victoria	6.45	7.84	6.35	6.15
IFOR	11.09	8.71	9.62	10.74
ITU	26.71	25.43	24.23	26.12

Ward Name	Dec	Nov	Oct	Sept
NICU	11.41	12.30	14.13	12.53
Maternity	15.53	13.71	14.90	13.95
Total	8.76	8.58	8.64	8.76

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 December. 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:

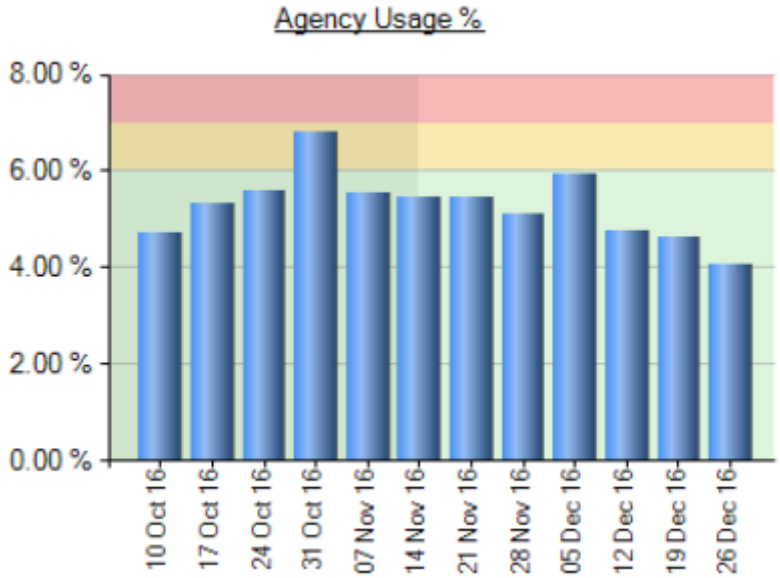
a) The system in place allows for the most appropriate use of high cost temporary agency staff across the organisation and provides a positive challenge mechanism for all requests.

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.

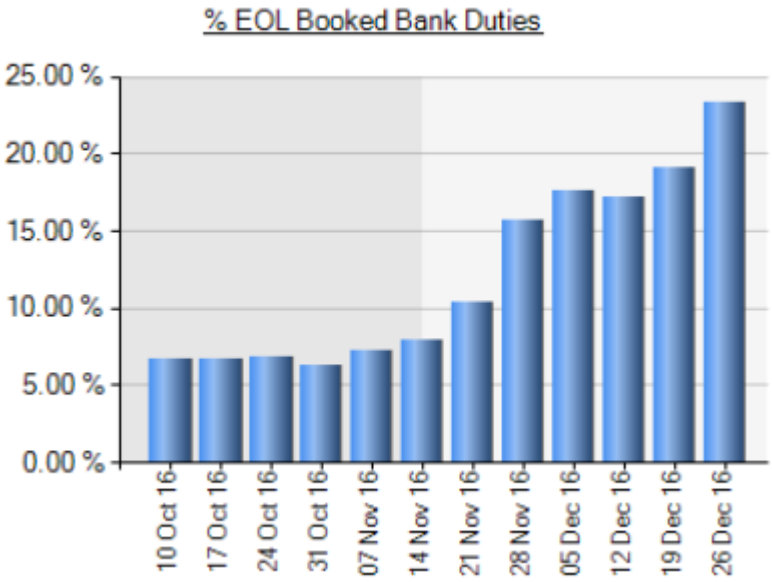
9.0 Agency Usage Inpatient Wards (November to date)

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 December 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 usage reduced during the month and achieved 4% in the last week of December.

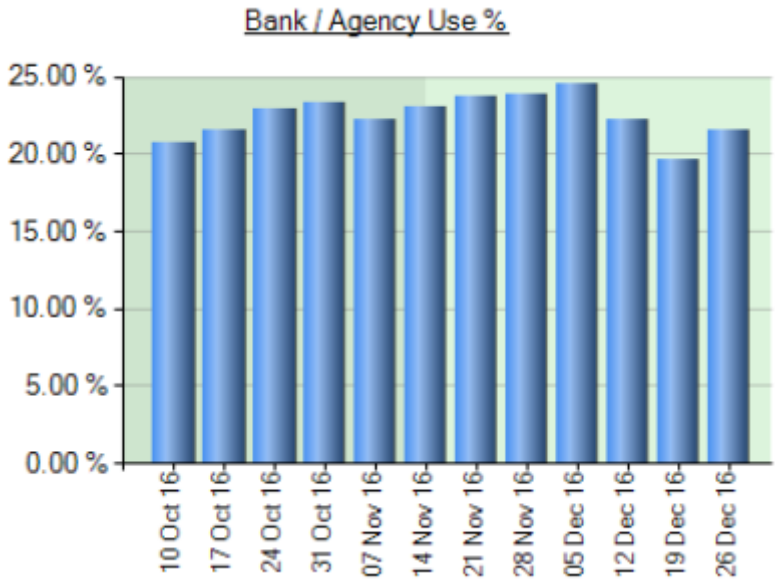


The introduction of the incentive bonus and the ability of staff to directly book themselves into bank shifts via their Employee on line accounts (EOL), has helped to reduce Agency usage.



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.

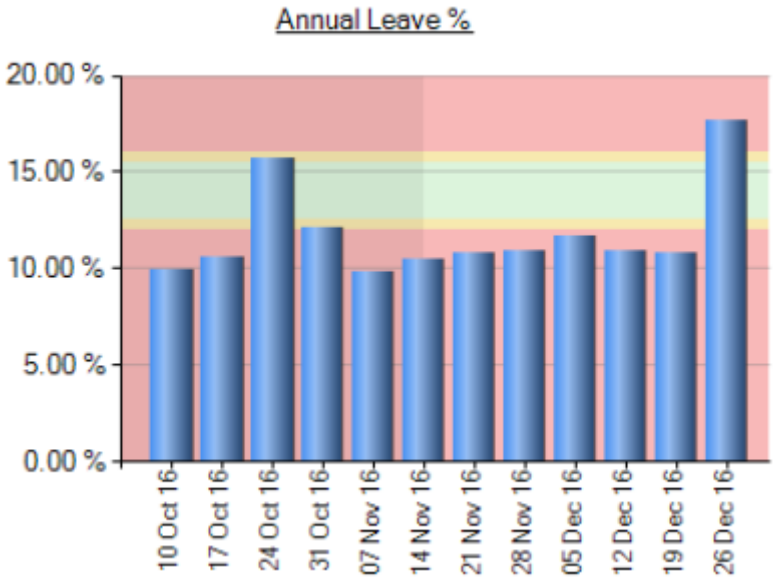
9.4 Temporary staffing usage (Bank and Agency) across inpatients wards remains high and fluctuates between 20 – 24%. Recruitment to reduce the current vacant posts is ongoing.



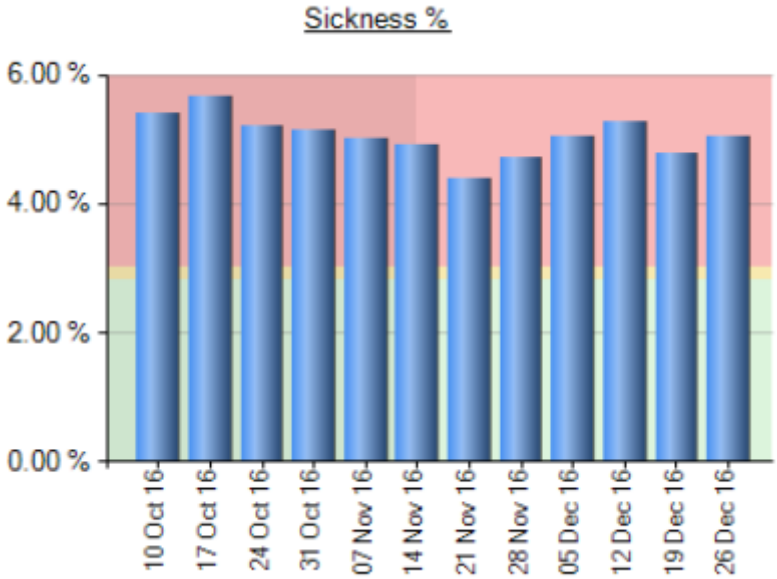
10.0 Managing Staff Resource

10.1 Annual leave taken from December to date varied over the month spanning the set tolerances of 14 -16%. These tolerance levels ensure all staff are allocated leave appropriately and 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 be monitored closely over the next couple of months to ensure sufficient staff take annual leave in a more consistent way by year end.



10.3 Sick leave reported in December was above the set parameter of less than 3%. 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 ICO and the December UNIFY return position

Updated tables

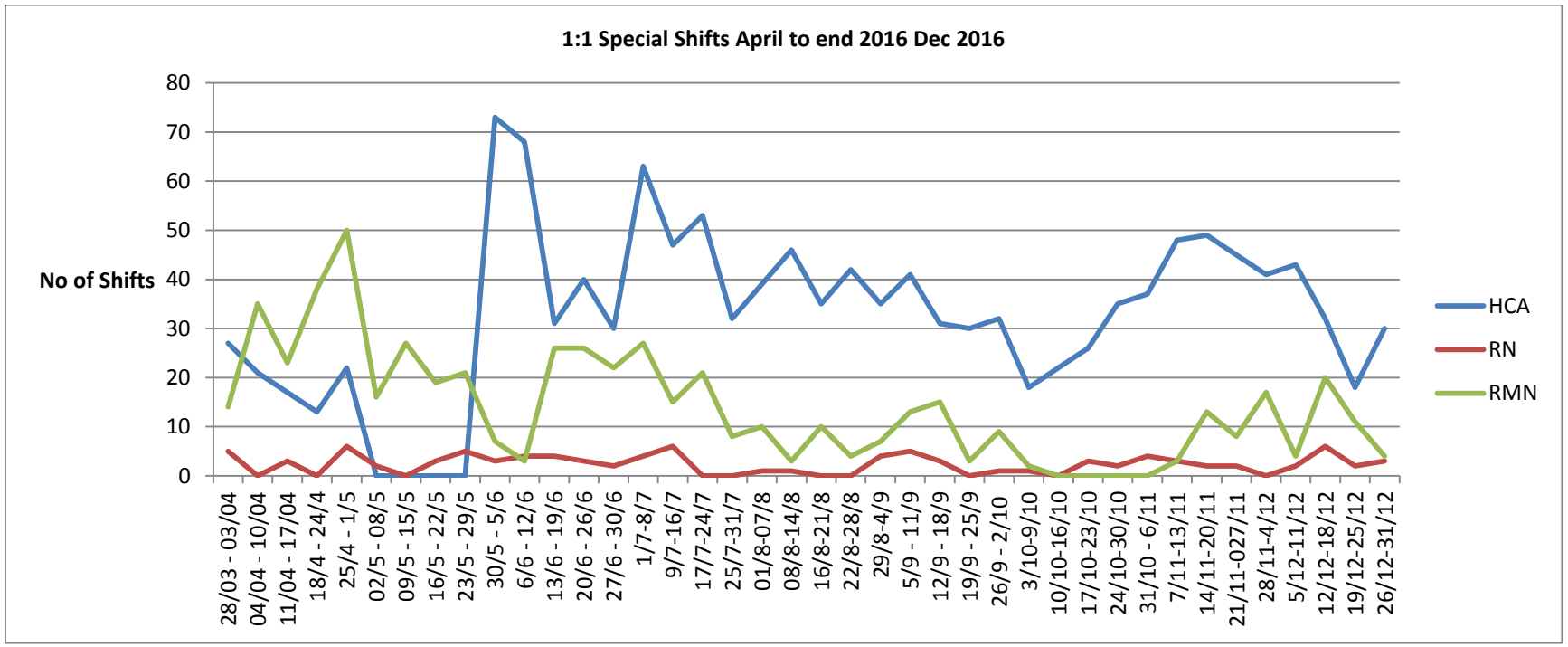
Fill rate data - summary
December 2016

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)				
35704	**33526**	**10369**	**12129**	**29090**	**28549**	**7666**	**9190**	**93.9%**	**117.0%**	**98.1%**	**119.9%**

Care Hours per Patient Day
December 2016

Total Patients at Midnight/Month	CHPPD Registered staff	CHPPD Unregistered staff	Average CHPPD (all staff)
9525	**6.52**	**2.24**	**8.76**

Appendix 2


1:1 Special Shifts April to end 2016 Dec 2016
No of Shifts
80
70
60
50
40
30
20
10
0
28/03 - 03/04
04/04 - 10/04
11/04 - 17/04
18/4 - 24/4
25/4 - 1/5
02/5 - 08/5
09/5 - 15/5
16/5 - 22/5
23/5 - 29/5
30/5 - 5/6
6/6 - 12/6
13/6 - 19/6
20/6 - 26/6
27/6 - 30/6
1/7-8/7
9/7-16/7
17/7-24/7
25/7-31/7
01/8-07/8
08/8-14/8
16/8-21/8
22/8-28/8
29/8-4/9
5/9 - 11/9
12/9 - 18/9
19/9 - 25/9
26/9 - 2/10
3/10-9/10
10/10-16/10
17/10-23/10
24/10-30/10
31/10 - 6/11
7/11-13/11
14/11-20/11
21/11-027/11
28/11-4/12
5/12-11/12
12/12-18/12
19/12-25/12
26/12-31/12
HCA
RN
RMN

Average fill rate for Registered and Unregistered staff day and night

	Day		Night	
	Nurses	Care Staff	Nurses	Care Staff
Ward Name	%	%	%	
Winter Ward	86.3%	97.0%	94.9%	95.3%
Cavell	91.8%	113.6%	97.5%	135.8%
Cloudesley	91.1%	100.4%	113.9%	101.8%
Coyle	111.6%	86.2%	155.4%	89.9%
Mercers	92.0%	104.3%	106.8%	101.7%
Meyrick	86.1%	132.2%	108.3%	155.6%
Montuschi	79.2%	232.3%	107.9%	NA
MSS	78.7%	186.0%	77.1%	167.7%
MSN	74.1%	140.4%	95.4%	236.0%
Nightingale	76.7%	201.3%	80.2%	214.0%
Thorogood	100.1%	82.6%	95.3%	133.3%
Victoria	97.9%	105.4%	96.4%	103.2%
IFOR	104.4%	100.0%	95.5%	100.0%
ITU	100.0%		100.0%	
NICU	92.8%		92.5%	
Maternity	101.5%	104.4%	96.1%	94.4%
Total	**93.9%**	**117.0%**	**98.1%**	**119.9%**

Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board

1 February 2017

Title:	December (Month 9) 2016/17 - Financial Performance		
Agenda item:	17/023	**Paper**	06
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 £0.6m deficit in December and a year to date position of £5.1m 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 December 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:	20 January 2017		

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

Use of Resources Rating

The Use of Resources Rating forms part of NHSI's Single Oversight Framework, replacing the previous Financial Sustainability Risk Rating (FSRR). It adds to the FSRR by introducing a metric for agency spend as part of the assessment of financial controls.

Scoring is still based on a scale of 1 to 4, although 4 is now seen as worst performing/highest risk, rather than lowest risk as was previously the case.

Use of Resource metrics	Current Period Plan	Current Period Actual	Current Period Variance
Liquidity Ratio (days)	4	4	0
Capital Servicing Capacity (times)	4	4	0
I&E Margin Rating	4	4	0
I&E Margin Variance from Plan		1	
Agency	2	3	1
Use of Resources Rating after overrides		**3**	

The table above shows that as at Month 9 the Trust's Use of Resources Rating is a 3, which under the Single Oversight Framework would trigger a 'potential support need' on review by NHSI.

Financial Overview

The Trust reported a £0.6m deficit in December and a year to date position of £5.1m deficit. This is in line with the planned year to date (YTD) performance.

Main issues of note:

- Pay expenditure was £0.4m adverse against plan in month, and is now £1.9m adverse year to date. In total the pay bill for December was £18.6m. Whilst slightly lower than November it is still the third highest monthly amount since April (£18.7m) and £0.1m above the average for the year. Other key points that should be noted, include:

    - Total agency costs for December were £0.8m, a decrease of c. £0.3m compared to November. Though agency costs fell, pay as a whole was still overspent. As a significant proportion of the Trust's CIP target is based on reducing agency spend, which links to increasing permanent and bank expenditure, failure to reduce agency spending further over the remaining quarter, together with the performance of other pay savings schemes will see the Trust fail its CIP target.

    - The main driver for the reduction in agency costs was in relation to Nursing (agency). As part of this, the cost of agency associated with qualified nursing was reduced. When assessed in relation to total qualified nursing spend agency equates to 5.68%, which improves on the position in November, 6.55%, and is favourable against the Trust's regulatory limit of 6%.

- Non Pay expenditure continues to be favourable against plan, £0.8m in month and £4.1m year to date.

- Total income was £0.5m adverse to plan in month. Particular points of note include:
    - Clinical income was adverse to plan by £0.6, although there was improvement in critical care income.
    - 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 has agreed an outturn with NHSE subject to final confirmation (both in line with expectations)

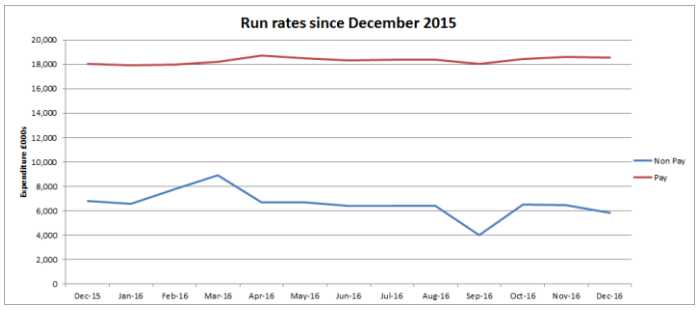
The in-month position of a £0.6m deficit was a minor improvement compared to November, £0.7m adverse. However, whilst the Trust is currently in line with its planned position it should be noted that Month 9 included non-recurrent benefits within the ICSU positions, following a deep dive of their initial financial results. Therefore 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.

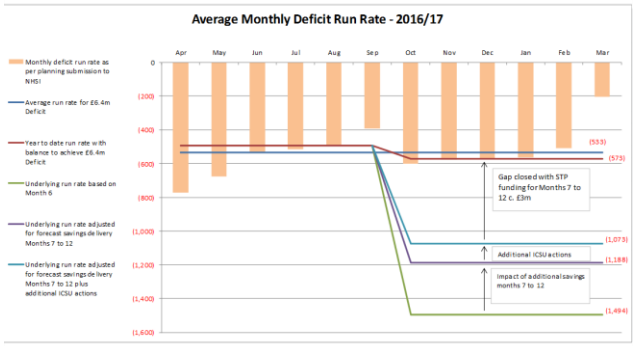
The current cash position of the Trust is £0.1m below plan. The position includes STP funding, for the first 2 quarters, which was received in November.

Capital spending commitments now total £2.9m (November £2.5m), with £1.7m actually incurred to date.

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	21,492	20,913	(579)	194,037	191,026	(3,011)	258,406
Non-Nhs Clinical Income	1,868	1,902	34	17,058	17,601	543	22,744
Other Non-Patient Income	2,302	2,330	28	19,891	19,188	(703)	26,538
Total Income	**25,662**	**25,145**	**(517)**	**230,986**	**227,815**	**(3,171)**	**307,688**
Non-Pay	6,714	5,842	872	59,426	55,313	4,113	79,594
Pay	18,109	18,555	(446)	163,978	165,932	(1,954)	217,855
Total Operating Expenditure	**24,823**	**24,397**	**426**	**223,404**	**221,245**	**2,159**	**297,449**
EBITDA	**839**	**748**	**(91)**	**7,582**	**6,570**	**(1,012)**	**10,239**
Depreciation	690	613	77	6,210	6,055	155	8,280
Dividends Payable	355	354	1	3,183	3,182	1	4,243
Interest Payable	276	330	(54)	2,403	2,382	21	3,238
Interest Receivable	(3)	(1)	(2)	(27)	(16)	(11)	(36)
Total	**1,318**	**1,296**	**22**	**11,769**	**11,603**	**166**	**15,725**
Net Surplus / (Deficit) - before IFRIC 12 adjustment	**(479)**	**(548)**	**(69)**	**(4,187)**	**(5,033)**	**(846)**	**(5,486)**
Adjust for impairments, IFRS & Donated assets	(93)	(8)	85	(937)	(22)	915	(914)
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**(572)**	**(556)**	**16**	**(5,124)**	**(5,055)**	**69**	**(6,400)**





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 December, £0.6m, showed improvement compared to November, but in light of the non-recurrent, in-month, benefits included within the ICSU positions 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

As highlighted last month the Trust has negotiated an end of year income figure with local commissioners and NHSE. Based on these agreements the ICSU forecasts calculated at Month 7 were accepted, as although they were adverse to budget delivery of them would provide a financial outturn where the Trust could still achieve its control total for the year.

The forecasts provided at Month 7 have therefore become control totals for ICSUs for the remainder of the financial year and are being monitored on a monthly basis. The table below provides the Month 9 actual results against the ICSU control totals, together with the results from the previous month.

Pay

	Previous Month (Month 8)			Current Month (Month 9)			Cumulative
	Forecast Control Total £000s	Actual £000s	Variance £000s	Forecast Control Total £000s	Actual £000s	Variance £000s	Variance to CT £000s
Children's & Young People	3,919	3,963	(44) ↑	3,919	3,979	(60) ↑	(104)
Clinical Support Services	1,279	1,383	(104) ↑	1,279	1,336	(57) ↑	(161)
Emergency & Urgent Care	1,937	1,996	(59) ↑	1,937	1,876	61 ↓	2
Integrated Medicine	2,795	2,946	(151) ↑	2,795	3,101	(306) ↑	(457)
Patient Access, Prevention & Planned Care	1,046	1,103	(57) ↑	1,046	1,026	20 ↓	(37)
Surgery & Cancer	2,918	3,111	(193) ↑	2,918	3,218	(300) ↑	(493)
Women's Health	1,533	1,627	(94) ↑	1,533	1,588	(55) ↑	(149)
Total Pay - Clinical ICSUs	15,427	16,129	(702) ↑	15,427	16,124	(697) ↑	(1,399)

Non Pay

	Previous Month (Month 8)			Current Month (Month 9)			Cumulative
	Forecast Control Total £000s	Actual £000s	Variance £000s	Forecast Control Total £000s	Actual £000s	Variance £000s	Variance to CT £000s
Children's & Young People	190	220	(30) ↑	190	195	(5) ↑	(35)
Clinical Support Services	1,348	1,337	11 ↓	1,348	1,413	(65) ↑	(54)
Emergency & Urgent Care	206	254	(48) ↑	206	280	(74) ↑	(122)
Integrated Medicine	257	313	(56) ↑	257	311	(54) ↑	(110)
Patient Access, Prevention & Planned Care	261	216	45 ↓	261	266	(5) ↑	40
Surgery & Cancer	771	796	(25) ↑	771	705	66 ↓	41
Women's Health	184	154	30 ↓	184	148	36 ↓	66
Total Non Pay - Clinical ICSUs	3,217	3,290	(73) ↑	3,217	3,318	(101) ↑	(174)

Combined Pay & Non Pay

	Previous Month (Month 8)			Current Month (Month 9)			Cumulative
	Forecast Control Total £000s	Actual £000s	Variance £000s	Forecast Control Total £000s	Actual £000s	Variance £000s	Variance to CT £000s
Children's & Young People	4,109	4,183	(74) ↑	4,109	4,174	(65) ↑	(139)
Clinical Support Services	2,627	2,720	(93) ↑	2,627	2,749	(122) ↑	(215)
Emergency & Urgent Care	2,143	2,250	(107) ↑	2,143	2,156	(13) ↑	(120)
Integrated Medicine	3,052	3,259	(207) ↑	3,052	3,412	(360) ↑	(567)
Patient Access, Prevention & Planned Care	1,307	1,319	(12) ↑	1,307	1,292	15 ↓	3
Surgery & Cancer	3,689	3,907	(218) ↑	3,689	3,923	(234) ↑	(452)
Women's Health	1,717	1,781	(64) ↑	1,717	1,736	(19) ↑	(83)
Total Expenditure - Clinical ICSUs	18,644	19,419	(775) ↑	18,644	19,442	(798) ↑	(1,573)

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, £5.0m has been delivered against a target of £6.9m. This equates to a 73% achievement. The CIP profile requires a material increase in the rate of cost improvement during the final quarter 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	355	117	33.0%	-238
Clinical Support Services	1,019	651	283	43.5%	-368
Emergency & Urgent Care	786	454	519	114.4%	66
Medicine, Frailty & Network Services	1,673	1,010	883	87.4%	-127
Outpatients Prevention & LTC	526	331	324	97.9%	-7
Surgery	2,613	1,665	866	52.0%	-799
Women's services	1,189	736	476	64.7%	-260
Corporate	2,307	1,670	1,175	70.4%	-495
Trustwide non-pay	0		390		390
Performance against operating plan	**10,715**	**6,871**	**5,033**	**73.3%**	**-1,838**

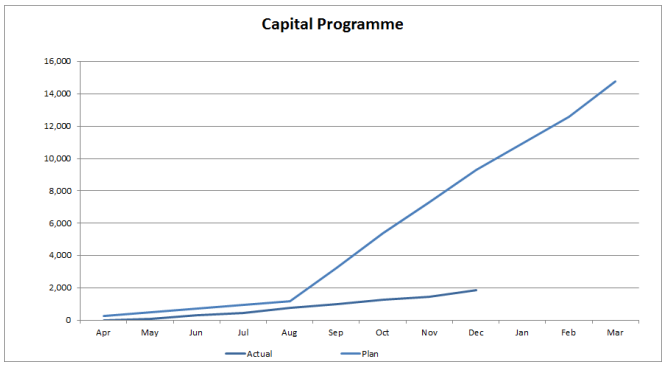
The table above shows actual performance against the original CIP plans, indicating a shortfall of c. £1.8m year to date. However, a number of non-recurrent benefits have been realised, which supports the Trust being on plan in overall terms year to date.

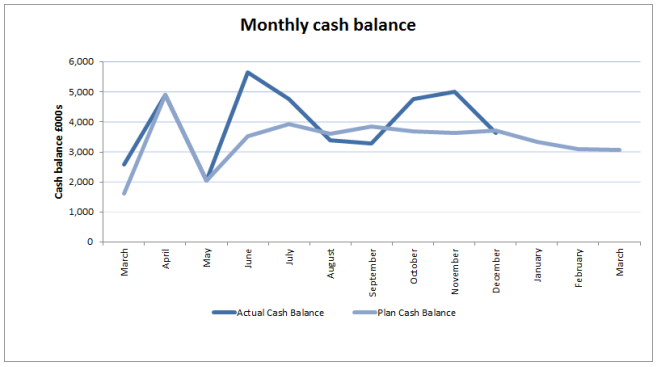
Monitoring of performance against CIP plans continues to be undertaken by the PMO via weekly update meetings, together with monthly deep dives. Shortfalls are principally linked to pay and non-pay schemes and the PMO is working with ICSUs to accelerate future schemes and replace those that will now not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

The Trust's planning submission still requires a cost reduction of £15.5m in 2017/18 for the overall target requirement, across the 2-year period (2016/17 & 2017/18), to be delivered. It should be noted that based on current calculations there will be a net shortfall of c. £1.2m against the original targets for 2016/17, which will be factored into the plans currently being developed for 2017/18.

Statement of Financial Position

	As at 1 April 2016 £000	Plan 31 March 2017 £000	Year to Date Plan YTD 31 December 2016 £000	Year to Date As at 31 December 2016 £000	Year to Date Variance YTD 31 December 2016 £000
Property, plant and equipment	194,785	203,023	199,903	191,334	8,569
Intangible assets	4,583	2,831	3,271	3,830	(559)
Trade and other receivables	693	851	836	610	226
Total Non Current Assets	**200,061**	**206,705**	**204,010**	**195,774**	**8,236**
Inventories	1,403	1,500	1,500	1,582	(82)
Trade and other receivables	23,535	25,393	20,520	30,681	(10,161)
Cash and cash equivalents	2,598	3,060	3,710	3,626	84
Total Current Assets	**27,536**	**29,953**	**25,730**	**35,889**	**(10,159)**
Total Assets	227,597	236,658	229,740	231,663	(1,923)
Trade and other payables	39,112	43,391	38,010	41,999	(3,989)
Borrowings	376	2,455	9,748	8,805	943
Provisions	795	756	768	256	512
Total Current Liabilities	**40,283**	**46,602**	**48,526**	**51,060**	**(2,534)**
Net Current Assets (Liabilities)	**(12,747)**	**(16,649)**	**(22,796)**	**(15,171)**	**(7,625)**
Total Assets less Current Liabilities	**187,314**	**190,056**	**181,214**	**180,603**	**611**
Borrowings	52,934	61,419	51,210	51,258	(48)
Provisions	1,773	1,513	1,583	1,773	(190)
Total Non Current Liabilities	**54,707**	**62,932**	**52,793**	**53,031**	**(238)**
Total Assets Employed	132,607	127,124	128,421	127,572	849
Public dividend capital	62,404	62,404	62,404	62,404	0
Retained earnings	(7,873)	(13,356)	(12,059)	(12,641)	582
Revaluation reserve	78,076	78,076	78,076	77,809	267
Total Taxpayers' Equity	132,607	127,124	128,421	127,572	849
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**	**3.5%**	**3.5%**





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 £10.1m includes £4.3m invoiced to Health Education England in December to cover quarter 4, for which payment is due to be received in January. The balance 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 to 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 9. The cash position at the close of month 9 was £3.6m.

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

Whittington Health Trust Board
1st February 2017

Title:	Trust Board Report January 2017 (December 2016 data)		
Agenda item:	**17/024**	**Paper**	**07**
Action requested:	For discussion and decision making		
Executive Summary:	**Emergency and Urgent Care** Attendance marginally down from the previous month with a slight improvement in performance from 85.1% to 85.8%. Ambulances activity consistently above average although conversion rate remains below 50% There is continued focus on the improvement plan with particular emphasis on the RAT (rapid assessment and treatment) model, SAFER bundle in particular pre 11 am discharge. To optimise flow and reduced pressure on the admitted pathway. The ECIP were invited to do a review of the front of house over 2 days and the main recommendations were; • maintain focus on RAT , • extend surgical pathways within ambulatory care, • focus on frailty using PDSA approach • Review medical staffing model in AAU. Each of these areas will be taken forward by ICSU CDs as part of part of the admitted pathway improvement work. **Cancer** The 14 day cancer target has been consistently achieved this financial year. The 62 days referral to treatment cancer target is under achieving in November 16, despite early indication last month showing improvement. There were 3 breaches. 1.5 was patient choice and 0.5 a breach due to a delay in reporting MRI in Gynaecology and 1 breach due to capacity within the Lung service. **Emergency Re-Admission within 30 days** Re-admission rate calculation has changed and it now includes day cases, as requested by the CSU and in line with reporting from other acute providers. The trust is 0.5% above the target of 5.5%. EUC and IM ICSUs are above the target at 10.8% and 6.7% respectively. **Delayed Transfer of Care** Although above the target of 4.5% it is now 6.1% (last month 10.1%). There remains an increased focus on DTOC with daily review & reporting of DTOCs and medically optimised patients		

	ED Patients Friend and Family Test Satisfaction score is below target at 83%, however ED response rate has gone up significantly due to the use of texts being sent to mobile phones after visit in ED. **Theatre Utilisation** Slightly reduction from 83.7% to 83.5%. **RTT Incomplete** This target has been consistently achieved to date. **Staff sickness absence** This indicator increased slightly from 2.8% to 3.0% (threshold 3.5%)
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:	21st January 2017

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

January 2017

Month 9 (2016 – 2017)

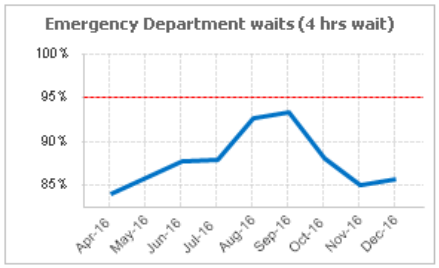
Date & time of production: 26/01/2017 13:51

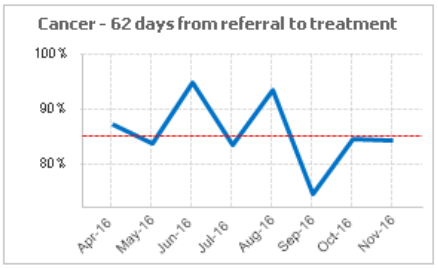
Section	Page
Performance Summary	3
Safe Services	4
Caring Services	6
Effective Services	8
Responsive Service	10
Well Led Services	12
Activity	14

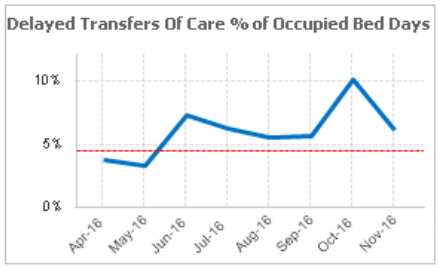
Date & time of production: 26/01/2017 13:51

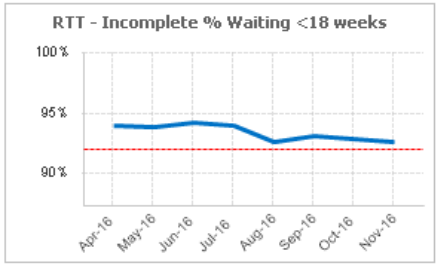
Summary Page - Indicators

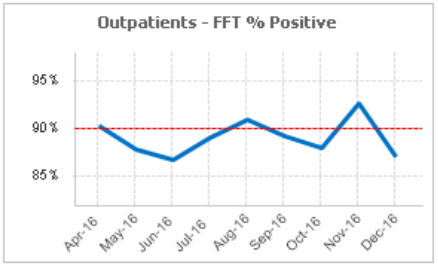
Category	Indicator	16_17 Target	Q1 Apr-16	Q1 May-16	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	2016-2017
ED	Emergency Department waits (4 hrs wait)	>95%	84.1%	85.9%	87.7%	87.9%	92.7%	93.4%	88.1%	85.1%	85.8%	87.8%
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	88	88	85	87	60	62	75	88	76	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%		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%	84.2%		85.6%
Admitted	Non Elective Re-admissions within 30 days	<5.5%	4.8%	5.6%	6.8%	6.4%	6.3%	5.7%	5.9%	5.9%	6.0%	5.9%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	3.8%	3.4%	7.4%	6.3%	5.5%	5.7%	10.1%	6.1%		5.3%
Access	RTT - Incomplete % Waiting <18 weeks	>92%	93.9%	93.8%	94.2%	93.9%	92.7%	93.1%	92.9%	92.6%	92.2%	93.3%
Outpatients	Outpatients - FFT % Positive	>90%	90.2%	87.7%	86.7%	89.1%	90.8%	89.2%	88.0%	92.6%	87.0%	89.5%
Community	Community - FFT % Positive	>90%	97.3%	97.5%	97.5%	97.9%	97.5%	98.4%	98.1%	98.2%	98.7%	97.9%
Staff	Staff - FFT % Recommend Care	>70%			80.1%			76.2%				77.9%

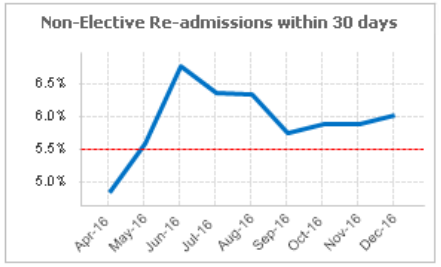












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Safe Services - Indicators and Performance

Category	Indicator	16_17 Target	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	Q3 Dec-16	2016-2017	Performance
Admitted	Admissions to Adult Facilities of pts under 16 yrs of age	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Admitted	HCAI C Difficile	<17	0	0	0	2	1	1	1	0	0	0	0	0	5	
All Areas	CAS Alerts Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
All Areas	Actual Falls	400	36	29	26	24	26	36	26	31	38	45	30	45	301	
Admitted	Avoidable Grade 3 or 4 Pressure Ulcers	0				4	2	1	3	5	5	5	1	4	30	
All Areas	Harm Free Care %	>95%	93.7%	93.6%	93.6%	92.2%	92.6%	93.5%	93.8%	91.9%	90.8%	93.3%	92.6%	93.2%	92.7%	
Maternity	Non Elective C-Section % Rate	>15%	18.1%	18.0%	18.1%	13.6%	18.9%	17.7%	16.4%	17.4%	20.2%	17.7%	21.6%	17.4%	17.9%	
Admitted	Medication Errors causing serious harm	0	0	0	0	1	0	0	0	0	0	0	0	0	1	
Admitted	MRSA Bacteraemia Incidences	0	1	0	0	0	0	0	0	0	0	1	0	0	1	
Admitted	Never Events	0	0	0	0	0	0	0	0	1	0	1	0	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%	21.1%	21.2%	
All Areas	Serious Incidents	0	4	8	2	3	6	3	3	4	6	9	8	3	45	
Admitted	VTE Risk Assessment %	>95%	95.3%	95.3%	95.1%	95.0%	96.0%	96.3%	98.0%	96.2%	96.6%	97.3%	96.4%		96.5%	

Date & time of production: 26/01/2017 13:51

Safe Services - Commentary

Falls

Whittington Health is taking part in the NHS Improvement Falls Project with focus on the Mary Seacole wards initially.

Avoidable pressure ulcers

Three avoidable Grade 3 pressure ulcers and one grade 4 were reported in December 2016. Three in District Nursing, two Grade 3's and one Grade 4. The two patients who developed Grade 3 had no evidence of repositioning regime discussion with the patient and/or carers. One patient pressure ulcers deteriorated from a Grade 2 to a grade 4 as the pressure ulcer was not being assessed in line with protocol.

A Grade 3 pressure ulcer was acquired on Meyrick Ward due to lack of adherence to protocol.

Lessons will be shared with the team and Julie Andrews will be leading within the patient safety forum to ensure strict adherence by all staff to our protocols.

Harm Free Care

Not achieved, but improved compared to last month. It includes all avoidable and unavoidable harm.

Non-elective C-section rate

Although above the target of 15%, for December the percentage is just under the year to date average of 17.9%. The trust accepted two further deliveries (total of 4 to date) under the collaborative working agreement with UCLH. This target is also reported on the NCLS dashboard and scored amber compared to other hospital within London.

Caring Services - Indicators and Performance

Category	Indicator	16_17 Target	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	Q3 Dec-16	2016-2017	Performance
ED	ED - FFT % Positive	>90%	94.2%	91.6%	85.4%	89.9%	92.0%	87.7%	89.4%	92.4%	95.6%	89.9%	82.1%	83.8%	86.7%	
ED	ED - FFT Response Rate	>15%	3.9%	6.1%	4.0%	4.6%	4.8%	5.1%	4.5%	3.4%	4.1%	4.1%	16.6%	16.6%	7.2%	
Admitted	Inpatients - FFT % Positive	>90%	94.5%	89.5%	94.2%	96.6%	93.6%	95.7%	96.7%	96.0%	95.1%	95.8%	92.7%	95.8%	95.3%	
Admitted	Inpatients - FFT Response Rate	>25%	11.9%	12.6%	14.0%	19.4%	15.5%	15.5%	19.3%	15.4%	20.4%	18.3%	18.0%	12.6%	17.2%	
Maternity	Maternity - FFT % Positive	>90%	95.3%	87.7%	87.9%	94.6%	92.1%	94.6%	91.6%	93.2%	91.1%	91.6%	93.8%	94.8%	93.0%	
Maternity	Maternity - FFT Response Rate	>15%	14.2%	19.4%	19.2%	19.3%	16.1%	18.3%	10.5%	18.9%	24.2%	23.1%	12.8%	24.6%	18.5%	
Outpatients	Outpatients - FFT % Positive	>90%	94.3%	82.2%	84.7%	90.2%	87.7%	86.7%	89.1%	90.8%	89.2%	88.0%	92.6%	87.0%	89.5%	
Outpatients	Outpatients - FFT Responses	400	141	73	144	133	171	166	229	229	305	408	516	193	2350	
Community	Community - FFT % Positive	>90%	98.0%	96.3%	98.5%	97.3%	97.5%	97.5%	97.9%	97.5%	98.4%	98.1%	98.2%	98.7%	97.9%	
Community	Community - FFT Responses	1500	812	983	753	778	752	628	563	609	621	645	880	549	6025	
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%	89.3%	89.8%	
All Areas	Complaints (including complaints against Corporate division)	N/A	34	21	48	23	23	31	26	38	32	25	19	32	249	
Community	End of Life % of patients dying in Pref. Place of care - DN	>70%	65.6%	76.0%	75.0%	95.5%	100.0%	96.0%	84.4%	85.7%	72.0%	71.4%	85.7%	83.3%	86.1%	

Date & time of production: 26/01/2017 13:51

Caring Services - Commentary

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

ED response rate has gone up significantly due to the use of texts being sent to mobile phones after the visit in ED.
Outpatients' response rate has gone down due to the not inputting of a large number of paper FFT response cards into Meridian. This error has since been addressed.

Complaints
Achieved
During December 2016 the Trust had 32 complaints that required responses, 28 complaints requiring a response within 25 working days and achieved a performance of 89% in regard to response times. The 4 remaining complaints were due in 40 working days.

A review of the complaints for this period shows that the majority of the concerns related to 'medical care' 25% (8), with 50% (4) of our patients indicating that they felt that "inadequate treatment" had been provided, and 25% (2) indicating that 'incorrect treatment' had been provided. 19% (6) related to 'attitude' where 33% (2) stated that staff displayed "inappropriate behaviour". 16% (5) complaints cited 'communication' as the main concern particularly in regard to "incorrect details" 40% (2). Out of the 32 complaints 69% of the closed complaints have been upheld (15) or partially upheld (5).

Effective Services - Indicators and Performance

Category	Indicator	16_17 Target	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	Q3 Dec-16	2016-2017	Performance
Maternity	Breastfeeding Initiated	>90%	91.7%	92.3%	93.3%	91.8%	93.4%	90.5%	95.2%	91.5%	90.6%	94.2%	90.2%	90.1%	92.0%	
Maternity	Smoking at Delivery	<6%	3.0%	7.4%	4.1%	4.4%	6.6%	6.2%	3.9%	4.4%	4.8%	3.2%	5.1%	4.8%	4.8%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	5.1%	5.3%	5.6%	4.8%	5.6%	6.8%	6.4%	6.3%	5.7%	5.9%	5.9%	6.0%	5.9%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	111.3	82.8	94.0	76.0	80.6	73.7	109.8	82.9	59.3				80.4	
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	88.0	69.0	54.9	42.8	124.1	64.3	77.2	76.8	84.9				78.4	
Trust	Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 mont...	1.14			0.68			0.69							0.69	
Admitted	Mortality rate per 1000 admissions in-months	14.4	8.2	6.7	7.5	6.5	4.7	6.1	5.8	5.8	4.2	6.5	7.9	7.2	6.1	

Date & time of production: 26/01/2017 13:51

Effective Services - Commentary

Non-Elective re-admission within 30 days

This indicator looks at non elective re-admissions who were discharged from Whittington Health and re-admitted to any speciality within the hospital within 30 days.

Re-admission rate calculation has changed and it now includes day cases, as requested by the CSU.

The trust is 0.5% above the target of 5.5%.

ICSU Name	M ...	Dec-16
Children and Young Person's		2.2%
Emergency and Urgent Care		10.8%
Integrated Medicine		6.7%
Surgery		4.2%
Womens Health Services		1.4%
Total		**6.0%**

All ICSUs have access to patient level data through Qlikview.

Responsive Services - Indicators and Performance

Category	Indicator	16_17 Target	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	Q3 Dec-16	2016-2017	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	84.6%	84.0%	81.6%	84.1%	85.9%	87.7%	87.9%	92.7%	93.4%	88.1%	85.1%	85.8%	87.8%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	85	94	103	88	88	85	87	60	62	75	88	76	78	
ED	Ambulance handovers waiting more than 30 mins	0	5	3	21	23	20	28	31		16	26	45		189	
ED	Ambulance handovers waiting more than 60 mins	0	0	0	0	0	2	9	0		0	1	4		16	
ED	12 hour trolley waits in A&E	0	0	1	0	0	2	1	1	0	0	1	1	0	6	
Cancer	Cancer - 14 days to first seen	>93%	93.2%	99.5%	98.9%	97.4%	96.4%	96.4%	97.3%	97.7%	96.6%	98.7%	97.2%		97.2%	
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	92.7%	98.3%	99.4%	98.1%	95.4%	99.2%	100.0%	100.0%	100.0%	100.0%	100.0%		98.9%	
Cancer	Cancer - 62 days from referral to treatment	>85%	93.8%	81.6%	91.4%	87.2%	83.6%	94.9%	83.3%	93.5%	74.5%	84.4%	84.2%		85.6%	
Cancer	Cancer - 31 days to first treatment	>96%	100.0%	100.0%	97.5%	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 - surgery	>98%	100.0%	100.0%			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Cancer	Cancer - 31 days to subsequent treatment - drugs	>93%		100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	100.0%	100.0%		100.0%	
Access	DM01 - Diagnostic Waits (<6 weeks)	>99%	99.1%	98.8%	99.4%	99.6%	99.4%	99.9%	99.3%	99.5%	99.7%	99.5%	99.8%	99.1%	99.6%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.3%	92.1%	92.7%	93.9%	93.8%	94.2%	93.9%	92.7%	93.1%	92.9%	92.6%	92.2%	93.3%	
Access	Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Date & time of production: 26/01/2017 13:51

Responsive Services - Commentary

ED

Attendance marginally down from the previous month with a slight improvement in performance from 85.1% to 85.8%. Ambulances activity consistently above average although conversion rate remains below 50%
There is continued focus on the improvement plan with particular emphasis on the RAT (rapid assessment and treatment) model, SAFER bundle in particular pre 11 am discharge, to optimise flow and reduced pressure on the admitted pathway.
The ECIP were invited to do a review of the front of house over 2 days and the main recommendations were;

- maintain focus on RAT ,
- extend surgical pathways within ambulatory care,
- focus on frailty using PDSA approach
- Review medical staffing model in AAU.

Each of these areas will be taken forward by ICSU CDs as part of part of the admitted pathway improvement work.
The ECIP team have been asked to review the 'back hospital 'and wider health and social care system with a tentative date for mid-February
Recruitment to the additional consultant posts is ongoing with three appointment made to date and expected to start in Q2 & Q3 17/18

12 hour trolley waits in A&E
There were no 12 hour trolley breaches this month.

Cancer – 62 days from referral to treatment
Note: When boxes are grey in this section it means that there were no patients in this category for the month.

The Indicator was non-compliant for the month of November at 84.2% against the standard 85%. There were 3 breaches: 1 Urology, 0.5 in Upper GI, 0.5 Gynaecology & 1 Lung services. Issues:

- Urology patient - sent to UCLH by day 36, however treatment delayed by patient choice
- Lung - capacity issue continuing
- Upper GI -patient choice
- Gynae – delay in reporting MRI scan

Responsive Services - Indicators and Performance

Category	Indicator	16_17 Target	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	Q3 Dec-16	2016-2017	Performance
Theatres	Hospital Cancelled Operations	0	16	3	3	19	4	7	1	6	1	5	6	2	51	
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	143	102	183	148	129	273	240	191	199	364	267		1811	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	4.3%	2.4%	4.1%	3.8%	3.4%	7.4%	6.3%	5.5%	5.7%	10.1%	6.1%		5.3%	
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%	67.8%	62.7%	
Community	IAPT Moving to Recovery	>50%		47.1%		47.4%	51.6%	48.0%	50.0%	51.7%	52.3%	45.7%	47.1%		49.4%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%				95.7%	95.0%	90.5%	95.1%	93.8%	94.6%	94.4%	94.3%		94.1%	
Community	GUM - Appointment Offered within 2 days	>98%	98.1%	99.4%	98.9%	98.7%	98.5%	99.7%	95.6%	97.8%	99.2%	99.9%	99.6%	99.8%	98.8%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	87.7%	83.8%	85.7%	88.6%	89.8%	87.9%	93.2%	94.6%	94.2%	91.8%	92.2%		91.5%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	94.5%	92.8%	94.7%	95.1%	96.1%	94.4%	94.9%	93.7%	88.3%	93.3%	94.1%		93.7%	

Date & time of production: 26/01/2017 13:51

Responsive Services - Commentary

Hospital Cancelled Operations

Two patient's operations were cancelled this month due to the theatre running out of time as previous cases overran.

Delayed Transfer of Care % of Occupied Bed days

This indicator improved. There remains an increased focus on DTO C in terms of reviewing and reporting which has resulted in a number of difficult discharge issues being resolved. Escalation processes in place including for out of borough DTOCs up to Director and COO level.

IAPT

The recovery rate for November increased from 45.7% in October to 47.1%. High levels of deprivation in the East of the borough, often causing or maintaining mental health difficulties contributes to high levels of volatility in outcomes. The digital therapy treatments offered, yield lower recovery rates. In November the recovery rate would have risen from 47.1% to 49% if digital treatments were excluded from the data. The size of the sample of people completing treatment per month creates volatility in recovery rates. For November, if 8 more patients had completed treatment in this period the recovery rate would have moved from 47.1% to 50%. The service continues to develop strategies, and specific training, to improve outcomes. Some of these initiatives are proving successful. For example, in December the recovery rate is 52.41% - the highest recovery rate year to date. Patient Satisfaction continues to exceed the 95% mark.

New Birth Visits November 2016

Haringey and Islington new births within 10-14 days have shown improvements for November - both above the yearly average.
HV vacancies remain a significant issue for both boroughs as NBV performance directly relates to this.

Islington: 16 (6.26%) late

6x parental choice; 2x in hospital; remainder due to vacancies - particularly in North Locality

Haringey: 24 (7.84%) late

10x in hospital; 4x late notifications; 1x family away; 5x DNA/mother unavailable; 4x no reason given/admin error

Well Led Services - Indicators and Performance

Category	Indicator	16_17 Target	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	Q3 Dec-16	Performance
HR	Appraisals % Rate	>90%	74%	74%	72%	71%	69%	68%	67%	66%	63%	66%	66%	67%	
HR	Mandatory Training % Rate	>90%	82%	82%	82%	81%	81%	81%	81%	81%	80%	81%	81%	82%	
HR	Permanent Staffing WTEs Utilised	>90%				87.1%	87.7%	87.8%	86.2%	87.1%	87.0%	88.1%	88.1%	87.7%	
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%	3.1%	2.9%	3.2%	3.0%	3.3%	3.2%	2.9%	2.9%	2.9%	3.3%	2.8%	3.0%	
HR	Staff turnover %	<10%				14.9%	14.9%	15.8%	15.7%	15.5%	15.7%	15.4%	14.9%	15.4%	
HR	Vacancy % Rate against Establishment	<10%				12.9%	12.3%	12.2%	13.8%	12.9%	13.0%	11.9%	11.9%	12.3%	

Date & time of production: 26/01/2017 13:51

Well Led Services - Commentary

Human Resources

Workforce KPIs are scrutinised at ICSU level on a monthly basis by the HR Business Partners and management colleagues. An overview of performance provided quarterly in the Performance Review meetings. Issues of note this month include:

- Slight increases in both appraisal and mandatory training, but both not meeting the 90% target at year end. The importance of meeting this is being re-emphasised in current round of performance reviews.
- Sickness has slightly increased, but still within target.
- Turnover has increased to 15.4 % and remains an area of concern. Work to identify factors contributing to this is underway, including exit interviews, and enhancing staff support across a range of practical areas.

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	Q3 Dec-16	Activity
ED	ED Attendances	**8605**	7878	8540	7908	8277	7513	8020	8253	8271	8238	
ED	ED Admission Rate %		17.6%	18.1%	17.8%	18.1%	17.8%	16.7%	16.2%	16.6%	17.5%	
Community	Community DNA Rate %	**<10%**	5.6%	5.2%	5.3%	5.4%	5.3%	5.2%	5.0%	5.1%	5.2%	
Community	Community Face to Face Contacts		58778	60550	61182	58088	54142	59589	59024	63544	53508	
Admissions	Elective and Daycase		1861	1860	2082	2004	1769	1935	1947	1875	1703	
Admissions	Emergency Inpatients		2129	2255	2175	2322	2117	2079	2036	2126	2105	
Referrals	GP Referrals to an Acute Service		6712	6178	6435	6143	5906	6350	5987	6302	5083	
Maternity	Maternity Births	**333**	325	324	311	340	299	337	315	324	301	
Maternity	Maternity Bookings	**377**	331	383	403	354	299	301	353	365	319	
Outpatients	Outpatient DNA Rate % - New	**<10%**	12.3%	12.1%	11.7%	11.7%	11.9%	12.3%	11.1%	11.4%	12.9%	
Outpatients	Outpatient DNA Rate % - FUp	**<10%**	11.4%	10.4%	10.2%	10.3%	9.8%	11.2%	10.1%	10.1%	12.4%	
Outpatients	Outpatient New Attendances		12861	13711	14025	13085	12656	13317	12862	13956	11456	
Outpatients	Outpatient FUp Attendances		29766	31553	32894	31115	30961	32012	31676	33655	27132	
Outpatients	Outpatient Procedures	**1279**	5594	5869	6291	6172	6261	6014	6259	6152	5265	
Theatres	Theatre Utilisation	**>95%**	78.1%	81.5%	80.7%	78.3%	78.2%	81.8%	81.5%	83.7%	83.5%	

Date & time of production: 26/01/2017 13:51

Activity - Commentary

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

Community DNA
Achieved target

Hospital DNA
Just underachieving, slightly increased from last month due to seasonal variation.

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

Theatre utilisation
Performance remains just below 84%

All specialities managed performance over 80% apart from Urology and Gynaecology with 77% and 75% respectively.
Actions:

- Remove two lists a week from Gynaecology to improve utilisation.
- Continue with improvement in urology ensuring staffing in place across entire theatre day.
- Rest of specialities just under 85% continue to have weekly reviews of theatre booking to ensure high productivity.
- Reviewing 17/18 activity plan and setting target numbers per consultant to achieve per list.

Whittington Health NHS

Whittington Health Trust Board
1 February 2017

Title:	Quality Committee Meeting 11 January 2017 Draft Minutes cleared by Chair and Executive Lead						
Agenda item:	**17/025**		**Paper**		**08**		
Action requested:	For the Board to note the business of the 11 January 2017 Quality Committee Meeting and its effective decision making						
Executive Summary:	This paper presents the draft 11January 2017 Quality Committee Minutes						
Summary of recommendations:	The Trust Board is asked to take assurance that the Quality Committee is compliant with its terms of reference and delegated authority						
Fit with WH strategy:	The Quality Committee, a sub-committee of the Trust Board, considers business relating to quality and safety of services						
Reference to related / other documents:	Duty of Candour, Being Open, SO's. SFI's and Scheme of Delegation, Duty of the Trust Board for quality and safety of patient care, Annual Governance Statement						
Date paper completed:	11 January 2017						
Author name and title:	**Gillian Lewis Corporate Governance Manager**		**Director name and title:**		**Anu Singh, Non-Executive Chair**		
Date paper seen by EC	**N/A**	**Equality Impact Assessment complete?**	**N/A**	**Risk assessment undertaken?**		**Legal advice received?**	**N/A**

DRAFT Minutes
Quality Committee, Whittington Health

Date & time:	Wednesday 11th January, 2 – 4
Venue:	Room 6 Whittington Education Centre, Whittington Hospital
Chair:	Anu Singh (AS) Non-Executive Director
Members Present:	Philippa Davies, Director of Nursing and Patient Experience Richard Jennings, Medical Director Yua Haw Yoe, Non-Executive Director Deborah Harris-Ugbomah, Non-Executive Director
In attendance	Steve Hitchins, Chairman Lynne Spencer (LS), Director of Communications & Corporate Affairs Daniela Petre (DP), Head of Risk Gillian Lewis (GL), Compliance and Quality Improvement Manager (minutes) Doug Charlton (DC), Deputy Director of nursing & Patient Experience Deborah Clatworthy (DCl), Head of Nursing, Surgery and Cancer Fiona Isacsson, Director of Operations S&C (deputising for Carol Gillen) Manjit Roseghini (MR), Head of Midwifery Helen Taylor (HT), Clinical Director CSS Gurjit Mahil, Director of Operations, WFS Alison Kett, Head of Nursing Cecil Douglas, Assistant Director of Facilities Julie Wilson, Quality and Safety Manager, CSU (External)
Apologies:	Carol Gillen, Chief Operating Officer Mark Madams, Head of Nursing, Children's Services Rachel Landau, Clinical Director EUC Julie Andrews, Associate Director for Patient Safety Sarah Hayes, Clinical Director PPP Clarissa Murdoch (SM), Clinical Director IM Beverleigh Senior (BS), Director of Operations, PPP Russell Nightingale (RN), Director of Operations, CYN Danielle Morrel, Director of Operations EUC

Agenda items

1.1	**Welcome & Apologies**	Chair
	AS opened the meeting and acknowledged that due to 'Perfect Week' clinical staff may need to leave the meeting early.	

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

1.2	**Minutes of the previous meeting (November 2016)**	Chair
	The minutes of the last meeting were approved with minor typo change. (DP should read DC, on p7 and p8)	

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

1.3	**Action Log**	Chair
	The Action Log was approved and updates recorded. AS recommended a block action to review all ongoing rolling actions and provide an update to the next Quality Committee. The committee discussed the clinical audit programme monitoring and reporting processes. DHU asked how this fed into the Audit and Risk Committee review of audits. The Committee responded that clinical audit is a specific form of quality improvement used in clinical settings and as such falls under the portfolio of the Medical Directorate. An annual report on Clinical Audit and Effectiveness was presented to the Quality Committee in November. In addition each ICSU gets quarterly reports from the clinical audit team, which outline both the mandatory audits and any locally registered audits. YHH asked how the learning from audits was disseminated. FI and HT noted that the audit team monitor ICSUs to ensure audits are completed, and depending on the findings, the report and learning are shared through the relevant route E.g. patient safety issues through the Patient Safety Committee.	

Actions	**Deadline**	**Owner**
See action tracker Review all rolling actions	 March 2017	 PD/ GL

2.	**LUTS Action Plan**	
	RJ presented the LUTS review and action plan, and highlighted the main challenges. RJ provided assurance to the Quality Committee that sufficient safeguards are in place	

	to mitigate the risks associated with the serious incident in the LUTS clinic in October 2015. However RJ noted that while anti-microbial prescribing now has better safeguards in place, more work still needs to be done. Nick Harper will be chairing the MDT on this work. With regard to the continuity of the service, RJ reported that the trust was still in the process of working with UCLH to find a suitable consultant. RJ highlighted that patients have become used to a particular consultant which will not be exactly replicated by the next consultant. RJ noted the continuing reputational risk for the trust, which will need to be managed. RJ added that it was resource intensive and challenging to meet letters from MPs, complaints from patients, press enquiries etc. The two criteria for continuing with service were; 1) A succession plan agreed for the retirement of Professor Malone Lee, and 2) Structures in place to meet the safety and governance concerns raised by RCP RJ informed the Quality Committee that he was continuing to keep NHSE and NHSI updated on the status of the LUTS clinic, and was also in regular contact with the GMC. LS noted there was a Board story from LUTS patient in February AS asked what support was available for patients who had expressed mental health worries when the service was suspended. One patient had previously stated the distress had led them to consider suicide. RJ noted these issues were addressed at the time with the patients. No further issues have been raised, however the trust will look to include a level of mental health support in future service plans.

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

3	**Quality Performance Reports**	**ICSU Leads**
3.1	The IM **Quality Report** was approved by the Quality Committee. Key points were highlighted as follows: • Falls bundle introduced. JKU and Victoria still have high number of falls, however harm from falls have reduced. Two falls on acute admission ward resulted in death, the Practice Development Nurse is now focusing on Mary Seacole wards to ensure falls assessments are done early to mitigate future risk. • Pressure ulcers have been well managed • Medication error reporting has improved • Complaints response rates at 100% for three months in a row • FFT response rate good. AK noted the ICSU would review patient comments and feedback as part of next report RJ highlighted that since January last year there have been 3 deaths from intracranial bleeds following falls. 2 are still under investigation (Dec and Jan) however initial	

learning will be disseminated to clinical staff. This will be a medical message focused on risks of anti-coagulation, how to reverse anti-coagulation and other specific guidelines on head injuries.

YH highlighted some DATIX actions that needed review, went overdue in December 2016. AS asked what the internal process was for reviewing actions. AK noted that all DATIX incidents and actions were reviewed monthly at ICSU board. There was no ICSU Board in December due to Christmas which could explain overdue actions.

AS highlighted theme emerging on delayed transfers of care, and proposed this a deep dive review for Quality Committee.

AK agreed, and noted there would be good learning from perfect week, which interlinks with delayed discharges. FI added that delayed transfers of care links in with the length of stay/ bed flow improvement plan. FI provided an example of improvements during Perfect Week due to having social services representatives attend the hospital to support discharge planning.

Action: Learning from Perfect Week, particularly on delayed transfers of care/ discharge to be presented to Quality Committee in March 2017.

AK presented the End of Life Annual Report and annual report. The report is due for approval at Trust Board in February and to CQRG. Key points included;

- The number of deaths and referrals to the Specialist Palliative Care Team (SPCT) are increasing
- The KPIs for 2015/16 were met
- CQC raised concerns in the July report relating to the End of Life Care (EOLC) service 7 day working, which is a NICE guideline. A business case was developed to enhance the service but unfortunately this was not practical. Whittington is currently working on developing a joint partnership with CNWL.
- Paediatric palliative care service have recently joined the EOLC steering group. Received 'outstanding' in CQC report.
- Plan to relaunch co-ordinate my care within the hospital in 2017/18

The Quality Committee discussed the action plan; PD queried the outstanding actions. AK noted that some actions are in progress but not yet embedded so remain amber.

SH added his input as being NED on Steering Group, and noted it was very experienced group but challenging with retirement of consultant this year.

YH asked about a combined bereavement service. AK noted EOLC only covers acute palliative care. Each of the specialities felt they needed to do things differently and signpost to relevant bereavement services (e.g. ED inpatient admission versus cancer patient).

RJ noted the trust is not commissioned to provide a psychological bereavement counselling service, however staff are well placed to support patients and families with answering questions about cause of death and decisions about palliative care. There is now a 'death bundle' in place which covers issues like duty of candour, communication, investigation processes etc.

The End of Life Annual Report will be presented to CQRG and Trust Board.

3.2	**The Women and Family Quality Report** was approved by the Quality Committee. Key points were highlighted as follows: • Highest reporting area was labour ward, as expected • Risk register has 23 current risks • Serious incidents - 3 declared in October, including maternal death; 4 current open SIs • 100% of complaints responding to within timeframe • Compliments received and logged for maternity services • Mandatory compliance improving FI asked suggested presenting safety incidents reporting trends as percentage for better benchmark. The LAS report was presented by Sinead O'Farrell and Manjit Roseghini. • The findings and feedback from the audit were very positive, particularly in relation to the level of engagement from mothers and families in the process. • Whittington Health has been chosen as a pilot site for the new supervision model (one of two south east sites chosen) • AS asked if there were additional resources for pilot. MR responded there was no additional funding or resources from NHS England so the pilot model was fitted within existing structure. • MR highlighted there will be a bridging process between the pilot and old model. However the new model is based on previous models used in areas like health visiting so there is experience to learn from in implementing the new model. • Restorative supervision will start in next few weeks.

Actions	**Deadline**	**Owner**
Learning from Perfect Week, particularly on delayed transfers of care/ discharge to be presented to Quality Committee in March 2017.	March 2017	CG

4.1	**PLACE Annual report**	**CD/ SP**
	CD outlined the findings from the annual PLACE report, and focused on the drop in food quality and the actions being taken to improve this. • Introduction of a revised patient menu, completed in July 2016 • New patient bedside booklets to be made available to wards later this year • Ward Protected Meal Times have been reviewed, resulting in a standardised protected meal time across the hospital • The trust Food and Hydration Strategy has recently been agreed • 24-hour patient meal availability introduced across hospital in July 2016 • Work continues supporting ward staff in improving the meal service experienced by patients • Continued undertaking of ward-based food tastings, part of our contract food service and quality monitoring program	

	CD noted that the Facilities team complete fortnightly reviews of the meal service, in addition to Sodexo's internal monitoring of the mealtimes. CD noted that Sodexo's survey doesn't always get sufficient response rates to make informed decisions. CD stressed that Whittington Health does not have an end-to-end service. This means that meals are handed over to ward staff to distribute to patients, which can lead to delays and is linked to food temperature complaints from patients. CD added that Whittington Health is one of only two hospitals within the Sodexo portfolio which does not have an end-to-end service. GL commented that in 2017 NEDs will get involved in PLACE reviews, after Board Seminars. DC noted it is difficult to compare tasting food when you are well versus when you are sick, so there is a limitation on any food tasting audits. AS asked CD if he was confident we would do better next year. CD stressed that since the benchmark and weighting changed between 2015 and 2016, it was difficult to directly compare results. However, part of ongoing management and improvement is to monitor meal service directly at ward level focusing on tasting of food, but also food delivery.

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

4.2	**Quality and Safety Risk Register**	DP
	DP presented the Quality and Risk Register; 10 new risks added. The Quality Committee approved the Risk Register. AS asked about the process with regard to target dates overdue. DP explained that the target date signifies the date for review; the target date should be revised following review if actions not completed. AS asked if the DP had confidence that the actions to mitigate the risks were appropriate, in spite of lapsed review dates. DCl and FI noted that risks are discussed at ICSUs but not always updated on DATIX and fed back to Daniela in a timely manner. However DP noted improvements with ICSUs keeping DATIX updated. AS and YH discussed benefit of using a case study example to see risk management process through the system. AS asked if all risk owners had similar process to managing risks; is there a standardised format for risk review at ICSU level. FI noted S&C ICSU developed a simple risk form for staff to complete, which is then reviewed at fortnightly senior risk team meetings to review risk, check scoring, agree actions. Only then is it put on risk register. A standing item at the ICSU Board meetings asks members to identify any new risks. SH noted the importance of getting Internal Audit to review risk management processes at the trust. Need consistency around scoring. LS informed the Quality Committee that	

	an annual audit on risk was due for completion by our Internal Auditors next quarter. It was proposed to use this report as basis for a Whittington-led risk review. RJ highlighted work being done by Julie Andrews with Patient Safety Forum and Dorian Cole as Freedom to Speak up Guardian, as well as improvements with sepsis and on Victoria ward where risks had been identified. YH discussed work with imaging department on risks. One reason stated for not acting on risks was insufficient funds. YH agreed to support team with process-map. HT added that the PMO and Sam Barclay were supporting this work. Action: Next quality committee to look at imaging risk review with YH

Actions	**Deadline**	**Owner**
Next quality committee to look at imaging risk review with YH	March 17	YHH/ HT

4.3	**Nursing Quality Indicators**	DC
	DC presented the Nursing Quality Indicators. The Quality Committee approved the report. Key points included: **1.** Safety Thermometer Patient with no acquired harms 95.8%, an improvement on last month with an average of 96% over the year so far. **2.** Patient Falls remains higher than expected at 26 but a reduction from last month (36) (average 29) **3.** No patient's falls resulting in serious harm **4.** Decrease in the number of patients not receiving the SKKIN bundle in community this month down from 35.4% to 29.5% (average 53%) **5.** Increase in Nutritional screening initiated in 48 hrs this month 95.8% (average 90%) **6.** Mandatory training remains stable at 81. % (average 56%) **7.** 2 Surgery and 2 Medicine triggered red shifts this month HT requested a change to the wording on medication incidents that cause harm.	

Actions	**Deadline**	**Owner**
Medication incident wording on Nursing Quality Indicators to be amended.	March 17	DC

4.4	**Nursing Safer Staffing Review**	DC
	DC presented the November safe staffing data, approved by the Quality Committee. Key issues included:	

	• A reduced fill rate for Registered Nurses displayed in the UNIFY report • Increase use of special shifts used to support vulnerable patients November (235) vs October (115) • Same level of Red Shifts reported in November (4) compared to October (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). • The continued use of agency and bank staff to support safe staffing

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

4.5	**Nursing and Midwifery Establishment Review**	LS
	LS presented the six monthly update on the Nursing and Midwifery establishment review. The review found that establishment levels were safe based on National Quality Board guidance and evidence based tools, however vacancies have increased in last six months. Turnover was 15% was presented a challenge for the trust. These issues are being considered in the Recruitment and Retention group. LS noted that 6 months ago, only 1-2 wards reported 100% occupancy, now most wards reported 100% occupancy. The report only shows patient in the bed at the time of survey, so the occupancy figure would not capture where multiple patients used the same bed over a 24 hour period. Acuity had also increased since the last review. DCl noted LS meets with each HON to discuss figures and check accuracy in the report, before final submission. AS asked if the report was useful operationally to make decisions. DCl confirmed the review was useful, particularly when acting as silver or gold on-call. FI asked about theatres staff. LS noted it was a difficult area to review, the figure is an indication PD noted Quality Committee were asked to review and approve the recommendations on behalf of the Trust Board. AS agreed to adopt recommendations on behalf of Board. .	

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

4.6	**Quality Assurance Report**	GL
	GL presented the Quality Assurance Report which included updates on the CQC action plan, the peer review programme, patient safety huddles and the Accessible Information Standard.	

	FI asked if the critical care actions had been closed. GL responded that this work was ongoing. PD explained the specific concerns raised by CQC with respect to mixed sex accommodation for L1 patients and noted that we had not received any complaints from patients. SH asked for more details on the peer review programme, with regard to frequency of visits and the comprehensiveness of the review. GL noted it was important to balance the time commitment of busy clinical staff, against the need for a useful review. As such the template had been piloted and amended over the last three months, and was quite comprehensive but easy to complete. SH suggested scores from peer reviews should be displayed in ward and service area noticeboards. GL agreed to look into this going forward.

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

4.7	**Nursing, Midwifery and AHP Education Q3 Report**	**LS**
	LS presented the quarterly Nursing, Midwifery and Education report. Key issues included; • The NMC visit outcome was: no concerns identified. • £132,614 was spent on continuing professional development courses and other learning opportunities. • 1,224 undergraduate student placement weeks were supported. • 204 staff were trained in dementia care. • 137 staff attended leadership development courses. • The library were awarded first place in the poster competition at the Annual London and South East NHS Libraries Conference. • 311 staff were trained in resuscitation. LS noted Whittington Health had been invited to join a national research programme on dementia.	

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

4.8	**CAS Annual Report**	

	GL presented the CAS annual report, approved by Quality Committee. All alerts were responded to within the required timeframes in 2016. GL noted patient safety alerts are now a standing agenda item at the Patient Safety Committee and the process is working well.

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

4.9	**Trust Policies**	**DP**
	GL noted the number of outstanding policies had started slipping again but that a number were due for ratification in January. AS asked if there were any safety risks associated with overdue policies. GL noted this would be policy specific. AS asked if there was process for risk assessing overdue policies. Action: PD and GL to discuss process for risk assessing overdue policies	

Actions	**Deadline**	**Owner**
PD and GL to discuss process for risk assessing overdue policies	March 17	PD/ GL

5.0	**Minutes from reporting groups**	**For information only**
	AS noted that the ICSU Boards were now encompassing quality and safety rather than holding separate quality and safety meetings. DCl noted that Julie Andrews attended the S&C ICSU Board to give opinion on the process for reviewing quality and safety. Action: PD to discuss with all ICSU Clinical Directors on the process for managing quality and safety at ICSU meetings	

Actions	**Deadline**	**Owner**
PD to discuss with all ICSU Clinical Directors on the process for managing quality and safety at ICSU meetings	March 17	PD

6.0	**For information only**	
	• Serious Incident Report • Quality Committee Annual Workplan	

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

7.	AOB	Lead
	None	

Actions	Deadline	Owner

Next meeting: Wednesday 8 March 2017, Room 6, Whittington Education Centre

Whittington Health NHS

Draft minutes of

The Whittington Health Charitable Funds Committee

4th January 2017

ITEM 17/026
Doc : 09

Present:	Tony Rice	TR	Non-Executive Director, Chair
	Stephen Bloomer	SB	Chief Finance Officer
	Graham Brogden	GB	Head of Fundraising
	Adrien Cooper	AC	Director of Environment
	Philippa Davies	PD	Director of Nursing & Patient Experience
	Siobhan Harrington	SMH	Deputy CEO & Director of Strategy
	Steve Hitchins	SH	Chairman
	Simon Pleydell	SP	Chief Executive Officer
	Lynne Spencer	LS	Director of Communications
	Jonathan Ware	JW	Head of Financial Accounts
	Vivien Bucke	VB	Business Support Manager, Finance

16/033 Welcome, Apologies for Absence & Declarations of Interest

33.1 No Declarations of Interest were received

16/034 Approval of Minutes of the meeting held on 2nd November 2016

34.1 The minutes were agreed as an accurate record.

16/035 Analysis of Fund Balances and their usage Paper 2a

35.1 The breakdown of fund balances shows a total balance of just under £3.8m; an increase of £86k since the last committee report. This reflects the receipt of the final Edith Layton £250k and also reflects increase in expenditure and bid processing since the arrival of the Charitable Funds accountant who has cleared remaining bids.

35.2 The main movement in funds is to separately identify the £1m maternity move from unrestricted general to unrestricted specific use funds, to demonstrate the true balance in the light of the number of bids recently received for the general funds and to reflect the Committee's wishes to earmark the £1m.

35.3 With regard to the Kanitz bequest the committee discussed the ideas put forward to date by the clinical team and expect a report to the next committee.

35.4 The committee discussed requests received for funding from general funds and expressed a preference for requests to be returned from an areas specific fund.

Financial Report Month 9 2016/17 Paper 2b

35.5 The committee discussed expenditure and noted the level of Expenditure has doubled compared to that at month 7 and noted this is line with the committee's aspiration.

16/036 Risk Profile of Fund Investment Paper 3

36.1 The committee discussed the risk profile and was satisfied that Trust is holding appropriate funding within the naming and fund manager process. It was not expecting to change the profile in the coming year. It was noted that the period of investment for maternity funding may change in the coming weeks.

16/037 Major Fundraising Scheme for Ifor ward Paper 4

37.1 Bright Horizons Day Nurseries & Foundation for Children and their preferred suppliers had viewed the site several times. The site, split currently by a dividing wall, could be either two areas or one large. The project team will be attending the Royal London Hospital who have two play spaces outdoor and indoor, to gain inspiration to then create plans and costs. At this stage Bright Horizons may fund all or some and the local toy project may be involved.

37.2 Members of the young people's forum are involved in the design. The scheme would come to fruition in September/October. The Committee agreed that in principle this was a good idea and this item would return with more detail.

16/038 Applications for Funding Paper 5

38.1 The committee approved the bids for Kanitz funding and staff meals on Christmas day.

Paper 5A Awards Ceremony & Process

38.2 The Committee agreed up to £30k expenditure from the general fund and the panel should try to obtain sponsorship**.** A short report by finance on expenditure and lessons for future years after the event will be produced. **PD** **JW**

16/039 Fundraising Update Report

39.1 Events highlighted were:

- £700 raised from bucket collections at Christmas events.
- There had been a million hits from publicity from the football team visits at Christmas and Communications hoped next year to record a message from players asking to support the charity.
- Christmas card sales raised £900

39.2 The most important campaign is the Maternity Unit appeal with other planned events of:

- A sponsored Abseil. The works were quoted at £20k in the Summer but if sponsorship could cover then this would be a possibility. Costs to be checked once more. **AC**
- Annual Rotary Club Quiz night on 9th February with 10 teams now involved.
- Charity runs
- Quiz night in February
- Sponsored Cycle rides (London to Brighton & London to Paris)
- The Lord Mayors walk

16/040 Any Other Business

40.1 None