Whittington Health NHS

T R U S T B O A R D PUBLIC

14.00 – 17:00
Wednesday 7 June 2017

Whittington Education Centre
Room 7

NHS
Whittington Health
NHS Trust

Meeting	**Trust Board – Public**
Date & time	**07 June 2017 at 1400hrs – 1700hrs**
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, Chief Nurse & Director of 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, Chief Nurse & Director of Patient Experience*	*Verbal*	*Note* 1400hrs
17/074	**Declaration of Conflicts of Interests** *Steve Hitchins, Chair*	*Verbal*	*Declare* 1420hrs
17/075	**Apologies & Welcome** *Steve Hitchins, Chair*	*Verbal*	*Note* 1425hrs
17/076	**Draft Minutes, Action Log & Matters Arising 03 May 2017** *Steve Hitchins, Chair*	1	*Approve* 1430hrs
17/077	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Note* 1435hrs
17/078	**Chief Executive's Report** *Simon Pleydell, Chief Executive*	2	*Approve* 1445hrs
Patient Safety & Quality			

17/079	**Serious Incident Report Month 01** *Philippa Davies, Chief Nurse & Director of Patient Experience*	3	*Approve* 1455hrs
17/080	**Safer Staffing Report Month 01** *Philippa Davies, Chief Nurse & Director of Patient Experience*	4	*Approve* 1505hrs
Performance			
17/081.a	**Financial Performance Month 01** *Stephen Bloomer, Chief Finance Officer*	5	*Approve* 1515hrs
17/081.b	**Capital Plan 17/20** *strategic item to be discussed with above* *Stephen Bloomer, Chief Finance Officer*	5.a	*Approve* 1525hrs
17/082	**Performance Dashboard Month 01** *Carol Gillen, Chief Operating Officer*	6	*Approve* 1535hrs
Strategy			
17/083	**Quality Account Review of 16/17 and Quality Account 17/18** *Richard Jennings, Medical Director*	07	*Approve* 1545hrs
17/084	**Service Improvement Strategy** *Carol Gillen, Chief Operating Officer*	08	*Approve* 1555hrs
Governance			
17/085	**Accounts for adoption and ISA260 External Audit** *David Holt, Non-Executive Director*	09	*Approve* *1605hrs*
17/086	**Board Assurance Framework** *Siobhan Harrington, Deputy Chief Executive* **Board Self Certification Statement** *Siobhan Harrington, Deputy Chief Executive*	10 10.a	*Approve* *1615hrs* *Approve* *1625hrs*
17/087	**Audit & Risk Committee Terms of Reference** *David Holt, Non-Executive Director*	11	*Approve* *1630hrs*
17/088	**Quality Committee Terms of Reference** *Anu Singh, Non-Executive Director*	12	*Approve* *1635hrs*
17/089	**Finance & Business Dvlpmt Committee Terms of Reference** *Tony Rice, Non-Executive Director*	13	*Approve* *1640hrs*
17/090	**Workforce Assurance Committee Terms of Reference** *Norma French, Non-Executive Director*	14	*Approve* *1645hrs*
17/091	**Charitable Funds Committee Terms of Reference** *Tony Rice, Non-Executive Director*	15	*Approve* *1650hrs*
17/092	**Remuneration Committee Terms of Reference** *Steve Hitchins, Non-Executive Director*	16	*Approve* *1655hrs*
Committee Minutes			
17/093	**Finance & Business Dvlptm Cmt draft 19 April Minutes 2017** *Tony Rice, Non-Executive Director* **Quality Committee draft 10 May Minutes** *Yua Haw, Non-Executive Director*	17a 17b	*Note* *Note*
AOB Urgent Business and Questions from the public			
	Lower Urinary Tract Services (LUTs) Patient Group		
Date of next Trust Board Meeting			
	05 July 2017 at 1400hrs to 1700hrs at the Whittington Education Centre Room 7, Magdala Avenue, N19 5NF		

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

Whittington Health NHS

ITEM: 01
Doc: 17/076

The draft minutes of the meeting of the Trust Board of Whittington Health held in public at 1400hrs on Wednesday 3rd May 2017 in the Whittington Education Centre

Present:	Greg Battle	Medical Director, Integrated Care
	Stephen Bloomer	Chief Finance Officer
	Janet Burgess	London Borough of Islington
	Philippa Davies	Chief Nurse and Director of Patient Experience
	Carol Gillen	Chief Operating Officer
	Deborah Harris-Ugbomah	Non-Executive Director
	Siobhan Harrington	Director of Strategy/Deputy Chief Executive
	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:	Norma French	Director of Workforce
	Kate Green	Minute Taker
	Sarah Hayes	Deputy Chief Nurse and Patient Experience
	Rob Sherwin	Associate Medical Director for Revalidation
	Lynne Spencer	Director of Communications & Corporate Affairs

Patient Story

Philippa Davies introduced Marianne, a patient currently undergoing extensive chemotherapy at Whittington Health, and accompanied by lead cancer nurse Karen Phillips. Marianne opened her presentation by saying how much it meant to her to be able to share her story with the Board. She had undergone a cycle of chemotherapy at Guy's the previous year, and said that despite the one at Whittington Health being extremely hard to go through, she would choose this every time. There were three main considerations for her; environment, scheduling, and anonymity.

Marianne proceeded to outline the differences between the two services. She described the physical environment of both, making comparisons between the two different hospitals which served to illustrate what had for her been particularly important in affording her a degree of privacy, less noise, and a more personal level of service. The commitment and ability of the staff from both Trusts was never called into question, it was the processes and environment that ultimately made the difference between the services. Of particular importance had been the fact that at Whittington Health the nurses themselves scheduled bookings, and because they were familiar with her personal circumstances as well as her treatment regime meant bookings could be scheduled sympathetically. It was also important to her that when she telephoned feeling unwell she would speak to someone that she knew and trusted.

Board members asked a range of questions of Marianne, including inviting her opinion on how some of her personal experiences might best be transferred to some of the Trust's larger services so that patients might gain the maximum benefit from them, and also suggesting that Guy's might benefit from hearing her story.

It seemed likely that the comparable size of the two Trusts was a factor, and it was noted that the CQC had commented favourably on inter-departmental relationships and communications.

17/58 Patient Survey Results – Picker Institute

58.01 Philippa Davies introduced Lucas from the Picker Institute. Lucas began by describing the methodology used, saying that the only comparative measures available in recent years were with other organisations across England, and for today's presentation he would be making a comparison with the previous year's results. The data presented was embargoed from publication until the Trust had its report from the Care Quality Commission.

17/59 Declaration of Conflicts of Interest

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

17.60 Welcome and apologies

60.01 Steve Hitchins welcomed everyone to the meeting and especially Sarah Hayes, newly appointed Deputy Chief Nurse, Rob Sherwin, Associate Medical Director, Sara Berry, co-chair of the Trust's Joint Staff Side, and Graham Laurie, former Trust Governor.

17/61 Minutes, Matters Arising & Action Log

61.01 It was noted that Janet Burgess had extended her apologies for non-attendance at the previous meeting. Other than this, the minutes of the Trust Board meeting held on 5th April were approved.

Action notes

61.02 57.01 (Information Governance Toolkit Level 2) had been completed and could therefore be closed; all other items were either on the agenda for that day's meeting or running to schedule.

17.62 Chairman's Report

62.01 Steve Hitchins drew the Board's attention to the mention made in the minutes of the April meeting about Janet Burgess's contribution to the autism awareness week and thanked her for that. He went on to congratulate all who had participated in the recent 'perfect week' led by Carol Gillen, saying that everyone he had come into contact with had been encouraged and had felt improvements had been made, there had been some evidence of healthy competition between wards, and there had also been positive feedback from the Emergency Care Improvement Programme (ECIP) team.

62.02 Representatives of Tottenham Hotspurs had visited the Trust over Easter and had distributed Easter eggs to the hospital wards. Very sadly however coach Ugo Ehiogu had unexpectedly died a few days later; Steve had written to express condolences on behalf of the Trust.

62.03 The previous week's Grand Round had focused on sepsis, and almost 300 staff had been in attendance – Steve commended Julie Andrews and Sarah Gillis for their work in organising this event.

62.04 Steve reminded Board colleagues that at their April meeting they had delegated the appointment of a Non-Executive Director to oversee the Trust's reporting of non-avoidable deaths to him and to Simon Pleydell – he was pleased to report that Graham Hart had agreed to take up this position.

17/63 Chief Executive's Report

63.01 It was noted that Philippa Davies's job title had changed to Chief Nurse and Director of Patient Experience, and Sarah Hayes was Deputy Chief Nurse and Patient Experience.

63.02 Simon was pleased to report on a number of key achievements carried out over recent weeks; the majority of access targets had been met, as had the Trust's financial control total. Expanding on the latter, Simon explained to the Board that the Trust had remained in deficit at the year end, but there had been a significant improvement on the previous year's position, and this meant that the Trust was in receipt (through the STP) of a number of financial bonuses. During the year the Trust had come to terms with a new and more stringent way of managing its finances, and it was of key importance to maintain controls.

63.03 Moving on to quality and safety, Simon informed the Board that the Trust's take-up of 'flu vaccinations of over 79% had been the highest in London, which he felt said a great deal about the Trust's staff and how they viewed their personal responsibility for keeping patients safe. The Trust was also in the top five organisations in England for its care and early identification of patients with sepsis. It was slightly disappointing that the Trust had declared two cases of MRSA during the year, but performance on C. Difficile had been good, and targets for this would stretch and improve during the coming year. Some challenges remained evident within the Quality Account, but the key point to note was the consistent improvement.

63.04 Overall, the Trust had performed well on its access targets including all cancer targets and community access. It was noted the ED target had not been achieved at 88.4% for the year although performance had risen to 91% at the end of the first month of the new financial year.

63.04 Several Trust staff had completed the London Marathon in aid of the Trust's charitable funds, raising almost £20k in total. The annual staff awards had now been launched, with the awards ceremony taking place on 29th June – all Board members were invited. The Trust had been nominated amongst the top patient safety organisations by CHKS, and there was to be an awards dinner the following week.

63.05 Simon spoke about the Schwartz Round scheduled to take place the following day. These events had been taking place in the community for some time, and he had recently attended an interesting one which had focused on the experiences of staff who had been treating patients at their own homes. Schwartz Rounds had now been re-launched at Whittington health, and the theme for the following day's event (at which Simon would be a keynote speaker) was 'the patient I will never forget'.

63.06 The general election had now been declared, meaning that the country was in 'purdah'. Communication would continue to staff congratulating them on the year's achievements whilst reminding them of the challenges ahead.

17/64 Serious Incident Report

64.01 Philippa Davies informed the Board that four serious incidents had been declared during March, taking the total to 58 incidents declared since 1st April 2016. It was noted that the figure given at the previous Board had been inaccurate and should have been five rather than seven. The four declared in March comprised the following:

- A patient fall resulting in a fractured neck of femur

- An unexpected admission to NICU
- An unexpected death following an elective procedure
- A patient death following emergency surgery

64.02 All these incidents are being actively investigated. Steve Hitchins enquired whether any trends were emerging, and also whether the Trust was learning from the incidents investigated. Richard Jennings replied that one of the continuing areas of focus was good communication, particularly in terms of handovers, and some external scrutiny had shown that there were some improvements that could be made in this area. There had been a focus on falls, and the Trust was part of a national collaborative to explore falls and what additional measures could be put in place to reduce them; there was also to be a 'deep dive' into this area at the Clinical Quality Review Group (CQRG) the following week.

64.03 Norma French said that the results of the staff survey showed that staff had become increasingly confident in reporting incidents. Richard added that the Trust was increasingly involving junior doctors in investigations; this initiative was being led by Julie Andrews in her role as associate medical director with responsibility for patient safety. In addition, handover data was more electronic than had previously been the case (although paper records were still used in some areas) which made systems far more robust than they had been two years ago.

17/65 Month 12 Safer Staffing Report

65.01 Philippa Davies informed the Board that wards had faced considerable challenges in terms of treating adolescents with mental health problems who needed specialling by RMNs. It was recognised that the wards at the Whittington were not an appropriate place for these patients to be treated, but there was a London-wide shortage of beds and although the Trust was in discussion with Camden & Islington Mental Health Trust it seemed unlikely that a solution would be forthcoming in the immediate future. There had been a degree of success in reducing the number of escalation beds, particularly on Victoria ward.

65.02 In answer to a question from Greg Battle about the rising number of adolescent patients with mental health problems and the shortage of appropriate provision, Carol Gillen replied that this was an issue that was frequently raised with the commissioners at CQRG, where a representative from NHS England was present, but to date the answer had been merely that there were capacity issues across London. Richard added that the issue had also been flagged up with ECIP, with whom discussions had been held around all issues that affected the patient pathway. Whittington Health provides some services for this client group, but those admitted to hospital tended to be the ones who were missing out on the Trust's Child & Adolescent Mental Health Services.

17/66 Q4 Quality & Patient Safety Report

66.01 Simon Pleydell had mentioned the two cases of MRSA declared by the Trust during 2016/17, but the post-infection investigations had given assurance that the care provided by the Trust to these patients had been good. The report did not discuss flu and Richard felt that there should be a review and a report back to the Board before the next season started. Patients could be admitted to hospital and subsequently catch 'flu, and the Trust had declared such cases. Over the last two years, every instance of a patient catching 'flu whilst in hospital had been declared as a serious incident investigated. Richard spoke about the importance of early identification of sepsis, saying that there had been a sharp increase in the number of pre-alerts raised and staff were growing in expertise in this area.

66.02 The Trust was now in Year 2 of its 'Sign up to Safety' pledge, and Richard updated the Board, saying that good progress had been made on sepsis, and there had been some positive progress made on reducing falls, though staff were by no means complacent, and still believed that further measures could be put in place to make more of an impact. Progress had also been made concerning the treatment of patients with learning disabilities, and the Trust was setting itself stretch targets for the reduction of pressure ulcers. Work on learning from patient deaths was now moving forward under the leadership of Julie Andrews and more recently Graham Hart as lead Non-Executive Director. Simon Pleydell spoke of the importance of avoiding complacency, a new target had been set following much debate, and this would be a critical year; it was hoped that the data on avoidable deaths would correlate with that provided for SHMI submissions.

17/67 Financial Report

67.01 Introducing the financial report for Month 12, Stephen Bloomer informed the Board that the Trust had met its control total target at year end, and that because the target agreed had been more challenging than that originally set the Trust had gained additional STF monies. The plan was to use available capital rapidly over the next year, and Stephen informed executive colleagues that they could congratulate staff who had worked so hard to reach the year end position and inform them that because of this they had achieved a significant amount of additional capital funding for the Trust over the next year.

67.02 Other highlights from the report included the revised capital programme and improvements in resolving debtor and creditor positions. Steve Hitchins spoke about the notable shift in culture over the last few weeks of the 2016/17 financial year, saying that it was well known that the best hospitals were ones with sound finances. David Holt expressed some concern about the run rate, and asked whether the executive team felt confident of the Trust's financial sustainability moving into the new financial year. Stephen Bloomer acknowledged there were significant challenges ahead, but hoped that the budget setting paper would show clear plans for addressing them.

17/68 Budget Setting 2017/18

68.01 Stephen Bloomer presented his paper on budget setting, which set out the position for each ICSU and corporate area, and also gave a description of the targeted support the team will be putting in in order to ensure that every team's run rate is in the correct place. The paper also described the CIP plans and the practical measures that would be taken to ensure teams had a good level of control going forward. Final budgets would be set over the next week or two, and there would be a clear baseline for all.

68.02 David Holt made the point that the Trust had had to achieve a great deal in the final quarter of 2016/17, and wondered whether this was because expectations had been unrealistic or whether the teams had failed to exert sufficient grip during the course of the year. He therefore felt that the Board should be seeking additional assurance that control would be exercised more rigorously earlier in the year than had been the case in previous years. Tony Rice noted the programme management capability in place to support the process, the help the Trust was receiving from BCG, and the additional number of cost improvement programmes identified. There was also a reserve in place which was positive, and overall, he felt moderately confident of success although the achievement of financial sustainability would inevitably involve a great deal of work.

68.03 Anu Singh asked whether the team was confident that the timelines for this work aligned with the BCG work. Stephen Bloomer replied that they were already in week three of the BCG work, which was scheduled to finish at the end of July; the expectations of BCG

were very clear and fully understood. Without doubt the pace required presented a challenge, and this was the reason for not having yet relaxed the financial constraints.

17/69 Performance Dashboard

69.01 Introducing the performance dashboard for Month 12, Carol Gillen said that steady progress had been made towards achieving the ED target; 88.4% had been achieved by the end of the year, and in April the team had exceeded its trajectory, coming in at 91.2%. This was despite an increased level of acuity amongst patients and a more challenged winter as well as a 10% increase in patients. The ECIP team had been into the department in December, January and April, and a positive feedback session had been held the previous Friday, where it had been acknowledged that the rise in patients with mental health needs continued to present the greatest challenge to the hospital.

69.02 Richard Jennings had described the Trust's work on falls in his patient safety report, and Carol therefore moved on to cancer, being pleased to report that all targets had been met at the end of the year. There had also been an improvement in delayed transfers of care. The readmissions target had not been met for the third month in a row, and as a result a deep dive exercise was planned. Theatre utilisation was being supported by BCG, with Deloitte and NHSI conducting benchmarking at the end of May.

69.03 Turning to the HR data, Carol was pleased to report that appraisal rates had risen again. Performance on dealing with complaints had also improved.

17/70 Health & Wellbeing Partnership Agreement

70.01 Simon reminded Board colleagues of previous discussions held on the Health & Wellbeing Partnership, which comprised all parties signing up to a partnership which would deliver integrated joined-up care within health and social care, and set objectives which would help to improve population health. There had been discussions on how NEDs could best be involved in the governance arrangements for this, and these discussions were set to continue in the months ahead. This was, Simon said, an important step, and part of the general move towards accountable care systems. Encouragement for moving in this direction had been forthcoming from the new North Central London leadership.

70.02 In answer to a question from Tony Rice about whether timescales were realistic, Simon replied that all parties were keen to make progress in this area, and there was always some danger that of delays were allowed for they were more likely to occur. There had already been a hiatus due to the changes taking place in the commissioning world, but once a strong programme manager was appointed to lead the partnership pace would increase. Steve Hitchins added that this was very much about integrated care and therefore consistent with Whittington Health's main focus. Janet Burgess said that Tony's point had been well made, but good and steady progress had been seen over recent months, and she personally felt that the time was right to begin speaking to the public about plans, and once the election was over this would be the next phase of work. Steve Hitchins agreed, suggesting it would be good if a joint approach could be taken. The Board approved the draft Agreement.

17/71 Corporate Objectives 2017/18

71.01 Introducing this item, Siobhan Harrington explained that the front sheet of the paper set out how well the Trust had performed against its objectives for the previous year as well as outlining those set for the year ahead. Objectives had been set in line with the Trust's clinical strategy as well as being designed in the context of the Health &

Wellbeing Partnership and STP priorities. Highlights included the continuing emphasis on safety, the CQC action plan and continuing to meet targets.

71.02 Some challenges remained, one of which was reducing the staff vacancy rate. The Trust had also not met its agency reduction target, though significant progress had been achieved in this area, some of which was attributable to the implementation of the new health roster. Other areas of focus would include improvements to the maternity services environment, implementation of the new dental contract, and partnerships. More specifically on the latter, Siobhan informed the Board that over 5000 people were now signed up to the community forum, although there was still much work to do.

71.03 Steve Hitchins enquired whether, in forming these objectives, whether directors had looked at the areas where the Trust had not made as good progress as it had hoped and the reasons for this. Simon replied that the specifics of most such issues would be addressed via individuals' objectives. Referring back to the staff vacancy challenge, he said that the best contribution that could be made was to actively make Whittington Health one of the most attractive places to work in London, as little could be done about the supply available.

71.04 Other areas highlighted included patient experience measures (following consultation with Healthwatch), tackling bullying and harassment, apprenticeships, research and development. Steve Hitchins asked for food to be included, perhaps involving some work with volunteers. David Holt commented that the language was far stronger this year, and suggested revisiting some of those objectives carried forward to see whether a similar tone might be achieved. Graham Hart added that the set of targets would also need to be revisited.

17/72 Heatwave Plan 2017/18

72.01 Carol Gillen informed the Board that Trusts had been required to draw up an annual heatwave plan since 2008. The plan showed the various levels of alert and at what stage it became necessary to activate business continuity plans. Summer begins on 1st June. The Plan was approved by the Board.

17/73 Draft Minutes of Workforce Assurance Committee

73.01 Graham Hart introduced the draft minutes of the Workforce Assurance Committee (WAC) meeting held on 26th April. The meeting had seen evidence of good progress taking place on a number of fronts, and a huge amount of work had gone into preparing the reports and papers that supported the committee. This being the case, it had been a pity that attendance had been poor by the executives, and whilst the Board was aware of the time being taken up with STP work, those unable to attend should please send a deputy. Norma French echoed this, saying that the quality of reports was improving each time. She added that from 12th June the team would be fully staffed.

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Action Notes Summary

Minute	**Action**	**Date**	**Lead**
66.01	**Quality and Patient Safety Report - Flu -** Richard felt that there should be a review of flu and a report back to the Board before the next flu season started as this had not been included in the May 2017 Quality and Patient Safety Report to the Board	**6 September**	**RJ**
71.04	**Corporate Objectives 2017/18** - Steve Hitchins asked for food to be included, perhaps involving some work with volunteers	**Closed**	**SMH**
73.01	**WAC** - Those executives unable to attend should please send a deputy to the WAC meetings	**Closed**	**NF**

Whittington Health

7 June 2017

Title:	Chief Executive Officer's Report for April 2017		
Agenda item:	**17/078**	**Paper**	**02**
Action requested:	For discussion and information		
Executive Summary:	The purpose of this report is to highlight specific issues to the Trust Board and to update the Board on local, regional and national key issues facing the Trust		
Summary of recommendations:	To note the report		
Fit with WH strategy:	This report provides an update on key issues for Whittington Health's strategic intent		
Reference to related / other documents:	Whittington Health's regulatory framework, strategies and policies		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Risks captured in risk registers and/or Board Assurance Framework		
Date paper completed:	31 May 2017		

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

CHIEF EXECUTIVE OFFICER REPORT

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

Top Hospitals CHKS Awards

We were absolutely delighted and very proud to have been named as the **best performing NHS Trust for quality of care across the UK,** as part of the annual **Top Hospital Awards 2016**.

CHKS used over 27 years of experience in the analysis of hospital data to decide the indicators on which each of the Top Hospitals programme awards are judged. Awards are made on the basis of an analysis of publicly available datasets and every NHS acute trust in England, Wales and Northern Ireland is included. Andy Lockwood, managing director, CHKS said:

"The staff and management team at the Whittington Health should take pride in having won this award. It is made on the basis of analysis of impartial indicators and shows a real commitment to improving the quality of care."

The detailed indicators included:

- Summary Hospital-level Mortality Index (SHMI)
- Risk adjusted length of stay
- Risk adjusted mortality index
- Percentage of patients >65 with fractured neck of femur with pre-op LoS<=2
- Cancer patients seen within 2 weeks - all suspected cancers
- Discharge to usual place of residence within 56 days of emergency admission for patients with stroke
- Discharge to usual place of residence within 28 days of emergency admission for patients with a hip fracture (aged 65+)
- Admitted patients' waiting time from point of referral to treatment
- Day case conversion to inpatient rate
- Patient reported outcomes score
- Rate of emergency readmission to hospital (>16; 28 days)
- Percentage of elective admissions where planned procedure not carried out (not patient decision)

Diabetes Awareness Event

Over 100 patients attended Saturday's diabetes support event which included an expert panel of speakers, presentations and information stalls covering a range of support topics including medicines in diabetes, managing high blood pressure, diet and coping with low mood swings. This was the first Type 2 diabetes event in the country.

MRSA Bacteraemia

We have reported zero cases up to the reporting month of April for hospital acquired MRSA bacteraemia. We will continue to manage our high profile infectious control campaign across the community and hospital to aim for zero reported cases in 2017/18.

Clostridium Difficile

We have reported 5 cases of Clostridium Difficile up to the end of May; 2 in April and 3 in May. The target is for no more than 17 cases this year.

Cancer Waiting Time Targets

We were pleased to have exceeded all but one of our cancer targets for March; reported in arrears in line with the national cancer data validation process.

- 31 days to first treatment 100% against target of 96%
- 31 days to subsequent treatment (surgery)100% against target of 98%
- 31 days to subsequent treatment (drugs)100% against a target of 93%
- 62 days from referral to treatment 92.9% against a target of 85%
- 14 days cancer to be first seen 94.6% against a target of 93%
- 14 days to be first seen for breast symptomatic 92.9% against a target of 93%

Community Access Targets

We are pleased that our Improving Access to Psychological Therapies (IAPT) targets continue to improve and for the month of April we recorded:

- 626 referrals - lower than average although April had 18 working days only
- 379 patients entered treatment – target 437 (expected to meet target from May)
- 15.74% access rate - target 15%
- 50% patients moved to recovery - target 50%
- 98% patients waiting for treatment <6 weeks - target 75%
- 75% of patients showed significant improvement – highest ever recorded
- 2455 patients attended contacts (Haringey 2343 and other 112)
- 95% of patients reported they were satisfied with their overall experience

STRATEGIC

Year End and Look Forward

We hosted a special year end and look forward staff meeting last month to thank staff for their fantastic achievements during the last year. Nearly 200 staff attended and we were able to discuss our ongoing plans to ensure sustainability as an integrated care organisation. We explained we will continue working within the North Central London Sustainability and Transformation Plan and the Islington and Haringey Wellbeing Partnership. Together we share the same vision of improving our population's health.

Strategic Estates Partnership (SEP)

We have continued to meet different providers and have received detailed final presentations. We have now closed the process and will be reporting to the Board in July on our decision for a preferred partner to help us deliver our Estate Strategy over the forthcoming years.

Pharmacy

The modernisation of our pharmacy has commenced and we expect to reopen in the summer. This important development will enable the expansion of the pharmacy so that

we can provide a larger range of stock of over the counter medicines. Meanwhile we will continue to operate the pharmacy services in the temporary location at the hospital.

OPERATIONAL

Cyber Attack

Our Information, Management and Technology (I&MT) function was not affected by the global cyber attack that took place on 12 May. This affected multiple NHS Trusts across the UK and other organisations globally. We would like to thank our staff who worked together throughout the period to ensure our systems remained safe and secure.

Lower Urinary Tract Services (LUTs)

Work has been continuing to secure the succession plan for clinical leadership of the LUTs service. Progress has been made with colleagues from UCL and UCLH. The plan will identify how the research governance will strengthen the clinical service model; we are working towards new arrangements being fully in place by June 2018. There are some details to be concluded before the plan can be brought to the Board.

With regard to the safety and governance concerns, a further desk top review against the Royal College of Physicians (RCP) recommendations was completed in May and a report will be sent to the RCP and NHS Improvement. The current inability to establish a functioning multi-disciplinary team is an ongoing challenge that we will work to resolve. This would need to be in place to enable the Trust to reopen to new patients. This is in line with the expectations of local and national commissioners.

Open Day 16 September

We will be hosting a special open day at our hospital on Saturday 16 September. The event will be a fantastic opportunity for our local community to find out more about what we do, including tours of our operating theatre, health promotion and information stalls with expert advice from our staff and special performances from local artists and choirs.

Emergency Department

Performance against the 95% target continued improved during April despite facing continued demand and continuing increased attendances *(in excess of 310 against an average of 260)* on a number of days over April. The improvements we are making reflect the implementation of continued changes within ED and across the hospital.

We achieved our trajectory of 90% for April which has been agreed to support the attainment of 95% performance by July 2017. (May has shown further improvement of 93.5% against our agreed trajectory of 91%)

LAS handover times have improved that demonstrates the success of the work of our handover triage nurse and wider teams.

We are now focusing on reducing the median time to treatment which is currently static at an average of 72 minutes. We will do this by streamlining the front door flow and expand our Rapid Assessment and Treatment (RAT). This will include the Introduction of HCAs into the RAT area to support registrars and consultants

All 5 X 12 hour trolley waits in April were informal mental health patients requiring a mental health bed and who were not suitable for a medical admission.

During March ECIP undertook a whole system review in agreement with the Islington A&E Delivery Board with the aim of making recommendations to the Board to enhance patient flow.

A mental health summit is planned for June with senior representation from each organisation to address some of the current mental challenges. We continue to work closely with Camden and Islington Mental Health NHS Trust who are now part of the 1100hrs daily CSU surge call so that any issues can be discussed in a timely manner and escalated appropriately.

WORKFORCE

New Nurses

We were pleased to recruit c.60 nurses from the Philippines last month. We will be continuing to implement our overall recruitment strategy to ensure our workforce plans meet the needs of our services to enable us to continue providing high quality and safe care for our patients.

Health and Wellbeing Champions

We have launched a new initiative to recruit champions to support our health and wellbeing programme. The aim is to recruit volunteer staff champions to help promote campaigns, share information, signpost services, promote a healthy culture, provide feedback to the health and wellbeing team and work with our occupational health and communications team.

Places filling fast for the London 10km run

We have nearly 50 runners for our next major charity event in London. The route will take in some of London's most iconic sights from Piccadilly to Westminster. Our Head of Fundraising, Graham Brogden is continuing to encourage more participants to help us raise money for our charitable fund. Please take part or sponsor a colleague to support our charity.

MONTH 1 (April 2017) FINANCE

We are reporting a £1.7m deficit at the end of April against a planned deficit of £1.4m in line with our annual planning submission to NHSI. This means we are off plan by £0.3m and the reason for this is the performance against income.

We planned for a lower activity level in April due to reduced working days, caused by bank holidays and additional weekends. However, even allowing for this the Trust was significantly under contracted level for NHS clinical income.

For our elective activity, outpatients across all the ICSUs reported £0.3m off plan for April, with the largest under-performance in paediatrics, general surgery and dermatology. Our non-elective activity was £0.4m adverse in month, with the largest under-performance in gastroenterology.

Our combined pay and non-pay expenditure met its target. Pay expenditure for April was £18.4m, slightly lower than both month12 pay spend and the average for 2016/17 of £18.5m. Pay expenditure for agency staff was £1.4m. This is a 9% reduction compared to the average monthly cost of agency staff during 2016/17 of £1.5m. Only CSS had an increase in agency costs compared to month12 and the average for 2016/17. Reducing the cost of agency remains a priority for 2017/18 to ensure we meet the national cap. Non pay expenditure for April was £6.4m in line with the average spend in 2016/17, but £1.2m less than month 12.

We have a £17.8m CIP target for 2017/18. To date £10.3m of plans have been identified, with a balance of c.£7.5m still to be identified. We planned to deliver £1.1m in month 1 but we reported £0.4m; a shortfall of £0.7m.

AWARDS

Staff Excellence Award May

Congratulations to John Hurst, Pharmaceutical Procurement Officer, who won the May staff excellence award. John has worked tirelessly in our hospital pharmacy to support the changes and modernisation programme taking place. John's operational leadership and professionalism is making sure that the service continues to run smoothly to support patients and staff.

Nurse Awards for 2017

We held our annual nurse conference in May and the winners were:

- Nurse of the year - Anthony Pender, Clinical Nurse Manager, Ambulatory Care
- Midwife of the year - Nuala Hammond-Norris
- Student of the year - Madeline Davies
- Healthcare Assistant of the year - Eddie Simple
- Team of the year (Acute) - Outpatient Department Team
- Team of the year (Community) - Community Respiratory Team
- Patient Safety Improvement Award - Joanne Eardley, senior practice development nurse medicine
- Chief Nurse Special Award - Francis Mahanzu, lead district nurse South & Central Islington
- Patient Choice Award - Helen Speight , Clinical Nurse Specialist paediatric oncology
- Outstanding service to nursing special award - Kay Delaney, Matron Intensive Care Unit

Annual Staff Awards

We will be hosting our Annual Award Ceremony on 29 June at the Royal College of Surgeons. We have received over 200 nominations for teams and individuals across all areas of the organisation. Our judging panel have met to shortlist the winners and they were very impressed with the high quality nominations. We will announce the shortlisted staff this month and they will be invited to the awards ceremony where the winners will be announced to celebrate their achievements.

Simon Pleydell
Chief Executive

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

Whittington Health

June 2017

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	**17/079**	**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 April 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:	19/05/2017		

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

Serious Incident 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 April 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 2 serious incidents during April 2017, one of which has been referred to the NELCSU for a de-escalation as following further investigation it was confirmed that no patients have come to any harm by the subsequent delay of treatment and therefore this no longer meets the criteria for an SI.

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
Unexpected Death Ref:31941 Submitted 9/5/2017	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 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.
Sub optimal care of deteriorating patient Ref: 4094	Feb 17	Patient was admitted with exacerbation of Chronic Obstructive Pulmonary Disease (COPD)

Category	Month Declared	Summary
Treatment Delay Ref: 4095	Feb 17	Patient underwent planned surgery was discharged home, and later presented to a neighbouring hospital with a CVA.
Unexpected Death- Influenza Ref: 4856	Feb 17	Patient was admitted and treated for community acquired pneumonia.
Safe guarding Incident - patient absconding from ward Ref: 4788	Feb 17	Teenager detained under section 5.2 of the Mental Health Act absconded prior to completion of essential treatment.
Delayed Diagnosis Ref: 5501	Feb 17	Delay in follow up CT scan and subsequent diagnosis.
Patient Fall Ref:6087	Feb 17 (Declared March 2017)	Patient stood to use commode and fell sideward resulting in a fractured neck of femur.
Unexpected Admission to NICU Ref: 6159	Feb 17 (Declared March 2017)	Following an emergency caesarean section infant was born in poor condition requiring resuscitation. The baby was transferred to the Neonatal Intensive Care unit.
Treatment Delay Ref:7557	Mar 17	Unexpected patient death following an elective procedure.
Sub optimal Care of deteriorating patient Ref:7662	Mar 17	Patient death following emergency surgery
Treatment Delay Ref:9668	Apr 17	De-escalation request has been made. Patient referral letters were not received resulting in a delay of treatment.
Unexpected Death Ref:9728	Apr 17	Patient was admitted for an urgent surgical intervention and subsequently had a cardiac arrest.

The table below details serious incidents by category reported to the NEL CSU. The Trust reported 2 serious incidents during April 2017.

STEIS 2017-18 Category	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Treatment Delay	1												1
Unexpected death	1												1
Total	2												**2**

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 investigation completed and submitted during April 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 1 report to NELCSU during April 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 April/May 2017.

Summary	**Actions taken as result of lessons learnt include;**
Safeguarding Incident • **Ref: 13782**	Safeguarding incident in relation to a patient on a current caseload. • Safeguarding supervision has been reviewed and safeguarding Named Nurse Advisors in operational practice will take on this role for Family Nurse Practitioners (FNP). • All professionals have been reminded that they can instigate a multi agency strategy meeting if concerns are raised in relation to the welfare of a child. • Early referral can now be made to children's services (social care) even if it is not clear the referral meets the threshold for intervention.
Unexpected Death • **Ref:31941**	Patient assessed and discharged by the Mental Health Liaison Team with referral to the crisis team. Patient was subsequently found unresponsive. • A review of the Adult Mental Health Crisis profoma has taken place. This has subsequently been updated to include a section on time of risk assessment, views of patient and relatives, and to link clearly what prescribed level of observation is required. • Establishment, skill mix and allocation within the Emergency Department is being reviewed to ensure that there is an appropriate level of nursing staff presence in the resuscitation

Summary	Actions taken as result of lessons learnt include;
	room at all times.

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.

A 'look back' exercise is taking place to review all serious incidents declared in 2016/17 – to identify any themes and trends and review actions detailed in action plans developed as a result of incident investigations. The findings of this exercise will be detailed in a future report to Trust Board.

Whittington Health NHS

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Whittington Health Trust Board

May 2017

Title:	Safe Staffing - Nursing and Midwifery – April data		
Agenda item:	**17/080**	**Paper**	**4**
Action requested:	For information		
Executive Summary:	This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in April 2017. Key issues to note include: 1. An increased fill rate for Registered Nurses displayed in the UNIFY report 2. Increased shift requests to provide enhanced care to support vulnerable patients April (179) vs March (137) 3. No shifts staff at red were reported in April 4. The number of RMN used to provide enhanced care for patients with a mental health conditions was lower in April (31) compared to March (47). 5. CHPPD measure during the month was increased to (8.84) in April compared to (8.76) on March 6. The continued use of agency and bank staff to support safe staffing. 7. There were no Datix reports in April highlighting staffing as an issue which were defined as “Patient Harm”		
Summary of recommendations:	Trust Board members are asked to note the April 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:	April 2017		

Author name and title:		**Sandra Harding-Brown** **Clinical Workforce Systems Lead (Healthroster)**		**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 April 2017.

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

2.3 Staff fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st – 30th April 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 – 86.3% Night – 92.3%
	Care hours per Patient Day - CHPPD	Overall the CHPPD for April was 8.84 which is lower than last month, the RN delivered care continues to be consistent
Staff are supported in their decision making by effective reporting.	No Red triggered shifts	No shifts triggered 'Red' in April 2017 this was less than March

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 86.3%for registered staff and 116.8%for care staff during the day and 92.3% for registered staff and 121.7% for care staff during the night.

3.3 On the day shift, 17 occurrences reported below 90% fill rates for qualified nurses. Seventeen occurrences with above 100% fill rate for unqualified nurse and four occurrences with 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 and South at above 200% for HCAs. In these areas Band 4 Assistant Practitioners have been appointed as HCAs thereby increasing the HCA workforce on the wards. 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
86.3%	**116.8%**	**92.3%**	**121.7%**

4.0 Additional Staff to provide 1:1 enhanced care

4.1 When comparing April's total requirement for 1:1 staff to provide enhanced care with previous month, the figures demonstrate an increase in the number of shifts required (Appendix 2). April saw 179 requests for 1:1 enhanced care provision compared to 137 requests in March. 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 staff booked for shifts to provide enhanced care for patients with a mental health condition was lower in April (31) compared to March (47). 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 provision of enhanced care for patients with mental health conditions and for caring for 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.

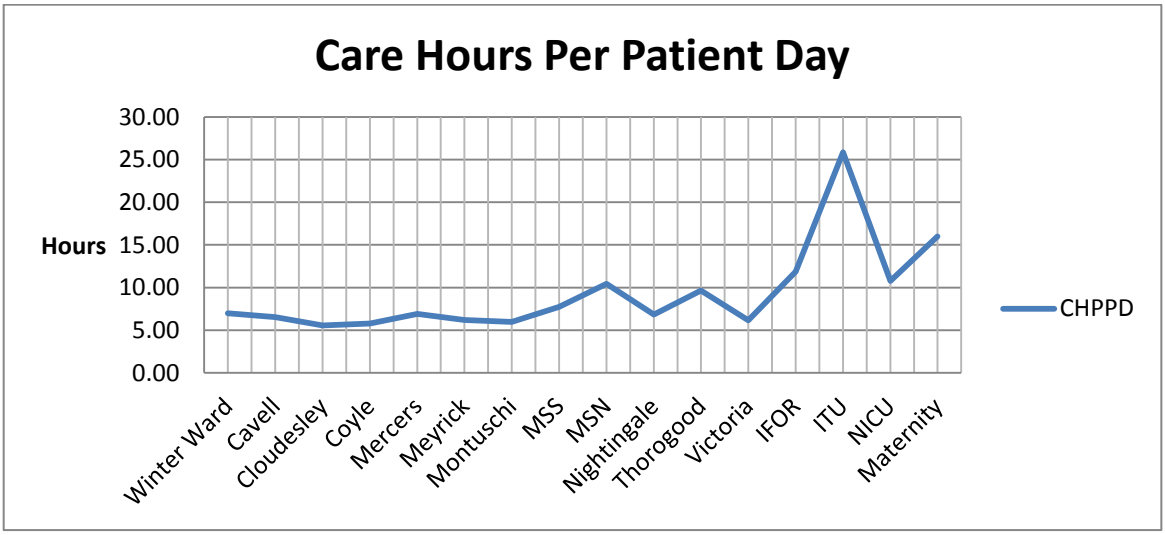
6.0 Reported Incidents of Reduced Staffing (Datix Reports)

6.1 Staff are encouraged to report using the Datix system any incident they believe may affect safe patient care. During April there were 29 Datix reports submitted relating to staffing, none of these incidences related to injury, harm or adverse outcome.

7.0 Care Hours per Patient Day (CHPPD)

7.1 Care hours per patient day is calculated using the patient count on each ward at midnight (23.59hrs). CHPPD is calculated taking the actual hours worked (split by registered

nurses/midwives and healthcare support workers) divided by the number of patients at midnight. The graph below shows the average individual care hours per patient for each clinical area. ITU have the most care hours (25.87) and Cloudesley ward have the least (5.57).



7.2 The average number of hours of Registered Nurse time spent with patients was calculated at 6.25 hours and 2.59 hours for care staff. This provides an overall average of 8.84 hours of care per patient day.

	CHPPD
Registered Nurse	**6.25**
Care Staff	**2.59**
Overall hours	**8.84**

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 increase in hours of care delivered in April compared to March.

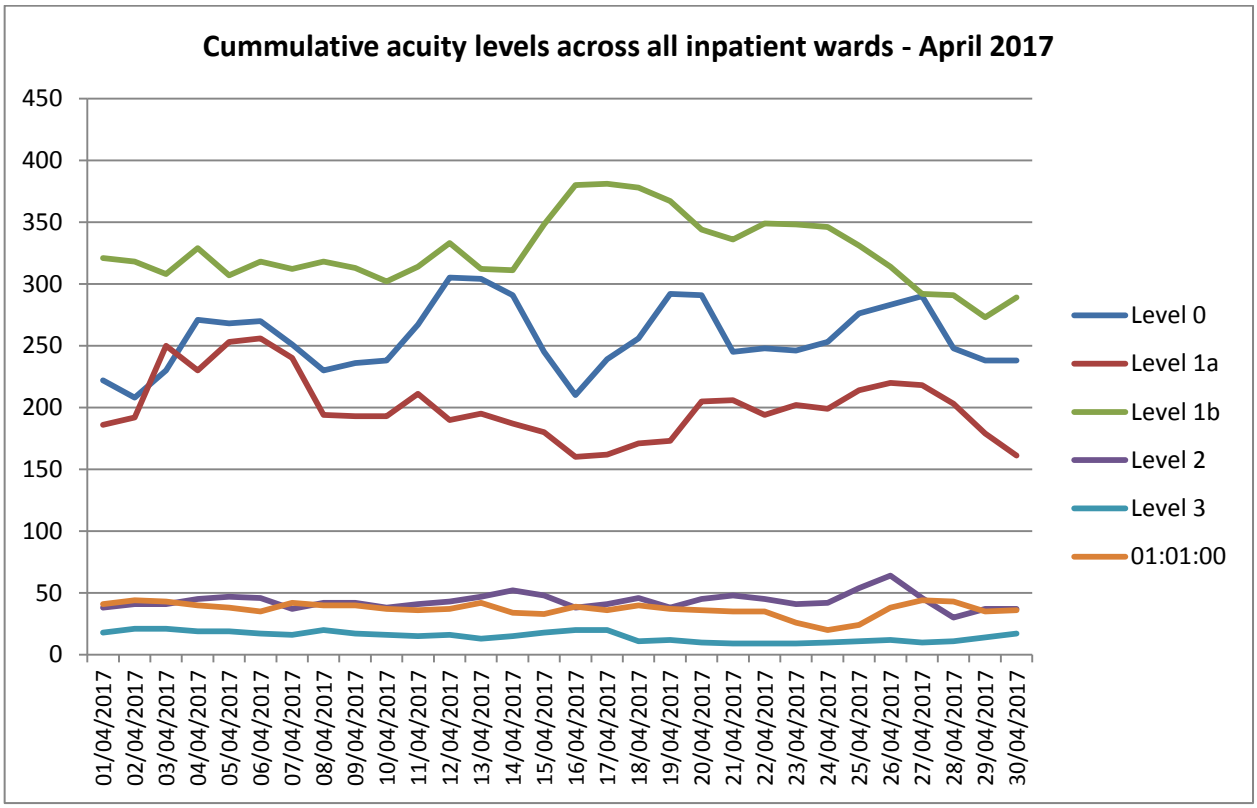
Ward Name	April	March	Feb	Jan
Bridges				
Winter Ward	6.97	6.05	5.97	5.66
Cavell	6.55	6.55	6.70	5.95
Cloudesley	5.57	5.68	5.59	5.39
Coyle	5.78	5.82	6.04	5.96

Mercers	6.90	6.72	6.54	6.81
Meyrick	6.19	6.05	5.82	5.51
Montuschi	5.99	5.16	5.94	6.13
MSS	7.76	7.79	7.02	6.81
MSN	10.43	9.32	9.17	8.39
Nightingale	6.84	6.63	6.02	6.25
Thorogood	9.66	10.36	7.93	6.67
Victoria	6.18	6.17	6.03	5.80
IFOR	11.88	12.45	12.97	12.85
ITU	25.87	26.31	25.36	26.82
NICU	10.77	11.70	11.33	11.30
Maternity	16.00	15.84	13.84	15.87
Total	8.84	8.78	8.46	8.54

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 April. As expected, there are a low number of level 3 patients and a high number of level 0 patients. The number of level 1b patients remains high. This increased number of dependant patients requires a greater nursing support.



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 then 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.

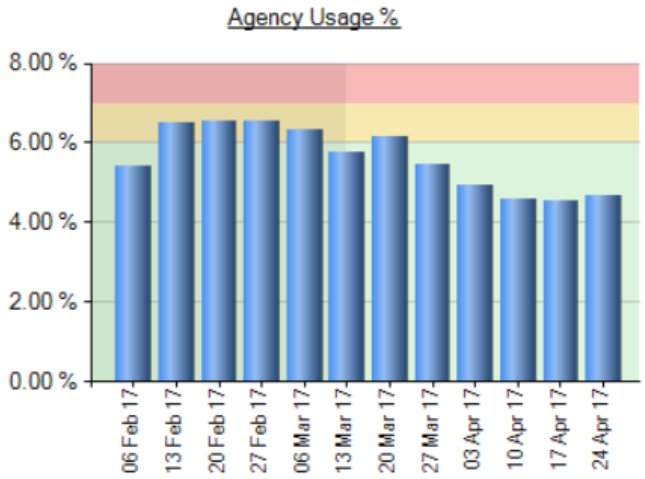
b) The process allows for an overview of the total number of temporary staff (agency) used in different clinical ward areas and provides a monitoring mechanism for the delivery of safe quality care.

10.0 Agency Usage Inpatient Wards (month ending April)

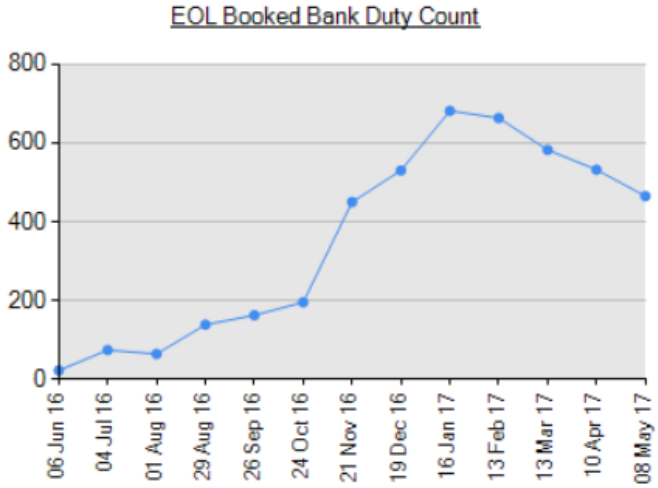
10.1 The utilisation of agency staff across all inpatient wards is monitored using the Healthroster system. The bar chart below graphically represents total usage of agency staff on inpatient wards month ending April (this is cumulative data captured from roster performance reports).

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 April relates to the opening of additional in-patient beds

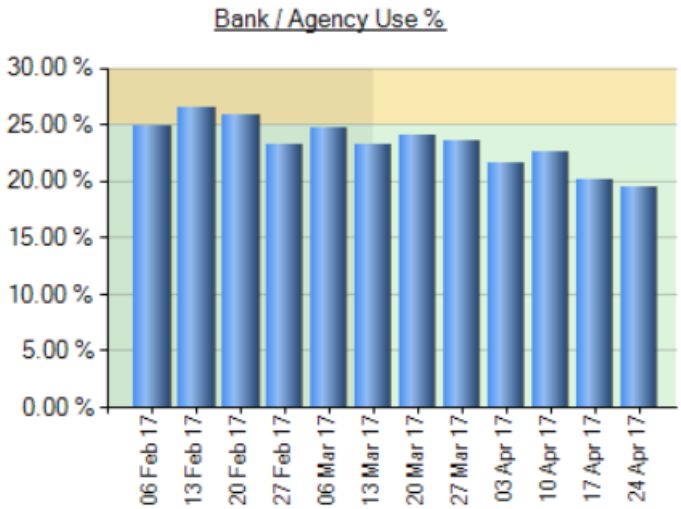


Bank staffs continue to book themselves directly into shifts and this is improving over time. This is however reliant on the wards making these shifts available with sufficient notice.



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.

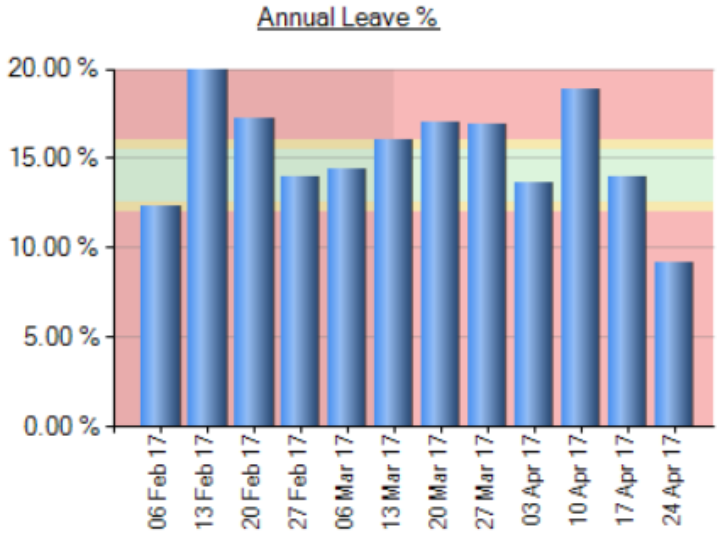
10.4 Temporary staffing usage (Bank and Agency) across inpatients wards remains high and fluctuates between 20 – 24%. Recruitment to reduce the current vacant posts is ongoing.



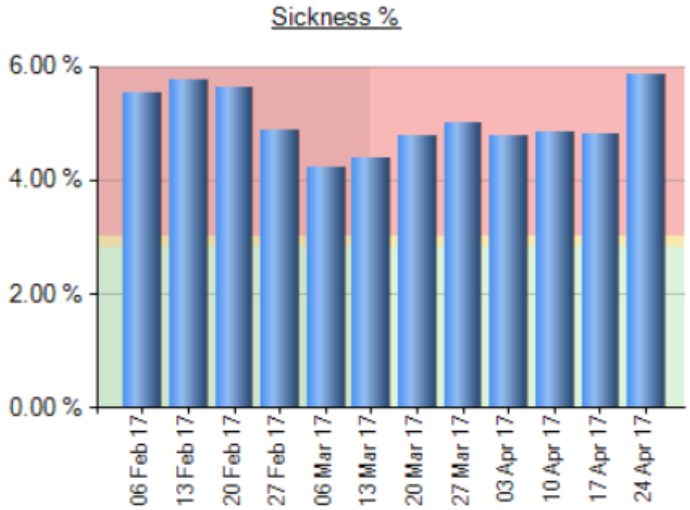
11.0 Managing Staff Resource

11.1 Annual leave taken from April 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 are aware of the need to remind staff to request and take holiday. This was monitored closely over the last couple of months to ensure sufficient staff take annual leave in a more consistent way by year end. The action for 2017/18 will be to monitor this more proactively



11.3 Sick leave reported in April was above the set parameter of less than 3%. Heads of Nursing ensure all individuals reporting back from sick leave undergo a sickness review. Work is underway with the HR Business Partners to review the sickness more regularly.



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 April UNIFY return position

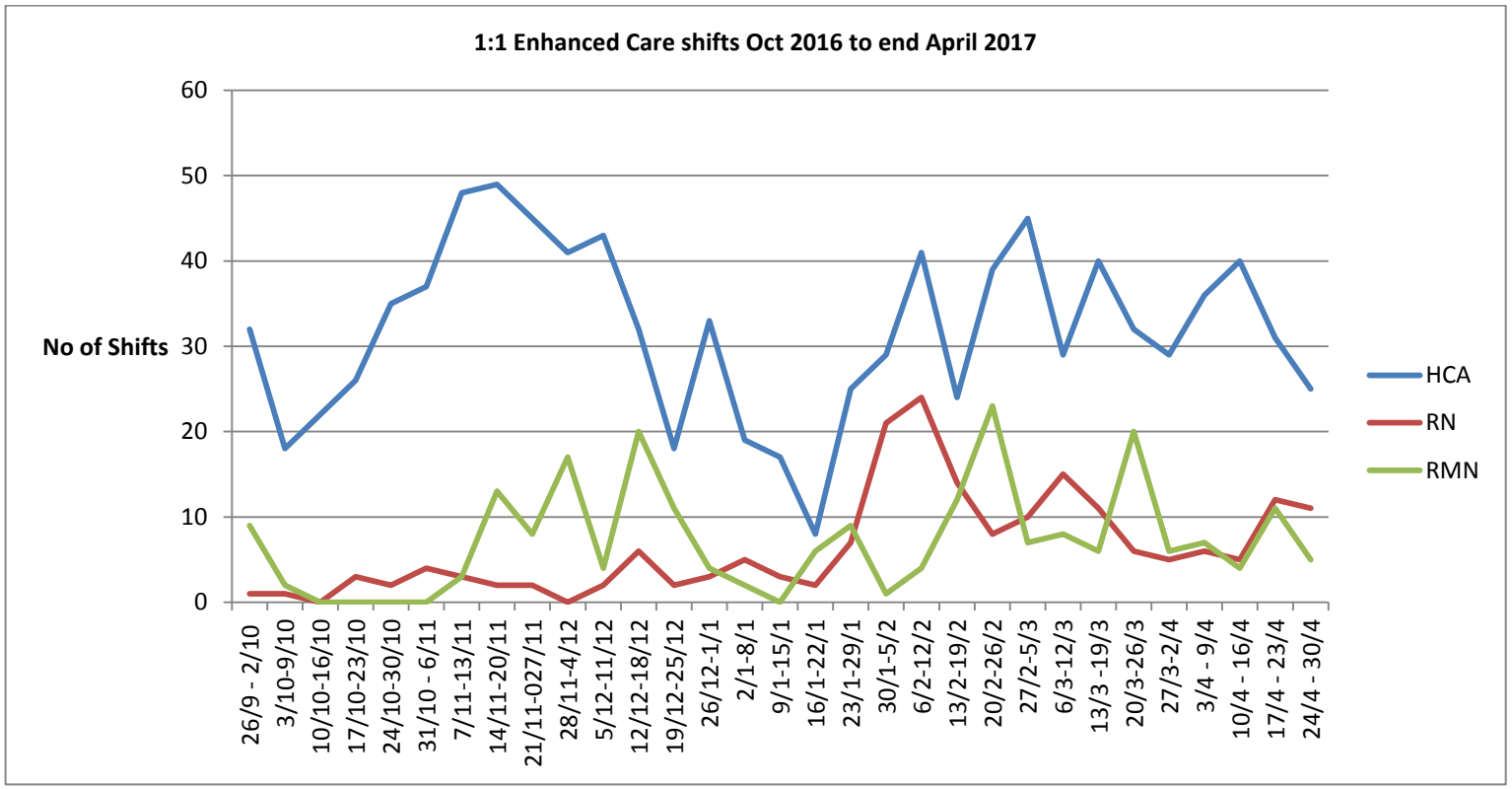
Updated tables

Fill rate data - summary
May 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)				
33821	**29176**	**11013**	**12859**	**27688**	**25560**	**8062**	**9814**	**86.3%**	**116.8%**	**92.3%**	**121.7%**

Care Hours per Patient Day
May 2017

Total Patients at Midnight/Month	CHPPD Registered staff	CHPPD Unregistered staff	Average CHPPD (all staff)
8754	**6.25**	**2.59**	**8.84**


1:1 Enhanced Care shifts Oct 2016 to end April 2017
No of Shifts
60
50
40
30
20
10
0
26/9 - 2/10
3/10-9/10
10/10-16/10
17/10-23/10
24/10-30/10
31/10 - 6/11
7/11-13/11
14/11-20/11
21/11-027/11
28/11-4/12
5/12-11/12
12/12-18/12
19/12-25/12
26/12-1/1
2/1-8/1
9/1-15/1
16/1-22/1
23/1-29/1
30/1-5/2
6/2-12/2
13/2-19/2
20/2-26/2
27/2-5/3
6/3-12/3
13/3 -19/3
20/3-26/3
27/3-2/4
3/4 - 9/4
10/4 - 16/4
17/4 - 23/4
24/4 - 30/4
HCA
RN
RMN

Appendix 3

Average fill rate for Registered and Unregistered staff day and night

	Day		Night	
	Nurses	Care Staff	Nurses	Care Staff
Ward Name	%	%	%	%
Winter Ward	72.9%	109.9%	93.6%	103.4%
Cavell	86.4%	98.3%	100.0%	99.4%
Cloudesley	79.7%	114.5%	107.3%	105.0%
Coyle	81.2%	112.6%	89.7%	99.4%
Mercers	86.8%	100.9%	99.3%	108.6%
Meyrick	82.3%	136.4%	113.1%	146.5%
Montuschi	77.8%	198.3%	109.2%	
MSS	59.1%	225.5%	70.7%	212.3%
MSN	77.5%	134.7%	94.9%	230.0%
Nightingale	106.0%	96.4%	98.2%	109.5%
Thorogood	99.7%	99.9%	99.9%	
Victoria	88.1%	75.7%	75.3%	98.8%
IFOR	87.1%	100.0%	86.6%	100.0%
ITU	100.0%		100.0%	
NICU	80.8%		84.2%	
Maternity	94.6%	129.0%	90.6%	116.6%
Total	86.3%	116.8%	92.3%	121.7%

Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board

7 June 2017

Title:	April (Month 1) 2017/18 – Financial Performance		
Agenda item:	**17/081a**	**Paper**	**5**
Action requested:	To agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends.		
Executive Summary:	The Trust is reporting a £1.7m deficit at the end of April (month 1) against a planned deficit of £1.4m, per the Trust's annual planning submission to NHSI. Actual performance therefore represents an adverse variance of £0.3m. The key driver for the adverse variance is the performance against income, with the combined pay and non-pay expenditure position being favourable to plan. The enhanced financial control measures introduced in quarter 4 of 2016/17 continue to have a positive effect with expenditure run rates remaining in line with those noted at the end of 2016/17. CIP delivery is behind plan at Month 1 and requires continuing focus to ensure plans are fully identified and delivered.		
Summary of recommendations:	To note the financial results relating to performance during April 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:	31 May 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**

Financial Overview

The Trust is reporting a £1.7m deficit at the end of April (month 1) against a planned deficit of £1.4m, per the Trust's annual planning submission to NHSI. Actual performance therefore represents an adverse variance of £0.3m.

The key driver for the adverse variance is the performance against income, with the combined pay and non-pay expenditure position being favourable to plan. The enhanced financial control measures introduced in quarter 4 of 2016/17 continue to have a positive effect with expenditure run rates remaining in line with those noted at the end of 2016/17.

Statement of comprehensive income

2017/18, Month 1 (April 2017)

Statement of Comprehensive Income	Month 1 Plan (£000s)	Month 1 Actual (£000s)	Month 1 Variance (£000s)
Nhs Clinical Income	20,682	20,484	(198)
Non-Nhs Clinical Income	1,949	1,994	45
Other Non-Patient Income	2,232	1,918	(314)
Total Income	**24,863**	**24,396**	**(467)**
Pay	18,276	18,404	(128)
Non-Pay	6,633	6,391	242
Total Operating Expenditure	**24,909**	**24,795**	**114**
EBITDA	**(46)**	**(399)**	**(353)**
Depreciation	721	668	53
Dividends Payable	346	347	(1)
Interest Payable	254	272	(18)
Interest Receivable	(3)	(1)	(2)
Total	**1,318**	**1,286**	**32**
Net Surplus / (Deficit) - before IFRIC 12 adjustment	**(1,364)**	**(1,685)**	**(321)**
Add back impairments and adjust for IFRS & Donate	(13)	0	13
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**(1,351)**	**(1,685)**	**(334)**

Income & Activity

The Trust had planned for a lower activity level in April due to reduced working days, caused by bank holidays and additional weekends. However, even allowing for this the Trust was significantly under contracted level for NHS clinical income.

Outpatients across all the ICSUs were £0.3m adverse in month, with the largest under-performances in Paediatrics, General Surgery & Dermatology, and non-elective activity was £0.4m adverse in month, with the largest under-performances in Gastroenterology. The underperformances in gastroenterology are being investigated as month 1 activity often generates anomalies.

Due to the nature of the contract signed, which has a 50% marginal rate applied to over or under-plan activity, the under-performance was offset by a favourable marginal rate adjustment of £0.4m.

The tables below provide the split of activity and income by category, together with a split of total income across ICSUs.

	Activity			Income		
Category	Month 1 Plan (excluding XBD)	Month 1 Actual (excluding XBD)	Month 1 Variance	Month 1 Plan £'000	Month 1 Actual £'000	Month 1 Variance £'000
Accident and Emergency	5,479	5,388	(91)	865	854	(10)
Adult Critical Care	693	538	(155)	807	658	(149)
Community Block	0	0	0	5,865	5,865	0
Day Cases	1,510	1,322	(188)	1,020	956	(63)
Diagnostics	1,948	1,910	(38)	196	192	(5)
Direct Access	78,232	71,131	(7,101)	855	735	(120)
Elective	165	188	23	643	723	80
Maternity - Deliveries	324	290	(34)	1,066	993	(73)
Maternity - Pathways	615	601	(14)	656	660	3
Non-Elective	1,542	1,617	75	3,106	2,779	(327)
OP Attendances - 1st	4,720	3,871	(849)	822	675	(147)
OP Attendances - follow up	11,319	9,873	(1,446)	726	583	(143)
Other Acute Income	10,933	9,846	(1,087)	2,558	2,850	292
Outpatient Procedures	1,534	1,585	51	273	289	15
Total SLA	**119,016**	**108,160**	**(10,856)**	**19,458**	**18,812**	**(646)**
Other Clinical Income				3,173	3,665	492
Other Non Clinical Income				2,232	1,918	(314)
Total Other	**0**	**0**	**0**	**5,405**	**5,584**	**179**
Grand Total	**119,016**	**108,160**	**(10,856)**	**24,863**	**24,396**	**(467)**

Income breakdown by ICSU		Month 1 Actual £'000
Children's Services	Clinical Income	1,523
	Other Non Clinical Income	10
Children's services total		**1,533**
Clinical Support Services	Clinical Income	1,487
	Other Non Clinical Income	14
Clinical Support Services total		**1,500**
Corporate Services	Clinical Income	9,560
	Other Non Clinical Income	1,776
Corporate Services total		**11,336**
Emergency & Urgent Care Services	Clinical Income	1,309
	Other Non Clinical Income	0
Emergency & Urgent Care Services total		**1,309**
Medicine, Frailty & Networked Services	Clinical Income	3,004
	Other Non Clinical Income	19
Medicine, Frailty & Networked Services total		**3,023**
OP, Prevenetion & LT conditions services	Clinical Income	36
	Other Non Clinical Income	0
OP, Prevenetion & LT conditions services total		**36**
Surgery	Clinical Income	3,261
	Other Non Clinical Income	98
Surgery total		**3,359**
Women & Family Services	Clinical Income	2,298
	Other Non Clinical Income	1
Women & Family Services total		**2,299**
Total Revenue		**24,396**

Monthly Run Rates – Expenditure

As noted above, whilst in total the Trust is reporting an adverse variance to plan, the combined pay and non-pay position is favourable. Main issues of note are:

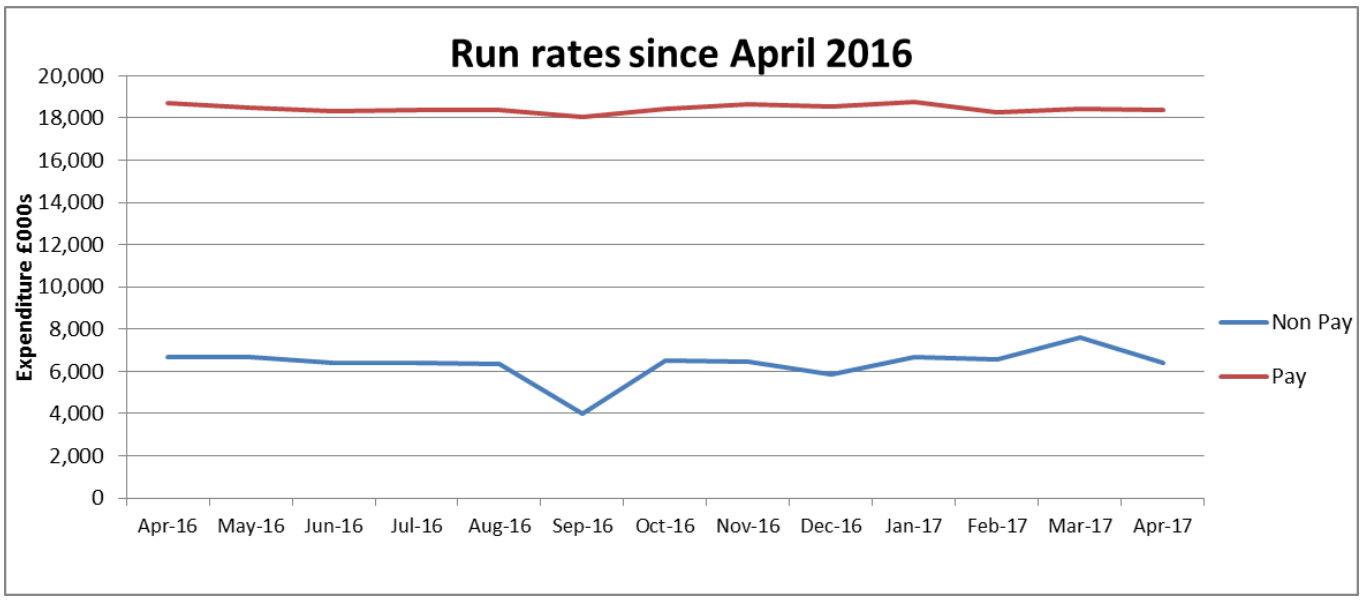
- **Pay**
  Total pay expenditure for April was £18.4m, which is slightly lower than both the month 12 pay spend and the average for 2016/17 (£18.5m).

  Within total pay expenditure agency staff related costs were £1.4m. This is a 9% reduction compared to the average monthly cost of agency staff during 2016/17 (£1.5m). Only CSS had an increase in agency costs compared to month 12 and the average for 2016/17.

  Reducing the cost of agency remains a priority for 2017/18. The Trust has been allocated an agency expenditure ceiling by NHS Improvement and the Trust financial plan assumes a material reduction in expenditure compared to 2016/17. All ICSU and corporate management teams are in the process of agreeing improvement trajectories and progress in the area will be reported frequently via the Finance & Business Development Committee.

- **Non Pay**
  Non pay expenditure for April was £6.4m, which is in line with the average spend in 2016/17, but £1.2m less than month 12. The grip and control measures introduced in the final quarter of 2016/17 continue to have a positive effect in reducing and maintaining expenditure levels and will remain in place for the foreseeable future.

The graph below provides the pay and non-pay expenditure run rates over a 13 month period from April 2016 to April 2017.



ICSU expenditure (actual) run rates were reported against their control totals in the latter months of 2016/17. The table below provides an analysis of the last two months (of 2016/17) pay and non-pay expenditure run rates together with Month 1 for the new financial year.

ICSU Monthly Run Rates

Pay

	Run Rate - Actual		
	2016/17 Month 11 £000s	2016/17 Month 12 £000s	2017/18 Month 1 £000s
Children's & Young People	3,975	3,934	3,896
Clinical Support Services	1,334	1,352	1,423
Emergency & Urgent Care	2,036	2,042	1,992
Integrated Medicine	3,239	2,936	2,953
Patient Access, Prevention & Planned Care	1,025	1,038	1,018
Surgery & Cancer	2,796	3,124	3,138
Women's Health	1,619	1,565	1,553
Total Pay - Clinical ICSUs	16,024	15,991	15,973

Non Pay

	Run Rate - Actual		
	2016/17 Month 11 £000s	2016/17 Month 12 £000s	2017/18 Month 1 £000s
Children's & Young People	142	215	180
Clinical Support Services	1,214	1,580	1,506
Emergency & Urgent Care	203	265	223
Integrated Medicine	199	393	273
Patient Access, Prevention & Planned Care	172	287	154
Surgery & Cancer	555	797	973
Women's Health	131	223	163
Total Non Pay - Clinical ICSUs	2,616	3,760	3,472

Combined Pay & Non Pay

	Run Rate - Actual		
	2016/17 Month 11 £000s	2016/17 Month 12 £000s	2017/18 Month 1 £000s
Children's & Young People	4,117	4,149	4,076
Clinical Support Services	2,548	2,932	2,929
Emergency & Urgent Care	2,239	2,307	2,215
Integrated Medicine	3,438	3,329	3,226
Patient Access, Prevention & Planned Care	1,197	1,325	1,172
Surgery & Cancer	3,351	3,921	4,111
Women's Health	1,750	1,788	1,716
Total Expenditure - Clinical ICSUs	18,640	19,751	19,445

NB – an increase in expenditure run rates for Surgery is to be expected having secured new contracts for dental activity. This is offset by an increase in the Trust's income.

Cost Improvement Programme

The Trust has a £17.8m CIP target for 2017/18. To date £10.3m of plans have been identified, with a balance of c. £7.5m still to be identified.

The Trust's planning submission identified a delivery of £1.1m in month 1. Actual delivery achieved was £0.4m resulting in a shortfall of £0.7m against plan.

Integrated Clincial Service Unit	Annual Plan £'000	Identified £'000	Gap £'000	Month 1 Actual £'000
Children's services	3,065	2,174	891	82
Clinical Support Services	2,334	1,187	1,147	25
Emergency & Urgent Care	2,157	910	1,247	41
Medicine, Frailty & Network Services	2,132	1,424	708	45
Outpatients Prevention & LTC	874	640	234	23
Surgery	3,159	1,996	1,163	114
Women's services	1,498	870	628	19
Estates & Facilities	1,322	546	776	5
Corporate	1,236	576	660	38
Total	**17,777**	**10,323**	**7,454**	**392**
Month 1 Plan (per planning submission)				1,098
Shortfall against plan at month 1				**(706)**

The Trust has taken advantage of the Finance Improvement 2 contract to procure the support of the Boston Consulting Group to ensure that the Trust has £17.7m of plans that are within the roadmap project management system, quality impact assured and demonstrating delivery by the end of July.

Statement of Financial Position

THE WHITTINGTON HEALTH NHS TRUST

Statement of Financial Position

			Year to Date
	As at 30 April 2017 £000	Plan 30 April 2017 £000	Plan variance 30 April 2017 £000
Property, plant and equipment	209,186	201,695	7,491
Intangible assets	3,946	2,973	973
Trade and other receivables	693	846	(153)
Total Non Current Assets	**213,825**	**205,514**	**8,311**
Inventories	1,799	1,500	299
Trade and other receivables	22,263	20,835	1,428
Cash and cash equivalents	5,965	3,107	2,858
Total Current Assets	**30,027**	**25,442**	**4,585**
Total Assets	**243,852**	**230,956**	**12,896**
Trade and other payables	36,470	38,749	(2,279)
Borrowings	1,802	485	1,317
Provisions	379	762	(383)
Total Current Liabilities	**38,651**	**39,996**	**(1,345)**
Net Current Assets (Liabilities)	**(8,624)**	**(14,554)**	**5,930**
Total Assets less Current Liabilities	**205,201**	**190,960**	**14,241**
Borrowings	60,158	62,083	(1,925)
Provisions	1,773	1,541	232
Total Non Current Liabilities	**61,931**	**63,624**	**(1,693)**
Total Assets Employed	**143,270**	**127,336**	**15,934**
Public dividend capital	62,404	62,404	0
Retained earnings	(12,862)	(13,144)	282
Revaluation reserve	93,728	78,076	15,652
Total Taxpayers' Equity	**143,270**	**127,336**	**15,934**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**

Property, Plant & Equipment: The value held at the end of April is £7.5m above plan, following the full valuation exercise undertaken as at 31 March 2017. The results of valuation were higher than those in the Trust's planning submission in December.

Trade Receivables are currently £1.4m above plan, the main driver for which is additional STF agreed as a result of the Trust achieving its financial targets for 2016/17. In total circa £4.2m of STF was owing at the end of April, which is expected to be received in June. This is offset by the continuing collection of debts with other organisations (both NHS & Non NHS).

Payables are currently £2.3m below plan. The positive variance is largely driven by significant clearance of outstanding creditors prior to year end. During 2017/18 to date, the Trust has been paying creditors within the statutory 30 day period.

Cash: The cash balance is £2.9m above plan at the end of month 1. This is due to the receipt of settlements for 2016/17 from CCGs made immediately after year end. The Trust continues to manage cash in a sustainable way to ensure that it remains a going concern through 2017/18.

Whittington Health NHS

The Whittington Hospital NHS Trust

Magdala Avenue

London N19 5NF

Trust Board

7 June 2017

Title:	Capital Programme 2017/18-2020		
Agenda item:	**17/081.b**	**Paper**	**5.a**
Action requested:	To approve the capital programme		
Executive Summary:	The paper outlines the draft capital plan for three financial years beginning 2017-18. It links to the annual operating plan submitted to NHSI in March and reflects the additional funding received for exceeding the agreed control target.		
Summary of recommendations:	The Trust Board is asked to 1. Note allocation criteria and latest risk evaluation; and 2. Approve the Capital Programme to go forward to the Trust Board		
Fit with WH strategy:	Delivering efficient, affordable and effective services. Meet statutory financial duties.		
Reference to related / other documents:	2017/18 Operational Plan, Corporate Risk Register and Board Assurance Framework		
Date paper completed:	2nd June 2017		

Author name and title:				**Director name and title:**		**Stephen Bloomer Chief Financial Officer**	
Date paper seen by EC	**6th June**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**yes**

Report to the Trust Board

Three Year Capital Programme 2017/18 -2019/20

7th June 2017

The paper outlines the draft capital plan for three financial years beginning 2017-18. It links to the annual operating plan submitted to NHSI in March and reflects the additional funding received for exceeding the agreed control target.

1 Background

Capital is based on the affordable cash position

1.1 The Capital Programme sets out the asset investments for the period being cognisant of the strategic aspirations of the Trust and the need to ensure that the current asset base is fit for purpose.

As a deficit Trust in receipt of Government support funding is limited

1.2 The capital allocation is based on the affordable cash position after accounting for PFI and capital financing liabilities. As a Trust in deficit Whittington Health requires funding to support its deficit to enable the release of non-cash expenditure to support its capital ambitions. The current cash constraints within the health system mean that there is a strong challenge to only fund those items of high risk in the coming financial year.

The Capital Management Group (CMG) oversee the process and monitor capital risk

1.3 The Trust has a Capital Management Group that oversees allocation of capital funding to the identified high risk areas and strategic priorities. The Group recommends a capital programme to the Trust Management Group.

1.4 In order to ensure that the capital programme addresses appropriate risk the key areas of capital spend ICSUs, Medical Physics, Information Technology, Governance and Risk and Estates are engaged in an exercise to evaluate the risks held within the Corporate Risk Register, Local Risk Registers and Board Assurance Framework. This has been completed and the output shown in the paper.

The CMG oversee in year performance and take corrective action

1.5 The Capital Monitoring Group oversees the programme making appropriate changes to funding to take account of timing difficulties or in year risk.

2 Detail

The Trust submitted an annual plan with £5.5m of available capital funding

2.1 The 2017-18 and 2018-19 operating plans for the Trust, outlines a capital funding availability £8.5m p.a. for 2017/18 reducing to £8m for the latter two years. This was calculated on the basis of forecast depreciation for 2017-18. Once PFI, MES and loan commitments have been removed from this, the remaining capital forecast was £5.5m. This is calculated as follows:

	17/18 £'000	18/19 £'000	19/20 £'000
Internal Funding	8,500	8,000	8,000
Contractual commitments:			
MES	1,987	2,052	1,750
PFI	888	948	916
Capital Loan interest	164	164	164
Internal funding after commitments	**5,461**	**4,836**	**5,170**
External Funding			
STF	2,600		
Charitable Donations		1,000	
Maternity Funding		7,000	
Total Funding Available	**8,061**	**12,836**	**5,170**

Please note this excludes dental mobilisation funding

There are additional capital funding sources in 2017/18 being £2.6m for exceeding the 16/17 control total and £1m from the Charity

2.2 In addition to the internally generated funding there are assumed external sources of funding and they are:

- £2.6m additional STF payments achieved for exceeding the agreed control target and this will be primarily used as funding towards the maternity project. This was confirmed by NHSI in April;
- £7m towards the maternity redevelopment as per the business case which has yet to be agreed; and
- £1m donation from the Whittington Health charitable fund for the maternity project which was agreed by the Charitable Funds Committee in January 2017.

2017/18 funding is £8.1m

2.3 For 2017/18 this gives a total funding of £8.1m of confirmed funding which exceeds the operational plan submitted in March.

The Trust will write to NHSI asking to increase the capital spending limits for 2017/18

2.4 At the time of writing the Trust has not received the agreed external funding or capital spending limits and will write to NHSI to get agreement for the higher than originally planned capital spend in year.

The programme is linked to risk to ensure the highest risk items are funded as priority.

2.5 Despite the increased allocation the capital need within the organisation is higher than the funding available so therefore the a risk based criteria has been applied and funding is allocated to high level (red) risks where mitigations are not available and the current risk is unsustainable. The risk based criteria is:

1. Highest priority group comprises of:

   - Honouring historical and contractual commitments
   - All risk register entries of 20 and above, including:
     i. Patient Safety and Quality of Care;
     ii. Strategic Board Priorities (e.g. Maternity);
     iii. CQC Requirements; and
     iv. Operating Delivery.
   - Commitments made via the financial turnaround and PMO to facilitate scheme delivery

2. Risk Register entries with a risk rating of between 16 and 20.

3. Risk register entries with a risk rating of less than 16

4. Business Cases Developments

CMG analysed all reported capital risks

2.6 In Q4 2016/17 CMG undertook an analysis of risk using the Board Assurance Framework, Corporate Risk Register, local Risk Registers, the list of assets in use which are over the normal depreciated age and the medical physics risk analysis.

CMG and the corporate risk team moderated the risk scoring and agreed the priorities

2.7 CMG helped by the corporate risk team went through the detail of the high risk areas to moderate and end ensure that scoring is broadly similar and having done this put together the 2017/18-2019/20 capital plan.

The key red risks are

2.8 The key red risks identified by the ICSU's and departments were:

- The physical estate for maternity services;
- Decontamination washers;
- Heating systems in L bloc;
- Improvements relating to fire doors and safety;
- Replacement of old IMT stock and licences linked to cyber security risks;
- Replacement of theatres stacks for trauma and orthopaedics; and
- Replacement of central stations and monitors

There were no capital related red risks remaining

2.9 There are no red risks outstanding on capital backlog maintenance after funding from this programme on the Corporate Risk Register (June 2017) or BAF (June 2017) and the latest a current red risk is replaced is 2018/19.

The plans introduce rolling asset replacement programmes

2.10 A number of rolling asset replacement schemes are included in this programme which include:

- Heating and energy efficiency, fire compliance and water safety in Estates and facilities
- IMT rolling programme for end user devices and infra-structure
- Bed replacement and patient monitor replacement

New developments can only be funded if they provide equivalent revenue benefits

2.11 The Trust does not have the capacity to fund development assets e.g. large IMT projects or new estate unless there are gains from business cases or CIP schemes that fund the revenue consequences of the cost of capital.

The capital plan is set out Appendix 1

2.12 Appendix 1 sets out the capital plan allocation. The allocation does not take account of the potential developments that could fall within the remit of a strategic estates partnership (SEP) which it is hoped would help the Trust develop an innovative and modern estate.

2.13 CMG approved the plan on June 2nd for approval by the Trust Management Group to go to Trust Board on June 7th

3 Recommendations

TMG is asked approve the capital programme to go forward at the Trust Board

3.1 The Trust Management Group are asked to

1. Note allocation criteria and latest risk evaluation; and

2. Approve the Capital Programme to go forward to the Trust Board

APPENDIX 1

Capital Programme 2017/19-2020

	17/18	18/19	19/20
	£'000	£'000	£'000
Estates Projects			
Maternity	2,200	7,800	-
Endoscopy washers	500	-	-
Heating L Block	75		
H Block Delapidations	50	50	
Escalator	30		
Norther Centre Lift		50	
Security systems	20	10	10
Heating, ventilation, air conditioning and controls	75	75	75
Asbestos	50	50	25
Water Safety	75	75	75
Fire saftey	150	50	50
Windows	50	50	50
Electrical	75	75	75
Pharmacy WOS estates works	255		
Roofing	150	150	150
SPEC CT Lead Lining	240		
Building fabrics internal & external	40	100	100
NICU improvement works	300	600	
Backlog Maintenance	100	215	540
Total	4,435	9,350	1,150
Medical Equipment			
Endoscopes	45	50	50
Haemodialysis Machine	25		
Theatre Stacks	52		
Mortuary Equipment	15		
8 ITU Beds	38	50	50
Transport Ventilator	30		
Omnifuse Pumps	28		
Patient Monitors	200	200	200
Incubators	70	70	70
Ultrasound	80	80	80
Scopes	50	50	50
Beds	50	50	50
Diathermy	100	10	10
Ventilators	50	50	50
ECG writer	40		
Dexa machine	75		
Omnicell	30		
General Replacement	365	500	1,200
Total	1,343	1,110	1,810
Information Technology			
IM&T computers & Apple Devices rolling replacement	400	400	660
Cyber-Security	200	200	200
Microsoft Licences	208		
Mobile EPR Devices (400 iPods)	75		
Total	883	600	860
Other			
PMO	500	676	250
Project Team costs	300	500	500
Contingency	600	600	600
Total	1,400	1,776	1,350
Total Programme	**8,061**	**12,836**	**5,170**

Whittington Health NHS

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

Whittington Health Trust Board
7th June 2017

Title:	Trust Board Report May 2017 (April 2017 data)		
Agenda item:	**17/082**	**Paper**	**6**
Action requested:	For discussion and decision making		
Executive Summary:	**Highlights** **Emergency and Urgent Care** Performance continues to improve and ED has over achieved on the agreed trajectory for April (90%) and is on target to achieve the May performance trajectory. This is despite the ED facing continued demand and also hitting very high number of attendances on several days over April. Improvement work is ongoing both on the admitted and non-admitted pathway to support attainment of the agreed monthly performance trajectory. This includes implementing the recommendations from the ECIP Reviews. **Cancer** Breast symptomatic under achieved by 0.1% due to 3 patient's DNA and rebooking could not be accommodated due to unavailability of radiologists. **Delayed Transfer of Care % of Occupied Bed days** Improved recording of medically optimised patient as resulted in a minor increase in DTOC patients. Improvements are being made in flow management to increase accuracy of estimated dates of discharge (EDD) through the use of Red to Green and standardisation of board rounds. **Emergency Re-Admission within 30 days** A small number of patients, who have been re-admitted several times over a short period, have been identified as the main cause of the increase in re-admissions. There are still patient who are seen in Ambulatory Care, who potentially require an elective procedure, who get admitted as a re-admission, these case also have an impact on the increase percentage. **FFT** FFT overall response rate dropped significantly affected by the Easter holiday falling during April 2017 **Hospital DNA** Remains 2% above target. This indicator is targeted in the Out-		

	patients Improvement Programme. As part of the Outpatient Plan the following initiatives should impact and reduce DNA rates • e-RS (Electronic Referral System) previously Choose and Book. There is an NHS e-Referrals CQUIN 2017/18 – 2018/19 that relates to GP referrals to Consultant-led 1st outpatient services and the availability of services and appointments on the NHS e-Referral Service. • As a provider Organisation to publish ALL such services and make ALL of our First Outpatient Appointment slots available on NHS e-Referral Service (e-RS) by 31 March 2018. Studies have shown that Electronic booking reduces patient-initiated cancellation of appointments, most likely because the patient has been able to select a convenient date in the first place. **HR** Both Appraisal and Mandatory Training compliance remain static at 80% and 82% respectively. Sickness absence remains below the threshold at 2.7%. **Complaints** Whittington Health is compliant in April at 100%
Summary of recommendations:	That the board notes the performance.
Fit with WH strategy:	All five strategic aims
Reference to related / other documents:	N/A
Reference to areas of risk and corporate risks on the Board Assurance Framework:	N/A
Date paper completed:	30th May 2017

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

Whittington Health NHS

Integrated Performance Report

May 2017

Month 1 (2017 – 2018)

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Caring Services	6
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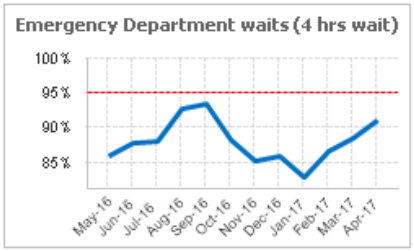
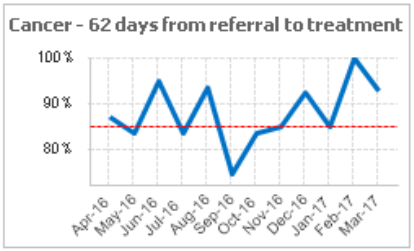
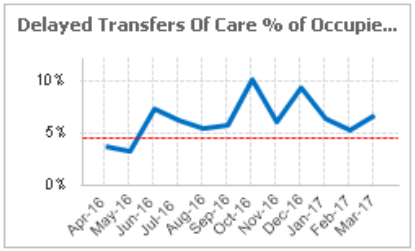
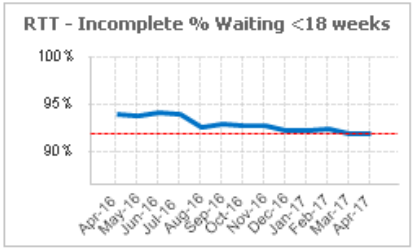
Summary Page - Indicators

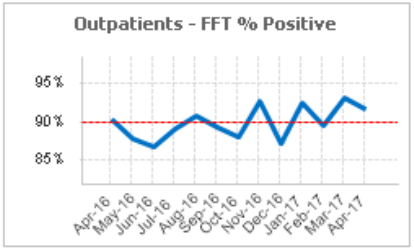
Category	Indicator	17_18 Target	Q1 May-16	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	2017-2018
ED	Emergency Department waits (4 hrs wait)	>95%	85.9%	87.7%	87.9%	92.7%	93.4%	88.1%	85.1%	85.8%	82.9%	86.6%	88.4%	91.1%	91.1%
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	88	85	87	60	62	75	88	76	77	69	72	72	72
Cancer	Cancer - 14 days to first seen	>93%	96.4%	96.4%	97.3%	97.7%	96.6%	97.8%	95.5%	93.4%	94.8%	96.8%	94.6%		
Cancer	Cancer - 62 days from referral to treatment	>85%	83.6%	94.9%	83.3%	93.5%	74.5%	83.3%	85.0%	92.3%	84.9%	100.0%	92.9%		
Admitted	Non Elective Re-admissions within 30 days	<5.5%	5.6%	6.8%	6.4%	6.3%	5.7%	5.9%	5.9%	6.0%	4.8%	5.7%	6.3%	6.1%	6.1%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	3.4%	7.4%	6.3%	5.5%	5.7%	10.1%	6.1%	9.3%	6.3%	5.4%	6.7%		
Access	RTT - Incomplete % Waiting <18 weeks	>92%	93.8%	94.2%	93.9%	92.7%	93.1%	92.9%	92.8%	92.2%	92.2%	92.4%	92.0%	92.0%	92.0%
Outpatients	Outpatients - FFT % Positive	>90%	87.7%	86.7%	89.1%	90.8%	89.2%	88.0%	92.6%	87.0%	92.5%	89.4%	93.1%	91.6%	91.6%
Community	Community - FFT % Positive	>90%	97.5%	97.5%	97.9%	97.5%	98.4%	98.1%	98.2%	98.7%	98.0%	96.8%	96.0%	98.5%	98.5%
Staff	Staff - FFT % Recommend Care	>70%		80.1%			76.2%						74.6%		

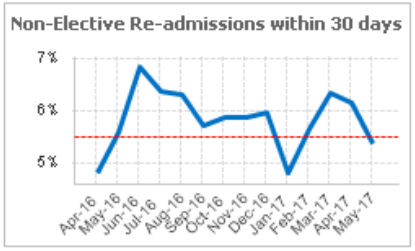












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Safe Services - Indicators and Performance

Category	Indicator	17_18 Target	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	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	2017-2018	Performance
Admitted	Admissions to Adult Facilities of pts under 16 yrs of age	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Admitted	HCAI C Difficile	<17	1	1	1	0	0	0	0	0	0	1	1	2	2	
All Areas	CAS Alerts Outstanding	0	0	0	0	0	0	0	0	0	0	3	0	0	0	
All Areas	Actual Falls	400	26	36	26	31	38	45	30	45	56	45	31	31	31	
All Areas	Avoidable Grade 3 or 4 Pressure Ulcers	0	2	1	3	5	5	5	1	3	2	1	2			
Admitted	Harm Free Care %	>95%	92.6%	93.5%	93.8%	91.9%	90.8%	93.3%	92.6%	93.2%	94.3%	92.9%	92.5%	93.2%	93.2%	
Maternity	Non Elective C-Section % Rate	>15%	18.9%	17.7%	16.4%	17.4%	20.2%	17.7%	21.6%	17.4%	20.5%	18.0%	21.4%	19.2%	19.2%	
All Areas	Medication Errors causing serious harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Admitted	MRSA Bacteraemia Incidences	0	0	0	0	0	0	1	0	0	0	1	0	0	0	
Admitted	Never Events	0	0	0	0	1	0	1	0	0	0	0	0	0	0	
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%	19.5%	22.4%	18.1%	18.1%	
All Areas	Serious Incidents	0	6	3	3	4	6	9	8	3	4	5	4	2	2	
Admitted	VTE Risk Assessment %	>95%	96.0%	96.3%	98.0%	96.2%	96.6%	97.3%	96.4%	95.9%	96.1%	96.0%	96.5%			

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Safe Services - Commentary

C.difficile associated diarrhoea
Two patients were diagnosed with trust attributable C. difficile associated diarrhoea since April 1st 2017, one surgical patient and one medical patients. Wards: Coyle and Cloudesley. Early investigation has not pointed to evidence of cross contamination as an underlying cause nor do any cases appear to be related to lapses in care. The wider IPC team have high vigilance about early detection and testing for CDAD in our patients and regular communications about CDAD are included in staff briefings/education sessions.

Actual falls
Out of the 31 falls in April 17, one resulted in moderate harm, but the incident happened in sheltered accommodation and was not attributable to Whittington Health.

Avoidable pressure ulcer
No avoidable PU's in the hospital. Community data not available yet.

Harm Free Care
This figure included new and old harm and scores consistently under the target due to the number of Pressure Ulcers in the community.

Non Elective C-section rate
Reduced to 19%
Whittington Health compared to other NCL Trust is not an outlier. The metrics require change in line with the national standards; a working group has been set up to address this.

Serious incidents
The trust reported 2 SI in April 2017. Both of these incidents were in Surgery and are in the process of investigation.

Caring Services - Indicators and Performance

Category	Indicator	17_18 Target	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	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	2017-2018	Performance
ED	ED - FFT % Positive	>90%	92.0%	87.7%	89.4%	92.4%	95.6%	89.9%	82.1%	83.8%	83.4%	83.9%	83.0%	84.0%	84.0%	
ED	ED - FFT Response Rate	>15%	4.8%	5.1%	4.5%	3.4%	4.1%	4.1%	16.6%	16.6%	14.6%	16.0%	14.6%	16.9%	16.9%	
Admitted	Inpatients - FFT % Positive	>90%	93.6%	95.7%	96.7%	96.0%	95.1%	95.8%	92.7%	95.8%	92.1%	96.1%	94.1%	98.0%	98.0%	
Admitted	Inpatients - FFT Response Rate	>25%	15.5%	15.5%	19.3%	15.4%	20.4%	18.3%	18.0%	12.6%	7.2%	17.1%	26.8%	21.6%	21.6%	
Maternity	Maternity - FFT % Positive	>90%	92.1%	94.6%	91.6%	93.2%	91.1%	91.6%	93.8%	94.8%	88.0%	89.4%	92.4%	93.6%	93.6%	
Maternity	Maternity - FFT Response Rate	>15%	16.1%	18.3%	10.5%	18.9%	24.2%	23.1%	12.8%	24.6%	30.4%	24.0%	27.8%	24.7%	24.7%	
Outpatients	Outpatients - FFT % Positive	>90%	87.7%	86.7%	89.1%	90.8%	89.2%	88.0%	92.6%	87.0%	92.5%	89.4%	93.1%	91.6%	91.6%	
Outpatients	Outpatients - FFT Responses	400	171	166	229	229	305	408	516	193	481	407	551	357	357	
Community	Community - FFT % Positive	>90%	97.5%	97.5%	97.9%	97.5%	98.4%	98.1%	98.2%	98.7%	98.0%	96.8%	96.0%	98.5%	98.5%	
Community	Community - FFT Responses	1500	752	628	563	609	621	645	880	549	697	1095	1169	725	725	
Staff	Staff - FFT % Recommend Care	>70%		80.1%			76.2%						74.6%			
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%	90.0%	100.0%	100.0%	100.0%	
All Areas	Complaints (including complaints against Corporate division)	N/A	23	31	26	38	32	25	19	32	22	34	38	22	22	
Community	End of Life % of patients dying in Pref. Place of care - DN	>70%	100.0%	96.0%	84.4%	85.7%	72.0%	71.4%	85.7%	83.3%	90.9%	90.7%	89.5%	83.3%	83.3%	

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Caring Services - Commentary

FFT
Part of April included the Easter holidays which affected the response rate for this month. ED percentage of positive responses increased by 1%, the response also rate increased. Inpatient response rate decreased by 5%, but the percentage of positive responses increased by 3.9%. Outpatients and community response rate fell, however the percentage of positive stayed above target.
Main arears of drop in response rate: District Nursing, MSK, Oral surgery, PT, SLT and SN.

End of life percentage of patients dying in preferred choice of care
Target achieved

Complaints
During April 2017 the Trust had 22 complaints requiring a response, 11 of which were required within 25 working days. The Trust achieved a performance of 100%, exceeding its target of 80%. 11 complaints were allocated 40 working days for investigation, 3 of which remain outstanding and overdue i.e. PPP (1), IM (1) and Surgery (1).

The majority of the complaints had been allocated to EUC 27% (6) and PPP 27% (6). 4 (18%) complaints were designated 'high risk', 5 (23%) were 'moderate' and 13 (59%) 'low'.

A review of the complaints for April shows that 'medical care' 23% (5) and 'communication' 23% (5), accounted for the majority of complaints. In regards to 'medical care most patients 60% (3) felt that 'inadequate treatment' had been provided, and in regard to communication 40% (2) felt that the communication included 'incorrect details'. In addition, 14% (3) complaints highlighted 'attitude' as the main concern with 67% (2) indicating that "inappropriate behaviour" had been displayed by a staff member.

Of those complaints that have closed (including those allocated 40 working days) 42% (8) were 'upheld', whilst 32% (6) were 'partially upheld', meaning that 74% of the 19 closed complaints were upheld in one form or another.

Effective Services - Indicators and Performance

Category	Indicator	17_18 Target	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	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	2017-2018	Performance
Maternity	Breastfeeding Initiated	>90%	93.4%	90.5%	95.2%	91.5%	90.6%	94.2%	90.2%	90.1%	90.1%	90.6%	91.6%	90.6%	90.6%	
Maternity	Smoking at Delivery	<6%	6.6%	6.2%	3.9%	4.4%	4.8%	3.2%	5.1%	4.8%	3.6%	5.6%	3.0%	5.4%	5.4%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	5.6%	6.8%	6.4%	6.3%	5.7%	5.9%	5.9%	6.0%	4.8%	5.7%	6.3%	6.2%	6.2%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	80.4	75.0	117.4	89.4	62.3	79.3	84.5	59.7	74.6					
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	123.9	64.8	83.3	82.2	89.7	76.7	85.7	22.2	92.9					
Trust	Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 mont...	1.14		0.69			0.69									
Admitted	Mortality rate per 1000 admissions in-months	14.4	4.7	6.1	5.8	5.8	4.2	6.5	7.9	7.2	11.7	9.1	7.9	7.2	7.2	
Community	IAPT Moving to Recovery	>50%	51.6%	48.0%	50.0%	51.7%	52.3%	45.7%	47.1%	52.4%	50.4%	49.1%	48.4%	50.3%	50.3%	

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Effective Services - Commentary

Non Elective Re-admission

Above target, decrease of 0.1%.

A small number of patients, who have been re-admitted several times over a short period, have been identified as the main cause of the increase in re-admissions... These are predominately in integrated medicine and Emergency and Urgent ICSUs.

IAPT

March and year end data

The recovery rate for March decreased from 49.12% in February to 48.43% in March, whilst 64.31% showed a reliable improvement in their symptoms. The recovery rate for the financial year of 2016/17 is 49.55% and the reliable improvement 66.41%. Both year-end outcomes show improvement over the previous years. A preview of April outcomes shows a recovery rate of 50.02%, and our highest reliable improvement recorded since the inception of the service at 75% in the month of April. Patient Satisfaction continues to exceed the 95% mark.

Responsive Services - Indicators and Performance

Category	Indicator	17_18 Target	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	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	2017-2018	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	85.9%	87.7%	87.9%	92.7%	93.4%	88.1%	85.1%	85.8%	82.9%	86.6%	88.4%	91.1%	91.1%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	88	85	87	60	62	75	88	76	77	69	72	72	72	
ED	Ambulance handovers waiting more than 30 mins	0	20	28	31	13	16	26	45	68	113	68	60			
ED	Ambulance handovers waiting more than 60 mins	0	2	9	0	1	0	1	4	22	37	13	3			
ED	12 hour trolley waits in A&E	0	0	1	1	0	1	1	1	0	2	3	2	5	5	
Cancer	Cancer - 14 days to first seen	>93%	96.4%	96.4%	97.3%	97.7%	96.6%	97.8%	95.5%	93.4%	94.8%	96.8%	94.6%			
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	95.4%	99.2%	100.0%	100.0%	100.0%	97.2%	98.2%	100.0%	93.4%	98.7%	92.9%			
Cancer	Cancer - 62 days from referral to treatment	>85%	83.6%	94.9%	83.3%	93.5%	74.5%	83.3%	85.0%	92.3%	84.9%	100.0%	92.9%			
Cancer	Cancer - 31 days to first treatment	>96%	100.0%	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%			
Cancer	Cancer - 62 Day Screening	>90%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%			
Cancer	Cancer - 62 Day Upgrade															
Access	DM01 - Diagnostic Waits (<6 weeks)	>99%	99.4%	99.9%	99.3%	99.5%	99.7%	99.5%	99.8%	99.1%	99.1%	99.6%	99.2%	99.0%	99.0%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	93.8%	94.2%	93.9%	92.7%	93.1%	92.9%	92.8%	92.2%	92.2%	92.4%	92.0%	92.0%	92.0%	
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 continued improved during April despite the ED facing continued demand and also hitting very high numbers attendances *(in excess of 310 against an average of 260)* on a number of days over April. The improvements are a reflection of the implementation of continued changes within ED and across the hospital. The organisation also managed to over achieve against its predicted trajectory of 90% for April which is set to support attainment of 95% agreed trajectory by July 17. LAS hand over times have also improved over recent months as the LAS hand over triage nurse has embedded into practice.

The organisation is now focusing its efforts on reducing the median time to treatment which is currently static at an average of 72 minutes, through streamlining the front door flow and expansion of Rapid Assessment and Treatment (RAT) including the Introduction of HCAs into RAT area to support registrars and consultants

12 hour trolley waits in A&E

All five 12 hour trolley waits in April were informal mental health patients requiring a mental health bed and who were not suitable for a medical admission. During March ECIP undertook a whole system review in agreement with the Islington A&E Delivery Board with the aim of making recommendation to the Board to enhance patient flow A mental health summit is planned for June with senior representation from each organisation to address some of the current mental challenges.

Whittington Health also continues to work closely with C&I who are now part of the 11am daily CSU surge call so that any issues can be discussed in a timely manner and escalated appropriately.

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.

0.1% below target due to 3 patient's DNA and rebooking could not be accommodated due to unavailability of radiologists.

Responsive Services - Indicators and Performance

Category	Indicator	17_18 Target	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	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	2017-2018	Performance
Theatres	Hospital Cancelled Operations	0	4	7	1	6	1	4	6	2	15	7	5			
Theatres	Cancelled ops not rebooked < 28 days	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			
Admitted	Delayed Transfers Of Care - Days Lost	N/A	129	273	240	191	199	364	267	348	236	192	255			
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	3.4%	7.4%	6.3%	5.5%	5.7%	10.1%	6.1%	9.3%	6.3%	5.4%	6.7%			
Maternity	Women seen by HCP / midwife within 10 weeks	>50%	43.8%	63.7%	74.5%	69.1%	72.8%	69.4%	67.2%	67.8%	54.1%	57.5%	50.9%	45.8%	45.8%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%	95.0%	90.5%	95.1%	93.8%	94.6%	94.4%	94.3%	97.2%	97.2%	93.6%	93.3%			
Community	GUM - Appointment Offered within 2 days	>98%	98.5%	99.7%	95.6%	97.8%	99.2%	99.9%	99.6%	99.8%	99.3%	99.5%	99.3%	98.7%	98.7%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	89.8%	87.9%	93.2%	94.6%	94.2%	91.8%	92.2%	91.6%	91.3%	93.3%	87.5%			
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	96.1%	94.4%	94.9%	93.7%	88.3%	93.3%	94.1%	94.6%	94.8%	93.3%	90.7%			

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Responsive Services - Commentary

Hospital Cancelled Operations

There were five cancelled ops in March 2017 one of which was urgent. Three patients were affected when the urology stack system malfunctioned One was a T&O over run, and one was a general surgery patient on which the consultant needed a urology scope that was not available as all were in us.

Action –urology stack system has been repaired and replacement included in capital programme for 17/18

Delayed Transfer of Care % of Occupied Bed days

Improved recording of medically optimised patient as resulted in a minor increase in DTOC patients. Length of stay meeting reviews all patients weekly to maximise effective discharge. Estimated dates of discharge (EED) are now being recorded on Medway more effectively. Improvements are being made in flow management to increase accuracy of EDD through the use of Red to Green and standardisation of board rounds.

New Birth Visits September 2016

Islington: 24 late (9.73%)

7x parental choice; 7x in hospital; 4x late notifications; 1x completed out of borough; 5x team error

Islington sustaining activity despite high percentage of HV vacancies

Haringey: 23 late (5.31% completed after 14 days, 7.19% not discharged/outcome which would have taken percentage in 10-14 days to 94.7%)

9x in hospital; 3x late notifications; 3x admin error/wrong Monthly Team Planner; 4x parent unavailable/away; 1x unable to get interpreter for required language in time

Well Led Services - Indicators and Performance

Category	Indicator	17_18 Target	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	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	2017-2018	Performance
HR	Appraisals % Rate	>90%	69%	68%	67%	66%	63%	66%	66%	67%	72%	75%	80%	80%		
HR	Mandatory Training % Rate	>90%	81%	81%	81%	81%	80%	81%	81%	82%	81%	82%	82%	82%		
HR	Permanent Staffing WTEs Utilised	>90%	87.7%	87.8%	86.2%	87.1%	87.0%	88.1%	88.1%	87.7%	87.7%	87.8%	87.8%			
HR	Staff FFT % recommended work	>50%		65.1%			59.7%						60.5%			
HR	Staff FFT response rate	>20%		19.6%			24.9%						24.4%			
HR	Staff sickness absence %	<3.5%	3.2%	3.2%	3.2%	3.2%	3.6%	3.8%	3.8%	3.7%	3.7%	3.6%	3.2%	2.7%	2.7%	
HR	Staff turnover %	<10%	14.9%	15.8%	15.7%	15.5%	15.7%	15.4%	14.9%	15.4%	15.3%	15.1%	14.3%	14.8%	14.8%	
HR	Vacancy % Rate against Establishment	<10%	12.3%	12.2%	13.8%	12.9%	13.0%	11.9%	11.9%	12.3%	12.3%	12.2%	12.2%			

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Well Led Services - Commentary

Human Resources

Both Appraisal and Mandatory Training compliance remain static at 80% and 82% respectively. Both WS (Women's Services) and PPP (patient access, prevention and planned care) ICSUs however have both achieved the appraisal target in that 90% of their staff have been appraised. Sickness absence remains below the threshold at 2.7%. As part of the budget setting for this year a programme of detailed work between finance, human resources and ICSU management lock-down establishments in each area. At the time of writing the report this was not completed – therefore accurate vacancy data was not available but will be next month.

Each of the ICSUs presented a comprehensive report on "People Issues" at the recent Quarterly Performance Review Meetings. These included detailed discussion of sickness absence hotspots; action plans (by department) to increase appraisal and Mandatory Training compliance; there was discussion on areas with high vacancy factors and plans to address. Finally each ICSU presented a detailed action plan to address the results of the 2016 Staff Survey results in their area of responsibility.

Activity - Indicators and Performance

Category	Indicator	17_18 Target	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	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Activity
ED	ED Attendances	**8285**	8540	7908	8277	7513	8020	8253	8271	8238	8254	7430	8528	8285	
ED	ED Admission Rate %		18.1%	17.8%	18.1%	17.8%	16.7%	16.2%	16.6%	17.5%	17.2%	17.1%	16.9%	17.2%	
Community	Community DNA Rate %	**<10%**	5.6%	5.7%	5.8%	5.7%	5.6%	5.3%	5.5%	5.6%	5.5%	5.5%	5.1%	4.9%	
Community	Community Face to Face Contacts		60564	61199	58106	54160	59650	59110	63775	53809	60406	56323	66215	52137	
Admissions	Elective and Daycase		1860	2083	2004	1769	1937	1947	1876	1713	1878	1686	1849	1606	
Admissions	Emergency Inpatients		2255	2177	2322	2117	2078	2036	2124	2111	2067	1927	2199	2116	
Referrals	GP Referrals to an Acute Service		6176	6432	6134	5903	6342	5976	6314	5165	5824	5421	6724	5131	
Maternity	Maternity Births	**333**	324	311	340	299	337	315	324	301	312	274	309	301	
Maternity	Maternity Bookings	**377**	383	403	354	299	301	353	365	319	323	308	382	275	
Outpatients	Outpatient DNA Rate % - New	**<10%**	12.1%	11.7%	11.7%	11.9%	12.3%	11.1%	11.3%	12.7%	12.4%	11.8%	12.0%	12.4%	
Outpatients	Outpatient DNA Rate % - FUp	**<10%**	10.4%	10.2%	10.3%	9.8%	11.2%	10.1%	10.1%	11.7%	12.5%	12.2%	11.9%	12.0%	
Outpatients	Outpatient New Attendances		9624	9492	8837	8362	8908	8660	9575	7910	8772	8360	9140	7343	
Outpatients	Outpatient FUp Attendances		17661	18672	17860	18092	18521	18665	19768	17111	18496	16862	18783	14937	
Outpatients	Outpatient Procedures		5870	6284	6163	6259	6014	6266	6183	5628	5948	5227	5789	4934	
Theatres	Theatre Utilisation	**>85%**	81.5%	80.7%	78.3%	78.2%	81.8%	81.5%	83.7%	83.5%	72.8%	81.1%	82.7%	84.9%	

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Activity - Commentary

Hospital DNA

Remains 2% above target. This indicator is targeted in the Out-patients Improvement Programme.

As part of the Outpatient Plan the following initiatives should impact and reduce DNA rates

- e-RS (Electronic Referral System) previously Choose and Book. There is an NHS e-Referrals CQUIN 2017/18 – 2018/19 that relates to GP referrals to Consultant-led 1st outpatient services and the availability of services and appointments on the NHS e-Referral Service.
- As a provider Organisation to publish ALL such services and make ALL of our First Outpatient Appointment slots available on NHS e-Referral Service (e-RS) by 31 March 2018.

We are currently also updating the Directory of Services (DOS) - which provides a comprehensive review of all eRS services including the information displayed to GPs in each service description i.e. Conditions Treated, Procedures Performed, Exclusions and Instructions to Patients.

The e-RS project has been “Roadmapped” with a trajectory to be 80% compliant by October 2017.The NHS e-Referral Service combines electronic booking with a choice of place, date and time for first hospital or clinic appointments. Patients can choose their first hospital or clinic appointment, book it in the GP surgery, online or on the phone.

Studies have shown that Electronic booking reduces patient-initiated cancellation of appointments, most likely because the patient has been able to select a convenient date in the first place.

DrDoctor, an online and text based service that allows patients to confirm, cancel and change bookings digitally, is being implemented for all services. Where it is currently already in use, DrDoctor not only makes a positive impact on reducing DNA’s but also by increasing utilisation so that appointment slots are filled.

Theatre Utilisation

0.1% below target. Theatre Productivity Work stream in place and monitoring progress.

Whittington Health NHS

Trust Public Board 7 June 2017

Title:	Quality Account Review 2017/18 and Quality Account 2017/18		
Agenda item:	**17/083**	**Paper**	**07**
Action requested:	Approval		
Summary	Quality remains our top priority. Our Quality Account Review 2016/17 describes some of our achievements in the past year and how we aim in 2017/18 to continue providing high quality and safe services to help local people live healthier, longer lives. Our commitment to quality is across all our community and hospital services. The Quality Account includes all statements from the two Healthwatch groups, the Joint Health and Overview Scrutiny Committee and the Clinical Commissioning Groups which cover our geographical area and services. KPMG, our external auditors will complete their audit next week in line with the timetable for the Trust to publish the Quality Account on the Department of Health website by the end of June 2017.		
Fit with WH strategy:	Aligned with Whittington health Clinical Strategy		
Reference to risk:	On relevant area of risk register and BAF where appropriate		
Date paper:	May 2017		

Author name and title:		**Helen Taylor, CD & Deputy Director of Strategy**		**Director name and title:**		**Siobhan Harrington, Deputy Chief Executive & Director of Strategy**	
Date paper seen by EC	**April /May 2017**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**BAF**	**Legal advice received?**	**n/a**

Whittington Health NHS

Quality Account 2016/17

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1. Statement on quality from the Chief Executive

1.1 Chief Executive's statement

Quality remains our top priority. Our Quality Account describes some of our achievements in the past year and how we aim to continue providing high quality and safe services to help local people live healthier, longer lives. Our commitment to quality is across all our community and hospital services.

The Trust won the CHKS Top Hospitals programme quality of care award 2017. The CHKS Top Hospitals awards celebrate excellence throughout the UK and are given to organisations for their achievements in healthcare quality and improvement.

We received our Care Quality Commission (CQC) full inspection report in July 2016 in which Whittington Health was rated 'Good' overall and 'outstanding' for caring; however within this, the community services were Good to Outstanding, and the hospital 'requires improvement'. Our focus has continued to be on completing actions to improve quality across both the hospital services and community services. These are outlined in this Quality Account.

Over the past year the teams delivering the care to our local community have developed a number of quality initiatives:

- We were one, of only 4, sites selected to pilot a new model of midwife supervision.
- We were shortlisted for the Patient Experience National Network Awards for the Footprints project. This project centred on hearing women's voices to improve care based on human rights principles.
- Our midwives were shortlisted for the British Medical Journal Awards for the Female Genital Mutilation service they run.
- Whittington Health achieved the highest flu vaccine levels in London for which our infection control team were awarded a staff excellence award.
- Our innovative team introduced gentle birth methods, which include reflexology and massage therapy for couples (promoting normality) in midwifery
- 'Excellent'. This was the Peer review classification result of our Paediatric Oncology Shared Care Unit. We are now looking to develop an adolescent service.
- Gold Standard Services. Our Paediatric Mental Health team is one of only two gold standard services in London.
- We are one of the few trusts that meet the Royal College of Paediatrics and Child Health and the NHS acute paediatric standards due to the consultant presence we have in our acute services.
- Self-Management Partnership. We have developed a service user self-management partnership with Tottenham Hotspur.
- Our Tissue Viability Team have led the red pressure reduction campaign in the Trust.
- Further innovation within our Improving Access to Psychological Services led to the development of a new mothers programme.
- Cheryl Hill our imaging manager was a finalist in the Emerging Leader category of the London Leadership Academy Annual leadership Awards.
- We are a pilot site for new pharmacist roles in GP practices and Urgent Care.
- We held 2 Inter-professional Integrated Care Education Days in April and May. These were extremely well received, with excellent feedback from the attendees.
- Advance Care Planning Workshops. We have run 8 events for our local GPs and Care Homes focussing on care of dying patients in the last days of life and supporting professional to look at ways of approaching difficult conversations with patients and their families
- 'Learning Together from Patient Safety Incidents and Complaints'. These inter-professional education events we have developed based on real patient stories, highlighting key learning points for various staff groups. The 10 Learning Together

events this year were attended by WH staff and colleagues working in social care, primary care and the voluntary sector

- 'Islington Integrated Schwartz Rounds'. These are the first Schwartz rounds of this kind to be established. They were set up and run in collaboration with our Community Education Provider Network (CEPN) partners, inviting colleagues from Camden and Islington Mental Health Trust, Islington Clinical Commissioning Group, London Borough of Islington and Whittington Health
- Our 'Outstanding' Care Quality Commission rated community dental service won a tender to deliver services across a further five boroughs in North Central and North West London

This year in June we will be having our first Annual staff awards.

Like many other NHS trusts, we had a challenging winter. The particular pressure for us has been around emergency medical care, especially for frail and elderly patients and those with mental health issues. We reported 87.36% percent performance for the year and have been working very closely with the Emergency Care Improvement Programme (ECIP) identifying and implementing quality improvements to our emergency pathway. One area of focus is to improve the experience of our mental health patients. Working in collaboration with Camden and Islington Foundation Trust and our wider partners we will review and improve the multiagency model of care for our mental health patients in crisis (Section 136 pathway). This will be launched at a workshop in June 2017.

Our excellent Integrated Care Ageing Team (ICAT) has been set up to provide in-reach into care homes in Islington and is looking to work closely with the Care Closer to Home initiatives of the Sustainability and Transformation Plan to continue to support high quality care for the older people we serve.

Within the community we are working to improve our for musculoskeletal services through working with the Haringey and Islington Health and Wellbeing Partnership and piloting new ways of working with Extended Scope Physiotherapists in three GP practices. Within our District Nursing Team we are improving our recruitment and retention through overseas recruitment and have increased the numbers of nurses undertaking the specialist practitioner District Nurse and Specialist Practitioner courses, as well as introduced our new scheduling system e-community which will increase continuity of visits and patient facing time. In addition the workforce model for health visiting and community paediatrics across Haringey and Islington is currently being reviewed with a view to ensuring an effective, sustainable and efficient service is provided to the Children and Young People which we serve.

During the year we continued to make the quality improvements that we pledged to make in our 'Sign up to Safety' commitment. These continue to focus on improving the care of patients with sepsis and acute kidney injury, reducing pressure ulcers both in the hospital and in the community, reducing harm from inpatient falls and improving the care we give to patients who have a learning disability. In the course of this year we have made significant measurable improvements in many of these areas.

I confirm that this Quality Account will be discussed at the Trust Board, and I declare that to the best of my knowledge the information contained in this Quality Account is accurate.

Chief Executive

1.2 About the Trust

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

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

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

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

1.3 Listening to our staff

This is the sixth year in which Whittington Health, as an Integrated Care Organisation (ICO), has conducted the national staff survey. The survey asks a random sample of the Trust's staff (1,227 people in 2016) a number of questions to see how they respond, giving an insight into the how staff feel about how the Trust is managed, its culture, and the services it provides.

Staff Engagement Indicator

The Care Quality Commission (CQC) report provides an overall indicator of staff engagement for Whittington Health and how it compares with other acute community Trusts. The possible scores range from 1 to 5 (with 1 indicating poor engagement and 5 high engagement).

The Trust's score of 3.83 is above the national average of 3.8 and a local improvement from 3.79 in 2015. The table below illustrates how this score is arrived at and how we were rated under each of the nine staff engagement questions.

Staff Engagement	Whittington Health Scores	National Scores for Acute Community Trusts
Advocacy		
I would recommend WH as a great place to work	3.59	3.50
I am happy with the standard of care provided	3.82	3.73
Care of patients is a top priority for Whittington Health	3.93	3.83
Involvement		
I am able to make suggestions to improve the work of my team / department	3.95	3.84
There are frequent opportunities for me to show initiative in my role	3.89	3.82
I am able to make improvements happen in my area	3.60	3.48
Motivation		
I look forward to going to work	3.60	3.61
I am enthusiastic about my job	3.94	4.00
Time passes quickly when I am working	4.13	4.14
Overall engagement score	**3.83**	**3.80**

Top Ranking Scores

Whittington Health compares most favourably with other acute community Trusts in England in the following areas:

	Indicator	Trust	National
1	Percentage of staff reporting errors, near misses or incidents witnessed in last month	97%	91%
2	Quality of appraisals	3.35 (score)	3.11 (score)
3	Percentage of staff/colleagues reporting most recent experience of violence	78%	67%
4	Percentage of staff agreeing that their roles make a difference to patients / service users	93%	91%
5	Percentage of staff reporting good communication between senior management and staff	36%	32%

It is encouraging to note improvements in areas such as good communication between senior managers and staff and the quality of appraisals, as these were targeted improvement actions from last year's survey. In addition there has been a focus on incident reporting and feedback and this appears to have been reflected in the results.

Bottom Ranking Scores

Where the Trust compares least favourably with other acute community Trusts is set out below.

	Indicator	Trust	National
1	Staff working extra hours	78%	71%
2	Staff suffering work related stress in last 12 months	42%	36%
3	Staff experiencing harassment, bullying or abuse from staff	30%	23%
4	Percentage of staff experiencing discrimination at work in the last 12 months	19%	10%
5	Percentage of staff experiencing harassment, bullying or abuse form patients, relatives or the public in last 12 months	31%	26%

Disappointingly, three of the bottom ranking scores (numbers 1 – 3) appeared in the same category in the Trust's 2015 results and have shown little improvement in year. It is the first time that the percentage of staff experiencing harassment, bullying or abuse from service users has been highlighted as a concern and this will require specific attention this year.

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (KF26)

30% of staff reported experiencing harassment, bullying or abuse from staff in the last twelve months, an increase from 29% in 2015.

Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion (KS21)

79% of staff reported believing that the Trust provides equal opportunities for career progression or promotion, a slight decrease from 80% in 2015.

At the trust Board in April 2017, the Trust agreed a robust action plan to tackle the areas of concern highlighted to us by staff. These actions range from evaluating findings from our Anti Bullying Advisers; tackling specific identified behaviours at a local level; rolling our unconscious bias training to all staff and creating focus groups to understand how we can better focus career management on improving diversity.

Progress on the 2015 Staff Action Plan

A corporate action plan was developed and an accountable executive identified for leading on each of the corporate priorities. The Trust Board approved this action plan in April 2016 with a progress update given in August 2016.

Good progress was made in the development and execution of the staff survey corporate action plan. There was high level engagement in cascading results through Integrated Clinical Service Units (ICSU) and more local service team meetings. Through the Clinical Directors and Human Resources (HR0 Business Partners there was more staff engagement and involvement of staff in the improvement plans at a local level.

Quarterly ICSU performance reviews ensure that local action plans are being delivered. All 31 of the corporate actions were completed by March 2017.

Significant progress has been made in each of these areas. Some of the actions taken included:

- Development of a staff communication and engagement plan;
- Organisational goals and objectives cascaded within service areas and individual objectives aligned;
- Focus on the quality and quantity of annual appraisal;
- Quarterly reporting of all workforce performance indicators to the newly established Workforce Assurance Committee;
- Occupational Health promoted the use of a stress self-assessment questionnaire;
- Bi-annual health and well-being events;
- Introduction of a half-yearly health and safety bulletin for all staff;
- Development of unconscious bias masterclass for all managers;
- Reinforced our organisational values and zero-tolerance of bullying including the introduction of Anti-bullying Adviser role across the Trust; Equality and diversity training introduced as management induction training;
- Mechanisms for staff feedback to those that report an incident reviewed;
- Quarterly analysis of learning from outcomes from reported incidences to all staff.
- Recruitment of the role of ‘Speak Up’ guardian for the Trust

2. Priorities for improvement and statements of assurance from the Board

2.1 Our quality priorities for 2017-18

Our quality priorities are aligned with the Trust's commitment to the 'Sign up to Safety' initiative, which aims to progressively improve quality over a period of three years. Many of the areas chosen for quality improvement in 2016/17 have been retained for the forthcoming year as we continue to consider these important. In addition, we include goals that we believe are important to us as a Trust and to our patients and community.

Goals and targets are developed following extensive consultation with staff and stakeholders. Each target has been developed by clinicians in issue-led quality groups, agreed at the patient safety forum and reviewed at all levels of the Trust, including by the Trust Management Group and Board. Following this, they are considered by our commissioners, local Healthwatch members, and presented to our local councillors.

In developing these priorities, we utilise a range of data and information available to us, such as learning from serious incidents, case note reviews, reviews of mortality and harm, complaints, clinical audits, outcomes from quality panel reviews, patient and staff experience surveys, and best practice guidance such as from NICE and national audits.

Our education quality targets are closely linked to the work we have been involved in with the Community Education Provider Networks where staff across Health, Social care and Primary Care have developed, with Whittington Health, Interprofessional programmes of education. The feedback from the staff and the patient and users has helped further refine what these quality objectives should be.

Our safety and quality priorities for 2017/18 are detailed in the table below:

Domain	Objective
Acute Kidney Injury (AKI) **Acute Kidney Injury is sudden damage to the kidneys that causes them to not work properly. This usually happens as a complication of another serious illness.**	At least 75% of patients with AKI include an AKI diagnosis in their discharge letter
	At least 90% of patients that develop grade 3 AKI have a medicine safety review within 24 hours
	At least 90% of patients with grade 3 AKI are seen by Critical Care Outreach Team within 24 hours.
Sepsis **Sepsis is a rare but serious complication of an infection. Without quick treatment, sepsis can lead to multiple organ failure and death.**	We will achieve the national CQUIN for sepsis with a particular focus on sepsis developing during inpatient stay
	We will work in partnership with local CCG's to raise patient awareness of sepsis including the distribution of "Could it be sepsis" leaflets distributed relevant local healthcare provider centres.

Falls **Anyone can have a fall, but older people are more vulnerable and likely to fall, especially if they have a long-term health condition.**	We will introduce StopFalls bundles across the hospital, and achieve 80% compliance with falls assessment documentation on the Acute Admissions Unit (*AAU)* and *Care Of Older People* wards
	We will reduce the number of avoidable falls resulting in serious harm to patients year on year
Pressure Ulcers **Pressure ulcers are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. They are sometimes known as "bedsores" or "pressure sores".**	To achieve a year on year reduction in all grades of pressure ulcers across the Integrated Care Organisation
	We are developing a cross borough target on the 'React to Red Initiative' with local partners.
Learning disabilities **A learning disability affects the way a person understands information and how they communicate. This means they can have difficulty:** - **understanding new or complex information** - **learning new skills** - **coping independently**	75% of patients who present to the Emergency Department with learning disabilities are given a priority assessment.
	We will introduce a care pathway for mothers with learning disabilities in the hospital All children and young people entering Child and Adult Mental Health Services (CAMHS) for a Choice appointment will be screened for Learning Disabilities
Medication errors Medication errors are patient safety incidents involving medicines in which there has been an error in the process of prescribing, dispensing, preparing, administering,	We will achieve a 10% increase in medication errors reported across the Integrated Care Organisation.
	We will achieve a 10% reduction in medication errors with harm.

monitoring, or providing medicine advice, regardless of whether any harm occurred.	
Research and Education	We will increase by 10 percent the number of National Institute of Health Research (NIHR) programmes in which we participate.
	We will achieve the recruitment target, set by the North Thames CLRN, for patients recruited into NIHR portfolio studies.
	We will continue to provide access to 'learning together from patient safety incidents and complaints workshops' based on real patient stories and aim to deliver 10 structured inter-professional learning events this year.
	100% of students placed at WH will have access to a named educational and clinical supervisor or mentor
	We will expand our portfolio of inter-professional learning opportunities for staff by offering training in Making Every Contact Count and access to the training offered by Haringey and Islington Community Education Provider Networks (CEPNs).
	We will offer upskilling opportunities to health professionals on how to teach and support people to self-manage their long term condition by offering the advanced development programme across Islington and Haringey.
	We will evaluate the access group, currently running in the East of Haringey's Improving Access to Psychological Therapies (IAPT) service, which Turkish patients are offered before the delivery of individual Cognitive Behavioural Therapy (CBT). We aim to establish its effectiveness in improving outcomes, and reducing DNAs and dropouts in this BME community
Patient Experience	We will reduce the amount of time patients wait for booked transport from home to hospital This will be monitored through real time information and contract specification.
	We will reduce outpatient clinic appointment cancellations.
	We will reduce noise at night from other patients. Improvement will be measured via the inpatient and

	outpatient National Survey Picker results and through 'real time' experience surveys (Meridian).
	We will improve continuity of care from District Nurses. This will be monitored through of e-community
	We improve the feedback we receive about our inpatient food. Improvement will be measured via the inpatient and outpatient National Survey Picker results and through 'real time' experience surveys (Meridian).

These patient experience priorities were determined through triangulation of information from complaints, local and national surveys (including FFT) and the very useful feedback from service users via the engagement and workshop event with Islington Healthwatch.

2.2 Statements of assurance from the Trust Board

2.2.1 Subcontracted services

During 2016-17 Whittington Health provided 101 services (41 Acute & 60 community services). Of these services the following are subcontracted:

Organisation details	Service details
Barts Health NHS Trust	Service and Development Support for Immunology/Allergy
Camden and Islington NHS Foundation Trust	Mental Health Services, ILAT contract & Psychology Service
Highgate Therapy Ltd	Psychosexual Services
University College London Hospitals Foundation Trust	South Hub TB Resources
University College London Hospitals Foundation Trust	ENT services
The Royal Free London NHS Foundation Trust	Provision of PET/CT Scans
The Royal Free London NHS Foundation Trust	Ophthalmology Services
Middlesex University	Provision of Moving and Handling Training Sessions

GP sub-contractors; Medical Practices: Morris House Somerset Gardens Tynemouth Road	Primary Care Anticoagulation Service for Haringey CCG
WISH Health Ltd A network of 8 local practices; four in North Islington and four in West Haringey.	Provide primary care services to the Urgent Care Centre at the Whittington Hospital

The Trust has reviewed all data available to them on the quality of care in these relevant health services through the quarterly performance review of the ICSU and contract management processes.

The income generated by the relevant health services reviewed in 2016-17 represents 100% of the total income generated from the provision of relevant health service that Whittington Health provides.

2.2.2 Participation in Clinical Audits 2016-2017

During 2016-17, **41** national clinical audits including **7** national confidential enquiries covered relevant health services that Whittington Health provides.

During that period Whittington Health participated in **100%** national clinical audits and **100%** of national confidential enquiries of those it was eligible to participate in.

The national clinical audits and national confidential enquiries that Whittington Health was eligible to participate in, and participated in, during 2016/17 are listed below. This includes the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Additionally listed are the non-mandatory national audits to which the Trust also participated during 2016/17.

Title of audit	Management body	Participated in 2016/17	If completed, number of records submitted (as total or % if requirement set)
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	National Institute for Cardiovascular Outcomes Research	✓	92 cases - 100% case ascertainment rate
Adult Asthma	British Thoracic Society	✓	23 cases
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	British Association of Urological Surgeons	✓	16 cases

Bowel Cancer (NBOCAP)	Royal College of Surgeons of England	✓	96 cases
Case Mix Programme (CMP) - Intensive Care Audit	Intensive Care National Audit & Research Centre	✓	804 cases – 100% case ascertainment rate
Child Health Clinical Outcome Review Programme - Chronic Neurodisability	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	1 case – 100% case ascertainment
Child Health Clinical Outcome Review Programme - Young People's Mental Health	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	3 cases - 100% case ascertainment
Diabetes (Paediatric) (NPDA)	Royal College of Paediatrics and Child Health	✓	107 cases
Elective Surgery (National PROMs Programme)	Health and Social Care Information Centre	✓	22 cases
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	Royal College of Physicians (London)	✓	124 cases
Inflammatory Bowel Disease (IBD) programme / IBD Registry	Royal College of Physicians (London)	✓	62 cases
Learning Disability Mortality Review Programme (LeDeR)	University of Bristol	✓	Ongoing
Major Trauma Audit	TARN - University of Manchester	✓	38 cases - 28% case ascertainment rate
Moderate & Acute Severe Asthma - adult and paediatric (care in emergency departments)	Royal College of Emergency Medicine	✓	15 cases
National Audit of Dementia - Dementia care in general hospitals	Royal College of Physicians	✓	44 cases
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre	✓	107 cases
National Comparative Audit of Blood Transfusion programme - Audit of Patient Blood Management in Scheduled Surgery	NHS Blood and Transplant	✓	4 cases

National Diabetes Audit - Adults - National Diabetes Foot Care Audit	Health and Social Care Information Centre, Diabetes UK, HQIP	✓	69 cases
National Diabetes Audit - Adults - National Diabetes Inpatient Audit (NaDia)	Health and Social Care Information Centre	✓	39 cases
National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit	Health and Social Care Information Centre	✓	12 cases – 97% case ascertainment rate
National Diabetes Audit - Adults - National Diabetes Transition	Health and Social Care Information Centre	✓	*No additional data submission is needed*
National Diabetes Audit - Adults - National Core Diabetes Audit	Health and Social Care Information Centre	✓	1827 cases
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	✓	101 cases
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research	✓	150 cases
National Joint Registry (NJR) - Knee and Hip replacements.	National Joint Registry	✓	Ongoing
National Lung Cancer Audit (NLCA)	Royal College of Physicians	✓	60 cases
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Royal College of Paediatrics and Child Health	✓	494 cases
National Prostate Cancer Audit	Royal College of Surgeons	✓	114 cases
Oesophago-gastric Cancer (NAOGC)	Health and Social Care Information Centre	✓	24 cases
Paediatric Pneumonia	British Thoracic Society	✓	Ongoing
Sentinel Stroke National Audit programme (SSNAP)	Royal College of Physicians	✓	Early Supported Discharge – 57 cases Community Rehabilitation Team – 9 cases
Severe Sepsis and Septic Shock (care in emergency departments)	Royal College of Emergency Medicine	✓	27 cases

Maternal, Newborn and Infant Clinical Outcome Review Programme data on 26 cases were submitted to MBRRACE-UK who allocate to the appropriate work stream			
Confidential enquiry into stillbirths, neonatal deaths and serious neonatal morbidity	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
National surveillance of perinatal deaths	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Confidential enquiry into serious maternal morbidity	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
National surveillance and confidential enquiries into maternal deaths	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Perinatal Mortality Surveillance	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Maternal mortality surveillance	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Medical and Surgical Clinical Outcome Review Programme			
Cancer in Children, Teens and Young Adults	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	Ongoing
Heart Failure	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	Ongoing
Acute Pancreatitis	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	5 cases– 100% case ascertainment
Physical and mental health care of mental health patients in acute hospitals	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	5 cases– 100% case ascertainment
Non-invasive ventilation	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	5 cases – 100% case ascertainment

Mental Health Clinical Outcome Review Programme			
Suicide by children and young people in England(CYP)	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), University of Manchester	✓	If cases identified to WH then participate
Suicide, Homicide & Sudden Unexplained Death	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), University of Manchester	✓	
The management and risk of patients with personality disorder prior to suicide and homicide	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), University of Manchester	✓	
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme			
Pulmonary rehabilitation	Royal College of Physicians / British Thoracic Society	✓	Ongoing
Secondary Care	Royal College of Physicians	✓	Ongoing

Additional (non-mandatory) National Audits undertaken during 2016/17

Title of audit	Management Body	Participated in 2016/17	Status
Minimum Data Sets for Palliative Care	National Council for Palliative Care	✓	Completed
Cardiac Rehabilitation	Health & Social Care Information Centre, British Heart Foundation	✓	Ongoing data collection
Systematic anti-cancer therapy - chemotherapy dataset	National Cancer Intelligence Network	✓	Ongoing data collection

National study of HIV in Pregnancy and Childhood	NSHPC	✓	Ongoing data collection
Society of Acute Medicine Benchmarking Audit	Society of Acute Medicine	✓	Completed
7 Day Services Self-Assessment Tool	NHS England, TDA	✓	Completed
NPDA - PREM audit	Royal College of Paediatrics and Child Health	✓	Completed
London Ambulance Service out of hospital cardiac arrest	London Ambulance Service	✓	Ongoing data collection
UNICEF Baby friendly initiative Mother's audit	UNICEF	✓	Ongoing
Smoking Cessation Audit	British Thoracic Society	✓	Completed
Consultant Sign-off (Emergency Departments)	Royal College of Emergency Medicine	✓	Completed
Sexual Health Screening and risk Assessment	British Association for Sexual Health and HIV	✓	Completed
SAS audit on Gonorrhoea management	British Association for Sexual Health and HIV	✓	Completed
BAD-PRPath NMSC Excision National re-audit	British Association of Dermatologist	✓	Completed
Complex Intra-abdominal Infections	Surgical Infection Society and Infectious Disease Society of America	✓	Completed
National Maternity and Perinatal Audit	Royal College of Obstetricians & Gynaecologists	✓	Ongoing data collection
6th National Audit Project of the Royal College of Anaesthetists - Perioperative Anaphylaxis in the UK	Royal College of Anaesthetists	✓	Ongoing data collection
Testing pulmonary rehabilitation audit dataset and new software	British Thoracic Society	✓	Ongoing data collection
The Right Iliac Fossa Pain Treatment (RIFT) Audit	West Midlands Research Collaborative	✓	Ongoing data collection
ESCP 2017 Snapshot audit - left	European Society of	✓	Ongoing data

colon, sigmoid and rectal resections	Coloproctology		collection
National Complicated Diverticulitis Audit	Yorkshire Surgical Research Collaborative	✓	Ongoing data collection
Closure of Intestinal Stoma	European Society of Coloproctology	✓	Completed
Term Neonatal Hypoglycaemia Admissions Audit	NHS England	✓	Completed

The reports of **11** national clinical audits/ national confidential enquiries were reviewed by the provider in 2016/17.

Whittington Health intends to continue to improve the processes for monitoring the recommendations of National Audits and Confidential Enquires in 2017/18 by ensuring:

- National audit and national confidential enquiries will continue as a key component of the Trust Integrated Clinical Service Units (ICSU) Quality Improvement programmes. Priority will be assigned to all mandatory projects thus maintaining our gold standard 100% participation rate with these studies.
- Monthly compliance with these programmes will be monitored via centralised reporting to each respective ICSU.
- Performance outcome presentations for national audits will be given at senior ICSU and corporate level meetings, including Trust speciality half day audit and quality improvement meetings.
- Optimal clinical and managerial leadership will remain essential to ensure national project completion and reflection.

Examples of results/actions being taken for previous national audits:

National Adult Asthma audit 2016 (BTS)

This annual audit focuses on adult asthma admissions to hospital, management in hospital and discharge arrangements. Results accordingly allow comparison and identification of any substantial change in the deficiencies which have been identified in previous years.

Whittington Health audited and submitted 23 cases for the period of September and October 2016. Results were submitted to National Adult Asthma Audit (BTS).

There are 5 best practice items, as below. From the audit results, we are able to assess our own practice and performance and benchmark ourselves against other NHS organisations:

• Assessment of inhaler technique;

• Review of medications;

• Provision of a written action plan and patient self-management;

• Consideration of triggering and exacerbating factors;

• Appropriate follow up arrangements.

Whittington Health promotes a standard practice of respiratory nurse specialists reviewing all adult patients with asthma, admitted to the hospital. The 5 best practice items are reviewed and actioned by these nurses.

Some key results:

- **Gender:** Of our 23 submissions 57% were male (national results 31%) and 43% were female (national result 69%).
- **Length of patient stay and readmission:** Our average length of stay was 4 days compared to national results of 2 days. Significantly however, we only had 4% (1 patient) readmitted within 3 months, compared to 16% nationally. Additionally, several clinical indicators i.e. number of individuals who were hypoxic on admission, had raised pCO2, were current smokers and had adverse psychological or behavioural factors were higher than national figures, demonstrating that our cohort of patients admitted are more unwell than the national average.
- 87% of our patients had **steroids within four hours** compared to 65% nationally. A total of 39% of our patients received these steroids within 1 hour which is gold standard practice. Nationally this figure was 33%.
- We scored 53% for the provision of a **written action plan**. This appears low at initial glance however 30% of patients already had a written action plan in place. Therefore, in total, 83% of our patients left hospital with a personal asthma action plan. The comparative national result was 41.2%. This result is particularly pleasing as the provision of a 'personal asthma action plan' is one of the key recommendations from the recent National Review of Asthma Deaths report.
- 100% of our patients were **discharged on inhaled steroids**; nationally this figure was 82%.

Our complete results demonstrate that our inpatient respiratory nurse specialists cover all elements that would be expected from an asthma 'care bundle'. For each of the five best practice elements, Whittington Health performed better than the national results.

National audit of Inpatient Falls (Report 2015/16)

The National Audit of Inpatient Falls (NAIF) is a clinically led, web-based audit of inpatient falls prevention care in acute hospitals in England and Wales. NAIF aims to improve inpatient falls prevention through audit and quality improvement.

Round 1 of the National Audit of Inpatient Falls took place in 2015. The first report showed data on nearly 5,000 patients aged 65 years or older across 170 hospitals, and reviewed how well hospital trusts and local health boards prevent inpatient falls in England and Wales, which are set against the NICE guideline (CG161) on falls assessment and prevention.

Our actions:

Whittington Health has a **low rate of falls compared to national figures** however we need to address our care plans to incorporate the 7 key indicators.

Plan: To review our current assessment and risk tool to ensure we incorporate these key indicator recommendations:

- Assessment for the presence or absence of delirium and dementia;
- Measurement of lying and standing blood pressure;
- Medication review
- Visual assessment
- Continence/ toileting care plan
- Appropriate mobility aid within patient reach
- Call bells in sight and reach of patient

National clinical audit of biological therapies 2016

The purpose of the National clinical audit of biological therapies is to measure the efficacy, safety and appropriate use of biological therapies in patients with Inflammatory Bowel Disease in the UK. The audit also aims to capture patients' views on their quality of life at intervals during their treatment.

What do we do well?

- In line with national recommendations, all new patients are being commenced on infliximab biosimilars. We are currently working with patients on established therapies to consider switching to biosimilars.
- Our patients undertake comprehensive pre-screening prior to treatment with biological therapies.
- Our patients have documented follow up within 3 months and at 1 year following initial treatment with biologics. A disease activity index is also recorded in all patients at baseline, 3 months and 1 year as a minimum. These steps will ensure that only appropriately responding patients continue to have treatment.
- Steroid use in all patients is kept to a minimum in line with national recommendations.

Plan for improvement:

- Clinicians will share findings and recommendations of this report at relevant multidisciplinary team, clinical governance and audit meetings.
- An updated record should be kept on all patients on biologics and where possible this should be submitted to the IBD Registry for national analysis.

The reports of **113** local clinical audits were reviewed by the provider in 2016/17.

Whittington Health intends to continue to improve the processes for monitoring the recommendations of local clinical audits in 2017/18 by ensuring:

- All clinical audits are mapped against the Care Quality Commission five areas under Key Lines of Enquiry of Safe, Effective, Caring, Responsive and Well-led.

- Capacity will continue to be channelled where appropriate away from small ad-hoc audits to major, national audits vital to safety without losing flexibility or suppressing good local ideas.
- Usage of the newly published quality improvement project form will be monitored on a regular basis. This will allow review of all QI projects to include clinical audit, Model for Improvement, Lean/6-Sigma and Service Evaluation projects.
- A programme of clinical audit awareness sessions, half-day clinical audit teaching workshops and ad hoc information dates by the Clinical Governance Department will continue throughout the coming year. Additionally, we plan to extend this remit to all quality improvement projects.
- Project actions will continue to be assigned to a senior clinician and managerial representative, if appropriate, with specific time scales for completion.
- Project performance will continue to be monitored on an ongoing basis with regular reporting via the ICSU Quality and Board meetings.

Examples of results and actions being taken for local clinical audit:

An audit cycle: Eye care in Intensive Care Unit

Intensive care unit (ICU) patients are at increased risk of developing exposure keratopathy due to intubation, sedation, paralysis and metabolic disturbance. The factors lead to reduced venous return from the eyes, impairment of the blink reflex, loss of the tone of the orbicularis oculi muscles and dysfunction of the corneal healing. Exposure keratopathy can lead to short and long-term visual impairment.

Objectives (conducted over two phases):

- To ascertain the adherence to nursing eye care guidance and elicit the risk factors and rate of exposure keratopathy in mechanically ventilated ICU patients;
- Modify the current eye care guide if necessary.
- Evaluate the effectiveness of the modified eye care guide.

Conclusion:

Exposure keratopathy is a common but preventable condition in mechanically ventilated patients in ICU with the major risks being lagophthalmos. However, prevention and treatment strategies can be developed to identify the patients at risk, prevent the development of exposure keratopathy and, if exposure keratopathy develops, to treat in accordance with best practice guidance. This audit cycle shows that there was no improvement by substitution of hypromellose with carbomer gel. This audit cycle raised awareness of exposure keratopathy in ICU patients and helped educate ICU nurses and doctors about the risk factors and importance of identify and giving regular eye care to patients at risk of developing exposure keratopathy.

Recommendations:

It is recommended that the Whittington ICU implements a modified eye care guide using lacri-lube as initially agreed and then undertake a related audit to measure the adherence to the modified eye care guide and measure its effectiveness in preventing exposure keratopathy.

Obstetric Weight and Nutrition (OWN) Clinic Audit

The OWN clinic has been set up in line with national guidelines (NICE 2010) on obesity in pregnancy and subsequent management. The audit was undertaken to identify if guidance is being followed and whether women are achieving good outcomes for themselves and their babies. It will help us to improve pathways and identify areas of practice that require improvement.

Improving the health and wellbeing of obese pregnant women prevents morbidity and helps to reduce other complications in pregnancy and birth such as post-partum haemorrhage, infections, potential for c-section. (NICE 2010)

The objectives were to identify if the OWN clinic is used in line with guidance:

- To identify where the problems are with the pathway
- To improve on the areas highlighted in the audit as requiring improvement
- To make recommendations for practice once the audit is completed
- To inform relevant professionals of outcomes of audit.

Conclusions include:

This is the first audit of the OWN clinic since its inception therefore there is no previous data is available for comparison. The results were very encouraging in terms of outcomes for mothers and babies. No babies were admitted to the neonatal unit and only one baby was over 5.0kg. One baby was readmitted postnatally to the paediatric ward for poor feeding.

The significant majority of women who were referred to the OWN clinic were appropriate referrals and all women were offered serial scans as per guidance.

Recommendations:

- All weights at booking must be recorded;
- Subsequent weights at 16 weeks, 28 weeks and at term must be clearly documented in notes;
- Midwives to receive reminder that women should be referred to the OWN clinic if they have a Body Mass Index (BMI) of 35 and over;
- All women with a BMI over 35 must have adequate thromboprophylaxis prescribed and administered. Evidence for this must be recorded in the women's notes including TTAs given;
- Women with BMI>40 should have a manual handling assessment antenatally;
- Re-audit in a year with a larger sample size.

Central line Associated Bloodstream Infections (CLABSI) in Paediatric Oncology patients at the Whittington in 2016

Central line associated bloodstream infections (CLABSIs) are known to be a significant cause of morbidity and mortality in this subset of patients: paediatric oncology. Therefore, it is important that we study the cause and nature of these infections in oncology patients to help inform clinical decisions and hopefully reduce rates of these infections.

The aim of this audit was to study the CLABSIs contracted by 4 of the 25 active oncology patients since January 2016.

We comprehensively examined the notes of the paediatric oncology patients known to have had a CLABSI in order to determine the causative organism, the antibiotic prescribed, the type of central line which the patient had and the patient's neutrophil count preceding the infection.

Conclusion:

- There was a higher incidence of CLABSI in those with Hickman lines compared with Port-a-caths or PICC lines.
- The most commonly isolated organism is Staphylococcus epidermidis and the data suggests patients are most vulnerable to this when neutropenic (low white cell blood count).
- Two patients who had CLABSI were not neutropenic, supporting the use of empiric antibiotics to any febrile oncology patient even if not neutropenic.

Action Plan:

- It is important to enforce strict protocols with regards to central lines in order to prevent these infections. These include meticulous hand hygiene, maximal aseptic technique when accessing the line, adequate patient/ parent education about line care and also optimal line type and site selection.
- Additionally every febrile patient should receive immediate empiric antibiotics even if not neutropenic.
- Finally the line should be removed as soon as it is no longer needed.
- This audit should be repeated annually to ensure the correct precautions are in place and the number of CLABSI are reduced as much as possible.

2.2.3 Participation in Clinical Research

At the time of writing (with 2 weeks until the recruitment upload cut-off), during 2016/17, 357 patients who received their care through Whittington Health were recruited into studies classified by the National Institute of Health Research (NIHR) as part of the NIHR research portfolio, once expected uploads are completed this is expected to rise to in excess of 480.

This compares to 284 patients in 2013/14, 701 in 2014/15 and 720 in 2015/16.

This year's reduction in recruitment can be attributed to a number of factors: the NIHR portfolio has fewer high volume recruiting studies available than in previous years, the mix of studies hosted within the trust has changed - there are more specialities involved though the studies are more specialised, there have been changes within the research delivery team that has meant some specialities have had reduced recruiting potential.

There are currently 48 NIHR portfolio studies in progress and recruiting at Whittington Health compared to 41 studies in 2015/16, 31 studies in 2014/15 and 21 in 2013/14. In addition to the 48 NIHR portfolio studies that are on-going, an additional thirteen non-portfolio studies were commenced so far in 2016/17, an increase of 5 studies on the previous year and puts the number at a similar level to 2014/15 having reduced to just eight studies in 2015/16.These studies are undertaken by nurses, allied health professional and trainee doctors and this year various paediatric and community services have hosted the majority of these studies. The results and impact of these studies are published in peer reviewed publications, at conference presentations and are valuable in their ability to innovate within the trust.

We are a year on from the ratification of the Whittington Health Research Strategy that underpins the clinical strategy and reflects the aim of enabling local people to 'live longer healthier lives'. A key strategic goal is to become a leader of medical, multi-professional education and population based research. We believe we are uniquely placed to take a life course approach to population based research and be at the forefront of the synergy between clinical service, education and clinical research. Progress is being made in our efforts to reach the targets within the strategy including the creation of a Research Assistant post to support one of our clinical academics with the development of paediatric population based research.

Participation in clinical research demonstrates Whittington Health's commitment to improving the quality of care that is delivered to our patients and also to making a contribution to global health improvement. We are committed to increasing the number of studies in which patients can participate, and the specialities that are research active, as we recognise that research active hospitals deliver high quality care. The Trust's research portfolio continues to evolve to reflect the ambitions of our Integrated Care Organisation and also reflects the health issues of our local population. The research portfolio includes CAMHS, dermatology, diabetes & endocrine, emergency medicine (and ICU), gastroenterology, haemoglobinopathies, hepatology, health visiting, IAPT, infectious diseases (TB), microbiology, MSK, oncology, orthopaedics, paediatrics, speech and language therapy, urology, and women's health.

2.2.4 Quality goals agreed with our commissioners for the year ahead (CQUINs)

A proportion of Whittington Health's income is conditional on achieving quality improvement and innovation goals between Whittington Health and our local CCGs through the Commissioning for Quality and Innovation payment framework.

Our CQUINs for 2017-18 are as follows:

- Improvement of Staff Health and Wellbeing
- Reducing the impact of Serious Infections (AMR and Sepsis)
- Improving services for people with mental health needs who present to ED
- Transitions our of Children and Young People's mental health services
- Offering advice and guidance
- NHS e-Referrals
- Supporting proactive and Safe Discharge
- Improving the assessments of wounds

- Personalised care and support planning

Further details of the agreed goals for 2017-19 are available electronically at:

https://www.england.nhs.uk/wp-content/uploads/2016/11/cquin-2017-19-guidance.pdf

2.2.5 Progress on our 2016-17 CQUINs

In 2016/17, 1.95% percent of our income was conditional on achieving quality improvement and innovation goals agreed between Whittington Health and our local commissioners through the CQUIN payment framework. These goals were agreed because they all represent areas where improvements result in significant benefits to patient safety and experience. Both Whittington Health and our commissioners believed they were important areas for improvement.

There is a full CQUIN team responsible for the achievement of CQUINs with an operational lead and a clinical lead. There is also a clinical lead and operational lead for each individual CQUIN.

Performance against CQUINS - pending end of year formal validation by Clinical Support Unit and Clinical Commissioning Groups

CQUIN scheme	Rationale / Objectives	Estimated Compliance
Staff Health and Wellbeing	To improve the support available for NHS staff to help promote their health and wellbeing in order for them to remain healthy and well.	Compliant
Sepsis	To make sure that the appropriate patients who attend the trust in an emergency are screened for sepsis, and receive the necessary antibiotics	Compliant
Antimicrobial Resistance	To reduce antibiotic consumption, encourage focus on antimicrobial stewardship and ensure antibiotic usage is reviewed within 72 hrs of prescribing.	Partially Compliant
Safe and Timely Discharge	To make sure we discharge patients early in the day, where possible, and that information in the discharge summaries sent to general practitioners is complete and timely.	Compliant
Obesity	To record selected patients BMI during admission, to provide advice and guidance to patients with a BMI >30 and record on discharge summary to GP	Compliant

Domestic Violence Prevention	To encourage the provision of specialist advice, information and support services for patients at risk of domestic violence, and to implement domestic violence screening for all patients in maternity.	Compliant
Nutrition and Hydration	To make sure that all COOP patients have a nutrition and hydration screen within 72hr of admission and that all at risk patients have an appropriate care plan in place.	Compliant
Child Health Information System (CHIS)	To promote the secure and timely transfer of clinical records between providers and the tracking of all HepB and BCG immunisations. This promotes best clinical care for the most vulnerable children which includes looked after children	Compliant
CAMHS	To ensure we improve involvement of carers, that unplanned admissions are appropriate and that we improve physical healthcare	Compliant
Oral Chemotherapy	To ensure that we minimise the amount of Oral Chemotherapy that is prescribed, yet not taken by patients - by reviewing length of prescription courses	Compliant

2.2.6 The Care Quality Commission and Whittington Health 2016/17

Whittington Health is required to register with the CQC at our acute and all of our community sites and our current registration status is 'registered without conditions'.

The CQC has not taken enforcement action against Whittington Health during 2016/17.

The CQC carried out a formal inspection of Whittington Health NHS Trust between 8 – 11 December 2015, with further unannounced inspections taking place on 14, 15 and 17 December.

This was the first inspection under the new CQC guidelines and the inspection team visited:

- **Acute hospital** – including emergency and urgent care, medicine (including older people's care), Surgery, Critical Care, Maternity and Gynaecology, Services for Children, End of Life, Outpatients and diagnostic services
- **Community services** – adults, children and young people, end of life care and CAMHS

The findings were published in July 2016. Whittington Health was rated as 'Good' overall and 'Outstanding' for caring.

	Safe	Effective	Caring	Responsive	Well-led
Whittington Health	**Requires Improvement**	**Good**	**Outstanding**	**Good**	**Good**

Summary of overall key question ratings for each sector

	Safe	Effective	Caring	Responsive	Well-led
Whittington Hospital	**Requires Improvement**	**Good**	**Good**	**Requires Improvement**	**Requires Improvement**
Community Services	**Good**	**Good**	**Outstanding**	**Good**	**Outstanding**

The summary report highlighted many areas of good practice across Whittington Health, including;

- Inspectors found staff to be highly committed to Whittington Health and delivering high-quality patient care
- Our patients were positive about the care they received and felt staff treated them with dignity and respect
- Learning from incidents was shared across the organisation to improve patient safety
- Community end of life care and community dental services were rated as outstanding
- The multi-disciplinary model of the ambulatory care service was commended
- Within ED there was “outstanding work” to protect people from abuse

However the CQC also identified areas for improvement across the ICO and the Trust has developed an action plan for improvement based on the ‘must do’ and ‘should do’ recommendations from the report.

Table outlining the CQC action plan:

CQC Recommendation	What we’ve done
To review our bed capacity and improve flow of patients through the hospital – with a particular focus on surgery and critical care.	We have implemented a new Acute and Emergency Pathway Improvement Plan, which focuses on bed management and patient flow. As a result, we have: • A pre 11.00am discharge campaign aimed at staff and patients, designed to reduce delays which aims to get patients home before lunch. • Increasing the number of nurse-led discharges, using a new set of criteria to make sure patients are ready to go home and have the right support in place. • Implementing best practice from other NHS Trusts to improve bed flow, by introducing ‘Red and Green’ day monitoring to identify any obstacles in patient flow. • We’ve introduced new dedicated cordless phones to help improve our communications between wards. Ward clerks can now be contacted anywhere on the ward – helping to reduce delays with porters and also

	providing a dedicated phone line for patients and family members to contact the ward on.
	Further Actions to Complete: • Recruitment to full establishment is expected to be completed by July 2018. • In order to manage the increase demand and acuity, the organisation is focusing on its Emergency Department (ED) Improvement plan and meeting the recommendations set out by Emergency Care Improvement Programme (ECIP) through; embedding the Frailty Pathway into practice, embedding a Rapid Assessment and Treatment (RAT) model to increase senior leadership and decision making at the ED front door, developing a new nursing model to support quicker London Ambulance Service hand over, the recruitment of additional ED Consultants, increasing criteria lead discharge and pre 11 discharges and working extremely closely with health and social work colleagues to safely support patient discharge. • The organisation was visited by ECIP during February. The visit focused on how on improving flow through medicine and surgery to compliment an earlier ECIP visit to the organisation that focused enhancing the front door flow. • The final report made 3 key recommendations for WH: Develop and implement a local version of the SAFER patient flow bundle, supported by the Red2Green approach Develop, measure and monitor a set of internal professional standards (IPS) for inpatient ward processes (e.g. expected time taken to complete a CT scan, expected time taken for the completion of social care paperwork, etc.) Consider the development of a full capacity protocol to support ambulance handover processes and reduce the risk in ED at times of peak escalation
Increase consultant cover in the Emergency Department	• A recruitment campaign is underway to increase the number of consultants in ED • ED have recruited 4/6 consultants required to achieve full establishment (12 consultants), and further interviews took place in April/ May.
	Further Actions to Complete: • Recruitment to full establishment is expected to be completed by July 2018
Within acute outpatient departments **a. Improve storage of records and ensure patients' personally identifiable information is kept confidential**	• A new health records quality assurance group has been established • Lockable trolleys for patient notes in use • Confidential waste bags kept at manned reception desks and locked away securely at night • Random spot checks now show staff have a good knowledge of patient confidentiality issues and information governance.

b. Improve disposal of confidential waste bags left in reception areas overnight.	Further Actions to Complete: • No further actions to take, however we are continuing to improve our records management and information governance training
Within critical care CQC raised concerns about; • **Underreporting incidents and near misses** • **Tailgating and security of ward** • **Mixed sex breaches and delayed discharges**	• A new Datix system is now in place and went live on 6 June 2016. • New staff training programme was introduced to encourage the reporting of incidents – the number of incidents reported has now increased. • Where specific areas of concern around tailgating were raised, security measures have been increased • Our improvement work on bed management and patient flow is designed to reduce delays in discharge and prevent mixed sex breaches
	Further Actions to Complete: • No further actions to take, however we continue to monitor incidents and a monthly report on mixed sex breaches is shared with our commissioners
Within surgery review local strategy for consent for surgery processes to follow best practice, to allow patients to have a 'cooling off' period in advance of their surgery, should they wish to reconsider their procedure	• The consent process has been reviewed and a pilot is underway way trialling new consent forms
	Further Actions to Complete • Following successful completion of the pilot, the new consent forms will be rolled out across surgery by the end of Quarter 2.
Within maternity services ensure the information captured for the safety thermometer tool is visible and shared in patient areas, for both patients and staff	• The maternity safety thermometer tool is now displayed in all maternity ward areas
	Further Actions to Complete • No further actions to take, the maternity safety thermometer is reviewed monthly
Within maternity services there was limited assurance about safety of women undergoing elective procedures in the second obstetric theatre and concerns about theatre staffing cover.	• Our staffing model has been reviewed and following successful recruitment campaign in March 2017, all posts have now been filled. • We have also increased the promotion of our Enhanced Recovery Programme so women feel more supported during their stay with us
	Further Actions to Complete • No further actions to take, safe staffing levels are monitored daily using our electronic rostering tool

Within palliative care **a. Need to increase palliative care consultant cover within the hospital to meet national guidance** **b. Need to improve the way we record information about whether patients were cared for at their 'preferred place of death'.**	• A business case to increase our consultant cover in line with national standards was approved and work is ongoing to increase consultant cover • An audit of patient notes has shown that we do record patient's preferred place of death • Analysis of the information showed that when possible to do so, patient's wishes are respected. However it is not always clinically safe to discharge patients back home
	Further Actions to Complete 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. We recognise the existing service falls short of this standard, however it is rare that services across London provide this in full. In order to optimise the current service and mitigate the risk of not providing 7 day cover we are working 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 plan
At Simmons House: Improve ligature risk assessments and the identification of associated risks	• A review of all ligature risks was undertaken following the inspection and any required actions have now been completed
	Further Actions to Complete • No further actions to take, a full environmental ligature risk assessment is completed annually at Simmons House
Requirement Notice *: At Simmons House: Sufficient equipment and/or medical devices that are necessary to meet people's needs should be available at all times and devices must be kept in full working order. They should be available when needed and within a reasonable time without posing a risk.	• The Whittington Health Resuscitation Team reviewed the emergency bag and confirmed that all necessary equipment was in place
	Further Actions to Complete • No further actions to take, regular reviews are now carried out to ensure equipment is in full working order
Requirement Notice *: At Simmons House: Oxygen cylinders were stored on top of a tall cupboard in	• There are two oxygen cylinders on site at Simmons House; one on a low shelf and one hanging on the back of the door, within easy reach in case of emergency

the clinic room and were not easily accessible in an emergency situation.	Further Actions to Complete • No further actions to take
Requirement Notice *: In community district nursing, CQC found examples where HCAs were not following trust guidelines with respect to insulin administration. Specific staff are required to be authorised to administer to specific patients only.	• Trust policy states that HCA competency for insulin administration is patient specific. • We carried out an audit to check that all HCAs working in the service had been competency assessed and were working within the policy guidelines. • All HCAs continue to be assessed and we keep a database to show which HCAs can administer insulin and to which patients.
	Further Actions to Complete • No further actions to take, we keep a database to show which HCAs can administer insulin and to which patients.

To ensure continuous quality improvement and shared learning, going forward since the CQC visit, the Trust has an ongoing programme of mock CQC visits across different clinical areas and patient safety huddles.

2.2.7 Quality of Data and Information Governance

Reliable information is essential for the safe, effective and efficient operation of the organisation. This applies to all areas of the Trust's activity from the delivery of clinical services to performance management, financial management and internal and external accountability. Understanding the quality of our data means we can accurately measure our performance and enable healthcare improvements.

The Trust monitors the quality of this data through use of quarterly benchmark reports and has developed a Data Quality Dashboard for services to monitor their own data quality on a regular basis.

There is no equivalent system in place yet for community data although the implementation of the Children's and Young Person's mandatory reporting dataset has commenced and data is starting to be published. Whittington Health has been supplying demographic and risk factor information consistently since the service commenced October 2015 while continuing to develop the reporting of the other data items. The overall data quality score for all children's data items reported up to October 2016 was 58% against a national score of 55%; the Trust was ranked 3rd out of the 10 London providers submitting data (the highest score was 63%).

Whittington Health's Integrated Clinical Service Units (ICSUs) have responsibility for data quality within their ICSU. The Trust has a Data Quality Group which includes representation from both the community and acute services and the ICSUs. This group is chaired by the Trust's Chief Operating Officer. This group is responsible for implementing an annual data improvement and assurance plan and measures the Trust's performance against a number of internal and external data sources.

Secondary Uses service

Whittington Health submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number and which included the patient's valid General Medical Practice Code were as follows:

	Percentage of records which included the patient's valid NHS number (%)	Percentage of records which included the patient's valid General Medical Practice Code (%)
Inpatient care	99.32%	97.99%
Outpatient care	99.49%	99.07%
Emergency care	95.86%	97.69%

Information Governance Assessment Report

In 2016/17 Whittington Health continued to work to deliver IG Level 2 compliance with the DoH IG Toolkit (IGT). Whittington Health achieved 74 percent, thus meeting full Level 2 compliance for the first time since becoming an Integrated Care Organisation, and also achieving some requirements at Level 3. This is a huge improvement on previous years' scores and has demonstrated year-on-year improvement in compliance with the standards.

The areas that continues to present a challenge to us is the achievement of the 95 percent target for all staff to have completed IG training annually, and IG serious incidents.

The IG training compliance rates will continue to be regularly monitored by the Information Governance Committee, including methods of increasing compliance. The IG department will continue to target staff with individual emails, Whittington bulletin messages and classroom-based Induction sessions.

As IG awareness increases throughout the organisation, our risk of an IG serious incident reduces correspondingly. However, there is room for improvement in terms of staff awareness of policies and procedures and departments complying with IG guidelines, especially when other pressures are continually increasing. We are confident that through increasing ITG training compliance and increasing general IG knowledge and awareness, the IG-related risks to the Trust will reduce.

Clinical coding audit

Whittington Health was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were the following:

Table of coding accuracy

Area audited	% Diagnoses Coded Correctly		% Procedures Coded Correctly	
	Primary	Secondary	Primary	Secondary
General Medicine	100.00	94.21	100.00	87.88
General Surgery	98.00	97.66	100.00	96.39
Gastroenterology	96.67	96.28	95.24	66.00
Obstetrics	100.00	90.26	100.00	91.03
Accident & Emergency	93.33	92.24	100.00	100.00
Overall	**98.00**	**94.20**	**99.22**	**87.94**

Actions taken to improve data quality

In 2016-17, Whittington Health implemented a number of projects to improve data quality, such as in improving the coding of activity, the systematic use of benchmarking data and other reviews, and developing a programme of audits and action plans to improve data quality.

To improve data quality in 2017/18, Whittington Health will require each Integrated Clinical Service Unit (ISCU) to have a Data Quality Improvement Plan, which will be reported against on a regular basis at the Data Quality Group.

2.3 National Performance Indicators

2.3.1 The Summary Hospital-level Mortality Indicator (SHMI)

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

Most recent performance:

Using the most recent data available, (released Mar17) that covers the period October 2015 to September 2016, the SHMI score for the Whittington is:

Whittington Trust SHMI score: 0.6897

- Lowest National Score: 0.6897 (Whittington Health)
- Highest National Score: 1.1638

Previous Performance:

The data released in March 2016 covered the period October 2014 to September 2015:

Whittington Health SHMI score: 0.6516

- Lowest national score 0.6516 (Whittington Health)
- Highest national score 1.198

The SHMI score represents a comparison against a standardised National Average. The 'national average' therefore is a standardised 100 and values significantly below 100 indicate a lower than expected number of mortalities (and vice versa for values significantly above).

Patients who are coded as receiving palliative care are included in the calculation of the SHMI. The SHMI does not make any adjustment for patients who are coded as receiving palliative care. This is because there is considerable variation between trusts in the coding of palliative care. Whittington Health coding from palliative care indicates that the combined % of deaths with either palliative care diagnostic coding, or under a palliative care specialty is 0.4% for the period Oct15-Sep16 (3 deaths out of 512) and 0.18% for the period of Oct14-Sept 15.

The Whittington Health NHS Trust considers that this data is as described as it is produced by a recognised national agency and adheres to a documented and consistent methodology.

Whittington Health is taking the following actions to further improve this score, and so the quality of its services, by:

- Providing regular learning events and resources for all staff to facilitate learning from incidents and findings from unexpected deaths;

- Ensuring that all inpatient deaths are systematically reviewed, and that any failings in care that suggest a death may have been avoidable are identified, systematically shared, learned from, and addressed.

2.3.2 Patient Reported Outcome Measures (PROMs)

The outcomes of these measures are reported one year in arrears. Two years ago no questionnaires were sent out to patient's pre or post operation due to an administrative error. This year Whittington Health participated in the PROMs project, however there was not a sufficiently high response rate to produce any statistically significant results (a minimum of 30 post-operative results for a given procedure are required).Post-operative response rates were also insufficient in 2015/16 (21).

The issue with questionnaires has now resulted in a low linkage performance for this performance measure. Questionnaires are now regularly sent out and chased up by the pre and post operation relevant staff and our return is now improving.

Finally please note that we only started undertaking varicose vein operative procedures at Whittington Health in April 2017, i.e. this year which is why the report is showing as null.

Table 1: Pre-operative participation and linkage

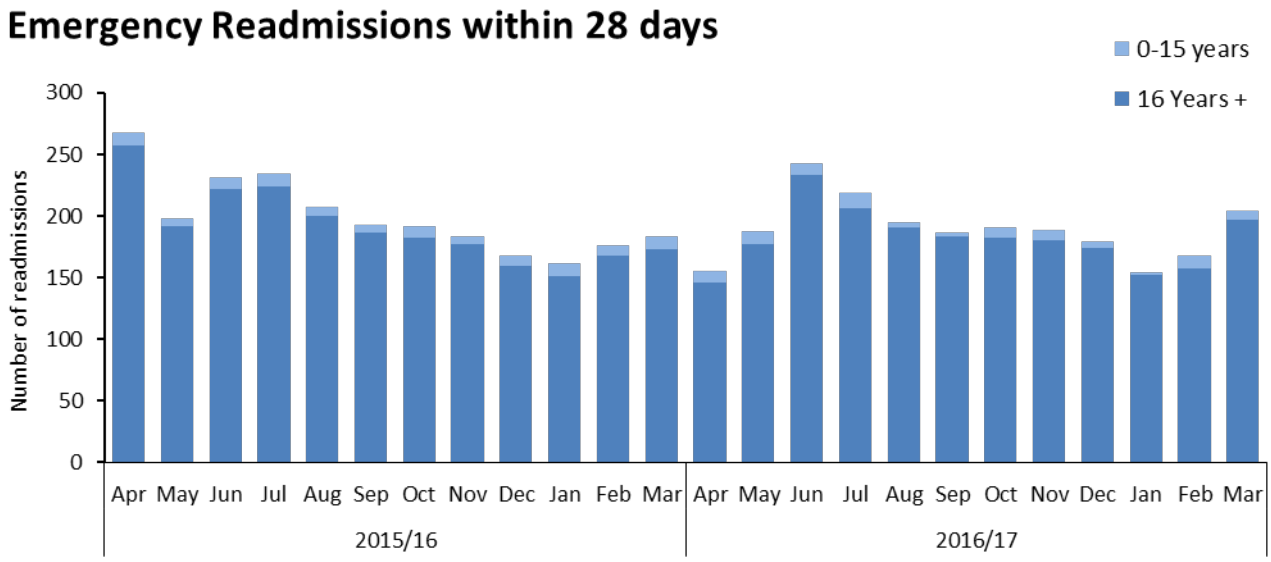
	Eligible hospital procedures	Pre-operative questionnaires completed	Participation Rate (%)	Pre-operative questionnaires linked	Linkage Rate (%)
All Procedures	296	206	69.6	141	74.6
Groin Hernia	139	80	57.6	48	69.6
Hip Replacement	88	64	72.7	52	79.9
Knee Replacement	69	62	89.9	41	71.4
Varicose Vein	*	*	*	*	81.8

Table 2: Post-operative issue and return

	Pre-operative questionnaires completed	Post-operative questionnaires sent out	Issue Rate (%)	Post-operative questionnaires returned	Response Rate (%)
All Procedures	206	52	25.2	22	41.1
Groin Hernia	80	44	55.0	18	48.7
Hip Replacement	64	0	0.0	0	37.4
Knee Replacement	62	8	12.9	4	37.0
Varicose Vein	*	*	*	0	39.1

The Whittington Health NHS Trust considers that this data is as described as it is produced by a recognised national agency and adheres to a documented and consistent methodology.

2.3.3 Readmissions



**Data is reported against the month of the emergency readmission*
***Data excludes patients between 0 and 4 years at time of admission*

The Trust considers that this data is as described as it has a robust clinical coding and data quality assurance process, and our readmission data is monitored through the Trust Board or TMG on a monthly basis. National data has not been published beyond 2011/12. Consequently, national comparison is not available and this information is generated locally by the trust.

The Trust intends to take the following actions to improve its readmissions rates:

- Launching a new clinical pathway for non-elective patients over the age of 75 with frailty, to provide early CGA/ geriatrician input in the Acute Admissions Unit for patients who have potential to be discharged ≤ 48 hours

- In 2017 we are introducing ward based Flow Liaison Officers to key wards to support timely and safe patient discharge using both Enhanced Recovery (medicine/ surgery) and Red to Green methodology.

2.3.4 Responsiveness

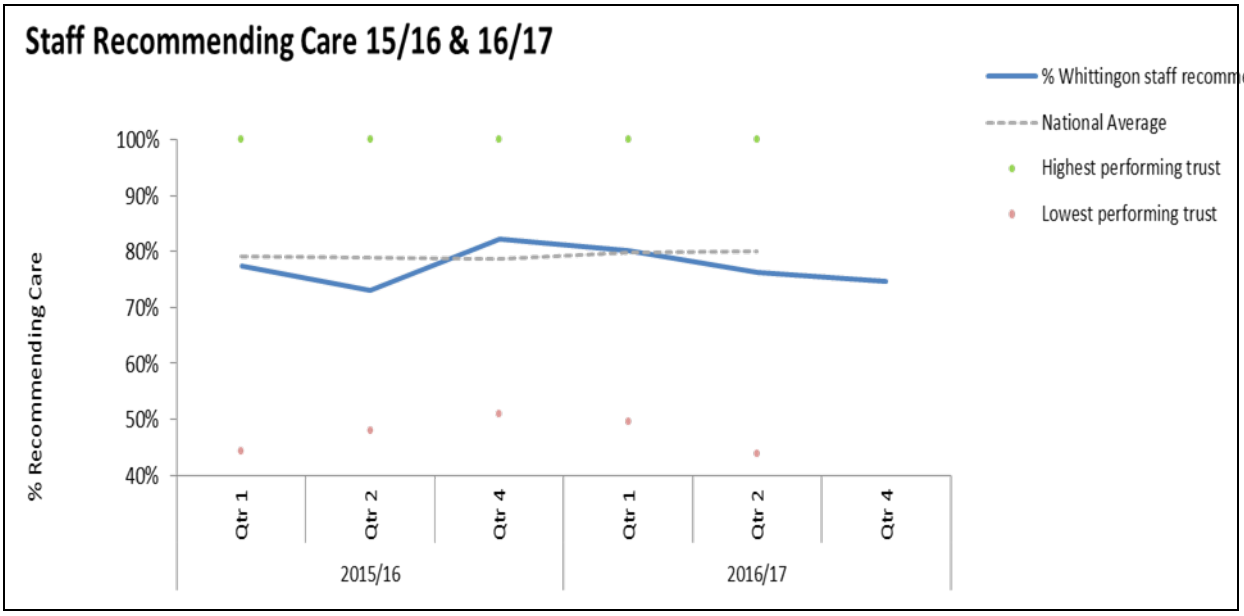
[Data not published until June 2017 – CQC]

Holding place for when the data becomes available.

2.3.5 Staff Friends and Family Test

FY	Month	% Whittingon staff recommending care	National Average	Highest performing trust	Lowest performing trust
2015/16	Qtr 1	77.5%	79.2%	100.0%	44.3%
	Qtr 2	73.2%	79.0%	100.0%	47.8%
	Qtr 4	82.3%	78.7%	100.0%	50.8%
2016/17	Qtr 1	80.1%	79.9%	100.0%	49.5%
	Qtr 2	76.2%	80.0%	100.0%	43.8%
	Qtr 4	74.6%	*National data not yet published		

Note: Staff Friends and Family Test is not conducted in Q3 due to the national staff survey taking place



The Whittington Health NHS Trust considers that this data is as described as it is collected, downloaded and processed in a robust manner, and checked and signed off routinely

Summary of Quarter 4 Whittington Health Responses

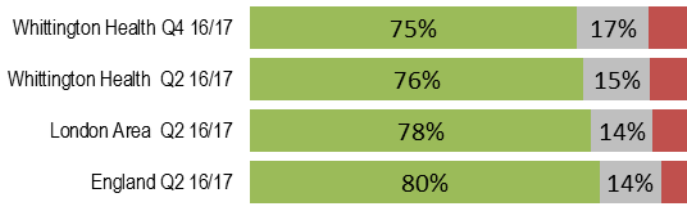
Total Respondents	986	**Response Rate**	24%

	Care	Work
	How likely are you to recommend	How likely are you to recommend
% Recommended	75%	61%
% Did not recommend	9%	23%

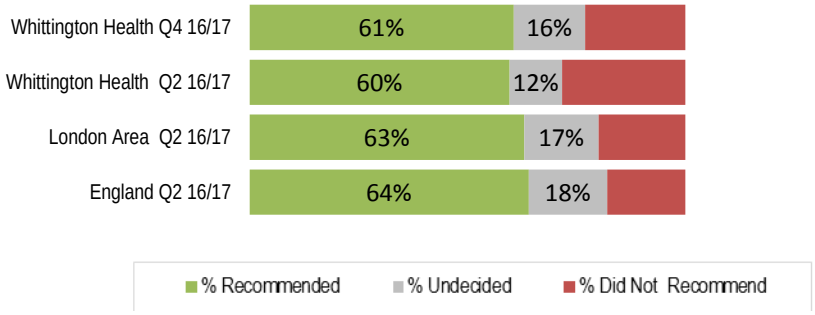
2) Numerator for % recommending: number of *'likely' or 'extremely likely'* responses

Proportion of employees recommending care and workplace

Care



Work



The Trust has high levels of staff engagement and our Family and Friends Test show that staff perception of the Trust's services to be high. We believe that the willingness of staff to recommend the Trust as a place to be treated is a strong and positive indicator of the standard of care provided

2.3.6 Venous Thromboembolism (VTE)

Every year, thousands of people in the UK develop a blood clot in the vein. It is known as the venous thromboembolism (VTE) and is a serious, potentially fatal, medical condition. Here at Whittington health we continue to strive towards ensuring all admitted patients are individually risk assessed and have appropriate thromboprophylaxis prescribed and administered. We have consistently achieved above 95% or above compliance over the past year.

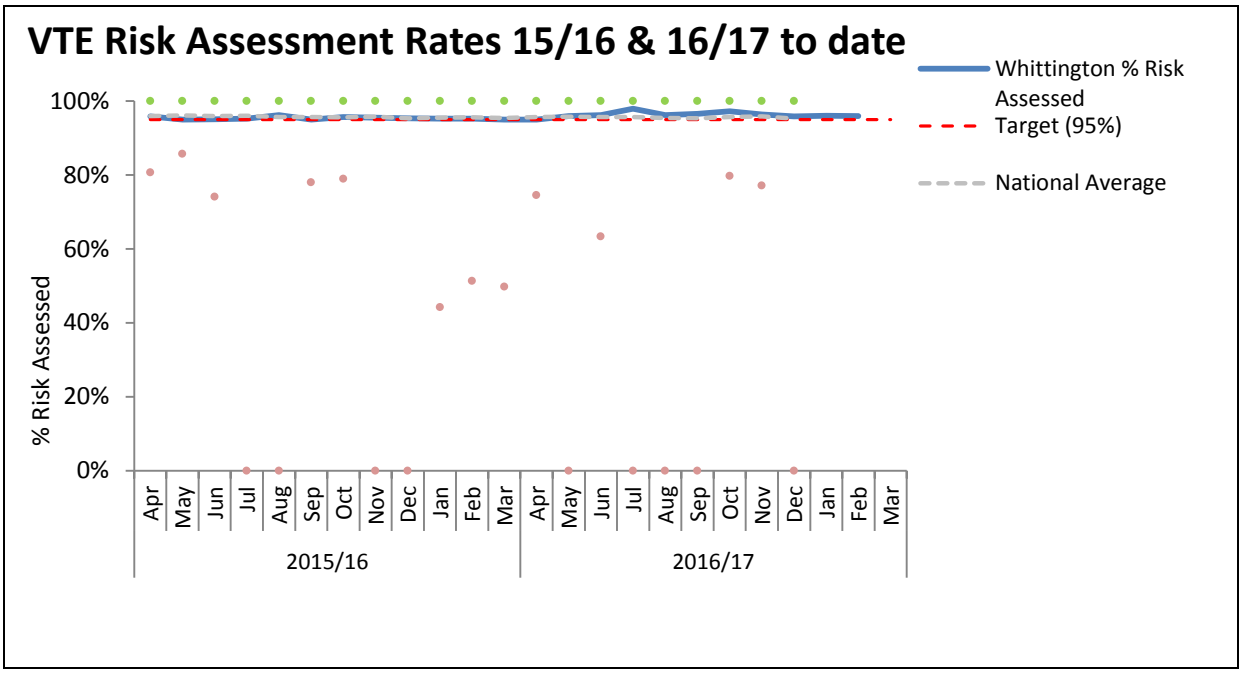
The Trust considers that this data is as described for the following reasons as it is generated via daily, weekly and monthly reports and submitted via the dashboard to executive level.

In 2016-17, the Trust has taken the following actions to improve our approach to VTE:

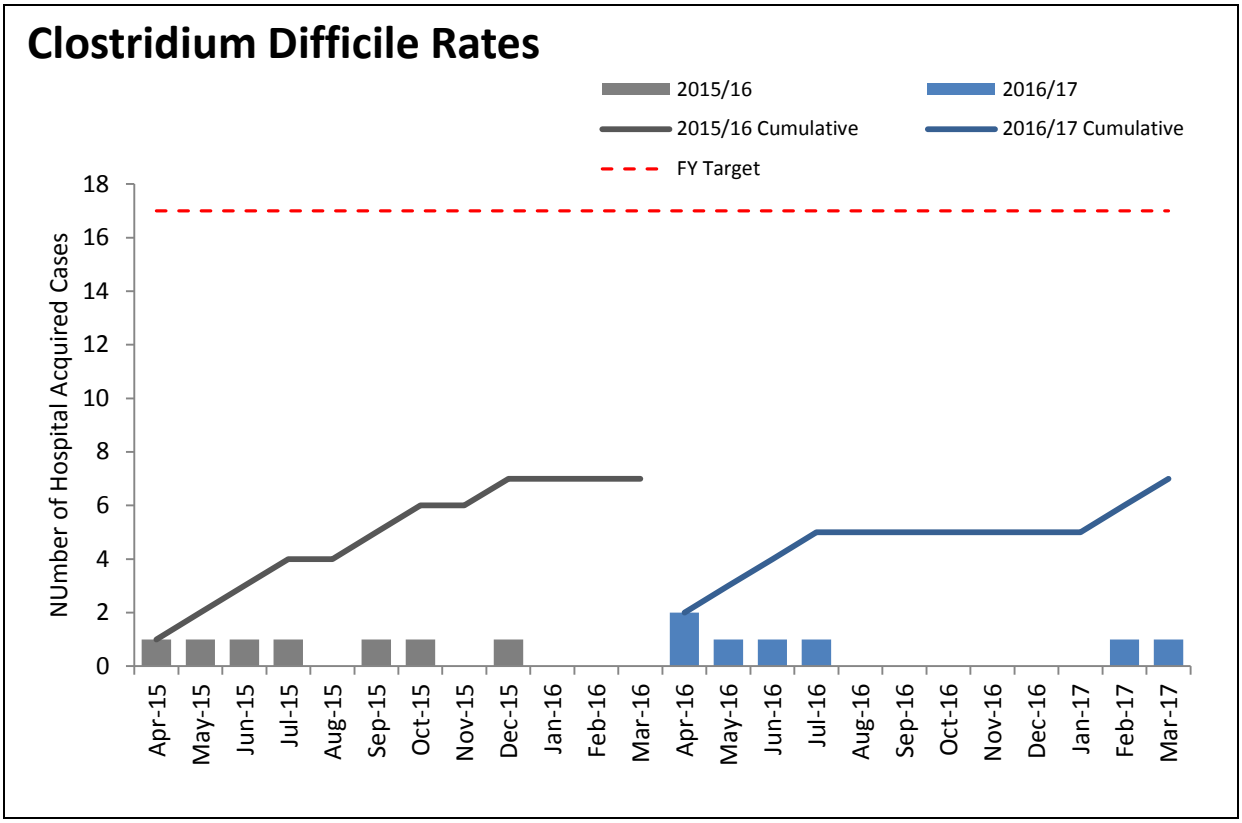
In an effort to continuously improve and review our pathways our medical colleagues undertook audits to ensure VTE compliance is robust and aligned with best patient outcome, for example, two of our doctors undertook an audit of Friday review sheets which is a process for senior clinicians to review and document the weekend plan of care. This identified good compliance across medicine but less so in surgery. Following this review we

have introduced a bespoke Friday review sheet across surgery. This document has an embedded VTE risk assessment, as a prompt mechanism, for clinicians working over the weekend – this ensures continuity of care across the seven days.

Another area of improvement in VTE care over the past year includes improved VTE pathway management. Previously the flow of patients who required further investigation and follow-up was sometimes circuitous with patients going between various health care settings and providers prior to decisions being made. There was also a significant delay in patients being reviewed in the haematology clinic due to work-load pressures. To address this, a regular clinic (initially monthly, now fortnightly) has been created in the Ambulatory care setting (a frequent site of diagnosis of VTE and referrals into haematology). In the initial 6 months this has led to a significant improvement in adherence to the NICE guidelines, improved patient satisfaction and stakeholder engagement. 91% of patients were able to be discharged with a care plan (sent to the patient, primary care and anticoagulation) with the remainder 9% of complex patients then being seen in the general haematology clinic for further follow-up. We are currently reviewing our guidelines on VTE in conjunction with our pharmacy colleagues to further streamline our service and in line with increased use of Direct Oral Anticoagulants (DOACs) in our trust.



2.3.7 Clostridium Difficile



*The Whittington Health NHS Trust considers that this data is as described as it is collected, downloaded and processed in a robust manner, and reviewed as part of routine board and departmental monitoring of infection control.

Month & Year		Whittington Health			National Total	Trust with lowest incidence	Trust with highest incidence
		Monthly Cases	YTD Cumulative	FY Target			
Apr-15		1	1	17	421	0	19
May-15		1	2	17	476	0	12
Jun-15		1	3	17	425	0	16
Jul-15		1	4	17	466	0	14
Aug-15		0	4	17	436	0	14
Sep-15		1	5	17	454	0	12
Oct-15		1	6	17	463	0	10
Nov-15		0	6	17	436	0	15
Dec-15		1	7	17	409	0	16
Jan-16		0	7	17	419	0	11
Feb-16		0	7	17	401	0	11
Mar-16		0	7	17	358	0	11
Apr-16		2	2	17	357	0	10
May-16		1	3	17	386	0	14
Jun-16		1	4	17	359	0	11
Jul-16		1	5	17	390	0	10
Aug-16		0	5	17	427	0	14
Sep-16		0	5	17	433	0	12

Oct-16		0	5	17	401	0	11
Nov-16		0	5	17	411	0	11
Dec-16		0	5	17	369	0	14
Jan-17		0	5	17	414	0	15
Feb-17		1	6	17	325	0	11
Mar-17		1	7	17	*national Data not yet published		

During 2016/17 we had seven *Clostridium difficile* cases attributable to Whittington Health. The following paragraphs outline the actions we have taken to reduce the number of *Clostridium difficile* cases that are attributable to Whittington Health.

Consultant led post infection review meetings (PIR) were held on all cases and the reports disseminated to relevant parties both internally and externally. Our agreed ceiling trajectory for 2016/17 was set at 17 cases and we reported six cases at year end.

Each patient case of attributable *Clostridium difficile* was thoroughly investigated with a full Consultant-led post-infection review focusing on all aspects of the patient pathway from admission to diagnosis. All cases were deemed unavoidable with no lapses in care.

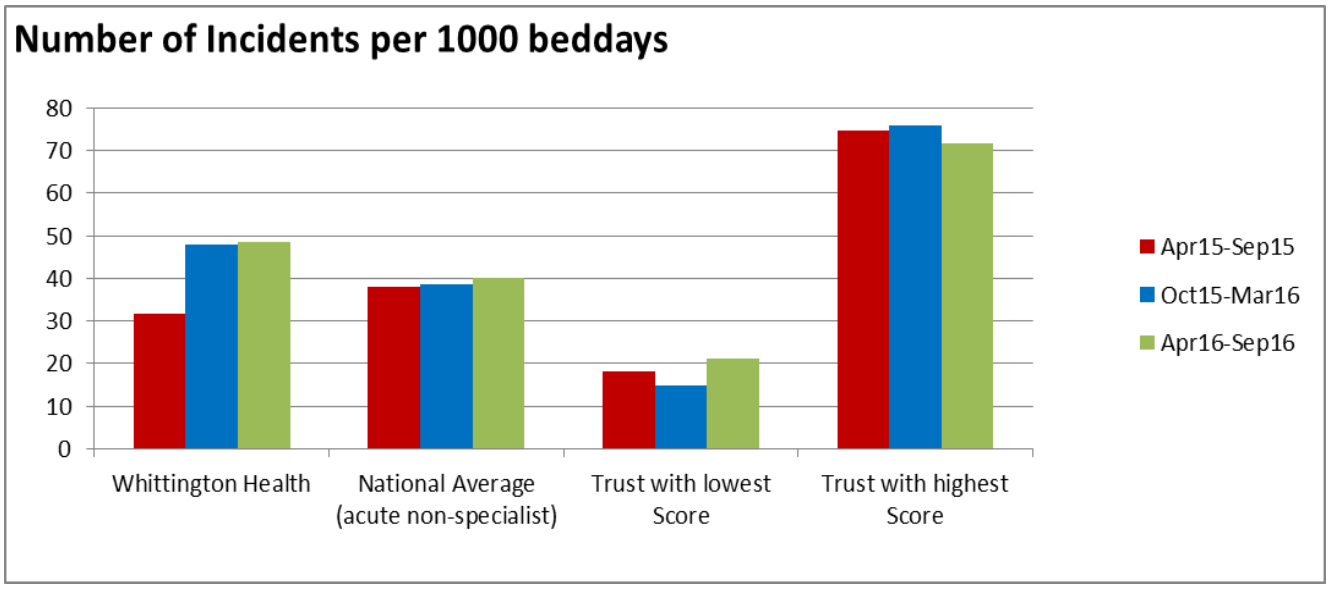
Infection Prevention and Control alerts are already placed on our Medway electronic patient records system for patients diagnosed with healthcare associated infections but it is apparent that these are not always reviewed prior to bed placement. A further alert has been introduced to the JAC electronic prescribing system to improve staff awareness and aid the correct bed placement of the patient in order to reduce the risk of cross contamination.

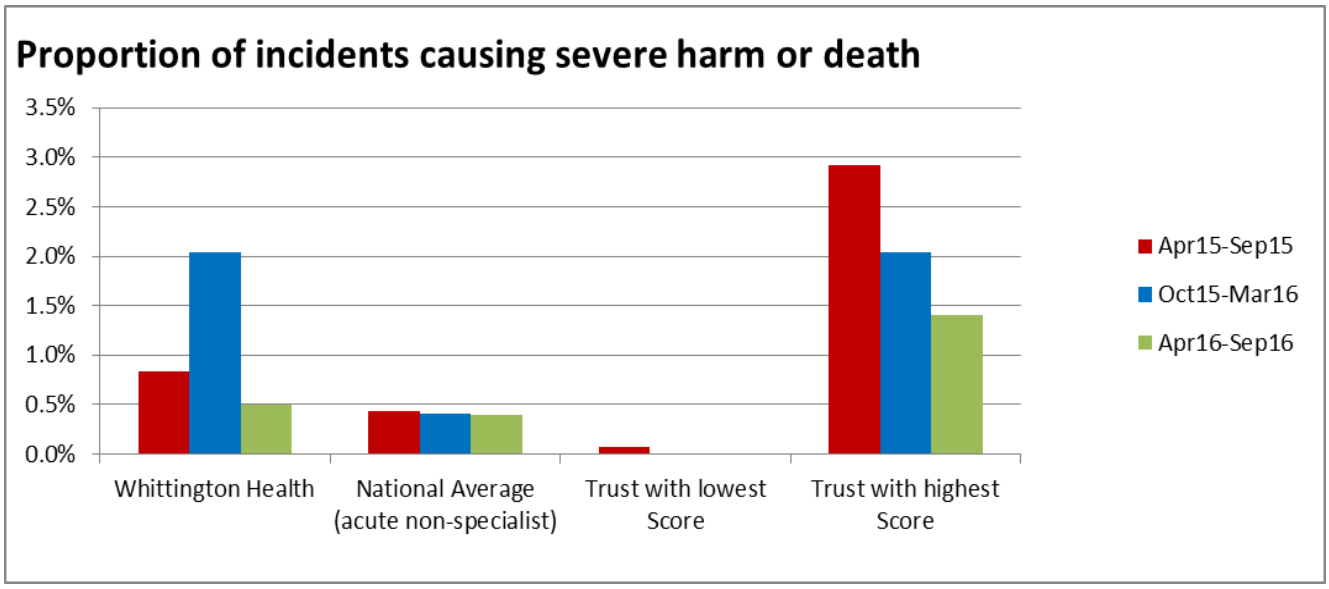
We purchased additional patient equipment to aid with the management of infectious / potentially infectious patients. Twenty two electronic blood pressure fixed monitors for our cubicles and 10 isolation carts to be used for cohort / individual bedside isolation.

Education sessions specifically on *Clostridium difficile* continue on our acute wards.

2.3.8 Patient safety incidents

		Apr15-Sep15	Oct15-Mar16	Apr16-Sept16
Number of Incidents	Whittington Health	1559	2506	2362
	National Total (acute non-specialist trusts)	632050	655193	





* The Whittington Health NHS Trust considers that this data is as described as it produced by a recognised national agency and adheres to a documented and consistent methodology

In April 2015 to September 2015 Whittington Health was an average reporter of patient safety incidents to the National Reporting and Learning System (NRLS). Between October 2015 and March 2016 there was a significant increase in reporting to NRLS such that Whittington Health is now in the top quartile of trusts reporting patient safety incidents. Whittington Health remained in the top quartile of trusts reporting safety incidents for April

2016 to September 2016. Whittington Health has reported 8% more incidents during October 2016 to March 2017.

This has been celebrated by the Trust in recognition that organisations that have high reporting numbers have been shown to be those with an established strong patient safety culture. At the time of reporting approximately 2.7% of the reports within the April 2016 to September 2016 NRLS data had not been validated.

Whittington Health appears to have a higher proportion of incidents causing severe harm or death compared to the national average for acute non-specialist trusts. This has, however, decreased in the last reporting period from 13% to 4.6%.

The Trust intends to or has taken the following actions to improve:

- Each patient safety incident (reported on Datix) that is believed to be associated with severe harm or death is reviewed within 72 hours by the ICSU clinical staff and immediate mitigating steps are put in place.
- These 72 hour reports are reviewed at the Serious Incident Executive Approval Group Panel weekly by the Medical Director, Chief Operating Officer and Director of Nursing (or representatives). Any further key learning messages relevant to staff are sent out via Trust-wide email at this stage. Full root cause analysis investigations are undertaken for all severe harm and death incidents with action plans created, reviewed and shared with relevant parties.
- Learning from incidents are shared through multiple outlets including patient cases on Moodle (interactive e-learning platform), messages of the week sent out via ICSU leads, Spotlight on Safety newsletter, Medicine Safety newsletter, Maternal Cats Eyes newsletter, learning site on intranet, patient safety forum and at team departmental and ward-based meetings.
- The Trust recognises the need to ensure that there is more complete ICSU sign-off prior to uploading data to the NRLS website.

During 16/17 unfortunately the Trust had 2 never events. One was a retained foreign object post-procedure and the other was a misplaced naso-gastric tube. Both of these events were fully investigated and root cause analysis conducted. The learning was disseminated across the organisation.

2.3.9 Friends and Family Test

Our goal is to provide our patients with the best possible experience by increasing the number of patients who respond and the percentage of patients who would recommend our Trust to friends and family if they needed similar care or treatment.

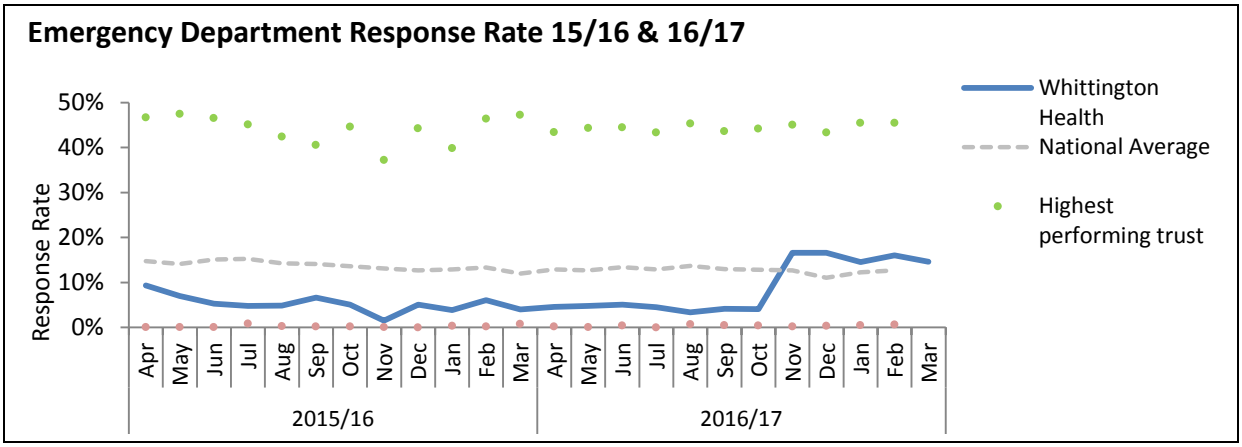
We know that treating our patients with compassion, kindness, dignity and respect has a positive effect on recovery and clinical outcomes. To improve their experience in our hospital and Community, we need to listen to our patients, their families and carers, and respond to their feedback. The Friends and Family Test (FFT) is one key indicator of patient satisfaction. Through our real time patient experience trackers, this test asks patients whether they would be happy to recommend our Trust to friends and family if they needed similar treatment.

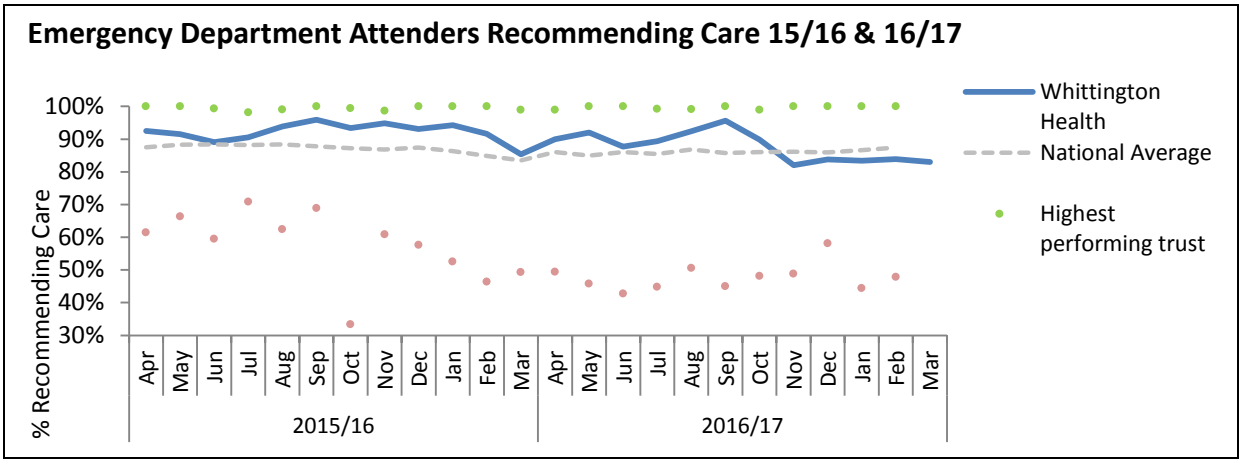
In 2016/17 we achieved our goal of increasing the percentage of inpatients and A&E patients who would recommend our Trust to friends and family, exceeding our target for both and improving on our performance last year.

For patients reporting a positive experience, interaction with staff is the most significant factor. When patients report a negative experience, the cause is usually due to ineffective systems and processes. We continue to take steps to improve our systems and processes to ensure that waiting and delays are kept to a minimum and, where they are unavoidable, patients are kept informed and the environment and staff are as welcoming and supportive as possible. We have achieved our goal through a number of improvements we made that were designed to ensure our services are caring, putting the individual at the centre of their own care, and treating them as we would like our own friends and family to be treated, while also enabling us to achieve our targets for 2015/16. These are described below.

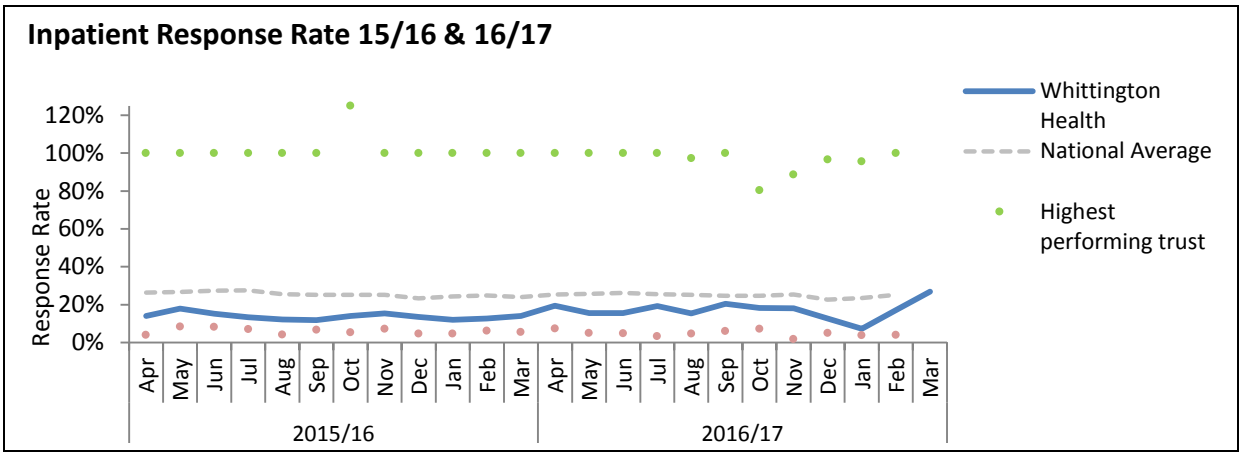
We have identified further improvements in our quality targets for next year which will continue to improve patient experience across Whittington Health.

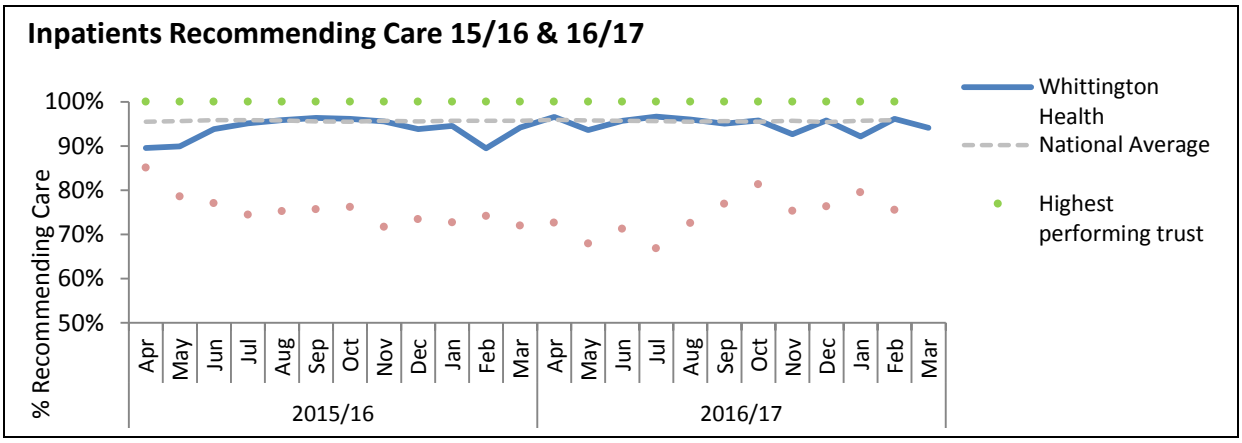
Friends and Family Tests in the Emergency Department





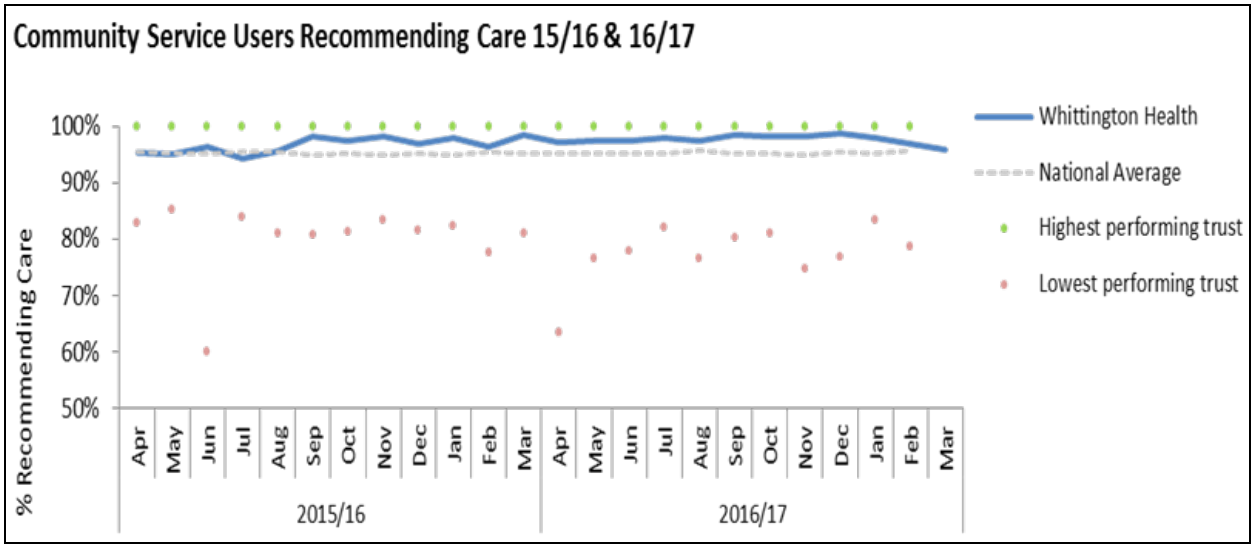
Friends and Family Tests Inpatient Results

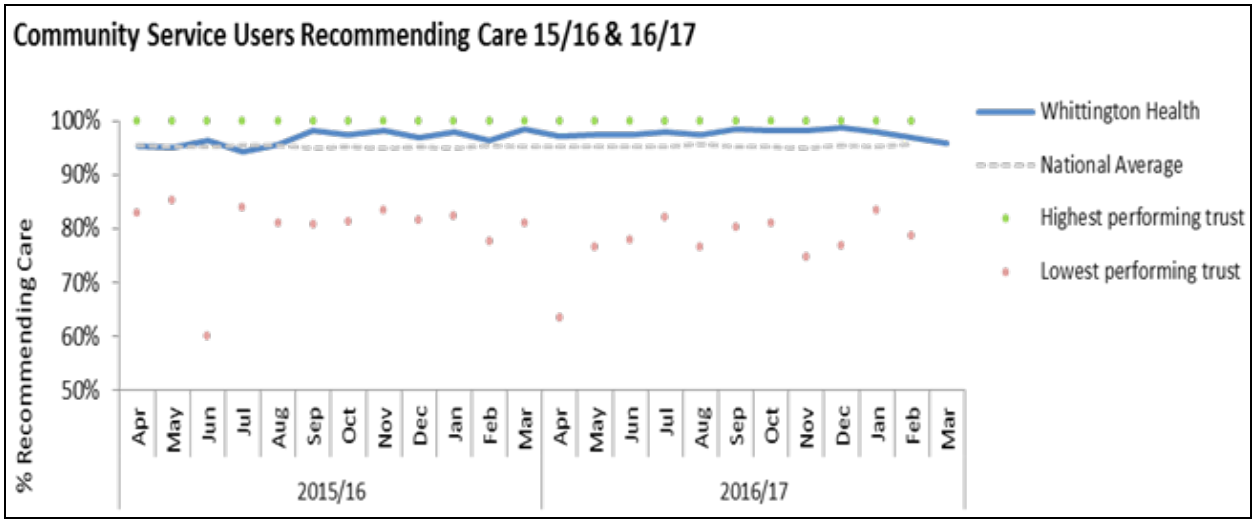




*The Whittington Health NHS Trust considers that this data is as described as it is collected, downloaded and processed in a robust manner, and checked and signed off routinely.

Friends and Family Test- Community Services Results.





While there have been consistently positive Friends and Family Test (FFT) responses for adult community services, the overall response rate has remained low. This includes the highest volume community service District Nursing (DN) . The nature of the patient group and one to one visiting makes introducing new ways of collecting feedback such as text messaging challenging. A sample of patients receive the FFT questionnaire via post and the DNs ask the patents to complete a survey on the DN iPad when they visit.

A 'You Said, We Did' approach is being rolled out and these improvements will be detailed in the service leaflet. In 2017/18 the service will be engaging one of the local voluntary sector organisations to visit patients for structured feedback.

We are pleased that the response rate for other adult community services such as Musculoskeletal, podiatry and 'Improving Access to Psychological Therapies' are increasing. In 2017/18 the services will be introducing text messaging and FFT emails to help improve response rates.

2.3.10 Duty of Candour

As soon as is reasonably practicable after becoming aware that a notifiable safety incident has occurred, the clinician in charge initiates a "being open discussion" with the patient and family or relatives acting on behalf of the patient.

Whittington Health clinicians actively encourage service users and relatives to ask questions and contribute to the Terms of Reference of serious incident investigations.

Duty of Candour meetings take place whilst the patient is an in-patient, i.e. at the "bedside" or when a patient is back at home following discharge or via community based care.

If an incident results in moderate harm or above, a Duty of Candour Lead is identified and appointed by the service, unit or department. The Duty of Candour Lead sends a written apology which clearly states:

- Whittington Health is sorry for the suffering and distress resulting from the incident;
- Whittington Health considers the safety of patients to be a top priority and compliance with the Duty of Candour is customary practice;
- A detailed inquiry into what happened and why, which will include investigation of the patient's concerns will be carried out;

- The patient or next of kin is contacted once again when the investigation has been completed and offered the opportunity to discuss the findings and receive a copy of the inquiry outcome.

Patients are encouraged to provide feedback about how Whittington Health is embracing candour and what improvements could be made to the Duty of Candour approach.

Our Board is responsible for ensuring that a culture of openness, trust, service improvement and sharing of learning is present within the organisation. It has overall responsibility for ensuring that the Trust's duties with regard to the management of Serious Incidents are appropriately discharged, including ensuring compliance with the Duty of Candour. The Board receives assurance of compliance through the Quality Committee.

Duty of Candour Key Performance Indicators are reported quarterly and monitored by the Clinical Quality Review Group in order to provide assurance to partner Clinical Commissioning Groups on Whittington Health compliance with the statutory Duty of Candour.

3. Quality in 2016/17

3.1 Progress against our 2016/17 quality priorities

In 2016/17 we reaffirmed our commitment to our Sign up to Safety pledges by aligning them with our quality priorities. The Sign up to Safety initiative aims to progressively improve quality in the chosen areas over a period of three years; 2016/17 was the second year of the campaign. The views were considered by the Quality Committee and ratified by the Trust Board following consultation with stakeholders.

The table below lists the 2016/17 quality priorities.

Trust Strategic Goals	Quality Priorities
To secure the best possible health and wellbeing for all our community	**1. Learning Disabilities** a) We will develop and implement 'Always Events' for patients with Learning Disabilities in a relevant clinical setting.
	b) We will aim for 75 percent of inpatients with learning disabilities to meet the Learning Disability specialist nurse during their admission.
	c) We will aim for 75 percent of **relevant** staff who work in our Emergency Department to have specific training in the care of patients with Learning Disabilities.
To integrate/co-ordinate care in person-centred teams	**2 Falls** a) We will reduce the number of inpatient falls that result in severe/moderate harm by 25 percent. Target = 4 falls of severe harm.
To deliver consistent high quality, safe services	**3 Sepsis** We will achieve the targets of the new and expanded national sepsis CQUIN in 2016/17:

	a) 90% of eligible **patients in ED** screened for sepsis (CQUIN)
	b) 90% of eligible **inpatients** screened for sepsis (CQUIN)
	c) 90% of **ED patients** diagnosed with sepsis, receive antibiotics within 60mins of arrival in ED and day 3 review (CQUIN)
	d) 90% of **inpatients** diagnosed with severe sepsis administered antimicrobials within 90 minutes and day 3 review (CQUIN)
To support our patients/users in being active partners in their care	**4. Pressure Ulcers** a) We will implement our 'React to Red' pressure ulcer prevention campaign
	b) We will have no avoidable grade four pressure ulcers.
	c) We will reduce the number of avoidable grade three pressure ulcers in the acute setting by 25 percent. Target based on average from 2014-16 = 6 Grade 3
	d) We will reduce the number of avoidable grade three pressure ulcers in the community by 25 percent. Target = 28
To be recognised as a leader in the fields of medical and multi-professional education, and population-based clinical research.	**5. Research and Education** a) We will increase by 10 percent the number of National Institute of Health Research (NIHR) programmes in which we participate
	b) We will launch and publish a newsletter to promote our research and education activities and engagement programmes. We will publish this at least four times a year.
To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population	**6. Patient Experience** a) We will improve the response rate of Family and Friends Test responses by 20 percent in the year. We will document and report our actions from patients' and carers' feedback within our Quarterly Patient Experience Report to the Quality Committee. Target for 2016/17= 25,063 responses
	b) We will develop our Patient and Carer Experience Strategy.
	c) We will revise our Communication and Engagement Strategy.
	d) We will establish a Community Forum which reflects the diverse community we serve.

	e) We will host a minimum of four engagement events and report to our Board on how we have improved opportunities for our patients, carers, public and stakeholders to engage and inform our strategic plans to help local people live longer healthier lives.

3.1.1 Priority 1: Learning disabilities

Always Events®, initially conceived in the US by the Picker Institute and now led by the Institute for Healthcare Improvement (IHI), are defined as those aspects of the care experience that should always occur when patients, their family members or other care partners, and service users interact with health care professionals and the health care delivery system.

Always Events® must meet four criteria:

1. Important: Patients, their family members or other care partners, and service users have identified the event as fundamental to improving their experience of care, and they predict that the event will have a meaningful impact when successfully implemented.

2. Evidence-based: The event is known to contribute to the optimal care of and respect for patients, care partners, and service users (either through research or quality improvement measurement over time)

3. Measurable: The event is specific enough that it is possible to determine whether or not the process or behaviours occur reliably. This requirement is necessary to ensure that Always Events® are not merely aspirational, but also quantifiable.

4. Affordable and Sustainable: The event should be achievable and sustainable without substantial renovations, capital expenditures, or the purchase of new equipment or technology. This specification encourages organisations to focus on leveraging opportunities to improve the care experience through improvements in relationship-based care and in care processes.

For 2016/17, we focused on making a referral to the learning disability nurse an ‘always event’ for all patients with a registered learning disability. As part of this project we introduced an electronic referral system to the learning disability nurse. In addition to increasing the number of referrals, this new system will allow us to identify areas of inappropriate referral for targeted training (e.g. service users with a mental health condition, autism or dementia referred to learning disability nurse).

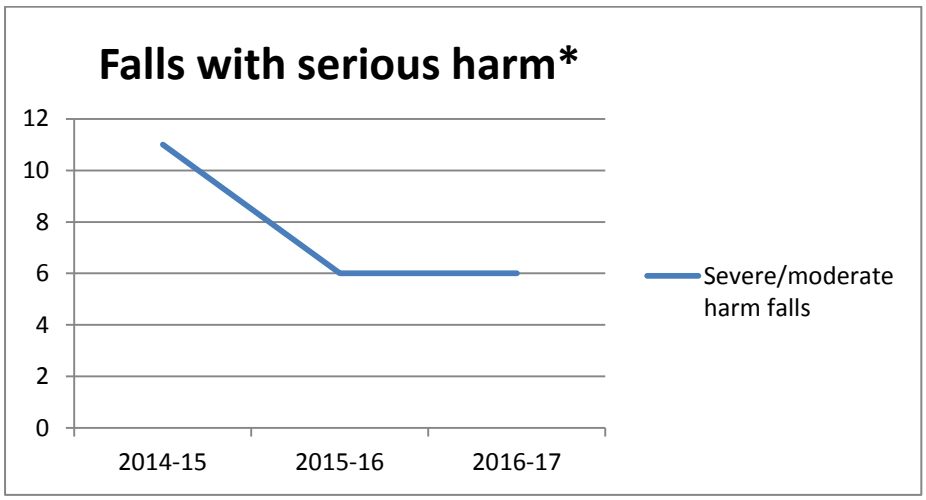
During 2016/17, the trust achieved its target for 75% of inpatients with a registered learning disability to be seen by the learning disability nurse. The electronic referral system has contributed to this achievement.

With regard to training, the trust has developed an e-learning module for learning disability awareness, which is provided in addition to face-to-face training across the Trust. The Trust has not yet reached its target of ensuring 75% of patient-facing staff in the Emergency Department have up to date training in learning disability, however training sessions are ongoing.

3.1.2 Priority 2: Falls

As part of Sign up to Safety, we pledged to reduce the number of inpatient falls that result in serious harm, to ensure that every patient has a falls risk assessment and to implement the 'falls care bundle' for high risk patients in acute settings. In 2015/16, we reduced the number of inpatient falls that resulted in serious harm (i.e. harm that met the criteria for a serious incident investigation) by 45%. In 2016/17, Whittington Health pledged to reduce the number of these inpatient falls by a further 25%, a target of 4 falls.

Unfortunately, we did not achieve our target in 2016/17, however during the year we developed a new 'falls bundle' which provides more comprehensive risk assessments and care plans for our patients, in line with the recommendations of the Royal College of Physicians. We ran a multi-disciplinary programme of education to raise awareness around the needs of patients with delirium and dementia, and added a delirium screening tool for inpatients on admission. In addition, there have been widely attended learning events on falls and more rapid feedback of learning from falls incidents. We have also been selected as one of only twenty trusts to participate in the NHSi falls collaborative. The project focuses on using the newly developed falls bundle to reduce falls on Mary Seacole North and South wards our acute admission wards.



*serious harm was defined as falls meeting the criteria for a serious incident investigation

3.1.3 Priority 3: Sepsis

Sepsis is diagnosed in approximately 260,000 patients in NHS England each year and is responsible for an estimated 44,000 deaths annually, including 1,000 paediatric deaths. Recognising sepsis early and commencing “sepsis 6” interventions rapidly, as well as escalating treatment plans for those with severe sepsis, is paramount in attempting to reduce these mortality figures.

Early recognition and rapid management of sepsis is a key patient safety objective for Whittington Health and monitored through our local Trust ‘Sign up to Safety’ priorities and the Trust’s quality priorities for 2016/17. In addition, it is also a national CQUIN.

Sepsis Quality Account, CQUIN and the ‘Sign up to Safety’ performance data

Whittington Health achieved the Quality Account priority to meet the national CQUIN in 2016/17 for all patients being admitted through the emergency department with sepsis. The national sepsis CQUIN data for Quarter 2 of 2016/17 showed this Trust as being one of the top 5 performing Trusts in England for meeting the sepsis CQUIN quality standards for both emergency admissions and inpatients. The Associate Medical Director for Patient Safety received a letter of congratulations from NHS England in recognition of this important achievement.

Adult patients diagnosed with sepsis are staying on average 1.5 days less in 2016/17 compared to 2015/16 which is probably relates to successful initiation of early management.

55% of adult patients diagnosed with sepsis in our Emergency department are arriving with a pre-hospital alert for sepsis (up from 10% in 2014/2015) which is a surrogate indicator of our integrated educational campaign to ensure all local healthcare providers think “could it be sepsis?”

There is further improvement required for patients developing sepsis during their inpatient stay with on average 80% of patients receiving antimicrobials within the hour against the desired objective of 90%.

Whittington Health performance against the sepsis national CQUIN

	Percentage of patients finally diagnosed with sepsis with completed sepsis pathways in notes	Percentage of patients with sepsis 6 care bundle completed within the hour from diagnosis	Percentage of patients with (sepsis receiving antimicrobials within 60 minutes of arrival to hospital (and have a 72 hour antimicrobials review from 2016/17)	Percentage of patients with sepsis diagnosed within hospital receiving antimicrobials within 90 minutes of diagnosis
CQUIN objective	>90%	n/a	>90%	>90%
Sign up for safety objective	n/a	n/a	>90%	>90%
Quality account objective	>90%	n/a	>90%	>90%
Internal objective	>90%	>90%	>90%	>90%
Q1 2015/16	46.0%	66%	55%	n/a
Q2 2015/16	46.9%	68%	59.4%	n/a
Q3 2015/16	45.6%	72%	67.4%	n/a
Q4 2015/16	63%	80%	78.2%	n/a
Q1 2016/17	66%	82%	82.2%	83%
Q2 2016/17			93%	88%
Q3 2016/17			93%	71%
Q4 2016/17				

3.1.4 Priority 4: Pressure Ulcers

In 2016/17, Whittington Health pledged to have

- No avoidable Grade 4 pressure ulcers across the ICO
- 25% decrease in Grade 3 pressure ulcers in community
- 25% decrease in Grade 3 pressure ulcers for inpatients

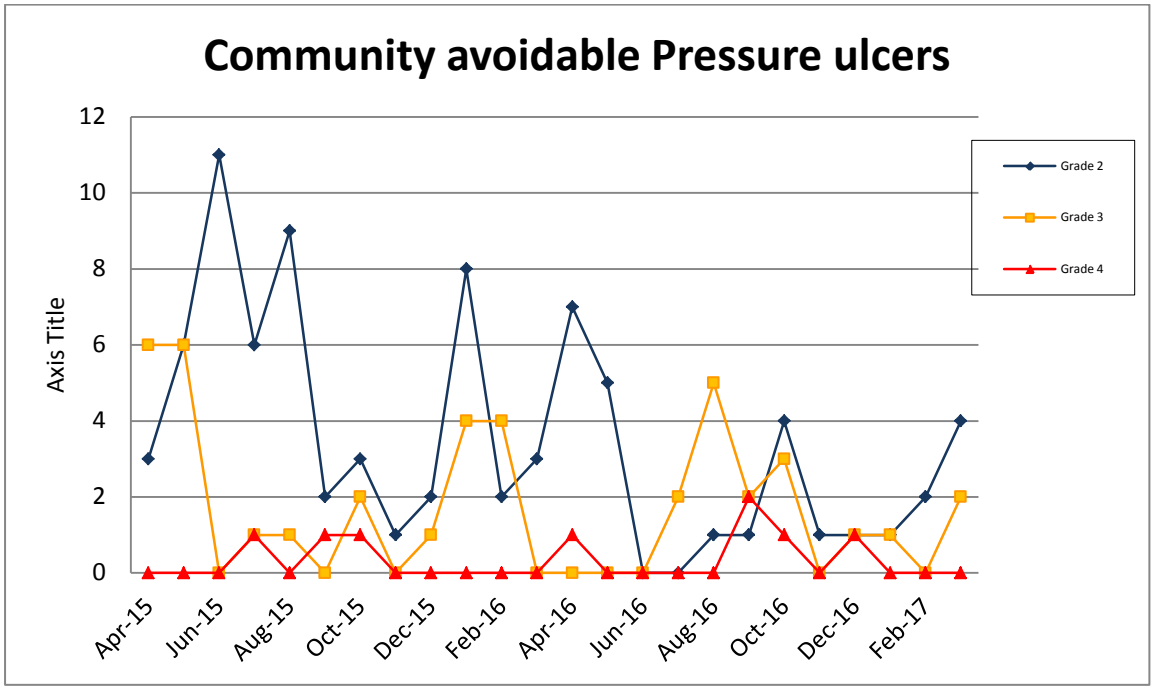
During 2016/17, Whittington Health launched the 'React to Red' campaign to raise awareness with staff, patients and carers on pressure ulcer prevention.

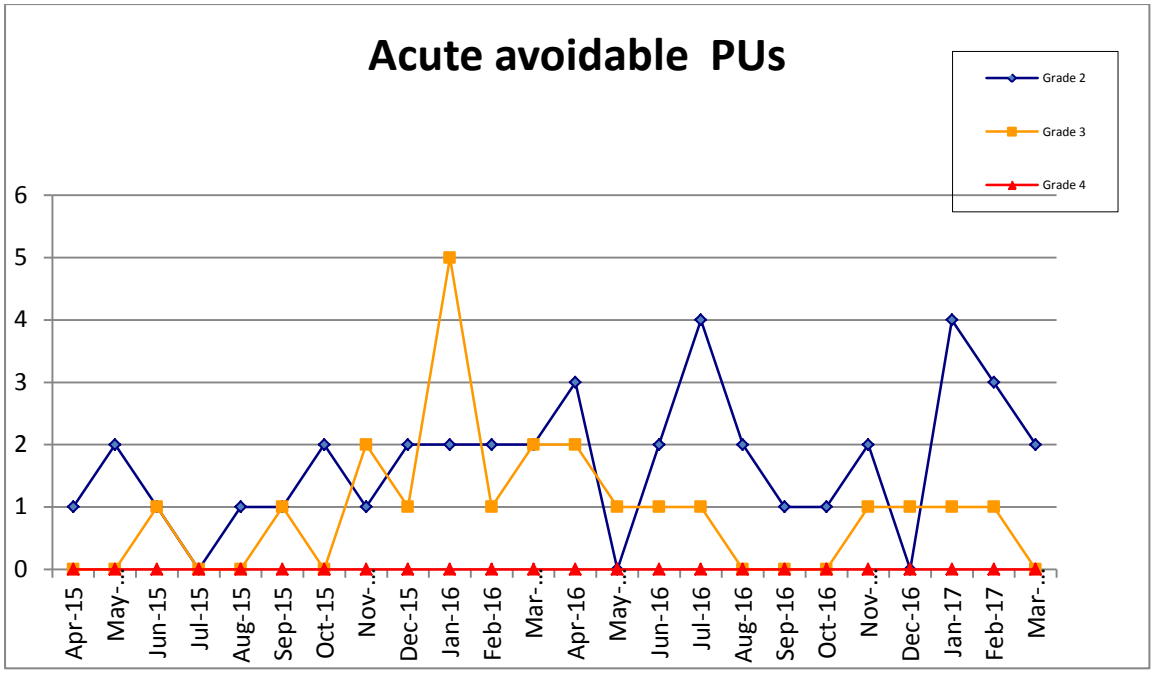
As part of this campaign, Whittington revised internal documents, introduced a new leg ulcer management pathway and developed a pressure ulcer prevention e-learning programme, to make pressure ulcer assessment, management and prevention easier for staff.

The second major component of the React to Red campaign focused on patients, carers and families. Whittington designed a key factsheet for patients and carers to support self-care and pressure ulcer prevention. Whittington also developed a pressure ulcer prevention carer's bundle, which is a comprehensive pack provided at discharge to anyone at risk of pressure ulcers.

We achieved our target to reduce avoidable grade 3 pressure ulcers in the community, with a reduction of 60% since 2015/16. However there were 5 avoidable grade 4 pressure ulcers reported in the community in 2016/17. In the acute setting, there were no avoidable grade 4 pressure ulcers reported and 8 avoidable grade 3 pressure ulcers since 2016/17. While this represents a decrease of 38% since 2016/17, this is still above the number reported in 2014/15.

The 'React to Red' campaign is ongoing to promote pressure ulcer prevention across the organisation.





3.1.5 Priority 5: Research and Education

Research

There are currently 48 NIHR portfolio studies in progress and recruiting at Whittington Health compared to 41 studies in 2015/16, 31 studies in 2014/15 and 21 in 2013/14. In addition to the 48 NIHR portfolio studies that are on-going, an additional thirteen non-portfolio studies were commenced so far in 2016/17, an increase of 5 studies on the previous year and puts the number at a similar level to 2014/15 having reduced to just eight studies in 2015/16. These studies are undertaken by nurses, allied health professional and trainee doctors and this year various paediatric and community services have hosted the majority of these studies. The results and impact of these studies are published in peer reviewed publications, at conference presentations and are valuable in their ability to innovate within the trust.

We are a year on from the ratification of the Whittington Health Research Strategy that underpins the clinical strategy and reflects the aim of enabling local people to 'live longer healthier lives'. A key strategic goal is to become a leader of medical, multi-professional education and population based research. We believe we are uniquely placed to take a life course approach to population based research and be at the forefront of the synergy between clinical service, education and clinical research. Progress is being made in our efforts to reach the targets within the strategy including the creation of a Research Assistant post to support one of our clinical academics with the development of paediatric population based research.

Participation in clinical research demonstrates Whittington Health's commitment to improving the quality of care that is delivered to our patients and also to making a contribution to global health improvement. We are committed to increasing the number of studies in which patients can participate, and the specialities that are research active, as we recognise that research active hospitals deliver high quality care. The Trust's research portfolio continues to evolve to reflect the ambitions of our ICO and also reflects the health issues of our local population. The research portfolio includes CAMHS, dermatology, diabetes & endocrine, emergency medicine (and ICU), gastroenterology, haemoglobinopathies, hepatology, health visiting,

IAPT, infectious diseases (TB), microbiology, MSK, oncology, orthopaedics, paediatrics, speech and language therapy, urology, and women's health.

Education

Whittington Health continues to have a reputation for excellent education.

Education Training Events

Over the last year, we have hosted a wide range of education and training events. These included 2 Inter-professional Integrated Care Education Days in April and May. These were extremely well received, with excellent feedback from the attendees. The theme of the first day was 'innovation and education'. As part of the programme, attendees had an opportunity to hear more about patient self-management and have been introduced to some of the tools for collaborative consultation. Day two focused on 'how to design an integrated service'. Attendees had an opportunity to hear about some of the innovative integrated care services set-up in NCEL area. There was a practical exercise in the afternoon, which encouraged attendees to explore and talk about opportunities and challenges them, as future leaders of the NHS, may face when thinking of joining up services in their local area. We had some really engaging speakers from clinical, academic and management realms, mainly from the Whittington but also some were external speakers. The attendees included specialist nurses, staff from the charity sector, Darzi fellows and specialty trainees from a range of specialities across London. The days were a very successful and we will be running these again in 2017.

Other events included 8 Advance Care Planning Workshops, led by WH clinicians, for our local GPs and Care Homes focussing on care of dying patients in the last days of life and supporting professional to look at ways of approaching difficult conversations with patients and their families.

Further developments have included learning events called 'Learning Together from Patient Safety Incidents and Complaints'. These inter-professional education afternoons are based on real patient stories, highlighting key learning points for various staff groups. So far, we have run 10 Learning Together events, attended by WH staff and colleagues working in social care, GP and voluntary sector. Feedback collected after each workshop suggested that attendees valued the opportunity to learn with and from each other. They reported increased confidence to discuss patient safety issues with their immediate colleagues and other teams and have been able to successfully apply some of the skills and knowledge gained at the workshop to change their way working. A poster about this work was presented at the UCLP Education Conference in December.

We have hosted two simulation training sessions for Core Medical trainees (CMTs), completing their rotations in North Central and East London geography, titled 'Acute Care at the Interface of Mental and Physical Health'. This interactive training was led by experienced clinicians and educators from Camden and Islington Mental Health, with support from UCLP Medical Education Simulation Fellows. The training provided an opportunity to further-develop knowledge, skills and confidence in supporting patients with both mental and physical health problems and increase understanding of services available to support patients with complex mental and physical health problems. The simulation training sessions were designed to address a number of CMT curriculum competencies for example Alcohol and substance misuse, Aggressive/disturbed behaviour, Suicidal ideation or Psychiatry and

Legal framework for practice. Both training sessions were extremely well received in their evaluations. As a result of this training, we have developed and piloted psychiatry simulation sessions for Foundation trainees at the Whittington.

In collaboration with our Community Education Provider Network (CEPN) partners, we have established the 'Islington Integrated Schwartz Rounds' – the first of its kind, inviting colleagues from Camden and Islington Mental Health Trust, Islington Clinical Commissioning Group, London Borough of Islington and Whittington Health. All rounds are held in various venues across Islington so easily accessible to colleagues working in the community and general practice. Schwartz Rounds are a multidisciplinary forum designed for staff to come together once a month to discuss and reflect on the emotional and social challenges associated with working in healthcare. Rounds provide a confidential space to reflect in and share experiences.

'The Art of Emergency Care', brought to the organisation by Kerry Wykes (Matron in our Emergency Medicine Department), is a highly innovative project, which was facilitated by MSc Applied Theatre Studies students from Royal Central School of Speech and Drama and multi-disciplinary staff working in the Emergency Department. The devising workshops explored patient and staff experience through theatre techniques and subsequent performances of the theatre pieces allowed for discussion, reflection and learning for larger groups of healthcare staff. Participants felt that, despite the pressure they are facing at work, this project allowed them to focus on what they can do to improve care, versus the system having to change.

WH hosted their first women only conference for female medical students and doctors on completing their clinical placements at WH.

We ran courses specifically designed for doctors training in different specialities and in general medicine. These included a new course we developed called "A Beginner's Guide to being a Specialist Registrar in Diabetes and Endocrinology". This was designed for junior doctors newly starting in specialist training, which can be a time of great challenge. We had very practical teaching, full of practical tips, from specialist nurses, dieticians and consultants. The junior doctors highly rated the course and have asked us to run it again. We are plan to run another course in 2017 but this time will be opening it to the wider team including nurses, dieticians, podiatrists, pharmacists and trainee GPs as well.

In February 2017, Whittington Health hosted the Clinical Examination for the Membership of the Royal College of Physicians (UK). This exam is designed to test the clinical knowledge and skill of trainee doctors who hope to enter higher specialist training to become a consultant. We are incredibly grateful to all the patients who came along for the doctors. It was a great success and the external examiners commented that the Whittington is always the gold standard exam that other centres try to aim for.

In September 2016, we re-launched the Whittington Grand Round. This is a weekly presentation chaired by Professor John Yudkin, Dr Michael Kelsey or Dr Rodric Jenkin. These presentations have covered research (e.g. using mathematical modelling in the breast cancer clinic), international health (e.g. compassionate communities in Kerala), social issues (e.g. caring for vulnerable pregnant women) and major medical problems (e.g. the rise of Hepatitis C and its treatment). We have opened the Grand Round up to all members of staff across all specialities and to local GPs.

GMC National Training Survey for Doctors in Training 2016

Whittington Health had some outstanding feedback in the GMC survey of doctors in training, with some specialties receiving the highest rating in the country. This is a national survey, sent to all doctors in training, and it asks them about the hospital where they are working and the support and education that they receive there.

Paediatrics training achieved the highest rating for: handover, workload, access to educational resources, local teaching and regional teaching. There was also good feedback in all the other areas, but not quite sufficient to reach the highest rating.

The Core Medical Training programme achieved the highest rating for: reporting systems, adequate experience, supportive environment and access to educational resources. There were good feedback in the other areas, but not quite sufficient to reach the highest rating.

Across the different areas surveyed, access to educational resources and reporting systems are the most highly rated reflecting the excellent work of the library and Richard Peacock the librarian.

Advanced Trauma & Life Support Course
The Whittington runs a successful, internationally recognised Advanced Trauma & Life Support Course, twice per year, for all doctors involved in the management of trauma patients. We have achieved a 100% pass rate for the last two courses and in the feedback the participants scored the last course highly across most categories with an average score of 91%. The Royal of College of Surgeons of England has congratulated us on this high performance.

WH Education structures, access and innovation.
All universities and other institutions of education now have in place IT learning platforms as an essential adjunct to learning and development, used by students and learners as a daily and routine resource. These platforms tend to be described as “virtual learning platforms” (VLP) and form an accessible IT driven platform for accessing lecture and workshop resources, virtual learning packages, reading and textbook resources, exercises, virtual laboratory and simulation classes, portfolio development to name a few functions. In summary VLPs are now an essential component of contemporary high quality education provision.

Within the health service, NHS driven educational provision has not routinely bought into the use of learning platforms such as Moodle. This is an anomaly as, without exception, all younger practitioners of the (regulated) degree entry professions will have experienced undergraduate (and increasingly, postgraduate) learning support through a VLP of some type. As an organisation that invests in workforce development, education and training in order to better deliver high quality healthcare services, we aim to use the best available resources and technology to enhance the training and support of our collective workforce.

During 2016, we successfully introduced a bespoke online platform for Whittington Health Education that is accessible for the workforce in general, and specifically for the continuing education and training of our multi-professional workforce.

We are currently running a broad scope of modules and courses on this platform; for example, Doctors Induction for A&E, GP Training packages, Grand Rounds, electrocardiogram interpretation for new A&E staff; induction for Nurses in A&E; treating minor injuries in A&E and others currently in development. New course development, education needs-based development, and delivery of in-house education and training are embedded within Whittington Health and the new platform will be a quality and accessibility adjunct to this delivery function.

In addition, we have instigated a "user and innovation group" comprising a cross sectional group of instructors and users who provide steer, strategy advice and innovation for the deployment of this education platform to ensure continued progressing and innovation for our education delivery activities.

The Whittington Health Education Conference
This successful event was held in March 2016, with the theme of "Building a Vision for Integrated Education - Showcasing innovation in education, learning & training at Whittington Health". The conference was attended by a multidisciplinary audience with many high quality abstracts submitted. For the first time, these abstracts were published in a peer reviewed journal, further providing quality dissemination for the education and workforce development activities of the Trust (Pharmacy Education, 2016; 16 (1): 52-63).

Community Simulation Hub.
The Community Simulation Hub project is a fully developed a simulation hub that brings health and care practitioners together for education and training. The training design puts patients, service users and their lifestyles at the heart of meeting their care needs. The Hub acts as a simulation centre for integrated and interprofessional training, with observation rooms and fully equipped learning environments to enable feedback of simulated practice in action to review and discuss for practitioner development. Training courses include

- Transition to Parenthood
- Making Every Contact Count
- Protecting Vulnerable Adults
- Chaperoning

And more are in development. This is a unique training environment and fully meets the integrated education and training mission of Whittington Health.

3.1.6 Priority 6: Patient Experience

Patients are at the heart of everything we do here at Whittington Health. We know that in order to improve the experience of patients in our hospital and community we need to listen to them, their families and carers, and respond to their feedback.

Throughout 2016/17, we have worked to improve our systems for collecting feedback and to enable us to capture the views of a more diverse patient population.

There are many ways in which we gather feedback, some examples are:

- National patient surveys, such as the cancer and inpatient surveys;
- Real-time patient experience trackers which ask specific questions including friends and family test, in specific areas of the hospital, such as A&E and outpatients and in

our community services and homes visited by our district nursing and health visiting teams
- Individual ad hoc surveys and questionnaires to support specific projects;
- Feedback received directly from patients in the form of complaints, letters, comments on Twitter, phone calls or comments to PALS, our patient advice and liaison service; Surveys looking at specific aspects of care or the environment such as PLACE;
- Ratings and comments left by patients on NHS choices.

This feedback is regularly triangulated by our patient experience team to paint a picture of what our patients are telling us and of where they think we need to improve.

We know from our work that for patients reporting a positive experience, interaction with staff is the most significant factor. When patients report a negative experience, the cause is usually due to ineffective systems and processes. The improvement programmes and strategies across the trust are supporting improvements across these areas.

We know it is not enough to just listen to our patients and the public; we want to actively involve them in helping us improve.

In 2016/17 we achieved our goal of increasing the percentage of inpatients and A&E patients who would recommend our Trust to friends and family, exceeding our target for both and improving on our performance last year. We also succeeded in increasing the number of response rates to our Friends and Family Test by over 20%.

In addition we developed a Community Forum which currently has 5000 members and we held 4 community meetings throughout the year. This engagement work will be extended in 17/18 as we develop a 3 year Patient and Carer Experience strategy. Through working with our local community and partners to we ensure that we develop a strategy that is ambitious and details annual improvement milestones.

We plan to review and strengthen our complaints processes still further in 2017/18. The primary objective is to resolve peoples' concerns as quickly and effectively as possible. Often this will be best achieved by the Patients Advice and Liaison Service (PALS); whether it is getting a cancelled appointment rescheduled or providing an immediate apology for a poor experience, PALS excel in this type of resolution. The complaints service will then be able to focus on concerns and complaints that require a formal investigation and response. We will review the process for sharing learning from complaints and look to join this up more effectively with learning from claims and patient safety incidents.

3.2 Local performance indicators

Performance figures are for full year of activity (16/17) unless otherwise stated

This section includes non-statutory indicators as part of the Quality Account.

Goal	Standard/benchmark	Whittington performance	
		16/17*	15/16
ED 4 hour waits	95% to be seen in 4 hours	**87.36%**	91.1%
RTT 18 Week Waits: Incomplete Pathways	92% of patients to be waiting within 18 weeks	**93.1%**	92.4%
RTT patients waiting 52 weeks	No patients to wait more than 52 weeks for treatment	**0**	0
Waits for diagnostic tests	99% waiting less than 6 weeks	**99.5%**	97.7%
Cancer: Urgent referral to first visit	93% seen within 14 days	**96.4%**	93.1%
Cancer: Diagnosis to first treatment	96% treated within 31 days	**99.7%**	99.5%
Cancer: Urgent referral to first treatment	85% treated within 62 days	**86.7%**	88.8%
Improved Access to Psychological Therapies (IAPT)	75% of referrals treated within 6 weeks	**94.6%**	94.5%

The Trust met its waiting time targets; however the emergency department waiting times need to be improved.

Within the operational plan the Trust identified that it will expand its programme of improvement for the Emergency Department. There are a number of plans in progress to recover both Emergency Department (ED) performance and flow across the acute admitted pathway, including but not exclusively:

- Front-door streaming: To ensure timely and appropriate care, in the right place by the right team and to maximise use of Ambulatory Care through appropriate diversion of acute medical assessment and paediatric patients, and transfer of medical clerking to the in-patient setting
- Revision and recruitment of ED workforce in order to facilitate rapid assessment treatment (RAT) and reduction in median Time To Treat and meet the ED standards by:
- Increasing the number of consultants by 6 WTE over the next 18 months. This will mean we will have consultant cover form 8-10pm from August 2017 when three of the new posts will be filled and we will be working further toward meeting the London ED standards over the next 8 months as we recruit the additional three posts.
- Developing the new Urgent Care Pharmacists roles with Health Education England
- Developing enhanced roles for nurses and health care assistants within the ED department.
- Improved speciality response/ agreements: To prevent unnecessary delays in decision making and/ transfer of care

- Development of Demand and Capacity tool/ Escalation Cards: To allow early warning of approaching problems and implementation of escalation plan
- Enhancement of Frailty Pathway: To ensure early Frailty Team input to enable appropriate management/ discharge support, to achieve Length of Stay (LoS) and readmission reduction
- Senior Clinician Review by noon: To ensure appropriate management to progress recovery and discharge
- Pre-11a.m. and Criteria Led Discharge: Ongoing promotion and training
- Advance Discharge to Assess model: To ensure patients are discharged when medically fit
- Enhanced Site Team and processes: To proactively manage flow/ discharge planning and timely communication
- Staff engagement: enhanced recovery workshops to support the streamlining of discharge
- Emergency Care Improvement Programme (ECIP): implement the findings of the 2 day review lead by Vince Connolly of the front door, ED, clinical decision unit, ambulatory care and acute admission unit once published.
- System wide improvement: working with Haringey and Islington and the wider STP urgent care pathway to develop system wide processes to improve the performance of ED.

4. Who has been involved in developing the Quality Account

We have worked with many internal and external stakeholders in the development of this year's Quality Account.

Internally, clinical and operational teams have been at the forefront of developing the Account, from frontline staff to management level. Clinical and operational leads were crucial in ensuring the Quality Account is detailed and provides accurate information. Clinical and corporate divisions worked together to produce the Quality Account. The Information, Clinical Governance and Risk Management teams have all had significant input into developing the Account. Externally, our Quality Account has been seen by our local CCGs, local Health Watch, JHOSC and our designated external auditors

5. Statements from external stakeholders

Healthwatch Islington Feedback

We welcomed the Trust's involvement of Healthwatch members in discussions around Quality Objectives. There are some positive examples of patient engagement within the organisation (the setting up of a Young People's Forum, involving Healthwatch members in PLACE assessments). A more systematic approach to this engagement would help to embed involvement across the organisation. We will support this engagement where we can. In Healthwatch's conversations with residents the hard work of staff, noted in this report, is also praised and we feed this in to the Patient Experience Committee.

The report highlights the good work of the Community Dental Service. Healthwatch Islington's Autism report also highlights the very positive patient experience of users of this service and the skills and kindness of the staff working there. We know that the Trust is doing a lot of work to ensure robust implementation of the Accessible Information Standard and we hope to start seeing the results of this, in particular for Deaf patients who have found patient letters difficult to understand, and in improved communication with patients with a range of disabilities.

For other community services, waiting times remain an issue and we hope that the Trust can bring these down, thus improving patient experience. The Trust has stated that they 'are currently redesigning the service and also the way appointments are being booked. One of the plans around appointments is to book them from health centre receptions for all patients needing appointments within 6 weeks. This ensures that clients who have the highest foot risk statuses will receive appointments on the day of being seen… The aim is to start this from April [2017]'. The Trust assured us that they did not foresee a negative impact of this policy on patients who need less regular appointments. We look forward to hearing about how this develops.

Healthwatch Haringey Feedback

Healthwatch Haringey
14 Turnpike Lane
London
N8 0PT
Tel: 020 8888 0579
Email: info@healthwatchharingey.org.uk
Web: www.healthwatchharingey.org.uk

healthwatch Haringey

Dr Helen Taylor
Whittington Hospital
Magdala Avenue
London
N19 5NF

19th May 2017

Dear Helen,

WHITTINGTON NHS TRUST QUALITY ACCOUNT 2017/18

Apologies for the delay in replying; the Healthwatch Haringey Statement is below:

We note and congratulate The Trust on winning a number of national awards for the quality of their services and service innovation in 2016/17. The Trust should also be commended on the local teams developing a number of quality initiatives in the delivery of the care to our local community.

We agree with the priorities identified for 2017/18 and the inclusion of Patient Experience in those priorities. The criteria identified in the Patient Experience category are generally process measures rather than outcome targets measuring improvements in patient experience and we would be happy to work with The Trust in developing some appropriate and achievable targets in this area.

The Trust has improved on a number of measures in the staff survey but we note that there are issues relating to bullying and harassment that need to be addressed. As noted in the Quality Account, patient experience is closely linked with the quality of the interaction with staff and therefore staff morale and motivation is a significant measure. It is interesting to note that although the percentage of staff recommending care is on a par with the national figures it has decreased in 2016/17 from 80.1% to 74.6% which is a reversal of the upward trend in 2015/16. Although staffing indicators are not included in the priorities for 2017/18 they should be the focus of attention to ensure that morale and motivation remain high.

The Patient Experience Forum was a new development in 2016/17 and although all innovations in this area are to be welcomed there is a need to develop a more systematic approach to patient engagement in the coming year. We look forward to being involved in this process and the development of the new three year Patient Engagement Strategy.

Kind regards,

Mike Wilson
Director

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Joint Health Overview and Scrutiny Committee Statement

Response from Islington Health and Care Scrutiny Committee and the North Central London (Barnet, Camden, Enfield, Haringey and Islington) Joint Health Overview and Scrutiny Committee received 24/05/17

The Islington Health and Care Scrutiny Committee and the North Central London Joint Health Overview and Scrutiny Committee welcomed the opportunity to review and comment on the detailed draft Quality Account. We have some comments on specific aspects of the report:

The CQC report in July 2016 identified the Whittington's Community Services as being Good or Outstanding and we felt that the Whittington should be commended on achieving this rating. The CQC report however highlighted that under the heading of 'Safe' that both Whittington Health and Hospital requires improvement, whilst Whittington Hospital was graded as requires improvement under 3 out of the 5 areas. We felt the plan to improve was useful but it wasn't clear if this was based on the 'must do's' or on both the 'must do's' and 'should do's'? In addition, the Islington Health and Care Scrutiny Committee requested the Whittington action plan in response to the CQC inspection, and once it was received was strongly of the view that it was far too lengthy, contained too many actions, and the committee felt there was a significant risk that effective response to the inspection outcomes could be lost through attempting to pursue too many different improvement goals. A shorter, more succinct and targeted action plan would be more likely to achieve better results. Whilst not directly related to the quality account the committee considers that the action plan, which presumably is intended to be one of the main drivers towards quality improvement over the next year, could in its present form adversely affect ambitions to achieve improvements to overall quality at the hospital.

We felt that whilst the quality priorities for 2017/18 are clearly laid out, it wasn't clear whether these were identical to last year's priorities or whether some had been added as we didn't get a clear understanding from the introduction what the Trust's previous quality priorities were.

We felt that the safety priorities were good, however we would have hoped for a higher compliance target to have been set within the documentation of falls within the AAU and Older Peoples wards.

We welcomed all the ideas to improve experience such as 'reducing noise levels at night' under Patient Experience but we would have liked to have seen further information on how this would be achieved.

In addition, we would have liked to have seen further clarity on the following:

- Within the more in depth look at how the Whittington Hospital is looking to improve, Graph 2.3.3 shows Emergency re admissions. The younger age range 0-16 is consistently higher than the older age range – we would like to understand why. We would have also liked to have seen further information about what actions are being put in place to reduce the re admission rate for 0-15yr olds? (page 35)

- Graph for VTE risk assessment (page 38): it was not clear what the lilac dots represent.

- Table of Whittington Health performance against the sepsis national CQUIN (page 49). The majority of the table indicates red or amber with the 'Percentage of patients with sepsis diagnosed within hospital receiving antimicrobials within 90 minutes of diagnosis' column indicating that the latest figure in Q3 2016/17 is 71% when the target is 90%. This figure is decreasing: it was not clear why.

NHS Islington Clinical Commissioning Group

Commissioners' Statement for 16/17 Quality Accounts

NHS Islington Clinical Commissioning Group (CCG) is responsible for the commissioning of Health services from Whittington Health NHS Trust on behalf of the population of Islington and all associate CCGs. In its capacity as lead co-ordinating commissioner NHS Islington CCG welcomes the opportunity to provide a statement for the 2016/17 quality account.

Commissioners can confirm that the Quality Account complies with the prescribed information, form and content as set out by the Department of Health. The information provided within the account have been checked against data sources made available as part of existing contract/performance monitoring discussions and the data presented within the account is accurate in relation to the services provided.

We commend the Trust on its overall rating of "good" by the Care Quality Commission (CQC) in July 2016 and the "outstanding" rating given to Community end of life care and community dental services. We note efforts made by the Trust during 2016/17 to robustly address the CQC's recommendations. We also commend improvements in the reduction of sepsis during 2016/17 which we hope will continue in 2017/18.

The Trust has proactively engaged with Islington CCG to ensure that commissioner's views have been considered and incorporated and we strongly support the eight quality priorities chosen by the organisation for 2017/18. We are encouraged by the Trust's plans to reduce the number of inpatient falls and pressure ulcers and hope to see significant improvements in outcomes concerning skin integrity for patients in community settings.

The CCG notes that during 2016-17, Whittington Hospital NHS Trust took part in 41 national clinical audits including 7 national confidential enquiries. The CCG would like to commend the Trust's commitment to an increasingly extensive research programme.

Commissioners fully support the quality priorities identified by the Trust for 2017/18.The CCG would have liked to have seen more emphasis on community care within the Quality Account but note this has been included in the eight priority areas and look forward to working with the Trust collaboratively to improve data quality to demonstrate delivery of high quality care.

We consider this Quality Account represents a fair and balanced overview of the quality of care at Whittington Hospital NHS Trust during 2016/17 and we look forward to the year ahead and working with Whittington Hospital NHS Trust to continually improve the quality and safety of health services for the population they serve.

6. How to provide feedback

If you would like to comment on our Quality Account or have suggestions for future content, please contact us either:

- By writing to:

  The Communications Department,

  Whittington Health,

  Magdala Avenue,

  London. N19 5NF

- By telephone: 020 7288 5983
- By email: communications.whitthealth@nhs.net

7. Appendix 1: Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance in the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amended Regulations 2011.

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

The Quality Account presents a balanced picture of the Trust's performance over the period covered, In particular, the assurance relating to consistency of the Quality Report with internal and external sources of information including:

- Board minutes;
- Papers relating to the Quality Account reported to the Board;
- Feedback from Healthwatch;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009,;
- the latest national patient survey;
- the latest national staff survey;
- the Head of Internal Audit's annual opinion over the trust's control environment;
- feedback from Commissioners;
- the annual governance statement; and
- CQC Intelligent Monitoring reports.

The performance information reported in the Quality Account is reliable and accurate.

There are proper internal controls over the collection and reporting of the measures of performance reported in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;

The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality stands and prescribed definitions, and is subject to appropriate scrutiny and review; and

The Quality Account has been prepared in accordance with the Department of Health guidance.

The directors confirm that to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

8. Appendix 2: Independent auditors' Limited Assurance report

Place holder initial feedback received

9. Glossary

Abbreviation	Definition
BTS	British Thoracic Society
C Diff	Clostridium Difficile
CCG	Clinical Commissioning Group
CEPN	Community Education and Provider Network
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUINS	Commissioning for Quality and Innovation
DATIX	Name of incident reporting system
DBS	Disclosure and Barring Service
DNA	Did not attend
DoLS	Deprivation of Liberty Safeguards
DTC	Day Treatment Centre
DVT	Deep Vein Thrombosis
ED	Emergency Department
FFT	Friends and Family Test
GMC	General Medical Council
HCAI	Healthcare Associated Infections
ICAM	Integrated Care and Acute Medicine
ICAT	Integrated Community Ageing Team
ICO	Integrated Care Organisation
IG	Information Governance
LoS	Length of Stay
MCA	Mental Capacity Act
MSK	Musculo-Skeletal
NIHR	National Institute of Health Research
NRLS	National Reporting and Learning System
PALS	Patient Advice Liaison Service
PE	Pulmonary Embolism
PROMs	Patient Reported Outcome Measures
RTT	Referral to Treatment
Red to Green	Approach to optimising patient flow. The objective is to change a patient from 'red' (a day where there is little or no value adding care) tor 'green' (a day of value for the patient's progress towards discharge and home).
SAFER patient bundle	SAFER is a practical tool to reduce delays for patients in adult inpatient wards
SCD	Surgery, Cancer and Diagnostics
Section 136	A multiagency model of care for our mental health patients in crisis
SHMI	Summary Hospital Level Mortality Indicator
SI	Serious Incident
TDA	Trust Development Authority

UCLH	University College London Hospitals
UCLP	University College London Partners
VTE	Venous Thromboembolism
WCF	Women’s Children & Families
YTD	Year to date

Whittington Health NHS

SERVICE AND QUALITY IMPROVEMENT STRATEGY

2017

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1.0 INTRODUCTION

1.1 This document sets out the imperative for developing a Service and Quality Improvement strategy and then proposes a number of elements that could be within this.

1.2 The document does not contend that it is the finished strategy, but rather a detailed proposition that can help Whittington Health further consider what it wants and needs. It is assumed the final agreed strategy may retain, remove and/or add other elements, but that this will help inform an organisational conversation.

1.3 This document is supplemented by a Quality Improvement Guide that may be issued to all staff. This primarily focuses on the levels of training in service improvement tools and methodology that Whittington Health may provide to staff, and complements section 4 '*Structured, tiered and mandatory training programme'* of this report. This guide is based on a similar document produced by NHS Wales. It is though not the contention of this document that training alone can create a culture of service improvement.

2.0 WHY DO WE NEED A SERVICE AND QUALITY IMPROVEMENT STRATEGY?

2.1 The health and social care needs of our local people are changing and there are serious issues facing health and care services in our locality.

2.2 In addition the financial situation remains challenging. The demand for health and social care is growing faster than increases in funding. Our local STP estimates a funding gap of £900m by 2020/21 if we do nothing.

2.3 The North Central London STP is a commitment to working together to find solutions at 'scale', seeking to also focus on the interests of local people and not individual organisations. However building the trust and relationships in the context of a system will take time.

2.4 WH must also find ways to improve service quality within its funding limits. This requires an internal strategy that complements the STP strategy, and one that further enhances the organisations sense of purpose

2.5 WH has a unifying purpose that everyone understands – *'Helping local people live longer healthier lives'.* Beneath this unifying purpose shared values provide a crucial compass for staff in complex and challenging times. No Board or Executive can provide guidance on every decision staff may need to take and thus such a compass is vital.

2.6 Whittington Health (WH) has encapsulated its values in its ICARE.

- Innovative
- Compassionate
- Accountable
- Respectful
- Excellence

WH has also crystallised what its commitment is within these and what it would '*love to see'*. In particular the elements of Innovative, Accountable and Excellence require a supporting service improvement culture as set out below:

ICARE VALUE	WH Commitment	Love to see

Innovation	• Welcome ideas • Willing to change	• New ideas & ways of working • Encouragement for suggestions • Creation of thinking space •
Accountable	• Learn from mistakes • Work SMART • Develop people •	• Learning from mistakes • SMART working
Excellence	• High quality services • Keep improving • Learn from mistakes	• Solution focused • Actively resourceful • Seeking opportunities to improve care

Source: ICARE Values feedback Oct 15 Trust Intranet

2.7 Arguably WH cannot expect staff to always follow these values without the other elements that help create a continual improvement culture and thus this is another reason why WH needs a Service and Quality improvement strategy (e.g. it might be only a small proportion of WH staff really understand what is meant by SMART yet it is a commitment and a 'love to see' in our values)

2.8 Perhaps in a Service Improvement culture the following would also be captured in ICARE

- respect and engage the workforce as valuable contributors of new ideas, not just 'hands' to follow orders
- remain relentlessly curious about the needs and experiences of patients, relatives and staff
- employ empirical learning cycles pervasively to continually test and learn from changes
- value interdependency, team-work, and systems thinking
- trust intrinsic motivation far more than extrinsic incentives

2.9 This underpins the theme that it has long been recognised that if the delivery of healthcare is to achieve its full potential, 'change making' has to become an intrinsic part of everyone's job, every day, in all parts of the system.

2.10 In some Providers quality improvement has become embedded into the fabric and culture of the organisation: Boards have made clear, long-term commitment to building their organisations' improvement capability, and staff at all levels, clinicians and non-clinicians alike, are encouraged, if not expected, to develop quality improvement skills and then hone them on improvement projects. These organisations can now point to improved patient outcomes and better experience scores – for both patients and staff – over several years (e.g. Frimley Health FT, ELFT)

2.11 Many Royal Colleges and professional bodies have also become enthusiastic service and quality improvement proponents. The Royal College of Physicians' *Learning to Make a Difference* programme, which gives junior doctors the chance to undertake a quality improvement project in place of a clinical audit, has been a particular success. However some organisations have not fully grasped what an opportunity it is to link this training requirement into a broader service and quality improvement strategy.

2.12 There are many organisations in which service and quality improvement remains a marginal activity, undertaken by a few isolated enthusiasts with limited support. Elsewhere, a greater familiarity with common quality improvement tools and techniques has not been accompanied by a clear understanding of how to drive and sustain change in a complex system. There is also a tendency in

some places to rush to 'the solution' before really understanding what the problem is, or whether, in fact, it is the right one to tackle.

2.13 If we are to create an organisation of committed improvers, who are ready and willing to make change happen then we need to consider engaging all staff in service and quality improvement.

2.14 Service and quality improvement should become normalised - *"…everyone in healthcare really has two jobs when they come to work every day: to do their work and to improve it"* (Executive Recommendation in The Berwick Report 2014)

2.15 Defining what is meant by 'Quality' is also important - *'Patient care that focuses on safety, effectiveness and patient experience' (NHS Constitution 2015)*

2.16 Defining what is meant by 'Quality Improvement' (QI) is similarly important. It is suggested Whittington Health QI is designed to make a difference to patients and is delivered by:

- Using understanding of our complex healthcare environment
- Applying a systematic approach
- Designing, testing, and implementing changes using measurement for improvement

2.17 Critical to QI is 'Quality Improvement education' that develops the capability and resilience to put quality improvement into action through delivery of:

- Knowledge in improvement science, systems and measurement
- Skills in managing complexity, leading change, learning and reflection, and ensuring sustainability
- Training in human factors that impacts those capabilities (e.g. emotional intelligence)
- Stakeholder engagement and communications including involvement of patients throughout the process

2.18 Those organisations that succeed understand what transformation really means. Staff at all levels will have the tools, leadership, support, permissions and space to undertake the work. However achieving success often only follows the culmination of trying and failing. To truly develop an enhanced culture of service and continual improvement WH must appreciate not every initiative will work perfectly first time. Space must be given for failure so long as the review and refocus disciplines also exist. Without this initiative will be curtailed. As further sections in this strategy propose WH could adopt and insist PDSA cycles as its improvement methodology to help generate this culture.

2.19 Whittington Health (WH) established a Programme Management Office in June 2016. The objectives of this team are:

- Support the delivery of a Road mapped CIP programme totalling £20m+ over 2 years
- Develop a strategy and actions that enhance WH's culture and ability to become a continually improving organisation

This report focuses on the second objective absorbing the themes and drivers highlighted in this section that underpin why WH must have a service and quality improvement strategy.

3.0 ELEMENTS WITHIN A SERVICE AND QUALITY IMPROVEMENT STRATEGY

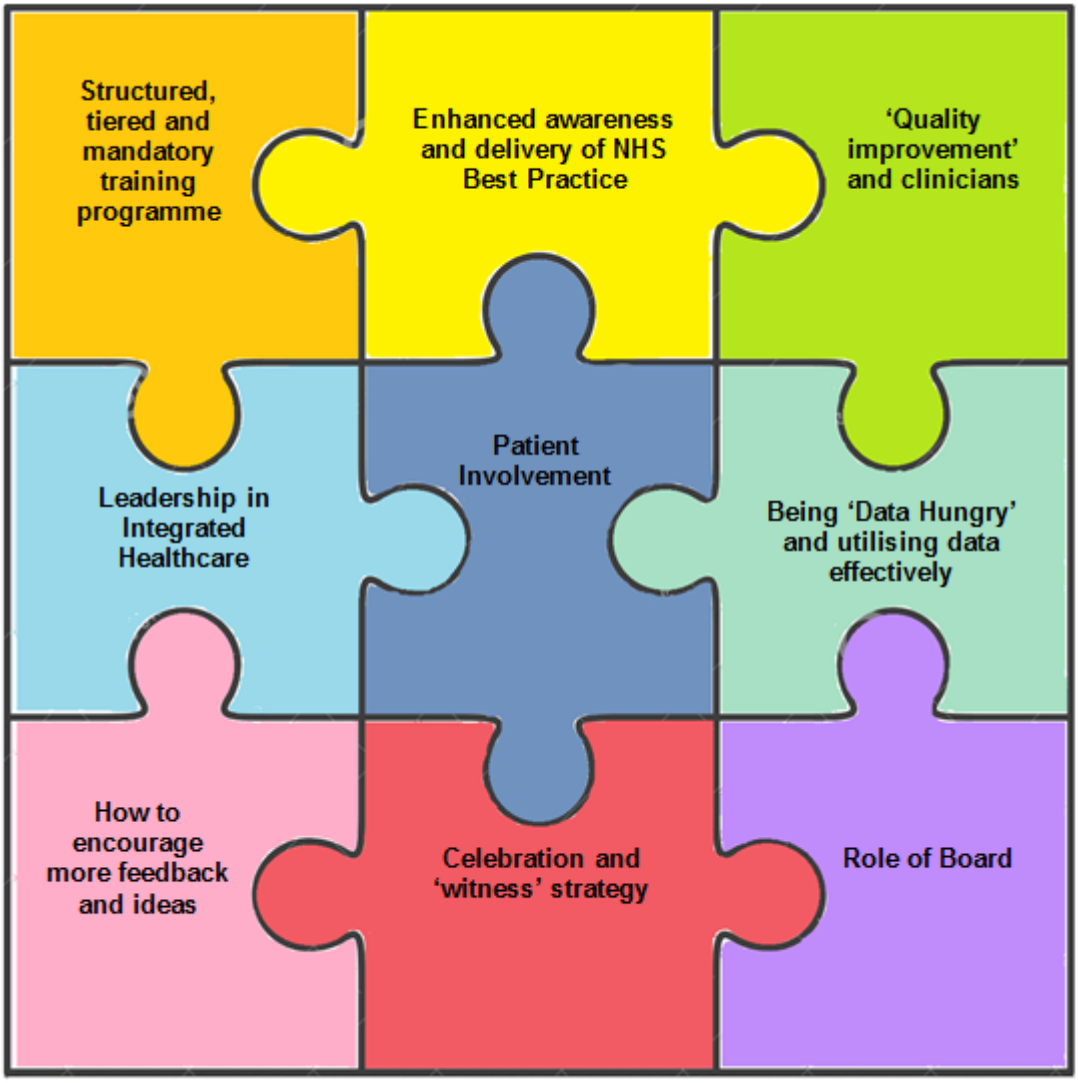
3.1 At its core WHs service and quality improvement strategy must focus on learning, training and role-modelling with the ambition of engaging every single member of staff in this endeavor.

3.2 The following 10 elements listed below could characterize WH's service and quality improvement strategy:

- Structured, tiered ‘service improvement’ training programme for all WH staff that is mandated
- Focus on ensuring WH delivers known Best Practice
- Clinical Audit is rebranded as Quality Improvement
- An improved understanding of how leadership in integrated health care is demonstrated
- Greater involvement of patients to inform and motivate service improvement
- A drive towards a more ‘data hungry’ organisation
- Improvements in how WH seeks out feedback and ideas from staff on a daily basis
- Improved support and incentives for service improvement ideas and pilots
- Celebration strategy that is more frequent and shares service improvement initiatives
- Communication strategy that explains why and how WH is going about this QI

3.3 These 10 elements would complement one another. For example all staff at induction and annually via mandatory training, should be made aware of how WH focuses on service and quality improvement and on how they can and must contribute. Crucially WHs service and quality improvement strategy must permeate everything that it does. However at present we could not contend this is the case.

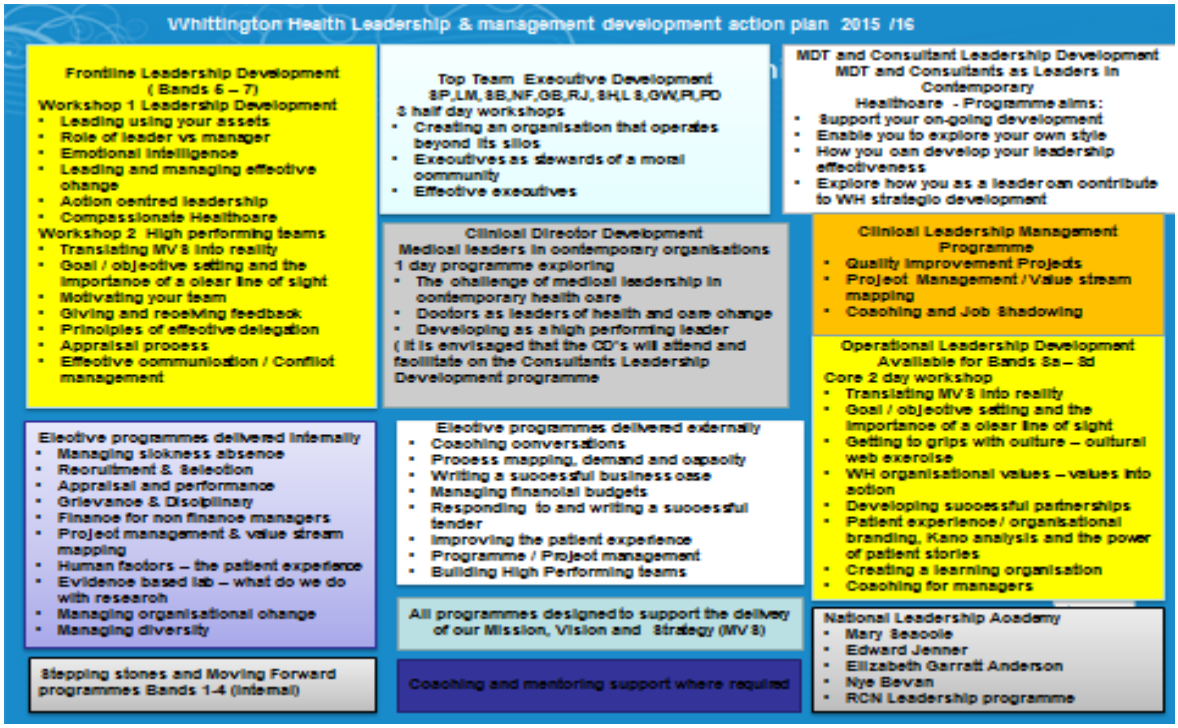
3.5 This document suggests that in order to create the required culture the 10 elements go together like a ‘jigsaw’.



3.4 This report now proceeds to describe each of these elements in more detail.

4.0 STRUCTURED, TIERED AND MANDATORY TRAINING PROGRAMME

4.1 Currently WH offers a great range of training and development opportunities (see table below)



4.2 However potentially missing is a greater emphasis on the skills and knowledge needed to drive a culture of service improvement and clarity on who must have these.

4.3 Furthermore reductions in unit cost, critical to WH's financial sustainability, arguably only come from:

- Streamlining wasteful processes
- Transformational innovation – new treatments/therapies
- Economies of scale

This requires training in the way people think and tackle problems.

4.4 The ability to understand, carry out and direct projects to improve the quality of the service is an essential skill. Thus effective quality improvement education is critical.

4.5 The Handbook of Quality and Service Improvement Tools (NHS Institute for Innovation & Improvement) highlights 8 sets of comprehensive tools, theories and techniques for improving quality and productivity. These are listed below with some of the component elements:

A. **Project Management**

- Scoping
- Benefits realisation
- Action planning & Responsibility charting
- Sustaining momentum

B. **Identifying Problems**

- Root Cause analysis incl. fishbone diagrams

- Pareto analysis
- Scatter diagrams

C. **Stakeholder and User Involvement**
- Stakeholder analysis
- Communications matrix

D. **Mapping the Process**
- Value stream mapping
- Process templates
- 'Sort & Shine'

E. **Measurement for improvement**
- Balanced scorecards
- Plan, Do, Study, Act (PDSA)
- Statistical Process Control (SPC)

F. **Demand and Capacity management**
- Theory of constraints
- Flow management
- Lean and Ohno's 8 wastes
- Enhanced recovery programmes; best practice on reducing DNAs, cancellations

G. **Thinking creatively**
- Brainstorming techniques
- Six Hats
- Fresh Eyes

H. **Human Dimensions of change**
- Discomfort zone
- Empowerment
- Managing conflict, resistance and addressing uncertainty

4.6 In order for staff to be confident in doing and participating in service and quality improvement, they need to be confident in the use of such quality improvement tools and techniques.

4.7 At WH whilst some staff have received formal training in some of the list in 3.2 none have been identified who have received all. Many, though possibly aware of the concepts, have received little or no training in these tools, theories and techniques.

4.8 **Importance of link to Appraisal:** WH also does not keep aggregated records of what service and quality improvement training has been delivered nor specified that this should be identified at appraisal. (Note: By way of comparison one of the most successful NHS Acute Trust, Frimley Health FT, has put 208 managers through a senior leadership programme which includes 'tools for change projects' or 'T4CP'. A number are now coming around again for mandated refresher training)

4.8 **Importance of link to Appraisal:** In order to more fully assess the benefit of training in such methodologies the appraiser would ideally have good insight from personal experience of using such approaches.

4.9 A critical mass of clinical and non-clinical staff would ideally have advanced quality improvement expertise. Theory by itself is usually insufficient; this approach will prove most effective if those trained are asked to lead/join a quality improvement project as part of their studies. This way learning is consolidated via practice.

4.10 Part of the difficulty is that certain tools can feel counter-cultural or unnecessarily complicated, therefore demystifying these can help. Part of the challenge is to present topics like statistical process control (SPC) in ways that are perhaps more familiar. For example:

- an SPC chart exists at the end of every patient's bed – it is just called a temperature chart!
- the essence of Lean is simply to create work flow making it easier for someone to do their job

4.11 WH's needs to think about what is the minimum an employee at a certain level should have knowledge of and competency in using. Importantly it should not be limited to only certain professions.

4.12 Whilst there are literally hundreds of improvement tools and techniques this document recommends WH focuses on the 8 elements encapsulated in the Handbook of Quality and Service Improvement Tools as listed in 3.2. The practical application of these tools using real problems would add significant value to creating an improvement culture.

4.13 The Quality Improvement Guide attached to this document suggests 3 tiers of training are considered in the first instance as follows:

- the top 30 senior leaders within WH be receive detailed training sufficient that can teach the basics to members of their teams - GOLD
- that the next 30 middle tier leaders within WH receive a shortened version on this training introducing the basic concepts, tools and techniques – SILVER
- all staff receive a basic level of training and awareness as part of mandatory training and corporate induction - BRONZE

4.14 It is suggested that the top 30 include relevant Executives, all ICSU Director of Operations and Clinical Directors, PMO, and other department heads and clinical leads.

4.15 It is suggested that the middle tier leaders include ICSU General and Service Managers, Heads of Nursing, Finance and HR Business Partners.

4.16 It is suggested that the theory training for senior leaders be consolidated into no more 5 days, and middle tier leaders into 3 days. However crucially there should be an annual 1 day refresher each year coupled with an emphasis in appraisal of where an employee has demonstrated competency and use of the training.

4.17 In addition it is suggested that the Trust annual mandatory training and/or corporate induction include a session on 'Service & Quality improvement in order to ensure that all staff receive some orientation on the following:

- that service and quality improvement is a component in everyone's job and why
- guidance on how staff can get involved in service and quality improvement
- that annual appraisal will include discussion of where/how the employee has contributed to service and quality improvement
- reference to WH's START/STOP icon and awards for Service and Quality improvement
- how service and quality improvement is celebrated at WH

It ought to be possible to deliver this component 'in house' and therefore the additional cost should be minimal e.g. £250 x 12 times a year = £3k

4.18 The estimated initial cost for this training is as follows:

Cohort	Per day cost	Total
GOLD Senior leaders 1 (15 staff) Initial training Annual refresher	£2k £2k	£10k (£2k from Y2)
GOLD Senior Leaders 2 (15 staff) Initial training Annual refresher	£2k £2k	£10k (£2k from Y2)
SILVER Middle Leaders (15 staff) Initial training Annual refresher	£2k £2k	£10k (£2k from Y2)
SILVER Middle Leaders (15 staff) Initial training Annual refresher	£2k £2k	£10k (£2k from Y2)
BRONZE All staff as part of annual mandatory training	£250	£3k (12 x £250 for monthly mandatory training sessions)
TOTAL		**£43k (£11k from Y2)**

4.19 WH may be able to commission some of the required training at a lower cost via NHS Elect and/or provide 'in-house' via its own skilled trainers. Further work is required to assess the cost associated.

4.20 After the initial 60 staff have been trained WH will need to i) set aside some resources for the training of any new joiners to these tiers ii) decide whether it wishes to create a 3rd tier. This though is just seen as a start, and whilst the Frimley FT example noted in 3.7 is not a direct comparison with a similar sized Trust it does give a sense of the longer term commitment adopted by successful organisations to equipping staff with the required skills.

4.21 The programme should be subject to a full PDSA, seeking and receiving feedback at different points in time, and adapting the approach as deemed necessary. The programme ought to role model the PDSA culture WH expects to characterise its service and quality improvement strategy.

4.22 WH also currently runs a Clinical Leadership Management Programme (CLM) delivered primarily by Dr Ahmed Chekairi. 12-15 employees, primarily clinical staff, partake in this course per annum and feedback is very good. The CLM programme covers:

- Personal insight/awareness
- Stakeholder and project management
- Quality improvement techniques
- Leadership & management

4.23 The programme endeavours to primarily help equip future clinical leaders with essential leadership and management skills and thus complements the commitment to having enhanced clinical leadership. Applicants self-select for CLM by deciding to apply.

4.24 It is recommended the CLM programme remains strongly supported, however that its syllabus is reviewed in due course so it also covers similar to that proposed for the tiers of leaders outlined in sections 3.10.

4.25 The current cost and time commitment associated with CLM is £4.5k for each cohort of 12-15 employees. Ahmed Chekairi and the Department of Organisational Development also deliver a project management and VSM one day workshop once a year. Again those attending tend to self-select rather than it be a mandatory component of how WH develops service improvement awareness and capability.

4.26 NHS Elect also deliver some specific Project / SI type workshops (e.g. writing a successful business case, process mapping and demand capacity etc.) and will deliver circa 6 days a year for WH. Similarly those taking up these training options tend to do so on an individual basis. WH may also be able to commission some of the training from UCLPartners improvement programme.

4.27 In addition it may also be valuable for WH invite Amar Shah from ELFT to a Board seminar session to discuss how his Trust went about establishing a similar approach and culture. ELFT is widely lauded for its approach, but this has taken a number of years to develop sustain, thus providing potentially useful lessons for WH.

5.0 ENHANCED AWARENESS AND DELIVERY OF NHS BEST PRACTICE

5.1 The NHS has spent considerable time assessing and communicating best practice across a range of key challenge areas. However for various reasons organisation have struggled to consistently apply these, and over time some staff forget the original principles or were never exposed to them in the first place. Constant changes in leadership can also mean that an organisation does not get to spend sustained time ‘ratcheting in’ best practice. Whilst context can change usually the principles behind best practice remain valid and applicable over a sustained period of time.

5.2 Possible examples of Best Practice that WH cannot be sure it still follows or has all key staff fully aware of are:

- ECIST Guidance on management of emergency flows
- Productive Ward series
- Productive Theatre series
- Productive Community Services
- Productive Endoscopy
  (Note: there may be others that WH would wish to add to this list)

5.3 Senior leaders should receive support to develop and sustain awareness of such best practice guidance.

5.4 Potentially WH could undertake a self-assessment audit against key 'Best Practice' guidance leading to an action plan to ensure it is using all the lessons possible. The PMO could take a lead role in this process.

5.5 It is vital that staff feel adopting Best Practice works for them so an imposition should be avoided. However what is not clear is how many staff have been exposed and are properly and fully aware of best practice. Help with the awareness is primarily what is recommended here, but such that WH is then clear why and how it diverges if that is then the conclusion.

6.0 'QUALITY IMPROVEMENT' AND CLINICIANS

6.1 A Service Improvement strategy has to have a strong association with improving clinical quality.

6.2 It is a fundamental duty of all doctors to contribute to systems of quality assurance and quality improvement. Promoting patient safety and the medical workforce in training is of particular importance.' (Patrick Mitchell, Director of National Programmes, Health Education England)

6.3 Evidence from Health Education England's Better Training Better Care programme (Jan 2015), which aimed to improve the quality of training for the benefit of patient care, demonstrated the importance of quality improvement training in allowing junior doctors to bring about change.

6.4 The trainee medical workforce rotates through numerous, varied, clinical posts over a period of several years and observes different models of care delivery in the process. Whilst doctors in training are thus very well placed to perceive how systems influence the delivery of patient care, these insights may be under-utilised.

6.5 In many Trusts trainee involvement in quality improvement has largely been through clinical audit, but there is increasing evidence that junior doctor-led audit is failing to deliver, with junior doctors perceiving their involvement as a 'tick-box exercise'. Crucially, audits undertaken by doctors in training often fail to change practice. However the approach at WH has been evolving to get doctors in training more involved in quality improvement and this should be strongly supported. Educational Supervisors may also require some additional training and support in quality improvement if they are to better oversee this direction of travel.

6.6 Sometimes the way organisations use the terminology of 'clinical audit' or 'quality improvement' can result in a sense the two may be in competition leading to an 'either'/'or' dichotomy. 'Research' can also occasionally get muddled into this. The following may be helpful descriptors:

- Research as *'what is the right thing to do'*
- Audit as *'are we doing the right thing'* and *'how well are we doing'*
- Quality Improvement as *'delivering the required change supported by improvement methodology and dynamic testing & measuring'*

6.7 Quality improvement should be seen as applying well-used methods for delivering change in complex systems to the so-called 'make change' part in the audit cycle. Each audit cycle can be viewed as a Plan-Do-Act-Study (PDSA) cycle.

6.8 A challenge is how to integrate formal and informal learning and embed them as part of a coherent approach to quality and safety improvement. The required culture of service and quality improvement means with every educational encounter that seeks to improve patient's wellbeing the question should be: 'Where does quality improvement fit into this, and how can we teach it?'

6.9 Making room in the timetable of our trainee's and in Consultants own job plans can be mandated and might be included through the consultant appraisal/revalidation process by setting clear

expectations of the output of Supporting Professional Activities (SPA) time, e.g. 1.0 out of total 2.5 SPAs set aside for demonstrating 'added value' to the organisation through local quality improvement initiatives. This approach is supported and recommended by the Academy of Royal Colleges in 'Quality Improvement-training for better outcomes' *(March 2016) (E.G Chelsea & Westminster NHS Trust have 4 posts each year for junior doctors to be Improvement fellows – 50% QI / 50% clinical)*

6.10 Ideally quality improvement workshops should be available and potentially mandated for all doctors and not just those who self-select.

6.11 Many senior doctors are new to the idea of 'improvement' as a methodology and may be hesitant to engage. Unfamiliarity with the concepts, methodology and language of quality improvement, and the experience of a tick-box exercise of traditional clinical audit with many trainees, and for some now with revalidation, has arguably not encouraged engagement. Yet of course at the same time we know that improving practice is not an alien concept to consultants.

6.12 Quality improvement can be viewed with less esteem than research. The tension that research holds the highest hierarchy in science and quality improvement possibly the lowest has perhaps lessened and evolved with time. Maybe what is under appreciated is that service and quality improvement provides a methodology for translation of research findings into practice, and quality improvement itself is underpinned by disciplined, rigorous methodologies. WH may need to ensure it does not view QI with less esteem.

6.13 The current position on clinical quality at WH has a number of strengths as follows:

- Highly positive CQC report for audit and effectiveness areas
- Strong commitment/high compliance rates with mandatory national and larger scale audit projects where there are named and engaged leads.
- Named departmental clinical audit leads for most departments
- Dedicated clinical audit co-ordinator with a high level of knowledge of clinical audit process
- Dedicated Head of Clinical Governance /NCEPOD Ambassador role with high level of skill and experience across the clinical governance agenda including acting as an Advisor to other Trusts on NICE guidance
- Functioning and reputation for strong integrated Clinical Guidelines committee
- Highly commended guidelines in place and adhered to by clinical staff
- High compliance rates with governance/compliance deadlines such as review of NICE protocols. (Note: Leading London Trust for NICE implementation)
- Established and effective interdepartmental relationships
- Registered clinical audit projects captured through a comprehensive Clinical Audit registration form based upon HQIP template
- Multidisciplinary QI meetings are established for some areas – e.g. surgical specialities.

6.14 However there are a number of weaknesses too as follows:

- Focus on static "pre and post interventions" clinical audit cycles rather than dynamic PDSA based QI projects
- Multiple smaller PDSA type QI projects occurring across the ICO that are not being registered and therefore changes/improvements and learning not fully captured
- Clinical audit lead engagement and effectiveness is currently variable
- Only a minority of departmental leads for clinical audit are community staff or non-medical staff and there is minimal collaboration between service improvement and clinical audit projects leading to loss of ICO strategic approach.
- Two WTE members of staff in "clinical audit department." There is a lead clinical governance role and another in audit co-ordinator role but variable clinical leadership currently provided and no ICO based overarching clinical audit/QI strategy for staff to follow.

- No clinical audit/effectiveness or QI committee has run for the last 30 months subsequent to resignation of Trust Director of audit and effectiveness in June 2014. This is contrary to the described structure set up as per terms of reference for the quality committee where it states that the clinical audit and effectiveness committee reports to the Trust Board Quality Committee.
- Limited bespoke QI training for staff and relatively low numbers of staff attending current clinical audit training sessions.

6.15 As part of a comprehensive Service and quality improvement strategy this document suggests a clear integrated re-branded Quality Improvement (QI) strategy is essential and that draws upon all aspects in recent publications (Berwick, 5YFV etc.) including a position that:

- Outlines our national, regional, sector and local QI priorities each year
- Integrates with the overall service improvement plans
- Outlines our commitment to enabling staff to take part in QI projects by providing mentors, registration, training and other support.
- Outlines the roles and responsibilities of QI department
- Outlines the role of the departmental QI leads

6.16 In order to deliver these enablers the actions listed below from 6.17 to 6.23 are recommended to help enhance the culture of service and quality improvement.

6.17 An initial meeting between head of clinical governance, medical director, service improvement staff, clinical leadership and management course staff, ISCU representatives and patient safety lead to ensure correct direction of travel.

6.18 That the current clinical audit/governance roles be 'refreshed' to QI department roles in line with roles of similar sized trusts e.g. Homerton

6.19 That each departmental clinical audit lead is asked if they wish to remain in the role, receives further training or swap roles with another member of staff. Within this review ideally more focus will also be given to non-medical and community based staff. The required organisational culture cannot be created if quality improvement remains primarily just for doctors.

6.20 That there is a re-launch of new QI lead roles that are communicated and publicised to all staff. Alongside this consideration should be given to re-launching of clinical audit days as QI half days and establish at least one as a corporate QI half day.

6.21 That a 4 times a year QI forum is launched to replace the previous Clinical Audit and Effectiveness committee.

6.22 That Whittington Health develops and advertises an Associate Medical Director role for QI (2PA) akin to leads for Revalidation and Patient Safety to put together a clinical QI strategy for Trust, line manage the current Head of Clinical Governance in collaboration with the Executive Medical Director and provide direction and support for the clinical QI departmental leads where required, provide QI training in collaboration with CLM team and chair QI forum and other QI events. The AMD role would require appropriate administrational and project support.

6.23 That the new AMD role will lead on refreshing policies, training materials and registration forms to provide up to date information on clinical QI. (Note: a new form has recently been introduced of QI projects. Previously it was branded as a *clinical audit* registration form)

6.24 The table below summaries the resource requirements.

	Resource requirement	**Estimated annual cost**

1.	2 PAs for new Associate Medical role leading on clinical quality improvement	£20k per annum
2.	Administrative support and sundries budget	£30k per annum
3.	TOTAL	£50k per annum

7.0 LEADERSHIP IN INTEGRATED HEALTHCARE

7.1 Whittington Health as an Integrated Care Organisation is in a unique position. Furthermore in 2016 the CQC gave WH a 'Good' overall rating and within this Community services performed particularly well.

7.2 However there is limited evidence that being an ICO has yet enabled WH to perform significantly better than other similar Trusts on things like length of stay, emergency attendance, emergency admission rates and lower outpatient referral and follow up rates. This would suggest the potential benefits of being an ICO have yet to be fully realised.

7.3 Arguably the issue remains more one of productive efficiency and not the culture and delivery of care. The 'Good' CQC rating is an excellent basis from which to further drive the potential benefits from being an ICO but does automatically confirm that productive efficiency opportunities are exhausted. There is a lack of confidence in recent benchmarking data and thus the position remains unclear.

7.4 It is recognised that clinical staff and management may be finding that more immediate pressures limit the time and energy available to really drive forward the potential ICO productive efficiency benefits.

7.5 It is clearly a key challenge for all health economies to reduce the need for people to attend acute hospitals whilst also enabling those who can be discharged earlier to be so and in this WH is no different.

7.6 To demonstrate leadership in integrated care WH may want to consider what it could do to further demonstrate the benefits aligned with the two key challenges set out in 7.5. A possible way forward is to run a number of all-day 'reflection and brainstorming' sessions attended by in-patient and community staff to crystallise what those on the 'front line' believe could be done better and would make a difference. (e.g. it might be a significant increase in Virtual ward capacity would 'pull' more patients from acute capacity but this requires discussion, frontline insights and testing. Potentially though WH's unique ICO status gives it significant advantages in such initiatives that it could further enhance and publicise). Such sessions, well facilitated, could also help further develop the sense of integration.

7.7 Such 'reflect and brainstorm' session can lead to more specific 'Kaizen' type events focused on the specific challenges of maximising the benefits from being an ICO. What this section primarily recommends though is that WH gives thought to how it further elicits the potential insights its ICO staff will inevitably have.

8.0 PATIENT INVOLVEMENT

8.1 It is well known that in order to have responsive services that provide good patient experiences, patients' needs must be at the centre of service design, reconfiguration and improvement.

8.2 Patients have a tremendous contribution to make to every part of service and quality improvement. They are able to bring their own particular knowledge and experience to the conversation, ensuring that the patient perspective is kept at the forefront.

8.3 Patient involvement in service and quality improvement may encompass wide-ranging participation. The patient is an expert on the experience of being a patient and in some cases may be already, or can become, an expert in their illness. It is very difficult to improve patient experience without listening in detail to what service users want, and cross-checking at every stage of a project that this is being achieved.

8.4 NHS England's '*Improving Experience of Care Through People Who Use Services' (Aug 2015)* report recognised that there is a critical role for 'patient leadership' and this should be seen as *'a core and essential component of a 21st century health and care system'*. Ten building blocks for developing patient leadership were recognised including involving patient leaders in the experience of care, shaping, co-designing and leading proposals and investing in their task-specific training and development. Gaining an understanding through the experience of service and quality improvement in action expands the breadth of settings a patient may wish to influence.

8.5 As regards service and quality improvement the basic consultative level of engagement just involves surveying patients about their care experiences. A second enhanced involvement level of engagement would have patients as advisors or 'advisory council' members. A partnership and shared lead model would have patients co-leading hospital safety and improvement committees. *(Note: of interest may be the 'Patient Voice' initiative used by Chelsea & Westminster NHS Trust – involves recent patients talking about their experience with junior doctors listening and asking questions)*

8.6 Currently WH does the basic level and some of the second enhanced involvement level Consideration perhaps should be given to further developing the third level – a partnership and shared lead model as part of a service and quality improvement strategy.

8.7 The focus should not be so much on the technicalities of quality improvement methodology but rather for patients to have an understanding of what good quality care looks like, the context of change, and the challenge of change.

8.8 Patients can have a critical role in prioritising next steps and helping to engage staff in the purpose of their work.

8.9 Research in the USA, where the volume and frequency of data capture on patient experience to date exceeds the NHS, identifies 3 types of suffering – 'inherent to the disease', 'inherent to the treatment', from 'avoidable defects in care & service'. The 'avoidable defects' typically identified in data analysis relate to teamwork, courtesy, waiting, environment, amenities, and recovery. Furthermore Surgery satisfaction rates are generally higher than Medicine (i.e. more multi-chronic co-morbidities meaning more difficult to meet needs), with Obstetrics typically in the middle. Further understanding and benefits are being derived from segmentation - by condition/procedure and by age, with this intelligence deemed vital for driving service improvements. (Source – Press Ganey 2016)

8.10 Further conclusions from this US research conclude that what patients most value are - confidence, working together, listening and empathy. This knowledge can help inform service and quality improvements.

8.11 A potential further lesson from the USA is the benefits generated from more transparency i.e.: when more patient feedback data was generated by Consultant episode and published on websites improvements increased at a more rapid rate. Much greater use also seems to be made of email surveys, and ipads given to patients whilst in hospital settings to 'collect in the moment' data.

8.12 In further developing its service and quality improvement strategy WH may wish to not only to consider how much further it may be working to involve patients in partnership but also assess if it can better segment patient experience feedback to crystallise the responses derived. It would not be that surprising if the general themes were similar to those distilled in the USA research but there may be some relevant differences. Regardless it is suggested that service and quality improvement

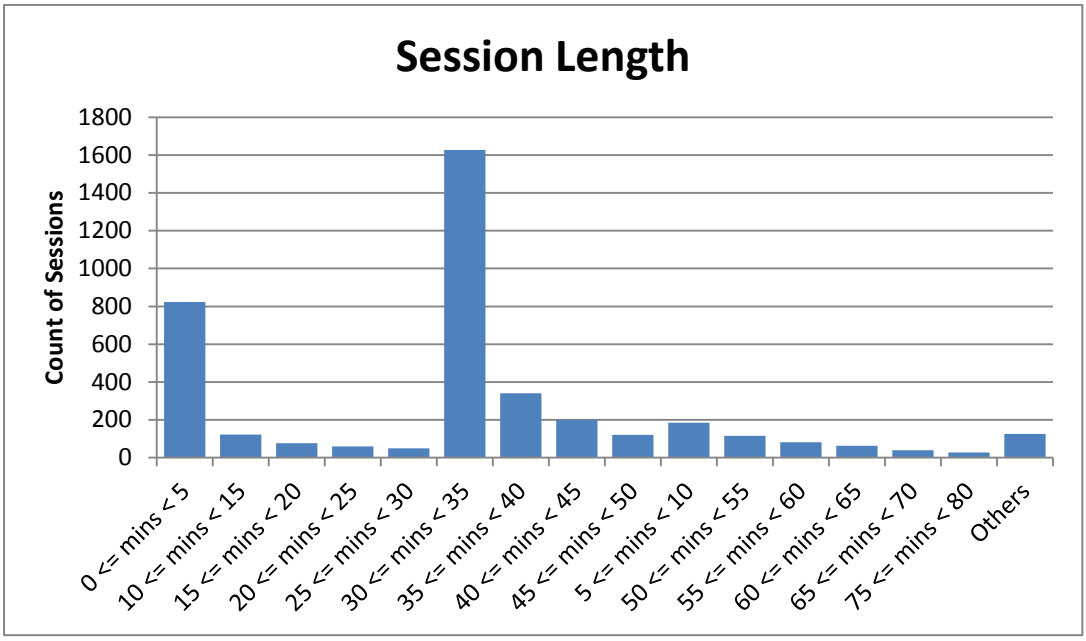
requires an increasing emphasis on a more sophisticated understanding and use of patient feedback.

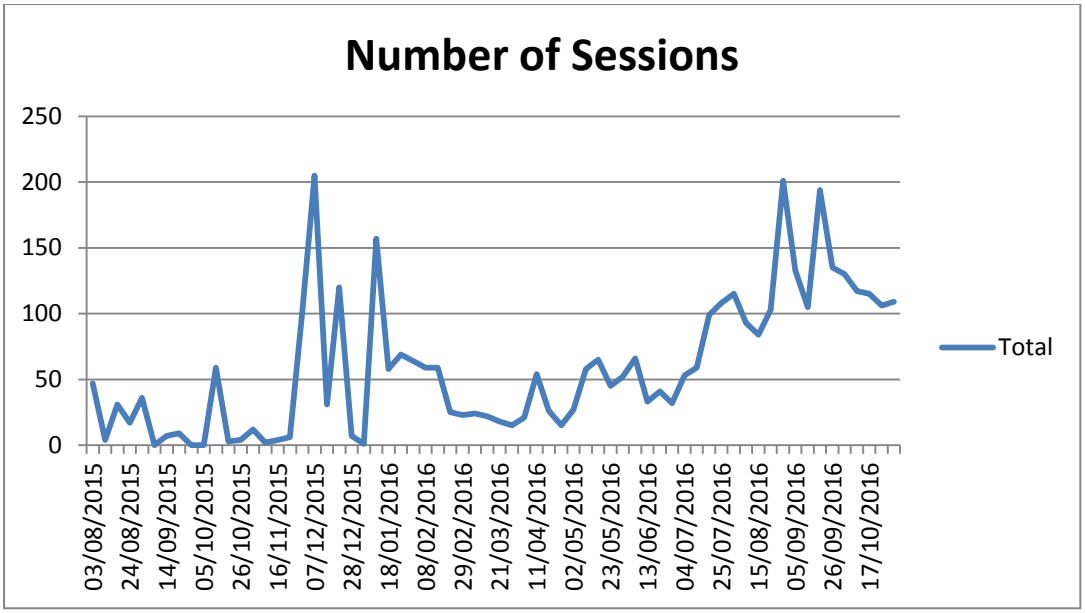
9.0 BEING 'DATA HUNGRY' AND UTILISING DATA EFFECTIVELY

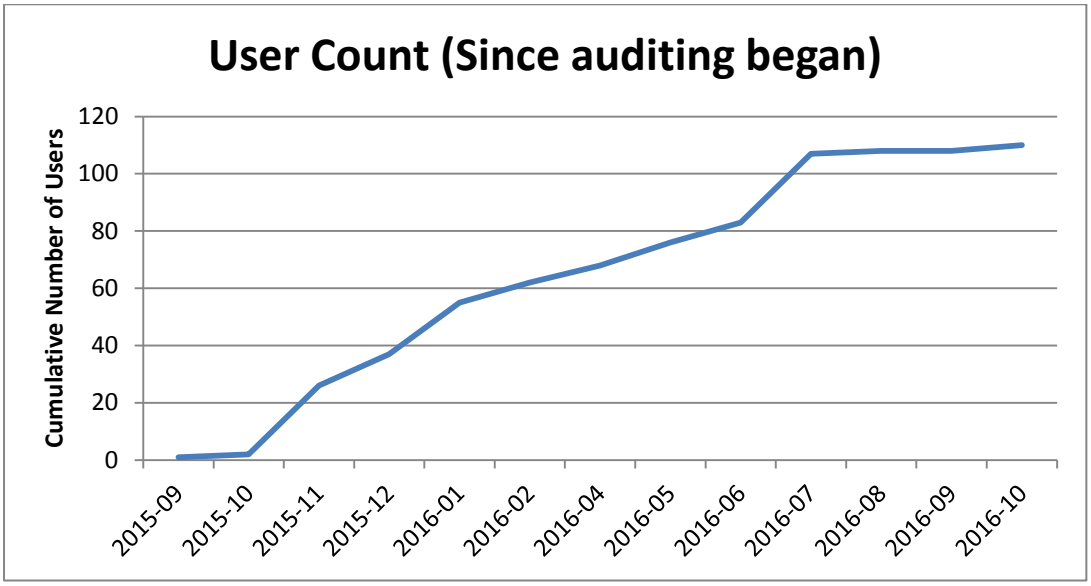
9.1 Health organisations have more data than ever at their disposal, however actually deriving meaningful insights from that data—and converting knowledge into action—is easier said than done.

9.2 To move from a culture that largely depends on heuristics to a continual service and quality improvement learning culture, which is more objective and data driven embracing the power of data and technology arguably requires a change from an expert based mind-set to one much more learning oriented. Synonymous with this is a data hungry organisation that also knows how to use data effectively (Note: a common mistake even for those 'data hungry' is a failure to ask for the right data to answer the question they are looking for, or similarly to ask the wrong question in the first place. This can require some training in understanding data)

9.3 Perhaps an indication of how data 'hungry' and prepared to meet that need, WH currently is comes from how much staff are using the business intelligence system QlikView. WH has data to show this as highlighted in the graphs below highlighting the position as at October 2016. It is felt the number has increased in recent months but would still warrant review.







9.4 There is clearly an increase in use of the QlikView system. However arguably this is still nowhere near what a data hungry, learning culture would expect in an organisation this size of over 4000 staff. For example very few Consultants use Qlikview and only one middle grade doctor has access to the system. QlikView has not been rolled out in any planned way as yet to the medical workforce. (Note: WH may have also reached its limit on current licences for Qlikview).

9.5 The issue is more about usage than provision, although easier to access provision can make a major difference. Thus there may be a case for WH reflecting on what sort of usage it wishes to drive towards as part of its service and quality improvement strategy. This reflection might include consideration of the following:

- *Clinicians – what do clinicians want, what should they look at, what do we want to encourage?*
- *Software licences* – do we need more to roll out much wider?
- *Identification of who could use it, why and benefits from it* – potential need to create a Trust wide list so WH can target appropriately.
- *Education* – agree with IM&T how WH can teach the identified potential users about Qlikview and its uses to maximise the potential benefits
- *Implementation strategy* – who we roll out to and when
- *Monitoring usage* – against a target of what we would hope/expect
- *Consider referring to usage rates in appraisal discussions* - many employees should be able to demonstrate how they have used information in an appropriate and effective way to

change/improve services. Reference in annual appraisal may help lead to up-skilling on information and its usage across the Trust

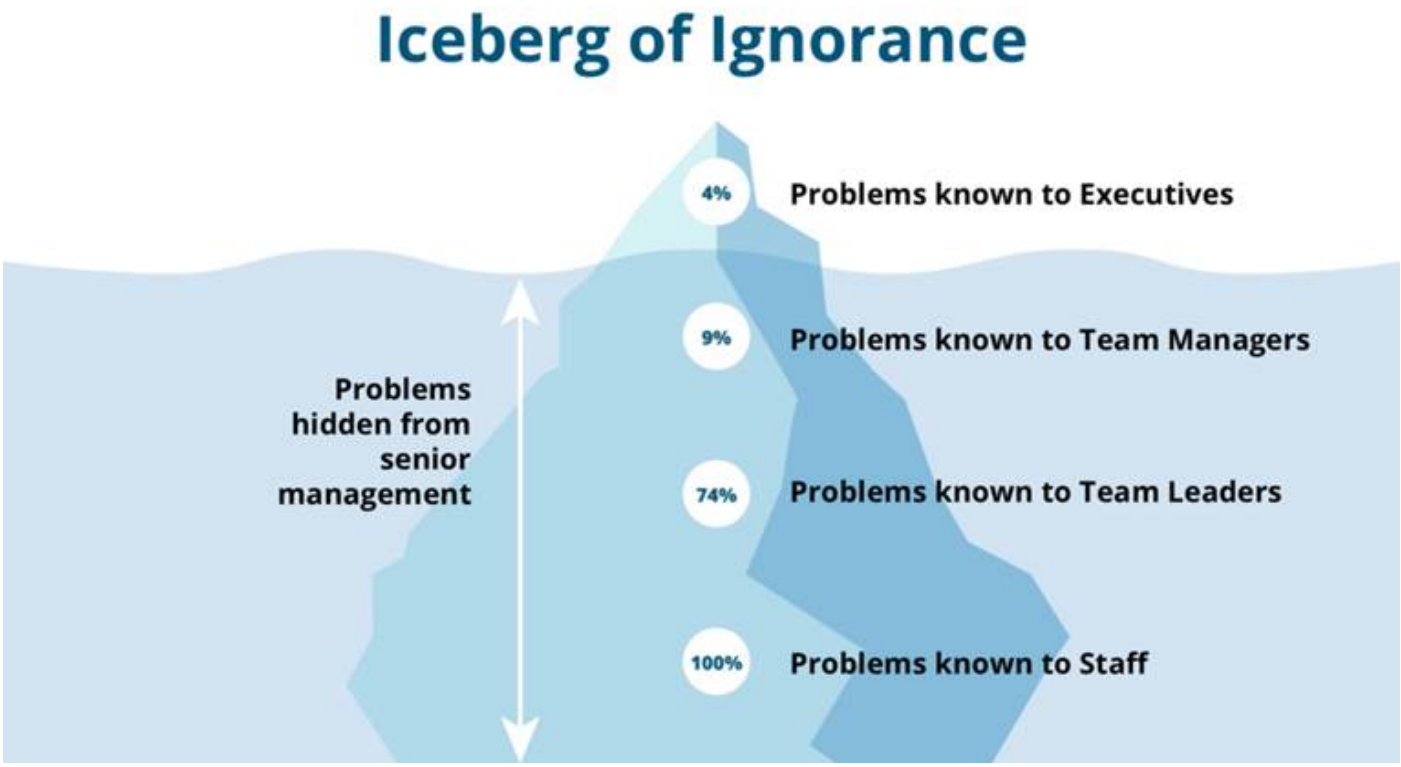
9.6 As well as better use of existing sources, a data hungry organisation may also seek to capture key information currently routinely missing. For example during 'Perfect Week' initiatives real time data on things like senior reviews of all in-patients has been manually captured, but the electronic mechanisms for capturing such useful information is limited. Another example might be all the information recorded on Ward Whiteboards. Increasingly Trusts are investing in electronic whiteboards and having the added value of a wealth of additional real time data aiding patient flow. Systematic service and quality improvement requires good data.

9.7 Through further rollout of Medway system updates and WH status as a proposed 'fast follower' to United Hospital's Bristol on the Global Digital Exemplar programme means WH can increase its ability to capture additional data. Alongside the system capability the data entry inputting processes need to be well considered i.e.- who is responsible, time to do this, ease of data entry.

10.0 HOW TO ENCOURAGE MORE FEEDBACK & IDEAS

10.1 Most organisations believe they actively seek out feedback from employees. However in practice whilst the intent is usually always genuine the mechanisms for staff to do this can be infrequent, cumbersome or untrusted (i.e. staff worry their candour about a problem/frustration may not always be welcome).

10.2 It is a well-recognised phenomenon that many of the problems face on a daily basis never get to the attention of senior leadership. This is sometimes described as the 'iceberg of ignorance.



10.3 Organisations generating a culture of continual service and quality improvement see employee feedback on their frustrations as a precious commodity as it is usually highlighting waste that can be addressed or a factor that if not addressed will turn the frustration into a staffing problem. The breadth and depth of small frustrations are potentially in many large organisations very significant

when aggregated. Because they may each be individually small they may not get prioritised by the predominant culture, and the skills to spot and identify them may also be lacking.

10.4 To further support the ability of staff to provide immediate feedback on frustrations and ideas for improvement the Whitt STOP/START icon as had been added to every desktop. (See logo below)

10.5 The dissemination of awareness of STOP/START however remains a 'work in progress' and could be further enhanced by increasing the confidence amongst staff that what gets raised does get attention. Currently the PMO review all the submissions whereas ideally it would be a broader cadre of senior leaders seeking to find, hear fix the sort of problems being raised. means the engagement Initial feedback from junior doctors has been the most positive. This also links to the strategy of more regularly asking this specific staff group to provide more detailed feedback on areas of frustration and ideas they have seen work well whilst working in other hospitals (i.e. Wasting Junior Doctors Time survey findings – Sept 2016 identified the equivalent of 4wte junior doctors absorbed in just 6 typical daily delays).

10.6 Critical to the success of such an approach is that when factors are raised that are amenable to quick resolution the Trust demonstrates that it can and will act quickly. This is crucial to generating the desired improvement culture. To date some of the issues raised via START/STOP should arguably have been quick to fix, but existing Trust systems and culture can militate against this.

10.7 Alongside initiatives such as START/STOP increasing use has been made of 'Survey Monkey', to get additional staff feedback. A good example is the recent survey that identified how much junior doctor time is wasted. Junior doctors really appreciated being asked and the ease with which feedback could be provided. The approach could be used with other staff groups on a more frequent basis (e.g. with ward managers to elicit feedback on what wastes their time; with ward staff to pick up issues related to retention before these manifest etc.)

10.8 Critically disseminating stories of WH seeking out feedback and quickly addressing frustrations is vital to creating the required service and quality improvement culture.

10.9 This document suggests WH consider how it builds use and awareness of START/STOP much more in all staff daily activity.

11.0 CELEBRATION AND 'WITNESS' STRATEGIES

11.1 This document suggests that 'Celebration' and 'Witness' strategies are different but two sides of the same coin and hence why they are grouped in this section.

11.2 Critical to creating a culture of continual service and quality improvement is a celebration strategy that provides positive reinforcement that this endeavour is highly valued.

11.3 It is a recommended that a celebration strategy focused on service and quality improvement endeavours and learning is urgently developed. This should be as frequent as possible. Annual is not enough.

11.4 The range and volume of service and quality improvement should be disseminated and shared via multiple means of communication. A simple once a month newsletter, whilst a start, is insufficient to really capture the attention of all staff.

11.5 There is considerable evidence that staff who feel their endeavours are not only appreciated by senior leaders, but often 'witnessed' feel more understood and better about their work. Periodically senior leaders in many organisations will spend time with staff 'witnessing' their daily endeavour and almost always it has a positive impact on both the parties. Thus the fact it is not a more standardised approach can on reflection seem both surprising and an opportunity.

11.6 Spending time 'witnessing' staff going about their daily endeavour can also elicit opportunities for service improvement especially if coupled with training on identifying waste and inefficiencies.

11.7 Many organisations distil this thinking into 'Back to the Floor' initiatives (e.g. Tesco insist all senior managers go 'back to the floor' once a fortnight). Many senior managers will have not at some point been involved in such an initiative. Sometimes though these fail to be maintained and the energy dissipates after an initial surge. Evidence from those that have sustained the approach is positive (e.g. Virginia Mason - Seattle, Beth Israel – Boston), and the 'role of management' evolves more to seeing this as critical time that must be protected in order to really help staff do a better job. When coupled with better awareness of service improvement techniques, especially 'lean' thinking, and initiatives such as START/STOP the potential to uncover a multitude of inefficiencies that can be fixed is very likely to arise.

11.8 Currently WH does not have a 'Back to the Floor' initiative but it could consider this as part of a 'Witness' strategy. Such a strategy tends to only work well if good preparation goes into placement management and capturing feedback. Some organisations have actually invested in administrative support that ensures placements are well organised, happen and generate learning and actions.

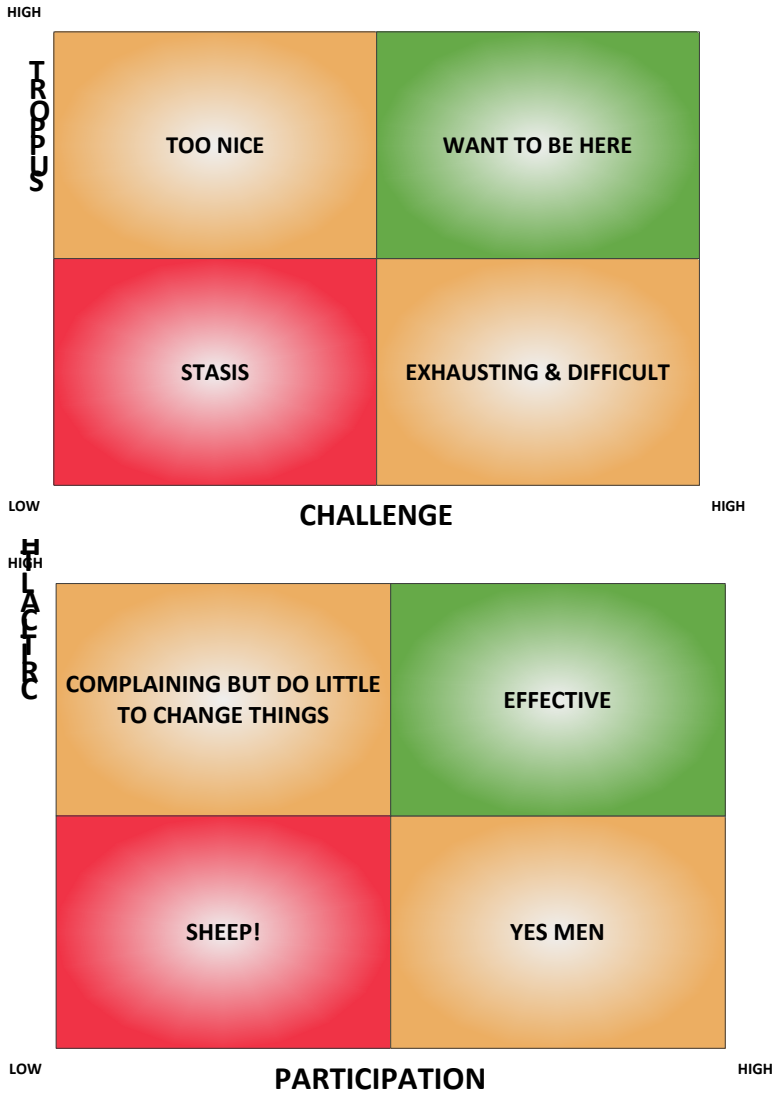
11.9 The challenge to 'Back to the Floor' initiatives can come in 3 main forms – other commitments take precedent; some staff feel uncomfortable and worried about being embarrassed; some are unsure why it's important. These understandable factors need to handled sensitively, although at the same time if the power of 'witness' via initiatives such as 'Back to Floor' is accepted they should not be deemed insurmountable.

12.0 ROLE OF BOARD

12.1 As well as considering, and in due course finalising, a service and quality improvement strategy ideally Board would also have oversight of all service and quality improvement projects and programmes ensuring the coordination and prioritisation of these.

12.2 Ideally Boards will role model best practice service and quality improvement approaches. For example ideally Boards would seek to deploy time-series charts (e.g. SPC) to review performance rather than the often used Red/Amber/Green reports that can be misleading. Championing the science of service improvement is important and can particularly engage the clinical community.

12.3 Organisations that succeed usually have a high level of internal challenge coupled with a high level of support and also seek a high level of critical thinking with a high level of participation (staff & customer/patients). The two 4 box quadrants below may be useful self -assessment tools that can help keep an organisation focused on the required culture for service improvement to thrive. The aim in each is to constantly strive to be in the upper right had side box.



12.4 Boards clearly have a key role in creating and sustaining in difficult times an open culture with the focus on learning, ownership and accountability rather than reprimand, as this facilitates a service and quality improvement culture. WH has much in its favour already regarding this, although recognising how critical it remains to any culture of service improvement, where sometimes things will fail, is vital. The key then is to insist a methodology such as PDSA is followed so the lessons from failure can be used.

12.5 Potentially Board should also ensure credible service and quality improvement support in the form of an enabling 'core' service and quality improvement support team. The core support could be an integral part of the organisation and/or a shared resource with other organisations in the system (e.g. UCL partners).

12.6 Key roles of the core service and quality improvement team would be around quality improvement data, setting up and facilitation of service and quality improvement projects and the ability to teach quality improvement skills. Individuals in these roles should be sufficiently senior and empowered 'enablers' to break down barriers and engage others to incorporate other perspectives e.g. financial planning and budgeting.

12.7 It is recommended that alongside a core quality improvement support team in organisations, there is attention given to quality improvement champions, coaching and how quality improvement language is used.

12.8 Currently WH may also benefit from some strengthening its business/investment case process to ensure systematic review of benefits realisation and key learning as part of its strategy to create an enhanced service improvement culture.

13.0 CONCLUSIONS / RECOMMENDATIONS

13.1 It is the suggestion of this document that WH should develop a Service and Quality improvement strategy for two key reasons:

- Because our environment and our survival demands it
- Because it is something we have committed to already in our organisation values

13.2 It is also a suggestion that such a strategy have multiple elements to ensure it fully permeates the organisational culture and all staff. This document sets out a proposition on what this might include.

13.3 The cost of developing such a strategy is not insignificant but perhaps comes more in the time commitment and prioritisation involved, be that in additional training or systematically committing to initiatives such as 'Back to the Floor'. This document does though highlight initial costs of £100k. This excludes the continuation of a PMO.

13.4 Calculating the benefits from such an overarching strategy is of course very difficult, although many of the service and quality improvements that the strategy may prompt and facilitate will be more measurable particularly with greater adherence to an improvement methodology.

13.5 In the introduction to this document it was suggested that this was not the finished strategy but rather a way of prompting a more detailed conversation about what the final strategy would look like. There may be considerable value in consulting further with staff about what they believe would work, potentially using the ideas within this document.

Whittington Health NHS

Service & Quality Improvement Strategy – Proposed Year 1 Action Plan

(Note: imminent proposed deadlines for TMG highlighted in **RED**)

Strategy Component	Action	Ownership	Target completion
1. Structured, tiered & mandatory training programme	• Confirm service & quality improvement training will be mandatory and signed off in appraisals	***TMG***	**End of April 17**
	• GOLD cohort to include: -Execs, Deputy Execs, CDs, & DoOs – estimate 20 staff	***TMG***	**End of April 17**
	• Confirm initial Y1 SILVER cohort to include: -Heads of Nursing, General & Service Managers, Specialty Consultant Leads, Dept Heads – estimate 30 staff	***TMG***	**End of April 17**
	• Confirm BRONZE training will apply to all WH staff and be designed/covered in annual mandatory training and corporate induction – all 4000+ staff	***TMG***	**End of April 17**
	• Confirm cost estimate of £50k to deliver GOLD/SILVER/BRONZE agreed in principle	***TMG***	**End of April 17**
	• To confirm Learning & Development to take primary role in organising and delivering training supplemented by PMO	**TMG**	**End of April 17**
	• Plan delivery of training, confirm costs and obtain budget approval	Learning & Development	By end of Q2 17
	• Develop Comms plan to go to all staff about the introduction of the service and quality improvement training	Director of Comms & Corporate Affairs	By end of Q1 17
	• Appraisal – amend appraisal guidance and documentation to ensure all staff have service improvement objectives that utilise SMART and demonstrate application of training in service improvement	HR / Learning & Development	By end of Q2 17

	• Appraisal – ensure key appraisers are trained/orientated in why it will be essential that appraisal underpins this focus on service improvement	HR / Learning & Development	By end of Q2 17
2. Enhanced awareness of NHS Best Practice	• Develop formal method of signing off senior staff awareness and understanding of known NHS Best Practice	Learning & Development / PMO	To complete by Q2 2017-18
	• Ensure implementation and adherence to known Best Practice enshrined in objectives, appraisal and PDPs	COO / Operations	To be enshrined in objectives/appraisals by Q3
	• Undertake initial self-assessment against specific Best Practice guidance	COO / Operations	To complete by Q3 2017-18
3. Quality Improvement & clinicians	• Confirm proposal to Re-brand 'Clinical Audi't function as 'Quality Improvement', including 'refresh' of roles	***TMG***	**End of April 17**
	• Confirm proposal to advertise and appoint to Associate MD for QI (2PAs) to lead on clinical QI strategy	***TMG***	**End of April 17**
	• Reconfirm that each Clinical Audit lead wishes to remain in the role and receives further Service/Quality improvement training	Medical Director	By end of Q2 17
	• Identify more non-medical and community based staff to become QI leads	All / Assoc MD for QI (once appointed)	By end of Q2 17
	• Re-launch new QI roles communicated and publicised to all staff	Assoc MD for QI (once appointed)	By end of Q2 17
	• Re-launch clinical audit half days as Quality Improvement half days with at least one a corporate QI half day	Assoc MD for QI (once appointed)	By end of Q2 17
	• Replace Clinical Audit & Effectiveness cmtee with 4	Assoc MD for QI (once	By end of Q2 17

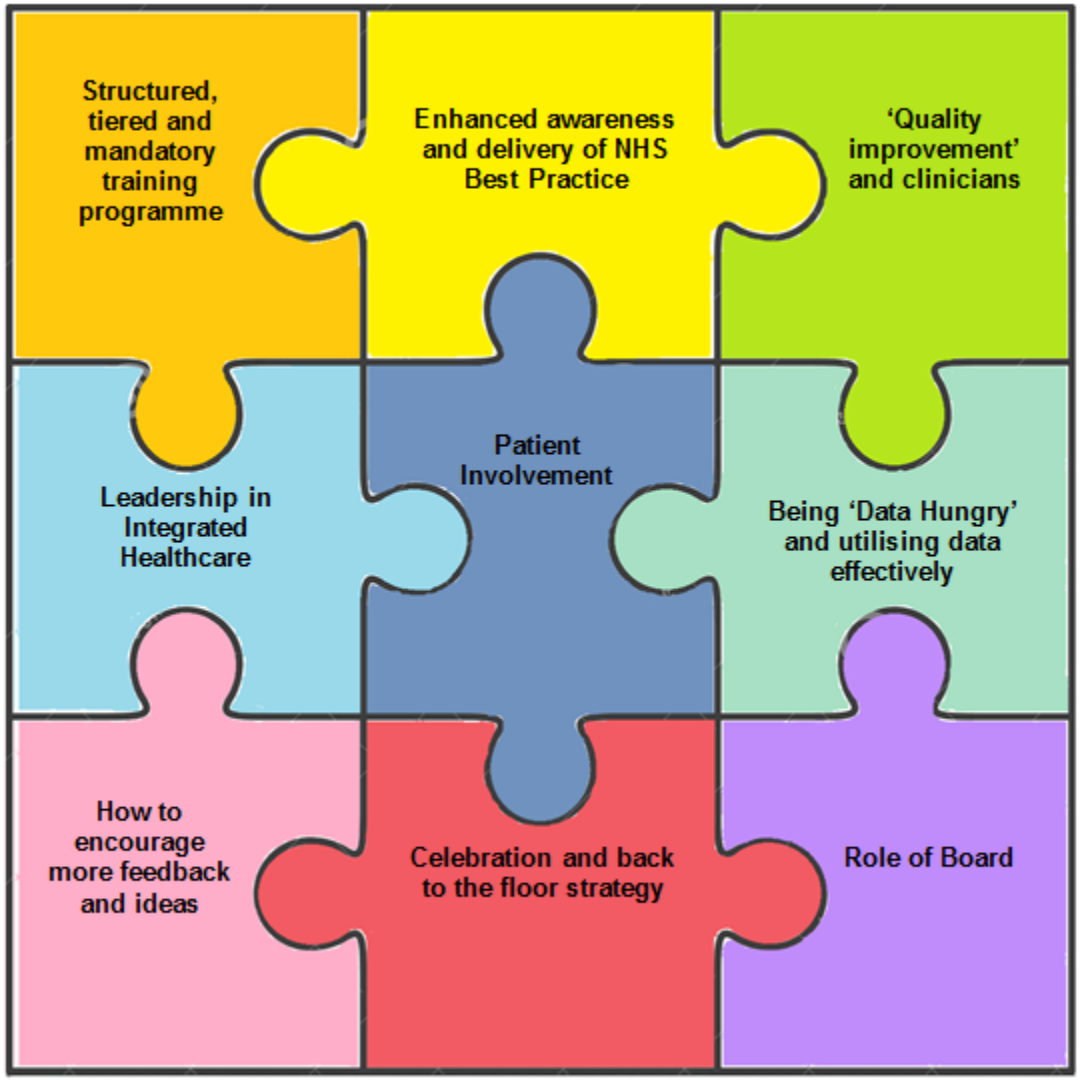
	times a year QI forum • Agree the proposed resources required for the above strategy (est at £50k pa) in principle	appointed) ***TMG***	 **End of April 17**
4. Leadership in Integrated Healthcare	• Discuss and confirm the 1-2 areas of productive efficiency WH wishes to focus on being the best nationally in integrated care and set this targeted ambition • Run 'reflection & brainstorming' sessions with front-line staff (potentially leading to more specific Kaizen event) to develop more detailed action plan to becoming the best in the specific areas identified	***TMG*** COO / PMO / Learning & Development	By end of Q1 17 By end of Q2 17
5. Patient Involvement	• Confirm the principle and objective to establish 'advisory' council(s) with patient representatives and whether to adopt a 'shared' lead model with patients co-leading hospital safety and improvement committees • Further design and implement 'advisory councils' • Replicate the Chelsea & Westminster 'Patient Voice' initiative • Confirm objective of a step change in acquiring patient feedback generated by Consultant episode and published on Trust website (including greater use of email, ipad, survey monkey to collect 'in the moment') • Design mechanisms for capturing and communicating patient feedback in this form • Consider further enhancement to segmenting patient experience (i.e similar to US) and proposition to TMG in of how this might be done	***TMG*** Director of Nursing Director of Nursing / Medical Director / Learning & Development ***TMG*** Head of Information / Director of Communication Director of Nursing / Head of Information	**By end of April 17** By end of Q2 2017-18 To commence Q3 17 By end of Q1 By Q3 17 By Q3 17

6. Being 'Data Hungry' and utilising data effectively	• Survey what clinicians want, what they should look at and how that is reinforced, and what does WH wish to encourage – findings/recommendations back to TMG	Head of Information / PMO / CCIO	By Q2 2017-18
	• Make decisions on recommendations received	***TMG***	Q2 17
	• Consider/conclude and action whether sufficient software licences are available	Head of Information / CCIO	By Q2 2017-18
	• Identify who should be expected to regularly use Qlikview and thus needs to be trained/re-trained	COO/ Head of Information / CCIO	By Q2 2017-18
	• Establish system to monitor usage and application, particularly amongst middle and senior level staff expected to be data conversant and progressing Service/QI projects	Head of Information / Learning & Development	By Q2 2017-18
	• Consider/conclude on referring to usage rates in appraisal discussion and ensure annual appraisal has specific discussion on using information effectively	COO / DoHR	By end of Q2 2017-18
	• Further develop the 'fast follower' Global Digital Exemplar strategy	Director of Finance / CCIO	By end of Q2 2017-18
	• Develop and implement Trustwide comms plan on 'fast follower' strategy	Director of Communication / CCIO	By end of Q2 2017-18
7. Encouraging more feedback and ideas	• Develop plan to build further awareness and ownership of START/STOP including metrics to inform Board/Exec of number/type received and how these are responded to/cleared	PMO / Head of Comms	By Q2 2017-18
	• Ensure appropriate time given for Board/Exec discussion on what staff are telling us via START/STOP	***TMG***	From Q2 17
	• Re-run the Junior doctor Survey monkey survey	Operations / PMO	June 17

	• Identify key staff groups to target with similar Survey Monkey questionnaire about the elements of their work that get delayed/frustrate and ideas they have – ward managers, nurses, AHPs	Operations / PMO	June 17
8. Celebration and 'Back to the Floor' strategy	• Strengthen the support to produce a Service/Quality Improvement monthly celebration strategy • Develop an enhanced communication plan for celebrating examples of Service/Quality improvement on a monthly basis as a minimum • Commit to principle of resourcing and mandating a 'back to the floor' initiative for appropriate cohort of staff. • Design the 'back to the floor' initiative and present proposed plan to TMG	Director of Communication & Corporate Affairs Director of Communications / Associate MD for QI (once appointed) ***TMG*** PMO / Learning & Development	By Q2 2017-18 By Q2 2017-18 **End of April 17** End of Q1 17

PMO/JW/27042017

Ten proposed elements to Service & Quality Improvement Strategy



Lessons from ELFT – 'It takes time and commitment'

Encouraging, Engaging & Inspiring	• Shaping stories • Focus on bright spots • Board hears QI stories every month • Social media • Measure if staff feel able to contribute	→	• Celebration strategy • QI improvement & clinicians • Leadership in integrated healthcare
Building skills and capability	• 88 Trained as coaches • 1474 Trained at some level in QI • Protected time	→	• Structured, tiered and mandatory training • Data hungry and utilising data efficiently • Enhanced awareness of best practice
Embedding into daily work	• 'The hardest bit' • What do you do in your week that you don't think adds value • Removed 80% of audit • Changed way data used • Changed leadership behaviours	→	• Start / Stop • QI Improvement & clinicians • Patient involvement • Appraisal and objectives
QI Projects	• Web platform to capture QI work • 8 QI leads supporting directorates • Every QI project has senior 'Sponsor' • 245 'Active projects' • PDSA/ Process mapping	→	• Medium/ Longer term role of PMO and learning & development function

Executive Offices
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Magdala Avenue
London N19 5NF

Whittington Health Trust Board

7 June 2017

Title:	Trust Board Assurance Framework		
Agenda item:	**17/086**	**Paper**	**10**
Action requested:	For approval		
Executive Summary:	This paper contains the latest updated Board assurance Framework, and risk profile matrix. This has been completed following the last round of quarterly performance reviews with ICSUs, discussion with individual executive colleagues and a review of the committee risk registers. There are two new risks - BAF 16 regarding the failure of the trust to implement cyber security against the threat of a cyber attack - BAF 17 regarding the failure of the Trust to have in place compliant junior doctor rotas Changes since the last review Three risks have downgraded their current risk rating - BAF7 – following a review of our capital programme we are currently working through plans to build a second collocated theatre and are also finalising our SEP decision – both of which have enabled us to re - evaluate the risk in building a collocated obstetric theatre from 16-12 - BAF11 – following an external review with recommendations and a period of more stable management we have reduced the risk regarding medical equipment from 16-12 - BAF 12 – with some additional actions; a peer review process and increased relationship building with the CQC we have reduced the current risk assessment on this risk from 16-12 - BAF 8- has been merged with BAF 4 due to the agency spend and workforce recruitment and retention interdependencies. - BAF 3- MSK waiting times have been removed as no longer seen a corporate risk within the BAF but remains on the risk register for the ICSU at a lower level. ED remains.		

	BAF 14 with regard to our urgent and emergency pathway we have added our risk regarding the specific care of people with mental health care needs on this pathway in the Trust following our analysis of incidents. Mitigations are in place and we continue to work with colleagues from the mental health trust to mitigate these risks. The highest current risks based on our assessment, with a risk rating of 20 are:- BAF5 – failure to deliver CIPs and transformation savings in 17/18 BAF 6 – failure to maintain liquidity and sufficient working capital due to delayed CCG payment and/or sufficient capital facility due to failure to receive STF funding. .
Summary of recommendations:	To note and approve the BAF
Fit with WH strategy:	Aligned with Whittington health Clinical Strategy and corporate objectives
Reference to related / other documents:	Corporate objectives Clinical strategy
Reference to areas of risk and corporate risks on the Board Assurance Framework:	N/A
Date paper completed:	28 May 2017

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

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 and MSK services	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 to access capital funding for maternity and neonatal FBC will delay building a second collocated 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	BAF 16	BAF 17
Red >15	Initial	Initial **Current** ↔	Initial **Current** ↔	**Current** ↔	**Current** ↔	**Current** Target ↔	Initial	**Current** ↔	**Current** ↔	Initial	Initial		Initial	Current ↔	Current ↔	Initial	Initial
Amber 11-15	**Current** ↔			Target			**Current** ↓			**Current** ↔	**Current** ↓	**Current** ↓	**Current** ↔	Target			
Yellow 6-10	Target	Target	Target		Target		Target	Target	Target	Target	Target	Target	Target		Target		
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) v3 June 2017 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/ Chief Nurse	**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 and React to Red campaign Falls reduction Plan STOP Falls Campaign Mortality and morbidity meetings Review of Trust governance structures Mock CQC Inspections, Safety Huddles, Serious Incident Investigation Processes	Quarterly Quality and safety reports to Board 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 CQC mock inspections	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 Regular monitoring of Quality Account objectives.	Quality Account process underway for completing 2017/18 Quality account Governance self assessment and review to be completed New Head of Risk and safety to undertake a review of the ICSU processes to ensure robust monitoring of quality and risk escalation.	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 **May 2017** Quality Account Process Streamlined and timely. Quality Impact Assessments in place. Quarterly reports to Trust board. 'Sign up to Safety' monitored through patient safety committee.	Aug-17	Sept 2017	**8**	
BAF2	CO1. Deliver quality, patient safety and patient experience.	Failure to provide an ongoing service to LUTS patients	Medical Director	**16**	Since the temporary suspension the service has continued without interrruption. The Consultant is continuing to work in the post and is on a fixed term contract. Improvement plan in place against the RCP review recommendations.	Safety and governance concerns raised by the Royal College of Physicians (RCP) review are being addressed and are being monitored.	Updates to Action plan developed in response to the RCP report TB updates on progress against action plan	Multidisciplinary meetings to ensure governance process and patient safety are not currently in place. Succession plan for clinical leadership progressing but not finalised.	Ongoing regular review and update of the action plan. The Executive Medical Director is gathering information to learn from the previous attempts to run an MDT to inform the set up of a sustainable MDT for the future.	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 Service user meeting March 2017 **May 2017** Discussion with UCLH, the commissioners, UCL and engagement with patients to secure a sustainable future for the service. Further desktop review against RCP action plan completed.	Jul-17	july 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 • Improvement plan to meet ED target includes work with intermediate care and discharge to assess work monitored at operational meetings. •monthly wholesystems delivery group oversees and monitors progress. Enhanced recovery programme in place including the SAFER care bundles which include the 'red to green' initiative. implement full capacity model	Performance reports to Trust Board and Quarterly Performance Review meetings ECIP report and action plan weekly operational meeting.	Monthly performance reports to TMG and TB ED consultant recruitment SI reports to TB monthley whole system improvement group	**Gaps in assurance:** ED Target not met although met agreed trajectory April 2017	ECIP review and report plus fullcapcity protocol set up. Oversight of whole system improvement plan. Ongoing recruitment of consultants for ED Bed management and escalation policies all in place Red to Green programme underway - to support improvements in flow	ICSU performance reviews, Trust Operational meetings, TMG and TB	ECIP progress acheived and trajectory in April ontrack to acheived and ontrack for May. CEO chair of Urgent and Emergency Care workstream at STP level 4 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.	Inability to increase substantive workforce capacity	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 •HR business partners in place • Weekly Vacancy Scrutiny Panel meetings • Workforce Assurance Committee (WAC) established • Recruitment & Retention Strategy agreed • Workforce KPIs reported to WAC • E-rostering and real time data • weekly tracking of temporary staffing by Executive team • New bank rates agreed	•Trust Board safety/quality/safe staffing reports and monthly performance report • Quality Committee safety/quality reports • Workforce KPI reports Reports to Trust Board Reports to TMG Reports to Workforce assurance committee ICSU performance reviews and challenge in place	Workforce strategy approved Monthly performance reports Reports to Worforce Assurance Committee Staff survey results Assurance on quality of care provided received through weekly executive challenge and ICSU performance reviews, and e-rostering live data.	Agency spend greater than planned	Implement Recruitment and retention Stratgey Monitor WAC workplan to strengthen controls and compliance with agency cap Continue to monitor KPIs New bank rates agreed Work with the STP on cross NCL agreed rates Develop rotations with UCLH and agreements for staff to work across both organisations. Overseas recruitment included in the wider ongoing recruitment drives Action to improve retention in relation to staff survey and FFT results for staff automation of VSP	Performance Reviews; TMG Workforce assurance Committee and TB	Regular recruitment days held including some international recruitment Workforce Assurance Committee meeting regularly Developing Vacancy Scrutiny Panel to be an automated process designed with Clinical Director input new bank sates agreed (except A&C). Calnder of recruitment events. Overseas recruitment drive Exit interviews conducted.	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 2017/18 and failure to plan for 2018/19 • Failure to deliver CIPs and savings to £17.3m • Non identification of credible CIP schemes • Non achievement of agreed Cost Reduction schemes	Chief Operating Officer	**20**	• Improved governance - ILG/weekly roadmaps/ monthly CIP steering group • PMO in place and led by COO • ICSU governance structure with financial controls and roadmaps in place • Quarterly Performance Reviews with ICSUs and Executive teams • Additional support through FIP2 for a frutehr 4 months with Boston Consulting group. Awaiting impact assessments • Targetted support & improved grip & control	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	16/17 outturn Deep dives to F&BD Communication to all staff Plan/roadmap/& gap analysis ILG reports	Gaps in controls: Unindentified CIP Continuing internal phasing	• ILG action plan & decision points • Targetted support from BCG to identify further schemes. Service Planning • Grip & Control Project	Trust Board TMG Finance and Business Development Committee	• ICSU targets agreed • ILG agenda • FIP2 partner in place CIP £10.2m 16/17 ICSUs to develop further schemes to close gap.	Mar-18	July 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 and delay in STF payment	Chief Financial Officer	**20**	• Monthly Contract Meetings • 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 • 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 Capital analysis Regularising Contracts	• 97% of income backed by signed contracts • 16/17 outturn • Finance Report to TB • Finance and Business development committee • Internal and external audit reports • Q1-Q3 2016/17 delivery to control total • Capital Plan • Improved CCG debt	Gaps in controls • No guarantee on working capital/EFL 17/18 as expected in July	• 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 • Improved cash monitoring in grip & control	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 Business Plan including EFL/Working Capital expectations	Mar-18	July 2017	**15**	F&BD010

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)
BAF7	CO3. Develop our business to ensure we are financially sustainable. CO1. Deliver quality, patient safety and patient experience.	Failure to access capital funding for the Maternity and Neonatal Full Business Case (FBC) will delay the modernisation of the unit and delivering the safety requirements of a second co- located theatre	Chief Financial Officer/ Deputy Chief Exec	16	Meetings with NHSI Capital planning process and report to Trust Board Maternity dashboard in place with reporting of KPIs and SIs	Capital to be sourced from NHSI or internal capital programme or from SEP arrangement Trust Board updates and papers re capital and 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 in place by July 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	ICSUs engaged in discussions regarding options and timescales. NHSI negotiations continue SEP procurement process to complete July 2017	Jul-17	July 2017	8	F&BD011
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 • Clinical 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 Business plans for CHINS not yet complete and model evolving.	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 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 Engaged in CHIN development meetings in both Islington and Haringey GPs being engaged and discussions with both commissioners and providers taking place	July 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/ Chief Operating Officer	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	COO/ Surgery ICSU CD	12	• Manager in place to lead department • Equipment library • New ICSU structures for stronger clinical leadership • Medical devices policy • External review completed and report received with recommendations	Capital plan and spend in medical equipment ICSUs clarityand feedback on maintaining medical equipment Surgery ICSU governance structure for feedback Internal audit reports External report and recommendations; improvement action plan	Spend against budget Management team settled Improvement plan underway	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 •External report and improvement plan against recommendations	ICSU Board and performance reviews Medical Devices committee reporting to health & safety committee capital monitoring group	Team settled and work underway regarding future model of medical equipment provision and maintenance Improvement plan against actions in response to recommendations in place following external review	Sep-17	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	Chief Nurse	12	Quality and safety work monitored through operational ICSUs and assured at Quality Committee and ICSU performance reviews 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 Mock CQC peer review programme in place, and patient safety huddles to support well-led domain; Board to ward engagement.	Quarterly segmentation score for the Trust CQC reports Finance and Quality and Performance reports to TB Internal and external audit Annual quality assurance report	NHSI identified Trust as Level 2 segment. CQC inspection report 2016. Board attendance in Patient safety huddles. Peer review reports. Regular CQC inspector relationship meetings with Chief Nurse.	Financial performance is challenging. CIP plans for 2017/18 to be completed. Controls have been increased to reduce spend; run rate improved but still remains above plan	CQC action plan now ongoing improvement plan in place and continuous focus on quality and safety including work with ECIP; actions continuing with internal peer review programme in place. Controls increased across organisation on authorisation of spend. Full engagement in the STP process and ongoing review of strategy within ICSUs and services working clinically in collaboration with UCLH.	ICSU Board and performance reviews ; TMG and Trust Board and sub committees of the Board	Currently identified as level 2 on the Single Oversight Framework with offer of support. CQC Good overall on last inspection and improvement plan continuing to be progressed and monitored by exception at TMG. Offered to be pilot with NHSI on use of resources audit. Peer review programme in place using CQC framework.	Jun-17	Dec 2017	10	
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	Chief Operating Officer	12	• Data Quality Group • Internal audit report and external report completed • Income steering group in place • IG governance in place • Community services improvement group in place • Qlikview being used operationally and within ICSUs • SLR reports in place and reported to TMG, finance and business development committee and individual ICSUs	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	Sep-17	March 2018	8	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 with risk identified in care of people with mental health care needs	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 Working with C&I mental health trust to improve care pathways for people with mental health needs External review commissioned Implement full capacity model	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 monthly whole systen improvement group	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 Review of mental health care pathways underway and close working with C&I mental health trust.	ICSUs, Trust operational meeting, TMG and Trust Board	External review of mental health care pathway and learning from recent incidents underway and closer working with mental health colleagues and others across the system to improve care. ECIP progress acheived and trajectory in April ontrack to acheived and ontrack for May. CEO chair of Urgent and Emergency Care workstream at STP level 4 out of 6 ED Consultants recruited	Jul-17	Sept 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 Competitive dialogue procurement process due to conclude July 2017	Gaps in control: Estates and Facilities directorate undergoing improvement Approvals will be needed for agreement of SEP partner from NHSI and STP 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 Engagement of all potential stakeholders regarding approvals processes	Executive Team TMG Trust Board	Second stage of competitive dialogue completing with regard to SEP so on track for potential prefered provider recommended to TB in July Engagement through next three months with stakeholders and public being planned	Jul-17	Dec 2017	6	

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)
BAF 16	CO1. Deliver quality, patient safety and patient experience.	Failure to establish cyber security across the Trust	Chief finance officer	16	IMT team in place and aware and mitigating the risk re cyber security Information Governance team in place and processes in place Work with neighbouring Trusts to learn from incidents and continue to mitigate risks Business continuity plans in place CCIO in place	Digital strategy in place and approach to investment agreed Audit and Risk Committee	Impact of recent NHS cyber attack Internal audit capital monitoring group IG committee	Gaps in control; Director of IMT being recruited Older PCs still in place in some areas of Trust	Delivering the digital strategy - fast follower exemplar programme Continuing to mitigate risk of cyber attack and learning from other Trusts Investment in cyber security as part of capital programme Escalation protocol in place - agreed across RF, UCL & WH with C& I London Compact - in place from autumn 18' 72 hour report for all waits in excess of 12 hours including any risks as a consequence if delay.	TMG ; Audit & Risk committee; TB	Investment in latest technologies to strengthen cyber security Patches rolled out to the organisation to mitigate vunerabilities	Jul-17	March 2018	8	
BAF17	CO1. Deliver quality, patient safety and patient experience.	Failure to deliver compliant junior doctor rotas across the Trust	Director of workforce / Chief Operating Officer/ICSU CDs	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 •HR business partners in place • Weekly Vacancy Scrutiny Panel meetings • Workforce Assurance Committee (WAC) established • Recruitment & Retention Strategy agreed • Workforce KPIs reported to WAC • weekly tracking of temporary staffing by Executive team • New bank rates agreed	Trust Board safety/quality/safe staffing reports and monthly performance report • Quality Committee safety/quality reports • Workforce KPI reports Trust has recently appointed its first substantive Medical HR Business Partner	Workforce strategy approved Monthly performance reports Reports to Worforce Assurance Committee Staff survey results Assurance on quality of care provided received through weekly executive challenge and ICSU performance reviews, and e-rostering live data.	Agency spend greater than planned rotas non-complaint in some areas due to lack of junior doctors	Implement Recruitment and retention Stratgey Monitor WAC workplan to strengthen controls and compliance with agency cap Continue to monitor KPIs New bank rates agreed Work with the STP on cross NCL agreed rates Develop rotations with UCLH and agreements for staff to work across both organisations. Overseas recruitment included in the wider ongoing recruitment drives Action to improve retention in relation to staff survey and FFT results for staff automation of VSP	Performance Reviews; TMG Workforce assurance Committee and TB	Regular recruitment days held including some international recruitment Workforce Assurance Committee meeting regularly Developing Vacancy Scrutiny Panel to be an automated process designed with Clinical Director input new bank sates agreed (except A&C). Calendar of recruitment events. Overseas recruitment drive Exit interviews conducted. New CD fast track VSP process for urgent clnical need in place	Jul-17	march 2018	8	

Executive Offices
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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

7 June 2017

Title:	Trust Board corporate governance self-assessment		
Agenda item:	**17/086**	**Paper**	**10A**
Action requested:	For agreement		
Executive Summary:	NHSI ask that the Trust Board review and complete a self-assessment of the corporate governance arrangements in the organisation and complete the attached template to be uploaded on the portal. The Executive Team has completed the review and added comments.		
Summary of recommendations:	To agree		
Fit with WH strategy:			
Reference to related / other documents:			
Reference to areas of risk and corporate risks on the Board Assurance Framework:			
Date paper completed:	31 May 2017		

Author name and title:		**Siobhan Harrington**		**Director name and title:**		**Lynne Spencer Director of communications and corporate affairs**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Risk assessment undertaken?**		**Legal advice received?**	

Self-Certification Template - Conditions G6 and CoS7

The Whittington Hospital NHS Trust

Foundation Trusts and NHS trusts are required to make the following declarations to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These Declarations are set out in this template.

Templates should be returned via the Trust portal.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Simon Pleydell	**Name**	Steve Hitchins
Capacity	Chief Executive	**Capacity**	Chair
Date	31 May 2017	**Date**	31 May 2017

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A	The Trust Board is assured that the Trust has systems for compliance with license conditions. All governance statements and annual documents approved and in place.

Self-Certification Template - Condition FT4

The Whittington Hospital NHS Trust

Foundation Trusts and NHS trusts are required to make the following declarations to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These Declarations are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	1 Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	Director of communications and corporate affairs in post. Committee structure in place. Trust Board and Executive all permanent and in place	Please complete Risks and Mitigating actions
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	NHSI guidance reviewed	Please complete Risks and Mitigating actions
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	All Terms of Reference of Board Committees annually reviewed. Latest review 7 June 2017. The Trust reviews its Standing Orders, Standing Financial Instructions and Scheme of Delegation annually	Please complete Risks and Mitigating actions
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	Annual Governance Statement and Annual report and Annual Accounts all finalised and approved by auditors on time. Board Assurance Framework in place. Business Planning process in place across the organisation.	Please complete Risks and Mitigating actions
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Quality account completed and successfully achieved limited assurance from external audit. Quarterly Quality & safety reports to Trust Board. Quality Committee in place. Trust Board performance report reviewed in 2016/17 and aligned to CQC framework.	Please complete Risks and Mitigating actions
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Trust Board and Executive team fully recruited to and permanent.	Please complete Risks and Mitigating actions

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature **Signature**

Name **Name**

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

Whittington Health NHS

Item: 17/087
Doc: 11

Audit & Risk Committee

Terms of Reference

Ratified by:	Audit & Risk Committee
Date ratified (current version):	
Name of originator/author:	David Holt, Committee Chair
Name of responsible committee/individual:	Audit & Risk Committee / Committee Chair
Date issued (current version):	4 October 2016
Review date:	October 2017

Audit and Risk Committee
Terms of Reference

1. Constitution

1.1 The Board of Directors hereby resolves to establish a Committee to be known as the Audit & Risk Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.

2. Role

2.1 The role of the Audit & Risk Committee is to support the Board of Directors and the Accountable Officer by reviewing the comprehensiveness, reliability and integrity of assurances to meet the Board and the Accounting Officer's requirements. To support this, the Audit Committee will have particular engagement with the work of Internal and External Audit and with Financial Reporting issues.

3. Membership

3.1 The Audit & Risk Committee will be appointed by the Board of Directors. The Committee shall be made up of three Non-executive Directors. The Chairman of the Trust must not be a member of the Committee.

3.2 Only members of the Committee have the right to attend and vote at Committee meetings. The Committee may require other officers of the Trust and other individuals to attend all or any part of its meetings.

3.3 All members of the Committee should be independent Non-Executive Directors of the Trust.

3.4 The Board should appoint the Chair of the Audit & Risk Committee from amongst its independent Non-Executive Directors.

3.5 At least one member of the Audit & Risk Committee should have recent and relevant financial experience.

4. Attendance

4.1 The Chief Finance Officer and appropriate External and Internal Audit and LCFS representatives shall normally attend meetings.

4.2 At least once a year the External and Internal Auditors shall be offered an opportunity to report to the Committee any concerns they may have in the absence of all Executive Directors and officers. This need not be at the same meeting.

4.3 The Chief Executive and other Executive Directors shall attend Committee meetings by invitation only. This shall be required particularly when the Committee is discussing

areas of risk or operation that are the responsibility of that Director. When an internal audit report or other report shows significant shortcomings in an area of the Trust's operations, the Director responsible will normally be required to attend in order to respond to the report.

4.4 The Chief Executive should be invited to attend, at least annually, to discuss with the Audit & Risk Committee the process for assurance that supports the Annual Governance Statement.

4.5 The Local Counter Fraud Specialist shall attend to agree a work programme and report on their work as required.

5. Quorum

5.1 This shall be at least two members.

5.2 The quorum necessary for the transaction of business shall be two. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

5.3 The Committee shall be deemed to be quorate if attended by any two non-executive directors of the Trust (to include the Chair or designated alternate) and two executive or associate directors.

5.4 All NEDs can act as substitutes on all Board Committees.

6. Frequency of meetings

6.1 The Committee shall meet at least four times per year.

6.2 The external or internal auditor may request a meeting when they consider it necessary.

6.3 The Secretary of the Committee shall maintain a register of attendance which will be published in the Trust's Annual Report.

7. Secretary

7.1 A Secretary shall be appointed for the Audit & Risk Committee.

8. Agenda & Papers

8.1 Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.

8.2 Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.

9. Minutes of the Meeting

9.1 The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.

9.2 Approved minutes will be forwarded to the Board of Directors for noting and the minutes of all meetings shall be formally recorded and approved at the subsequent meeting. A formal summary report or draft minutes will be submitted to the Trust Board following each meeting, thus enabling the Trust Board to oversee and monitor the work programme, functioning and effectiveness of the Committee.

9.3 Members and those present should state any conflicts of interest and the Secretary should minute them accordingly.

9.4 In advance of the next meeting, the minutes and the log of action points will be circulated to all involved, so that the action log can be updated and included in the papers for the meeting.

10. Annual General meeting

10.1 The Chair of the Committee will normally attend the Annual General Meeting prepared to respond to any questions on the Committee's activities.

11. Duties

The Committee should carry out the following duties for the Trust:

11.1 Governance, Risk Management and Internal Control

11.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.

11.1.2 In particular, the Committee will review the adequacy of:

11.1.2.1 all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission's *Judgement Framework*), together with any accompanying Head of Internal Audit

statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors

11.1.2.2 the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

11.1.2.3 the Board Assurance Framework and the underlying integrated assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

11.1.2.4 the policies for ensuring compliance with relevant regulatory, legal, and code of conduct requirements in conjunction with the Clinical Quality, Safety, and Governance Committee

11.1.2.5 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect

11.1.2.6 the system of management for the development, approval and regular review of all trust policies, including those for ensuring compliance with relevant regulatory, legal and code of conduct requirements

11.1.2.7 the financial systems

11.1.2.8 the system of management of performance and finance across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives

11.1.2.9 the Internal and External Audit services, and counter fraud services

11.1.2.10 compliance with Board of Directors' Standing Orders (BDSOs) and Standing Financial Instructions (SFIs)

11.1.3 The Committee should review the Assurance Framework process on a periodic basis, at least twice in each year, in respect of the following:

11.1.3.1 the process for the completion and up-dating of the Assurance Framework;

11.1.3.2 the relevance and quality of the assurances received;

11.1.3.3 whether assurances received have been appropriately mapped to individual committee's or officers to ensure that they receive the due consideration that is required; and

11.1.3.4 Whether the Assurance Framework remains relevant and effective for the organisation.

11.1.4 The Committee shall review the arrangements by which Trust staff can raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety, or other matters. The Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

11.1.5 In relation to the management of risk, the Committee will:

11.1.5.1 Maintain an oversight of the Trust's risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements

11.1.5.2 Review processes to ensure appropriate information flows to the Committee from executive management and other board committees in relation to the Trust's overall control and risk management position

11.1.5.3 Receive reports from other Committees highlighting control risks identified during the course of their work which require further review action and outlining the action to be taken.

11.1.5.4 Review the effectiveness and timeliness of actions to mitigate critical risks including receiving exception reports on overdue actions.

11.1.5.5 Review the statements to be included in the Annual Report concerning risk management.

11.1.6 The Committee will, at least once a year, review on behalf of the Board of Directors the operation of, and proposed changes to, the standing orders, standing financial instructions and scheme of delegation.

11.1.7 The Committee will monitor the effectiveness of the processes and procedures used in undertaking due diligence

11.1.8 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit, the Local Counter-Fraud Service, and other assurance functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

11.1.9 The Committee shall review at each meeting a schedule of debtors balances, with material debtors more than six months requiring explanations/action plans.

11.1.10 The Committee shall review at each meeting a report of tender waivers since the previous meeting.

11.2 Internal Audit

11.2.1 The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors. This will be achieved by:

11.2.1.1 consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

11.2.1.2 review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework

11.2.1.3 consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources

11.2.1.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation

11.2.1.5 monitoring and assessing the role of and effectiveness of the internal audit function on an annual basis in the overall context of the Trust's risk management framework

11.2.1.6 ensuring that previous internal audit recommendations are followed up on a regular basis to ensure their timely implementation

11.3 External Audit

11.3.1 The Committee shall review the work and findings of the External Auditor appointed by the Trust Board, and consider the implications and management's responses to their work. This will be achieved by:

11.3.1.1 approval of the remuneration to be paid to the External Auditor in respect of the audit services provided

11.3.1.2 consideration of recommendations to the Trust Board relating to the appointment and performance of the External Auditor

11.3.1.3 confirming the independence of the external auditor, including approval of any non-audit work and fees.

11.3.1.4 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate, with other External Auditors in the local health economy

11.3.1.5 discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

11.3.1.6 review all External Audit reports, including agreement of the annual audit letter before submission to the Board of Directors and any work carried out outside the annual audit plan, together with the appropriateness of management responses

11.4 Counter fraud

11.4.1 The Committee will review the adequacy of the Trust's arrangements by which staff may, in confidence raise concerns about possible improprieties in matters of financial reporting and control and related matters.

11.4.2 In particular the Committee will:

11.4.2.1 review the adequacy of the policies and procedures for all work related to fraud and corruption as required by NHS Protect.

11.4.2.2 approve and monitor progress against the operational counter fraud plan.

11.4.2.3 receive regular reports and ensure appropriate action in significant matters of fraudulent conduct and financial irregularity

11.4.2.4 monitor progress on the implementation of recommendations in support of counter fraud.

11.4.2.5 receive the annual report of the local counter fraud specialist.

11.5 Raising concerns (whistleblowing) policy

11.5.1 The Committee will review, at least annually, the effectiveness of the Trust's raising concerns policy including any matters concerning patient care and safety.

11.5.2 The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow-up action.

11.6 Other Assurance Functions

11.6.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the Trust.

11.6.2 These will include, but will not be limited to, any reviews by NHS Improvement, Department of Health Arm's Length Bodies or Regulators / Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

11.6.3 In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. Particularly with the Quality, Committee, it will meet at least annually with the Chair and/or members of that Committee to assure itself of the processes being followed.

11.6.4 In reviewing the work of the Quality Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function at least annually.

11.6.5 The Audit & Risk Committee should incorporate within its schedule a review of the underlying processes for the Information Governance Toolkit and the Quality Accounts production to be able to provide assurance to the Board that these processes are operating effectively prior to disclosure statements being produced.

11.6.6 The Audit & Risk Committee will oversee the work of the Health and Safety Committee and receive regular performance and assurance reports.

11.6.7 The Audit & Risk Committee will oversee the work of the Information Governance Committee and receive regular performance and assurance reports.

11.7 Management

11.7.1 The Committee shall request and review reports and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

11.7.2 They may also request specific reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements.

11.8 Financial Reporting

11.8.1 The Committee will monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

11.8.2 The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors, focusing particularly on:

11.8.2.1 the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee

11.8.2.2 changes in, and compliance with, accounting policies and practices

11.8.2.3 unadjusted mis-statements in the financial statements

11.8.2.4 major judgemental areas

11.8.2.5 significant adjustments resulting from the audit

11.8.3 The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board of Directors.

11.9 Appointment, reappointment, and removal of external auditors

11.9.1 The Committee shall appoint the Auditor Panel to make recommendations to the Board of Directors on its behalf, in relation to the setting of criteria for appointing, re-appointing, and removing External Auditors.

11.9.2 The Committee shall approve the terms of reference of the Auditor Panel, and review the function and membership of the Auditor Panel annually.

12. Other Matters

12.1 At least once a year the Committee will review its own performance, constitution and Terms of Reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board of Directors for approval.

12.2 The Committee should consider holding a discussion at the end of some meetings with regards to the effectiveness of the committee, considering those areas highlighted within this paper.

13. Sources of Information

13.1 The Committee will receive and consider minutes from the other Committees when requested. The Committee will receive and consider other sources of information from the Chief Finance Officer.

14. Reporting

14.1 The minutes of the Committee, once approved by the Committee, will be submitted to the Board of Directors for noting. The Committee Chair shall draw the attention of the the Board of Directors to any issues in the minutes that require disclosure or executive action.

14.2 The Committee will report annually to the Board of Directors on its work in support of the Annual Governance Statement , specifically commenting on the completeness and integration of risk management in the Trust, the integration of governance arrangements, and the appropriateness of the self-assessment against the Care Quality Commission's *Judgement Framework*.

14.3 The Committee will make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.

14.4 The Committee will produce an annual report to the Board of Directors.

15. Authority

15.1 The Committee is a non-executive committee of the Board of Directors and has no powers, other than those specifically delegated in these Terms of Reference. The Committee is authorised:

15.1.1.1 to seek any information it requires from any employee of the Trust in order to perform its duties

15.1.1.2 to obtain, outside legal or other professional advice on any matter within its terms of reference via the Trust Secretary

15.1.1.3 to call any employee to be questioned at a meeting of the Committee as and when required.

16. Monitoring and Review:

16.1 The Board of Directors will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the Chair of the Committee might provide.

16.2 The Secretary will assess agenda items to ensure they comply with the Committee's responsibilities.

16.3 The Secretary will monitor the frequency of the Committee meetings and the attendance records to ensure minimum attendance figures are complied with. The attendance of members of the Committee will be reported in the Annual Report.

16.4 Terms of reference considered at Audit Committee on 02.03.17.

16.5 Terms of reference approved by Board of Directors on xx.xx.xx

To be reviewed at least annually.

Whittington Health NHS

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Quality Committee of Trust Board
Terms of Reference, May 2017
[Minutes approved at Quality Committee, 10th May 2017]

1. Constitution and Authority

The Quality Committee is constituted as a standing Committee of the Trust Board. Its constitution and terms of reference shall be as set out below, subject to amendment by the Trust Board.

The Committee is authorised by the Trust Board to act within its terms of reference and provide scrutiny in terms of quality for all services provided by the Integrated Care Organisation. The committee is authorised to obtain such internal information as is necessary to exercise its functions and discharge its duties. It is authorised to conduct deeper reviews of services with supporting evidence from all parts of the ICO and escalate findings as necessary to the Trust Board.

Subject to the conditions set out in the Trust's Standing Orders, the Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the organisation with relevant experience and expertise if the committee feels this is necessary to exercise its functions and discharge its duties, in the course of appointing external representation the committee will notify the Trust Board.

2. Purpose

The purpose of the Committee is to focus on service quality and improvement through the following three NHS defined components:

- Patient Safety and Clinical Risk
- Audit and Effectiveness, and
- Patient Experience.

3. Role

The role of the Committee is to ensure the establishment and maintenance of effective risk management and quality governance systems within the Trust.

This can be defined as being:

i. To provide assurance to the Trust Board that the Trust has adequate systems and processes in place to ensure and continuously improve patient safety, quality, clinical effectiveness, management of risk

ii. To provide assurance to the Trust Board that the Trust has effective structures in place to measure and continuously strive to improve the effectiveness of care

iii. To provide assurance to the Trust Board that the Trust is responding to patients' feedback about their experiences and taking action appropriately.

iv. To promote a culture of openness and transparency across the Trust, which values innovation and improvement.

4. Duties

4.1 To monitor, review and implement quality assurance and risk management strategies and action plans, including quality assessments for all Cost Improvement Plans.

4.2 The Committee has risk management duties;

- to review the Quality and Safety Risk Register monthly (defined as risks of >12, specific to quality and safety).
- to seek assurance that risks to patients are minimised through the application of a comprehensive risk management system.
- to contribute to the review of the Trust Risk Management Strategy.

4.3 The Committee will receive reports from each ICSU twice per year, with a focus on areas within the ICSU quality report which are below target, as well as areas of excellence.

4.4 The Committee will review, approve and monitor implementation of the Trust's Quality Strategy and Quality Account.

4.5 The Committee has responsibility for monitoring organisational compliance against the CQC Essential Standards of Quality and Safety, and providing assurance to the Trust Board that effective systems are in place to monitor compliance (ie quality inspection programme)

4.6 The Committee will receive reports on the Patient Safety Huddles programme, providing assurance to the Trust Board of executive visibility and Board-to-ward contact. (CQC well-led domain)

4.7 The Committee will seek assurance on patient safety issues through regular reporting, including the National Safety Thermometer, Sign up to Safety, learning from serious incidents, infection control, and clinical incidents.

4.8 To seek assurance that there are robust arrangements in place for the management of safeguarding adults and children and a system in place for managing patients who are Deprived of their Liberties (DoLs) at Whittington Health.

4.9 To seek assurance on clinical audit and effectiveness through regular reporting, including national audits, NICE guidelines, and recommendations from relevant external reports.

4.10 To seek assurance on patient experience through regular reporting, including the friends and family test, complaints, PALS, and equality and diversity.

4.11 To seek assurance that appropriate action is taken in response to adverse clinical incidents, complaints and litigation.

4.12 To seek assurance that the research programme and associated governance frameworks is implemented and appropriately monitored.

4.13 The Committee will receive workforce information concerning, Mandatory Training, Turnover, Sickness Absence, Vacancy Rates and Bank/Agency Usage and any other aspects of workforce monitoring where this impacts on quality for the organisation via ICSU reporting and by exception at chair's request.

4.14 To review the NHS Constitution and assurance action plan annually.

4.15 The Committee will receive regular reports and/or minutes from reporting groups, including Quality and Safety ICSU meetings.

4.16 The Committee will maintain oversight of all relevant national and external reports (e.g. Francis Inquiry, Berwick, Winterbourne)

5. Membership

- Non-Executive Director (Chair, casting vote)
- Non-Executive Director (Deputy Chair)
- Non-Executive Director
- Medical Director
- Chief Nurse and Director of Patient Experience
- Chief Operating Officer

6. Attendees

The committee is empowered to request any other office employed by the Trust to attend meetings for the purpose of providing advice, clarification, recommendation or explanation in respect of any matter that falls within the responsibilities of the Committee.
Regular attendees are expected to be managers preparing functional papers and the following;

- Deputy Chief Nurse
- Head of Governance and Risk
- ICSU X 7 Directors of Operations (or ICSU Clinical Directors, to be agreed by each ICSU)

7. Terms of Membership

Membership to be reviewed as part of the Terms of Reference review annually.

8. Administration

The Compliance and Quality Improvement Manager will ensure the effective and efficient management of the Committee under the leadership of the Committee Chair and Chief Nurse..

9. Planning and Recording

The Quality Committee will agree an annual workplan.

10. Reporting and Accountability

The Quality Committee is accountable to the Trust Board and will provide formal minutes and/or assurance reports with an action tracker after each meeting.

The following groups report to the Quality Committee:

- Patient Safety Committee
- Patient Experience Committee
- Safeguarding Adults and Safeguarding Children's Committees
- ICSU Quality and Safety Boards

11. Frequency of Meetings

Quality Committee meetings will be held every two months, with a minimum of six per year. Members are required to attend a minimum of four meetings per year. In the event of any executive member being unavailable, a nominated deputy should attend in their place, and such deputies should be recorded in the minutes as having been in attendance. A record of attendance will be included in the Trust annual governance statement.

12. Quorum

The Committee shall be deemed to be quorate if attended by any two non-executive directors of the Trust (to include the Chair or designated alternate) and two executives. All NEDs can act as substitutes on all Board Committees.

13. Monitoring and Self-Assessment

An annual self-assessment monitoring the effectiveness of the Quality Committee will be prepared by the Director of Communications and Corporate Affairs and an outcome report agreed by the Quality Committee.

Whittington Health NHS

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Finance & Business Development Committee Terms of Reference

Ratified by:	**The Trust Board**
Date ratified (current version):	
Name of originator/author:	**Tony Rice/Stephen Bloomer**
Name of responsible committee/individual	**Finance & Business Development Committee/Committee Chair**
Date issued (current version):	**10 May 2017**
Review date:	**10 May 2018**

1. Constitution

1.1 The Board of Directors hereby resolves to establish a Committee to be known as the Finance & Business Development Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.

2. Authority

2.1 The Finance and Business Development Committee is constituted as a standing committee of the Trust Board. Its constitution and terms of reference are set out below and can only be amended with the approval of the Trust Board.

2.2 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee of the Trust and all employees are directed to cooperate with any request made by the Committee.

2.3 The Committee is authorised by the Trust Board to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

3. Purpose

3.1 The Finance and Business Development Committee shall review financial performance, business planning, business development and investment decisions of the Trust. The Committee will focus on assurance around risks (financial, delivery and regulatory) in both plans and delivery of plans. The Committee will seek assurances, mitigations and recovery action plans where appropriate.

3.2 The Committee will work with the CEO and Executive Management to ensure the organisation has the structure, resources and capacity for business development that will enhance core operations.

3.3 The Board may request that the Committee reviews specific aspects of finance and/or business development matters where the Board requires additional scrutiny and assurance.

4. Membership

4.1 The Committee shall be appointed by the Trust Board and be composed of:

- Three Non Executive Directors appointed by the Board
- Chief Executive Officer
- Chief Finance Officer
- Chief Operating Officer
- Director of Strategy/Deputy Chief Executive Officer

4.2 One Non Executive member of the Board will be appointed as the Chair of the Committee by the Trust Board.

4.3 A quorum shall be three members, at least two of whom should be Non Executive members of the Trust Board.

4.4 The Committee shall be deemed to be quorate if attended by any two non-executive directors of the Trust (to include the Chair or designated alternate) and two executive or associate directors.

4.5 All NEDs can act as substitutes on all Board Committees.

4.6 The Secretary of the Committee shall maintain a register of attendance which will be published in the Trust's Annual Report.

5. Attendance

5.1 The Committee may invite other Trust staff to attend its meetings for specific agenda items as appropriate.

5.2 The Chief Finance Officer will ensure the provision of a Secretary to the Committee and appropriate support to the Chair and committee members. This shall include agreement of the agenda with the Chair and the Chief Finance Officer, collation of papers, taking the minutes and keeping a record of matters arising and issues to be carried forward and advising the Committee on pertinent areas.

6. Secretary

6.1 A Secretary shall be appointed for the Finance & Business Development Committee.

7. Agenda & Papers

7.1 Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.

7.2 Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.

8. Minutes of the Meeting

8.1 The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.

8.2 Approved minutes will be forwarded to the Board of Directors for noting and the minutes of all meetings shall be formally recorded and approved at the subsequent meeting. A formal summary report or draft minutes will be submitted to the Trust Board following each meeting, thus enabling the Trust Board to oversee and monitor the work programme, functioning and effectiveness of the Committee.

8.3 Members and those present should state any conflicts of interest and the Secretary should minute them accordingly.

8.4 In advance of the next meeting, the minutes and the log of action points will be circulated to all involved, so that the action log can be updated and included in the papers for the meeting.

9. Frequency of meetings

9.1 There will be 6 meetings per year. Additional meetings may be arranged to discuss specific issues but any such meetings should be infrequent and exceptional.

10. Review

10.1 The terms of reference shall be reviewed by the Finance and Business Development Committee and approved by the Trust Board at least annually.

11. Duties

Finance

11.1 Review the Trust's annual financial plans: revenue (OpEx), capital (CapEx), working capital, investments, borrowing and key performance targets; ensuring these are consistent with operational plans and risk assessed. Financial Plans should also be assessed against regulatory requirements and demonstrate appropriate consultation with key stakeholders, as appropriate.

11.2 Gain assurance that an appropriate performance management process is in place to allow the executive to identify the need for corrective action and identify emerging risks.

11.3 Oversee and evaluate the development of the Trust's financial strategy to deliver its integrated business plan (IBP), incorporating a review of the risks and opportunities.

11.4 Review and maintain an overview of the Trust's contract and service delivery agreements (>£5m pa) and material supplier agreements (>£1m pa) and ensure an adequate assessment of delivery risk. The Committee may wish to conduct a review of any new and innovative contract structures below the figures above.

11.5 Review the Trust's Estates Strategy to ensure consistency with overall Trust Strategy assess for acceptable risk (delivery risk and residual risks). Any disposal plans should be assessed for political and reputational risks.

11.6 Review major investment plans (business cases) as defined by:

- Capital schemes (including leased assets and property) with an investment value in excess of £1 million.
- All revenue investment proposals with a cost implication in excess of £3 million over three years
- All proposed asset disposals where the value of the asset exceeds £1 million.

11.7 Review Trust performance against in-year delivery of the financial plan (income, expenditure, capital, cash, working capital and regulatory requirements), including delivery of the Trusts improvement programme supporting the financial plan; while recognising that the primary ownership and accountability for the Trust's financial performance rests with the full Trust Board.

11.8 Request, review and monitor any corrective action against financial plans.

11.9 Oversee the development of information systems to support the business interests of the Trust, including the review and development of performance and financial reporting.

11.10 To Oversee the development and application of Service Line Reporting and Reference Costs to support operational improvement and strategic decision making.

11.11 Consider key financial policies, issues and developments to ensure that they are shaped, developed and implemented in the Trust appropriately.

11.12 Request and receive training and development to assist the Committee in its responsibilities. This will include sessions from the Trust finance team and where appropriate from external sources.

11.13 Address any specific requests by the Trust Board in relation to finance matters.

Business Development

11.14 Oversee and evaluate the development of the Trust's Business Development Strategy to deliver its integrated business plan (IBP), incorporating a review of consistency with Trust Strategy, risks (business, delivery and reputational) and market conditions.

11.15 Approve the resource structure, operating policies and procedures for the preparation of business development bids.

11.16 Receive, review and recommend to the Board proposals for new business development and existing major contracts due for renewal: market development, acquisitions, potential investments and disinvestments in order to recommend options to the Board.

11.17 Review the case for, and make recommendation to the Trust Board for, the establishment of any subsidiary bodies, joint ventures, strategic partnerships or other commercial partnerships (within the Trust's delegated authority under the Health and Social Care Act 2012) having regard to the risk profile and adequacy of investment requirements.

11.18 Make recommendations to the Trust Board in relation to any due diligence, warranties, assignments, investment agreements, intellectual property rights etc. related to joint ventures, commercial partnerships or incorporation of startup companies.

11.19 Monitor the outcomes of business development initiatives. Receive regular reports and updates from management regarding progress in the achievement of the business development elements of the Strategic Plan.

11.20 Examine any matter referred to the Committee by the Trust Board.

11.21

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Workforce Assurance Committee

Terms of Reference

1.0 Purpose

The purpose of the Committee is to provice assurance to the Trust Board:

- that there is an effective structure, process and system of control for workforce governance and risk management;
- that human resources services are provided in line with national and local standards and policy and in line with the Trust's corporate objectives;
- with regard to the development and delivery of the Trust's Workforce Strategy;
- that the Trust complies with relevant equality, diversity and human rights legislation.

2.0 Responsibilities

The Committee will lead on assurance in relation to the workforce; including the following:

2.1 To keep under review the development and delivery of the Trust's Workforce Strategy to ensure performance management is aligned to strategy implementation. The Committee will ensure that the workforce is agile and adaptable so that the Trust can respond swiftly to changes in the external environment;
2.2 To receive details of workforce planning priorities that arise from annual business planning processes and to receive exception reports on any significant risks or issues;
2.3 To ensure that effective workforce enablers are put in place to drive high performance and quality improvement;
2.4 To review performance indicators relevant to the Committee;
2.5 To monitor and evaluate Trust compliance in relation to the Public Sector Equality Duty;
2.6 To advise the Board on key strategic risks relating to workforce and employment practice and consider plans for mitigation as appropriate;
2.7 To receive and review regular reports on human capital management including leadership capability, workforce planning, cost management, regulation of the workforce and their health and wellbeing;
2.8 To receive and review reports on the staff survey and ensure that action plans support improvement in staff experience and services to patients;

2.9 Remit For Non-Executive Directors

- Ensure there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning workforce planning and provision.
- Review data on workforce on a regular basis and hold Executive Directors to account for ensuring that the right staff are in place to provide high quality care to patients.
- Ensure that decisions taken at a Board level, such as implementing cost improvement plans, have sufficiently considered and taken account of impacts on staffing capacity and capability and key quality and outcome measures.
- Understand the principles which should be followed in workforce planning, and seek assurance that these are being followed in the organisation.

3.0 Membership

The membership of the Committee shall comprise:

- At least two Non-Executive Directors (one of whom shall Chair this Committee);
- Director of Strategy/ Deputy CEO
- Director of Workforce;
- Assistant Director of Nursing Education & Workforce;
- Assistant Director of Learning & OD
- Chief Operating Officer;
- Director of Finance
- Deputy Director of Workforce
- Director of Integrated Care Education Representative

All members of the Committee are expected to attend.
Any Non-Executive Director may act as a substitute in the event of an NED Committee member being unable to attend
Other staff will be invited to attend as required.
On occasions deputies may attend with the agrement of the Chair in advance.
Attendance will be reported to the Trust Board and in the annual accounts / report.

4.0 Agenda Setting

- The agenda setting process will be initiated two weeks prior to the meeting by the Director of Workforce;
- A formal agenda and papers will be forwarded to all members one week prior to the meeting;
- If agenda items are required to be heard in confidence, the Director of Workforce will make arrangements for a separate confidential agenda and minutes, and ensure the meeting is conducted in such a way as ensures confidentiality.

Routine agenda items will include:

- The Workforce performance dashboard

5.0 Accountability and Authority

The Committee is accountable to the Trust Board and is a standing committee of the Board.
The Committee is authorised by the Board to investigate any activity within its remit. It is authorised to seek any information it requires from any employee of the Trust, and all employees are directed to co-operate with any request made by the committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice. It may secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

An annual review of committee effectiveness will be conducted, normally to take place in April.

6.0 Reporting

The Committee reports to the Board.

The Chair of the Committee will provide a verbal report to the Trust Board after each meeting.

Draft committee minutes will be circulated with Trust Board papers for the Board meeting immediately following each committee.

7.0 Review Date

The Committee's programme and functioning will be reviewed after one year.

Whittington Health NHS

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CHARITABLE FUNDS COMMITTEE

Terms of Reference

1. Constitution and Purpose

The purpose of the Charitable Funds Committee is to oversee the governance of the charitable funds and discharge the delegated responsibilities from the Board. It is a committee of the Board and has no executive powers, other than those specifically delegated in the Terms of Reference and those delegated by the Board in Public Session.

The Committee is established to represent the interests of the Trust, as the Corporate Trustee of Whittington Hospital Charitable Funds. It will;

i. Oversee the operation of the Charity investments owned by the Charity

ii. Seek assurance that the Charity is operating in accordance with relevant legislation and with the regulations associated with its registration with the Charities Commission

iii. Raise funds for the Charity and ensure its successful contribution to the efforts of the Whittington Health Trust

2. Membership

The membership of the Committee shall consist of:

- Three Non-Executive Directors, currently Tony Rice, Steve Hitchins and one to be confirmed, of which one member is to be the Chairman of the Charitable Funds Committee (Tony Rice)
- Chief Finance Officer
- Chief Executive Officer
- Director of Nursing
- One medical staff representative
- One non-medical clinical staff representative

All members are required to nominate a deputy to attend meetings if they cannot be present themselves.

Committee membership will be reviewed by the Board as part of the annual review cycle.

The Head of Fundraising, Director of Communications and Head of Financial Services will also regularly attend the Committee.

3. Quorum

A quorum of the committee will consist of a minimum of three members:

- a Non-Executive Board Member or Trust Chairman,
- the CFO or nominated deputy
- the CEO or nominated deputy

4. Frequency

There will be no less than four meetings (quarterly) and the Chair will have option to call other meetings if required to deal with high volume of bids.

5. Reporting

The Minutes of the Charitable Funds Committee meetings shall be formally recorded and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

6. Authority

The Charitable Funds Committee (CFC) has been formally constituted by the Board in accordance with its Integrated Governance -standing orders and standing financial instructions, with delegated responsibility to make and monitor arrangements for the control and management of the trust's charitable funds and will report through to the Trust Board.

The Committee is a standing committee of the Board and has only those powers specifically delegated in these terms of reference

It is authorised to seek any information from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The Committee is also given delegated authority by the Board to establish sub-committees or working groups, or to align itself as part of a joint committee as required.

7. Duties

The duties delegated to the Committee are as follows:

- To set the strategic framework for investments.
- To monitor investment performance.
- To govern, manage, regulate and plan the finances, accounts, investments, assets, business and all affairs of the charity.

- To advise the Trustee (the Whittington Health NHS Trust Board) of their legal obligations under Charity Law.
- To seek advice from the Charity Commission and professional financial/investment advisors, where appropriate, on the investment of funds and formulate a reserves and investment policy.
- To disseminate information and guidance to fund holders to ensure their compliance with Charity Law.
- To monitor quarterly financial and fund activity.
- Decide whether donations given with restrictions applied should be accepted by the Charity
- Approve the request to open a new fund
- To consider recommendations for new major appeal to be taken to the Trust Board
- To review year end accounts of the Charitable Funds as at 31st March and the annual report to the Charity Commission.
- To regularly review the expenditure of funds, the level of fund balances and advise the Trustee on investment strategies.
- Review the spending plans and balances held within individual Charitable Funds
- To ensure that systems are in place to provide appropriate and effective financial controls and procedures in order that the funds are operated correctly, that money is used for the appropriate purpose and the funds are not overspent.
- To encourage the use of the funds for the benefit of patient and staff welfare, including professional development and training.
- To review changes in legislation and approve plans for their implementation.
- To consider and/or develop projects and campaigns which warrant funding, by promoting the benefits of the fund to CPFT staff members and identifying funding needs
- To determine and disseminate best practice guidelines for fundraising and fund expenditure.
- In conjunction with the investment managers/advice, agree an investment policy which lays down guidelines in respect of

    a. The balance required between income and capital growth

    b. The balance of risk within the portfolio

c. Any categories of investment which the Trust does not wish to include in the portfolio on ethical grounds

d. Determine a policy for the distribution, or otherwise, of realised and unrealised gains on losses on investments

- To raise or receive funds from community, corporate and individual donors

8. Delegated Powers

The delegated authorities for individual transactions are:

Up to £2,000	Fund Holder and CFO
£2,001 - £5,000	Fund Holder, CFO and another Executive Director
£5,000 - £500,000	Charitable Funds Committee
Above £500,000	Trust Board

9. Administration

It shall be the responsibility of the Chair to arrange for the following:

- The publication of an annual list with the dates, time and venue of each meeting.
- Arrange for the agenda and relevant papers to be distributed to the Committee, at least one week prior to the meeting.
- A record of any action points to be made and for this to be distributed to the Committee, no later than 14 days following the meeting.
- Action points carried forward to a future meeting to be followed up.
- Provide an exception commentary to the Board (as Trustee) as and when required.
- Distribute minutes to the Chair of the Audit Committee for assurance purposes.
- Liaison with Chairs of other Board Committees, raising matters of significance which need to be brought to the attention of those Committees, ensuring that the Chair and Chief Executive are aware at all times.
- Timely production of minutes for the Board.

10. The Committee will receive the following reports on a quarterly or annual basis:

Quarterly Reports

- Finance Report

- Transactions under £5,000 approved after the previous meeting
- Quarterly investment valuation and review
- Details of the Charity's operational plan cash requirements
- Fund balances
- Details of all non-pay transactions itemising those over £25,000 in value
- Details of funds highlighting those with balances in excess of £100,000
- Fundraising update
- Fundraising events performance against targets

Annual Reports

- Annual Accounts and Letter of Representation signed on behalf of the Charity (for approval)
- Report of the audit of the accounts and audit opinion from the external auditor
- Charitable Funds Annual Report (for approval)

10. Review

The Terms of Reference shall be reviewed on an annual cycle or at the direction of the Board when compliance with them will be monitored against the minutes of the meetings held in the previous 12 month period.

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Board of Directors Nominations and Remuneration Committee

Terms of Reference

1. Constitution

The Board of Directors (the "Board") hereby resolves to establish a Committee of the Board to be known as the Board of Directors' Nominations and Remuneration Committee (the "Committee"). The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2. Terms of Reference

Nominations Role

2.1.The Committee shall, in respect of nominations:

2.1.2 Regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Executive Directors and make recommendations to the Board with regard to any changes. Make recommendations to the Board to improve its own governance and effectiveness.

2.1.3 Give full consideration to and make plans for succession planning for Executive Directors, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future, including the route to Foundation Trust status.

2.1.4 Be responsible for identifying and nominating for appointment, candidates to fill posts within its remit as and when they arise.

2.1.5 Ensure that Executive Directors meet the requirements of the 'Fit and Proper' Persons Test.

2.1.6 Before an appointment is made, evaluate the balance of skills, knowledge and experience on the Board and, in the light of this evaluation, agree a description of the role and capabilities required for a particular appointment.

2.1. 7 Consider any matter relating to the continuation in office of any Executive Director at any time, including the suspension or termination of service of an individual as an employee of the NHS Trust.

2.1.8 To consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of its responsibilities.

Remuneration Role

2.2 The Committee shall in respect of remuneration:

2.2.1 Establish and keep under review a remuneration policy for Executive Directors.

2.2.2 Consult the Chief Executive about proposals relating to the remuneration of Executive Directors.

2.2.3 In accordance with all relevant laws, regulations and Trust policies, determine the terms and conditions of office of the Executive Directors, including all aspects of salary and the provision of other benefits (for example allowances or payable expenses).

2.2.4 Shall determine the levels of remuneration and terms of employment for Executive Directors to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff.

2.2.5 Use national guidance and market benchmarking analysis in the annual determination of remuneration of the Executive Directors.

2.2.6 Approve the arrangements for the termination of employment of any Executive Director and other contractual terms, having regard to any national guidance.

2.2.7 Approve contractual payments over £50,000 to all staff.

2.2.8 Approve any non-contractual severance payments to all staff.

2.2.9 Ensure that any proposed compromise agreement is justified and that it is drafted in such a way as not to prevent proper public scrutiny by NHSTDA, the Department of Health or external auditors.

2.2.10 Oversee the performance review arrangements for the Executive Directors ensuring that each receives an annual appraisal

3 Membership and attendance

3.1The membership of the Committee comprises:

• Chairman of the Board (Chair)
• All Non-Executive Directors
• The Chief Executive shall be a member but will withdraw from the meeting during any discussions regarding his terms of condition and remuneration.

3.2. The Director of Human Resources shall normally be invited to attend meetings in an advisory capacity. Other members of staff and external advisers may attend all or part of a meeting by invitation of the committee chair where required.

4 Quorum

4.1No business shall be transacted at a meeting unless the Chairman or Vice Chairman or Senior Independent Director and three Non-Executive Directors are present for the whole meeting.

5 Frequency of meetings

5.1The committee shall meet at least once a year.

6 Authority

6.1The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6.2The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

7 Monitoring Effectiveness

7.1The Committee will undertake an annual review of its performance against its work plan in order to evaluate the achievement of its duties.

8 Other Matters

8.1The Committee shall be supported administratively by the Director of Corporate Affairs, whose duties in this respect will include:

• Agreement of the agenda with the Chairman;

Collation and distribution of the papers;

8.2 The Director of Workforce will minute the meeting.
8.3 Minutes of the last Remuneration Committee will be taken in the private meeting.

9 Review

9.1These terms of reference will be reviewed at least annually as part of the monitoring effectiveness process.

Finance & Business Development Committee, 19th April 2017

Draft Minutes

Attendance: Tony Rice, Deborah Harris-Ugbomah, Steve Bloomer, Carol Gillen, Mark Inman, John Watson, Vivien Bucke (Secretary).

Apologies: Graham Hart, Simon Pleydell & Siobhan Harrington

1. **Minutes of the previous meeting and Action Notes**
The minutes of the previous meeting were agreed as an accurate record.

2. CIP/PMO Outturn 2016/17 & paper 6 2017/18 CIP Plan

2.1 JW described that the cost improvement programmes are starting to produce results, albeit still at a slower and lesser rate than forecast. The CIP target is unlikely to be achieved in 16/17. He felt the processes via the Programme Management Office (PMO) are in place and the Trust areas to address.

2.2 It was noted that the Trust had taken the benefit of the national FIP2 Contract and that it had been pared with BCG. The proposal for the Finance and Business Development Committee/the Trust Board is an intensive four month programme with an expected ROI of 6:1. This will be agreed at the Trust Board.

2.3 JW described the target of £17.5m of which £15.5m will be new cost out schemes and £5.5m are green and £4m in development from the idea stage. The committee discussed the gap and the process for funding it.

2.4 SB confirmed that with regard to the Procurement workstream PPS have an external agency analysing spend across Whittington Health and other PPS trusts to create a plan to deliver £2m of benefit to Whittington Health in 16/17. The Committee discussed the Carter benchmarks and back office initiatives.

2.5 The Committee discussed the IMT enabling workstream and were pleased to note the improvements made and will receive updates on the subsequent transformation and savings achieved.

2.6 The Committee did not think it would be able to assure the Board that the 16/17 target will be achieved however it was assured that plans to address the gap are in place through PMO and FIP2 support.

3. Performance Report Month 12

3.1 In response to a query from TR, CG confirmed that attaining 95% Emergency & Urgent Care performance is a nationwide issue and the Trust had been categorised as level 2 i.e. light touch from ECIP (emergency care improvement programme). The Trust is seeing shoots of improvement and had been able to achieve 90% this month. TR asked about theatre utilisation and CG confirmed she was awaiting feedback but some specialities had performed well in terms of reducing DNA. TR raised manual admission of patients and was told that the Trust was looking at using IT as a key enabler such as Dr Doctor.

4. Finance Report Month 12

4.1 The control total of £6.5m deficit agreed with NHSI had been achieved with improved expenditure control and CIP delivery in Q4. The committee discussed the closure of the year end position and the discussions with the regulator including the potential for additional STF payments. The Committee noted the interim Month 12 position.

4.2 This is a significant achievement and the management team should be congratulated for their successful efforts to hit a milestone which looked unlikely at the half year.

5. 2017/18 Budgets

5.1 The Trust financial plan was submitted in December and refreshed in March 2017 with an agreed control total for 2017/18 of £0.6m surplus which created the financial envelope for the budget setting process. The Committee agreed the principles in the paper and noted the timeline for completion. The Committee discussed the financial risks for the 17/18 financial year.

7. Costing

7.1 MI stated that there had been good engagement with the ICSUs on Service Line Reporting and SLR is producing increasingly good data to help inform management decisions and take actions. The Committee discussed the highlights in the report and the SLR performance of ICSUs.

7.2 MI presented the community disaggregation project and the outputs by service line and commissioner. The Committee discussed the next steps. The Committee noted the progress in costing and thanked MI.

7a The Carter Review

7.3 MI presented the model hospital and described its use within the organisation, its limitation given Whittington Health is an ICO and the tool being acute focussed.

7.4 SB described the next steps for the use of the Carter metrics and the Committee noted progress. It was discussed that achievement of the indicated target of bringing costs into line with the national median in Carter or in Reference Costs would more than eliminate the current deficit. As such the Trust welcomed The Carter initiative and the accompanying information and lessons to be learnt on what other, better performing Trusts are doing to manage costs.

8.

8.1 **Business Development Update**

This paper would be discussed fully along with the Dental Tender presentation at the next meeting.

8.2 It was noted that the only current major prospect is the forthcoming tender for community services in Barnet and Enfield. This has a value of £400m over the next five years. Caution was expressed about entering into any lead roles for contracts on a scale that could materially adversely impact the core financial position despite the fact that the

Trust has great expertise in community services that could benefit the delivery of such needs to the people of Barnet and Enfield.

9. Forward Plan

9.1 Work had been undertaken to identify the appropriate level of review and governance work and set the requisite number of meetings accordingly. The Forward Plan set the timing for the various areas of review beyond the standing agenda of CIP and Business Development Update and Deep Dives as necessary. This would be shared with the Board asap.

9.2 It was noted that the Chair will meet with the CFO informally and DHU thought this was sensible. It was noted that Graham Hart had relayed the same view to the Chair.

10. Risk Register

SB said that fundamentally very similar risks will be taken into next year and he asked the Committee if they felt the risks were appropriate and represented their view. The Chair and DHU believed the likelihood, such as failure to manage the budget had improved and risk ratings should be lessened going forward. SB agreed to review and this would be included in the revised register going to the next meeting.

Whittington Health
NHS Trust

Item17/093
17.b

Minutes
Quality Committee, Whittington Health

Date & time:	10th May 2017 at 14:00 – 16:00
Venue:	Room 6 Whittington Education Centre, Whittington Hospital
Chair:	Yua Haw Yoe (YHY), Non-Executive Director
Members Present:	Philippa Davies (PD), Director of Nursing and Patient Experience Deborah Harris-Ugbomah (DHU), Non-Executive Director Carol Gillen (CG), Chief Operating Officer
In attendance	Sarah Hayes (SH), Deputy Chief Nurse Dorian Cole, Head of Nursing, PPP James Connell, Patient Experience Manager Helen Taylor (HT), Clinical Director, CSS Rachel Landau, Clinical Director, EUC Daniele Morrell, Director of Operations, EUC Emmeline Closier, PDN (Deputising for S&C) Lisa Smith, Assistant Director of Nurse Education and Workforce (Item 4.7 only) Stella Balsamo, Safeguarding Children's Judith Jackson, AHP Representative Alison Kett, Head of Nursing (IM)
Apologies:	Anu Singh (AS), Non-Executive Director Richard Jennings (RJ), Medical Director Debbie Clatworthy (DCl), Head of Nursing, Surgery and Cancer Lynne Spencer (LS), Director of Communications and Corporate Affairs Fiona Isacsson (FI), Director of Operations, Surgery and Cancer Gurjit Mahil (GM), Director of Operations, Women's Health Chandrima Biswas, Clinical Director, Women's Health

Agenda items

1.1	**Welcome & Apologies**	Chair
	Yua Haw Yoe was deputising as chair for Anu Singh. Apologies noted as above.	

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

1.2	**Declarations of Conflicts of Interests**	Chair
	No Conflicts of Interests were noted.	

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

1.3	**Minutes of the previous meeting (January 2017) and Action Log**	Chair
	Approved with no amendments. See Action Tracker for updates on actions.	

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

1.4	**Matters Arising**	Chair
	None	

Actions	**Deadline**	**Owner**

2.	**Quality Account**	**HT**
2.1	HT presented the draft Quality Account which has been out to consultation with key stakeholders. It was noted that the quality priorities for 2017/18 are linked to Trust's Sign up to Safety, 3 year pledge. PD noted a workshop was held with Healthwatch Islington to discuss the Quality Account. The session focused on co-producing patient experience targets for next year. The discussion centred around patient survey findings and the experiences of those service users at the meeting. Patient experience areas for improvement include patient transport, with a plan to reduce the current 2-hour window for collection, through the use of smartphone apps to track drivers or a 20 minute alert for arrival of transport telephone call. PD emphasised that this service had an additional cost but was being considered in the new contract. RL added that in addition, this was an opportunity to review transport waits from hospital to home.. PD added that noise on wards is another area for improvement focus, in addition to reduction of out patient cancellations.	

	It was noted that research activity is lower across the trust than in 2014-15 and that this was also an important area of focus in the coming year. YHH suggested including a section on the actions taken to mitigate bullying across the trust to make it more explicit on the trust's achievements to date. The Duty of Candour should expand on what is offered to patients as part of the process, e.g. patients are given the opportunity to contribute to terms of reference for investigation. HT noted that the template was quite acute-focused, and work was ongoing to add more community aspects. External audit is a mandated requirement, DH noted that in order to provide limited assurance the Quality Account needs stakeholder comments. HT noted auditors had received first stage of draft account, next stage would include feedback. Quality Committee congratulated HT and all staff involved in the timetabling of the Quality Account, which was timelier this year.

Actions	**Deadline**	**Owner**
Section on actions taken to mitigate bullying to be added to staff survey section of Quality Account. And Duty of Candour section to be expanded.	June 2017	HT

3.	**ICSU Quality Performance Dashboards (ICSU Leads)**
3.1	The **EUC Quality Report** was approved by the Quality Committee. Key points were highlighted as follows: • ED trajectory achieved for year, however performance challenging with closure of winter beds • 341 attendances at ED on Monday, the highest ever on record. No explanation found currently for higher attendances • CG described the actions taken with bed management to mitigate patient flow problems as a result of high attendances. CG emphasised that planning for bed flow should be based on average capacity, not spikes. Need to base plans for managing bed flow and capacity on average, not daily spikes.

	• Family and friends continuing to improve. Using text message service to feedback on FFT is increasing response rate. • Fall with fractured tibia reported on Mary Seacole North in May. SH noted the actions being taken as part of NHSi STOPfalls on Seacoles programme. NHSi attended last week and were impressed with improvement work. PD highlighted that a CQC Relationship meeting was scheduled on Wednesday 17th May and that the focus at this meeting would be on falls, and actions taken to minimise occurances. • RL provided an update on mental health coroner inquests. PD noted that considerable time and resource was put in to preparing for each inquest and that it should not be underestimated the stress staff experience when attending such events. Hence it is important that staff receive all the support they require in terms of preparation and post inquest support. PD also highlighted that the number of inquests has been increasing nationally.CG added that mental health was a challenging area across NCL and an area for improvement. Areas to focus improvement work include reducing attendance at ED through improved primary care and community mental health support. • Refurbishment of 136 suite is ongoing; this was an area identified for improvement in patient experience feedback. • Aggregated review of the cluster of mental healthincidents is in progress and is being undertaken by an independent investigation team – Verita. Camden & Islington MHT and our CCG have also had an opportunity to contribute to the terms of reference Improvement in appraisal, mandatory training, and incident reporting. YHH congratulated the ICSU on hard work to improve training and appraisal • RL described an incident where a patient with Pulmonary Embolism self-discharged, and sadly passed away. Coroner highlighted danger of risks not being adequately explained to patients, RJ has sent out letter to all clinical staff outlining the actions to be taken.
3.2	The **S&C Quality Report** was approved by the Quality Committee. S&C ICSU report presented by Emmeline Closier; key points were highlighted as follows: • All staff in Mercers and Coyle have been booked onto face to face training, following a reduction in compliance from last month • 3 unwitnessed falls with no harm reported on Coyle Ward. • FFT response rate fallen due to technical problems with iPad which have now been resolved, paper cards used in the interim period • Increase in use of agency on Thorogood due to patient dependency • PD noted that the staffing level ratings eg ‘the shift was Amber’ were not clear to lay people and she will discuss with the Heads of Nursing outside the meeting. • PD queried the risk with regard to the inability to weigh critically ill patients in Critical Care Unit. SH noted a new contract was in progress. CG noted this was discussed at the quarterly review, determined that risk should have been reduced. The Committee were assured that new beds had been ordered and the situation recified.

	• CG noted medical devices risk was also discussed at quarterly review and downgraded following risk assessment. The action from the ICSU performance meeting was to send out a letter to all clinicians about the indemnity; once sent rating revised. • PD congratulated ICSU on WHO surgical checklist compliance.

Actions	**Deadline**	**Owner**
Description of staffing levels to be reviewed to ensure they are clear for the public and staff		PD

4.	**Quality governance**	
4.1	**Q4 Patient Safety Report Quality**	
4.1	Deferred to July 2017 meeting, RJ unable to attend meeting	

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

4.2	**Patient Experience Report**	SH
	The **Patient Experience Report** was approved by the Quality Committee. Key points were highlighted as follows: • Food and noise at night issues identified in patient survey incorporated into quality account for 2017/18 • Maternity FFT high response rate and positive ratings • Dorian Cole working on community FFT; giving teams achievable targets to improve response rates. Using emails for FFT responses. • Graham Brogden worked hard to get football clubs involved in visiting patients, particularly the elderly care wards.	

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

4.3	**Q4 Quality Impact Assessments – verbal update**	PD
	PD discussed the cost improvement plan proposals from maternity and surgical ICSUs. Plans presented to the DoN and MD to date have been quality impact assessed and approved. DH asked if there were many CIPs which are rejected on review. CG stated that the scheme proposals have had robust interrogation at ICSU level and it would	

	be unlikely that schemes presented for QIA do not meet the standard for consideration.. DH asked if as a trust we had to make a quality declaration. HT stated this was part of operational plan, which shows how trust triangulates workforce, finance and quality and quality account.	
		Owner
None		

4.4	**Quality and Safety Risk Register**	GL
	GL noted that technical issues with DATIX had caused discrepancies in the risk register report. A data cleansing exercise will be completed before the July meeting and an SOP developed to simplify the risk management process for staff and standardise reporting. Risk updates; • Endoscopy risk options appraisal presented to TMG, completed by new Head of Medical Devices. Business case was presented to Finance Committee • Maternity beds were delivered, risk reduced. • Medical records risk has been risk reduced, ICSU Board meeting • Breast service interviews have taken place, weekly meetings with team, still a risk but reduced and now managed at local level.	

Actions	**Deadline**	**Owner**
Data cleansing of Risk Register on DATIX and SOP to be developed	July 2017	

4.5	**Q4 Safeguarding Adults' and Children's Report**	**DC**
	Stella Balassmo presented the Safeguarding Children's report. • PD noted concerns raised via commissioners that we are not making the progress we planned with regard to achieving compliance with safeguarding training. • SB noted that technical difficulties in ESR are affecting the compliance rating and feel training is being underreported. YHH asked if training details could be manually inputted into ESR. SB noted there was a gap in administrative support for learning and development team. • Action plan in place to address the problems, including data cleansing exercise on ESR to ensure competencies match job roles. • SH described two Serious Case Reviews; 16 year old, vulnerable child, found deceased in her flat. Had been living with 19 year old with chronic	

	pain who also sadly died. These cases are subject to a multi-agency investigation.. Safeguarding Adults presented for information. Any questions to be sent outside of meeting with Theresa Renwick, Adult Safeguarding Lead.

Actions	Deadline	Owner
None		

4.6	Trust policies	GL
	The Trust Policy update paper was approved by the Quality Committee.	

Actions	Deadline	Owner
None		

4.7	Annual and Q4 Nursing, Midwifery and AHP Education Report	LS
	The **Annual (and Q4) Nursing, Midwifery and AHP Education Report** was approved by the Quality Committee. Key points were highlighted as follows: • The Nursing Associate national pilot commenced – 20 on adult and 6 on paediatric course- Successful NHSi visit reviewing nursing associate programme • £218,529 was spent on continuing professional development courses and other learning opportunities. • 1,347 undergraduate student placement weeks were supported. • 231 staff trained in dementia care. • 88 staff attended leadership development courses. • 295 staff trained in resuscitation. • CPD pathway project, assisting people from IAPT, radiography and ITU on post-graduate training programmes • Successful NMC visit to maternity and paediatric units, received good report PD asked what the dropout figure was for postgraduate courses. LS noted it was unusual for staff to drop out of postgrad levels, only 1 or 2 in last year. PD asked if the dementia training figure was cumulative or in year. LS confirmed this was in year training. PD noted useful to show cumulative figures alongside as this was a great achievement. PD asked if LS was concerned about funding cuts; LS felt confident that the trust could bid for funding to fill gaps.	

Actions	Deadline	Owner
None		

4.8	Quality Committee self-assessment	LS
	GL provided summary of annual self-assessment review. • PD agreed with recommendation to have patient or carer representative at group, and proposed asking patients via Patient Forum to apply to join Committees. • AHP conference discussed improving representation. Asked to include AHP rep as core member at meeting. Quality Committee agreed for AHP representative to be added to core attenders. • Terms of Reference approved subject to changes to membership and reporting groups as outlined in the report.	

Actions	Deadline	Owner
Consider process for involving patients on Quality Committee, to be discussed at Executive Committee		PD

5.0	Minutes from reporting groups	For information only
	The minutes were taken as read.	

Actions	Deadline	Owner
None.		

6.0	For information only	
	The papers were taken as read.	

Actions	Deadline	Owner
None		

7.	AOB	Lead
	None	

Actions	Deadline	Owner

None.		

Next meeting: Wednesday 12th July 2017, Room 6, Whittington Education Centre