NHS
Whittington Health
NHS Trust

Meeting	**Trust Board – Public**
Date & time	**1 March 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
17/027	**Declaration of Conflicts of Interests** *Steve Hitchins, Chair*	*Verbal*	*Declare* 1420hrs
17/028	**Apologies & Welcome** *Steve Hitchins, Chair*	*Verbal*	*Note* 1425hrs
17/029	**Draft Minutes, Action Log & Matters Arising 1 February 2017** *Steve Hitchins, Chair*	1	*Approve* 1430hrs
17/030	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Note* 1435hrs
17/031	**Chief Executive's Report** *Simon Pleydell, Chief Executive*	2	*Approve* 1445hrs
Patient Safety & Quality			

	Freedom to Speak Up Guardian - Presentation by Dorian Cole		***1455hrs***
17/032	**Serious Incident Report Month 10** *Philippa Davies, Director of Nursing & Patient Experience*	3	*Approve* 1510hrs
17/033	**Safer Staffing Report Month 10** *Philippa Davies, Director of Nursing & Patient Experience*	4	*Approve* 1520hrs
17/034	**End of Care Life (EOL) Update** *Carol Gillen, Chief Operating Officer*	5	*Approve* 1530hrs
17/035	**Board Assurance Framework** *Siobhan Harrington, Deputy Chief Executive*	6	*Approve* 1540hrs
Strategy			
17/036	**UCLH and Whittington Health Clinical Collaboration MOU** *Simon Pleydell, Chief Executive*	7	*Approve* 1550hrs
17/037	**Digital Strategy 2017-2020** *Steven Bloomer, Chief Finance Officer*	8	*Approve* 1600hrs
Performance			
17/038	**Financial Performance Month 10** *Stephen Bloomer, Chief Finance Officer*	9	*Approve* 1610hrs
17/039	**Performance Dashboard Month 10** *Carol Gillen, Chief Operating Officer*	10	*Approve* 1620hrs
Governance			
17/040	**Trust Board & Senior team Declaration/Conflicts of Interests Annual Register & NHS England new guidance** *Steve Hitchins, Chair*	11	*Declare* 1630hrs
Any other urgent business and questions from the public			
	No items		
Date of next Trust Board Meeting			
	05 April 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: 1
Doc: 17/029

The draft minutes of the meeting of the Trust Board of Whittington Health held in public at 1400hrs on Wednesday 1st February 2017 in the Whittington Education Centre

Present:	Stephen Bloomer	Chief Finance Officer
	Philippa Davies	Director of Nursing and Patient Experience
	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 Alison and Paul Taylor and Kay Middleton. Kay was a user of the Trust's LUTS clinic, and Alison and Paul parents of a child who had been referred to the clinic.

Kay, a psychologist by profession, explained that she had suffered for some time with LUTS and had frequently found it difficult to get definitive test results. Her symptoms had worsened considerably some two years ago, and she had been treated with antibiotics, but found that after a very short time her symptoms had returned. She eventually saw a urologist, who initially advised her to let her symptoms become stronger in order to be sure of getting some test results, and she had to be admitted to hospital, but still her tests came back clear.

Medicine being her first degree, she conducted some personal research and found Whittington Health's LUTS clinic, and within a week of entering their treatment regime, was much improved and able to resume work; two years later she is well and not taking any medication. She described the clinic and her treatment as literally "life-saving".

Paul and Alison's daughter Alice had suffered from UTIs since the age of three (she was now seven). She had been seen frequently by a doctor and referred for tests, but these tests had come back sometimes positive for the infection, sometimes not. Referred to her local specialist hospital, she was diagnosed with 'painful bladder syndrome' – aged six, Alice was in chronic pain, unable to sleep, and her schoolwork was suffering. Having tried to treat her himself with little success, a private specialist referred her to Professor Malone-Lee. Within three days she had begun to improve, and now, a year later, is fully recovered and no longer on antibiotics.

Wishing to tell the Board what they had learned from Alice's illness and treatment, Alison Taylor said that primary and secondary care doctors appeared to have insufficient experience in this field, there are no NICE guidelines, this is a neglected area of medicine, and tests miss up to 50% of infections. The Whittington Health's LUTS clinic is the only international one available, and children referred there tend to have been referred by specialists who have exhausted all

other options. She ended by thanking Board members for listening to their patient stories. Simon Pleydell reiterated that the Board was committed to securing the future of the clinic, and thanked Mr & Mrs Taylor and Dr Middleton for sharing their experiences and thus bringing their stories to life. On behalf of the Board, Steve Hitchins thanked Dr Middleton and Mr & Mrs Taylor for attending and for sharing their stories.

17/15 Declaration of Conflicts of Interest

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

17/16 Apologies and welcome

16.01 Steve Hitchins welcomed everyone to the meeting. Apologies for absence were received from Siobhan Harrington.

17/17 Minutes, Matters Arising & Action Log

17.01 Richard Jennings requested an amendment to minute 178.03 (LUTS Clinic), and agreed to supply an alternative from of words outside the meeting.

17.02 Other than this, the minutes of the Trust Board meeting held on 4th January were approved. There were no matters arising other than those scheduled for discussion.

17/18 Chairman's Report

18.01 Steve Hitchins began his report by thanking those Non-Executive Directors who had participated in the recent 'Perfect Week', saying that much had been learned. The following day he and Norma French were to visit the College of North East London; he had also recently visited City & Islington College. Discussions had been held around interns, apprenticeships and generally building a pipeline for local employers. The community forum was progressing well, as were plans for an art competition, and contact had been made with all schools in Islington and Haringey.

18.02 Steve had been in San Francisco the previous week, and had been fortunate to have the opportunity to visit Kaiser Permanente – a slide show was available for those wishing to see more detail of this.

18.03 Accompanied by Philippa Davies and Richard Jennings, Steve had attended the funeral of risk management team member Jonathan Rowe. Jonathan's family had been pleased to see how many Whittington Health colleagues had attended, and there would be a memorial to Jonathan at the Trust in a few months' time.

17/19 Chief Executive's Report

19.01 Reporting on progress with the STP, Simon Pleydell informed the Board that a strategic commissioning organisation for the whole of the North Central London sector was being established; Helen Pettison had been appointed as its Chief Executive, and she would be taking up post in April. Moving forward, Trusts were scrutinising the numbers assumed in contracts, and Simon was concerned that progress on this was not as fast as he would have hoped, but positive work was ongoing.

19.02 A meeting had been held the previous day with the Haringey and Islington Health & Wellbeing Board, where continuing concerns had been expressed about public and patient engagement. It was acknowledged that communications could not commence because there were no clear or agreed plans to enable meaningful communication. A paper had been produced which set out the planned joint approach to integrated care and leaders of both local authorities agreed this was the best way forward. Janet Burgess supported Simon's point about partnership working and jointly setting the agenda. She agreed that progress was fairly slow, but this was perhaps inevitable given the size of the agenda and the changes required. She agreed that communicating to the public was a priority but there needed to be a definite and clear plan before factual messages could be shared. She felt the inclusion of social care to be a positive step. Steve Hitchins paid tribute to the continuing strong relationship between Whittington Health and Islington and Haringey local authorities.

19.03 The Trust was performing well with delayed discharges; the bigger challenge was the volume of patients attending the hospital. There was to be another Board meeting the following Thursday, where the reality of developing care closer to home and integrated networks would form a key part of the agenda. A substantive programme director was to be appointed to lead the Health & Wellbeing Board.

19.04 Simon paid tribute to all staff who had been involved in the Trust's 'flu campaign. This had been a great success, with the take-up rate of staff having received the vaccination being the highest in London. Simon reminded everyone of the very real danger of 'flu, adding that there had been a recent death from 'flu at the hospital.

19.05 Schwarz Rounds were getting underway, and Simon reminded Board members to ensure dates for these events were in diaries. He commended them as an excellent opportunity to share experiences and in some cases act as a 'release valve' for staff to talk about issues that they had faced. Tony Rice had attended one where the topic had been mental health, describing it as a brilliant exposition of the complexities people dealt with on a day to day basis. Simon felt there would be mileage in holding a Schwarz Round on caring for people in their own homes, as this brought about completely different challenges from caring for people in hospital or even community clinics and health centres. The Trust had been successful in obtaining funding towards the development of mindfulness programmes for staff; these were to be led by the IAPT team and represented real value.

19.06 There continued to be immense pressure on the Trust Emergency Department (ED), and Simon explained that the Trust priority was to support staff who continued to work hard to maintain a safe high quality service.

19.07 Moving on to the Strategic Estates Partnership, Simon said that the Trust was now in the process of moving from three bidders to two. The next phase was to decide on the balance between the need to maintain commercial confidentiality and the desirability of seeking a wider view on ideas. What was clear was that the Trust was in possession of a site that held real value, and positive actions and decisions must be taken to fulfil our role of custodian of that potential. The final partner was likely to be selected in May or June, and the Trust would then enter into a process with NHS Improvement (NHSI).

19.08 Simon ended his report by speaking about the Trust's financial position, stressing the need for the Trust to meet its agreed control total by the end of the financial year. NHSI had made this requirement clear, and the Trust needed to continue to take all appropriate measures to ensure this was achieved and to deliver against its targets.

19.09 Board members congratulated Kate Green on being named 'employee of the month'.

17/20 Serious Incident Report

20.01 Philippa Davies informed the Board that three serious incidents had been declared during December, one of which had subsequently been de-escalated. Drawing attention to the table contained within the report, she explained that the incident which dated back to May 2016 related to the need to carry out an external review; this had been agreed with the Trust's commissioners.

20.02 Richard Jennings added that a number of incidents had taken place where patients had died after leaving the Trust's ED. Although there appeared to be no obvious pattern or trend around these incidents, it had been agreed that an external review would provide should be commissioned, details of which were to be finalised. Further detail on this would be reported back to the Board.

20.03 In January, two patients had died following falls, and Richard Jennings informed the Board that some important learning had come from these incidents, particularly around neurological assessments and anti-coagulation medication. Steve Hitchins suggested that some of the learning from SIs could usefully be brought to the Board, and Richard agreed that this should form a part of a future report.

17/21 Safe Staffing Report

21.01 Philippa Davies introduced the safe staffing report covering December, saying that there had been an increase both in the need for specials as compared with the previous month due to the number of vulnerable patients on the wards, and also the number of RMNs required to provide specialist care for mental health patients.

17/22 Quarterly Safety & Quality Report

22.01 Richard Jennings explained that this report covered two quarters, Quarter 2 (July to September) and 3 (October to December). He drew attention to the section on mortality indicators (which were still good) that showed the seasonal variation both within the Trust and nationally. This report focused on indicators in the winter months and in the narrative compared 2014/15 data with 2015/16, both locally and nationally. Respiratory disease was to some extent a contributory factor.

22.02 Moving on to infectious diseases, Richard reminded the Board that the Trust had declared one case of MRSA during this period. As mentioned earlier the take-up rate amongst staff of the 'flu vaccination had been the highest in London. There had been a rise in the number of in-patients suffering from 'flu, and Richard informed the Board that for the last two years if any patient was found to have contracted the disease in hospital and subsequently died from any associated condition their death was treated as an SI and a Root Cause Analysis (RCA) investigation was carried out. At the time of writing none had been so categorised, but due to the rising number of patients with 'flu it was 2 likely this might change. In answer to a question from Tony Rice about particular strains of the disease, Richard replied that people tended to forget how dangerous 'flu was, and gave a brief history of some of the notable outbreaks.

22.03 Much good work had been carried out on reducing the incidence of pressure ulcers, but Richard acknowledged that this remained a challenge in the community. Some pressure ulcers were termed 'avoidable' because they had been acquired whilst the patient was under the care of the Trust, but there were challenges inherent in caring for people in their own homes. Tony Rice had been out with the District Nursing Team and had personally observed this and understood the difficulties. David Holt asked whether Richard could explain the peak in Grade 3 pressure ulcers shown in the report; Richard

replied it was possible that the peak might be attributable to the small numbers and he was seeking further clarification from his team.

22.04 Turning to Section 6 of the report, Richard said that he was pleased with the rise in incident reporting. The Trust had a good reporting culture, and had been seeking a rise in reports. Steve Hitchins asked whether this could be fed back to staff, and Richard said that it was, adding that the one of the most powerful incentives to report was for staff to see what had been done as a result of learning from an incident.

22.05 The mortality review process was not at the stage it should be, and would not be until the next financial year. The plan, Richard said, was that from the following year not only would the process be carried out, but also reported on. They were on an improvement trajectory, and the Board would be kept informed of progress.

22.06 The seven day service survey showed that the Trust was well within the standards achieved by comparable organisations and in the top quartile both for patients receiving a consultant review when they required it on a Saturday or Sunday and for being seen twice on these days when necessary, and Richard felt the Trust was performing well in this area.

22.07 Lynne Spencer drew attention to the new patient safety newsletter and distributed copies, thanking Gillian Lewis for having been instrumental in its production. Simon Pleydell reminded the Board of the CQC's recommendation that the Trust should maintain an up-to-date reporting position saying that he felt this had been achieved, and said that the seven day audit results were commendable.

17/23 <u>Financial Report</u>

23.01 Stephen Bloomer reported that the Trust's financial position was broadly on plan, having given a commitment to NHS Improvement that it would achieve its control total by the end of the financial year. There continued to be overspend on pay, but for the first time he was able to report that nursing agency spend was within cap. Pay overspend could broadly be attributed to winter pressures and the consequent increase in patients.

23.02 All but one of the Integrated Clinical Service Units (ICSUs) had not met their financial targets within the month, and plans had been agreed with them to improve this position and get them back on track. The corporate teams were also off trajectory for their financial targets and the capital programme was behind schedule. Tony Rice congratulated the executive team on the efforts made to reduce agency spend, and hoped the forthcoming work on medical productivity would improve the overall position.

23.03 David Holt registered a degree of disappointment in the performance of the ICSUs, saying this would be scrutinised through the Finance & Business Development Committee; there needed to be a cultural change on how staff manage budgets.

17/24 Performance Dashboard

24.01 Carol Gillen reported that activity within Emergency & Urgent Care had reduced very slightly from that declared the previous month, although the service remained acutely challenged. As an example, the number of ambulances coming to the Trust had previously been 50 per day and had now reached between 60 and 66. To some extent the Trust was a victim of its own success since it was known to be good and efficient at handover. Less than half of patients (42%) brought to the hospital by ambulance were subsequently admitted to hospital, and Simon reiterated that there was still much to do in order to improve treatment within the community; this was a whole system issue, and one which was being studied in detail by the Emergency & Urgent Care Board. There was a detailed improvement plan, and progress against this was evident.

24.02 The ECIP team had been invited to carry out a review of the ED 'front of house'. The main recommendations arising from this centred around:

- maintaining a focus on the Rapid Assessment Team
- extending surgical pathways within ambulatory care
- focusing on frailty, and
- reviewing the medical staffing model in the AAU.

The ECIP team was to return to the Trust to review the hospital and wider health and social care systems.

24.03 The Trust's performance on cancer waits continued to improve although the 62 day target had not been met, and there were issues around the transferring of patients to UCLH which needed to be addressed; from April breaches were no longer to be shared. Much of the backlog within the urology service had been cleared. A detailed review of ED readmissions was to be carried out.

24.04 Delayed transfer of care cases had reduced, with the Trust performing well in this area due in no small part to effective working with local authority partners. There had been an improved rate for the Friends & Family Test (FFT) in ED, and a slight improvement in theatre utilisation. RRT performance was good, although there would be some catching up to do in future weeks due to the suspension of some cases in January.

24.05 Moving on to HR performance, Carol said there had been a slight increase in staff sickness. In answer to a question from Steve Hitchins about HR performance, Norma French replied that a great deal of work had been carried out by the HR Business Partners working in conjunction with the ICSUs, and she was confident in both the figures and the positive progress made. Deborah Harris asked for some detail on the Friends & Family test, and Philippa Davies replied that this would be an item for discussion at the next Quality Committee meeting. Deborah asked about the learning from complaints; Philippa said that this was contained in the detailed reports prepared by Angel Bellot for the Quality and Patient Experience Committees. Information on compliments was also recorded and reported. Richard Jennings added that information from complaints suggested a theme of patients having difficulty in contacting the Trust, and in particular experiencing difficulties in changing their out-patient appointments.

24.06 David Holt commended the quality of the new-style report, and in particular on the commentary contained within it, which explained not just facts about performance but also what was being done to address things.

17/25 Quality Committee

25.01 Anu Singh introduced the draft minutes of the Quality Committee held on 11th January. She drew attention to the committee's regular review of the risk management approach, including mitigations, targets and timescales, and informed the Board that Yua Haw Yoe was working on a case study approach within the imaging department. The committee had planned to carry out a detailed examination of delayed transfers of care but recent data had given cause for reconsidering this.

25.02 Steve Hitchins commended both Anu and Philippa for the improvements made to the functioning of the committee and noted it had become more strategic. He confirmed that risk management and reporting was on the next Board seminar Agenda.

17/26 Charitable Funds Committee

26.01 Reporting on the meeting which had taken place on 4th January, Tony Rice said that the new system had begun to produce dividends in terms of ideas for both spending and fundraising. Two ideas for the former were a children's play area on Ifor Ward, and an awards event for staff, which was to be a three-year commitment. The main commitment remained maternity services, but if the redevelopment was not now imminent, then there would be a need to rethink the committee's priorities. Steve Hitchins expressed the view that any major decision should be brought to the full Board for ratification. It was noted that the first staff award event would take place on 29th June at the Royal College of Surgeons, Lincoln's Inn Fields.

Action Notes Summary

Minute	**Action**	**Date**	**Lead**
17.01	Richard Jennings requested an amendment to minute 178.03 (LUTS Clinic), and agreed to supply an alternative from of words outside the meeting.	**Complete**	**RJ**
20.02	SI external review detail to be reported back to the Board.	**tbc**	**RJ**
20.03	Learning from SIs to be brought to the Board in future	**Complete - Within future quarterly patient & safety reports**	**RJ**
22.05	Mortality review process/progress – Keep Board informed	**Complete – Within future quarterly patient & Safety reports**	**RJ**
24.05	Friends & Family test for discussion at Quality Committee	**Complete – on 8 March Quality Committee Agenda**	**PD**
26.01	Charity Committee - main commitment remained maternity services but if the redevelopment was not imminent, then there would need to be a rethink of priorities. Steve Hitchins said that any major decision should be brought to the full Board for ratification.	**tbc**	**SB**

Nursing and Patient Experience
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Whittington Health

March 2017

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	**17/03**	**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 February 2017. 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:			

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 January 2017.

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 4 serious incidents during January 2017 bringing the total of reportable serious incidents to 49 since 1st April 2016.

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All serious incidents are reported to North East London Commissioning Support Unit (NEL CSU) via StEIS and a lead investigator is assigned to each by the Clinical Director of the relevant Integrated Clinical Support Unit.

All serious incidents are uploaded to the NRLS (National Reporting and Learning Service) in line with national guidance and CQC statutory notification requirements.

3.2 **The table below details the Serious Incidents currently under investigation**

Category	Month Declared	Summary
Safeguarding Incident Ref:13782	May 16	Safeguarding incident in relation to a patient on a current caseload.
Unexpected death Ref: 25397 (submitted 21/02/2017)	Sept 16	Unexpected death of patient with bilateral pulmonary embolism.
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.

Category	Month Declared	Summary
Unavoidable Death Ref: 30701	Nov 16	Inappropriate surgical referral and delayed diagnosis.
Unavoidable Death Ref:30716	Nov 16	Delay in implementing DNAR / end of life care pathway/inappropriate pain management.
Unexpected Death Ref:30720 (submitted 21/02/2017)	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
Delayed Diagnosis - Colposcopy Ref:30095 (submitted 16/02/2017)	Nov 16	A delay in reviewing biopsy results, led to delay in diagnosis.
Unexpected Death Ref:31941	Dec16	Patient assessed and discharged by the Mental Health Liaison Team with referral to the crisis team. Patient was subsequently found unresponsive.
Patient Fall (ward 1) Ref: 33339	Dec 16	Patient fell from standing position resulting in a fractured skull and intra-cerebral bleed.
Patient Fall (ward 2) Ref:390	Jan 17	Patient fell forward from the bottom of the bed resulting in a subdural haematoma
Patient Fall (ward 2) Ref:2718	Jan 17	Patient had an unwitnessed fall resulting in a fractured neck of femur.
Delayed Diagnosis Ref:2722	Jan 17	A delay in diagnosing a perforation of the gastrointestinal tract.
Patient Fall (ward 3) Ref:2706	Jan 17	Patient had an unwitnessed fall resulting in subdural haematoma.

The table below details serious incidents by category reported to the NEL CSU. The Trust reported 3 serious incidents during January 2017.

STEIS 2016-17 Category	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Total
Safeguarding	0	1	1	0	1	0	1	0	0	0	4
Attempted self-harm	0	0	0	0	0	0	0	1	0	0	1
Confidential information leak/loss/Information governance breach	1	2	1	0	1	1	0	0	0	0	6
Diagnostic Incident including delay	2	1	0	0	0	1	1	1	0	1	7
Failure to source a tier 4 bed for a child	0	0	0	1	0	0	0	0	0	0	1
Failure to meet expected target (12 hr trolley breach)	0	0	0	0	0	0	1	0	0	0	1
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	1	1	1	0	0	2	1	0	0	0	6
Maternity/Obstetric incident mother only	0	0	0	0	1	0	1	0	0	0	2
Medical disposables incident meeting SI criteria	0	0	0	0	0	0	1	0	0	0	1
Nasogastric tube	0	0	0	0	0	0	1	0	0	0	1
Slip/Trips/Falls	0	0	0	1	0	0	0	0	2	3	6
Sub optimal Care	0	0	0	0	0	0	1	1	0	0	2
Treatment Delay	0	0	0	0	0	0	1	0	0	0	1
Unexpected death	0	1	0	1	0	1	0	5	1	0	9
Retained foreign object	0	0	0	0	0	1	0	0	0	0	1
Total	4	6	3	3	3	6	9	**8**	**3**	**4**	**49**

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 January 2017.

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 8 reports to NELCSU during January 2017.**

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 January 2017.

Summary	Actions taken as result of lessons learnt
• **Ref 23932**	**Information Governance breach - Lost patient list found by a member of WH staff**. • The trust are reviewing solutions for not having RiO printable diary sheet with patient identifiable paperwork in transit. • Process flowchart designed for agency & bank staff to be updated and reintroduced. • Regular audits are being undertaken within the DN service to make sure that agency staff are routinely returning patient lists to the office after completion of their visits.
• **Ref:26486**	**Patient deterioration during NasoGastric (NG) feeding.** • Learning from a previous Never Event involving a misplaced NG tube was evident in the actions taken following discovery of this incident, In order to improve care provided to NG patients one additional recommendation has been made which is to involve the (on call) physio if NG feeding is to be continued overnight. • Speech and Language and Dietetic staff are collaborating on guidance to assist MDT decision making regarding appropriateness of NG tube insertion. • Lessons learned to be included in all NG training programmes and education sessions. Monthly 'New Nurses orientation programme' ・Monthly 'Fundamentals of Nursing' study days ・Part of the ward daily teaching.
• **Ref:26963**	**Maternal Death - Patient deterioration 10 days post delivery resulting in cardiac arrest.** • Thromboembolism Prophylaxis in Pregnancy guideline to reference Instrumental Vaginal Delivery guideline to clarify a mid- or low cavity vaginal delivery. • Maternity Day Assessment Unit (MDU) unit guideline and the Triage assessment guideline to be cross-referenced in terms of the frequency of blood pressure checks on the patient that presents with raised blood pressure. • Postnatal VTE assessment to be made mandatory as part of the delivery notes in order to identify risk factors for thromboprohylaxis whatever the mode of delivery. VTE checkbox in the postnatal notes to be updated to bring it in line with current guidance from the RCOG. • Create a mandatory field in the electronic records to input postnatal Risk factors to identify if the patient is at risk of developing VTE and requires prophylactic LMW Heparin.
• **Ref: 27113**	**Delayed diagnosis. - Delayed diagnosis due to failure to follow up investigation result.** • To ensure that the clinical policy in development for alerting and checking Radiology and Histopathology reports requested in Emergency Department and Out-patient to be agreed and disseminated as soon as possible. Relevant clinical directors and clinical leads to ensure that this is communicated across teams.

Summary	Actions taken as result of lessons learnt
	• Training to be made available to all clinicians about how to use Anglia ICE effectively to check results of requested investigations and results and to log outcomes.
• **Ref: 27258**	**Discharge Planning failure.** - **Patient discharged from hospital without appropriate discharge plans in place**. • Discharge processes to include utilisation of the discharge checklist. • All nurses on the ward to receive additional training on discharge planning.This will include improved understanding of the community services, using the 'Street index' for Haringey and Islington. In addition discharge planning should be incorporated into the new nurse's induction programme including a shadowing shift with the District Nurses. • All senior nurses should be involved in discharge planning so this is not reliant on the shift lead to organise discharge. This will improve relationships with the ward and community staff. • Ward nurses to routinely shadow community nurses to develop their knowledge of processes in the community. • Consideration being given to trial 'risk rated' discharge planning whereby those patients rated as complex receive a follow up phone call from the ward.
• **Ref.27253**	**12 hour trolley breach -A patient had a prolonged wait in the Emergency Department (ED) due to lack of bed availability in appropriate setting.** • A robust escalation plan developed for patients waiting over 6 hours in ED. • Patients waiting for more than 6 hours will have a named staff member who will be responsible for monitoring and facilitating the process of the patient being transferred from ED to a ward. • There needs to be clarity about the roles and responsibilities relating to patient flow from ED, including CDU. This should be covered by the change in transfer policy.
• **Ref.28068**	**Missing Swabs following instrumental delivery and suturing tear.** • 'Swab Instrument and Needle' guideline updated to make it explicit as to where swabs should be placed during a procedure. • Refresher training is now provided regularly for all staff involved in procedures that require swab counts. • Live skills and drills dealing with obstetric emergencies recommenced on 14/10/2016 and are now taking place fortnightly and include swab counting as part of the programme. • A multidisciplinary discussion to be held in regard to supporting staff to challenge colleagues practicing outside of agreed protocols and guidelines.
• **Ref.27586**	**Baby born in poor condition was transferred to the Neonatal Intensive Care –unavoidable death.** • GAP GROW training -relevant staff working to have received training by 31st March 2017.

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

January 2017

Title:	Safe Staffing - Nursing and Midwifery – January data		
Agenda item:	**17/033**	**Paper**	**04**
Action requested:	For information		
Executive Summary:	This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in January 2017. Key issues to note include: 1. A increased fill rate for care staff displayed in the UNIFY report 2. Reduced use of special shifts used to support vulnerable patients January (114) vs December (252) 3. Reduced level of Red Shifts reported in January (3) compared to December (4) 4. The number of RMN 'specials' used to care for patients with a mental health conditions was lower in January (26) compared to December (57). 5. CHPPD measure during the month was decreased from (8.54) in January compared to (8.76) in December 6. The continued use of agency and bank staff to support safe staffing. 7. Staff initiated 27 Datix reports in January highlighting staffing as an issue. One report relating to a patient harm from a fall.		
Summary of recommendations:	Trust Board members are asked to note the January 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 January 2017.

1.2 To provide context for the Trust Board on the UNIFY safe staffing submission for the month of January 2017.

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 December 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 January 2017 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 – 89.2% Night – 92.4%
	Care hours per Patient Day - CHPPD	Overall the CHPPD for January was 8.54 which is lower than last month, the RN delivered care continues to be consistent
Staff were supported in their decision making by effective reporting.	0.2% of Red triggered shifts	3 shifts triggered red in January 2017 this was less than December
	5.3% of shifts remained partially mitigated (Amber shifts)	74 shifts i.e. 5.3% of all shifts in month. This was a decrease on December'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 89.2% for registered staff and 112.7% for care staff during the day and 92.4% for registered staff and 119.8% for care staff during the night.

3.3 On the day shift, nine wards reported below 90% fill rates for qualified nurses. Twelve wards had above 100% fill rate for unqualified nurse and six 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, Mary Seacole North at above 200% for HCAs. 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 a 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
89.2%	**112.7%**	**92.4%**	**119.8%**

4.0 Additional Staff (Specials 1:1)

4.1 When comparing January's total requirement for 1:1 'specials' with previous month, the figures demonstrate a decrease in the number of shifts required (Appendix 2). January saw 114 requests for 1:1 specials compared to 252 requests in December. The requests made for this level of care were to ensure the safe management of particularly vulnerable groups of patients.

4.2 The number of RMN 'specials' used to care for patients with a mental health condition was lower in January (26) compared to December (57). 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 January 3 shifts triggering red.

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

5.4 Wards triggering red shift

	Initial Red Shifts				
Wards	Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	% of shifts where staffing fell below agreed levels and triggered a red rating
Mercers	1	2	0		**3**

5.5 Summary of factors affecting red triggering shifts

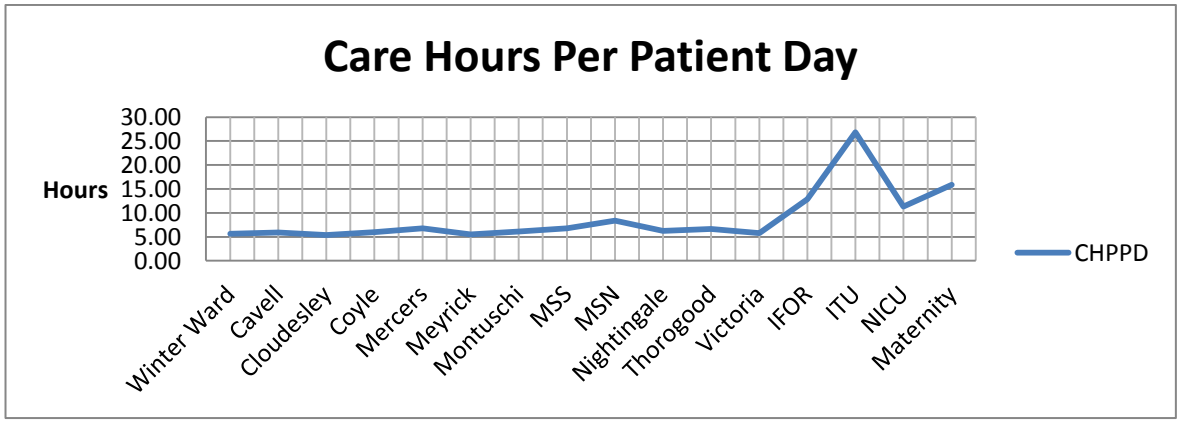
a. Temporary staffing fill
b. Vacancy rate – Nurse Vacancy rate at ward level remains high and continues to impact on temporary staffing requirement.
c. 'Specialing' requirement
d. Additional beds opened to increase bed base capacity

6.0 Reported Incidents of Reduced Staffing (Datix Reports)

6.1 All staff are encouraged to report any incident they believe may affect safe patient care using the trust risk management Datix system. During January, 27 Datix reports were submitted relating to staffing. These Datix reports outline a range of issues from increased patient demand to reporting the level of staffing available. Of the 27 incidents reported on the Datix system, one related to patient harm. The incident took place during the ward handover between nurses where a patient fell. This was managed appropriately. All other incidents reported were risk assessed and managed appropriately by the senior nursing team or site managers.

7.0 Care Hours per Patient Day (CHPPD)

7.1 Care hours per patient day are 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 (26.82) and Cloudesley ward have the least (5.39).



7.2 The average number of hours of Registered Nurse time spent with patients was calculated at 6.16 hours and 2.37 hours for care staff. This provides an overall average of 8.54 hours of care per patient day.

	CHPPD
Registered Nurse	**6.16**
Care Staff	**2.37**
Overall hours	**8.54**

7.3 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.

7.4 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.

7.5 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.

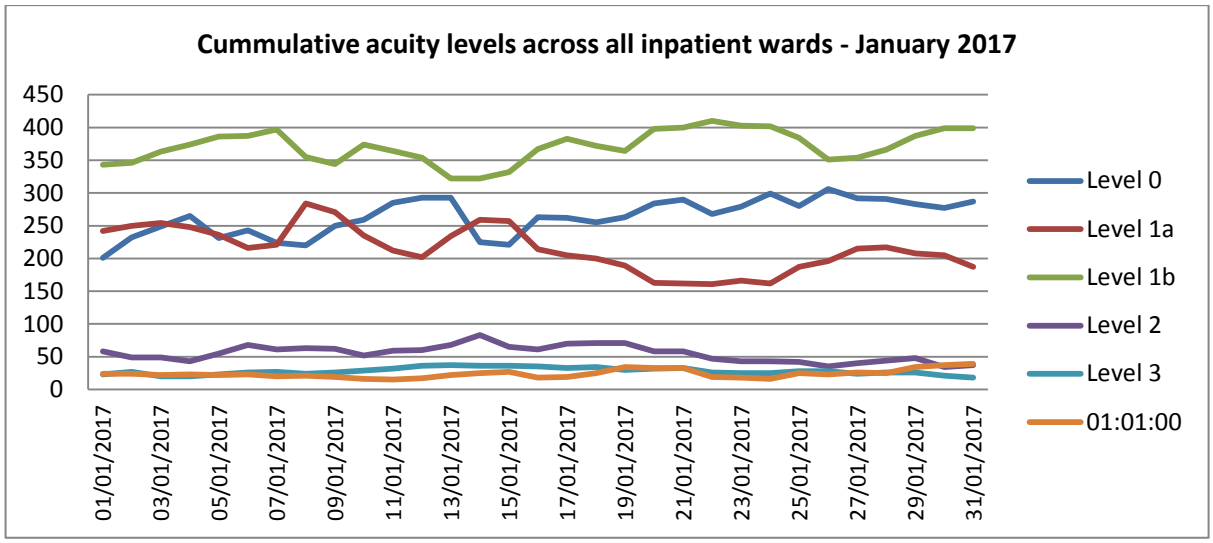
7.6 The table below shows the CHPPD hours for each in patient ward over the last four months and indicates the level of need remained stable overall. There is a slight decrease in hours of care delivered in January compared to December.

Ward Name	Jan	Dec	Nov	Oct
Bridges				
Winter Ward	5.66	5.51	6.93	
Cavell	5.95	7.00	6.89	7.20
Cloudesley	5.39	5.57	5.32	5.80
Coyle	5.96	5.90	5.57	5.62
Mercers	6.81	7.13	6.65	6.78
Meyrick	5.51	6.20	6.39	5.87
Montuschi	6.13	6.31	6.02	5.86
MSS	6.81	7.10	7.04	6.98
MSN	8.39	8.98	8.42	7.95
Nightingale	6.25	5.93	5.91	6.33
Thorogood	6.67	7.09	6.85	7.78
Victoria	5.80	6.45	7.84	6.35
IFOR	12.85	11.09	8.71	9.62
ITU	26.82	26.71	25.43	24.23
NICU	11.30	11.41	12.30	14.13
Maternity	15.87	15.53	13.71	14.90
Total	8.54	8.76	8.58	8.64

8.0 Patient Acuity

8.1 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.

8.2 The graph below demonstrates the level of acuity across inpatient wards in January. 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 required greater nursing support.



9.0 Temporary Staff Utilisation

9.1 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 made by the Deputy Director of Nursing.

9.2 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.

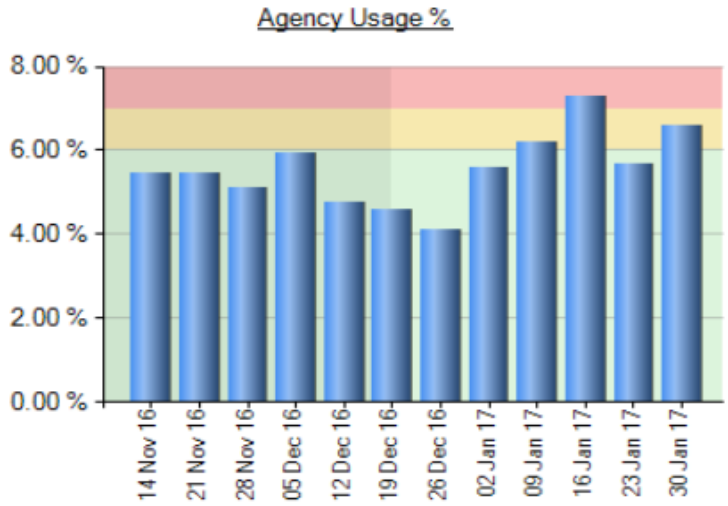
b) The process allows for an overview of the total number of temporary staff (agency) used in different clinical ward areas and provides a monitoring mechanism for the delivery of safe quality care.

10.0 Agency Usage Inpatient Wards (month ending January)

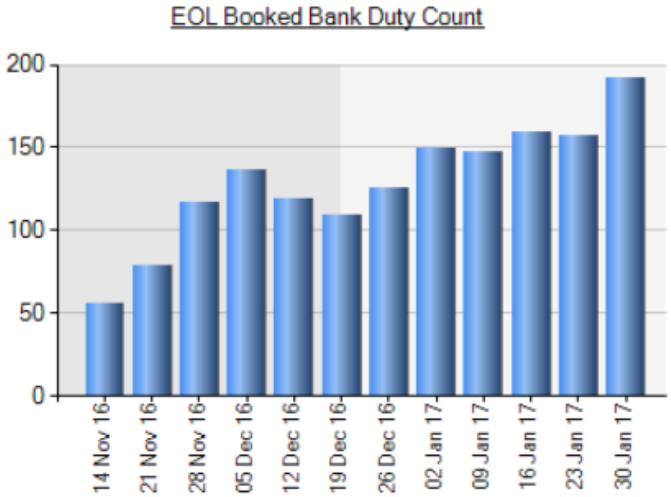
10.1 The utilisation of agency staff across all inpatient wards is monitored using the Healthroster system. The bar chart below graphically represents total usage of agency staff on inpatient wards month ending January (this is cumulative data captured from roster performance reports).

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

The increase in Agency usage during January relates to the opening of additional in-patient beds during a period of patient demand.

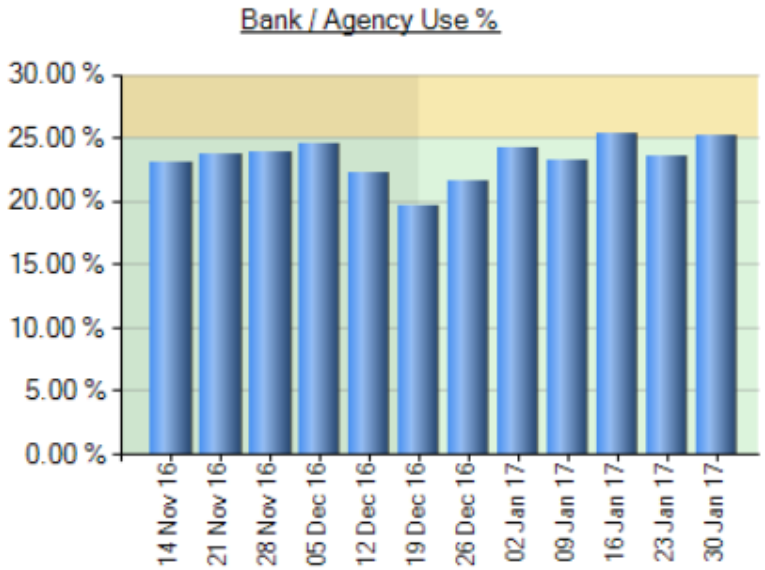


Staff wishing to work on the nursing/midwifery bank continue to book themselves directly into shifts using the employee on-line facility (EOL) with the usage of the facility continuing to improve over time. This is process is reliant on the ward managers making shifts available on the system with sufficient notice.



10.3 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.

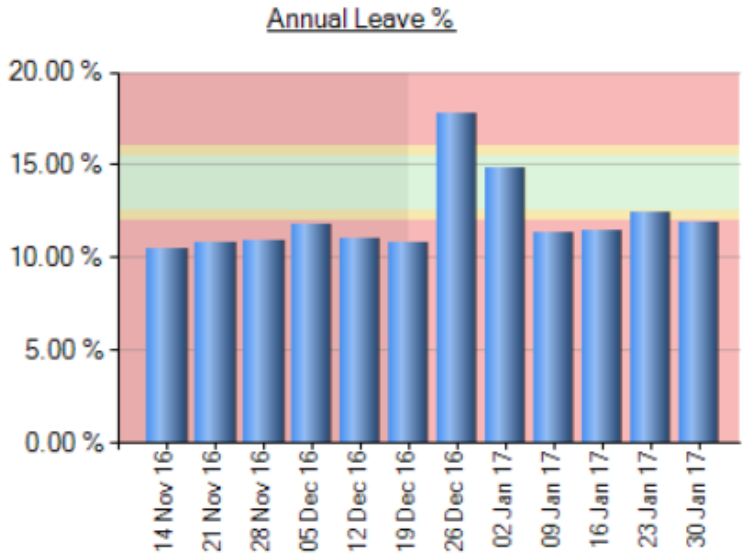
10.4 Temporary staffing usage (Bank and Agency) across inpatients wards remains high and fluctuates between 20 – 24%. Recruitment to reduce the current vacant posts is ongoing.



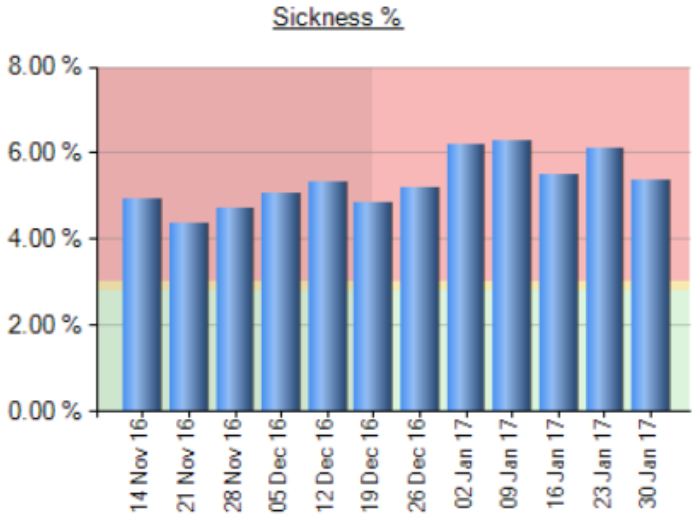
11.0 Managing Staff Resource

11.1 Annual leave taken from January 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.

11.2 Heads of Nursing/Midwifery 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.



11.3 Sick leave reported in January was above the set parameter of less than 3%. Heads of Nursing/Midwifery ensure all individuals reporting back from sick leave undergo a sickness review.



12.0 Conclusion

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

Appendix 1

Updated tables

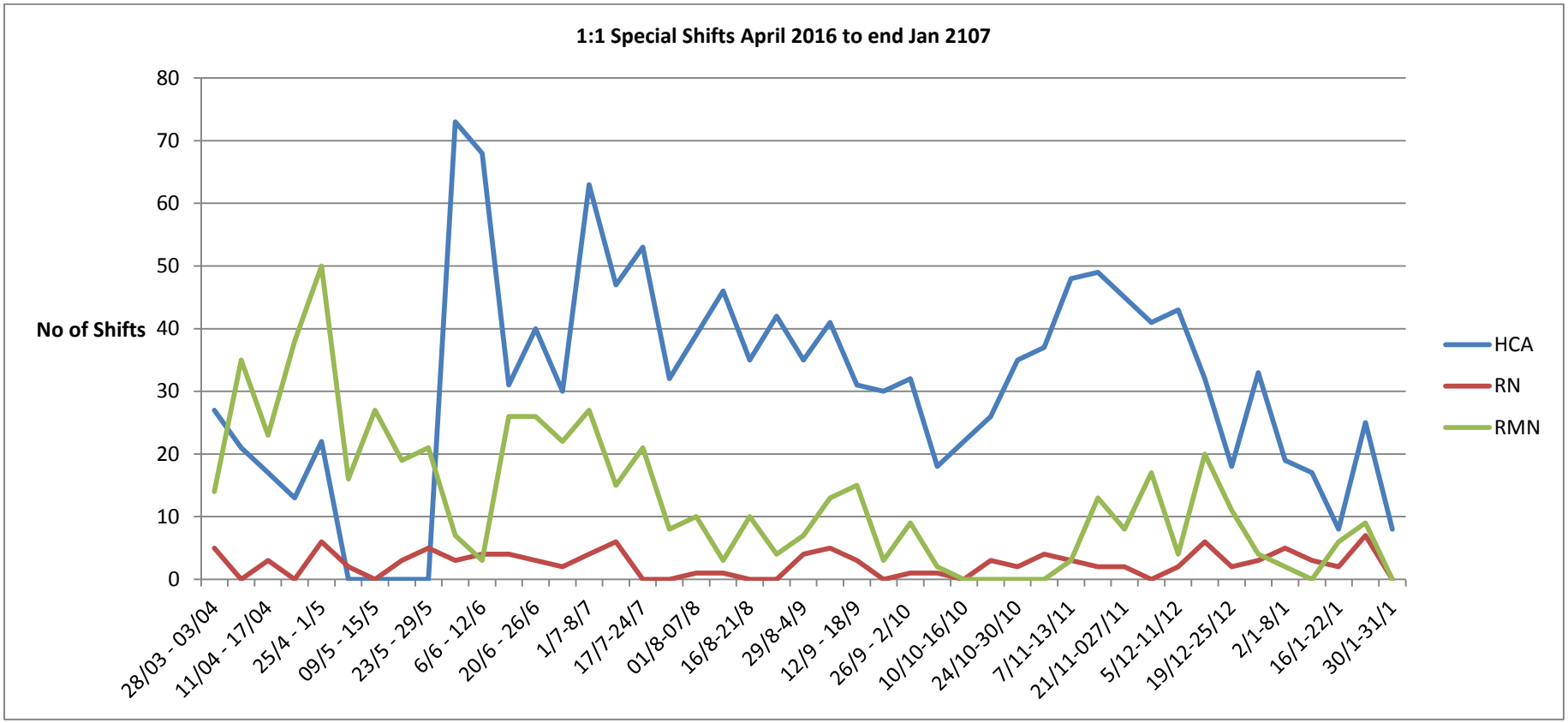
Fill rate data - summary
January 2017

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)				
36658	**32717**	**11628**	**13100**	**30502**	**28180**	**8648**	**10363**	**89.2%**	**112.7%**	**92.4%**	**119.8%**

Care Hours per Patient Day
January 2017

Total Patients at Midnight/Month	CHPPD Registered staff	CHPPD Unregistered staff	Average CHPPD (all staff)
9882	**6.16**	**2.37**	**8.54**

Appendix 2


1:1 Special Shifts April 2016 to end Jan 2107
No of Shifts
80
70
60
50
40
30
20
10
0
28/03 - 03/04
11/04 - 17/04
25/4 - 1/5
09/5 - 15/5
23/5 - 29/5
6/6 - 12/6
20/6 - 26/6
1/7-8/7
17/7-24/7
01/8-07/8
16/8-21/8
29/8-4/9
12/9 - 18/9
26/9 - 2/10
10/10-16/10
24/10-30/10
7/11-13/11
21/11-027/11
5/12-11/12
19/12-25/12
2/1-8/1
16/1-22/1
30/1-31/1
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	86.0%	100.0%	98.8%	105.3%
Cavell	82.8%	107.6%	98.6%	113.5%
Cloudesley	86.3%	99.9%	105.2%	102.0%
Coyle	96.6%	104.4%	93.9%	106.9%
Mercers	82.6%	129.7%	93.7%	108.8%
Meyrick	80.0%	109.6%	101.3%	122.8%
Montuschi	79.1%	209.1%	107.1%	NA
MSS	64.3%	91.6%	75.8%	97.8%
MSN	71.3%	129.1%	92.1%	234.2%
Nightingale	100.7%	103.1%	74.3%	106.8%
Thorogood	94.7%	109.0%	92.4%	
Victoria	103.8%	93.6%	96.4%	110.8%
IFOR	100.8%	100.0%	99.3%	100.0%
ITU	100.0%		100.0%	
NICU	80.3%		83.8%	
Maternity	92.7%	137.8%	87.7%	115.0%
Total	89.2%	112.7%	92.4%	119.8%

Whittington Health NHS

End of Life Care Strategy Update – January 2017

1.0 Introduction

In July 2008 the National End of Life Care Strategy was published by the Department of Health highlighting the importance of promoting high quality care for all adults at the end of life. The Whittington Health End of Life and Palliative Care Strategy for Acute Adult Services: Closing the Gaps was developed in July 2015 which outlined the current service and improvements required to meet the national standards and areas identified for improvement in national minimum data set audit 2014/15.

The End of Life Group oversees monitors and reviews the implementation of a gap analysis action plan for the Trust (See appendix 1).

This paper provides an update on acute services in Whittington Health as well as EOLC for paediatric and adult community nursing. The paper focusses on adult specialist palliative care services as specialist palliative care for adults is provided by The North London Hospice in Haringey and the Ellipse Team (CNWL) in Islington.

2.0 Activity

2.1 Referrals to Whittington Health Specialist Palliative Care Team (SPCT) since 2013/2014

Table 1

	13.14	14.15	15.16
Total referrals + continuing patients	300	411	458
Total actual patients	267	354	394
Islington residents	139	183	225
Haringey residents	89	168	172
Barnet residents	19	26	22
New patients (Total)	250	338	372
Percentage of non cancer referrals	%	50%	48%
Continuing patients	5	6	2
Re-referrals from previous year	12	10	20
Re-referrals during year	33	57	65
Discharges	196	261	281

Information from National Minimum Dataset.

During 2015/6 SPCT received 456 referrals, with an additional 2 patients carried over from the preceding year which equates to an increased referral rate of 58% over the last 5 years. 99.9% of all referrals were acknowledged and assessed within 1 working day. 428 referrals were received on a weekday and of those 364 (85%) were acknowledged

and 340 (75%) were assessed on the actual day of referral. 28 referrals were received at the weekend (twice as many as the previous year) and 66 referrals were made after 4pm on a weekday.

2.1 Deaths

	13.14	14.15	15.16 (6 mths)
Deaths known to SPCT ,exc ED. (percentage of all deaths)	98 (37%)	148 (36%)	165 (39%)
% palliative care patients deaths on LCP or equivalent	40%	NR	50%
Total hospital deaths	400	430	421
% of all hospital adult deaths Care Plan ordered	19.50%	23%	29%

* Not Recorded

3.0 Quality and Performance Indicators'

The SPCT aim to respond to the referrer within 24 hours or the next working day (if referral sent after 4pm Friday, at weekend or on Bank Holiday) During 2015/2016 456 referrals were received. The target was met in 99.9% of referrals.

The contracted Key Performance indicators for 15/16 were achieved

- 50% of nursing staff in adult in patient wards to have completed the Sage and Thyme training and an introduction to Palliative care.
- Provide a quarterly report on progress of the palliative care service against the 14/15 national audit.

An audit was conducted on the Usage of End of Life Medication Protocols and Care Plan Aid on Adult Wards and ITU to evaluate the outcome for patients for whom EOL medications prn were prescribed and to identify the percentage of all patients who died in hospital (exc ED) who had EOL medications prescribed prn. Findings were very positive in that 95% of patients for whom EOL medication prn was prescribed died within 6 months, the majority within 3 months. 69% died in hospital. Of all patients who died in hospital 70% had end of life medications prescribed prn.

Data for the National Audit was submitted in August 2015 which was published at the beginning of April 2016. There was improvement as compared to the 14/15 national audit but a number of areas continued to require improvement (see Appendix 2 for improvement action plan)

Complaints which have an EOLC/dying component are now reported quarterly to the end of life steering group. Key themes are poor communication and documentation.

4.0 EOLC update against the six Strategic goals of our Clinical Strategy

1. To secure the best possible health and wellbeing for all of our community.

The CQC inspection in December 2015 highlighted that palliative care services staff were not always aware of patient's wishes in regard to their 'preferred place of death'. They did not always record and analyse if patients were cared for at their 'preferred place of death'. The SPCT completed a baseline audit for the 198 patient seen from January to August 2016 to ascertain how many patients had discussed preferred place of death (PPD) and whether this had been recorded in the medical notes.

Out of the 198 patients, 66 patients died in Whittington Hospital. SPCT recorded a PPD with 34 (52%) of these patients, 17 (50%) specifically expressed a wish to die in hospital and 11(32%) said they wanted to die at home. 5, 15% said they had no preference.

SPCT did **not** record a PPD with 32 (48%) of these patients. Of these, 11 were unconscious, 3 had severe dementia, 4 died within 24 hours of review by SPCT, 4 were unable to communicate a preference, 5 preferred not discuss PPD.

It would appear that the SPCT are proactively discussing PPD with patients but recognise a standardise approach to record keeping should be introduced to ensure the Multidisciplinary Team are fully aware of the discussions.

2. To integrate/co-ordinate care in person centred teams.

There is an alert facility on Medway, the electronic patient record. An alert is placed on a patients record when they are known to the acute or community palliative care teams. Emergency Department staff are alerted immediately to contact the relevant team to gain up to date information in regard to the patient's treatment plan.

The acute oncology service MDT and the GI MDT includes active palliative care representation maintaining the person at the centre of care.

Coordinate my Care will be re-launched in the Trust during 2017 to further promote integrated care and help people achieve their preferences for place of care and death.

3. To deliver consistently high quality, safe services.

To meet NICE guidelines, it is recommended as a minimum, that people have access to 24/7 Specialist Palliative Care (SPC) telephones advice and 9am to 5pm, 7 days a week face-to-face visiting. The EOLC Group recognise the existing service falls short of this standard, however it is rare that services across London provide this in full.

The trust has been committed to provide a 7 day Specialist Palliative Care service by the end of 2016 and the principle was approved at the Trust Management Group.

In considering the way forward the following options were proposed:-

Option 1 – 5 day cover + 7 day telephone cover provided by CNWL = £556K

Option 2 – 5 day cover without telephone cover provided by CNWL = £360K

Option 3 - 5 day cover without telephone cover provided by WH = £260K

However the Integrated medicine ICSU proposed that additional funding is not financially viable over the next 2 years unless a more comprehensive service across NCL is developed. The EOLC therefore accepted the proposal to adopt Option 3.

In order to optimise the current service and mitigate the risk of not providing 7 day cover the EOLC group has agreed to work collaboratively with CNWL palliative care services to

- Strengthen the governance of both organisations by collaborating on data collection, care pathway, clinical guideline, audit and education.
- Share posts including rotational roles for the MDT.
- Developing clinical leadership with the team; creation of a new Nurse Consultant post.
- Explore options of closer collaboration including formal consolidation of the service.
- Introduce training roles within the team to facilitate succession planning.

4. To support our patients/users in being active partners in their care.

A friends and family survey will be launched in 2017 following approval from Patient Experience.

5. To be recognised as a leader in the fields of medical and multi-professional education, and population-based clinical research.

A Nursing and AHP Training Strategy for EOLC was developed in 2016/17. This strategy describes a stepped approach to training whereby new staff are expected to complete the 'Sage and Thyme communication skills training within 6 months, obtain a set of essential face to face or e-learning skills within the first year and enhanced training for those in more senior positions.

Sage and Thyme training was delivered to 237 individuals from a variety of staff groups during the financial year 2015-16

The SPCT participated in the orientation programme for new nurses.

The SPCT have delivered end of life/palliative care introductory sessions to 263 staff since 4th June 2016. Topics covered included an introduction to the intranet resources available to staff, an understanding of what palliative care is, control of common symptoms and supporting those important to the patient immediately after the patient has died.

Pharmacists (16+), the Critical Care outreach team (2), Therapists (14), the General Surgery team (14) and student midwives (11) have all had educational sessions from the SPCT this year.

18 training sessions were delivered to a range of doctors. 16 of these sessions were to junior and middles grade doctors 2 to consultants only and 1 to a range of all doctor grades.

Resources have been developed on the intranet to enable staff to have EOLC guidelines out of hours. Training to use these resources has been delivered to all junior doctors as they start in the trust, staff on call and consultants.

6. To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population.

There are a number of improvements to the SPCT service which have been captured in the gap analysis action plan (Appendix 1). Additional improvements include.

a) Updating the resources available for professionals in the intranet
    - Lothian guidelines updated and expanded (closing gap from 2013 NCDAH)
    - Opioid conversion charts added
    - Patient/relative information leaflets added

b) Referral and discharge pathways updated to improve implementation of best practice by non SPC professionals
    - The End of Life Care Plan aid was updated in line with '5 priorities of care'
    - Added end of life leaflet, & comfort and communication pages.
    - Introduced Palliative care as a section prompt on ICE discharge summary updated weekly by team at local clinical caseload meeting.
    - EOL medication audit results used to give confidence to clinicians in identifying EOL patients
    - Poster presentation of EOL medication results and prognostication by a medical trainee.
    - Arranged for the Haringey SPCT to access to ICE

4.0 Progress against gap analysis

For further detail about the progress against the gap analysis see appendix 1.

The SPCT are currently collating a revised action plan which will be monitored at the EOLC group.

5.0 Adult Community Palliative Care

Specialist community palliative care is provided by CNWL Foundation Trust in Islington and North London Hospice in Haringey. Hands on symptom control, psychological support and other nursing care is provided by the Whittington Health District Nursing Service and makes up a significant part of their caseload. The service continues to provide a 24 hour service to patients in both boroughs with patients at end of life making up a significant part of out of hours workload. Palliative care provided by the District Nursing service was reviewed by a palliative care specialist as part of the December 2015 CQC inspection and contributed significantly to the good rating received. Death of patients on the District Nursing caseloads in their preferred place of care is monitored monthly as part of the nursing quality indicator process and over 80% has been consistently achieved over the year against a target of 90%. There is an action plan in place to increase this further over the next year.

District Nursing runs a successful palliative care rotation programme within the teams whereby one nurse is the key worker for patients with palliative care needs ensuring continuity for patients and enhancing the skill base of the District Nursing Teams as well as linking closely with the specialist palliative care teams in each borough.

Currently District Nurses assess and manage the fast track continuing care packages for patients with palliative care needs in Islington. This work has grown significantly in recent years particularly as patients with palliative care needs are living longer and discussions with commissioners have been successful in securing extra funding for this work which will be handed over to the mainstream continuing care team in April 2017 releasing capacity in the District Nursing Service to provide hands on care. In Islington the District Nurse Teams are also piloting new NCL end of life care documentation which fits with the 'Excellence at the end of life' agenda which if successful will be rolled out across both boroughs.

There has been a successful programme of training provided to the District Nurses by the Haringey specialist palliative care team and the District Nurses were an active part of the Haringey dying matters week in 2016. In addition North London hospice now provide a day and night sitting service for patients at the end of life which has complimented the service provided by Marie Curie, and has meant that District Nurses have been able to facilitate more patients to stay at home as their preferred place of care in the last six months of life

6.0 Paediatric Palliative Care Services (Life Force)

Life Force is the paediatric palliative community care team for Camden, Haringey and Islington. The team supports all families who have a child with a life limiting/life threatening condition. Some of the children can be on the teams caseload for a few months, some for a number of years, some transitioning into adulthood. The aim of the team is to ensure choice in place of care at end of life.

The team consists of 2.6 w.t.e. specialist nurses, three respite nursery nurses, one play specialist and 0.4 w.t.e. psychologist. The service also has a service level agreement with Great Ormond Symptom Care team who provide us with Consultant hours and an out of hour telephone support.

One of the specialist nursing posts has been funded by the WellChild organisation. This funding is for a three-year period which comes to an end March 2017, however the organisation has agreed to continue funding until March 2017.

Life Force are able to offer a Home Loan Toy service, funded by Haven House, one of the local children's hospices. Sensory toys are provided for periods of up to three months. Besides providing fun to the child, it allows the service to reach other families and identify gaps in support where evident.

Life Force in conjunction with Noah's Ark (another local children's hospice) are one of three national pilot sites for a Family Support Volunteers Project, being led by Together for Short Lives (the National Charity for paediatric palliative care). This is a one-year project aiming to recruit volunteers to support families on the Life Force caseload.

Life Force have had a successful CQC report December 2015, with the team deemed Outstanding and for the category of Well Led was awarded Outstanding.

For the period January 2016 – 2017 Life Force have:-
Supported 8 children and young people at end of life, bereavement follow is offered from the team and they will be invited to our yearly memory day.
We have had 71 Referrals
We have had 50 Discharges

The recent launch of the NICE guidelines for End of life care for infants, children and young people was launch December 2016 and Life Force at currently in the process of undertaking a gap analysis. One obvious gap is 24 hour face to face visits to the home as necessary. Life Force are working with non statutory partners to see if this can be resolved.

7.0 Future Developments (2017-18)

A). relaunch coordinate my care within Hospital

B). extend current service to meet NICE guidelines for 7-day provision

C). Develop bereavement support for relatives and carers of patients who have died in the care of Whittington Hospital.

D). Succession planning

E) For Life Force (paediatrics) working with GOS on the national implementation of an Advanced Care Planning document for all children with a life limiting/life threatening condition.

Appendix 1

Gap Analysis update

(See separate excel spreadsheet)

Appendix 2

Dying in Hospital Audit Report (2016) Action Plan (1st April 2016)
(Organisational Audit Indicators where the answer did not meet the standard)

Standard not met	Action	Lead	Date to be completed	Completed/ Update
Is there a lay member on the Trust Board with a responsibility/role for the end of life	• Identify and appoint a Lay member to the role of EOLC lead.	Greg Battle	Oct 15	Completed - Steven Hitchins has been appointed as EOLC trust Lead and attends Steering Group Meetings.
Did your trust seek the bereaved relatives or friends views during the last two financial years?	• Establish baseline of activity for individual speciality (recognition that each speciality will require a different approach) • Specialities to pilot different approaches to obtain views from the bereaved. • Report updates and share progress with between specialties.	Ruth Law	July 16	Completed - RL sent out a questionnaire in March 16 to each clinical lead asking how they are or would like to approach views of the bereaved. A pilot is currently in progress on MAU to use the pathway co-ordinator to ask questions. EOLC nursing team have set up a survey on Meridian to survey views of their services and will commence implementation in 2016.
Between 1st April 2014 and March 31st 2015 did formal in-house training included/cover specific communication skills training for care in the last days of life for **medical staff?**	Encourage all grades of medical staff to attend SAGE and THYME training.	Anna Kurowska	July 2016	Completed Consultants and others have attended SAGE and THYME training.
Between 1st April 2014 and March 31st 2015 did formal in-house training included/cover specific communication skills training for care in the last days of life for **nursing staff?**	• Identify and deliver End of life education on communication (Sage and Thyme) • Incorporate EOLC training Sage and Thyme in Training Strategy.	Fiona Paterson	Sept 2015	Completed - Training Strategy launched in Sept 2015 which includes Sage and Thyme (communication) Training

	• KPI – For 50% of all ward staff to be trained in Sage and Thyme.			
Between 1st April 2014 and March 31st 2015 did formal in-house training included/cover specific communication skills training for care in the last days of life for **Nursing Non Registered staff?**	• Identify and deliver End of life education on communication (Sage and Thyme) • Incorporate EOLC training Sage and Thyme in Training Strategy. • KPI – For 50% of all ward staff to be trained in Sage and Thyme.	Fiona Paterson	Sept 2015	Completed - Training Strategy launched in Sept 2015 which includes Sage and Thyme (communication) Training
Between 1st April 2014 and March 31st 2015 did formal in-house training included/cover specific communication skills training for care in the last days of life for **Allied Health staff?**	• Identify and deliver End of life education on communication (Sage and Thyme) • Incorporate EOLC training Sage and Thyme in Training Strategy. • KPI – For 50% of all ward staff to be trained in Sage and Thyme.	Fiona Paterson	Sept 2015	Completed - Training Strategy launched in Sept 2015 which includes Sage and Thyme (communication) Training
Access to face to face Specialist Palliative Care for at least Monday to Sunday?	• Identify requirements to deliver 7 day specialist EOLC. • Draft Business case • Ratify business case through appropriate governance committee • Implement recommendations	Alison Kett/Paul Attwal	July 16	Completed - Business case approved at TMG and EOLC steering Group March 16. Insufficient funds to create 7 day service 2016-17, in negotiation with potential partners to join up services and introduce 7 day service 2017-18
Does the Trust have one or more EOL Facilitators	• For further discussion at next EOLC steering group to explore need for separate post.	Alison Kett/Fiona Paterson	July 16	Completed - EoL care facilitation is a significant part of SPCT role; separation risk dilution of expertise. The expectation is that the criteria will be met in 16-17 audit

Trust Board

1 March 2017

Title:	Board Assurance Framework, BAF				
Agenda item:	**17/035** **Paper 06**				
Recommendations:	The Trust Board is asked to approve the board assurance framework which derives from ICSU, Directorates and other risk registers held across the Trust.				
Executive Summary:	The BAF provides a structure and process that enables the organisation to focus on those risks that might compromise achieving its strategic goals and objectives. It maps out both the key controls and mitigating actions that should be in place. **The top risks on the BAF are** BAF 5 – rated 20 Failure to deliver CIPs and transformation savings for 2016/17 •Failure to deliver CIPs and savings to £18m •Non identification of credible CIP schemes •Non achievement of agreed CIP schemes BAF 6 – rated 20 Failure to maintain liquidity and a sufficient level of working capital due to delayed CCG payment and/or Insufficient working capital facility due to failure to receive £6.5m STF				
Fit with WH strategy:	Aligns to Clinical Strategy				
Reference to related / other documents:	Risk Matrix Sub-Committee Risk Registers				
Reference to areas of risk and BAF:	n/a				
Date paper completed:	February 2017				
Paper previously presented at:	n/a				
Author name and title:	**Executive Directors**	**Director name and title:**		**Siobhan Harrington, Deputy CEO**	
Equality Impact Assessment complete?	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

BAF Risk Profile

	BAF1: Failure to maintain the quality of patient care expected from Quality Account and Clinical Strategy targets	BAF2: Failure to provide an ongoing service to LUTS patients	BAF3: Failure to meet performance targets, in particular ED	BAF4: Failure to recruit and retain quality staffing	BAF5: Failure to deliver CIPs and transformation savings for 2016/17	BAF6: Failure to maintain liquidity and a sufficient level of working capital	BAF7: Failure of delivering the maternity modernisation and redevelopment including a second co- located theatre	BAF8: Failure to reduce reliance on agency staffing	BAF9: Failure to align WH population health model to the final NCL STP	BAF10: Failure to sustain the breast service due to workforce changes	BAF11: Failure to effectively manage the maintenance of medical devices will lead to patient safety and quality risks	BAF12: Failure to ensure regulatory compliance with the NHSI single oversight framework and CQC	BAF13: Failure to ensure high quality data will result in poor decision making that will impact on the Trust reputation, income and quality of services	BAF14: Failure to maintain patient flow will result in poor patient experience, impact on patient safety and cost more financially	BAF 15: Failure to modernise the Trust's estate may detrimentally impact on quality and safety and patient experience and the Trust's financial sustainability
Red >15	Initial	Initial Current	Initial Current	current	Current	Current T	Current	Current	Current	Initial	Current		Initial	Curren t	Current
Amber 11-15	Current			T						Current		Current	Current	T	
Yellow 6-10	Target	Target	Target		T		T	T	T	T	T	T	T		T
Green <6															

Summary of BAF:

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

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

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

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

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

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

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

Sources for BAF

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

Whittington Health NHS

Board Assurance Framework (BAF) v2 June 2016 DRAFT

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

Strategic Goals2015-20

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

BAF Ref	Corporate Objective	Risk	Accountable Director	Current risk rating	Existing Controls in Place	Possible Sources of Assurance	Positive Assurance Received 2016/17	Gaps in controls/ assurance and	Action plans to mitigate risk	Reporting/ Monitoring arrangements	Progress	Action Deadline	Next Review Date	Forecast risk rating (post actions)	Risk Register Codes (for reference)
BAF1	CO1. Deliver quality, patient safety and patient experience.	Failure to maintain the quality of patient care expected from Quality Account and Clinical Strategy targets	Medical Director/ Director of Nursing and Patient Experience	**12**	Developing our Organisation –ICARE values and behaviours CQUIN & contract monitoring process Quality impact review process of all cost improvement programme ICSU Board governance meetings ISCU Deep Dive Performance meetings Quality Committee Appraisal / revalidation Pressure ulcer reduction plan Falls reduction Plan Mortality and morbidity meetings Review of Trust governance structures	Quality and safety report Report from Quality Committee Internal Audit Reports BI-annual nursing skill mix review National patient and staff surveys National clinical audits Infection Prevention and Control report Serious incident report Patient stories Board walkabouts Safety Huddles CQRG Review meetings with commissioners	Quarterly Patient Safety reports to Board and Quality Committee (July, Sept, February 2017) Quality Committee minutes to TB National benchmark data and TB Performance report monthly ICSU performance reviews with Executive quarterly	Gaps in control: Fully embedded governance structure within the ICSUs Quarterly reports postponed Annual review of governance not yet completed	Quality Account process underway for completing 2018/19 Quality account Governance self assessment and review to be completed Review of ICSU management and resource February 2017 Quality impact process for CIPs to be reinstigated February 2017 Process for quarterly reporting to TB now in place and reports to be completed quarterly	Quality Committee Trust Board CQRG Trust Management Board	**February 2017:** Quality Account priorities off target in 3/5 safety areas; sign up to safety - AKI; pressure ulcers and falls **August 2016 and February 2017:** Quality and Patient Safety report presented to Board	Apr-17	April 2017	**8**	
BAF2	CO1. Deliver quality, patient safety and patient experience.	Failure to provide an ongoing service to LUTS patients	Medical Director	**16**	• Medical Director and ISCU central leadership group managing action plan • Clinical and Medical experts in Trust advising leadership group on actions • NHSI Medical Director liaison • Reported as SI on STEIS in line with policy • National clinical guidance • RCP review • Patient User Group established	RCP review report and action plan SI report and action plan	RCP report Patient stories TB reports on progress against action plan	Quality and safety concerns Succession plan not in place	Desk Top review to complete February 2017 Review of patients prescribed Nitrofuratoin to be completed by end of February Ongoing dialogue with UCLH re clinical collaboration and development of a tertiary service model including commissioners Agreement on Childrens pathway Agreement with commissioners on future funding model Communication with all stakeholders and user group including response to letters TB report due March 2017 Clinical Collaboration MOU to be signed by both Trust boards in March 2017	Executive Team Trust Board	**February 2017:** Desk top review completed Childrens pathway agreed in principle UCLH/WH and CCG meeting taken place Met with JML Next service user meeting planned for March 2017	Apr-17	April 2017	**8**	w32973 Steis 2015 33773 Surgery ICSU RR
BAF3	CO1. Deliver quality, patient safety and patient experience	Failure to meet performance targets in ED	Chief Operating Officer	**16**	• Performance management monitoring • Action plans developed to meet ED targets, monitored at operational meetings. • Daily teleconferences with system wide health economy to work collectively to support better patient flow. •Management of ward bed capacity/opening of additional wards •ESP working in Secondary Care clinics facilitates the seamless management between Primary and Secondary care •Close links with Consultants and Haringey GPwSI ESP Peer support groups	Performance reports to Trust Board and Quarterly Performance Review meetings ECIS report and action plan	Monthly performance reports to TMG and TB ED consultant recruitment SI reports to TB Wellbeing partnership	**Gaps in assurance:** ED Target not met	ED and flow improvement plans in place following ECIS review and report Ongoing recruitment of consultants for ED Bed management and escalation policies all in place	**ICSU performance reviews, Trust Operational meetings, TMG and TB**	ECIS report and action plan being delivered CEO chair of Urgent and Emergency Care workstream at STP level 3 out of 6 ED Consultants recruited	Ongoing in year	June 2017	**8**	605/ 279/ 189/ 683
BAF4	CO2. Develop and support our people and teams.	Failure to recruit and retain quality staffing	Director of Workforce	**16**	• Workforce strategy in place • ICSU governance structure with strong clinical leadership and Performance Reviews quarterly with Executives •Workforce Assurance Committee in place with responsibility for R&R KPIs monitored •Stable team within HR	•Trust Board safety/quality/safe staffing reports and monthly performance report • Quality Committee safety/quality reports • Workforce KPI reports • Safe staffing electronic tool in place and being used	Workforce strategy approved Monthly performance reports Reports to Worforce Assurance Committee Staff survey results	**Gaps in assurance:** High turnover of staff, ongoing vacancy rate FFT staff results	Ongoing recruitment drives Action to improve retention in relation to staff survey and FFT results for staff	Performance Reviews; TMG Workforce assurance Committee and TB	Regular recruitment pipeline reports to ICSUs Monthly AHP nursing and midwifery meetings, chaired by Director of Workforce Regular recruitment days held including some international recruitment Workforce Assurance Committee meeting regularly	Ongoing in year	June 2017	**12**	WAC5
BAF5	CO3. Develop our business to ensure we are financially sustainable.	Failure to deliver CIPs and transformation savings for 2016/17 and failure to plan for 2017/18 savings schemes of c£18m • Failure to deliver CIPs and savings to £10m • Non identification of credible CIP schemes • Non achievement of agreed CIP schemes	Chief Operating Officer	**20**	• PMO in place and led by COO • CIP work programme and schemes developed by Boston Consultancy initially for 2 year programme 2016-8 • ICSU governance structure with financial controls and roadmaps in place • Quarterly Performance Reviews with ICSUs and Executive teams • NHSI performance meetings with Executives monthly	Reports to Trust Board Reports to TMG Reports and deep dive monitoring to Finance and Business Development Committee Internal Audit reports and recommendations which are agreed with management actions monitored and reported as implemented Performance reviews with ICSUs	Delivery of CIP reported as part of Finance Report to TB Deep dives to F&BD Communication to all staff February 2017 with additional controls in place	Gaps in controls: Unindentified CIP for 2017/18 Gaps in assurance: CIP targets not met to date	All ICSU performance reviews completed in January focused on forecast to year end and mitigations in place to deliver to control total All ICSUs and corporate directorates completing templates re CIP plans for 2017/18 by February 17th.	Trust Board TMG Finance and Business Development Committee	CIP delivery for 2016/17 now forecast to year end and part of control total. All roadmapped for delivery TMG discussion on CIP plans for 2017/18 with CDs presenting plans to date and confidence re delivery of challenge; detailed planning underway and due for completion in February 2017	Apr-17	April 2017	**10**	F&BD007
BAF6	CO3. Develop our business to ensure we are financially sustainable.	Failure to maintain liquidity and a sufficient level of working capital due to delayed CCG payment and/or Insufficient working capital facility due to failure to receive £6.5m STF	Chief Financial Officer	**20**	• Regular CFO/Deputy CEO and CCG meetings • Regular CFO/Deputy CEO and NHSI meetings • Weekly monitoring of cash and working capital by the Finance team • Increased monitoring and reporting to Finance and Business Development Committee (now meets more frequently since 2015) • Monitored and reported to TMG, F&BD & Board - •Ability to use draw-down facility if agreed borrowing is exceeded	Reports to Trust Board Reports to TMG Reports and deep dive monitoring to Finance and Business Development Committee	Finance Report to TB Finance and Business development committee Internal and external audit reports Q1-Q3 2016/17 delivery to control total	Gaps in controls Forecast delivery not on track; actions to recover in place	• Performance reviews with ICSUs focus on corrective financial actions to meet control total • Monitor and report cash & liquidity at NHSI monthly performance meetings • Cash managment discussed at F&BD and reported to Board • Capital spend trajectory reported within financial reports	Trust Board TMG Finance and Business Development Committee	Additional controls put in place to deliver control total to secure the STF monies - February 2017 All forecasts and mitigating actions agreed Discussion with NHSI colleagues ongoing Planning and budget setting for 2017/18 underway	Apr-17	June 2017	**15**	F&BD010
BAF7	CO3. Develop our business to ensure we are financially sustainable. CO1. Deliver quality, patient safety and patient	Failure of delivering the maternity modernisation and redevelopment including a second co- located theatre	Chief Financial Officer/ Deputy Chief Exec	**16**	•Meetings with NHSI •Capital planning process and monitoring group that reports to Trust Board •Maternity dashboard in place with reporting of KPIs and SIs	Capital to be sourced from NHSI, internal capital programme or from SEP arrangement TMG and Trust Board updates and papers re capital, maternity and SEP process ICSU performance reviews TMG papers	STP letter of support received regarding the Maternity and neonatal redevelopment Patient experience feedback to Patient Experience committee	Gaps in controls Clear updated plan for Maternity and neonatal redevelopment underway but not yet complete	Updated plan outlining options and risks to be taken to TB in 2017 and linked to Trust Capital programme 2017/18 Continued work with NHSI to mitigate financial risks Develop and implement a fundraising campaign when the plan is finalised to enable a comprehensive marketing plan to be developed Complete procurement process for a SEP partner Meet maternity targets to demonstrate market growth Through the clinical collaboration work with UCLH develop joint schemes to deliver better outcomes for local women	Finance and Business Development Committee Trust Management Group and Trust Board Maternity Steering Group and Transformation Board	TB paper due 2017. ICSUs engaged in discussions regarding options and timescales. NHSI negotiations continue SEP procurement process to complete June 2017	Apr-17	July 2017	**8**	F&BD011

BAF Ref	Corporate Objective	Risk	Accountable Director	Current risk rating	Existing Controls in Place	Possible Sources of Assurance	Positive Assurance Received 2016/17	Gaps in controls/ assurance and	Action plans to mitigate risk	Reporting/ Monitoring arrangements	Progress	Action Deadline	Next Review Date	Forecast risk rating (post actions)	Risk Register Codes (for reference)
BAF8	CO3. Develop our business to ensure we are financially sustainable.	Failure to reduce reliance on agency staffing	Director of Workforce/ Chief Financial Officer/ COO	16	• Weekly Vacancy Scrutiny Panel meetings • Workforce Assurance Committee (WAC) established • Recruitment & Retention Strategy agreed • Workforce KPIs reported to WAC • Monthly ICSU deep dives on agency usage • E-rostering and real time data	Reports to Trust Board Reports to TMG	Assurance on quality of care provided received through ICSU deep dives (monthly) and e-rostering live data	**Gaps in assurance:** Agency costs greater than planned.	Implement R&R strategy Monitor WAC workplan to strengthen controls and compliance with agency cap. Continue to monitor KPIs	Workforce Assurance Committee Finance and Business Development Committee	**August 2016:** ICSU deep dives carried out, with particular attention on temporary staff spend. Review of process for securing temporary medical staff implemented Review of medical staff bank rates approved	Ongoing in year	Nov-16	8	F&BD022
BAF9	CO4. Further develop and expand our partnerships and engagement.	Failure to align Whittington Health's population health model to the final NCL STP	Deputy Chief Executive/Director of Strategy	16	• Engagement with NCL STP process • Whittington Health Medical Director as co-Clinical Lead for STP process • Haringey and Islington Wellbeing Partnership Governance Collaboration with UCLH	Final STP submission Open and transparent public engagement in place HWB meetings	Current clinical models being described align with agenda of integrated care and population health Development of CHIN model for NCL founded on integrated care model in Islington and work of the integrated care pioneer	**Gaps in assurance:** STP work not complete Public engagement process not yet fully evolved Engagement in visioning and mobilisation of CHINS not yet happened	Progress the work of the Haringey and Islington Wellbeing Partnership and enabling the workstreams to deliver with momentum Engage fully with primary care locally on the development of CHINs Review the business plans with ICSUs re their integrated care plans for next year and year after to align with evolving CHINs	Joint HWB TMG Trust Board	Joint governance in place and Programme Director for the Haringey and Islington Wellbeing Partnership Workstreams being developed with clinical engagement from Trust Briefings on the development of CHINS and member of the Care Closer to Home Board at the NCL STP level Invite to Islington CHINs mobilisation meeting 3 March GPs being engaged and discussions with both commissioners and providers taking place	June 2017	Sept 2017	8	
BAF10	CO1. Deliver quality, patient safety and patient experience.	Failure to sustain the breast service due to workforce changes.	Surgery ICSU CD	16	Agreed as priority clinical area to collaborate with UCLH MDT in place Locum surgeon and radiologists in place with plan to recuit and also agreement of sessions from UCLH team	Performance targets for Breast Cancer; NCL Cancer Board and Breast Cancer commissioning Board.	Clinical team in place New breast cancer lead in place	Improvement plan not formally in place with UCLH although agreement on direction of travel	Moved room timetables to relieve pressure on the service Arranged weekly meetings with Breast Service manager Arranged outsourcing for complex procedures on ad hoc basis Arranging joint post breast consultant radiographer with UCLH Agreeing surgical arrangements with UCLH	TMG Surgery ICSU Board NCL Cancer Board	Progress being made with developing relationship with UCLH clinical colleagues. Risks being managed however needs weekly monitoring and detail of improvement plan	Jun-17	Sept 2017	8	666
BAF11	CO1. Deliver quality, patient safety and patient experience.	Failure to effectively manage the maintenance of medical devices will lead to patient safety and quality risks materialising	Surgery ICSU CD	16	• Manager in place to lead department • Equipment library • New ICSU structures for stronger clinical leadership • Medical devices policy	Capital plan and spend in medical equipment ICSUs clarityand feedback on maintaining medical equipment Surgery ICSU governance structure for feedback Internal audit reports	Spend against budget Management team settled	There has been a period of instability in the management of medical devices	• Review of team and resource • ICSU governance and forums reporting • Business Case requires agreement • A planned preventative maitenance (PMM) programme has been instigated and the status of PMMs are KPIs to the Medical Devices Committee	ICSU Board and performance reviews capital monitoring group	Team settled and work underway regarding future model of medical equipment provision and maintenance	Mar-07	Sept 2017	8	695
BAF12	CO1. Deliver quality, patient safety and patient experience.	A failure to ensure regulatory compliance with the single oversight framework and CQC	Director of Nursing	16	Quality and safety work monitored through operational ICSUs and assured at Quality Committee Financial performance assured at FBD committee and monitored through ICSUs performance reviews; Executive, TMG and TB Operational performance monitored and managed through ICSUs, TOM,TMG and TB Strategic change reported to TB and increasingly connected to STP Leadership and improvement capability overseen by TB and Executive and TMG	Quarterly segmentation score for the Trust CQC reports Finance and Quality and Performance reports to TB Internal and external audit	Level 2 segment for WH - February 2017. CQC inspection report 2016	Financial performance is challenging. CIP plans for 2017/18 to be completed. Controls have been increased to reduce spend however run rate still remains above plan	CQC action plan in place and continuous focus on quality and safety Controls increased across organisation on authorisation of spend. Budget setting underway and CIP planning a priority for all ICSUs and corporate team. Full engagement in the STP process and ongoing review of strategy within ICSUs and services working clinically in collaboration with UCLH. Leadership and capability. All executives accessing coaching. Clinical Directors developing their development programme.	ICSU Board and performance reviews ; TMG and Trust Board and sub committtees of the Board	Currently identified as level 2 on the Single Oversight Framework with offer of support. CQC Good overall on last inspection and action plan continuing to be progressed and monitored by exception at TMG	Jun-17	Dec 2017	12	
BAF13	CO3. Develop our business to ensure we are financially sustainable.	Failure to ensure high quality data will result in poor decision making that will impact on the Trust reputation, income and quality of services	Director of Strategy	16	• New leadership by Deputy CEO • New Data Quality Group • Internal audit report and external report completed • Income steering group in place • IG governance in place	Internal audit External reviews of data quality TB and TMG performance reports ICSU performance reviews	Internal audit reports Improved performance reports across the Trust and Clickview in place	Community data quality requiring improvement	• Implement Audit Recommendations • Training for staff to improve • data quality improvement plan required • clinical engagement through ICSUs Actions in place against those identified by external review	data quality group ICSU Boards TMG	data quality improved across the Trust; community services improvement group in place chaired by Medical Director in Integrated Care and working through plan	Jun-17	Dec 2017	12	718
BAF14	CO3. Develop our business to ensure we are financially sustainable.	Failure to deliver safe and high quality urgent and emergency pathway resulting in patients waiting for care and treatment	Chief Operating Officer	16	Urgent and emergency care Board in place with all partners ECIP review conducted and action plan in place Real time information and review in place Management across ED now fully established within urgent and emergency care ICSU	ECIP review and further external reviews TB performance report to Board TMG reports and discussion at Trust operational meeting	ECIP review which identified areas of good practice and areas for improvement CQC report 2016 Patient safety huddles	Gaps in assurance: shortage of mental health beds and ability of mental health providers to respond effectively ED consultants being recruited but not yet fully established	ECIP action plan in place and being monitored through ICSUs, Trust operational meeting and TMG Complete recruitment of 3 further ED Consultants Focus on flow through hospital including increasing pre 11 discharges and active management of any DTOCs	ICSUs, Trust operational meeting, TMG and Trust Board		Apr-17	July 2017	12	688
BAF15	CO1. Deliver quality, patient safety and patient experience.	Failure to modernise the Trust's estate may detrimentally impact on quality and safety of services, poor patient outcomes and affect the patient experience.	Director of Strategy	16	Estates Strategy and delivery plan in place Controls in place to monitor quality and safety and patient experience and ICSU management structure through to TMG and Executives and Trust Board Director of Environment in place and procurement for a strategic estates partner underway	Estates Strategy Estates Strategy Delivery Plan	Estates Strategy agreed at Trust Board, Feb 2016 Estates Strategy delivery vehicle agreed at Trust Board, June 2016	Gaps in control: Estates and Facilities directorate undergoing improvement Approvals will be needed for agreement of SEP partner from NHSI following TB decision Gaps in assurance: Lack of ongoing stakeholder and community engagement	SEP project plan to ensure process runs to time and resourced Communication plan in place and being reviewed to ensure engagement with staff and the public and other stakeholders regarding the SEP	Executive Team TMG Trust Board	Second stage of competitive dialogue underway with regard to SEP so on track for potential prefered provider recommended to TB in June Engagement through next three months with stakeholders and public being planned	Jun-17	Dec 2017	6	

Trust Board 1 March 2017

Title:	Whittington Health NHS Trust and UCLH NHS Foundation Trust Clinical Collaboration		
Agenda item:	**17/036**	**Paper**	**07**
Executive Summary:	Whittington Health and UCLH have had a strong history of working together, delivering care across a common local population. Following formalising a clinical collaboration since last summer it is proposed that the two Trusts now sign a memorandum of understanding. The MOU clarifies the detail of our working relationship and enables us to structure more clearly how we will take the work forward with momentum. This work will align with the work of the Haringey and Islington wellbeing Partnership and the NCL STP. The Clinical Collaboration aims to improve the quality, safety and experience across a common local population in Haringey, Islington and Camden by improving services across the two trusts and supporting a population approach to health care. The Collaboration aims to reduce costs to the health system by sharing best practice, strengthening clinical relationships, changing pathways and rationalising support services where mutually agreed.		
Summary of recommendations:	The Board to approve the memorandum of understanding. Note that the Board of UCLH will sign the memorandum of understanding on 8 March.		
Fit with WH strategy:	Aligns with a population health approach and Clinical Strategy		
Reference to related / other documents:	Complies with national policy and NHS Trust's duties to provide value for money, high quality and safe services.		
Ref areas of risk/BAF:	Captured on relevant Risk Register		
Date paper written:	20 February 2016		

Authors name and title:		Simon Pleydell, CEO, Siobhan Harrington, Deputy CEO, Richard Jennings, Medical Director, Steve Bloomer, CFO, Steve Hitchins Chair of WH and Marcel Levi, CEO, Richard Murley, Chair, Tim Jaggard, FD of UCLH		**Director name and title:**		**Simon Pleydell, Chief Executive**	
Date paper seen by TMG	**28 Feb 2016**	**Equality Impact Assessment complete?**	**N/A**	**Quality Impact Assessment complete?**	**Y**	**Financial Impact Assessment complete?**	**Y**

Memorandum of Understanding between Whittington Health NHS Trust and University College London Hospitals NHS Foundation Trust

Background:

Whittington Health and UCLH have been working together for many years in ad hoc areas wherever this has made sense organisationally or clinically. We are part of the same Strategic Transformation Plan sector which has a number of particularly relevant workstreams around fragile services, and workforce efficiencies which we believe can all be progressed effectively between the two trusts.

Reason for agreement

Whittington Health have particular strengths in their community provision and the integrated nature of their care offering. UCLH have particular strengths in specialist care and access to research. This complementarity lends itself well to a mutual partnership building on, exploiting, and learning from the strengths from both sides. The two organisations believe that an agreement between them will help to prioritise further collaboration for the benefit of patients and the trusts. It will help to set the tone of that collaboration, and provide the principles and the behaviours expected to make the most of it. It will also provide a mechanism to address any issues that arise. It will enable transparent staff, patient and stakeholder communication and it will create a solid and secure basis on which to make decisions and work together.

Purpose of the collaboration

The collaboration aims to improve the quality, safety and experience across a common local population in Haringey, Islington and Camden by improving services across the two trusts and supporting a population approach to health care. It also aims to reduce costs to the health system by sharing best practice, changing pathways and rationalising support services where mutually agreed.

Duration

This MOU will be formally reviewed three years after signature with an annual sense check and an option to extend on agreement from both parties.

Objectives

To undertake projects to achieve the objectives below as agreed annually in a work plan approved by the Partnership Board.

- To improve quality, safety and patient experience: specifically we will work together to create and support standard approaches; creating effective joined up pathways through sharing of data and implementation of any changes in a timely fashion.

- To secure efficiencies and higher quality through minimising duplication of deployment, and related activity, sharing best practice, expertise and experience, and maximising resource allocation across the two trusts.
- To create a flexible workforce where we support each other to improve resilience of services, reduce duplication, and improve training of staff and quality of care.
- To use common data and information securely to support clinical improvements.
- To strengthen clinical services and improve our resilience to external pressures.
- To strengthen and maintain local access to services.
- To consider the benefits of joint approaches to capacity and workforce issues.

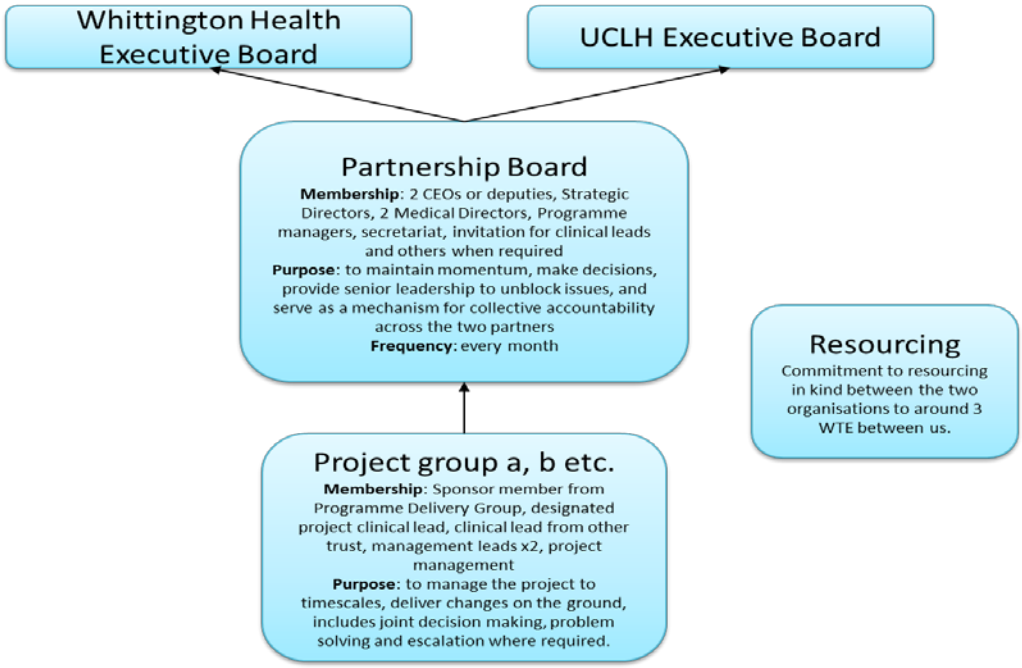
Principles and behaviours

The two trusts will work collaboratively on those things that are aligned with the principles and behaviours outlined below:

- Mutual preferred partner
- All work should align with STP aspirations and should support STP governance processes
- The work should also align with the aspirations of the Camden Local Care Strategy and the Haringey and Islington Health and Wellbeing Partnership.
- The two trusts should maintain their corporate integrity, identity and organisational form
- We are driving improved patient outcomes and value for money in all interventions
- We will maintain momentum
- We will work with a principle of mutual benefit and responsibility
- We will work as equal partners, co-operating with each-other, acting reasonably and fairly in all its dealing
- We will jointly resource the work making staff available as required in sufficient numbers for activities associated with the Programme as agreed by the Partnership Board.
- We will respond in time to actions allocated so that the Programme can be maintained

Governance

Ultimate accountability and decision making remains with the individual trust boards. There will be individual clinically led project boards reporting to a partnership board meeting monthly which will report to trust executive boards. The partnership board will be a smaller decision making and escalation group with papers circulated to a wider group to include nursing, finance, communications and HR directors with an open invitation to them to attend when required.



In scope

All appropriate, back office, estate, clinical support services and clinical services and pathways will be in scope in so far as they meet the principles above, provide a good case for change, and are prioritised by the partnership board.

Out of scope

This MOU and programme of work will **not** consider any form of overall organisational form change including, for avoidance of doubt, merger between the two trusts.

Programme of work

A programme of work will be agreed each year by the partnership board and then by the respective trust boards and kept up to date.

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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board

1st March 2017

Title:	Draft Digital Strategy 2017-2020		
Agenda item:	**17/037**	Paper	**08**
Action requested:	For approval		
Executive Summary:	The Digital Strategy 2017-2020 sets out our :- Vision : To become the most digitally integrated care organisation in the NHS which will enable the delivery of patient centred high quality, safe and sustainable care to our community Mission : To empower patients and staff to securely access information anytime, anyplace, on any device It has been developed to focus on :- - patients and staff, not technology - transformation, not transaction - alignment to Trust, NCL and National strategies, with significant input from the ICSUs It also sets out where we are now and the proposed ICSU priorities alongside the mandated national ones for approval. It has previously been discussed and approved at the Board Seminar and Trust Management Group. Having a Board approved and owned Digital Strategy is fundamental to improving our Digital Maturity and to being selected as a Global Digital Exemplar “Fast Follower”, which attracts up to £5m central funding from NHS England.		
Summary of recommendations:	For approval		
Fit with WH strategy:	Essential enabler to support Trust and National strategies		
Reference to other docs :	Five Year Forward View Personalised Health And Care 2020		
Date paper completed:	24/02/17		

Author name and title:		**Glenn Winteringham Director of IM&T**		**Director name and title:**		**Glenn Winteringham Director of IM&T**	
Date paper seen by TMG	**14/02 /17**	**Equality Impact Assessment complete?**	**N\A**	**Quality Impact Assessment complete?**	**N\A**	**Financial Impact Assessment complete?**	**N\A**

NHS
Whittington Health
NHS Trust

Digital Strategy 2017-2020

March 2017

Table of Contents

Foreword

This document sets out the new Digital Strategy 2017-2020 to support the Trust deliver its clinical and business objectives.

It describes our ambition to become the most digitally advanced integrated care organisation in the NHS over the next four years.

The document is structured into three main sections :-

- **Future Vision -** outlines how patients and staff will use digital services to improve care, outcomes and experience
- **Where are we now ?** – outlines the current status of digital services using digital maturity indices
- **How do we get there ?** – outlines the programmes of work to deliver the future vision

Digital Strategy Consultation

The new Digital Strategy has been developed through an extensive consultation with key staff to ensure it aligns with the Trust's clinical and business needs via :-

- Trust business planning away day – Oct 2016
- Trust Board seminars – Oct and Nov 2016
- ICSU specific workshops – Oct/Nov 2016
- Trust strategies *e.g. Clinical, Workforce, Estates*

The patient perspective has been drawn from a number of national reports *e.g. Kings Fund[1], Nuffield Trust[2], PHAC2020[3], The Good Things Foundation[4],* and the Islington Integrated Pioneer project.

02 Introduction

This chapter describes the Policy and Digital context

Policy Context

The NHS is facing unprecedented financial and operational pressures as it strives to deliver the vision set out in the Five Year Forward View (2014)[5].

The current models of care and levels of funding will not address the demographic challenges of a growing population, which is living longer, often with multiple long term conditions.

To address these widening gaps in health and well being, care and quality, and financial sustainability, NHS England set up :-

- **New Care Models** programme - 50 vanguards to develop blueprints for new integrated models of care
- **Sustainability and Transformation Plans (STP)** – 44 local footprints to deliver improved, sustainable health and care

North Central London (NCL) STP

In 2015/16 NCL had a deficit of £121m, which will increase to £876m by 2021 if nothing changes[6].

The vision for the NCL STP is to :-

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

Alignment to National Strategies

"The goal of digitisation of health is to promote better health, better healthcare and lower cost .....

...digitising effectively is not simply about the technology, it is mostly about the people"

Robert Wachter, Making IT Work (2016)

Disruptive technologies such as smartphones and cloud computing have transformed the way we consume services *e.g. on-line banking, retail, travel, social interactions*, with one notable exception, healthcare.

Our new Digital Strategy aligns to the NHS England initiatives to embrace digitisation and achieve its vision to "operate paperless at the point of care" :-

- **Personalised Health and Care 2020 (2014)** [3]
  - real time, interoperable digital records by 2020
- **Wachter Review : Making IT Work (2016)** [7]
  - Chief Clinical Information Officers (CCIOs) to lead adoption of digital working
- **Local Digital Roadmaps (2016)** [8] - local digital strategies to support delivery of STPs

Alignment to Trust Strategies

Digitisation is the transformational enabler that underpins the delivery of other strategies

Strategy	Requirement	Digital Strategy deliverable
Clinical Strategy 2015-2020[9] *"Helping local people live longer, healthier lives"*	Safer integrated care closer to home	Access to a comprehensive Shared Care Record of acute, community, primary & social care data
Nursing & Midwifery Strategy 2016-2021[10] *"Reduce harm and provide the best possible care"*	Better observations compliance and national early warning scores (NEWS) Safe, efficient nursing rotas to match skill mix with patient acuity	Capture e-observations at the point of care and alert clinicians to deteriorating patients E-rostering and safer care system integrated with temporary staffing
Estates Strategy 2016-2021[11] *"Enable non-clinical support and corporate services space to be reconfigured and used more efficiently"*	Change working practices to reduce occupancy levels and reduce costs	Secure access to digital services from anywhere on any device to enable remote working
Workforce Strategy 2016-2021[12] *"Provide excellent care delivered by expert and caring staff .... that demonstrates our ICARE values"*	Workforce planning and performance management to maximise productivity Education, training and learning	E-job planning, rota compliance, leave and on-call management and reporting Develop flexible, digital packages to enhance skills to deliver high quality care *e.g. MOODLE*

03 Future Vision

This chapter describes how digital technology will transform healthcare of our patients and staff

Our Vision

To become the most digitally integrated care organisation in the NHS which will enable the delivery of patient centred high quality, safe and sustainable care to our community

Our Mission

To empower patients and staff to securely access information anytime, anyplace, on any device

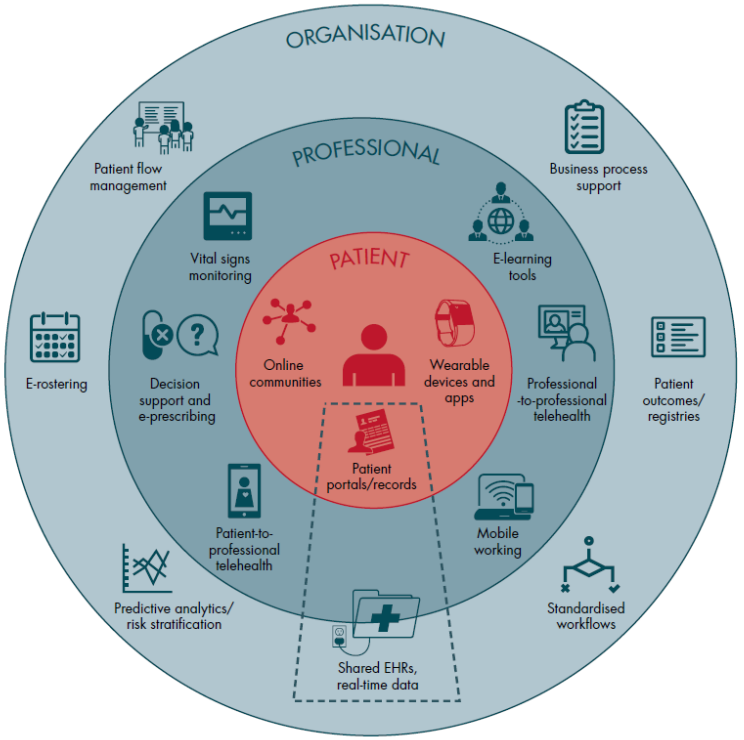
Patient Centric Digital Model

Digital technology can deliver improvements in quality and efficiency, as well as revolutionise the patient experience by transforming how and where they access health and care services.

The diagram illustrates a potential future digital landscape (Nuffield 2015)[2]. At its centre is the patient using technologies to manage their health *e.g. wearable devices/apps*, and to engage with health care providers *e.g. patient portal*.

Next are the technologies that support health care professionals with decision support, access to others' expertise and management of those patients at greatest risk.

Finally, there are a number of organisational wide tools which enable operational efficiency and financial sustainability *e.g. patient flow, analytics, e-rostering*. The Electronic Health Record (EHR) straddles across the whole model and is the foundation of the Digital Strategy.



Key Themes

The future vision for the Digital Strategy is underpinned by four key digital themes :-

Digitally Connected Patients - empower patients to actively manage their health and care

Digitally Enabled Workforce – enable staff to access shared health and care records

Business Intelligence and Analytics – insight driven culture to improve quality, outcome & research

Digital Infrastructure – provide secure access and interoperability

Digitally Connected Patients

Health inequalities cost the NHS over £5.5bn per annum. 12.6m citizens have limited digital skills and 5.3m never access the internet. Improving their digital skills so they can manage their healthcare on-line will reduce inequalities and release significant cost savings

The Good Things Foundation and NHSE have run a Widening Digital Participation programme[4] to train digitally excluded patients to manage their own health and reduce inequalities.

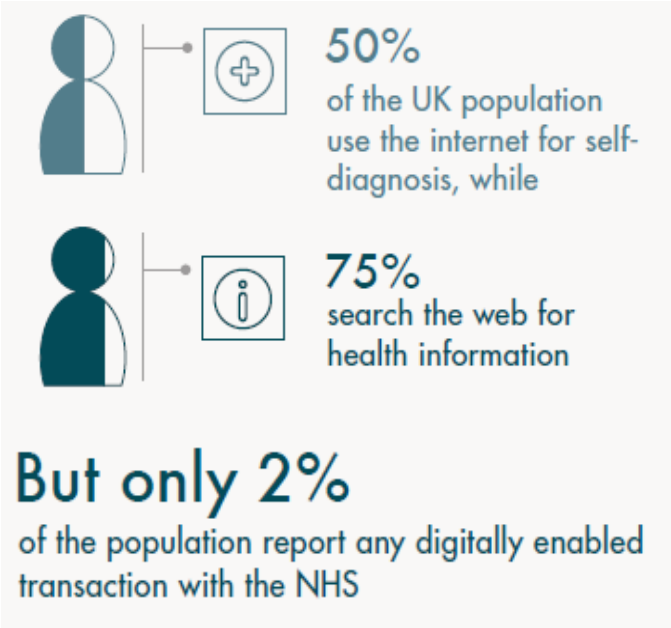
221,941

people trained to use digital health resources and tools over three years.

£6m

potential savings from reduced GP and A&E visits in year three of the programme.

Based on a cost to the NHS of £45 per GP visit, if everyone had the Basic Digital Skills to access health information online would provide savings of £121 million a year by 2025



Digitally Connected Patients

We will transform our models of care by enabling patients to manage their own health using digital services.

As a patient I want to	Digital Requirement	Strategic Fit Solutions
View and input to my digital health record	Access to a patient portal	Access **Carecentric** to view all historical episodes, future contacts and add/amend data
Develop and manage my personal care plan	Access to a patient portal	Receive digital training by **The Good Things Foundation** and amend care plan on **Carecentric**
Use on-line resources and wearable technology to manage my health and care	Remote monitoring for preventive and self-care management	Use **Telehealth** to capture biometrics *e.g.* ***AliveCor*** *heart monitor,* ***MyMHealth*** *self management apps*
Book and manage appointments at my convenience	Enable e-booking transactions	Access **DrDoctor** to book or amend future appointment and receive reminders
Have a choice between a physical or virtual consultation where appropriate	Enable virtual consultations	Use **Skype** or other virtual tools *e.g. FaceTime, WebEx*

Digitally Enabled Workforce

We will transform our ways of working by giving staff access to digital services anytime, anyplace.

As a clinician I want to	Digital Requirement	Strategic Fit Solutions
View a real time, accurate, and complete integrated digital care record for my patients	Access to a shared care record	Use **Carecentric** to view acute, community, primary, and social care data
Develop and share care plans across health and social care	Access to a shared care record	Use **Carecentric or CareMyWay** to create and update care plans
Use decision support tools to improve patient safety and quality of care	Enable electronic observations	Implement **VitalPAC** and **CareFlow** to alert when patients are deteriorating *e.g. AKI, Sepsis*
Access best practice guidance to reduce clinical variation and improve outcomes	Trust wide standardised care pathways	Use **Carecentric or CareMyWay** to create and update care plans
Operate digitally at the point of care and stop using paper based processes	Access to mobile devices and interoperable digital tools	Implement virtual desktops and personal mobile devices, access scanned health records

Business Intelligence and Analytics

We will transform our decision making by developing an insights driven culture to improve patient quality, safety, outcomes and effectiveness.

We want to use data to	Digital Requirement	Strategic Fit Solutions
Improve population health outcomes and reduce inequalities	Access to a population health platform	Utilise **MedeAnalytics** or **HealtheIntent** to risk stratify populations and develop patient registries
Shift from a reactive response to historical data to proactive management using predictive data	Data mining and modelling tools	Invest in commercial modelling tools
Develop an adaptive learning culture to rapidly implement data driven quality improvements	Real time access to performance, outcomes and effectiveness data	Use **Qlikview** dashboards and applications Improve patient safety using **HealthRoster** to optimise rotas that match skill mix to patient acuity
Collaborate with academia and industry to share knowledge, undertake research & drive innovation	Access to on-line resources and collaboration tools	UCLP, DeepMind, Health Innovation Network, Advisory Board, Global Digital Exemplars

IT Infrastructure

We will transform our IT infrastructure by implementing a secure, resilient, and mobile operating platform.

We want to our IT Infrastructure to	Digital Requirement	Strategic Fit Solutions
Protect the Trust's information assets from cyber security threats e.g. ransomware, malware	Robust Cyber Security platform	Annual Cyber Security audits and penetration tests to test cyber status and address gaps
Enable "mobile first-digital first" approach to access and capture data anytime, anywhere on any device	Mobile devices and applications	Virtual desktops, mobile devices , use bespoke and commercial web applications
Support integration & interoperability to share clinical data across the Trust and externally	Open supplier interfaces (APIs) and integration engine	Adopt standards *e.g. FHIR, HL7, CDA, XDS,* to exchange and share clinical data
Enable virtual communication and collaboration	Unified Communication platform	Mitel MiVoice and MiCollab tools
Provide resilience with near 100% availability	Real time data replication	Cloud hosted solutions, virtualised servers with replicated data stores

Current Data Silos Can Compromise Patient Care

In 2016, we treated **752** patients with community acquired pneumonia with an average LOS of **9.2** days.
The example patient journey below shows how the current disparate data silos can compromise patient care.

Dot is a 78 year old lady with twice daily carers. She has become unwell with a fever, cough and shortness of breath

Attends ED

ED Consultant has no access to Dot's GP record or her outpatient letters. Dot can't remember her home situation

Admitted to Hospital

Medical SpR has no access to Dot's GP prescribed medications. Dot can't remember them or her allergy to penicillin. They call the GP to check but they are not available

Medicines Management

Pharmacist has no access to Dot's social care records so unaware carers help with her medicines. Dot can't remember the pharmacy which delivers repeat medicines to her home

Therapy Assessment

Acute therapist has no access to Dot's community records so they don't know her most recent baseline function assessment

Discharge Planning

Dot is discharged and referred on by multiple people to multiple teams using multiple formats

Social Services referral

Social services have no access to health records. Referred via e-mail for a package of care

District Nursing referral

District nursing have no access to acute records. Referred via e-mail for medication administration.

GP Discharge Letter

GP has no access to acute records. Only aware of Dot's hospital care on receipt of a discharge letter in the post

Impact of Data Silos on Patient Care

Currently, clinicians are required to access multiple IT solutions using different logins and conduct numerous patient searches to collate data into a composite record for treatment.

They must also use multiple communication tools to elicit further information e.g. e-mails, phone calls, bleeps, paper notes.

These data silos can have a significant impact on patient safety, care, and experience :-

- **Patient Safety** : Adverse events because clinically relevant data is not available on demand e.g. allergies, drugs
- **Patient Care** : Longer lengths of stay, higher costs and increased risk of harm because of delays in treatment waiting for information
- **Patient Experience** : Patient complaints and poor experience because of repeated clinical histories and tests, ; poor booking processes ; lack of integrated care plans

Shared Care Records Can Improve Patient Care

The example patient journey below shows how a shared care record can improve patient care.
All professionals involved with Dot can now view her shared record to provide better health and care.

GP is alerted to Dot's admission and can view her care in hospital. She books a nurse practitioner to visit Dot when she is home

District nursing can access Dot's discharge plan so they can arrange support for her medications at home and remotely monitor her health

Dot can interact with her record and can choose to give access to professionals via the patient portal

Social worker is alerted to Dot's planned discharge and updates the shared care plan to arrange home care support for her

ED consultant can access Dot's GP record for her history and via her outpatient letters see she is being treated by the respiratory team

Medical SpR can access Dot's GP medications and her penicillin allergy so he can safely prescribe her antibiotics

Acute therapist can access Dot's community record to see her baseline function assessment. And send e-discharge assessment to Social Care

Impact of Shared Care Records on Patient Care

Clinicians will be able to access a comprehensive real time shared health and care record anywhere, anytime. They will login once to access an aggregated patient record and be able to access more detail in the disparate IT systems in patient context.

They will be able share integrated care plans across health and social care to ensure much better co-ordination of multi agency resources and deliver care closer to home.

Accessing a shared care record will have significant benefits for patient safety, care, and experience :-

- **Patient safety** : Reduced adverse events and harm because clinically relevant data is available on demand
- **Patient Care** : Avoid admissions, shorter lengths of stay and lower costs as minimal delays in treatment
- **Patient Experience** : Improved patient experience because patients are empowered to book and amend appointments. Clinicians can also avoid duplicated actions e.g. clinical histories and tests

04 Where are we now ?

This chapter describes the current status of our digital services

Current IM&T Services

IM&T provide Trust wide services for Information Management, Clinical Coding, Telecomms, Patient Applications and IT Technical Services (IT Service Desk, Devices, Networks, Storage, Data Centres, Security, Integration, Web Services)

6,133 devices

6.8m budget *(2.2% of Trust)*

4,500+ users

72 staff *(1.6% of Trust)*

100+ locations

80% excellent user rating

Digital Maturity Indices

There are three different Digital Maturity Indices available to assess the current status of our services. They all show the Trust to have some digitally advanced functionality :-

The **Clinical Digital Maturity Index (CDMI)** is a benchmarking tool managed by Digital Health Intelligence to assess digital maturity by measuring the implementation of a number of core and advanced modules

The **Health Information and Management System s Society (HIMSS)** is recognised as the global leader for assessing digital maturity using a comprehensive survey to measure the adoption of technology to improve care and is independently validated on site with end users

The **Digital Maturity Assessment (DMA)** is a self assessment tool managed by NHS England to measure the effective use of digital technology against 3 key themes : organisational readiness, capability and infrastructure

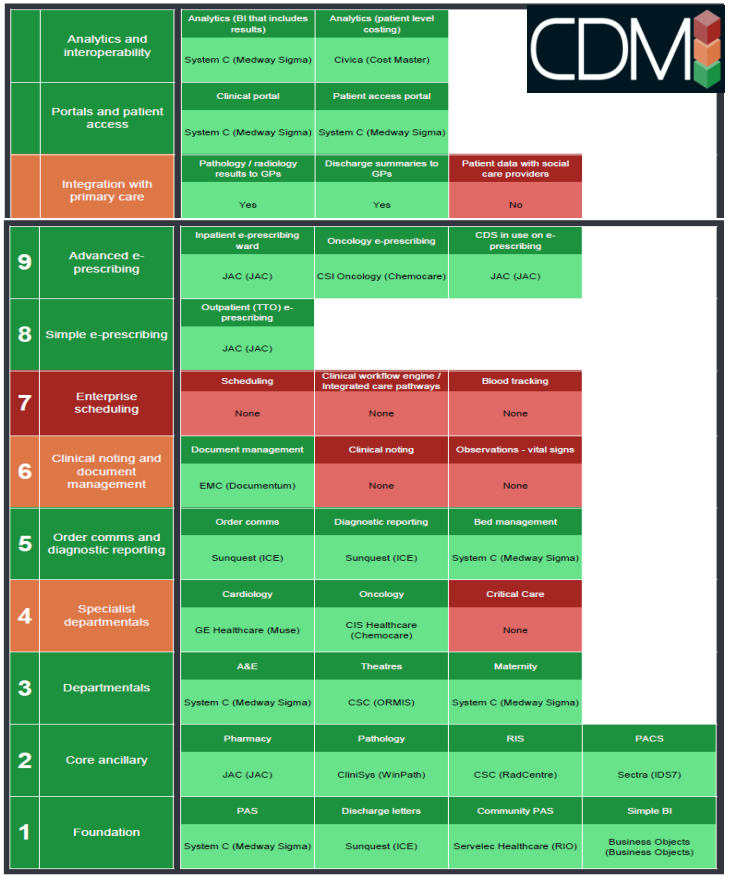
Clinical Digital Maturity Index (CDMI)

The diagram shows our Clinical Digital Maturity Index (CDMI) in 2015. The green coding denotes we have achieved digital maturity in **27/34** clinical functions.

Subsequently, **2/7** red rated gaps have been addressed ; we are the only London Trust to send digital assessments to Social Care ; and we are live with clinical noting in a number of paper-lite services *e.g. Ambulatory Care, ED, TB, Podiatry*

The plans for the 5 remaining red rated gaps are :-

1. **Critical Care**
   Plan to implement an ITU solution in 2017
2. **Vital Signs Observations**
   EPR supplier has an integrated e-obs & alerting solution
3. **Clinical Workflow/Integrated Care Pathways**
   EPR supplier is developing this functionality
4. **Scheduling**
   EPR supplier is developing this functionality
5. **Blood Tracking**
   Pending outcome of Pathology Service Review



Health Information and Management Systems Society (HIMSS)

The diagram shows the HIMSS Electronic Medical Record Adoption Model. There are currently no NHS Trusts that have achieved level 7 and there are only 3/153 providers who have achieved level 6.

In 2015, UCLP benchmarked all its providers and Whittington Health was ranked **4/16**. We had the second lowest number of clinical functions to implement to progress up to level 6 :-

Stage 3 : Capture nursing documentation on EPR

Stage 4 : Fully compliant

Stage 5 : Manage non-Radiology images in PACS

Stage 6 : Capture medical documentation on EPR

Decision support for medical documentation

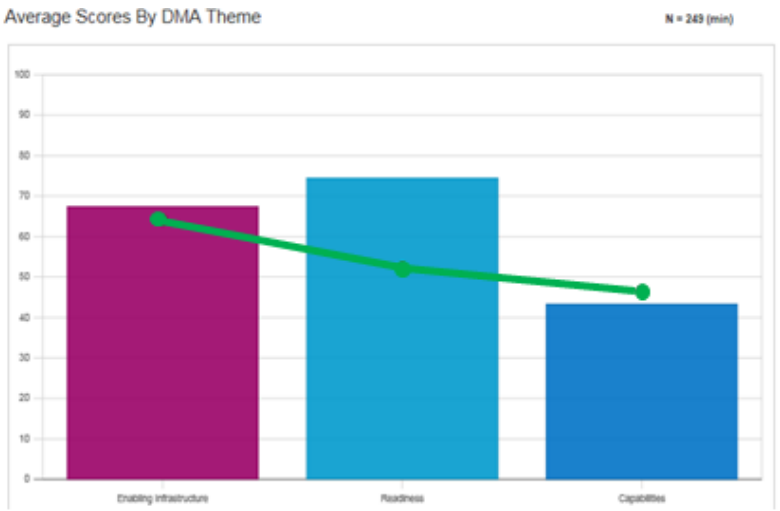
Closed loop auto-identification and medication administration at the point of care

European EMR Adoption Model℠	
Stage	**Cumulative Capabilities**
Stage 7	Complete EMR; CCD transactions to share data; Data warehousing feeding outcomes reports, quality assurance, and business intelligence; Data continuity with ED, ambulatory, OP.
Stage 6	Physician documentation interaction with full CDSS (structured templates related to clinical protocols trigger variance & compliance alerts) and Closed loop medication administration.
Stage 5	Full complement of PACS displaces all film-based images.
Stage 4	CPOE in at least one clinical service area and/or for medication (i.e. e-Prescribing); may have Clinical Decision Support based on clinical protocols.
Stage 3	Nursing/clinical documentation (flow sheets); may have Clinical Decision Support for error checking during order entry and/or PACS available outside Radiology.
Stage 2	Clinical Data Repository (CDR) / Electronic Patient Record; may have Controlled Medical Vocabulary, Clinical Decision Support (CDS) for rudimentary conflict checking, Document Imaging and health information exchange (HIE) capability.
Stage 1	Ancillaries – Lab, Radiology, Pharmacy – All Installed OR processing LIS, RIS, PHIS data output online from external service providers.
Stage 0	All Three Ancillaries (LIS, RIS, PHIS) Not Installed OR Not processing Lab, Radiology, Pharmacy data output online from external service providers.

Digital Maturity Index (DMI)

The diagram shows our Digital Maturity Assessment (DMA) from January 2016 (green line) compared to the NHS average.

The Trust was above the national average for capability but below for infrastructure and organisational readiness.



The Trust has made significant progress over the last 12 months to improve its DMA score, most notably in regard to **organisational readiness**.

Our readiness score has increased from 52% up to **84%** maturity due to the following developments :-

- Appointment of a Chief Clinical Information Officer

- Establishment of a multi-disciplinary Clinical Advisory Group (CAG) to champion the adoption of digital working

- Significant increase in Board engagement e.g. NED lead for technology, multiple presentations to Trust Board, Board Seminars and underlying governance structures

- 5 year capital allocation

- new Digital Strategy 2017-2020 for Board approval

Universal Capabilities

We are digitally advanced with achieving the Local Digital Roadmap universal capabilities.

Mandated Requirement	Our Status
Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions	**Achieved.** Clinicians can view via the Medical Interoperability Gateway which is interoperable with our Carecentric shared care record
Clinicians in urgent and emergency care can access key GP-held information for those patients most likely to present in U&EC	**Achieved.** Clinicians can view via the Medical Interoperability Gateway which is interoperable with our Carecentric shared care record
GPs receive timely electronic discharge summaries from secondary care	**Achieved.** All admitted care discharge summaries sent digitally
Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care	**Achieved.** Only London Trust sending digital notices to Social Care (Islington) via the London Adaptor using a new Interoperability standard
Clinicians in unscheduled care can access child protection information	**In Progress.** Interface to access CP data in patient context from RIO
Professionals are made aware of end-of-life preference information	**Not Achieved.** Awaiting roll out of Co-ordinate My Care across London

Carecentric Shared Care Record

The Trust went live with its Shared Care Record in December 2016. Clinicians can now access clinical data from separate systems in a single view i.e. no multiple logins or patient searches :-.

- **Acute Care** (real time)
  ED, Admitted Care, Outpatient and Clinical Correspondence
- **Community** (overnight feed)
  Appointments. Assessment forms and progress notes will be next
- **Primary Care** (real time)
  Problems, allergies, medications, results

There are three significant developments planned for 2017 :-

- **Social Care**
  Care team and carer, Risks, Disabilities, Case Plans
- **Person Held Record (PHR)**
  Patients will have on-line access to view their record
- **GP Interoperability**
  GPs will be able to access Carecentric within their GP system

Carecentric Shared Care Record

Real time access to disparate patient data in a single view is transforming our patient care :-

This is FAB ! Saves so much time and means much less important clinical detail is missed
Respiratory Consultant

Positively affected my work on take, made taking history much easier , much more streamlined
SHO, Medical Assessment Unit

Carecentric is easy, quick and reliable. Used during weekend post-take when we weren't able to get in touch with a GP to find out a new patient's regular medications. This proved crucial as the patient hadn't informed us he was on warfarin
FY1, Care of the Elderly

Much easier to find medications for patients that are unable to give full histories, found it very useful,
SHO, Emergency Department

05 Digital Transformation Programme

This chapter describes the digital transformation programme required to deliver the future vision

NHS Mandated Priorities 2017-18

Future Vision Key Theme	Project	Requirement	Funding	Benefit
Digitally Connected Patients	Electronic Referral Service (e-RS)	NHSE mandated targets :- 80% referrals made via e-RS by October 2017 100% e-RS slot availability by April 2018 100% referrals made by October 2018	£0K	Create paperless NHS to improve patient care, experience and reduce delays
Digitally Enabled Workforce	Child Protection	Universal capability to access Child Protection information from unscheduled care settings	£6K capital	Alert professionals when a child/unborn baby with a child protection plan (CPP) or looked after child status (LAC) visits unscheduled care setting
	Child Health	New Child Health network hub for NCL & NEL which requires 3 new IT solutions :- Child Health Information System (CHIS) e-Redbook Health Visitors application	Tbc	Population register to reduce health inequalities in access and outcomes E-Redbook is the first digital Child Health Record to record their health, growth and development
	End of Life	Universal capability to access pan-London end-of-life preference information	Tbc	Empowers patients to make and share decisions about their care pan-London
Business Intelligence and Analytics	Pharmacy	NHSE mandated requirement to implement Directory of Medicines and Devices (DM+D)	£25K capital	National interoperability standard to share data on availability and use of licensed drugs
	Community CSDS	Mandated submission of Community Services Data Set (CSDS)	£0K	National monitoring of community activity for planning services
	Emergency Department	Mandated submission of Emergency Care Data Set (ECDS)	£0K	National monitoring of ED performance and demand management

Trust Priorities 2017-18

Future Vision Key Theme	Project	Requirement	Cost	Benefit
Digitally Connected Patients	Transforming Outpatients	Patients book & amend appointments on-line	£108K pa – CIP	Improve efficiency, patient experience, and reduce DNAs to support delivery of £1m CIP
		Enable virtual outpatient consultations	Tbc	
	Digital Inclusion	Community Forum	Tbc	Digital engagement with our local population to actively involve in shaping our future plans Train residents in the 5 basic digital literacy skills
		The Good Things Foundation	£0K	
Digitally Enabled Workforce	Shared Care Record	Roll out Carecentric trust wide ; pilot in 13 GP practices ; pilot Patient Portal	£5K	Real time access to acute, community, primary and social care data will improve care & safety
	Acute EPR	Personal Demographic Service (PDS) module	£120K - capital	Real time NHS number to link patient records
	Community EPR	Off-line access to RIO using Store & Forward	£0K	Release travel time directly back into clinical care
	E-Community	Develop and implement new solution	£40K - CIP	Optimise District Nursing productivity
	Operate Paperless at Point of Care	100% digital workflows in ED and OP clinics, GP and Community requesting on ICE	Tbc	Real time access to patient data will reduce delays and improve patient safety and care
	Scanning Strategy	Management of paper based records	Tbc	Available on-demand, release space
	Improving Medical Productivity	Implement e-job planning, rota compliance, medic on duty, leave and on-call	£115K yr 1 - CIP £193K yr 2-5 – CIP	Improve productivity, rota compliance, & reduce agency spend to support delivery of £1m CIP
	E- observations	Digitised observations at the point of care with automated alerting of early warning scores	£900K - capital	Identification of deteriorating patients *e.g. AKI, Sepsis* will improve patient safety and outcomes
	ITU/HDU		Charitable Funds	
	PACS/VNA	Ingest non-Radiology images *e.g. Cardiology* and videos *e.g. Michael Palin, MSK, Paediatric*	£150K - capital	Single integrated view for all digital images and videos for a patient
Intelligence and Analytics	Qlikview Enterprise Reporting	Promote use of live dashboards and develop new ones *e.g. Finance, Imaging, Pharmacy*	£20K - capital	Real time data to improve decision making. Able to query Trust summary down to patient level data
IT Infrastructure	Cyber Security	Implement KPMG Cyber Security audit actions	£250K - capital	Mitigate risk of cyber attacks
	Devices	68% of PCs ; 32% of iPADS are > 5 years old, re-instate rolling replacement programme	£1,900K - capital	More secure, efficient, supported devices ; fewer fails, reduced support costs

Trust Requirements 2018-20

Below are specific requirements identified by the ICSUs which have not already been highlighted in the National or Trust priorities

Children & Young Persons	Emergency & Urgent Care	Integrated Medicine	Patient Access, Prevention & Planned Care	Surgery & Cancer	Women's Health	Clinical Support Services
Capture nursing documentation on Medway EPR to operate paperless at point of care (HIMSS level 3)						Blood Tracking
Capture medical documentation on Medway EPR to operate paperless at point of care (HIMSS level 6)						Digital Histo-Cytology
Capture non-Radiology images into PACS to operate paperless at point of care (HIMSS level 5)						
Implement standardised care pathways with decision support and closed loop medication administration (HIMSS level 6)						
Partner with UCLP, Google DeepMind, Health Innovation Network, System C to develop and adopt innovative solutions						
Unified Communications Platform to improve productivity, virtual collaboration, remote working and customer service						
Digital comms to increase market share and income	Paperless ED	Develop patient portal to support self management of long term conditions		New Theatre System and digital pre-assessment forms	Implement Foetal Monitoring and integrate with EPR	Community e-prescribing
	Interoperability with LAS & OoH records	Tele-health *e.g. remote devices, wearable tech*	E-referral-grading-booking process	UCLH vanguard Cancer system	Integration of Maternity with ICE and JAC	

Governance

The proposed governance structure to oversee the delivery of the Digital Strategy :-

Trust Board

- Monitor delivery of Digital Strategy
- Ratify annual digital development plans and investment priorities

Trust Management Group

- Monitor delivery of Digital Strategy
- Approve annual digital development plans and investment priorities

Digital Steering Group

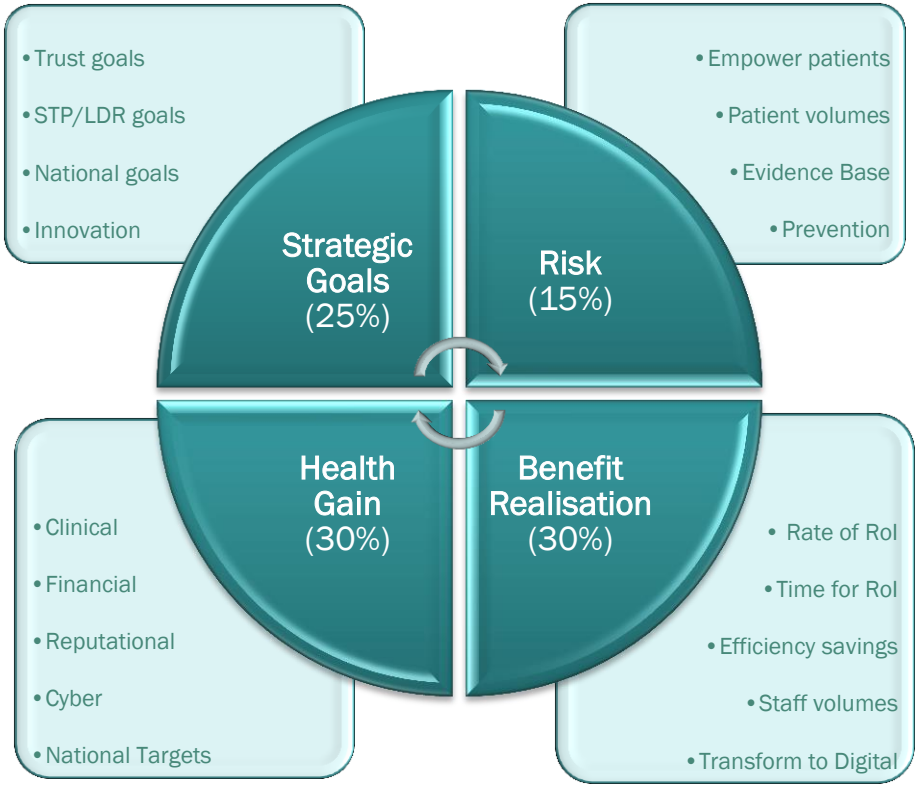
- Manage delivery of Digital Strategy
- Recommend digital development plans and investment priorities
- Link to PMO for service improvement and CIP

Clinical Advisory Group

- Promotes adoption of Digital Strategy
- Develops annual development plans and investment priorities

Investment Model

A investment model has been developed to prioritise IT funding to deliver the Digital Strategy :-



All future investments in technology should be prioritised using the model in advance of a full business case

06 Acknowledgements

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7 **Making IT Work : Harnessing the Power of Health IT to Improve Care in England**, *Robert Wachter, (2014)*

8 **North Central London Local Digital Roadmap** , *(2016)*

9 **Whittington Health Clinical Strategy 2015-2020**, *(2015)*

10 **Whittington Health Nursing & Midwifery Strategy 2016-2021** , *(2016)*

11 **Whittington Health Estates Strategy 2016-2021** , *(2016)*

12 **Whittington Health Workforce Strategy 2016-2021** , *(2016)*

Document Control

Category	Description	Date
Authors	Glenn Winteringham, Director of IM&T Sam Barclay, Chief Clinical Information Officer (CCIO)	
Approval	Trust Board Seminar Trust Management Group Trust Board	08/02/17 14/02/17 01/03/17
Status & Version	Final - 7.0	24/02/17

The authors would like to express their thanks and gratitude to all those who contributed to the development and refinement of the Digital Strategy 2017-2020.

Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board

1 March 2017

Title:	January (Month 10) 2016/17 - Financial Performance		
Agenda item:	17/038	**Paper**	09
Action requested:	To agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends.		
Executive Summary:	The Trust reported a £0.8m deficit in January and a year to date position of £5.9m deficit. This is £0.2m adverse against the planned year to date (YTD) performance. The Trust continues to forecast delivery of its control total position, and has put in place enhanced financial controls to support this.		
Summary of recommendations:	To note the financial results relating to performance during January 2017		
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:	23 February 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 Metric

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	3	(1)
Capital Servicing Capacity (times)	4	4	0
I&E Margin Rating	4	4	0
I&E Margin Variance from Plan		2	
Agency	2	3	1
Use of Resources Rating after overrides		**3**	

The table above shows that as at Month 10 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 £0.8m deficit in January and a year to date position of £5.9m deficit. Results for January mean that the Trust is now £0.2m adverse against its planned position for the year to date.

Main issues of note:

- Pay expenditure was £0.7m adverse against plan in month, and is now £2.6m adverse year to date. In total the pay bill for January was £18.8m which is highest monthly amount this financial year, and £0.3m above the average for the year. Other key points that should be noted, include:

    - Total agency costs for January were £1.0m, an increase of c. £0.2m compared to December. The increase in agency costs, coupled with the overall increase in the monthly pay expenditure is having a significant impact on the Trust's ability to achieve its CIP target and overall financial control total. 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 remainder of the financial year, together with the performance of other pay savings schemes will see the Trust fail its CIP target.

    - There were increases in a number of areas with respect to agency costs including admin & clerical, nursing, and scientific staffing, which were partially offset by a reduction in medical staffing. Overall, agency spend was 5.2% of the monthly pay bill up from 4.1% in December. When assessed in relation to total qualified nursing spend, nursing agency equates to 8%, a marked increase from the 5.7% achieved in December, and in excess of the Trust's regulatory limit of 6%.

- Non Pay expenditure continues to be favourable against plan, but less so than previous months. The in-month favourable variance being <£0.1m, and £4.1m year to date.

- Total income was £0.2m favourable against plan in month. Particular points of note include:
    - Clinical income was £0.1m favourable against plan.
    - SLA clinical income is on plan in month. However, within this electives have underperformed by £0.5m, predominantly in Surgery.
    - The income position includes partial achievement of income efficiencies (CIP).

The in-month position of a £0.8m deficit sees a worsening in performance compared to December (£0.6m adverse). As a result the Trust is now £0.2m off its planned position and will require cost reductions in run rates for February and March in order to achieve the annual 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.

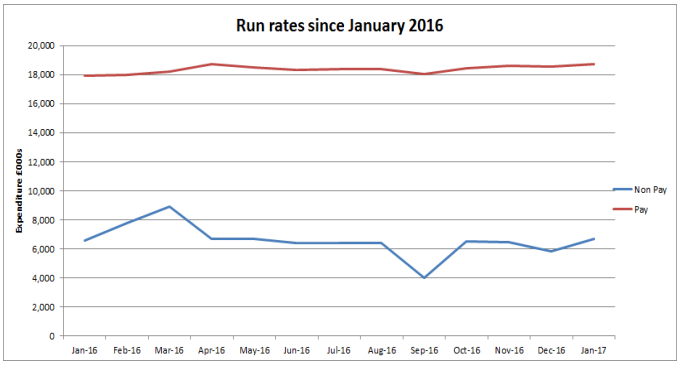
The month end cash balance of £4.1m is £0.8m above plan. The position includes STP funding for the first 2 quarters.

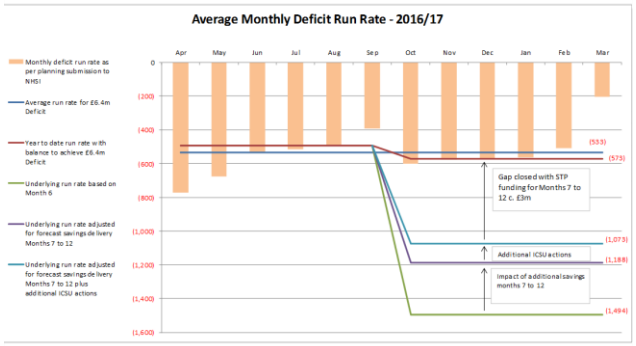
Capital spending commitments now total £2.9m with £2.5m (December £1.7m) actually incurred to date. It should be noted that in response to a national request from NHSI the Trust has re-forecast its capital spend for the year, with the revised total now being £6m.

Statement of Comprehensive Income

2016/17, Month 10 (January 2017)

Statement of Comprehensive Income	In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	YTD Budget (£000s)	Ytd Actuals (£000s)	Variance (£000s)	Full Year Plan (£000s)
Nhs Clinical Income	21,466	21,411	(55)	215,502	212,437	(3,065)	252,706
Non-Nhs Clinical Income	1,895	1,929	34	18,953	19,529	576	22,455
Other Non-Patient Income	2,202	2,390	188	22,092	21,577	(515)	26,115
Total Income	**25,563**	**25,730**	**167**	**256,547**	**253,543**	**(3,004)**	**301,276**
Non-Pay	6,717	6,676	41	66,141	61,993	4,148	73,085
Pay	18,098	18,752	(654)	182,076	184,684	(2,608)	219,414
Total Operating Expenditure	**24,815**	**25,428**	**(613)**	**248,217**	**246,677**	**1,540**	**292,499**
EBITDA	**748**	**302**	**(446)**	**8,330**	**6,866**	**(1,464)**	**8,777**
Depreciation	690	651	39	6,900	6,706	194	8,280
Dividends Payable	353	198	155	3,536	3,380	156	4,243
Interest Payable	278	274	4	2,681	2,655	26	3,238
Interest Receivable	(3)	0	(3)	(30)	(17)	(13)	(36)
Total	**1,318**	**1,123**	**195**	**13,087**	**12,724**	**363**	**15,725**
Net Surplus / (Deficit) - before IFRIC 12 adjustment	**(570)**	**(821)**	**(251)**	**(4,757)**	**(5,858)**	**(1,101)**	**(6,948)**
Add back impairments and adjust for IFRS & Donate	(7)	7	(14)	930	29	901	116
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**(563)**	**(828)**	**(265)**	**(5,687)**	**(5,887)**	**(200)**	**(7,064)**





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 of £0.8m in January was c. £0.2m worse than December and highlights the need for 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 previously reported the forecasts provided by ICSUs, at Month 7, have become their control totals for the remainder of the financial year, and are being monitored on a monthly basis.

The table below provides the Month 10 actual results against the ICSU control totals, together with the results from the previous month.

Pay

	Previous Month (Month 9)			Current Month (Month 10)			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	3,979	(60) ↑	3,919	4,018	(99) ↑	(203)
Clinical Support Services	1,279	1,336	(57) ↑	1,279	1,361	(82) ↑	(243)
Emergency & Urgent Care	1,937	1,876	61 ↓	1,937	2,123	(186) ↑	(184)
Integrated Medicine	2,795	3,101	(306) ↑	2,795	2,905	(110) ↑	(567)
Patient Access, Prevention & Planned Care	1,046	1,026	20 ↓	1,046	1,016	30 ↓	(7)
Surgery & Cancer	2,918	3,218	(300) ↑	2,918	3,130	(212) ↑	(705)
Women's Health	1,533	1,588	(55) ↑	1,533	1,655	(122) ↑	(271)
Total Pay - Clinical ICSUs	15,427	16,124	(697) ↑	15,427	16,209	(782) ↑	(2,181)

Non Pay

	Previous Month (Month 9)			Current Month (Month 10)			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	195	(5) ↑	190	173	17 ↓	(18)
Clinical Support Services	1,348	1,413	(65) ↑	1,348	1,707	(359) ↑	(413)
Emergency & Urgent Care	206	280	(74) ↑	206	242	(36) ↑	(158)
Integrated Medicine	257	311	(54) ↑	257	219	38 ↓	(72)
Patient Access, Prevention & Planned Care	261	266	(5) ↑	261	281	(20) ↑	20
Surgery & Cancer	771	705	66 ↓	771	703	68 ↓	109
Women's Health	184	148	36 ↓	184	169	15 ↓	81
Total Non Pay - Clinical ICSUs	3,217	3,318	(101) ↑	3,217	3,494	(277) ↑	(451)

Combined Pay & Non Pay

	Previous Month (Month 9)			Current Month (Month 10)			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	4,174	(65) ↑	4,109	4,192	(83) ↑	(222)
Clinical Support Services	2,627	2,749	(122) ↑	2,627	3,067	(440) ↑	(655)
Emergency & Urgent Care	2,143	2,156	(13) ↑	2,143	2,365	(222) ↑	(342)
Integrated Medicine	3,052	3,412	(360) ↑	3,052	3,124	(72) ↑	(639)
Patient Access, Prevention & Planned Care	1,307	1,292	15 ↓	1,307	1,297	10 ↓	13
Surgery & Cancer	3,689	3,923	(234) ↑	3,689	3,833	(144) ↑	(596)
Women's Health	1,717	1,736	(19) ↑	1,717	1,824	(107) ↑	(190)
Total Expenditure - Clinical ICSUs	18,644	19,442	(798) ↑	18,644	19,702	(1,058) ↑	(2,631)

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

In-month ICSUs were c. £1.1m adverse to their expenditure control totals. However, included within the Trust's Month 10 position is c. £1m of non-recurrent mitigations, mainly in the form of income, which has offset this in arriving at the overall Trust position of a £0.8m deficit in January.

Cost Improvement Programme

Year to date, £5.6m has been delivered against a target of £7.3m. This equates to a 76% achievement. The CIP profile requires a material increase in the rate of cost improvement over the remaining months 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	437	207	47.4%	-230
Clinical Support Services	1,019	774	283	36.6%	-491
Emergency & Urgent Care	786	564	519	92.0%	-45
Medicine, Frailty & Network Services	1,673	1,010	883	87.4%	-127
Outpatients Prevention & LTC	526	396	509	128.5%	113
Surgery	2,613	1,981	1,041	52.6%	-940
Women's services	1,189	887	541	61.0%	-346
Corporate	1,592	1,271	1,213	95.4%	-58
Trustwide non-pay	0		390		390
Performance against operating plan	**10,000**	**7,320**	**5,586**	**76.3%**	**-1,734**

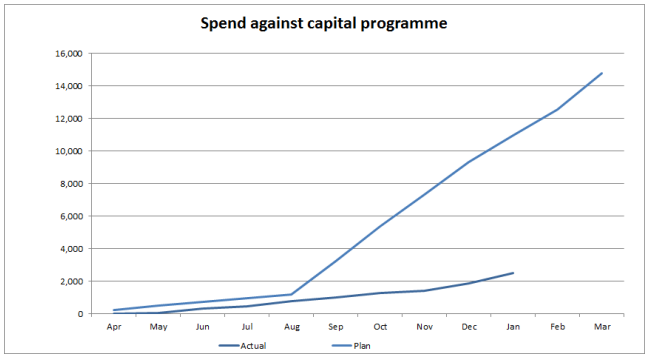
The table above shows actual performance against the original CIP plans, indicating a shortfall of c. £1.7m year to date. However, a number of non-recurrent benefits have been realised, which supports the Trust being only £0.2m adverse against plan, in overall terms, year to date.

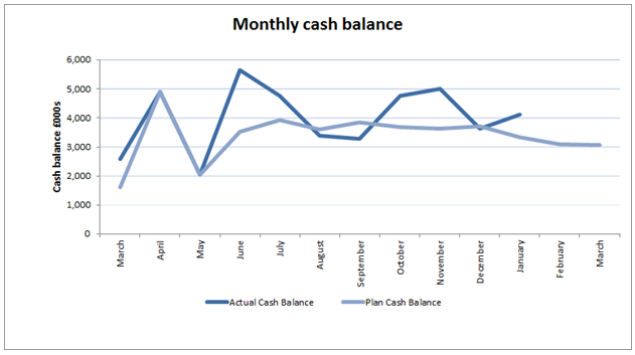
Monitoring of performance against CIP plans continues to be undertaken by the PMO via regular meetings. Shortfalls are principally linked to pay and non-pay schemes and the PMO is working with ICSUs to accelerate future schemes and replace those that will now not achieve during the current financial 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 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 January 2017 £000	Year to Date As at 31 January 2017 £000	Year to Date Variance YTD 31 January 2017 £000
Property, plant and equipment	194,785	203,023	200,811	191,480	9,331
Intangible assets	4,583	2,831	3,122	3,661	(539)
Trade and other receivables	693	851	841	602	239
Total Non Current Assets	**200,061**	**206,705**	**204,774**	**195,743**	**9,031**
Inventories	1,403	1,500	1,500	1,712	(212)
Trade and other receivables	23,535	25,393	20,678	34,488	(13,810)
Cash and cash equivalents	2,598	3,060	3,330	4,114	(784)
Total Current Assets	**27,536**	**29,953**	**25,508**	**40,314**	**(14,806)**
Total Assets	**227,597**	**236,658**	**230,282**	**236,057**	**(5,775)**
Trade and other payables	39,112	43,391	38,341	47,279	(8,938)
Borrowings	376	2,455	9,567	8,796	771
Provisions	795	756	765	201	564
Total Current Liabilities	**40,283**	**46,602**	**48,673**	**56,276**	**(7,603)**
Net Current Assets (Liabilities)	**(12,747)**	**(16,649)**	**(23,165)**	**(15,962)**	**(7,203)**
Total Assets less Current Liabilities	**187,314**	**190,056**	**181,609**	**179,781**	**1,828**
Borrowings	52,934	61,419	52,196	51,258	938
Provisions	1,773	1,513	1,562	1,773	(211)
Total Non Current Liabilities	**54,707**	**62,932**	**53,758**	**53,031**	**727**
Total Assets Employed	**132,607**	**127,124**	**127,851**	**126,750**	**1,101**
Public dividend capital	62,404	62,404	62,404	62,404	0
Retained earnings	(7,873)	(13,356)	(12,629)	(13,433)	804
Revaluation reserve	78,076	78,076	78,076	77,779	297
Total Taxpayers' Equity	**132,607**	**127,124**	**127,851**	**126,750**	**1,101**
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 £13.8m is mainly due to delayed settlement of outstanding activity invoices for 2015/16 and 2016/17. Discussions to clear the outstanding amounts remain on going, but progress has been slow due to the link with issues in Accounts Payable.

Payables: The Trust is in the process of approving and paying significant creditor balances and furthermore the Trust is in discussions with local providers to reduce outstanding balances. As reported previously the Trust will not achieve the Better Payments Target in 2016/17, due 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 10. The cash position at the close of month 10 was £4.1m.

Whittington Health Trust Board
1st March 2017

Title:	Trust Board Report February 2017 (January 2017 data)		
Agenda item:	**17/039**	**Paper**	**10**
Executive Summary:	**Emergency and Urgent Care** Performance against the 95% target was extremely challenged in January, as was the performance across the sector. The main challenges were patient acuity, increase in LAS activity and ED attendances. The Islington ED delivery board has taken on a piece of work to look specifically at acuity and changes compared to last year. This work showed that whilst there was an increase of 4x baseline activity for ED and UUC when comparing Sept-Dec 15 to Sept to Dec 16 there was also a significant higher proportional increase in the acuity of patients. **Cancer** All targets achieved. **Emergency Re-Admission within 30 days** Target achieved **Theatre Utilisation** Theatre utilisation in January was low due to number of procedures changed due to pressures on bed capacity across the Trust. 83.5% for December 2016 reduced to 72.8% in January 2017. **Falls** Whittington Health's NHS Improvement Falls Project, with focus on the Mary Seacole wards, has completed the first 30 days of the 90 day project. Patient journey through the wards has been mapped and an improvement of use of the falls bundle is noticed. Further work, identifying falls and related to falls tasks to improve patient safety, is the next part of the projects' focus. **Appraisal and sickness** Despite the operational pressures we reported improvements in compliance in both mandatory training and appraisal rate. Sickness absence remained within target.		
Summary of recs:	Note the performance		
Fit with WH strategy:	All five strategic aims		
Ref to risks/ BAF:	N/A		
Date completed:	23rd February 2017		

Author name and title:		**Hester de Graag, Performance Lead**		**Director name and title:**		**Carol Gillen, Chief Operating Officer**	
Date paper seen by EC	**28 Feb**	**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

Whittington Health NHS

Integrated Performance Report

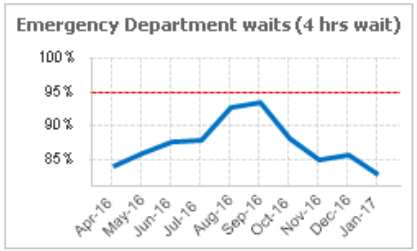
February 2017

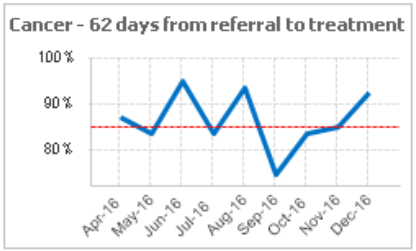
Month 10 (2016 – 2017)

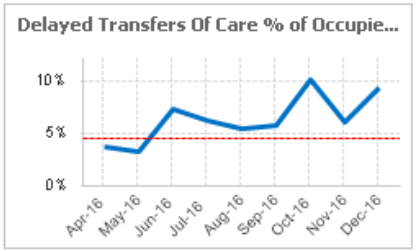
Date & time of production: 27/02/2017 08:37

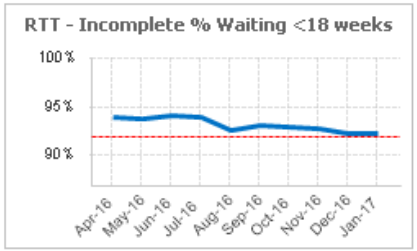
Summary Page - Indicators

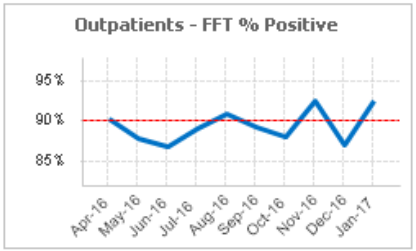
Category	Indicator	16_17 Target	Q1 Apr-16	Q1 May-16	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	2016-2017
ED	Emergency Department waits (4 hrs wait)	>95%	84.1%	85.9%	87.7%	87.9%	92.7%	93.4%	88.1%	85.1%	85.8%	82.9%	87.3%
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	88	88	85	87	60	62	75	88	76	77	78
Cancer	Cancer - 14 days to first seen	>93%	97.4%	96.4%	96.4%	97.3%	97.7%	96.6%	97.8%	95.5%	93.4%		96.5%
Cancer	Cancer - 62 days from referral to treatment	>85%	87.2%	83.6%	94.9%	83.3%	93.5%	74.5%	83.3%	85.0%	92.3%		86.2%
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%	4.8%	5.8%
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%	9.3%		5.7%
Access	RTT - Incomplete % Waiting <18 weeks	>92%	93.9%	93.8%	94.2%	93.9%	92.7%	93.1%	92.9%	92.8%	92.2%	92.2%	93.2%
Outpatients	Outpatients - FFT % Positive	>90%	90.2%	87.7%	86.7%	89.1%	90.8%	89.2%	88.0%	92.6%	87.0%	92.5%	90.0%
Community	Community - FFT % Positive	>90%	97.3%	97.5%	97.5%	97.9%	97.5%	98.4%	98.1%	98.2%	98.7%	98.0%	97.9%
Staff	Staff - FFT % Recommend Care	>70%			80.1%			76.2%					77.9%

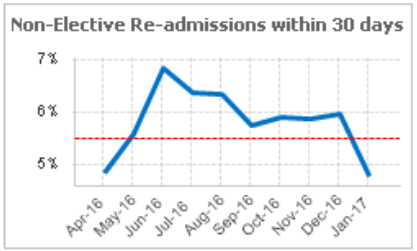












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Safe Services - Indicators and Performance

Category	Indicator	16_17 Target	Q4 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	Q4 Jan-17	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	2	1	1	1	0	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**	29	26	24	26	36	26	31	38	45	30	45	57	358	
Admitted	Avoidable Grade 3 or 4 Pressure Ulcers	**0**			4	2	1	3	5	5	5	1	4	2	32	
All Areas	Harm Free Care %	**>95%**	93.6%	93.6%	92.2%	92.6%	93.5%	93.8%	91.9%	90.8%	93.3%	92.6%	93.2%	94.3%	92.8%	
Maternity	Non Elective C-Section % Rate	**>15%**	18.0%	18.1%	13.6%	18.9%	17.7%	16.4%	17.4%	20.2%	17.7%	21.6%	17.4%	20.5%	18.1%	
All Areas	Medication Errors causing serious harm	**0**	0	0	1	0	0	0	0	0	0	0	1		2	
Admitted	MRSA Bacteraemia Incidences	**0**	0	0	0	0	0	0	0	0	1	0	0	0	1	
Admitted	Never Events	**0**	0	0	0	0	0	0	1	0	1	0	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%	21.3%	21.2%	
All Areas	Serious Incidents	**0**	8	2	3	6	3	3	4	6	9	8	3	4	49	
Admitted	VTE Risk Assessment %	**>95%**	95.3%	95.1%	95.0%	96.0%	96.3%	98.0%	96.2%	96.6%	97.3%	96.4%	95.9%		96.4%	

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Safe Services - Commentary

Falls
Whittington Health's NHS Improvement Falls Project, with focus on the Mary Seacole wards, has completed the first 30 days of the 90 day project. Patient journey through the wards has been mapped and an improvement of use of the falls bundle is noticed. Further work, identifying falls and related to falls tasks to improve patient safety, is the next part of the projects' focus.

Avoidable pressure ulcers
Of the 2 grade 2 pressure ulcers reported one was in the hospital and one in the community. The first pressure ulcer developed due to inappropriate assessment and therefore an inappropriate action plan was put in place. The latter was a pressure ulcer deteriorating from grade 2 to 3 due to no equipment put in place on time.

Harm Free Care
Third consecutive month of slight improvement, although still under target. It includes all avoidable and unavoidable harm.

Non-elective C-section
Looking through our patient cohort the service has had higher risks patients in January 2017. This has led to the increase in the non-elective C-section rate. Compared to the other NCL Trusts we are Amber. We are also continuing to work with UCLH which will increase the number of C-sections.

Serious Incidents
Whittington Health declared 4 serious incidents in January 2017. All 4 were falls related.

Caring Services - Indicators and Performance

Category	Indicator	16_17 Target	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	Q4 Jan-17	2016-2017	Performance
ED	ED - FFT % Positive	>90%	91.6%	85.4%	89.9%	92.0%	87.7%	89.4%	92.4%	95.6%	89.9%	82.1%	83.8%	83.4%	86.1%	
ED	ED - FFT Response Rate	>15%	6.1%	4.0%	4.6%	4.8%	5.1%	4.5%	3.4%	4.1%	4.1%	16.6%	16.6%	14.6%	7.9%	
Admitted	Inpatients - FFT % Positive	>90%	89.5%	94.2%	96.6%	93.6%	95.7%	96.7%	96.0%	95.1%	95.8%	92.7%	95.8%	92.1%	95.2%	
Admitted	Inpatients - FFT Response Rate	>25%	12.6%	14.0%	19.4%	15.5%	15.5%	19.3%	15.4%	20.4%	18.3%	18.0%	12.6%	7.2%	16.2%	
Maternity	Maternity - FFT % Positive	>90%	87.7%	87.9%	94.6%	92.1%	94.6%	91.6%	93.2%	91.1%	91.6%	93.8%	94.8%	88.0%	92.3%	
Maternity	Maternity - FFT Response Rate	>15%	19.4%	19.2%	19.3%	16.1%	18.3%	10.5%	18.9%	24.2%	23.1%	12.8%	24.6%	30.4%	19.7%	
Outpatients	Outpatients - FFT % Positive	>90%	82.2%	84.7%	90.2%	87.7%	86.7%	89.1%	90.8%	89.2%	88.0%	92.6%	87.0%	92.5%	90.0%	
Outpatients	Outpatients - FFT Responses	400	73	144	133	171	166	229	229	305	408	516	193	481	2831	
Community	Community - FFT % Positive	>90%	96.3%	98.5%	97.3%	97.5%	97.5%	97.9%	97.5%	98.4%	98.1%	98.2%	98.7%	98.0%	97.9%	
Community	Community - FFT Responses	1500	983	753	778	752	628	563	609	621	645	880	549	697	6722	
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%	66.7%	88.2%	
All Areas	Complaints (including complaints against Corporate division)	N/A	21	48	23	23	31	26	38	32	25	19	32	22	271	
Community	End of Life % of patients dying in Pref. Place of care - DN	>70%	76.0%	75.0%	95.5%	100.0%	96.0%	84.4%	85.7%	72.0%	71.4%	85.7%	83.3%	90.9%	86.6%	

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Caring Services - Commentary

FFT

At Whittington Maternity FFT response has increased due to the positive strategies adopted following a low response in Nov 2016 of only 12%, now reaching above the target of 15% consistently. This was achieved raising awareness, particularly by matrons and senior staff, increasing volunteer support on the postnatal ward and in the community and using a telephone surveys. A weekly summary is shared in the department.

Surgery FFT Response Rate - Admitted

The response rate has reduced for inpatients due to operational pressures over January on the surgical wards and the availability of volunteers. The service depends on volunteers to help patients fill in the questionnaires. This has been escalated to Patient Experience Services and HoN is liaising with Volunteers Services to increase the availability of volunteers.

Complaints

During January 2017 the Trust had 22 complaints requiring a response, 15 of which were required within 25 working days. The Trust achieved a performance of 67% in regard to its target of 80%. Unfortunately, this is the first time that the Trust has not hit its target since November 2015.
The majority of the complaints had been allocated to Surgery & Cancer 32% (7), PPP 23% (5) and Integrated Medicine 18% (4). One complaint was designated ‘high risk’, 3 were ‘moderate’ and 18 (82%) ‘low’.
A review of the complaints for this period (22) shows that ‘medical care’ accounted for 3, with 2 of our patients indicating that they felt that “inadequate treatment” had been provided; 3 related to ‘attitude’ where 2 stated that staff appeared “inconsiderate, uncaring or dismissive”. In addition, 3 complaints cited ‘communication’ as the main concern.
6 complaints remain outstanding as at 7 January. Of those that have closed, 62% (10) were ‘upheld’, whilst 31% (5) were ‘partially upheld’, meaning that 94% of the closed 16 complaints, were upheld in one form or another.

Effective Services - Indicators and Performance

Category	Indicator	16_17 Target	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	Q4 Jan-17	2016-2017	Performance
Maternity	Breastfeeding Initiated	>90%	92.3%	93.3%	91.8%	93.4%	90.5%	95.2%	91.5%	90.6%	94.2%	90.2%	90.1%	91.4%	91.9%	
Maternity	Smoking at Delivery	<6%	7.4%	4.1%	4.4%	6.6%	6.2%	3.9%	4.4%	4.8%	3.2%	5.1%	4.8%	3.6%	4.7%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	5.3%	5.6%	4.8%	5.6%	6.8%	6.4%	6.3%	5.7%	5.9%	5.9%	6.0%	4.8%	5.8%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	82.2	93.3	75.6	80.4	74.5	114.9	83.9	58.4	75.3				80.2	
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	68.5	54.5	42.6	123.8	64.8	81.3	78.2	84.5	76.5				78.8	
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	6.7	7.5	6.5	4.7	6.1	5.8	5.8	4.2	6.5	7.9	7.2	11.8	6.6	

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Effective Services - Commentary

Non Elective re-admission rate within 30 days
Target achieved.

Responsive Services - Indicators and Performance

Category	Indicator	16_17 Target	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	Q4 Jan-17	2016-2017	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	84.0%	81.6%	84.1%	85.9%	87.7%	87.9%	92.7%	93.4%	88.1%	85.1%	85.8%	82.9%	87.3%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	94	103	88	88	85	87	60	62	75	88	76	77	78	
ED	Ambulance handovers waiting more than 30 mins	0	3	21	23	20	28	31		16	26	45			189	
ED	Ambulance handovers waiting more than 60 mins	0	0	0	0	2	9	0		0	1	4			16	
ED	12 hour trolley waits in A&E	0	1	0	0	0	1	1	0	1	1	1	0	2	7	
Cancer	Cancer - 14 days to first seen	>93%	99.5%	98.9%	97.4%	96.4%	96.4%	97.3%	97.7%	96.6%	97.8%	95.5%	93.4%		96.5%	
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	98.3%	99.4%	98.1%	95.4%	99.2%	100.0%	100.0%	100.0%	97.2%	98.2%	100.0%		98.5%	
Cancer	Cancer - 62 days from referral to treatment	>85%	81.6%	91.4%	87.2%	83.6%	94.9%	83.3%	93.5%	74.5%	83.3%	85.0%	92.3%		86.2%	
Cancer	Cancer - 31 days to first treatment	>96%	100.0%	97.5%	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 - surgery	>98%	100.0%			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Cancer	Cancer - 31 days to subsequent treatment - drugs	>93%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	100.0%	100.0%			100.0%	
Access	DM01 - Diagnostic Waits (<6 weeks)	>99%	98.8%	99.4%	99.6%	99.4%	99.9%	99.3%	99.5%	99.7%	99.5%	99.8%	99.1%	99.1%	99.5%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.1%	92.7%	93.9%	93.8%	94.2%	93.9%	92.7%	93.1%	92.9%	92.8%	92.2%	92.2%	93.2%	
Access	Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

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Responsive Services - Commentary

ED four hours' wait and Ambulance handover time
Performance against the 95% target was extremely challenged in January. The Whittington in conjunction with the CCG has undertaken a detailed piece of work to review the key challenges. This work showed that whilst there was an increase of 3% in baseline activity for ED and UUC when comparing Sept-Dec 15 to Sept to Dec 16, there was a higher proportional increase in the acuity of patients which is summarised below;

- The number of patients triaged for ED (Majors) rose by 16% and the number of patients triaged as Urgent, Very Urgent or Immediate Resus rose by 13% with a reduction of 6% in the number of patients triaged as standard
- There was a 20% rise in the number of patients requiring Resus
- There was a 10% rise in the number of ambulance conveyances triaged as Urgent, Very Urgent or Immediate Resus
- The average number of patients in the department by hour rose by 12%
- Bed days lost to Delayed Transfers of care rose by 60% with the main causes being waits for nursing, residential or further NHS placements and Cardiology and Thoracic Medicine saw an increase in average length of stay.

In order to respond to the increase in acuity and LoS driven by DTOC, the organisation is focusing on; embedding the Frailty Pathway into practice, embedding a 'RAT' model to increase senior leadership and decision making at the ED front door and a new nurse model to support quicker LAS hand over, the recruitment of additional ED Consultant's, increasing criteria lead discharge and pre 11 discharge and working extremely closely with health and social work colleagues to safely support patient discharge. The organisation has also invited ECIP to support with a piece of work to review and make recommendations on improving flow through medicine and surgery which will take place in February.

The organisation held their 2nd 'perfect week' on 9th January which was a very successful exercise, facilitating operational improvements that have further improved quality and performance going into February.

12 hour trolley waits in A&E
Both 12 hour trolley waits in Jan were informal mental health patients requiring a mental health bed and who were not suitable for a medical admission. In order to facilitate bed availability going forward and to help prevent patients waiting over 12 hours for a mental health bed, appropriate escalation continues and C&I are now part of the 11am CSU surge call every day so that any issues can be discussed in a timely manner.

Responsive Services - Commentary

Cancer – 62 days from referral to treatment
Note: When boxes are grey in this section is means that there were no patients in this category for the month.
Compliant for December 2016

Responsive Services - Indicators and Performance

Category	Indicator	16_17 Target	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	Q4 Jan-17	2016-2017	Performance
Theatres	Hospital Cancelled Operations	0	3	3	19	4	7	1	6	1	4	6	2	15	65	
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	102	183	148	129	273	240	191	199	364	267	348		2159	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	2.4%	4.1%	3.8%	3.4%	7.4%	6.3%	5.5%	5.7%	10.1%	6.1%	9.3%		5.7%	
Maternity	Women seen by HCP / midwife within 10 weeks	>50%	38.7%	33.9%	40.4%	43.8%	63.7%	74.5%	69.1%	72.8%	69.4%	67.2%	67.8%	54.1%	61.9%	
Community	IAPT Moving to Recovery	>50%	47.1%		47.4%	51.6%	48.0%	50.0%	51.7%	52.3%	45.7%	47.1%	52.4%		49.6%	
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%	97.2%		94.4%	
Community	GUM - Appointment Offered within 2 days	>98%	99.4%	98.9%	98.7%	98.5%	99.7%	95.6%	97.8%	99.2%	99.9%	99.6%	99.8%	99.3%	98.8%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	83.8%	85.7%	88.6%	89.8%	87.9%	93.2%	94.6%	94.2%	91.8%	92.2%	91.6%		91.5%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	92.8%	94.7%	95.1%	96.1%	94.4%	94.9%	93.7%	88.3%	93.3%	94.1%	94.6%		93.8%	

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Responsive Services - Commentary

Hospital Cancelled Operations

In January 2017 there were 15 patients cancelled on the day, this was predominantly due to significant bed pressures throughout January 2017. All planned elective inpatient surgery was reviewed on a daily basis to ensure that urgent and cancer patients were all seen in a timely manner. Across January the elective day case work was not cancelled to try to keep activity going. However despite all efforts:

9 patients were cancelled on the day due to there being no hospital bed available
1 patient needed an additional test before surgery was undertaken
1 patient was cancelled to allow a trauma case to take place, effect of bed pressures
2 patients were cancelled due to no doctor to assist in the cases
2 patients were cancelled due to overrun of previous cases; this was also an effect of bed pressures

Delayed Transfer of Care % of Occupied Bed days

Increase in DTOC due to availability of discharge packages of care in Islington and several neighbouring boroughs. Escalation processes in place including for out of borough DTOCs up to Director and COO level.

New Birth Visits September 2016

Improvement seen in Islington and a slight decrease in visits within 14 days in Haringey.

Islington: 12 (5.4%) late

4x parental choice 4x in hospital 4x team errors, Islington sustaining NBV activity despite vacancies

Haringey: 22 (6.9%) late

9x in hospital - only acceptable exception. Would have achieved 94% if these were excluded; 7x late notifications/re-allocated to different team (Christmas period); 1x family moved out; 1x removal in - not a NBV; 1x parent declined;

Well Led Services - Indicators and Performance

Category	Indicator	16_17 Target	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	Q4 Jan-17	2016-2017	Performance
HR	Appraisals % Rate	>90%	74%	72%	71%	69%	68%	67%	66%	63%	66%	66%	67%	72%		
HR	Mandatory Training % Rate	>90%	82%	82%	81%	81%	81%	81%	81%	80%	81%	81%	82%	81%		
HR	Permanent Staffing WTEs Utilised	>90%			87.1%	87.7%	87.8%	86.2%	87.1%	87.0%	88.1%	88.1%	87.7%	87.7%	87.5%	
HR	Staff FFT % recommended work	>50%		69.6%			65.1%			59.7%					62.1%	
HR	Staff FFT response rate	>20%		14.7%			19.6%			24.9%					22.3%	
HR	Staff sickness absence %	<3.5%	2.9%	3.2%	3.0%	3.3%	3.2%	2.9%	2.9%	2.9%	3.3%	2.8%	3.0%	3.0%	3.0%	
HR	Staff turnover %	<10%			14.9%	14.9%	15.8%	15.7%	15.5%	15.7%	15.4%	14.9%	15.4%	15.3%	15.3%	
HR	Vacancy % Rate against Establishment	<10%			12.9%	12.3%	12.2%	13.8%	12.9%	13.0%	11.9%	11.9%	12.3%	12.3%	12.5%	

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Well Led Services - Commentary

Human Resources

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

Despite the operational pressures across the Trust we are able to report improvements in compliance in both mandatory training and appraisal rate. Sickness absence, vacancy rate and turnover remain unchanged.

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	Q4 Jan-17	Activity
ED	ED Attendances	8605	7878	8540	7908	8277	7513	8020	8253	8271	8238	8256	
ED	ED Admission Rate %		17.6%	18.1%	17.8%	18.1%	17.8%	16.7%	16.2%	16.6%	17.5%	17.2%	
Community	Community DNA Rate %	<10%	5.6%	5.2%	5.3%	5.4%	5.3%	5.2%	5.0%	5.1%	5.2%	5.0%	
Community	Community Face to Face Contacts		58778	60553	61182	58088	54144	59619	59081	63740	53690	59958	
Admissions	Elective and Daycase		1861	1860	2082	2004	1769	1935	1947	1876	1711	1867	
Admissions	Emergency Inpatients		2129	2255	2175	2322	2117	2079	2036	2124	2111	2060	
Referrals	GP Referrals to an Acute Service		6710	6177	6434	6137	5903	6344	5983	6318	5137	5781	
Maternity	Maternity Births	333	325	324	311	340	299	337	315	324	301	312	
Maternity	Maternity Bookings	377	331	383	403	354	299	301	353	365	319	323	
Outpatients	Outpatient DNA Rate % - New	<10%	12.3%	12.1%	11.7%	11.7%	11.9%	12.3%	11.1%	11.3%	12.7%	12.5%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	11.4%	10.4%	10.2%	10.3%	9.8%	11.2%	10.1%	10.0%	11.7%	12.9%	
Outpatients	Outpatient New Attendances		8711	9725	9602	8931	8475	9011	8757	9658	7967	8641	
Outpatients	Outpatient FUp Attendances		16904	17842	18870	18031	18303	18694	18815	19926	17178	17768	
Outpatients	Outpatient Procedures		5604	5870	6287	6167	6263	6019	6273	6184	5389	5727	
Theatres	Theatre Utilisation	>95%	78.1%	81.5%	80.7%	78.3%	78.2%	81.8%	81.5%	83.7%	83.5%	72.8%	

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Activity - Commentary

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

Community DNA
Achieved target

Hospital DNA
Under achieving, similar to last month.

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

Theatre utilisation
Theatre utilisation in January was significantly low due to bed capacity across the Trust. As described on the Responsive Indicator page, 12 patients were cancelled due to bed pressures for elective surgery in January, and the decision was taken on a day by day basis to cancel planned elective cases. Urgent and cancer patients were prioritised to ensure treatment in a timely manner. The service tried to fill the cancelled operation slots from inpatients with day cases, but it was often not possible for the day case patient to change their arrangements at short notice.
Going forward the service needs to ensure that the summer months are optimised booking surgery for inpatients, when bed capacity is not as pressured as in the winter period. Theatre utilisation will also be affected in February 2017.

Trust Board – 1 March 2017

Title:	Trust Board and senior staff Register of Declaration of Conflicts of Interests 2017/18		
Agenda item:	**17/040**	**Paper**	**11**
Executive Summary:	The Department of Health's Code of Conduct and Code of Accountability describes public service values which underpin the work of the NHS. It aligns with the highest standards of corporate behaviours which all individuals within Whittington Health must have regard in their work. The new NHS England guidance for Managing Declarations of Conflicts of Interest is attached to this report and is effective from 1 June 2017. The Trust Board and senior staff Register of Declarations of Conflicts Interests 2017/18 is attached to this report and includes Trust Management Group members' and other senior staff for completeness and transparency.		
Summary of recommendations:	To receive and agree to comply with the: • Department of Health Code of Conduct and Code of Accountability for Trust Boards • NHS England guidance for Managing Declarations of Conflicts of Interest To note the revised annual Trust Board and senior staff Register of Declarations of Conflicts Interests 2017/18.		
Fit with WH strategy:	Compliant with the new NHS England Declaration of Conflicts of Interest, the Nolan Principles, the NHS Trust Board Code of Conduct and Code of Accountability in the NHS, the NHS Constitution and the Trust NHS Counter Fraud policy.		
Reference to related / other documents:	Trust Standing Orders (SOs), Standing Financial Instructions (SFIs) and Scheme of Delegation (SD)		
Ref to areas of risk and corporate risks on the BAF:	All risks are captured on the Trust Board Risk Registers and/or Board Assurance Framework (BAF) where relevant		
Date paper completed	February 2017		

Author name and title:		**Lynne Spencer, Director of Corporate Affairs and Communications**		**Director name and title:**		**Lynne Spencer, Director of Corporate Affairs and Communications**	
	Date paper seen by TMG	**Equality Impact Assessment complete?**	**Supports equality duties**	**Risk assess-ment?**	**Part of the governance review**	**Legal advice received ?**	**Complies with statutory requirements**
	28/02/17	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

Whittington Health Trust Board and senior managers : Register of Declarations of Conflict of Interests 17/18

Non-Executive Directors – voting Board members

Steve Hitchins	Chairman (wef 01/01/14)	• Non Executive Director and Vice Chair, Newlon Housing Trust; (Registered social housing provider) • Non Executive Director, Euradia Registered Charity (fundraising & research for diabetes) • Director: Steve Hitchins Ltd (Consultancy) • Member: Liberal Democrats Conflicts of interests that may arise out of any known immediate family involvement • Wife : voting member of House of Lords who sits on Liberal Democrat benches
Anu Singh	Non-Executive Director (wef 14/01/14)	• Director, Independent Futures; an all age service to help disabled people achieve an independent, active and enjoyable life for as long as possible Conflicts of interests that may arise out of any known immediate family involvement • Nil
David Holt	Non-Executive Director (wef 13/07/2015)	• NED/SID at Tavistock and Portman NHSFT • NED, Chair of Audit Committee, Hanover Housing Association • Deputy Chair, Chair of Audit Committee Ebbsfleet Development Corporation (DCLG) • NED and Chair of Audit Committee, Planning Inspectorate Conflicts of interests that may arise out of any known immediate family involvement • Wife Dr Kim Holt employed by Whittington Health – Children's Safeguarding Lead Haringey
Deborah Harris-Ugbomah	Non Executive Director (wef 1.5.16 – 30.4.20)	• Non Executive Director, Moorfields Eye Hospital NHS FT • Director, MEH Ventures LLP Conflicts of interests that may arise out of any known immediate family involvement • Nil
Prof Graham Hart	Non-Executive Director (wef 01/09/15)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil
Tony Rice	Non-Executive Director (wef 21/02/14)	• Chair, Dechra Pharmaceuticals PLC Conflicts of interests that may arise out of any known immediate family involvement • Nil
Yua Haw Yoe	Non-Executive Director (wef 01/04/16)	• Assessment Manager, United Kingdom Accreditation Service Conflicts of interests that may arise out of any known immediate family involvement • Nil

Executive Directors – voting Board members

Simon Pleydell	Chief Executive (wef 01/04/14 on contract until 01/01/15)	• Member of CHKS Advisory Board Conflicts of interests that may arise out of any known immediate family involvement • Nil
Siobhan Harrington	Deputy Chief Executive Director of Strategy (wef 01/04/14)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Son, Whittington Health staff (Pharmacy Department)
Stephen Bloomer	Chief Finance Officer (wef 03/06/15)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil
Richard Jennings	Executive Medical Director (wef 01/06/14)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Wife - Macmillan Patient Experience and Patient Involvement Lead for Cancer Vanguard from 10 April 2017
Philippa Davies MBE	Director of Nursing and Patient Experience (wef 01/08/14)	• Director & Trustee Kissing it Better Charity no. 1148795 Conflicts of interests that may arise out of any known immediate family involvement • Nil
Carol Gillen	Chief Operating Officer (wef 16/03/16)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil

Associate Directors – non-voting Board members

Greg Battle	Executive Medical Director Integrated Care (wef 06/06/11)	• GP Partner Goodinge Group Practice : General Medical Services • GP Wish. GP service provision to Whittington Health UCC Conflicts of interests that may arise out of any known immediate family involvement • Nil
Lynne Spencer	Director of Communications & Corporate Affairs (wef 02/02/15) (Company Secretariat)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Son, Management Consultant at Camden CCG
Norma French	Director of Workforce (wef 23/06/15)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Husband is consultant physician at CNWL (at UCLH)

Glenn Winteringham	Director of IM&T (wef 01/10/11)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil
Adrien Cooper	Director of Environment (wef 03/10/16)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil
Mick Corti	Director of Procurement (wef 10/10/16)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil

Clinical Directors

Chandrima Biswas	Clinical Director Women's Health	• tbc Conflicts of interests that may arise out of any known immediate family involvement • tbc
Clarissa Murdoch	Clinical Director Integrated Medicine	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil
Helen Taylor (wef 1/7/16)	Clinical Director Clinical Support Services	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Daughter worked as bank staff as admin assistant
Neeta Patel (wef July 2015)	Clinical Director Children & Young People	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil
Nick Harper Wef July 2015)	Clinical Director Surgery & Cancer	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Partner Cassie Williams Assistant Director of Primary Care Quality and Development Haringey Clinical Commissioning Group
Rachel Landau (wef July 2015)	Clinical Director Emergency & Urgent Care	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil
Sarah Hayes (wef August 2015)	Clinical Director Patient Access, Prevention & Planned Care	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Partner is CCG governing board member for Tower Hamlets CCG

Director of Operations

Paul Attwal (wef 19/11/15)	Director of Operations Integrated Medicine	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil
Russell Nightingale (wef 4/4/16)	Director of Operations Children & Young People	• Numerato – business consultancy Conflicts of interests that may arise out of any known immediate family involvement • Nil
Fiona Isacsson	Director of Operations Surgery & Cancer (wef Feb 2014)	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil
Beverleigh Senior (wef 30/11/15)	Director of Operations Patient Access, Prevention & Planned Care	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil
Gurjit Mahil (wef 11/4/16)	Director of Operations Women's Health	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil
Danielle Morrell	Director of Operations Emergency & Urgent Care	• Employed by UCLH and seconded to Whittington Health. Undertaking piece of work looking at Whittington providing services for UCLH (virtual ward) Conflicts of interests that may arise out of any known immediate family involvement • Nil
Stuart Richardson (wef 11/01/17)	Director of Operations Clinical Support Services	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil

Senior Staff (appendix B of Gifts, Hospitality and Conflicts of Interest Policy ~ WH intranet)

Bridget Coleman	Independent Contractor, Pharmacy	• Director of Patient & Clinician Education, Helicon Health Conflicts of interests that may arise out of any known immediate family involvement • Nil
John Byrne	Head of Medical Physics & Clinical Engineering	• Director of National Association of Medical Devices Educators and Trainers (NAMDET) Conflicts of interests that may arise out of any known immediate family involvement • Nil
David Grant	Consultant Radiologist	• Consultant Radiologist & Chair of Medical Advisory Committee at St. John and St Elizabeth NW8 • Consultancy Radiology Advisor 4Ways Healthcare • Consultant Radiologist The London Clinic • Co Medical Director London Upright MRI Centre Conflicts of interests that may arise out of any known immediate family involvement • Nil
Helen Gordon Wef 10/7/2015	Lead HR Consultant	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil
Paul Abdey	Lead Resus Officer	• Nil Conflicts of interests that may arise out of any known immediate family involvement • Nil
		•

CODE OF CONDUCT

CODE OF ACCOUNTABILITY

for NHS BOARDS

CODE OF CONDUCT

Public Service Values

General Principles

Openness and Public Responsibilities

Public Service Values in Management

Public Business and Private Gain

Hospitality and Other Expenditure

Relations with Suppliers

Staff

Compliance

CODE OF ACCOUNTABILITY

Status

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The Board of Directors

The Role of the Chair

Non-Executive Directors

Reporting and Controls

Declaration of Interests

Employee Relations

CODE OF CONDUCT

Public service values must be at the heart of the National Health Service. High standards of corporate and personal conduct based on a recognition that patients come first, have been a requirement throughout the NHS since its inception. Moreover, since the NHS is funded from public money, it must be accountable to Parliament for the services it provides and for the effective and economical use of taxpayers' money.

There are three, crucial public service values that must underpin the work of the NHS.

Accountability – everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

Probity – there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.

Openness – there should be sufficient transparency about NHS activities to promote confidence between the NHS organisation and its staff, patients and the public.

General Principles

Public service values matter in the NHS and those who work in it have a duty to conduct NHS business with probity. They have a responsibility to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.

The success of this Code depends on a vigorous and visible example from boards and the consequential influence on the behaviour of all those who work within the organisation. Boards have a clear responsibility for corporate standards of conduct and acceptance of the Code should inform and govern the decisions and conduct of all board directors.

Openness and Public Responsibilities

Health needs and patterns of provision of health care do not stand still. There should be a willingness to be open with the public, patients and with staff as the need for change emerges. It is a requirement that there is consultation on major changes before decisions are reached. Information supporting those decisions should be made available to the public in a way that is understandable, and positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000.

NHS business should be conducted in a way that is socially responsible. As large employers in the local community, NHS organisations should forge open and positive relationships with the local community and should work with staff and partners to set out a vision for the organisation in line with the expectations of patients and the public. NHS organisations should demonstrate to the public that they are concerned with the wider health of the population including the impact of the organisation's activities on the environment.

The confidentiality of personal and individual patient information must be respected at all times.

Public Service Values in Management

It is unacceptable for the board of any NHS organisation, or any individual within the organisation for which the board is responsible, to ignore public service values in achieving results. Chairs and board directors have a duty to ensure that public funds are properly safeguarded and that at all

times the board conducts its business as efficiently and effectively as possible. Proper stewardship of public monies requires value for money to be high on the agenda of all NHS boards.

Accounting, tendering and employment practices within the NHS must reflect the highest professional standards. Public statements and reports issued by the board should be clear, comprehensive and balanced, and should fully represent the facts. Annual and other key reports published in good time and made publically available, to allow full consideration by those wishing to attend public meetings on local health issues.

Public Business and Private Gain

Chairs and board directors should act impartially and not be influenced by social or business relationships. No one should use their public position to further their private interests. Where there is a potential for private interests to be material and relevant to NHS business, the relevant interests should be declared and recorded in the board minutes, and entered into a register which is available to the public. When a conflict of interest is established, the board director should withdraw and play no part in the relevant discussion or decision.

Hospitality and Other Expenditure

Board directors should set an example to their organisation in the use of public funds and the need for good value in incurring public expenditure. The use of NHS monies for hospitality and entertainment, including hospitality at conferences or seminars, should be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. NHS boards should be aware that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage respect for the NHS in the eyes of the community.

Relations with Suppliers

NHS boards should have an explicit procedure for the declaration of hospitality and sponsorship offered by, for example, suppliers. Their authorisation should be carefully considered and the decision should be recorded. NHS boards should be aware of the risks in incurring obligations to suppliers at any stage of a contracting relationship.

Staff

NHS boards should ensure that staff have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature. The board must establish a climate:

- that enables staff who have concerns to raise these reasonably and responsibly with the right parties;
- that gives a clear commitment that staff concerns will be taken seriously and investigated; and
- where there is an unequivocal guarantee that staff who raise concerns responsibly and reasonably will be protected against victimisation.

Compliance

Board directors should satisfy themselves that the actions of the board and its directors in conducting board business fully reflect the values in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon. All

board directors of NHS organisations are required, on appointment, to subscribe to the Code of Conduct.

CODE OF ACCOUNTABILITY

This Code is the basis on which NHS organisations should seek to fulfil the duties and responsibilities conferred upon them by the Secretary of State for Health.

Status

NHS trusts are established under statute as corporate bodies to ensure that they have separate legal personalities. Statutes and regulations prescribe the structure, functions and responsibilities of their boards and prescribe the way their chairs and directors are to be appointed.

Code of Conduct

All chairs and non-executive directors of NHS trusts are required, on appointment, to subscribe to the Code of Conduct. Breaches of this Code of Conduct should be drawn to the attention of the NHS Trust Development Authority, (NHS TDA).

NHS managers are required to take all reasonable steps to comply with the requirements set out in the Code of Conduct for NHS Managers. Chairs and non-executive directors of NHS boards are responsible for taking firm, prompt and fair disciplinary action against any executive director in breach of the Code of Conduct for NHS Managers.

Statutory Accountability

The Secretary of State for Health has statutory responsibility for the health of the population of England and uses statutory powers to delegate functions to NHS organisations who are thus accountable to him and to Parliament.

NHS trusts provide services to patients (these may be acute services, ambulance services, mental health or other special services, e.g. for children) and must ensure that they are of high quality and accessible.

National standards of quality and safety

NHS trusts providing care in hospitals are required to register with the Care Quality Commission (CQC). It is a condition of registration that hospitals meet five national standards of quality and safety. They mean that patients can expect:

- to be respected, involved and told what's happening at every stage
- care, treatment and support that meet their needs
- to be safe
- to be cared for by staff with the right skills to do their job properly
- hospitals to routinely check the quality of its services

Boards are required to ensure that hospitals continue to meet these minimum standards.

Financial accountability

NHS trusts are subject to external audit by the Audit Commission. NHS boards must co-operate fully with the NHS TDA and the Audit Commission when required to account for the use they have made of public funds, the delivery of patient care and other services, and compliance with statutes, directions, guidance and policies of the Secretary of State. The Chief Executive/ Permanent

Secretary of the Department of Health, as Accounting Officer for the NHS, is accountable to Parliament.

The work of the Department of Health and its associated bodies is examined by the House of Commons Health Committee. Its remit is to examine the expenditure, administration and policy of the Department of Health. Two other Parliamentary Committees, the Public Accounts Committee and the Public Administration Select Committee, scrutinise the work of the Department of Health and the health service.

The Board of Directors

NHS boards comprise executive directors together with non-executive directors and a chair appointed by the NHS TDA on behalf of the Secretary of State for Health. Together they share corporate responsibility for all decisions of the board. The chief executive is directly accountable to the board for meeting their objectives, and as Accountable Officer, to the Chief Executive of the NHS TDA for the performance of the organisation.

Boards are required to meet regularly and to retain full and effective control over the organisation; the chair and non-executive directors are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for Health, through the NHS TDA, for the discharge of these responsibilities.

The NHS TDA provides the line of accountability from local NHS trusts to the Secretary of State for the performance of the organisation.

The duty of an NHS trust board is to add value to the organisation, enabling it to deliver healthcare and health improvement within the law and without causing harm. It does this by providing a framework of good governance within which the organisation can thrive and grow. Good governance is not restrictive but an enabling ingredient to underpin change and modernisation.

The role of an NHS board is to:

- be collectively responsible for adding value to the organisation, for promoting the success of the organisation by directing and supervising the organisation's affairs
- provide active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed
- set the organisation's strategic aims, ensure that the necessary financial and human resources are in place for the organisation to meet its objectives, and review management performance
- set the organisation's values and standards and ensure that its obligations to patients, the local community and the Secretary of State are understood and met.

Further information is available in *The Healthy NHS Board: Principles for Good Governance.*

The Role of the Chair

The overarching role of the chair is one of enabling and leading, so that the attributes and specific roles of the executive team and the non-executives are brought together in a constructive partnership to take forward the business of the organisation.

The key responsibilities of the chair are:

- leadership of the board, ensuring its effectiveness on all aspects of its role and setting its agenda
- ensuring the provision of accurate, timely and clear information to directors

- ensuring effective communication with staff, patients and the public
- arranging the regular evaluation of the performance of the board, its committees and individual directors and
- facilitating the effective contribution of non-executive directors and ensuring constructive relations between executive and non-executive directors.

A complementary relationship between the chair and chief executive is important. The chief executive is accountable to the chair and non-executive directors of the board for ensuring that the board is empowered to govern the organisation and that the objectives it sets are accomplished through effective and properly controlled executive action. The chief executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the board.

Further information is available in *The Healthy NHS Board: Principles for Good Governance*

Non-Executive Directors

Non-executive directors are appointed by the NHS TDA on behalf of the Secretary of State for Health to bring an independent judgement to bear on issues of strategy, performance, key appointments and accountability, through the NHS TDA to Ministers and to the local community.

The duties of non-executive directors are to:

- constructively challenge and contribute to the development of strategy
- scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance
- satisfy themselves that quality and financial information is accurate and that controls and systems of risk management are robust and defensible
- determine appropriate levels of remuneration of executive directors and have a prime role in appointing, and where necessary, removing senior management and in succession planning and
- ensure the board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses.

Non-executive directors also have a key role in a small number of permanent board committees such as the Audit Committee, Remuneration and Terms of Service Committee, the Clinical Governance Committee and Risk Management Committee.

Further information is available in *The Healthy NHS Board: Principles for Good Governance.*

Reporting and Controls

It is the board's duty to present through the timely publication of an annual report, annual accounts and other means, a balanced and readily-understood assessment of the organisation's performance to:

- the Department of Health, on behalf of the Secretary of State
- the NHS Trust Development Authority
- the Audit Commission and its appointed auditors and
- the local community.

Detailed financial guidance, including the role of internal and external auditors, issued by the Department of Health must be observed. The Standing Orders of boards should prescribe the terms on which committees and sub-committees of the board may be delegated functions, and should include the schedule of decisions reserved for the board.

Declaration of Interests

It is a requirement that chairs and all board directors should declare any conflict of interest that arises in the course of conducting NHS business. All NHS organisations maintain a register of member's interests to avoid any danger of board directors being influenced, or appearing to be influenced, by their private interests in the exercise of their public duties. All board members are therefore expected to declare any personal or business interest which may influence, or may be *perceived* to influence, their judgement. This should include, as a minimum, personal direct and indirect financial interests, and should normally also include such interests of close family members. Indirect financial interests arise from connections with bodies which have a direct financial interest, or from being a business partner of, or being employed by, a person with such an interest.

Employee Relations

NHS boards must comply with legislation and guidance from the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf, and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money. Fair and open competition should be the basis for appointment to posts in the NHS.

The terms and conditions agreed by the board for senior staff should take full account of the need to obtain maximum value for money for the funds available for patient care. The board should ensure through the appointment of a remuneration and terms of service committee, that executive board directors' remuneration can be justified as reasonable. Board directors' remuneration for the NHS organisation should be published in its annual report.

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First revision April 2002
Second revision July 2004
Third revision April 2013

Managing Conflicts of Interest in the NHS

Guidance for staff and organisations

Publications Gateway Reference: 06419

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Publications Gateway Reference:	0
Document Purpose	Guidance
Document Name	Managing Conflicts of Interest in the NHS
Author	NHS England
Publication Date	07 February 2017
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, CSU Managing Directors, Foundation Trust CEs , Medical Directors, Directors of Nursing, NHS Trust Board Chairs, NHS England Regional Directors, NHS England Directors of Commissioning Operations, All NHS England Employees, Directors of HR, Directors of Finance, NHS Trust CEs
Additional Circulation List	Care Trust CEs, GPs
Description	This guidance provides guidance for the management of conflicts of interest in the NHS. It is applicable to Clinical Commissioning Groups, NHS Trusts and NHS Foundation Trusts and NHS England. Other bodies involved in the provision of NHS services are invited to consider implementing this guidance.
Cross Reference	Managing Conflicts of Interest: Revised Statutory Guidance for CCGs
Superseded Docs (if applicable)	
Action Required	Review and update existing relevant organisational policies.
Timing / Deadlines (if applicable)	**This guidance comes into force 1 June 2017**
Contact Details for further information	england.psu@nhs.net

Document Status

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Scope of this guidance

This guidance is intended to protect patients, taxpayers and staff covering health services in which there is a direct state interest. It comes into force on 1 June 2017.

It is applicable to the following NHS bodies:

- Clinical Commissioning Groups ('CCGs')
- NHS Trusts (all or most of whose hospitals establishments and facilities are situated in England) and NHS Foundation Trusts - which include secondary care trusts, mental health trusts, community trusts, and ambulance trusts
- NHS England

For the purposes of this guidance these bodies are referred to as 'organisations'.

The principles of this guidance will be included in a revised version of the statutory guidance for CCGs issued by NHS England pursuant to its powers under s.14O and s.14Z8 of the National Health Service Act 2006. Until this guidance comes into force existing guidance issued under these powers continues to apply, and is accessible at: https://www.england.nhs.uk/commissioning/pc-co-comms/coi/"

NHS Trusts and NHS Foundation Trusts must have regard to this guidance through its incorporation into the NHS Standard Contract pursuant to General Condition 27.

Its applicability to NHS England will be delivered through amendments to our Standards of Business Conduct.

This guidance does not apply to bodies not listed above (i.e. independent and private sector organisations, general practices*, social enterprises, community pharmacies, community dental practices, optical providers, local authorities – who are subject to different legislative and governance requirements). However, the boards/governing bodies of these organisations are invited to consider implementing the guidance as a means to effectively manage conflicts of interest and provide safeguards for their staff. The requirements of GC27.2 of the generic NHS Standard Contract (2017/18 and 2018/19 edition) should be interpreted in that light.

* However, GP practice staff should note that the requirements in the statutory guidance for CCGs on the management of conflicts of interest (referred to above) continue to apply to GP partners (or where the practice is a company, each director) and individuals in a practice directly involved with the business or decision making of their CCG.

Contents

1. Purpose

1.1. Every year the taxpayer entrusts NHS organisations with over £110 billion to care for millions of people. This money must be spent well, free from undue influence.

1.2. To deliver high quality and innovative care organisations need to work collaboratively with each other, local authorities, industry and other public, private and voluntary bodies. Partnership working brings many benefits, but also creates the risk of conflicts of interest.

1.3. Organisations and the people who work with, for, and on behalf of them (referred to as **'staff'** in this guidance) want to manage these risks in the right way. Staff and organisations may already be taking steps to do this. However, how this should be done has not always been made clear and there is variation in current practice – implementation of this guidance will make things easier and enable greater consistency across the NHS.

1.4. By implementing this guidance staff and organisations will understand what to do to take the best action and protect themselves from allegations that they have acted inappropriately.

This guidance:

- Introduces consistent principles and rules for managing conflicts of interest.
- Provides simple advice to staff and organisations about what to do in common situations.
- Supports good judgement about how interests should be approached and managed.

2. Action: What should staff and organisations do?

Action for staff	Action for organisations
DO • Familiarise yourself with this guidance and your organisational policies and follow them. • Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent. • Regularly consider what interests you have and declare these as they arise. If in doubt, declare.	**DO** • Ensure that you have clear and well communicated processes in place to help staff understand what they need to do. • Identify a team or individual with responsibility for: - Reviewing current policies and bringing them in line with this guidance. - Providing advice, training and support for staff on how interests should be managed. - Maintaining register(s) of interests. - Auditing policy, process and procedures relating to this guidance at least every three years.
DON'T • Misuse your position to further your own interests or those close to you. • Be influenced, or give the impression that you have been influenced by, outside interests. • Allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money.	**DON'T** • Avoid managing conflicts of interest. • Interpret and deploy this guidance in a way which stifles the collaboration and innovation that the NHS needs.

Organisations should ensure their policies as a minimum meet the standards in this guidance. They can also introduce local requirements that are more stringent, on the basis of their own circumstances, should they think this is necessary. Organisations may wish to adopt or adapt the Model Policy at Annex A to assist with implementation.

3. Definitions: Conflict of interest

3.1. For the purposes of this guidance a 'conflict of interest' is defined as:

> "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."

3.2. A conflict of interest may be:

Actual	Potential
There is a material conflict between one or more interests	There is the possibility of a material conflict between one or more interests in the future

3.3. Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently. It will be important to exercise judgement and to declare such interests where there is otherwise a risk of imputation of improper conduct.

3. Definitions: Interests

3.4. 'Interests' can arise in a number of different contexts. A material interest is one which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision.

3.5. Interests fall into the following categories:

Financial interests	Non-financial professional interests	Non-financial personal interests	Indirect interests
Where an individual may get direct financial benefit* from the consequences of a decision they are involved in making	Where an individual may obtain a non-financial professional benefit* from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career	Where an individual may benefit* personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career	Where an individual has a close association** with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit* from a decision they are involved in making

* A benefit may arise from the making of gain or avoiding a loss

** These associations may arise through relationships with close family members and relatives, close friends and associates, and business partners. A common sense approach should be applied to these terms. It would be unrealistic to expect staff to know of all the interests that people in these classes might hold. However, if staff do know of material interests (or could be reasonably expected to know about these) then these should be declared.

Further guidance on how to interpret these categories is at Annex B.

4. Declarations: Processes to follow

4.1. Organisations should support staff to understand that having interests is not in itself negative, but not declaring and managing them is.

4.2. All staff must be aware of how and to whom declarations should be made, declaring material interests at the earliest opportunity (and in any event within 28 days) via a positive declaration to their organisation. Therefore, declarations should be made:

- On appointment with an organisation
- When a person moves to a new role or their responsibilities change significantly
- At the beginning of a new project/piece of work
- As soon as circumstances change and new interests arise

4.3. Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as **'decision making staff'**.

4.4. Because of their influence in the spending of taxpayers' money, organisations should ensure that, at least annually, decision making staff are prompted to update their declarations of interest, or make a nil return.

4.5. Organisations should define decision making staff according to their own context, but this should be justifiable and capture those groups of staff that have a material influence on how taxpayers' money is spent.

4.6. The following non-exhaustive list describes who these individuals are likely to be:

- Executive and non executive directors* who have decision making roles which involve the spending of taxpayers' money
- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services
- Those at Agenda for Change band 8d** and above
- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of good, medicines, medical devices or equipment, and formulary decisions.

4.7. There may be occasions where staff declare an interest but, upon closer consideration, it is clear that this is not material and so does not give rise to the risk of a conflict of interest. The team or individual responsible for managing organisational policy should decide whether it is necessary to transfer such declarations to an organisation's register(s) of interests.

* equivalent roles in different organisations carry different titles – this should be considered on a case by case basis

** reflecting guidance issued by the Information Commissioner's Office with regard to Freedom of Information legislation: https://ico.org.uk/media/1220/definition-document-health-bodies-in-england.pdf

5. Management: Principles and situations

5.1. Organisations should manage interests sensibly and proportionately. If an interest presents an actual or potential conflict of interest then management action is required.

5.2. Some common sense management principles should be adopted by organisations which, for the purposes of this guidance, are referred to as 'general management actions':

- Requiring staff to comply with this guidance
- Requiring staff to proactively declare interests at the point they become involved in decision making
- Considering a range of actions, which may include:
  - deciding that no action is warranted
  - restricting an individual's involvement in discussions and excluding them from decision making
  - removing an individual from the whole decision making process
  - removing an individual's responsibility for an entire area of work
  - removing an individual from their role altogether if the conflict is so significant that they are unable to operate effectively in the role
- Keeping an audit trail of the actions taken

5.3. Each case will be different. The general management actions, along with relevant industry/professional guidance, should complement the exercise of good judgement. It will always be appropriate to clarify circumstances with individuals involved to assess issues and risks.

5.4. However, there are a number of common situations which can give rise to risk of conflicts of interest, being:

- Gifts
- Hospitality
- Outside employment
- Shareholdings and other ownership interests
- Patents
- Loyalty interests
- Donations
- Sponsored events
- Sponsored research
- Sponsored posts
- Clinical private practice

The following pages discuss the risks and issues posed in these situations, and the principles and rules that staff and organisations should adopt to manage them.

Gifts

What are the issues?	Staff in the NHS offer support during significant events in people's lives. For this work they may sometimes receive gifts as a legitimate expression of gratitude. We should be proud that our services are so valued. But situations where the acceptance of gifts could give rise to conflicts of interest should be avoided. Staff and organisations should be mindful that even gifts of a small value may give rise to perceptions of impropriety and might influence behaviour if not handled in an appropriate way. A gift means any item of cash or goods, or any service, which is provided for personal benefit, free of charge, or at less than its commercial value.
Principles and rules	Overarching principle applying in all circumstances: • Staff should not accept gifts that may affect, or be seen to affect, their professional judgement. Gifts from suppliers or contractors: • Gifts from suppliers or contractors doing business (or likely to do business) with an organisation should be declined, whatever their value. • Subject to this, low cost branded promotional aids may be accepted where they are under the value of a common industry standard of £6* in total, and need not be declared. *The £6 value has been selected with reference to existing industry guidance issued by the ABPI: http://www.pmcpa.org.uk/thecode/Pages/default.aspx

Gifts (continued)

Principles and rules	Gifts from others sources (e.g. patients, families, service users): • Gifts of cash and vouchers to individuals should always be declined. • Staff should not ask for any gifts. • Gifts valued at over £50 should be treated with caution and only be accepted on behalf of an organisation (i.e. to an organisation's charitable funds), not in a personal capacity. These should be declared by staff. • Modest gifts accepted under a value of £50 do not need to be declared. • A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value). • Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.
What should be declared	• Staff name and their role with the organisation. • A description of the nature and value of the gift, including its source. • Date of receipt. • Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).

Hospitality

What are the issues?	Delivery of services across the NHS relies on working with a wide range of partners (including industry and academia) in different places and, sometimes, outside of 'traditional' working hours. As a result, staff will sometimes appropriately receive hospitality. Staff receiving hospitality should always be prepared to justify why it has been accepted, and be mindful that even hospitality of a small value may give rise to perceptions of impropriety and might influence behaviour. Hospitality means offers of meals, refreshments, travel, accommodation, and other expenses in relation to attendance at meetings, conferences, education and training events, etc.
Principles and rules	Overarching principles applying in all circumstances: • Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement. • Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event. • Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors – these can be accepted if modest and reasonable but individuals should always obtain senior approval and declare these. Meals and refreshments: • Under a value of £25 - may be accepted and need not be declared. • Of a value between £25 and £75* - may be accepted and must be declared. • Over a value of £75* - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on an organisation's register(s) of interest as to why it was permissible to accept. • A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or an estimate that a reasonable person would make as to its value). *The £75 value has been selected with reference to existing industry guidance issued by the ABPI http://www.pmcpa.org.uk/thecode/Pages/default.aspx

Hospitality (continued)

Principles and rules	Travel and accommodation:
	• Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
	• Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on an organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type.
	• A non exhaustive list of examples includes:
	  o offers of business class or first class travel and accommodation (including domestic travel).
	  o offers of foreign travel and accommodation.

What should be declared	• Staff name and their role with the organisation. • A description of the nature and value of the hospitality including the circumstances. • Date of receipt. • Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).

Outside employment

What are the issues?	The NHS relies on staff with good skills, broad knowledge and diverse experience. Many staff bring expertise from sectors outside the NHS, such as industry, business, education, government and beyond. The involvement of staff in these outside roles alongside their NHS role can therefore be of benefit, but the existence of these should be well known so that conflicts can be either managed or avoided. Outside employment means employment and other engagements, outside of formal employment arrangements. This can include directorships, non-executive roles, self-employment, consultancy work, charitable trustee roles, political roles and roles within not-for-profit organisations, paid advisory positions and paid honorariums which relate to bodies likely to do business with an organisation. (Clinical private practice is considered in a separate section).
Principles and rules	• Staff should declare any existing outside employment on appointment, and any new outside employment when it arises. • Where a risk of conflict of interest is identified, the general management actions outlined in this guidance should be considered and applied to mitigate risks. • Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from an organisation to engage in outside employment. • Organisations may also have legitimate reasons within employment law for knowing about outside employment of staff, even this does not give rise to risk of a conflict. Nothing in this guidance prevents such enquiries being made.
What should be declared	• Staff name and their role with the organisation. • A description of the nature of the outside employment (e.g. who it is with, a description of duties, time commitment). • Relevant dates. • Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).

Shareholding and other ownership interests

What are the issues?	Holding shares or other ownership interests can be a common way for staff to invest their personal time and money to seek a return on investment. However, conflicts of interest can arise when staff personally benefit from this investment because of their role with an organisation. For instance, if they are involved in their organisation's procurement of products or services which are offered by a company they have shares in then this could give rise to a conflict of interest. In these cases, the existence of such interests should be well known so that they can be effectively managed.
Principles and rules	• Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with their organisation. • There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts. • Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this guidance should be considered and applied to mitigate risks.
What should be declared	• Staff name and their role with the organisation. • A description of the nature of the shareholding/other ownership interest. • Relevant dates. • Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).

Patents

What are the issues?	The development and holding of patents and other intellectual property rights allows staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas. Staff are encouraged to be innovative in their practice and therefore this activity is welcomed. However, conflicts of interest can arise when staff who hold patents and other intellectual property rights are involved in decision making and procurement. In addition, where product development involves use of time, equipment or resources from their organisation, then this too could create risks of conflicts of interest, and it is important that the organisation is aware of this and it can be managed appropriately.
Principles and rules	• Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by their organisation. • Staff should seek prior permission from their organisation before entering into any agreement with bodies regarding product development, research, work on pathways, etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property. • Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this guidance should be considered and applied to mitigate risks.
What should be declared	• Staff name and their role with the organisation. • A description of the patent or other intellectual property right and its ownership. • Relevant dates. • Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).

Loyalty interests

What are the issues?	As part of their jobs staff need to build strong relationships with colleagues across the NHS and in other sectors. These relationships can be hard to define as they may often fall in the category of indirect interests. They are unlikely to be directed by any formal process or managed via any contractual means - it can be as simple as having informal access to people in senior positions. However, loyalty interests can influence decision making. Conflicts of interest can arise when decision making is influenced subjectively through association with colleagues or organisations out of loyalty to the relationship they have, rather than through an objective process. The scope of loyalty interests is potentially huge, so judgement is required for making declarations.
Principles and rules	Loyalty interests should be declared by staff involved in decision making where they: • Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role. • Sit on advisory groups or other paid or unpaid decision making forums that can influence how their organisation spends taxpayers' money. • Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners. • Are aware that their organisation does business with an organisation with whom close family members and relatives, close friends and associates, and business partners have decision making responsibilities. Where holding loyalty interests gives rise to a conflict of interest then the general management actions outlined in this guidance should be considered and applied to mitigate risks.
What should be declared	• Staff name and their role with the organisation. • A description of the nature of the loyalty interest. • Relevant dates. • Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).

Donations

What are the issues?	A donation is a charitable financial payment, which can be in the form of direct cash payment or through the application of a will or similar directive. Charitable giving and other donations are often used to support the provision of health and care services. As a major public sector employer the NHS holds formal and informal partnerships with national and local charities. Staff will, in their private lives, undertake voluntary work or fundraising activities for charity. A supportive environment across the NHS and charitable sector should be promoted. However, conflicts of interest can arise.
Principles and rules	• Acceptance of donations made by suppliers or bodies seeking to do business with an organisation should be treated with caution and not routinely accepted. In exceptional circumstances a donation from a supplier may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value. • Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for an organisation, or is being pursued on behalf of that organisation's registered charity (if it has one) or other charitable body and is not for their own personal gain. • Staff must obtain permission from their organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign. • Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued. • Staff wishing to make a donation to a charitable fund in lieu of a professional fee they receive may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.
What should be declared	• Organisations should maintain records in line with their wider obligations under charity law, in line with the above principles and rules.

Sponsored events

What are the issues?	Sponsorship of NHS events by external parties is valued. Offers to meet some or part of the costs of running an event secures their ability to take place, benefiting NHS staff and patients. Without this funding there may be fewer opportunities for learning, development and partnership working. However, there is potential for conflicts of interest between the organiser and the sponsor, particularly regarding the ability to market commercial products or services. As a result there should be proper safeguards in place to prevent conflicts occurring.
Principles and rules	• Sponsorship of events by appropriate external bodies should only be approved if a reasonable person would conclude that the event will result in clear benefit for the organisation and the NHS. • During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation. • No information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied. • At an organisation's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event. • The involvement of a sponsor in an event should always be clearly identified in the interest of transparency. • Organisations should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event. • Staff should declare involvement with arranging sponsored events to their organisation.
What should be declared	• Organisations should maintain records regarding sponsored events in line with the above principles and rules.

Sponsored research

What are the issues?	Research is vital in helping the NHS to transform services and improve outcomes. Without sponsorship of research some beneficial projects might not happen. More broadly, partnerships between the NHS and external bodies on research are important for driving innovation and sharing best practice. However, there is potential for conflicts of interest to occur, particularly when research funding by external bodies does or could lead to a real or perceived commercial advantage. There needs to be transparency and any conflicts of interest should be well managed.
Principles and rules	• Funding sources for research purposes must be transparent. • Any proposed research must go through the relevant health research authority or other approvals process. • There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services. • The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service. • Staff should declare involvement with sponsored research to their organisation.

What should be declared	• Organisations should retain written records of sponsorship of research, in line with the above principles and rules.
	• Staff should declare:
	  • their name and their role with the organisation
	  • a description of the nature of the nature of their involvement in the sponsored research
	  • relevant dates
	  • any other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance)

Sponsored posts

What are the issues?	Sponsored posts are positions with an organisation that are funded, in whole or in part, by organisations external to the NHS. Sponsored posts can offer benefits to the delivery of care, providing expertise, extra capacity and capability that might not otherwise exist if funding was required to be used from the NHS budget. However, safeguards are required to ensure that the deployment of sponsored posts does not cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition.
Principles and rules	• Staff who are establishing the external sponsorship of a post should seek formal prior approval from their organisation. • Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and confirm the appropriateness of arrangements continuing. • Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. For the duration of the sponsorship, auditing arrangements should be established to ensure this is the case. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise. • Sponsored post holders must not promote or favour the sponsor's specific products, and information about alternative products and suppliers should be provided. • Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.
What should be declared	• Organisations should retain written records of sponsorship of posts, in line with the above principles and rules. • Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this guidance.

Clinical private practice

What are the issues?	Service delivery in the NHS is done by a mix of public, private and not-for-profit organisations. The expertise of clinicians in the NHS is in high demand across all sectors and the NHS relies on the flexibility that the public, private and not-for-profit sectors can provide. It is therefore not uncommon for clinical staff to provide NHS funded care and undertake private practice work either for an external company, or through a corporate vehicle established by themselves. Existing provisions in contractual arrangements make allowances for this to happen and professional conduct rules apply. However, these arrangements do create the possibility for conflicts of interest arising. Therefore, these provisions are designed to ensure the existence of private practice is known so that potential conflicts of interest can be managed. These provisions around declarations of activities are equivalent to what is asked of all staff in the section on Outside Employment.
Principles and rules	Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises* including: • where they practise (name of private facility) • what they practise (specialty, major procedures). • when they practise (identified sessions/time commitment) *Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf

Clinical private practice (continued)

Principles and rules	Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed): • Seek prior approval of their organisation before taking up private practice. • Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.** • Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on his or her behalf.** ** These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf Where clinical private practice gives rise to a conflict of interest then the general management actions outlined in this guidance should be considered and applied to mitigate risks.
What should be declared	• Staff name and their role with the organisation. • A description of the nature of the private practice (e.g. what, where and when you practise, sessional activity, etc). • Relevant dates. • Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).

5. Management: Strategic decision making groups

5.5. Many organisations use boards (or committees and sub-committees of boards), advisory groups, and procurement panels to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts
- Awarding grants
- Making procurement decisions
- Selection of medicines, equipment, and devices

These are referred to in this guidance as 'strategic decision making groups'.

5.6. It is important that the interests of those who are involved in these groups are well known to those involved. Organisations must therefore identify relevant strategic decision making groups and ensure they operate in a manner consistent with the following principles, which reflect wider standards of good governance:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant interests
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise
- Any new interests identified should be added to the organisation's register
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement

5.7. If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting
- Ensuring that the member does not receive meeting papers relating to the nature of their interest
- Requiring the member to not attend all or part of the discussion and decision on the related matter
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate
- Removing the member from the group or process altogether

5.8. The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. An example is the need for clinical involvement, when clinicians may hold and represent a diversity of interests. Good judgement is required to ensure proportionate management of risk. The composition of groups should be kept under review to ensure effective participation.

5. Management: Procurement decisions

5.9. Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients.

5.10. Organisations should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process. NHS Improvement and NHS England have published detailed and specific guidance on procurement processes which staff and organisations should consult.

5.11. For the avoidance of doubt, nothing in this section or this guidance waives or modifies any existing legal requirements relating to conflicts of interest and procurement decisions.

NHS Improvement Guidance on Procurement, Patient Choice and Competition: https://www.gov.uk/government/publications/procurement-patient-choice-and-competition-regulations-guidance

NHS England Guidance on Conflicts of Interest for CCGs**:** https://www.england.nhs.uk/commissioning/pc-co-comms/coi/

6. Transparency: Maintenance and publication of register(s)

Maintenance of Register(s)

6.1. Organisations must ensure that a nominated team or individual collates and maintains up to date organisational register(s) of interests. An interest should remain on the register(s) for a minimum of 6 months after the interest has expired. Organisations should retain a private record of historic interests for a minimum of 6 years after the date on which it expired.

6.2. Template declaration of interests and register of interests forms for organisations to use are provided at Annex C and D. They should always contain:

- The returnee's name and their role with the organisation
- A description of the interest declared (reflecting the content of section 5 of this guidance for common situations)
- Relevant dates relating to the interest
- Space for comments (e.g. action taken to mitigate conflict)

6.3. Using the common format in the templates will help minimise burdens on staff who might need to submit returns to multiple organisations.

Declaration of interests template

Publication

6.4. All staff should declare interests and, as a minimum, organisations should publish the interests of decision making staff at least annually in a prominent place on their website. Organisations without websites should maintain registers locally, available for inspection on request.

6.5. The format of published registers should be accessible and contain meaningful information. Adopting the templates and advice on content in this guidance will assist organisations in this task.

6.6. Organisations should put in place processes for staff to make representations that information on their interests should not be published. This will allow for, in exceptional circumstances, an individual's name and/or other information to be redacted from any publicly available registers where the public disclosure of information could give rise to a real risk of harm or is prohibited by law.

6.7. As well as taking these steps, organisations should seek to ensure that staff who are subject to wider transparency initiatives such as the ABPI Disclosure UK scheme are aware of and comply with them: http://www.abpi.org.uk/our-work/disclosure/Pages/disclosure.aspx

Register of interests template

7. Breaches: How should these be dealt with?

7.1. There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or organisations. For the purposes of this guidance these situations are referred to as 'breaches'.

7.2. Organisations should identify a team or individual to be notified of breaches, and be clear as to how staff or other parties can raise concerns about these. Staff should be encouraged to speak up about actual or suspected breaches, in compliance with their organisation's whistleblowing policy.

7.3 Organisations should also identify a team or individual empowered to investigate breaches, involving organisational leads for human resources, fraud, audit etc. as appropriate. Each breach needs to be investigated and judged on its own merits and this should start with those involved having the opportunity to explain and clarify any relevant circumstances.

7.4. Following investigations organisations should:

- Decide if there has been or is potential for an actual breach and the severity
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum
- Consider who else inside and outside the organisation should be made aware of the breach
- Take appropriate action, such as clarifying existing policy, taking action against the staff member(s) responsible for the breach, or escalating to external parties such as auditors, NHS Protect, the Police, statutory health bodies and/or regulatory bodies

7.5. When dealing with instances of breach organisations may want to take legal or other appropriate advice prior to imposing sanctions which could have serious consequences for those involved. A range of responses should be considered in terms of proportionate sanctions for breaches, including:

- Employment law action
- Reporting incidents to external bodies
- Contractual or legal consequences

Further information on the consequences of breaches and the range of potential sanctions is at Annex E.

7.6. Organisations should consider whether reports on breaches, the impact of these, and action taken (i.e. if strong management action or sanctions are taken) should be considered by their governing body, audit committee, executive team or similar on a regular basis.

7.7. To aid transparency organisations should consider whether anonymised information on breaches and action taken in response should be prepared and published on websites on a regular basis.

8. Resource Annexes

ANNEX A – Model Conflict of Interest Policy
[due for publication in March 2017]

ANNEX B – Types of interests

ANNEX C – Template interests declaration form

ANNEX D – Template interests register

ANNEX E – Potential sanctions for breach of conflicts of interest policies

Annex B – Types of interests

Type of interest	Description
Financial interests	Where an individual may get direct financial benefits* from the consequences of a decision their organisation makes. This could include: • A director (including a non-executive director) or senior employee in another organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding • A shareholder, partner or owner of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding • Someone in outside employment • Someone in receipt of secondary income. • Someone in receipt of a grant. • Someone in receipt of other payments (e.g. honoraria, day allowances, travel or subsistence). • Someone in receipt of sponsored research.
Non-financial professional interests	Where an individual may obtain a non-financial professional benefit* from the consequences of a decision their organisation makes, such as increasing their professional reputation or status or promoting their professional career. This could include situations where the individual is: • An advocate for a particular group of patients. • A clinician with a special interest. • An active member of a particular specialist body. • An advisor for the Care Quality Commission or National Institute of Health and Care Excellence. • A research role.

* A benefit may arise from the making of gain or avoiding a loss

Annex B – Types of interests (continued)

Type of interest	Description
Non-financial personal interests	This is where an individual may benefit* personally from a decision their organisation makes in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is: • A member of a voluntary sector board or has a position of authority within a voluntary sector organisation. • A member of a lobbying or pressure group with an interest in health and care.
Indirect interests	This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit* from a decision they are involved in making. This would include**: • Close family members and relatives. • Close friends and associates. • Business partners.

* A benefit may arise from the making of gain or avoiding a loss

** A common sense approach should be applied to these terms. It would be unrealistic to expect staff to know of all the interests that people in these classes might hold. However, if staff do know of material interests (or could be reasonably expected to know about these) then these should be declared.

Annex E – Potential sanctions

Disciplinary sanctions

Staff who fail to disclose any relevant interests or who otherwise breach an organisation's rules and policies relating to the management of conflicts of interest are subject to investigation and, where appropriate, to disciplinary action. This may include:

- Employment law action which might include:
  - Informal action – such as reprimand or signposting to training and/or guidance.
  - Formal action – such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion or dismissal.
- Referring incidents to regulators.
- Contractual action against organisations or staff.

Professional regulatory sanctions

Statutorily regulated healthcare professionals who work for, or are engaged by, organisations are under professional duties imposed by their relevant regulator to act appropriately with regard to conflicts of interest. Organisations should consider reporting statutorily regulated healthcare professionals to their regulator if they believe that they have acted improperly, so that these concerns can be investigated. These healthcare professionals should be made aware that the consequences for inappropriate action could include fitness to practise proceedings being brought against them, and that they could, if appropriate be struck off by their professional regulator as a result.

Information and contact details for the healthcare professional regulators are accessible from the Professional Standard Authority website:

http://www.professionalstandards.org.uk/what-we-do/our-work-with-regulators/find-a-regulator

Annex E – Potential sanctions (continued)

Civil sanctions

If conflicts of interest are not effectively managed, organisations could face civil challenges to decisions they make – for instance if interests were not disclosed that were relevant to the bidding for, or performance of contracts. In extreme cases, staff and other individuals could face personal civil liability, for example a claim for misfeasance in public office.

Criminal sanctions

Failure to manage conflicts of interest could lead to criminal proceedings including for offences such as fraud, bribery and corruption. This could have implications for the organisation concerned and linked organisations, and the individuals who are engaged by them.

The Fraud Act 2006 created a criminal offence of fraud and defines three ways of committing it:

- Fraud by false representation
- Fraud by failing to disclose information and
- Fraud by abuse of position.

In these cases an offender's conduct must be dishonest and their intention must be to make a gain, or a cause a loss (or the risk of a loss) to another. Fraud carries a maximum sentence of 10 years imprisonment and/or a fine and can be committed by a body corporate.

The Bribery Act 2010 makes it easier to tackle this offence in public and private sectors. Bribery is generally defined as giving or offering someone a financial or other advantage to encourage a person to perform certain activities and can be committed by a body corporate. Commercial organisations (including NHS bodies) will be exposed to criminal liability, punishable by an unlimited fine, for failing to prevent bribery.

The offences of bribing another person or being bribed carries a maximum sentence of 10 years imprisonment and/or a fine. In relation to a body corporate the penalty for these offences is a fine.

INTERESTS DECLARATION FORM

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Mr John Smith	*Senior Policy Manager, Commissioning Directorate, Organisation A*	*Hospitality received - £95 from Organisation Z to pay for travel to speak at conference on Managing Conflicts of Interest on 21/12/16*	*21/12/2016*	*21/12/2016*	*Approval to attend event and accept hospitality given by Mary Baker, Head of Unit*

Please see below for information on how to populate the above boxes

The information submitted will be held by Whittington Health for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that Whittington Health holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to Whittington Health as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, internal disciplinary, or professional regulatory action may result.

I **do / do not [delete as applicable]** give my consent for this information to published on registers that Whittington Health holds.
If consent is NOT given please give reasons:

Signed: **Date:**

Please return this form Lynne Spencer, Director of Communications & Corporate Affairs, Whittington Health, ground Floor, Jenner Building

GUIDANCE NOTES FOR COMPLETION OF SPECIMEN INTERESTS DECLARATION FORM

Name and Role:	Insert your name and your position/role in relation to the Organisation you are making the return to
Description of Interest:	Provide a description of the interest that is being declared. This should contain enough information to be meaningful (e.g. detailing the supplier of any gifts, hospitality, sponsorship, etc). That is, the informaiton provided should enable a reasonable person with no prior knowledge should be able to read this and understand the nature of the interest. Types of interest: **Financial interests** - This is where an individual may get direct financial benefits from the consequences of a decision they are involved in making **Non-financial professional interests -** This is where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career **Non-financial personal interests -** This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career **Indirect interests -** This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making A benefit may arise from both a gain or avoidance of a loss.
Relevant Dates:	Detail here when the interest arose and, if relevant, when it ceased
Comments:	This field should detail any action taken to manage an actual or potential conflict of interest. It might also detail any approvals or permissions to adopt certain course of action