

**T R U S T   B O A R D PUBLIC**

14.00 – 17:00

Wednesday 6 September 2017

Whittington Education Centre  
Room 7





Meeting	Trust Board – Public		
Date & time	06 September 2017 at 1400hrs – 1700hrs		
Venue	Whittington Education Centre, Room 7		
AGENDA			
<b>Members – Non-Executive Directors</b> 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		<b>Members – Executive Directors</b> 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	
<b>Attendees – Associate Directors</b> Dr Greg Battle, Medical Director (Integrated Care) Norma French, Director of Workforce Lynne Spencer, Director of Communications & Corporate Affairs			
<b>Secretariat</b> Kate Green, Minute Taker			
Contact for this meeting: <a href="mailto:lynne.spencer1@nhs.net">lynne.spencer1@nhs.net</a> or 07733 393178			
Agenda Item		Paper	Action and Timing
Patient Story			
	<b>Patient Story</b> <i>Philippa Davies, Chief Nurse &amp; Director of Patient Experience</i>	Verbal	Note 1400hrs
17/106	<b>Declaration of Conflicts of Interests</b> <i>Steve Hitchins, Chair</i>	Verbal	Declare 1420hrs
17/107	<b>Apologies &amp; Welcome</b> <i>Steve Hitchins, Chair</i>	Verbal	Note 1425hrs
17/108	<b>Draft Minutes, Action Log &amp; Matters Arising 5 July 2017</b> <i>Steve Hitchins, Chair</i>	1	Approve 1430hrs
17/109	<b>Chairman’s Report – Chair’s Action Name Change</b> <i>Steve Hitchins, Chair</i>	2	Note 1440hrs
17/110	<b>Chief Executive’s Report</b> <i>Simon Pleydell, Chief Executive</i>	3	Approve 1450hrs
Patient Safety & Quality			
17/111	<b>Serious Incident Report Month 04</b> <i>Richard Jennings, Medical Director</i>	4	Approve 1500hrs
17/112	<b>Safer Staffing Report Month 04</b> <i>Philippa Davies, Chief Nurse &amp; Director of Patient Experience</i>	5	Approve 1510hrs
17/113	<b>Quality &amp; Patient Safety Report (Quarter 1 - April to June)</b> <i>Richard Jennings, Medical Director</i>	6	Approve 1520hrs

17/114	<b>Care Quality Commission Update</b> <i>Philippa Davies, Chief Nurse &amp; Director of Patient Experience</i>	7	Approve 1530hrs
<b>Performance</b>			
17/115	<b>Financial Performance Month 04</b> <i>Stephen Bloomer, Chief Finance Officer</i>	8	Approve 1540hrs
17/116	<b>Performance Dashboard Month 04</b> <i>Carol Gillen, Chief Operating Officer</i>	9	Approve 1550hrs
17/117	<b>Corporate Objectives Q1 RAG report</b> <i>Siobhan Harrington, Deputy Chief Executive/Director Strategy</i>	10	Approve 1600hrs
<b>Strategy</b>			
17/118	<b>North Central London Sustainability &amp; Transformation Plan</b> <i>Simon Pleydell, Chief Executive</i>	11	Approve 1610hrs
<b>Governance</b>			
17/119	<b>Equality &amp; Inclusion Annual Report 2016/17</b> <i>Norma French, Director of Workforce</i>	12	Approve 1620hrs
17/120	<b>Medical Appraisal &amp; Revalidation Annual Report 2016/17</b> <i>Richard Jennings, Medical Director</i>	13	Approve 1630hrs
17/121	<b>Modern Slavery Statement 2016/17</b> <i>Lynne Spencer, Director Corporate Affairs / Communications</i>	14	Approve 1640hrs
<b>Trust Board Committee Draft Minutes</b>			
17/122	1) <b>Charitable Funds</b> <i>Tony Rice, Non-Executive Director</i> 2) <b>Quality</b> <i>Anu Singh, Non- Executive Director</i> 3) <b>Remuneration</b> <i>Steve Hitchins, Chairman</i> 4) <b>Workforce Assurance</b> <i>Graham Hart, Non-Executive Director</i>	15	Note 1650hrs
<b>AOB Urgent Business and Questions from the public</b>			
	None notified to the Trust		
<b>ANNUAL GENERAL MEETING</b>			
06 September 2017 at 1800hrs to 1900hrs at the Whittington Education Centre Room 7, Magdala Avenue, N19 5NF			
<b>Date of next Trust Board Meeting</b>			
06 October 2017 -1400hrs-1630hrs -Whittington Education Centre, Magdala Avenue, N19 5NF			
<b>Register of Conflicts of Interests:</b> 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 - <a href="mailto:communications.whitthhealth@nhs.net">communications.whitthhealth@nhs.net</a> .			



**The draft minutes of the meeting of the Trust Board of Whittington Health held in public at 1400hrs on Wednesday 5<sup>th</sup> July 2017 in the Whittington Education Centre**

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

### Patient Story

Philippa Davies introduced Madeline Shaer, a patient in receipt of services from the tissue viability, district nursing and podiatry teams. Madeline was accompanied by Jane Preece, tissue viability specialist, and Dorian Cole, Head of Nursing for the Patient Access, Prevention & Planned Care ICSU.

Jane Preece introduced the presentation, saying that Madeline had been known to Trust services for around six years; she suffered from Type 2 diabetes, and had recurrent leg and toe ulcers. Madeline had re-presented to the service in March with infected ulcers, and following a detailed assessment, the decision was made to follow a course of treatment which included debridement and medical larvae therapy. Barring scans, much of this care was able to be conducted at home, with day to day support from the district nursing team supported by the tissue viability team.

Madeline explained that she had been involved in an accident 8-10 years ago, following which she had been hospitalised for two weeks. This March she had noticed a small ulcer; this had been examined by doctors, all of whom had expressed the view that it was 'healing well'. Madeline had been sceptical about this, so had contacted Jane and begun treatment; by this time the ulcer had deteriorated. Although confident of the treatment she was receiving, Madeline felt that this resulted in a longer time before her ulcer healed.

Dorian Cole commented on the importance of good care co-ordination, not just face to face between staff but also using technology such as Facetime. This was key particularly when changes in staff were taken into account. Madeline expanded on this, saying that she felt district nursing visits were inconsistent for quality of care as some nurses did not always adhere to good practice for hand hygiene. Jane assured the Board this had been raised directly with the team leader, and Philippa undertook to report back the result. There was some discussion about how

patients can best raise such issues – and whether they feel confident to do so – and it was suggested relevant telephone numbers be included on care plans.

On behalf of the Board, Steve Hitchins extended his thanks to Madeline for attending the Board meeting and for her courage in recounting her story. He assured her that Philippa or one of her team would be in touch to report back on discussions with the district nursing team about the importance of hand hygiene.

#### 17/94 Declaration of Conflicts of Interest

94.01 Tony Rice declared an interest in Xerxes a building supplies group called Omnis.

#### 17.95 Welcome and apologies

75.01 Steve Hitchins welcomed everyone to the meeting. Apologies for absence had been received from Carol Gillen; Fiona Isacson was in attendance as her deputy.

#### 17/96 Minutes, Matters Arising & Action Log

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

#### Action notes

96.02 All items on the action log had either been completed and could therefore be closed, or were scheduled on the Board forward planner for discussion either at a future Board meeting or seminar.

96.03 It was noted that 86.03 (junior doctor workforce and skill mix) had been discussed at Trust Management Group the previous day as this was a major risk in terms of the Trust being unable to guarantee finding the necessary supply of doctors to fill rotas. A short-term plan was needed to enable the Trust to cope now, and a longer-term plan for supporting people to work in different ways.

#### 17.97 Chairman's Report

97.01 Steve Hitchins began by reporting on the recent staff awards ceremony held at the Royal College of Surgeons. This had been attended by some 250 people; it had been enjoyed by all and had been a celebration of success. There was a Flickr platform on which people could view pictures of the event. Steve thanked Simon for making this happen, and Philippa and the Communications Team for their professional organisation of the event.

97.02 Steve also drew attention several events he had participated in or attended since the last meeting, highlighting the following:

- a programme of visits to community dental services
- the first meeting of the STP Advisory Board
- the very positive Speech & Language Therapy Annual Conference, where he had noted that staff group's enthusiasm for being part of the ICO
- a recent meeting of the community forum, which had increased in size.

97.03 He had also recently attended the weekly Muslim Prayer Meeting, and on Thursday would be attending an event which had been organised to support all staff who had been

affected by recent events in London. All were welcome to attend this event, which would be taking place in N19 at 2.00pm.

- 97.04 The closing date for applications for the Chief Executive post had now passed, and Steve was pleased to announce a strong field of candidates. He hoped that Board colleagues would become involved in the appointments process, as well as staff and other stakeholders, and had extended invitations to attend presentations and focus groups accordingly.

#### 17/98 Chief Executive's Report

- 98.01 Returning to the staff awards ceremony, Simon said that he had been particularly pleased with the range of staff nominated for awards from both the community and the hospital. He hoped this event would be repeated in future years. Simon also reported on the Schwartz Rounds, saying that three had now taken place at the Trust. Schwartz rounds encourage people to talk about what it takes to deliver care and the challenges people sometimes face and how we can support one another as colleagues. He encouraged all Board members to attend.

- 98.02 Moving to performance, Simon was concerned that the Trust had declared 5 cases of C. Difficile against a target of no more than 17 during the year, however none had been declared the previous month which was a positive step. The Trust continued to perform well on its cancer targets. There was general improvement in the Emergency Department (ED); the Trust had met its trajectory targets in the first two months of 2017/18, although it had failed to do so in June, and there was a direct correlation between the period of very hot weather that month and the dip in performance. Performance had now however improved again and Simon felt the target was achievable. He was therefore pleased to report that the Trust had met the requirements for additional funding in the first quarter.

- 98.03 The Pharmacy was due to re-open soon as the new wholly owned subsidiary once some minor technical points had been agreed with NHS Improvement, and Simon was impressed with the quality of the environment.

- 98.03 There was to be a Whittington Health Open Day on 16th September. This would provide the chance to showcase the work of the Trust, and was particularly important in terms of recruitment and retention. There would be opportunity to demonstrate to local young people the range of careers available within the NHS.

- 98.04 The Trust's financial position would be covered by Stephen Bloomer's report, but Simon said that there were still some challenges to face before the organisation reached a position where it could be comfortable. The position on expenditure was good, income less so, and there was further work to do on CIPs. Simon commended staff for their control over expenditure and in particular the decrease in the use of agency staff and the use of temporary staff as a whole.

- 98.05 Forty-six people were due to take part in the 10k run in Central London on 9th July to support fundraising for the Whittington charity, and Simon hoped for a good performance, bearing in mind the Trust held an excellence charter award from the Mayor of London for its work on health and wellbeing! Steve Hitchins added his thanks to all who were participating to raise vital money for the Trust charitable funds.

- 98.06 Deborah Harris added her congratulations to all who had been involved in the staff awards ceremony, describing the occasion as having a sense of family and really championing people; she felt that the efforts made had been greatly appreciated by staff.

She hoped that this would become embedded in the annual calendar of the Trust as it did a great deal for morale.

#### 17/99 Serious Incident Report

99.01 Philippa Davies informed the Board that two serious incidents had been declared during May. She had amended the report to show comparative data following David Holt's request at the previous meeting, and would be taking advantage of the August break to develop a more detailed report for the future.

99.02 Referring to the table at 3.3, Richard Jennings said that there had been a number of recent Information Governance incidents, as a result of which he and Philippa had written to staff reminding them of the importance of encryption. In relation to this, David Holt asked whether, if staff were asked whether they had all the necessary equipment to encrypt data they would respond in the affirmative. Richard replied that they would undoubtedly say that more could be done, but he was confident that all staff had the ability to store encrypted data. Most IG incidents tended to involve the loss of paper lists, and there was ongoing discussion about what further steps could be taken to reduce paper and increase the use of technology. Anu added that this subject had been raised at the patient safety huddle she had attended that morning.

#### 17/100 Safer Staffing Report

100.01 Philippa Davies informed Board colleagues that Board papers had been discussed at Trust Management Group, and as a result she would be making some minor changes to this report in terms of names of wards etc. She added that there had been a reduction in the use of specials and RMNs in-month; this was because the Trust was using its own staff to provide care and not because of any reduction in either the number or level of acuity of patients.

#### 17/101 Financial Report

101.01 Stephen Bloomer informed the Board that the Trust had reported a £0.6m deficit at the end of Month 2 against its planned deficit of £0.4m as reflected in the Trust's annual planning submission. The Trust was also behind on its CIP plans, not yet having the full value of all schemes, and thus being unable to generate a full year's worth of savings. The team was therefore beginning to work on non-recurrent savings which would help the Trust to reach its planned year-end position.

101.02 The Trust was under plan for clinical income, which presented a significant challenge. Areas underperforming included paediatrics, general surgery and dermatology. Fiona Isacson explained that some of this had been caused by vacant posts, which had now been filled.

101.03 Stephen confirmed that finance colleagues and ICSUs had worked well together to control expenditure, the position on which was better than had been planned, which demonstrated that the financial control environment continues to assist the Trust to stay close to its target. David Holt emphasised the importance of progressing CIP schemes before the summer.

101.04 The business planning process for the following two years had now started; this included setting out the financial targets and how the Trust should be developing its business planning strategy.

## 17/105 Performance Dashboard

105.01 Fiona Isacson began her report by informing the Board that 12 hour trolley waits in ED continued to be a cause for concern, adding that most of these waits involved mental health patients. The Emergency Care Improvement Programme (ECIP) would be returning to the ED to carry out a further piece of work following Carol's return from leave. The Trust failed to meet the two week cancer target in April, but had achieved all cancer targets in May.

105.02 Moving on to delayed transfers of care, Fiona said that indications for June demonstrated considerable improvement.

105.03 Greg Battle expressed his concern regarding the current situation with mental health patients, and stressed the need for joint working with Camden & Islington Mental Health Trust to resolve the position.

## 17/106 Strategic Business Continuity Plan

106.01 Fiona Isacson informed the Board that the strategic business continuity plan had already been scrutinised by both Trust Management Group and the Trust Operational meeting. The plan, which provides assurance that the Trust has reviewed all of its business continuity arrangements and processes, was presented to the Board for formal ratification, and the Board was content to approve this. In answer to a question from David Holt about whether this was standard practice across NHS Trusts, Fiona replied that it was, although with local variations as necessary. The plan was also approved by NHS England.

## 17/107 Lower Urinary Tract Services (LUTS)

107.01 Siobhan Harrington reported on a meeting held the previous evening with twelve users of the LUTS clinic, at which Rob Sherwin and local commissioners had also been present. She felt that considerable progress had been made, but reported there were still complicated issues to be resolved. The research programme and clinical trials had been discussed with UCLH; this was a key point in the Royal College report. It was also noted that new referrals would in future come through secondary care providers and would be referred to the LUTS clinic only when it became clear that other options had been exhausted. A table top review had also been conducted which demonstrated the progress made, and the products of this would be sent to NHSE, the Royal College and the commissioners.

107.02 The main remaining issue to be resolved was that of the MDT, which was now a wider group with more clinicians, and it had been agreed that the commissioners would be part of the decision-making process around this. Users had expressed their disappointment at not being given a date by which the clinic would open to new referrals, but Siobhan was clear that there would need to be at least two MDT meetings before any judgement could be made about the efficacy of the new arrangements. This point was echoed by Richard Jennings, who briefly described the criteria through which a well-functioning MDT might be judged. In answer to a question from David Holt about the frequency of MDT meetings, Richard replied that there were no hard and fast rules (and the frequency of MDT meetings varied between specialties) but capacity issues needed to be taken into account, as did the need to give clinicians the time to check that outcomes were consistent with the recommendations of the MDT. It was noted that users were likely to attend the Joint Overview & Scrutiny Committee the following Friday.

17/108 Nursing & Midwifery Revalidation

108.01 Philippa Davies informed the Board that of the 1261 nursing and midwifery staff employed by the Trust 380 had already been successfully revalidated, and there had been none the Trust had felt unable to support through the process. It was noted that staff had found this process to be less onerous than they had expected it to be.

17/109 Any other business

109.01 There being no other business, the meeting concluded with questions from members of the public and staff.

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**Action Notes Summary**

Minute	Action	Date	Lead
86.03	<b>Junior doctor workforce and skill mix</b> - major risk of being able to guarantee finding necessary supply of doctors to fill rotas. SP reported a short-term plan was needed to enable the Trust to cope now, and a longer-term plan for supporting people to work in different ways.	<b>tbc</b>	<b>NF</b>
99.01	<b>Serious Incidents</b> - develop a more detailed report for the future.	<b>September</b>	<b>PD</b>

**Trust Board**  
**6 September 2017**

<b>Title:</b>		<b>Whittington Hospital National Health Service Trust change to Establishment Order 1992 No. 2510 to enable its name change</b>					
<b>Agenda item:</b>		<b>Item 17/109</b>		<b>Agenda 02</b>			
<b>Action requested:</b>		Ratify the Chair’s Action dated August 2017					
<b>Executive Summary:</b>		<p>The Trust became an Integrated Care Organisation in 2011 and has used the working name ‘Whittington Health NHS Trust’ rather than the legacy name on the Establishment Order which is ‘Whittington Hospital NHS Trust’. This has caused confusion for stakeholders, staff and the public because the Trust trades as an Integrated Care Organisation. For example, the Establishment Order name is listed on websites and regulatory documents as a hospital provider only. The change of name reflects both community and hospital services.</p> <p>A consultation was undertaken in line with Department of Health requirements to enable the due parliamentary process to be undertaken to change the Trust name.</p> <p>The draft Order presented proposes amendment to the Whittington Hospital National Health Service Trust (Establishment Order) 1992, which first established the Whittington Hospital National Health Service Trust.</p> <p>The Establishment Order will be laid before parliament on 5 September to enable a new Order to be issued to the Trust. Once this has been received the Trust can officially change its name on relevant documentation and websites etc. It is likely the new Establishment Order will be received the following working week beginning 11 September 2017.</p>					
<b>Fit with WH strategy:</b>		Aligns with the Trust Integrated Care Organisation’s aims and objectives					
<b>Reference to relate documents:</b>		Whittington Hospital National Health Service Trust Establishment Orders 1992 No. 2510 , 1995 No.1125 , 2011 No.1184. The Whittington Health Standing Orders and Standing Financial Instructions					
<b>Date completed:</b>		August 2017					
<b>Author name and title:</b>		Lynne Spencer, Director Communications and Corporate Affairs		<b>Director name and title:</b>		Steve Hitchins, Chair	
<b>Date paper seen by EC</b>	4/9/17	<b>Equality Impact Assessment complete?</b>	N/A	<b>Risk assessment undertaken?</b>	n/a	<b>Legal advice received?</b>	N/A



**2017 No. 0000**

**NATIONAL HEALTH SERVICE, ENGLAND**

**The Whittington Hospital National Health Service Trust  
(Establishment) (Amendment) Order 2017**

*Made* - - - - - \*\*\*

*Coming into force* - - - - - \*\*\*

The Secretary of State for Health makes the following Order in exercise of the powers conferred by sections 25(1) and 272(7)(a) and (8)(a) of the National Health Service Act 2006(a).

In accordance with section 25(3) of that Act, the consultation prescribed in regulations made under that section has been completed(b).

**Citation and commencement.**

**1.**—(1) This Order may be cited as the Whittington Hospital National Health Service Trust (Establishment) (Amendment) Order 2017 and comes into force on [insert date].

**Amendment of name of trust**

**2.**—(1) The Whittington Hospital National Health Service Trust is to be called the Whittington Health National Health Service Trust.

(2) The Whittington Hospital National Health Service Trust (Establishment Order) 1992(c) is amended as follows.

(3) In article 1(2) (citation, commencement and interpretation) in the definition of “the trust”, for “Hospital” substitute “Health”.

(4) In article 2 (establishment of the trust), for “Hospital” substitute “Health”.

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- (a) 2006 c.41 (“the 2006 Act”). Section 179(2) of the Health and Social Care Act 2012 (c.7) provides for the repeal of section 25 of the 2006 Act but this provision is not yet in force.
- (b) S.I. 2010/743, to which there are amendments not relevant to this Order. The prescribed consultation under regulation 2(2) of S.I. 2010/743 is, before making an order under section 25(1) of the 2006 Act in relation to an NHS trust, consultation by the Secretary of State with that NHS trust.
- (c) S.I. 1992/2510, to which there are amendments not relevant to this Order.

- (5) The change of name effected by paragraph (1) does not—
- (a) affect any right or obligation of any person; or
  - (b) invalidate any instrument (whether made before, on or after the day on which this Order comes into force) which refers to the Whittington Hospital National Health Service Trust, and all instruments and other documents which refer to that name must be construed as referring to the Whittington Health National Health Service Trust.

Signed by authority of the Secretary of State for Health.

*Philip Dunne*  
Minister of Health,  
Department of Health

Date

#### **EXPLANATORY NOTE**

*(This note is not part of the Order)*

This Order amends the Whittington Hospital National Health Service Trust (Establishment Order) 1992, which established the Whittington Hospital National Health Service Trust.

Article 2 changes the name of the trust to the Whittington Health National Health Service Trust.

No impact assessment has been produced for this instrument as it has no effect on private sector and civil society organisations, and no significant effect on the public sector.



<b>Title:</b>		Chief Executive Officer’s Report for July 2017					
<b>Agenda item:</b>		<b>17/110</b>		<b>Paper</b>		<b>03</b>	
<b>Action requested:</b>		For discussion and information					
<b>Executive Summary:</b>		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					
<b>Summary of recommendations:</b>		To note the report					
<b>Fit with WH strategy:</b>		This report provides an update on key issues for Whittington Health’s strategic intent					
<b>Reference to related / other documents:</b>		Whittington Health’s regulatory framework, strategies and policies					
<b>Reference to areas of risk and corporate risks on the Board Assurance Framework:</b>		Risks captured in risk registers and/or Board Assurance Framework					
<b>Date paper completed:</b>		30 August 2017					
<b>Author name and title:</b>		<b>Lynne Spencer, Director of Communications &amp; Corporate Affairs</b>		<b>Director name and title:</b>		<b>Simon Pleydell, Chief Executive</b>	
<b>Date paper seen by EC</b> n/a	n/a	<b>Equality Impact Assessment complete?</b>	n/a	<b>Quality Impact Assessment complete?</b>	n/a	<b>Financial Impact Assessment complete?</b>	n/a



## **CHIEF EXECUTIVE OFFICER'S REPORT**

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

### **Official name change to 'Whittington Health NHS Trust'**

We became an Integrated Care Organisation in 2011 and have used the working name 'Whittington Health NHS Trust' rather than the legacy name on the Establishment Order 'Whittington Hospital NHS Trust'.

This has caused confusion for stakeholders, staff and the public because the Trust trades as an Integrated Care Organisation. For example, we are listed on the CQC website as a hospital provider only. The change of name will better reflect both our community and hospital services.

A consultation was undertaken in line with Department of Health requirements to enable the due parliamentary process to be undertaken on 5 September 2017. We will receive a revised Establishment Order later this month which will enable us to use our name Whittington Health NHS Trust officially.

### **Care Quality Commission (CQC)**

We will be working with the CQC over the coming months to review some areas of our services at both our hospital and in the community. This forms part of the CQC routine inspection process and builds on our previous inspection in 2015 when we were ranked 'good' overall with our hospital requiring improvement. Our ambition is to raise our overall scoring for the hospital from requires improvement to good. The Board will receive a report today by our Chief Nurse who is our executive lead for the inspection.

### **National Heart Failure Audit 2015/16**

The National Heart Failure Audit includes a range of quality markers and mortality data. In 12 of 13 categories we exceed the mean national attainment for patients admitted with acute heart failure. These quality measures determine better outcomes; reducing inpatient mortality, improved quality of life and reduced readmission rates. These reflect the high quality of inpatient care our staff are providing at the hospital and the close integration of hospital and community care across the organisation.

### **Providing one of the best patient experiences for patient cancer care**

We were pleased to receive the results of the 2016 National Cancer Patient Experience Survey. We achieved our best ever rating, placed 35 overall in the UK and 2<sup>nd</sup> in London – behind the Royal Marsden. This represents significant improvement from 2010, when we were ranked 2<sup>nd</sup> from the bottom. Patients were asked to rate their care on a scale of zero (very poor) to 10 (very good) and we averaged 8.8.

### **Simmons House rated 'Excellent'**

The Simmons House team have been rated as excellent by the Quality Network for Inpatient CAMHS, part of the Royal College of Psychiatrists. This rating is a clear reflection of the ongoing commitment and dedication of the team who consistently provide outstanding care in an increasingly challenging climate.

The inspection team paid tribute to the 'highly skilled' team in place and were impressed by a number of schemes in operation at Simmons House including; a leavers group, goal based outcome work and ongoing collaboration between young people and parents throughout care. Congratulations to Simmons House as they celebrate their 50<sup>th</sup> birthday this year.

### **MRSA Bacteraemia**

One incident of MRSA bacteraemia has been reported in the month of July which means we have reported 1 MRSA for this reporting year (1 April to 31 July 2017). We will continue to manage our high profile infectious control campaign across the community and hospital to aim for no more reported cases in 2017/18 as part of our zero tolerance approach.

### **Clostridium Difficile**

We have reported 6 cases of Clostridium Difficile up to the end of July; 2 in April, 3 in May and 1 in June. The target is for no more than 17 cases this year.

### **Cancer Waiting Time Targets**

We exceeded all but 1 (narrowly missed by under 1%) of our cancer targets for June; reported in arrears in line with national cancer data validation process.

- 31 days to first treatment 100% against target of 96%
- 31 days to subsequent treatment (surgery) 100% against target of 98%
- 31 days to subsequent treatment (drugs) 100% against a target of 93%
- 62 days from referral to treatment 84.4% against a target of 85%
- 14 days cancer to be first seen 95.3% against a target of 93%
- 14 days to be first seen for breast symptomatic 100% against a target of 93%

### **Community Access Targets**

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

- 703 referrals received (50 less than June)
- 394 entered treatment (43 below target but still above target of 161 for the year)
- 52.03% recovery rate
- Patients waited just over 2 weeks for a first appointment in July (15 days)
- Of those completing treatment, 95% had a first appointment within 6 weeks and 99.5% within 18 weeks
- 95% had a first appointment within 6 weeks and 99.5% within 18 weeks
- 97% satisfied with overall experience

## **STRATEGIC**

### **North Central London Partners**

The Board will review the updated plan today and it sets out the North Central London overall vision that was agreed in October 2016. The revised plan sets out:

- Our vision: A place where no-one gets left behind

- Our strategic framework for change covering prevention; service transformation; productivity; and enablers
- The programme governance to achieve the change
- Detailed plans for prevention; health & care closer to home; urgent & emergency care; planned care; mental health; cancer; maternity; children & young people; workforce; estates; and digital
- An updated financial analysis, including investment plans
- Our approach to communications and engagement
- Equalities analysis and impact assessment
- Conclusion and next steps

## **OPERATIONAL**

### **Emergency Department (ED)**

Performance against the 95% target remained at 92% in July. Our sustained improvement is a result of the ED improvement plans. We are continuing to improve our performance with London ambulance patient handovers as part of our improvement plan.

There were 2 x 12 hour trolley waits in July, both mental health patients requiring mental health bed transfers. External experts (ECIP) have completed a mental health system review and recommended a number of key actions that we will consider with Camden and Islington Mental Health NHS Trust to support our collective improvements for both in-hours and out-of-hours services.

We are confident that our focus on the emergency care pathway across the hospital and community will ensure we meet our target of 95% for the reporting year of 2017/18 and to ensure our patients receive high quality, safe and timely care.

### **Perfect Week**

We want to make sure our hospital is functioning as efficiently as possible, and to help us achieve this we are launching another Perfect Week initiative. This programme has worked well previously and it supports our staff to change the way patients are seen, treated and discharged to improve safety, patient experience, and performance.

### **Clinical Director**

I am pleased to announce that Nadine Jeal, a Musculoskeletal Advanced Practice Physiotherapist, has taken up the post of Clinical Director for the Patient Access, Prevention and Planned Care Integrated Clinical Support Unit from the beginning of September.

## **WORKFORCE**

### **Friends and Family Test (FFT)**

We were very pleased to see that many colleagues shared their personal or a family member's personal experience of receiving excellent care on our latest FFT results for Q1 (April to June). The professionalism and patient care of staff was cited on many occasions and I would like to thank all colleagues for their continued commitment to outstanding patient care.

Friendly staff, good team working, supportive managers and good learning opportunities were all mentioned by colleagues as reasons why they would recommend Whittington Health as a place to work.

Whilst we can be encouraged by many positive comments it is important to note our overall trend rate is slightly down from last year:

- From 75% to 69% of staff recommending Whittington Health to friends and family if they needed care
- From 61% to 54% of staff recommending Whittington Health as a place to work

The survey was open for a shorter period of time, leading to fewer members of staff taking part this quarter and this may be a factor in the downturn of positive responses. However, it is important that we take action to address some of the specific issues raised in the survey.

Although we have put in a number of steps in place to tackle the ongoing issue of bullying, including the introduction of Bullying and Harassment Advisors and our Freedom to Speak Up Guardian, we know it is still a significant concern for a number of colleagues. It is absolutely essential that we continue to make addressing any instance of bullying a priority.

Colleagues also reported experiencing a lack of support from managers and/or leaders and back office processes. We need to get better at how we respond to concerns from colleagues. We are currently looking at how we can make some of our systems more accessible and our corporate functions have been tasked with reviewing their information on the intranet to ensure it is clear.

#### **FINANCE MONTH 4 (April to July 2017)**

During the first quarter of the year all Integrated Clinical Support Units (ICSUs) agreed their activity targets, funded establishment and non-pay budgets. From that agreed balance the remainder of our 2 year Cost Improvement Programme (CIP) was deducted leaving a net budget allocation for each team. This process enabled as much funding as possible to be transferred to the front line. To enable this revised model to work ICSUs must deliver within the agreed funding envelope. This is important as after our first four months of the reporting year (April to July) ICSUs are significantly overspending which is being driven by two things:

- Incomplete CIP plans
- Activity and income are behind plan

Whilst it is recognised that teams cost management has improved this year, without delivering the changes required in the CIP ICSUs will not meet their agreed targets and this puts our overall control total at risk. If we do not meet our financial control total we will not collect an element of the sustainability and transformation funding (£6.5m for the full financial year) and this will reduce the size of our capital programme going forward. Achievement of our control total continues to be our main financial target for the year.

At the end of July we are reporting a £0.4m deficit for the year to date against a planned deficit of £0.3m. This includes a number of one-off benefits (£1m) so the underlying variance is £1.1m away from the plan. During July income exceeded our plan, although we remain behind for the year. We continued to overspend because we have not achieved our cost improvement target which is £2.3m behind plan. Whilst enhanced

financial controls and non-recurrent measures have helped to bridge the gap, this remains a significant risk.

The CIP target is challenging but opportunities were identified to achieve it but these have slipped. Forecasts suggest that in-year recurrent cost improvement is likely to be between £9m to £12m with a most likely return being £11m which is an improvement on previous years but leaves an outstanding requirement to meet £6.5m of non-recurrent measures.

To respond to the predicted CIP shortfall the corporate project management office (PMO) is leading work on cross cutting initiatives and helping ICSUs to complete the final detail and quality impact assessment for schemes still in planning stage. In addition to this, ICSUs are working with Finance to look at non-recurrent actions that can be taken to ensure that the agreed budgets are achieved.

The other key area of improvement required is within outpatients where there is a year-to-date shortfall of £0.6m driven primarily by first outpatient appointments. This area of income is an opportunity to address part of this financial gap.

The pressures above means we do not have reserves available to support new initiatives that do not have an in year pay back. All areas will be working with our PMO to ensure opportunities are set out into plans and to find the non-recurring cost reduction. ICSUs have been asked to produce recovery plans to deliver the levels of planned outpatient care.

## **AWARDS**

### **Staff Excellence Awards**

Congratulations to Kieran Fordham, mental health nurse, who won the July staff excellence award. Kieran has is a friendly and happy member of staff who makes time for young people and helps to fund new toys and therapeutic sensory equipment for our patients.

Congratulations to Yvonne Smith, Healthcare Assistant, Islington district nursing team who won the August staff excellence award. Yvonne won for her professionalism, high standards and competence. Patients frequently praise and comment on Yvonne's compassion with patients.

**Simon Pleydell**  
**Chief Executive**

## Whittington Health

### August 2017

Title:		Serious Incidents - Monthly Update Report					
Agenda item:		17/111		Paper		04	
Action requested:		For Information					
Executive Summary:		This report provides an overview of serious incidents (SI) submitted externally via StEIS (Strategic Executive Information System) during June and July 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:		<ul style="list-style-type: none"><li>Supporting evidence towards CQC fundamental standards (12) (13) (17) (20).</li><li>Ensuring that health service bodies are open and transparent with the relevant person/s.</li><li>NHS England National Framework for Reporting and Learning from Serious Incidents Requiring Investigation,</li><li>Whittington Health Serious Incident Policy.</li><li>Health and Safety Executive RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013).</li></ul>					
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:		16/08/2017					
Author name and title:		Jayne Osborne, Quality Assurance Officer and SI Co-ordinator		Director name and title:		Richard Jennings, Medical Director	
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) during June and July 2017. This includes serious incident reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.

### 2. Background

The Serious Incident Executive Approval Group (SIEAG), comprising the Executive Medical Director/Associate Medical Director, Chief Nurse and Director of Patient Experience, Chief Operating Officer, Head of Governance and Risk and SI Coordinator meet weekly to review Serious Incident investigation reports. In addition, high risk incidents are reviewed by the panel to determine 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 7 serious incidents during June and July 2017, bringing the total of reportable serious incidents to 13 since 1st April 2017.

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
Treatment Delay Ref:11957	May 17	A delay in a patient receiving their medication (antibiotics) in the District Nursing service.
Delayed Diagnosis Ref: 12022	May 17	A delay in diagnosing an adenocarcinoma.
Delayed Diagnosis Ref: 14674	June 17	Delayed follow-up to abnormal chest x-ray, resulting in delayed cancer diagnosis
Unexpected Death Ref:14668	June 17	A patient suffered a cardiac arrest and died 48 hours after presentation to the hospital.
Suboptimal care - delayed referral Ref:14676	June 17	Delay in referral to the SLT service and suboptimal care in relation to nutritional management during inpatient admission.
Information Governance Incident Ref:16783	July 17	A ward handover sheet with patient details was found by hospital staff in a public area in the Hospital.
Delayed Diagnosis Ref:16865	July 17	Following an elective procedure a patient had to be returned to theatre for revisional surgery to address an anastomatic leak (a recognised

Category	Month Declared	Summary
		complication of colorectal surgery).
Medication Incident Ref:18101	July 17	A patient's prophylactic medication was suspended in error. Patient subsequently collapsed on the ward and found to have developed a large pulmonary embolism.

**3.3 The table below detail serious incidents by category reported to the NEL CSU between April 2016 – March 2017.**

STEIS 2016-17 Category	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Safeguarding	0	1	1	0	1	0	1	0	0	0	1	0	5
Attempted self-harm	0	0	0	0	0	0	0	1	0	0	0	0	1
Confidential information leak/loss/Information governance breach	1	2	1	0	1	1	0	0	0	0	0	0	6
Diagnostic Incident including delay	2	1	0	0	0	1	1	1	0	1	1	0	8
Failure to source a tier 4 bed for a child	0	0	0	1	0	0	0	0	0	0	0	0	1
Failure to meet expected target (12 hr trolley breach)	0	0	0	0	0	0	1	0	0	0	0	0	1
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	1	1	1	0	0	2	1	0	0	0	0	1	7
Maternity/Obstetric incident mother only	0	0	0	0	1	0	1	0	0	0	0	0	2
Medical disposables incident meeting SI criteria	0	0	0	0	0	0	1	0	0	0	0	0	1
Nasogastric tube	0	0	0	0	0	0	1	0	0	0	0	0	1
Slip/Trips/Falls	0	0	0	1	0	0	0	0	2	3	0	1	7
Sub optimal Care	0	0	0	0	0	0	1	1	0	0	1	1	4
Treatment Delay	0	0	0	0	0	0	1	0	0	0	1	1	3
Unexpected death	0	1	0	1	0	1	0	5	1	0	1	0	10
Retained foreign object	0	0	0	0	0	1	0	0	0	0	0	0	1
<b>Total</b>	<b>4</b>	<b>6</b>	<b>3</b>	<b>3</b>	<b>3</b>	<b>6</b>	<b>9</b>	<b>8</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>4</b>	<b>58</b>

**3.4 The table below detail serious incidents by category reported to the NEL CSU between April 2016 – July 2017**

The Trust reported 7 serious incidents during June and July 2017.

STEIS 2016-17 Category	2016/17 Total	April 2017	May 2017	June 2017	July 2017	Total 17/18ytd
Safeguarding	5	0	0	0	0	0
Attempted self-harm	1	0	0	0	0	0
Confidential information leak/loss/Information governance breach	6	0	0	1	1	2
Diagnostic Incident including delay	8	0	1	1	1	3
Failure to source a tier 4 bed for a child	1	0	0	0	0	0
Failure to meet expected target (12 hr trolley breach)	1	0	0	0	0	0
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	7	0	1	0	0	1
Maternity/Obstetric incident mother only	2	0	0	0	0	0
Medical disposables incident meeting SI criteria	1	0	0	0	0	0
Medication Incident	0	0	0	0	1	1
Nasogastric tube	1	0	0	0	0	0

Slip/Trips/Falls	7		0	1	0	0	1
Sub optimal Care	4		0	0	1	0	1
Treatment Delay	3		1	1	0	0	2
Unexpected death	10		1	0	1	0	2
Retained foreign object	1		0	0	0	0	0
<b>Total</b>	<b>58</b>		<b>2</b>	<b>4</b>	<b>4</b>	<b>3</b>	<b>13</b>

#### 4. Submission of SI reports

All final investigation reports are reviewed at the weekly SIEAG meeting chaired by an Executive Director (Trust Medical Director or Chief Nurse and Director of Patient Experience). 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 the appropriate action to take to prevent future harm.

On completion of the report the patient and/or relevant family member receive a final outcome letter highlighting the key findings of the investigation, lessons learnt and the actions taken and planned to improve services. A 'being open' meeting is offered in line with duty of candour recommendations.

The Trust has executed its duties under the Duty of Candour for the investigations completed and submitted during June and July 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, and 'message of the week' in Maternity, and '10@10' in Emergency Department. Learning from identified incidents is also published on the Trust Intranet making them available to all staff.

##### 4.1 The Trust submitted 11 report to NELCSU during June and July 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 June and July 2017.

Summary	Actions taken as result of lessons learnt include;
Patient Fall Ref: 6087 (Ward 1) Ref: 2718 (Ward 2) Ref:12014 (Ward 3)	Ward 1: Patient stood to use commode and fell sideward resulting in a fractured neck of femur.  Ward 2: Patient had an unwitnessed fall resulting in a fractured neck of femur.  Ward 3. Patient had an unwitnessed fall in the toilet resulting in a non-displaced impacted medial tibial plateau fracture. <ul style="list-style-type: none"> <li>• Increase awareness and training in the STOPfalls bundle across the Trust, including lying/standing BP and postural hypotension</li> <li>• A new approach is being piloted to maintain patient safety on wards, especially for those patients deemed as being at high risk of falls called Baywatch. This ensures that if the allocated nurse needs to leave the bay unattended another member of staff will be</li> </ul>

Summary	Actions taken as result of lessons learnt include;
	asked to be in the bay and on Baywatch until the nurse returns.
Unexpected Admission to NICU Ref: 6159	<p>Following an emergency caesarean section infant was born in poor condition requiring resuscitation. The baby was transferred to the Neonatal Intensive Care unit.</p> <ul style="list-style-type: none"> <li>The maternity practice development team are developing a training plan for bank midwives to ensure that all midwives (substantive and bank staff) attend annual training for obstetric emergencies and CTGs.</li> </ul>
Unexpected Death Ref: 30726	<p>Patient left the Emergency Department while waiting to be transported to another unit and was later found unresponsive.</p> <ul style="list-style-type: none"> <li>Review guidelines and departmental guidance for staff on managing absconding risk and discharge.</li> <li>Develop clear guidance for nursing and medical staff in the ED as to whether patients require an IV cannula.</li> </ul>
Delayed Diagnosis Ref:2722	<p>A delay in diagnosing a perforation of the gastrointestinal tract.</p> <ul style="list-style-type: none"> <li>Teaching sessions to clinical teams have been developed around the assessment and management of patients presenting with abdominal pain when they have a complex past history and/or they are on immune suppressing medications.</li> </ul>
Unexpected Death Ref:9728	<p>Patient was admitted for an urgent surgical intervention and subsequently had a cardiac arrest and died.</p> <ul style="list-style-type: none"> <li>Educational events are being held to ensure all staff taking respiratory rates have the background knowledge, equipment and skills required and that they are clear on the processes for escalation to critical care.</li> <li>There has been a change in current Trust guidelines, all 2222 calls are placed for all resuscitation calls regardless of locations.</li> <li>The development of a more robust process to ensure blood test results for surgical patients are made available earlier in the day.</li> <li>Structured ward round being developed, to be jointly led by nursing and medical staff and include reference to the Trust electronic prescribing system, available blood tests and comprehensive review of TPR and fluid balance charts.</li> </ul>
Unexpected Death- Influenza Ref: 4856	<p>Patient was admitted and treated for community acquired pneumonia.</p> <ul style="list-style-type: none"> <li>Standard form of documentation to be agreed for all patients exposed to influenza to ensure all key information is available in the clinical notes.</li> <li>All patients exposed to influenza to be commenced on prophylaxis immediately unless there is a contraindication.</li> <li>This case will be used to highlight the importance of flu vaccination in future flu campaigns</li> </ul>
Sub optimal Care of deteriorating patient Ref:7662	<p>Patient death following emergency surgery</p> <ul style="list-style-type: none"> <li>Clear guidelines and SOP to be developed for managing large bowel obstruction</li> <li>Educational sessions arranged for junior doctors on the management of large bowel obstruction</li> </ul>

## **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. The Trust also runs a series of multi-disciplinary learning workshops throughout the year to share the learning from serious incidents and complaints, and learning is disseminated through 'Spotlight on Safety', the trustwide patient safety newsletter. Themes from serious incidents are captured in an annual review, outlining areas of good practice and areas for improvement and trustwide learning.

## **6. Summary**

The Trust Board is asked to note the content of the above report which aims to provide assurance that the serious incident process is managed effectively and lessons learnt as a result of serious incident investigations are shared widely.

## Whittington Health Trust Board

6/9/17

Title:		Serious Incident Annual Review 2016-17						
Agenda item:		17/111		Paper			4.a	
Action requested:		For agreement						
Executive Summary:		<p>In 2016/17, the Trust reported 54 serious incidents across the hospital and community services, including one Never Event, under the category ‘retained foreign object post-procedure’.</p> <p>The purpose of this report is to summarise the key learning from all serious incidents reported in 2016/17, in order to identify any themes or trends and drive quality improvement across the trust.</p>						
Summary of recommendations:								
Fit with WH strategy:		Clinical Strategy, Risk Management Strategy						
Reference to related / other documents:		SI Framework, NHS England						
Reference to areas of risk and corporate risks on the Board Assurance Framework:								
Date paper completed:		30/8/17						
Author name and title:		Gillian Lewis, Head of Governance and Risk		Director name and title:		Richard Jennings, Medical Director		
Date paper seen by EC		Equality Impact Assessment complete?		Quality Impact Assessment complete?		Financial Impact Assessment complete?		



## Annual review of Serious Incident reports: 2016-17

Gillian Lewis, Head of Governance and Risk, August 2017

### Introduction

*Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.*

SI Framework, NHS England, March 2015

In 2016/17, the Trust reported 54 serious incidents across the hospital and community services, including one Never Event, under the category 'retained foreign object post-procedure'.

The purpose of this report is to summarise the key learning from all serious incidents reported in 2016/17, in order to identify any themes or trends and drive quality improvement across the trust.

### Methodology

1. Review of all serious incidents for underlying themes and trends, focusing on the root cause, learning and recommendation sections
2. Deep dive reviews into specific themes, identified from the broad STEIS categories;
  - a. Inpatient falls
  - b. Information governance breaches
  - c. Delayed diagnosis (cancer)
  - d. Never Event in maternity
3. Review of all serious incidents for good practice

### Part 1: Overview of serious incidents

In 2016/17, there were a total of 58 serious incidents reported on STEIS, the national reporting system. Of these four were later de-escalated following the findings of the RCA investigation. There was one Never Event reported, under the category 'retained foreign object post-procedure' due to an incident of a retained swab following forceps delivery.

Serious incidents Declared 2016-2017 by Month as of 31/03/2017													
	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
<b>Integrated Clinical Service Unit</b>													
Integrated Medicine	0	0	1	1	2	1	3	0	1	1	2	0	12

Emergency & Urgent Care	0	1	0	1	0	2	1	2	2	3	0	0	12
Surgery	1	0	0	0	0	0	0	4	0	0	1	3	9
Patient Access, Prevention and Urgent Care	0	1	0	0	0	0	1	0	0	0	0	0	2
Childrens Services	1	3	0	1	0	0	1	1	0	0	1	0	8
Women & Family Services	1	1	2	0	1	2	3	1	0	0	0	1	12
Clinical Support Services	1	0	0	0	0	1	0	0	0	0	1	0	3
Central Business Unit	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Total SIs declared</b>	<b>4</b>	<b>6</b>	<b>3</b>	<b>3</b>	<b>3</b>	<b>6</b>	<b>9</b>	<b>8</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>4</b>	<b>58</b>

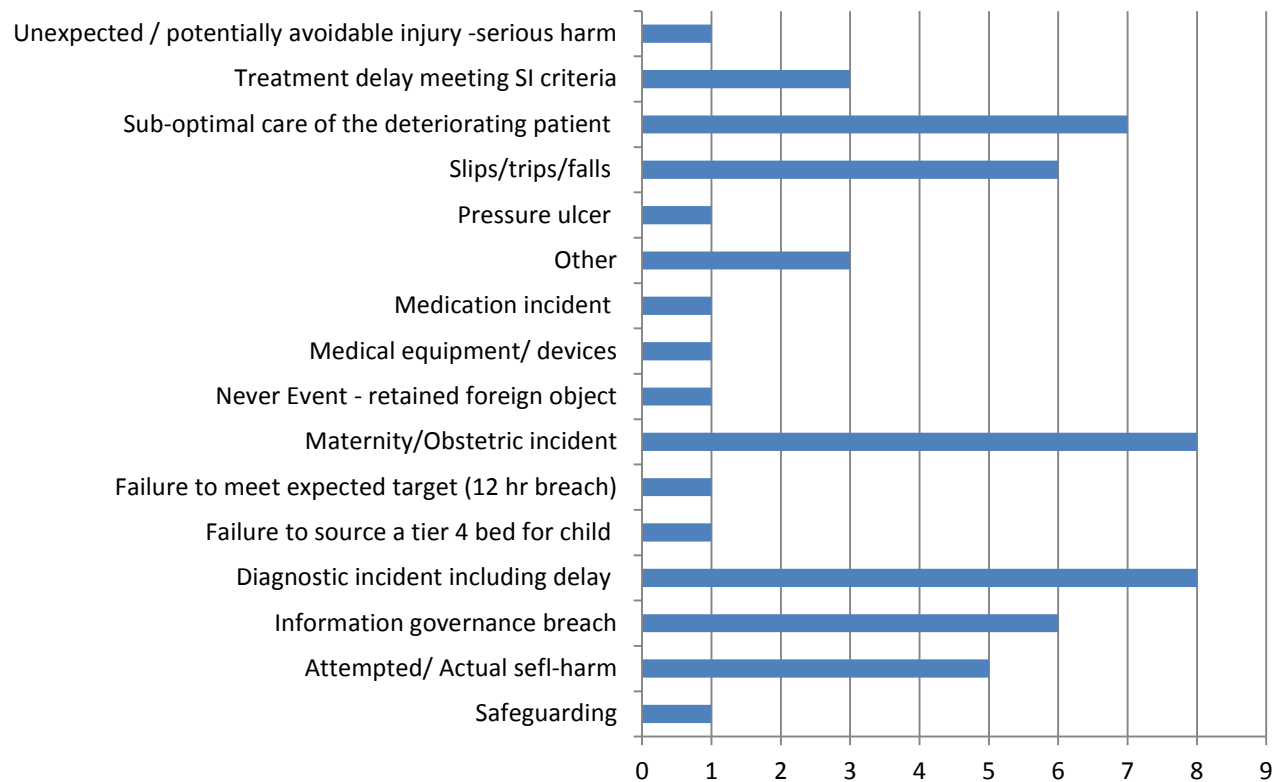
The higher number of serious incidents reported in maternity, emergency services and surgery is expected due to the high risk nature of these areas. These areas all report a high volume of incidents in total, with the majority graded as low or no harm. District Nursing, is incorporated in the Emergency and Urgent Care ICSU and is the third highest reporting service in the Trust, after ED and Maternity services (District Nursing reported 513 incidents in total in 2016/17, with 450 of these graded as no harm/ low). Integrated Medicine is also expected to be a higher reporter of serious incidents given the volume of inpatient activity which is covered by the Integrated Medicine ICSU.

The main categories (as defined by STEIS) related to falls, maternity, information governance and delayed diagnosis; these will be explored in more detail in the second section of the report. An independent review is also currently in progress to investigate the practice of managing patients with mental health conditions who present to ED, following a number of unexpected deaths in the area. This has therefore not been looked at as part of the detailed review section within this report, however all serious incidents were considered for common themes and trends.

The Trust now has a systematic process for reviewing all inpatient deaths (introduced in April 2017) and escalating any relevant reviews to the Serious Incident panel for investigation. The learning from these reviews is shared locally, through the trust mortality networks, through patient safety newsletters, through ICSU meetings and from October through a trust board level paper.

Table 2: Categories of serious incidents reported on STEIS

## Serious incidents reported on STEIS



In all 54 incidents it is possible to identify a number of key themes which are common across all categories and reflect areas for shared learning and improvement.

**The first encompasses care and service delivery problems which cover a failure to follow the correct management plan for a patient, not identifying signs of deterioration early enough or not escalating risks appropriately.** In some instances, there were no clear escalation pathways or clinical guidelines available for staff to follow. In these incidents the recommendation centred on providing clear, readily available procedures for staff to follow. However, in other incidents the existing guidelines were simply not followed. The findings from these investigation reports recognise human factors as the principal contributing factor and are therefore not as easy to solve.

Addressing human factors and mitigating the associated risk is one of the principal challenges in healthcare. The findings from these reports showed that it was not always possible to implement fail-safes which would completely reduce the risk of human error. The recommendations therefore focused on simplifying practice and improving staff awareness through training. This is a key priority for shared learning across the trust. There is scope in many areas across the trust to simplify practice, provide clearer one-page flowcharts for staff to follow and provide visual cues to support staff in high pressure situations. Further, learning from incidents where basic human error is a primary factor emphasise the importance of continuous practice. Regular live drills are in operation in some parts of the trust, and this report recommends using live drills more widely in 2018.

**A second recurring care and service delivery problem related to the process for managing referrals, follow-up appointments and discharge planning processes.** The contributing factors highlighted shortcomings in standardised process and the shortfalls of paper-based systems.

The Trust has made significant improvements in 2017 in streamlining processes and moving to electronic systems. One example is the introduction of internal electronic referral forms for outpatient appointment requests. This new electronic form replaced the previously paper based system. Consequently outpatient referrals are now legible, auditable and can be more easily processed by the Access Centre. This will improve patient safety by mitigating the risks associated with papers forms (e.g. forms going missing, forms illegible, no contact details for referrer) which result in delays.

A campaign to improve discharge planning, through earlier pre-11 discharge was initiated following the CQC inspection in December 2015 to allow better patient flow and bed management across the hospital. The campaign focused on nurse-led discharge through the TICKED checklist, and early use of the discharge planning team to manage complex cases. TICKED is an acronym highlighting the key aspects of discharge planning – TTAs and Transport; Inform Next of Kin; Care package and Section 5; Keys; Equipment; Dressed, Discharge letter and District Nurses. Other discharge planning improvements introduced following serious incidents include ensuring District Nursing patient leaflets are available on every ward to be given to patients discharged to the service, holding monthly MDT reviews of frequent attenders to better manage complex or vulnerable patients, and raising awareness amongst hospital staff on the importance of community care coordination and the role of the District Nursing team.

A further improvement in discharge planning has been the improvements made in Dictate IT. This system allows outpatient letters to be sent electronically to the GP and automatically uploaded to GP electronic system. This reduces the time for printing and mailing and reduces the risk of discharge letters being lost. Further, since November, all outpatient letters and GP referrals are available online for all relevant staff to access; this is a major step forward in patient safety.

**The final contributing factor which threads throughout the investigation reports points to poor communication, particularly between staff in different professions and across organisations.** In 2017, the trust hosted a number of successful learning workshops which were attended by multi-disciplinary staff from across the health and social care sector. These events help improve communication and encourage joint working. In 2018, the trust will continue to hold multi-disciplinary learning workshop to promote cross-organisational learning and better communication.

In 2017/18, the Trust will be working towards improving the sharing of patient information with primary and social care services, through Whittington Health's integrated care record Carecentric. It is hoped this will led to more integrated working between health and social care, and in particular improve communication with GPs.

## **Part 2: Themed Review by category**

### **Inpatient Falls**

Between 1<sup>st</sup> April 2016 and 31<sup>st</sup> March 2017 Whittington Health declared six serious incidents where falls by patients was a primary factor. The patient suffered fractures in three cases, and there were three incidents of falls associated with patient death (2 patient deaths were felt on balance of probability to have been caused by the fall and 1 death was contributed to but not caused by the fall). Three falls took place on Mary Seacole North, and one on Mary Seacole South; the Seacole wards were consequently selected as an area of focus for falls reduction through the 'STOPfalls on Seacoles' project as part of a national collaborative on falls reduction.

There were no clear trends but communication was an underlying theme identified in the learning section of the investigations, as well as issues around privacy and dignity when patients want to move or go to the toilet unassisted. Maintaining independence and dignity is difficult in hospital. Healthcare professionals need to find a balance between promoting independence and maintaining patient safety, as well as respecting patient's right to privacy against the risk of falls. This is a particular issue when patients who have good mobility, but are at high risk of falls, attempt to go to the toilet independently without alerting or waiting for staff to accompany them..

Handovers, bay/bed supervision, escalation pathways, and falls documentation were all highlighted as areas for improvement across the trust. These actions have been taking forward through the development of a revised STOPfalls risk assessment form and falls bundle, and clearer guidance on escalation procedures for neurosurgical trauma cases. Baywatch is a new initiative which has arisen directly as a result of investigation findings to improve practice. Baywatch is a multi-disciplinary approach to maintaining patient safety at all times, especially those identified as being at very high risk of falls. If a named nurse needs to leave the bay unattended at any point, they must first ask a colleague to be on 'Baywatch', ensuring the bay is not left unsupervised. Any staff member or volunteer can be part of Baywatch, from domestic staff and porters, to the Chief Executive, and it has been well received across the hospital. The initiative has now been rolled out across all wards through a trustwide communications campaign and individual ward training.

### **Delayed Diagnosis (Cancer)**

There were three serious incidents reported where there was a potential delay in cancer diagnosis related to imaging results not being followed-up appropriately, and two reports which were not identified until the 2017-18 STEIS reporting year but took place in 2016/17. Another incident related to a patient on the two week wait dermatology referral was missed. There were two recurring themes emerging from these investigation reports; a failure in the process for following up abnormal imaging results, in particular when requested by the Emergency Department, and issues around minimising the risk of human error when managing referrals. Staffing issues and workforce capacity within the imaging service were also identified as a contributing factor in the reports.

Contemporaneous reporting is currently not available for all imaging in the Emergency Department; imaging scans are reviewed by the ED clinician at the time, but the report from the radiologist follows a few days later. The London Commissioning Standards state that there should be “immediate access [to x-ray] with formal report received by the ED within 24 hours of examination” and that “all abnormal reports are to be reviewed within 24 hours by an appropriate clinician and acted upon within 72 hours”, *Quality and Safety Programme, Acute Emergency and Maternity Services, London Health Programmes, 2013*. Whittington Health has not been able to meet the timescales in the London Commissioning Standards in the past but has a plan in place to improve against these standards as a result of ED consultant recruitment.

The Emergency Department have a system in place for reviewing imaging reports to ensure that the correct management plan was followed at the time of discharge from ED. However the investigations found inconsistencies and gaps in this process which were contributing factors in the serious incidents. The Emergency and Radiology departments are working together to develop an approach to the review of x-ray reports following ED attendance, that is adequate, robust, and sustainable, and is able to be audited and monitored against the London Commissioning standards.

As outlined previously in the report, improvements have been made through the introduction of internal electronic referral forms for outpatient appointment requests. Already since its introduction one potential serious incident has been avoided, when a cancer referral sent incorrectly to the Access Centre was immediately identified and rectified. An ENT referral was sent to the Access Centre via the electronic referral system, the Access Centre immediately identified that this was not the correct pathway for the referral, and contacted the referrer (on electronic forms, contact details are a mandatory field). The referrer then re-referred the patient appropriately to Royal National ENT for treatment. Under the previous process, it is unlikely this error would have been identified as promptly, leading to delays in referral and subsequent treatment.

### **Information Governance Breaches**

In 2016/17 there were six information governance breaches reported as serious incidents across the hospital and community sites. This is an increase on 2015/16 and partly reflects more awareness of information governance breaches across the Trust and better reporting DATIX.

Incidents included clinic letters being mistakenly put into the wrong pre-addressed envelope, use of non-nhs email addresses when sharing patient identifiable information and patient lists being left in public places. The principal theme running through the information governance incidents was the high risk of human error arising from paper-based systems. To mitigate the risk of these type of errors occurring there has been a trustwide awareness campaign including emails, screensavers, articles in ‘Spotlight on Safety’ as well as a revived push from ICSUs to ensure all staff are up to date with IG training. In the community,

RiO Store and Forward was rolled-out which provides staff access to the electronic record system via iPads.

In addition to improving staff awareness, systems and processes are being reviewed to identify possible safeguards to human error through the use of electronic devices and revised administrative processes.

### **Never Event: Retained swab, maternity**

Never Events are defined by NHS Improvement as serious incidents which are wholly preventable if national guidance is followed and which have the potential to cause serious patient harm or death.

In 2016, the trust reported a never event after a retained swab was found in a patient's vagina, five days after forceps delivery of a live infant. The 'retention of a foreign object in a patient after a surgical/invasive procedure' is regarded as 'wholly preventable' if the WHO surgical safety checklist is followed and a full swab, instrument and sharp count is completed.

In this incident, a large un-clipped swab was placed inside the vagina. This was not communicated to the scrub nurse responsible for the swab count. The scrub nurse and HCA noted a discrepancy in the final swab count, with one swab missing. However the operator was not informed of this discrepancy in the count. A swab was then found in the bin bag and assumed to be the missing swab. The swab count was marked as 'complete'; the initial discrepancy was not communicated to all staff or documented in the notes. Staff on labour ward were therefore not aware of the risk of a potential retained swab. Fortunately the harm suffered by the patient as a result of this incident was low, and the patient recovered fully.

Following this investigation the learning has been widely shared across the trust, not only in maternity services. Key learning messages for staff emphasised the importance of communication, good documentation and being alert to the risks of human error. Specific changes in practice as a result of this Never Event include revising the swab count guidance, live drills in maternity theatres, refresher training on swab counting and a live database of all staff trained.

### **Notable practice**

The Serious Incident template includes a section for notable practice. A common theme throughout was the prompt escalation and action taken once the incident was identified. This included clinical management of the patient, (for example, there were a number of references to the timely response of the Critical Care Outreach Team), as well as mitigating actions taken to prevent harm to future patients (for example, carrying out caseload reviews to identify if any other patients were affected). The majority of incidents were reported on DATIX, the Trust incident reporting system, promptly and there was good evidence of

compliance with the Duty of Candour. Maternity services, in particular, showed good patient engagement with the investigation process in line with Being Open and Duty of Candour.

These examples illustrate a strong patient safety culture across the trust, one which is open and transparent and which recognises the value in learning from mistakes.

## Benchmarking data

It is difficult to accurately benchmark NHS trusts using serious incident data. The SI framework does not have a set classification list for serious incidents; instead Trusts are expected to review each incident on a case by case basis, focusing on the level of harm to the patient and the potential for learning. In this way, there is scope for flexibility in the interpretation of serious incidents, and differences in the number of serious incidents reported between trusts may represent variances in thresholds for reporting rather than variations in the safety of practice. Whittington Health is a member of the London Patient Safety Network which is working together to identify ways to compare serious incident data in a way that supports shared learning to drive patient safety improvement.

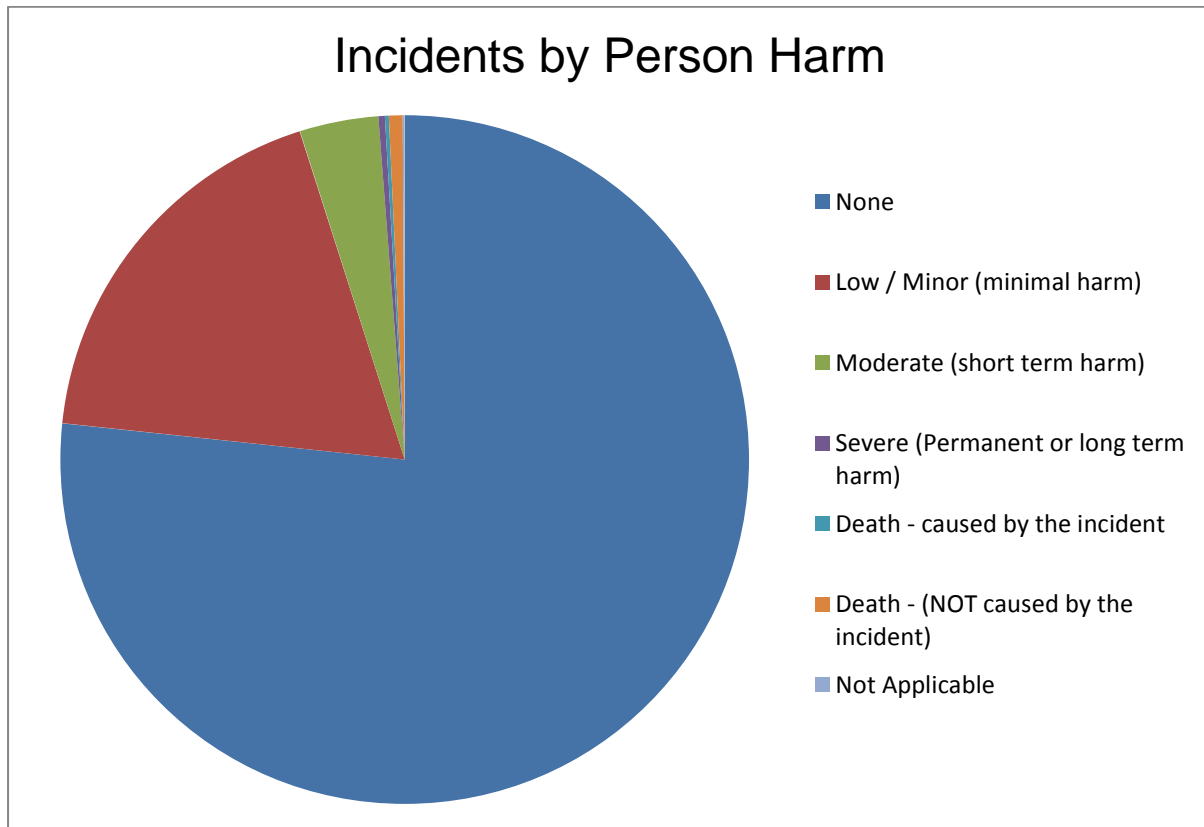
SI Framework criteria for a serious incident is defined as *'acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services'*

The data below shows that Whittington has a high rate of SIs reported per occupied bed days, however the data does not take into account that Whittington is an Integrated Care Organisation with community services.

Organisation	Trust type	Number of <b>Serious Incidents</b> (data extracted from STEIS on the 14th Feb 2017)			Rate of reported SI per (an average of) 1000 occupied overnight beds		
		Q1 2016-17	Q2 2016-17	Q3 2016-17	Q1 2016-17	Q2 2016-17	Q3 2016-17
Community Trust 1	Community	45	52	44	459.0	539.2	391.5
Large Trust -1	Large	46	33	37	42.3	34.7	38.0
Large Trust -2	Large	67	56	38	72.5	61.3	42.7
Large Trust -3	Large	11	3	6	15.5	4.3	8.6
Medium Trust -1	Medium	14	20	22	28.2	43.5	45.6
Medium Trust -2	Medium	6	13	6	14.0	30.7	14.4
Medium Trust -3	Medium	6	11	11	16.3	30.5	25.6
Medium Trust -4	Medium	7	21	8	7.6	25.9	8.4
Medium Trust -5	Medium	18	25	35	37.2	51.9	70.6
THE WHITTINGTON HOSPITAL NHS TRUST	Medium	12	11	18	43.3	43.3	64.1

The NRLS incident reporting national statistics provide a more accurate benchmark of the safety culture of trusts nationally. It is generally accepted that trusts who report a high

number of incidents (low harm, near miss) are more open and transparent, encouraging staff to learn from mistakes. Whittington Health has improved significantly since 2015, moving from being in the bottom quartile for incident reporting to the top quartile in 2016. As illustrated in the graph below, the ratio of moderate/severe harm incidents to those reported with low harm or none across the Trust is very low.



## Mechanisms for shared learning

Staff and the public retain information differently; some individuals prefer written guidelines and reports, others need visual prompts and yet others use real life examples and practical demonstrations to retain information. One size doesn't fit all and the Trust uses a wide variety of mechanisms to share learning and embed good practice.

- Trustwide learning workshops using case studies
- Spotlight on Safety (and service specific newsletters Cats Eyes and Medicines Matters)
- Staff awareness campaigns via Communications (e.g. STOPfalls, Information Governance) using screensavers, posters and events
- Reflective sessions with individual staff and teams
- Trustwide communication via weekly Noticeboard and targeted emails
- ICSU and corporate governance structure for cascading information (ICSU and Trustwide Patient Safety Committees) and local arrangements such as '10@10' in Emergency Department
- Patient Safety Learning section on intranet

- Compliance with action plans as a standard Term of Reference when a similar serious incident occurs
- Patient Safety Forum monthly
- Grand Rounds monthly

### **Plans for 2017/18**

For 2017/18 the Trust will be continuing to work to embed the existing mechanisms for shared learning to improve practice. In addition, there are a number of new initiatives in progress or due to start in the coming year. An update on the progress of these projects will be provided in the next annual report.

- Review processes for monitoring SI action plans to develop a more robust process
- Revising 'Visible Leadership' programme to provide targeted support to staff based on findings from serious incidents, peer reviews, audits, complaints and claims
- Aggregated report on complaints, claims, incidents and PALS to be revised with a renewed focus on identifying themes on a quarterly basis
- 'Learning from excellence' pilot in children's services

In 2018/19, it is hoped that the annual SI report will show that the Trust has learnt from the mistakes identified as recurring themes in this report, through a focus on patient safety and trustwide learning.

**Appendix 1: Incidents reported in 2016-17 by service**

	Total
Emergency Department	1462
Maternity and Obstetrics	935
District Nursing	513
Acute Assessment Wards (Mary Seacoles)	329
Acute Medical Wards (Nightingale, Montuschi, Victoria)	322
Care of Older People Wards (Cloudesley, Meyrick, Cavell)	274
Surgical Wards (Coyle, Mercers, Thorogood)	267
Acute and Community Paediatrics	234
CAMHS and Community Child Psychology Services	229
Critical Care	209
Acute Medicine (including Mary Seacole, Mercers, Nightingale, Montuschi Wards)	134
Site Management (Bed managers)	114
Theatres	112
Health Visiting and Family Nurse Partnership	102
Adult Community Nursing Service (Islington and Haringey)	99
Ambulatory Care (Adult)	94
Surgical specialties (Outpatient Clinics)	73
Gynaecology	61
Children Additional Needs and Disability Services	56
Contraception and Sexual Health	52
Physiotherapy	52
Imaging	50
Bridges Rehabilitation Unit	49
Rehabilitation	49
Outpatients	43
Health Centre Managers	41
Pathology	40
Pharmacy	40
Podiatry	36
Simmons House	35

Speech and Language Therapy	31
Access Centre/Call Centre	30
Intermediate Care (Islington)	30
Medical Specialties	28
Adult Learning Disability Services	27
Community Dental	26
Cavell Rehabilitation Unit	21
Anaesthetics	20
Endoscopy	20
Trauma and Orthopaedics	17
Looked after Children	16
Security	16
Community Rehabilitation (Haringey)	15
Facilities & Estates	15
General Surgery	14
Health Visiting & Early Years Services (Child Health Promotion Programme and Immunisation)	13
Integrated Diabetes Service	12
Oncology	11
Gynaecology - Hospital	9
Information Management	9
Integrated Network Coordination Service	9
Integrated Respiratory Service	9
NICU / SCBU	9
Ambulatory Care (Children)	8
Diabetes and Endocrinology	8
Drug and Alcohol Service (PCADS)	8
ECG	8
Immunisation (Children)	8
Information Technology	8
Speech & Language Therapy, Camden and Acute	8
Continuing Healthcare (Islington)	7
External Organisation	7
In-patient Therapies	7
Integrated Cardiology Service	7
Integrated Multi-disciplinary Services for Children with Additional Needs	7
Respiratory	7
Safeguarding (Children)	7
Continuing Care	6
Day Treatment Centre	6

Haringey Contraception & Sexual Health Services (CASH)	6
Islington CAMHS (Child and Adolescent Mental Health Service)	6
Musculoskeletal and Physiotherapy	6
Tissue Viability & Lymphoedema (Community)	6
Biochemistry	5
Bladder and Bowel Care Service	5
Chronic Pain	5
Community Rehabilitation (Islington)	5
Expert Patient Programme	5
North London TB service	5
Care Home Specialist Nurse	4
Family Nurse Partnership	4
Health and Safety	4
Human Resources	4
Medical Physics	4
Nutrition & Dietetics (Haringey and Islington)	4
Audiology & Vestibular Medicine	3
Cardiology	3
Children in Care	3
Children's Community Nursing	3
Gynaecology - Community	3
Haematology	3
Hanley Road Primary Care Centre	3
Medical Director	3
Medical Records	3
Medical Secretariat	3
Occ Health and Wellbeing	3
Pre-Assessment Unit	3
Thalassaemia	3
Clinic 3B - Hypertension	2
Colposcopy	2
Gastroenterology	2
Improving Access to Psychological Therapies (IAPT)	2
Information Governance	2
Islington Care Homes Development	2
Mobility and Seating Solutions	2
Ophthalmology	2
Organisational Development	2

Paediatric Ambulatory Care	2
Payroll	2
Safeguarding School Nursing Service	2
School Health (School Health Promotion & National Childhood Measurement Programme)	2
Staff Residence	2
Substance Misuse Services	2
Telecommunications	2
Universal Children's Services	2
Whittington Court Retail Units	2
Acute Pain Team	1
Adult Community Referral and Booking Team	1
Car Parking	1
Clinic 4A - General Surgery	1
Clinic 4B - General Surgery	1
Clinic 4D - Paediatrics	1
Communications and Corporate Affairs	1
Discharge Co-ordinators	1
Expert Patient and Health Promotion	1
Facilitating Early Discharge (FEDS)	1
Financial Planning	1
Learning Disabilities	1
Lung Function	1
Management Accounts	1
Michael Palin Centre	1
Mortuary	1
Operations and Performance	1
Paediatric Occupational Therapy	1
Patient Experience	1
People (Human Resources)	1
Portering	1
Rheumatology	1
Safeguarding	1
Smoking Cessation	1
Surgical Secretariat	1
Women's Secretariat	1

Total	7611
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Executive Offices

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The Whittington Hospital NHS Trust

Magdala Avenue, London

N19 5NF

## Whittington Health Trust Board

August 2017

<b>Title:</b>	Inpatient Safe Staffing - Nursing and Midwifery – June and July data		
<b>Agenda item:</b>	<b>17/112</b>	<b>Paper</b>	<b>05</b>
<b>Action requested:</b>	For information		
<b>Executive Summary:</b>	<p>Due to the Trust Board not sitting in August, this paper summarises the safe staffing position for nursing and midwifery on our hospital wards in June and July 2017. The key issues to note are:</p> <ol style="list-style-type: none"> <li>1. The improved utilisation of Allocate 'Safe Care' and associated staffing levels to match the acuity and dependency needs of our patients.</li> <li>2. A decreased fill rate in Registered Nurse shifts as detailed in the UNIFY report, due partly to patient acuity assessment and monitoring and the allocation of staff as described above,</li> <li>3. An increase in shift requests to provide enhanced care to support vulnerable patients June (n=199) and July (n=213).</li> <li>4. There were 5 shifts in June and 8 shifts in July which initially triggered 'Red' prompting a review of available staff. These shifts are constantly reviewed to mitigate any risks to patient safety.</li> <li>5. The number of Registered Mental Health Nurses used to provide enhanced care for patients with a mental health condition showed little variation in June (n=26) and July (n=23).</li> <li>6. The Care Hours Per Patient Day (CHPPD) measure during the month decreased in July (8.84) from (8.92) in June.</li> <li>7. There is continued use of agency and bank staff to support safe staffing. Many are Whittington Health staff undertaking additional shifts via the nurse 'Bank' or regular agency staff, who are familiar with the organisation and ward/department area.</li> <li>8. There were no Datix reports submitted in June or July where 'staffing' was highlighted as an issue which resulted in 'Patient Harm'</li> </ol>		
<b>Summary of recommendations:</b>	To note the June UNIFY return position and processes in place to ensure safe staffing levels in the organisation.		
<b>Fit with WH strategy:</b>	Efficient and effective care; Francis Report recommendations. Cummings recommendations; NICE recommendations.		
<b>Reference to related / other documents:</b>			
<b>Reference to areas of risk and corporate risks on the Board Assurance Framework:</b>	3.4 Staffing ratios versus good practice standards.		

<b>Date paper completed:</b>		August 2017					
<b>Author name and title:</b>		Sandra Harding-Brown  Clinical Workforce Systems Lead (Healthroster and HealthMedic)		<b>Director name and title:</b>		Philippa Davies – Chief Nurse and Director of Patient Experience	
<b>Date paper seen by EC</b>		<b>Equality Impact Assessment complete?</b>		<b>Risk assessment undertaken?</b>		<b>Legal advice received?</b>	



## Ward Staffing Levels – Nursing and Midwifery

### 1.0 Purpose

- 1.1 To provide the Trust Board with assurance in regard to the management of safe nursing and midwifery staffing levels for the month of June and July 2017.
- 1.2 To provide context for the Trust Board on the UNIFY safe staffing submission for the months of June and July 2017.
- 1.3 To provide assurance of the constant review of nursing/midwifery resource using Healthroster 'Safe Care'.

### 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 and ITU. The data extracted provides information relating to the dependency and acuity requirements 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 June/July data by ward please see section 4.2).
- 2.5 Staff fill rate information appears on the NHS Choices website [www.nhschoices.net](http://www.nhschoices.net). Fill rate data from 1<sup>st</sup> to 30<sup>th</sup> June 2017 and 1<sup>st</sup> to 31 July for Whittington Hospital have been 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.

## Summary of Staffing Parameters

Standard	Measure	Summary (June)	Summary (July)
<b>Patient safety is delivered though consistent, appropriate staffing levels for the service.</b>	Unify RN fill rate	Day – 85.7% Night – 92.4%	Day – 87.3% Night – 92.3%
	Care hours per Patient Day - CHPPD	Overall the CHPPD for June was 8.92 which is lower than last month, the RN delivered care continues to be consistent	Overall the CHPPD for July was 8.84 which is lower than last month, the RN delivered care continues to be consistent
<b>Staff are supported in their decision making by effective reporting.</b>	Red triggered shifts	5 shifts triggered 'Red' in June 2017	8 shifts triggered 'Red' in July 2017

### 3.0 Safe staffing

At a number of points each day, the senior nurses review the nursing capacity on the wards to ensure that there are sufficient nursing hours to deliver safe care to patients. An assessment is made which takes into consideration the patient acuity and nurse hours available.

#### 3.1 Patient Acuity

- 3.1.1 Each morning the care requirements of patients are assessed using the Safer Nursing Care Tool (SNCT) definitions. Those patients requiring a low level of care hours are assigned level 0 and those requiring intensive care (defined in hours) are assigned level 3.
- 3.1.2 As would be anticipated, there were a low number of level 3 patients and a high number of level 0 patients during June and July. The number of level 1b patients remains high. This increased number of dependant patients require a greater level of nursing support.

#### 3.2 Staffing Requirement

- 3.2.1 In order to deliver safe staffing levels it is essential that sufficient nursing care is planned for the wards. The new SaferCare module of the Healthroster system provides an estimate of the total 'actual' nursing hours required to provide the necessary care, taking the acuity and dependency of patients into consideration.

The Trust reports each month its ability to align the planned nursing requirement with the 'actual' number of staffing hours. The 'actual' is taken directly from the nurse roster system (Healthroster). On occasions when there is a deficit in 'planned' hours versus 'actual' hours, staff are redeployed

between wards are other areas to ensure safe staffing levels across the organisation. Over the past two months there has been flexing up and down of the number of beds on Victoria, Coyle and Cloudeley wards to manage acuity and flow. This is reflected in this month's submission and the Head of Nursing for integrated medicine will be working with the clinical workforce systems lead to set planned hours for September and October as we increase bed numbers in line with winter pressure allocation.

- 3.2.2 Appendix 1 details a summary of 'actual' versus 'planned' fill rates in July. The average fill rate was 87.3% for registered staff and 114.3% for care staff during the day and 92.3% for registered staff and 128.1% for care staff during the night.

The 'actual' versus 'planned' fill rates in June were 85.7% for registered staff and 111.4% for care staff during the day and 92.4% for registered staff and 118.1% for care staff during the night.

- 3.2.3 The Trust fill rate for July is outlined below

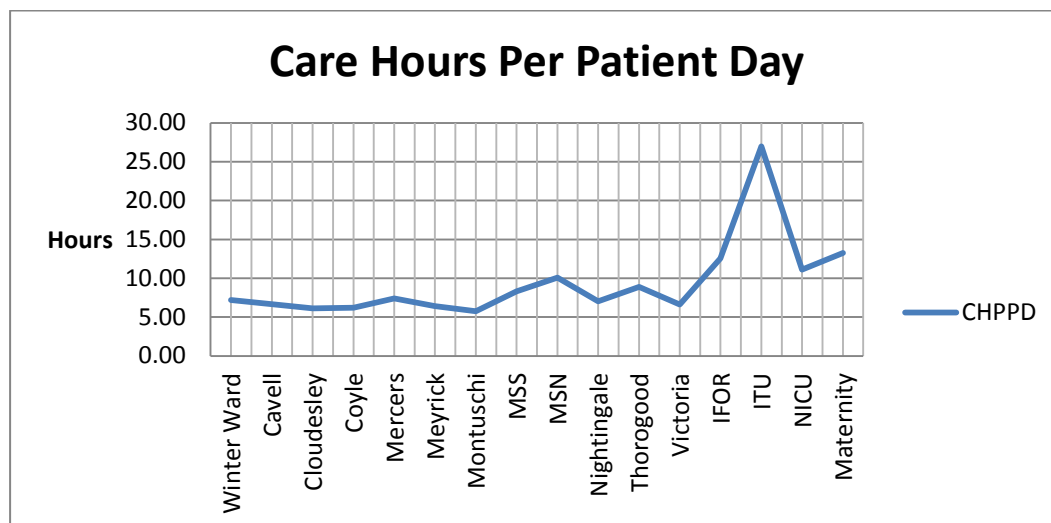
Day		Night	
Average fill rate registered Nurses /Midwives	Average fill rate Care Staff	Average fill rate registered Nurses/Midwives	Average fill rate Care Staff
<b>87.3%</b>	<b>114.3%</b>	<b>92.3%</b>	<b>128.1%</b>

- 3.2.4 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.

## 4.0 Care Hours per Patient Day (CHPPD)

Care hours per patient day is another matrix used to show the acuity levels and case mix of patients on each ward. The value is calculated using the actual hours worked (split by registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight (23.59).

The graph below shows the average individual CHPPD for each clinical area, in July. ITU have the most care hours (26.96) and Montuschi ward have the least (5.78).



- 4.1 Across the Trust the average number of hours of Registered Nurse time spent with patients in July was calculated at 6.23 hours and 2.59 hours for care staff. This provides an overall average of 8.84 hours of care per patient day.

	CHPPD (June)	CHPPD (July)
<b>Registered Nurse</b>	6.36	6.59
<b>Care Staff</b>	2.56	2.59
<b>Overall hours</b>	8.92	8.84

- 4.2 The table below shows the CHPPD hours for each in patient ward over the last four months and indicates the level of need remained stable overall. There is a slight decrease in hours of care delivered in July compared with June.

Ward Name	July	June	May	April
Bridges				
Cavell	7.18	6.53	7.03	6.97
Bridges rehab ward	6.67	7.73	6.55	6.55
Cloudesley	6.11	5.89	5.77	5.57
Coyle	6.23	6.08	6.38	5.78
Mercers	7.41	6.99	7.07	6.90
Meyrick	6.43	6.08	5.63	6.19
Montuschi	5.78	5.74	5.94	5.99
MSS	8.32	8.22	7.79	7.76
MSN	10.08	10.26	9.90	10.43
Nightingale	7.04	6.00	6.91	6.84

Thorogood	8.89	8.77	8.14	9.66
Victoria	6.61	6.09	6.26	6.18
IFOR	12.55	12.00	11.65	11.88
ITU	26.96	26.67	26.32	25.87
NICU	11.10	11.72	13.25	10.77
Maternity	13.27	15.21	15.56	16.00
<b>Total</b>	<b>8.84</b>	<b>8.92</b>	<b>9.05</b>	<b>8.84</b>

## 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 Deputy Chief Nurse and Heads 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 as well as professional judgement of patient dependency and staffing levels by a senior nurse familiar with each clinical area. Actions are agreed to ensure all areas are made safe and a ward where 'red' staffing has triggered is constantly monitored by the Head of Nursing and matron while a plan is put in place to increase staffing, no ward is allowed to continue with red staffing levels throughout a shift. 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 (hours short > 22 hours)', 'amber (hours short > 11.5 hours)' or 'green (< 11 hours short)' according to figures generated by Safecare. This figure is a combination of nursing hours and takes into account patient numbers, acuity and dependency.
- 5.3 A decision as to whether a ward staffing triggers red is taken once the review of staffing and dependency has taken place. A red trigger is classified as more than half an hour at red level. It will usually be when the hours short is greater than 22 hours for more than 30 mins after the review made at the bed meeting. This flag is added to Healthroster by Matron after an assessment and possible redeployments are made.
- 5.4 There were 13 red flags triggered in June and July. The Deputy Chief Nurse and Heads of Nursing have reviewed the approach to recording red flags to make this process more robust and therefore there are a higher number reported than in previous months. Frequency and trends will be regularly reviewed by the Deputy Chief Nurse throughout September and included in the next board report.

## 6.0 Reported Incidents of Reduced Staffing (Datix Reports)

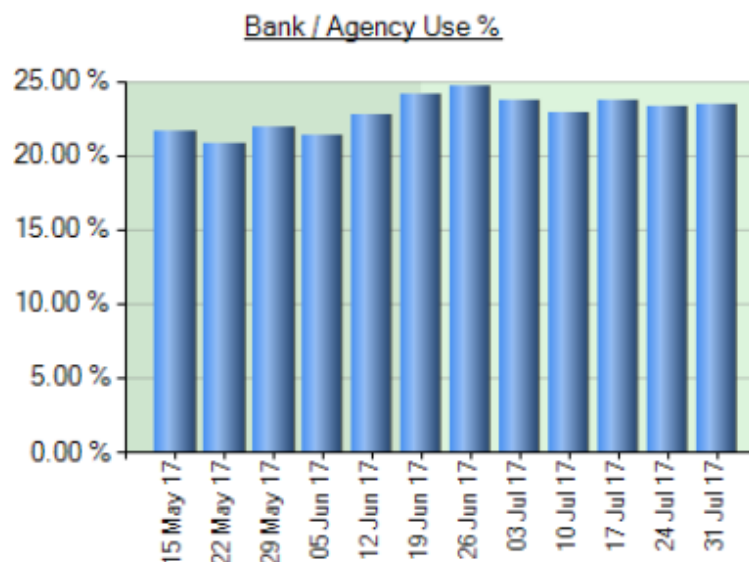
- 6.1 Staff are encouraged to report, using the Datix system, any incident they believe may affect safe patient care. During June and July there were 15 and 16 Datix reports respectively submitted relating to staffing, none of these incidences related to injury, harm or adverse outcome.

## **7.0 Additional Staff required to provide 1:1 enhanced care**

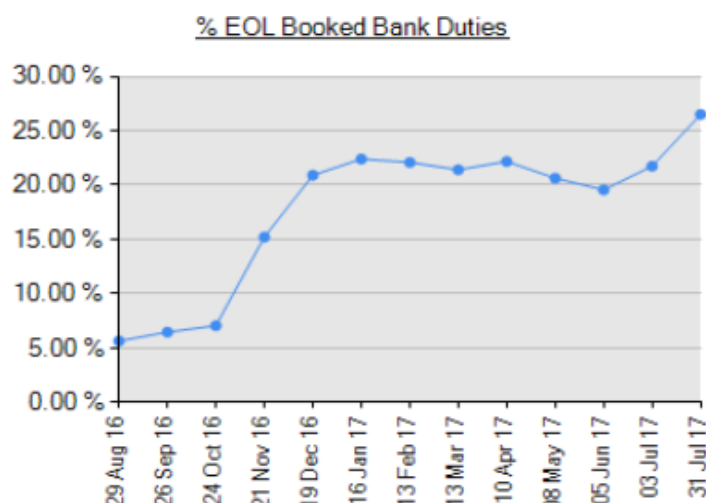
- 7.1 When comparing June and July's total requirement for one to one staffing staff to provide enhanced care with the previous month, there is an increase in the number of shifts required (Appendix 2). In June and July there were 199 and 190 requests for 1:1 enhanced care provision compared to 35 requests in May. The requests made for this level of care were to ensure the safe management of particularly vulnerable groups of patients.
- 7.2 The number of Registered Mental Health (RMN) nurses booked for shifts to provide enhanced care for patients with a mental health condition was higher in June (26) and July (23) compared to May (5). All requests for RMNs are validated by the Heads of Nursing and a clinical assessment made as to the therapeutic need. These requests June then be downgraded to provide an HCA rather than an RMN.
- 7.3 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. The lead nurse for quality and safety is currently reviewing the process for the provision of one to one nursing care. This review will ensure that there is consistency in quality and care offered, and requests are made and authorised in line with best practice and an appropriate decision support tool.

## **8.0 Temporary Staff Utilisation**

- 8.1 Temporary staff utilisation (nursing and midwifery) across the hospital is now monitored regularly by the Deputy Chief Nurse and Heads of Nursing, a member of the temporary staffing team will also attend or report unfilled shifts to the site meeting in the near future. All requests for temporary staff (agency) on the wards are reviewed by the Head of Nursing/Midwifery. A further review and final authorisation is then made by the Deputy Chief Nurse.
- 8.2 Monitoring the request for temporary staff in this way serves two purposes:
  - 8.2.1 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.
  - 8.2.3 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.
  - 8.2.4 Temporary staffing usage (Bank and Agency) across inpatients wards remains high and fluctuates between 20 – 24% depending on nurse vacancies and the need to provide additional support for 1:1 care or additional beds. Recruitment to reduce the current vacant posts is ongoing.



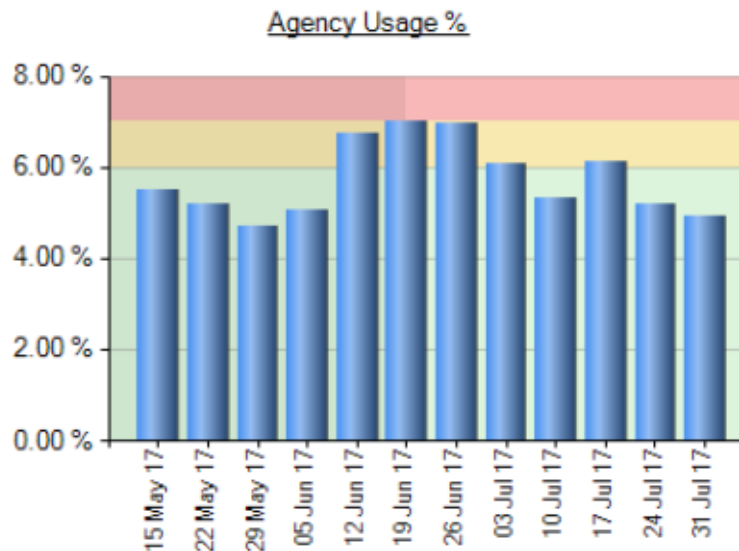
- 8.3 Bank staff continue to book themselves directly into shifts and this is improving over time. This is however reliant on the wards making these shifts available with sufficient notice.



Whilst there is an upward trend in the direct booking process, less than 30% of bank shifts are booked by the staff themselves. This remains an area of service improvement.

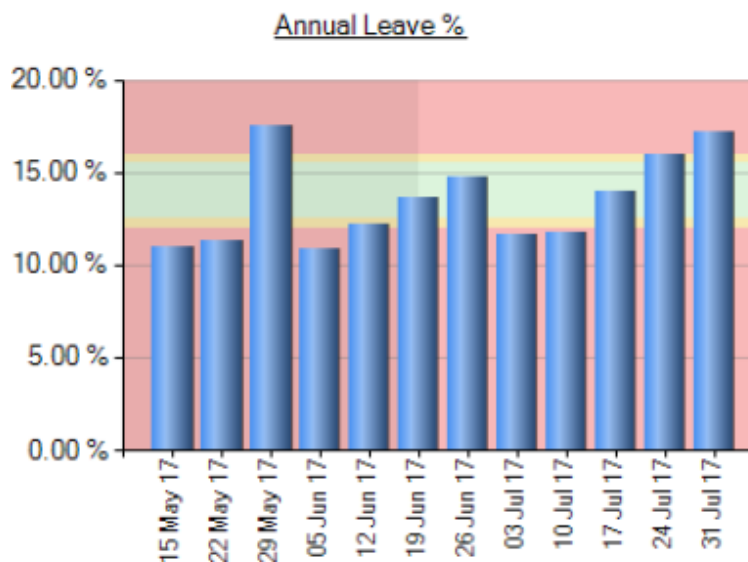
## 9.0 Agency Usage Inpatient Wards (month ending July)

- 9.1 The utilisation of agency staff across all inpatient wards is monitored using the Healthroster system. The bar chart below graphically represents total usage of agency staff on inpatient wards month ending July (this is cumulative data captured from roster performance reports).
- 9.2 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 5% target, less that the agreed KPI.

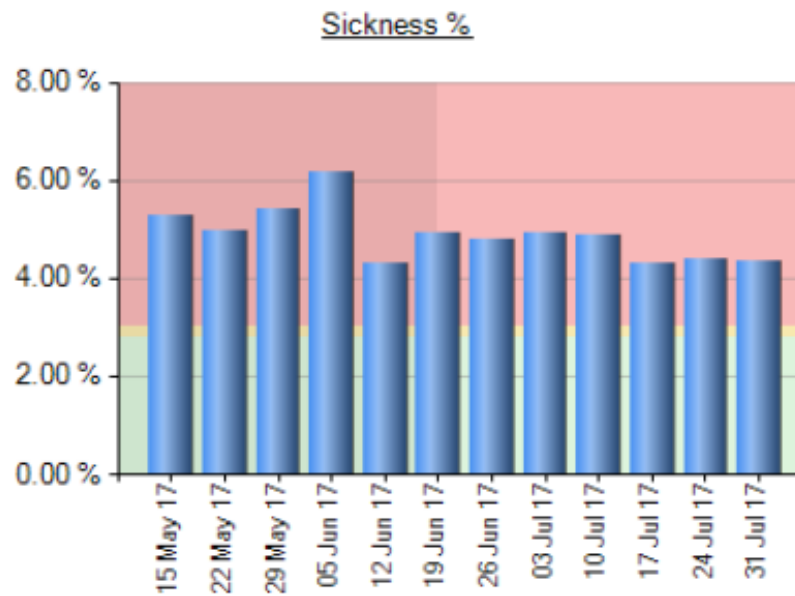


## 10.0 Absence Management

- 10.1 The management of absence is crucial to effective resource management. The key absences to track are annual leave and sickness. 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.
- 10.2 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.



- 10.3 Sick leave reported in June 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.



## 11.0 Conclusion

- 11.1 Trust Board members are asked to note the work currently being undertaken to proactively manage the nursing/midwifery resource across the ICSUs and the June and July UNIFY return position

## Appendix 1

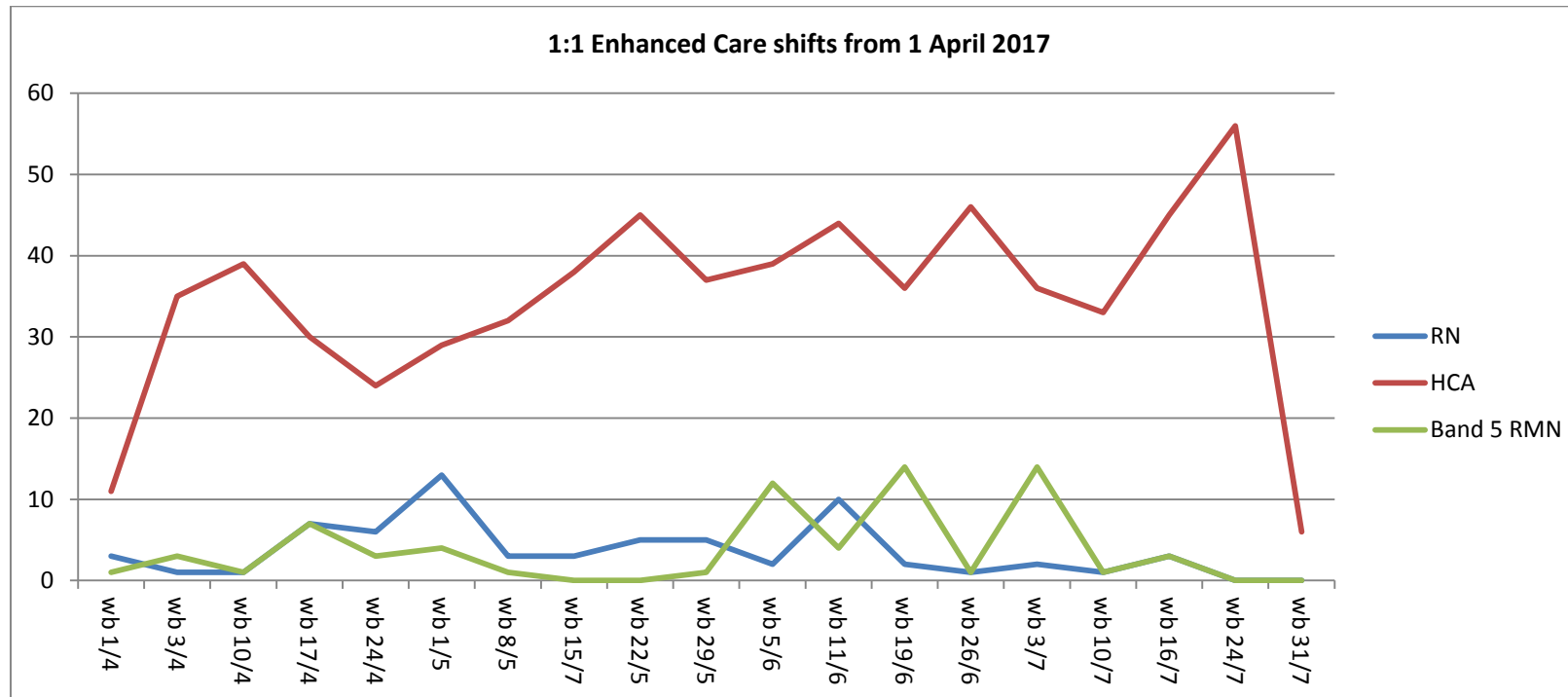
### Fill rate data - summary July 2017

Day				Night				<u>Average</u> fill rate data-Day		<u>Average</u> 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)	87.3%	114.3%	92.3%	128.1%
32976	28795	10541	12044	27207	25104	8006	10260				

### Care Hours per Patient Day July 2017

Total Patients at Midnight/Month	CHPPD Registered staff	CHPPD Unregistered staff	Average CHPPD (all staff)
8621	6.25	2.59	8.84

**Appendix 2: Enhanced Care requirement to date**



**Appendix 3: Average fill rate for Registered and Unregistered staff day and night,**

<u><b>JULY</b></u>	Day		Night	
	<b>Nurses</b>	<b>Care Staff</b>	<b>Nurses</b>	<b>Care Staff</b>
Ward Name	%	%	%	%
Cavell Winter Ward	90.8%	118.2%	99.6%	116.9%
Cavell (Bridges Rehab)	91.5%	97.8%	99.4%	99.4%
Cloudesley	82.7%	114.0%	106.5%	148.1%
Coyle	90.3%	98.1%	98.6%	102.2%
Mercers	95.9%	100.4%	98.1%	104.5%
Meyrick	82.3%	137.3%	107.0%	169.4%
Montuschi	78.7%	186.6%	108.3%	NA
MSS	64.7%	202.4%	77.6%	226.1%
MSN	85.6%	116.0%	105.3%	231.0%
Nightingale	108.0%	109.6%	88.0%	128.9%
Thorogood	105.9%	92.7%	107.3%	0.0%
Victoria	79.9%	115.7%	96.9%	114.5%
IFOR	84.0%	100.0%	74.7%	100.0%
ITU	100.0%		100.0%	
NICU	78.3%		81.0%	
Maternity	89.5%	94.8%	88.6%	100.0%
<b>Total</b>	<b>87.3%</b>	<b>114.3%</b>	<b>92.3%</b>	<b>128.1%</b>



**Whittington Health****Trust Board****6<sup>th</sup> September 2017**

<b>Title:</b>		<b>Quarterly Safety and Quality Board Report</b> <b>Quarter 1 2017/18: September 2017</b>					
<b>Agenda item:</b>		<b>17/113</b>		Paper		<b>06</b>	
<b>Action requested:</b>		For the Board to discuss and make any additional recommendations.					
<b>Executive Summary:</b>		This is the regular paper for the Trust Board to provide an overview of safety and quality in the organisation.					
<b>Summary of recommendations:</b>		It is recommended that the contents are discussed					
<b>Fit with WH strategy:</b>		To deliver consistent high quality, safe services.					
<b>Reference to related / other documents:</b>		Quality Account 2015-16 Sign up to Safety Pledges Clinical Strategy 2015-20 CQC standards 7 day services clinical standards					
<b>Date paper completed:</b>		29 <sup>th</sup> August 2017					
<b>Author name and title:</b>		<b>Richard Jennings, Executive Medical Director</b>		<b>Director name and title:</b>		<b>Richard Jennings, Executive Medical Director</b>	
<b>Date paper seen by EC</b>		<b>Equality Impact Assessment complete?</b>	<b>NA</b>	<b>Risk assessment undertaken?</b>	<b>NA</b>	<b>Legal advice received?</b>	<b>NA</b>

## 1) Executive Summary

This is the regular paper for the Trust Board to provide an overview of safety and quality in the organisation. On this occasion, this report includes a review of heart failure and COPD.

This report provides an update on mortality, and the Trust's HSMR and SHMI figures remain assuring.

## 2) Contents

- 1) Executive Summary
- 2) Contents
- 3) Mortality
  - 3.1 HSMR
  - 3.2 SHMI
- 4) Infection control report
  - 4.1 MRSA Related Issues
  - 4.2 *Clostridium difficile* diarrhoea
  - 4.3 MSSA/E.coli Bacteraemia Episodes
  - 4.4 Infection Prevention and Control Training
  - 4.5 Other Relevant Healthcare Associated Infection (HCAI) Issues
- 5) Sign up to Safety
  - 5.1 Sign up to Safety Progress Update – Falls
- 6) Safety and Quality Review: Heart Failure
- 7) Safety and Quality Review: COPD
- 8) Update on learning from incidents, near misses, inquests, complaints and claims
- 9) References

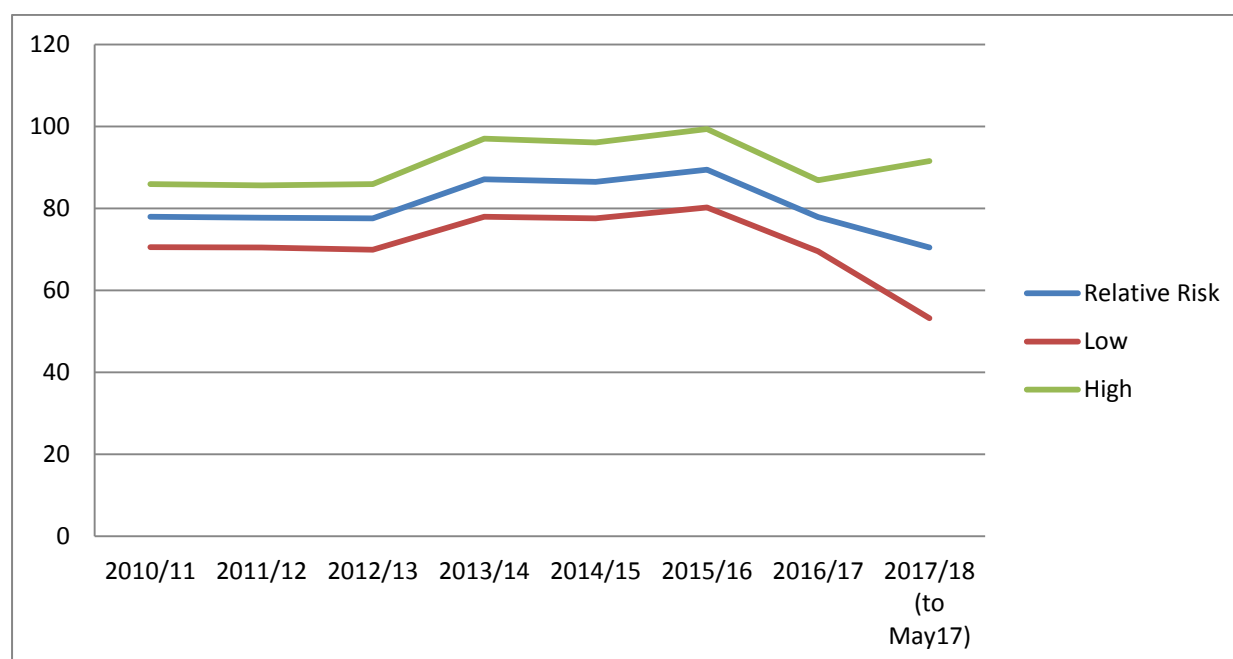
## 3. Mortality

This Trust's HSMR and SHMI have both been 'lower than expected' since 2005/06.

### 3.1 Hospital Standardised Mortality Ratio (HSMR)

The Hospital Standardised Mortality Ratio (HSMR) is a measure of the number of deaths in a hospital expressed as a number which is a ratio of the national average, which is set at 100. HSMR is an overall quality indicator that compares a hospital's mortality rate with the average national experience, accounting for the types of patients cared for. It has been used by many hospitals worldwide to assess and analyse mortality rates and to identify areas for improvement. HSMR is calculated as the ratio of the actual number of deaths to the expected number of deaths, multiplied by 100. A ratio less than 100 indicates that a hospital's mortality rate is lower than the average national rate of the baseline year.

**Chart 1: Whittington Health Hospital Standardised Mortality Ratio (HSMR) by financial year (April 2010 – May 2017)**



The blue line on the above Chart 1 represents this Trust's HSMR. The HSMR reported for each trust includes High and Low values which make up a 'confidence interval' – set here with 95% certainty. This defines the range that can be explained by normal variation within the system and states where 95% of values will fall. If the entire confidence interval range is *below* the standardised mean of 100, there have been fewer (with 95% certainty) deaths in the trust than expected. The opposite is true when the interval range is above the standardised mean.

### 3.2 Summary Hospital-level Mortality Indicator (SHMI)

SHMI was developed in response to the public inquiry into the Mid Staffordshire NHS Foundation Trust. It is used along with other information to inform the decision making of Trusts, regulators and commissioning organisations.

National guidance emphasises that SHMI is not a measure of quality of care, but is meant as an indicator for further investigation.

SHMI is calculated in a way that is similar to the HSMR calculation, but unlike HSMR, the SHMI calculation takes into account deaths within 30 days of discharge of hospital as well as inpatient deaths.

Whittington Health continues to have the lowest SHMI score in England. We consider this data is as described because the data is obtained from Hospital Episodes Statistics data and sourced via the HSCIC Indicator portal.

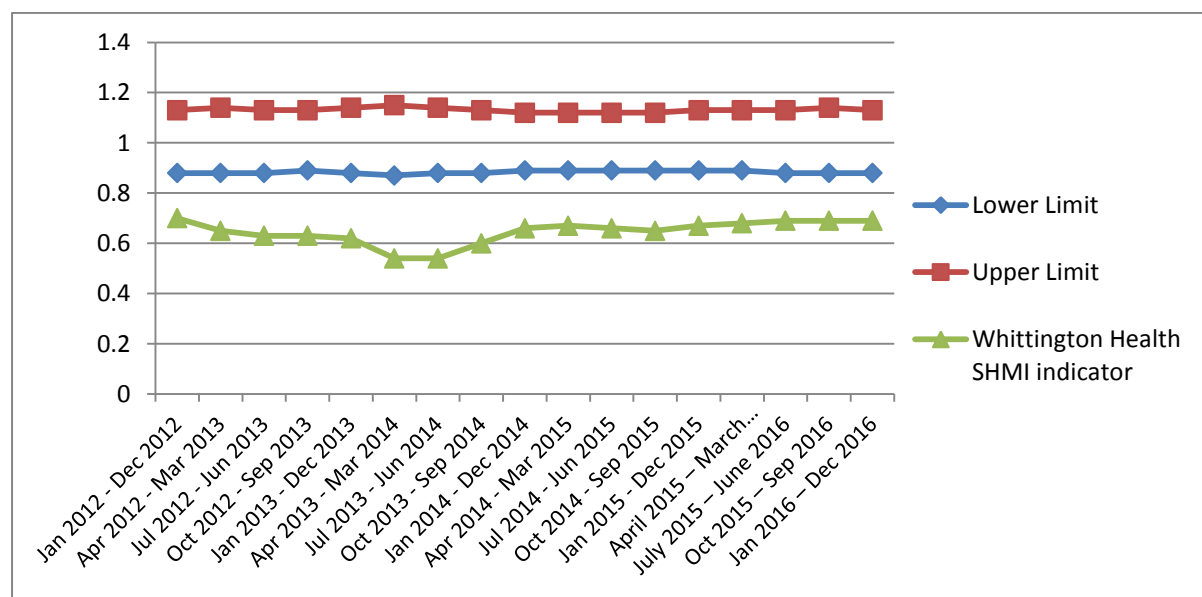
The most recent data available (released in June 2017) covers the period January 2016 – December 2016:

<b>Whittington Health SHMI score</b>	<b>0.6907</b>
<b>National standard</b>	<b>1.00</b>
<b>Lowest national score</b>	<b>0.6907 (Whittington Health)</b>
<b>Highest national score</b>	<b>1.1894</b>

**Table 1: Whittington Health Summary Hospital-level Mortality Indicator (SHMI) (April 2010 – September 2016)**

<b>Data Period</b>	<b>Lower Limit</b>	<b>Upper Limit</b>	<b>Whittington Health SHMI indicator</b>
Jan 2012 - Dec 2012	0.88	1.13	0.7
Apr 2012 - Mar 2013	0.88	1.14	0.65
Jul 2012 - Jun 2013	0.88	1.13	0.63
Oct 2012 - Sep 2013	0.89	1.13	0.63
Jan 2013 - Dec 2013	0.88	1.14	0.62
Apr 2013 - Mar 2014	0.87	1.15	0.54
Jul 2013 - Jun 2014	0.88	1.14	0.54
Oct 2013 - Sep 2014	0.88	1.13	0.6
Jan 2014 - Dec 2014	0.89	1.12	0.66
Apr 2014 - Mar 2015	0.89	1.12	0.67
Jul 2014 - Jun 2015	0.89	1.12	0.66
Oct 2014 - Sep 2015	0.89	1.12	0.65
Jan 2015 - Dec 2015	0.89	1.13	0.67
April 2015 – March 2016	0.89	1.13	0.68
July 2015 – June 2016	0.88	1.13	0.69
Oct 2015 – Sep 2016	0.88	1.14	0.69
Jan 2016 – Dec 2016	0.88	1.13	0.69

**Chart 2: Whittington Health Summary Hospital-level Mortality Indicator (SHMI) (January 2012 – December 2016)**



In the above Chart 2 the lower limit (blue diamonds) represents the lower 95% confidence limit from the national expected value; the upper limit (red squares) represents the upper 95% confidence limit from the national expected value.

## 4. Infection control report

### 4.1 MRSA Related Issues

There has been one Trust-attributable MRSA bacteraemia since 1 April 2017. The Post-Infection Review has taken place and it is likely that it was a contamination rather than a real bacteraemia. This has gone to the Department of Health for review and final attribution.

The Infection Prevention and Control Team (IPCT) continue to monitor, investigate and feedback on MRSA colonisation transmission events on our COOP wards, Orthopaedic Ward and Augmented Care Areas (Critical Care and Neonatal Unit). Table 2 documents MRSA colonisation events.

**Table 2: Whittington Health MRSA colonisation acquisition events April 2017-June 2017 (one Trust-attributable case)**

MRSA acquisition April 2017 - March 2018													
	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Running total
ITU	0	0	0										0
NICU	0	0	0										0
SCBU	0	0	0										0
Meyrick	0	0	0										0
Cloudesley	0	0	3										3
Bridges - Cavell rehab	0	3	0										3
Coyle #NOF	0	0	0										0
Cavell	0	0	0										0

#### 4.2 *Clostridium difficile* diarrhoea

For 2017-18 there have been six cases. Consultant-led Post-Infection Reviews have been held on all cases and the reports disseminated to relevant parties. The agreed tolerance for 2017/18 has also been set as 17. The breakdown of cases by ward is shown in table 3.

**Table 3: Whittington Health *Clostridium difficile*-associated diarrhoea cases by ward**

Date	No. of Cases	Ward
April 2017	2	Coyle, Cloudesley
May 2017	3	Victoria, Coyle, Cloudesley
June 2017	0	
July 2017	1	Cavell
August 2017 (to 29 <sup>th</sup> August 2017)	0	

The sixth case (July 2017) shown in table 3 was the same patient as case four (May 2017), the patient was found to be *C. difficile* positive with at least 28 days gap between specimens. A Post-Infection Review was performed and there were no issues with care of this patient.

The IPC nurses will continue to review all CDT requested samples daily. The IPC nurses update JAC and Medway with alerts.

#### **4.3 MSSA/*E.coli* Bacteraemia Episodes**

There has been one Trust-attributable MSSA bacteraemia since 1 April 2017. There are no set national or local thresholds for MSSA bacteraemia.

There have been three *E.coli* bacteraemias and short Post-Infection Reviews have been completed. We are attempting to reduce the number of *E.coli* bacteraemias by 20% this year to be on target for the national reduction by 50% by 2021. In 2016/17 there were 12 Trust-attributable *E.coli* bacteraemia episodes.

#### **4.4 Infection Prevention and Control Training**

Infection Prevention and Control mandatory clinical and non-clinical training is now provided predominately via E-learning. As of 30 June 2017, 80% of Whittington Health staff has received recent (within the last 2 years) IPC training.

Bespoke clinical and non-clinical face to face IPC training is delivered at least weekly at various sites throughout the ICO by our IPC nursing staff. IPC Link Practitioner study days are held twice a year. The last study day was held on 17 May 2017 excellent feedback was received from attendees. The next study day is scheduled for October 2017. Face to face IPC training is provided monthly for all staff.

#### **4.5 Other Relevant Healthcare Associated Infection (HCAI) Issues - Carbapenemase Producing Enterobacteriaceae (CPE)**

Since the last report there has been one new CPE case at Whittington Health. It was found in a rectal swab of a patient who had been in another hospital within the past 12 months. Unfortunately they had been in a bay of four; therefore patients who have been in contact with this patient have commenced screening.

For the year 2017/18 there have been two new CPE cases at Whittington Health, neither are Trust attributable.

### **5. Sign up to Safety**

'Sign up to Safety' is a national three-year patient safety initiative, partly in response to the Francis and Berwick Reports. Its aim is to reduce avoidable harm across the country by half in three years. In March 2015 the Trust devised our own local Sign Up to Safety priorities have been chosen to provide a strong foundation for the Trust to continually promote quality across the organisation.

Table 4 shows the Sign up to Safety pledges made by the Trust. This year, as in previous years, the quality priorities set for the Trust reflect the Trust's Sign up to Safety pledges; these were developed in consultation with the leads for each of the safety domains.

**Table 4: Whittington Health 'Sign up to Safety' pledges and Quality Account quality improvement priorities for 2017/18**

Domain	Agreed 'Sign up to Safety' Pledges	Lead	Year 3: Targets 2017-18 (Quality Account)
AKI	<b>We will aim for all cases of Acute Kidney Injury to be promptly recognised and appropriately treated.</b>	Mark Harber	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	<b>We will aim for all cases of severe sepsis to be recognised and treated according to the "sepsis six" care bundle early interventions within the first hour.</b>	Julie Andrews	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	<b>We will aim to reduce the number of in-patient falls that result in serious harm. We will ensure that every patient is assessed for risk of falling and that this risk is re-assessed in line with the patients' clinical needs in particular those patients with dementia. This will be supported by the continued development of a 'falls care bundle' for use in all acute clinical areas for high risk patients.</b>	Rebecca Maud/Jo Eardley	We will introduce 'StopFalls' bundles across the trust, and achieve 80% compliance with falls assessment documentation on the Acute Admissions Unit (AAU) and <i>Care Of Older People</i> wards.
			We will reduce the number of avoidable falls resulting in serious harm to patients year on year.
Pressure Ulcers	<b>We will aim to eliminate avoidable grade 3 and 4 pressure ulcers within our integrated care organisation.</b>	Jane Preece	To achieve a year on year reduction in all grades of pressure ulcers across the ICO.
			We are developing a cross borough target on the 'React to Red Initiative'.

Learning Disabilities	<b>We will aim to reduce avoidable harm and avoidable poor patient experience in patients with Learning Disability by putting in place recognised improvement initiatives to make our care more responsive to the individual needs of each patient.</b>	Helen Odiembo	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.

### 5.1 Sign up to Safety progress update – Falls

Whittington Health was one of 19 Trusts that took part in the NHS Improvement Falls Collaborative. The NHS Improvement Collaborative was a 90 day programme, between February and May 2017 aimed at helping trust to improve the management of falls in an inpatient setting. This programme was set up to re-energise the falls prevention improvement movement and ensure that providers have the information, skills and tools to reduce injurious inpatient falls and improve reporting and care.

Following involvement with the NHSI Collaborative a number of initiatives have been introduced, or re-energised. These have been led by the Trust's Lead Nurse for Falls Prevention and Awareness:

- “Bay watch” – this is a tag system whereby patients that have been risk assessed as having a high risk of falling are not left unsupervised when the nurse looking after that bay on the ward goes on a break, or needs to leave the bay for any reason. This has been introduced through the use of a badge for the bay. If the nurse looking after the bay needs to leave the bay for a short period of time then he/she will hand a badge to another colleague. Bay watch does not need to be undertaken by a nurse, and can be undertaken by any member of staff. Bay watch was launched at the Trust's recent Falls Week, which was held 19<sup>th</sup> – 23<sup>rd</sup> June.
- Lying and standing blood pressure readings – Lying and standing blood pressure readings are being taken for high risk patients to help assess the patient's risk of falling when they move from a lying or sitting position to a standing position.
- Last year the Trust introduced a new ‘Falls Prevention Bundle’, this bundle consists of updated nursing and medical documentation, wrist bands that are worn by patients who have been assessed as being at a high risk of falling, and colour coded magnets (yellow). The yellow magnets are used next to the patient's name on the patient boards that are used for staff handovers. This helps to ensure that all staff are aware of the patients on the ward who are at a higher risk of falling.

## 6. Safety and Quality Review: Heart Failure

Acute Heart Failure (HF) is a relatively common acute emergency and nationally HF either causes or complicates about 5% of emergency admissions. It is a life threatening condition and is often poorly managed resulting in a high inpatient-mortality. The quality of the care during an index admission also determines subsequent mortality and the disease burden for the patients. Optimal heart failure care can minimise, reduce or abolish the symptoms of shortness of breath, heavy legs and fatigue, amongst others. For many the same approach, of optimal inpatient HF care, will also reduce early readmissions and all-cause mortality over subsequent months and years.

In the UK approximately 900,000 people have heart failure and HF accounts for up to 2% of total NHS expenditure. This Trust admits about 250 patients per year where HF was thought to be the primary cause of that admission – interestingly whilst nationally there has been a step-wise increase in HF coded admissions, year by year, this figure has remained relatively constant for the Whittington, arguably reflecting the well-integrated HF services across Whittington Health.

National data has consistently shown that specialist cardiology care during inpatient admission, and initiation of optimal medical therapy, is associated with better patient outcomes both during the inpatient stay and at one year after discharge.

The National HF Audit for 2015/16 has just been released (in August 2017) and has been highlighted by NHS England, and recognised by the national media, as a “good news NHS story”. The National Heart Failure Audit was established in 2007 to monitor the care and improve the treatment of patients with acute heart failure in England and Wales. The Audit includes all patients discharged from hospital with a primary diagnosis of heart failure and so reports on 66,695 acute HF admissions, in this report.

The main positive finding of this latest national audit is that the figures for all-cause mortality in patients admitted to hospital because of heart failure is well down on those from 2014/15, both during the inpatient episode at 8.9% compared with 9.6%, and during follow up out to one year, reflecting the quality of inpatient care during the index admission. These figures are still far too high and the Whittington data shown in table 6 are well inside the published numbers, yet still give scope for improvement.

This national audit also contains hospital and trust specific data, from which numbers for the best practice tariff are taken and from which data to inform CQC inspections is also taken.

There are thirteen key heart failure quality measures that are included in the National Heart Failure Audit and that are published by Trust:

- The patient received an echo-cardiogram
- The patient was a cardiology inpatient
- The patient's care had input from the consultant cardiologist
- The patient's care had input from a specialist
- The patient with heart failure with left ventricular systolic dysfunction\* had ACEI (angiotensin converting enzyme inhibitors) on discharge
- The patient with heart failure with left ventricular systolic dysfunction\* had ACEI or ARB (angiotensin receptor blockers, where patients intolerant of ACEI) on discharge

- The patient with heart failure with left ventricular systolic dysfunction\* had a beta blocker on discharge
- The patient with heart failure with left ventricular systolic dysfunction\* had an MRA (mineralocorticoid antagonist) on discharge
- The patient received discharge planning
- The patient was referred to the heart failure nurse for a follow-up
- The patient was referred to the heart failure nurse for a follow-up (patients with Left ventricular systolic dysfunction only)
- The patient was referred to the cardiology team for a follow-up
- The patient was referred to cardiac rehabilitation

\*And no contraindication to specified treatment

The key data shows that this Trust is performing better than the national average figures for the Audit cycle in question (see below). This cycle was one in which Best Practice Tariff (BPT) was optional and it is the first time this Trust has achieved the required Best Practice Tariff targets, with a submission of 70% of HES coded HF, and of those patients 60% or more had also been seen by the Specialist HF team. The potential additional income from this for the Trust is estimated to be of the order of £150,000-£200,000 annually. In the cycle currently underway, submitting data for the BPT is no longer optional and a failure to meet the target may also result in a financial penalty for the Trust.

In summary, the data from this latest audit shows that this Trust out-performs the national average on twelve key heart failure quality measures and is close on the 13<sup>th</sup> as shown in table 5. However, comparisons with the preceding audit cycle 2014/2015 suggest there is no room for complacency. This table is useful in helping identify those areas where we need to invest and improve.

**Table 5: National Heart Failure Audit: Whittington Health (WH) 2014/15 and 2015/16 against National (Nat.) average for 2015/16**

	Echo	Montuschi Inpatient (specialist ward)	Consult. Cardio	Spec review	ACEI on discharge	ACEI or ARB on discharge	Beta blocker	MRA	Discharge Plan	HF nurse follow-up	HF nurse LVSD follow-up	Cardio follow-up	Ref to cardiac rehab
<b>Nat. average for 2015/16</b>	90%	45.7%	56.9%	79%	61%	73.7%	80.4%	45.4%	87.3%	54.8%	70.8%	47.2%	12.10%
<b>2015/16 WH</b>	100%	51.9%	74.7%	87.1%	86.4%	90.6%	93.8%	73%	89.9%	64.8	82.9%	63.2%	11%
<b>2014/15 WH</b>	96.8%	64.5%	82.6%	97.9%	90.9%	96.3%	96.4%	90.1%	90.3%	69.8%	81.8%	70.5%	14.4%

There are still important areas in which improvements could be made to the care this Trust gives to patients with heart failure, and some of these are summarised in table 6 below.

Alongside the important clinical aspects of this there is a very substantial amount of work going on to ensure accurate Audit data entry, and to ensure that that this corresponds appropriately with the HES coding for the hospital. A number of key colleagues, including

those in the Trust's Coding Department and those in the HF team, have worked very positively and professionally, often volunteering discretionary time, to ensure accurate audit data and coding for hospital discharges where a diagnosis of HF is being invoked.

The authors of this annual heart failure report have suggested that this data is presented by the HF lead to the Trust Board. This Trust's HF lead is Dr Suzanna Hardman, who is one of the co-authors of the national report and who has been instrumental in preparing this section of this Quarterly Safety and Quality Board Report. It is proposed that at a future date, Dr Hardman should, with a patient, present a patient story to the Board focused around heart failure, to provide some specific examples of the issues put into context by this report.

The full report is available in the public domain on the NICOR website using the following link:

<http://www.ucl.ac.uk/nicor/audits/heartfailure/documents/annualreports/annual-report-2015-6-v8.pdf>.

**Table 6: Heart failure – key successes and concerns**

National Audit	Key Successes	Key Concerns	Key Actions following the audit
National Heart Failure (HF) Audit 2015/2016 just published - August 2017	<p>The Whittington acute hospital met the criteria for the best practice tariff (BPT) for the 2015/2016 cycle for the first time.</p> <p>The best Practice Tariff is applied when: data from <math>\geq 70\%</math> of patients with a HES coded diagnosis of HF as the cause of the hospital admission are entered into the National Heart Failure Audit. For these patients, scrutiny of the Audit confirms that <math>\geq 60\%</math> had face-to-face specialist HF input during their admission.</p> <p>The Whittington outperformed the National Average on 12 of the 13 collected variables.</p> <p>In particular 100% patients had an echo (comparator 90%), 87% patients were seen by a specialist and 74% by</p>	<p>Although we outperformed the average from the National Audit for 2015/2016, when compared with our Audit data from the previous cycle, our performance was less good than our performance in the preceding cycle 2014/15 in 9 of 13 reported variables.</p> <p>We have concerns around the current level of administrative support for the Audit, and the HF team capacity - specifically the inpatient specialist nurse provision.</p>	<p>Widespread presentation of the data to the local team, and wider dissemination to clinicians, managers and others across the Integrated Care Organisation. This is to ensure that there is a better understanding of the required care for this vulnerable patient group, how that is best delivered, and the barriers to this happening. This will include a presentation to the Trust Board, as recommended in the Audit report.</p> <p>The administrative support for the Audit and the specialist HF nurse provision for the acute site will be under discussion.</p> <p>The Trust aims to integrate a HF bundle within the current electronic discharge summary, which would</p>

<p>consultant in cardiology, (with comparators of 79.1% and 56.9% respectively).</p> <p>For those with heart failure attributed to a reduced ejection fraction, 90.6%, 93.8% and 73% were discharged home on ACEI or ARB, Beta-blocker and MRA respectively – comparative figures for these key disease modifying drugs for the Audit mean were 73.7%, 80.4% and 45.4%.</p> <p>These key disease modifying drugs extend life expectancy; reduce symptoms and likelihood of readmission.</p> <p>Whittington Health all - cause inpatient mortality for acute admissions was &lt;50% of the 8.9% national figure, 25% of the 30 day and &lt;50% of the 12 month all-cause mortality for those who survived to discharge.</p>	<p>facilitate improved patient care, reliable <a href="#">Audit data</a> collection and support Trust HES coding for those patients in whom HF is invoked as a diagnosis.</p>
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## 7. Safety and Quality Review: Chronic Obstructive Pulmonary Disease (COPD)

There has been a well-established cycle of national COPD audits over the last 15 years that have been voluntary but with high participation rates that have driven quality improvement in COPD care. These have been led by the British Thoracic Society, The European Respiratory Society and more recently, The Royal College of Physicians.

The Royal College of Physicians has now been commissioned by HQIP to lead on future COPD audits which, from 2017, are mandatory and involve prospective, continuous data collection on all patients admitted with an acute exacerbation of COPD.

The National COPD Secondary Care Clinical Audit, which commenced in February 2017, requires prospective, 'real time' data collation study on a scale, not previously required at the Whittington.

The data for previous low volume, snap shot audits were collected retrospectively by members of the Respiratory Team. This model will not work for a prospective, ongoing audit of all patients admitted with an acute exacerbation of COPD, where the majority of patients are admitted onto an acute medical ward.

Data on more than 350 plus patients per annum who are cared for by a variety of teams in a variety of settings meet the inclusion criteria and therefore need to be uploaded. Data will need to be collated from every patient's case notes, using a RCP approved data collection tool and entered into a secure and bespoke web-based audit portal. The data collection tool is currently paper based however the plan is to also upload to Anglia ICE, for ease of usage.

Best practice tariff for COPD was introduced in April 2017 (for 2 year period) and attainment against the Tariff will be measured by this secondary care audit. Best practice will be considered achieved when (at a Trust level):

- 60% of patients with a primary diagnosis of COPD, admitted for an exacerbation of COPD, receive specialist input to their care within 24 hours of admission, *and*
- Where they receive a discharge bundle before discharge.

Whittington Health achieved the Best Practice Tariff for Q1, 2017. Of note, only 32 of 136 participating Trusts met this target (equating to 23.5%), demonstrating the significant challenge presented to Trusts.

#### **Resource requirements:**

The Trust is currently reviewing the resources that are required to meet this continuous audit.

**Quality improvement:** The core aim of this audit is to further drive improvements in the quality of care and services provided for COPD patients. Oversight is provided by the newly formed COPD Care Quality Review Group which is jointly led by a Consultant Respiratory Physician, Acute Medical Consultant and Head of Clinical Governance.

This has afforded a great opportunity for a multidisciplinary shared leadership team approach across acute medicine and respiratory medicine, to make real improvements to the quality of outcomes for this cohort of patients and for the Trust to demonstrate nationally, what we do well and the potential of an integrated care organisation to transform patient care.

The consequence of not undertaking this work will have a significant reputational impact to the Trust.

#### **What have we achieved thus far?**

- Achievement of the Best Practice Tariff for COPD, in the first Quarter of 2017;
- Good public demonstration of Whittington engagement at the first London, RCP led Workshop;
- Formation of a proactive, multidisciplinary group of clinical and operational staff to oversee the efficacy of this work and the facilitation of a number of QI offshoots such as, *ward spirometer provision assessment; planned cycle of respiratory ED '10 at*

*10s' from September 2017; pulse oximeter loan scheme for doctors – charitable funds bid.*

- Demonstrable delivery of high 'value' care for COPD patients:

#### *Acute Care*

- Make and treat for correct diagnosis
- Evidence-based care for respiratory failure
- Evidence-based care for frightening breathlessness
- Care delivered with kindness, respect and empathy

#### *Delivery of high value COPD interventions*

- Evidence-based treatment for tobacco dependence
- Explanation of & referral to pulmonary rehabilitation
- Enable mastery and self-care of COPD
- Responsibly prescribed inhaled therapy
- Co-ordination so care can continue

### **8. Dissemination of learning from Serious Incidents, near misses, inquests, complaints and claims**

#### **KnowledgeShare**

The Whittington Health Library team have worked to provide trust staff with KnowledgeShare. KnowledgeShare provides regular, personalised email updates about new high-level evidence and policy documents so as to remain informed about the latest developments in their field. Currently the trust has 528 staff members signed-up to receive the updates and feedback has been positive. The KnowledgeShare updates are now also adding Spotlight on Safety Bulletins are now being added to KnowledgeShare alerts.

#### **Grand Round**

The trust is relaunching its programme of Grand Rounds in September. Grand Rounds occur on Wednesday lunchtimes, each week is presented by a different team.

**Table 7: Grand Round topics for September 2017**

<b>Month</b>	<b>Wednesday</b>	<b>Topic</b>
<b>Sep</b>	<b>6</b>	Falls
	<b>13</b>	Patient story – surgical case
	<b>20</b>	VTE
	<b>27</b>	Emergency Medicine

## **Learning together – Learning disabilities**

The next Learning Together workshop is being planned around the theme of Learning Disability. The event will be divided into two sections - a patient story, which will be presented as part of the Grand Round, followed by facilitated group work later in the afternoon.

## **9. References**

1. NHS Digital Indicator Portal, NHS Digital, available from <https://indicators.hscic.gov.uk/webview/>
2. British Society for Heart Failure, National Heart Failure Audit <http://www.bsh.org.uk/resources/national-heart-failure-audit/>
3. Royal College of Physicians, National COPD audit, available from <https://www.rcplondon.ac.uk/projects/national-copd-audit-programme>
4. NICOR (UCL). National Heart Failure Audit 2015/16, available from <http://www.ucl.ac.uk/nicor/audits/heartfailure/documents/annualreports/annual-report-2015-6-v8.pdf>

## Whittington Health Trust Board

September 2017

<b>Title:</b>		CQC Inspection Update: September 2017					
<b>Agenda item:</b>		<b>17/114</b>		<b>Paper</b>		<b>07</b>	
<b>Action requested:</b>		For information					
<b>Executive Summary:</b>		This report will <ul style="list-style-type: none"><li>• update the Board on the recent changes to the CQC methodology and inspection framework,</li><li>• provide an outline of the current CQC inspection schedule for Whittington Health</li><li>• provide an overview of the CQC Insight profile for Whittington Health, published in July 2017</li></ul>					
<b>Summary of recommendations:</b>		n/a					
<b>Fit with WH strategy:</b>		Clinical Strategy					
<b>Reference to related / other documents:</b>		CQC inspection framework					
<b>Reference to areas of risk and corporate risks on the Board Assurance Framework:</b>		BAF and Corporate Risk Register					
<b>Date paper completed:</b>		24/8/17					
<b>Author name and title:</b>		<b>Gillian Lewis, Head of Governance and Risk</b>		<b>Director name and title:</b>		<b>Philippa Davies, Chief Nurse and Director of Patient Experience</b>	
<b>Date paper seen by EC</b>		<b>Equality Impact Assessment complete?</b>		<b>Risk assessment undertaken?</b>		<b>Legal advice received?</b>	



## **CQC Inspection: September 2017**

### **Background**

Following a consultation in 2016, the CQC have revised their methodology for regulating health and social care services to make it 'more targeted, responsive and collaborative'. In June 2017, the CQC published updated guidance outlining how they monitor, inspect and regulate NHS trusts. The key change since 2015 is that the CQC will now undertake more focused inspections, based on previous ratings and information received from a variety of sources including stakeholder feedback, performance data and independent reviews. The CQC have also introduced CQC Insight, a revised information sharing system which brings together in one place the information the CQC hold about services and analyses it to help the CQC decide what, where and when to inspect.

### **How the CQC inspect NHS trusts**

The CQC aim to inspect each trust at least once between June 2017 and spring 2019, in the next phase of regulation and approximately annually after that. The type of inspection will vary depending on the information the CQC have relating to the quality of services provided at the trust. The CQC's main approach is to carry out inspections of certain core services followed by an inspection of the well-led key question at trust level. However, in some cases the CQC will look at all core services (a comprehensive inspection) and sometimes just look at specific areas of concern (a focused inspection).

The inspection of the well-led key question will be announced and covers trust-wide leadership, governance, management and culture, as well as considering improvements and changes since the last inspection. A small team of inspectors and specialist advisors with appropriate experience will look at a range of evidence applicable at the overall trust board level. This includes interviews with board members and senior staff, focus groups, analysis of data, strategic and trust-level policy documents, and information from external partners. The scope and depth of assessment of the well-led question varies for each provider and will be carried out in conjunction with NHS Improvement where appropriate.

### **Frequency of Inspections**

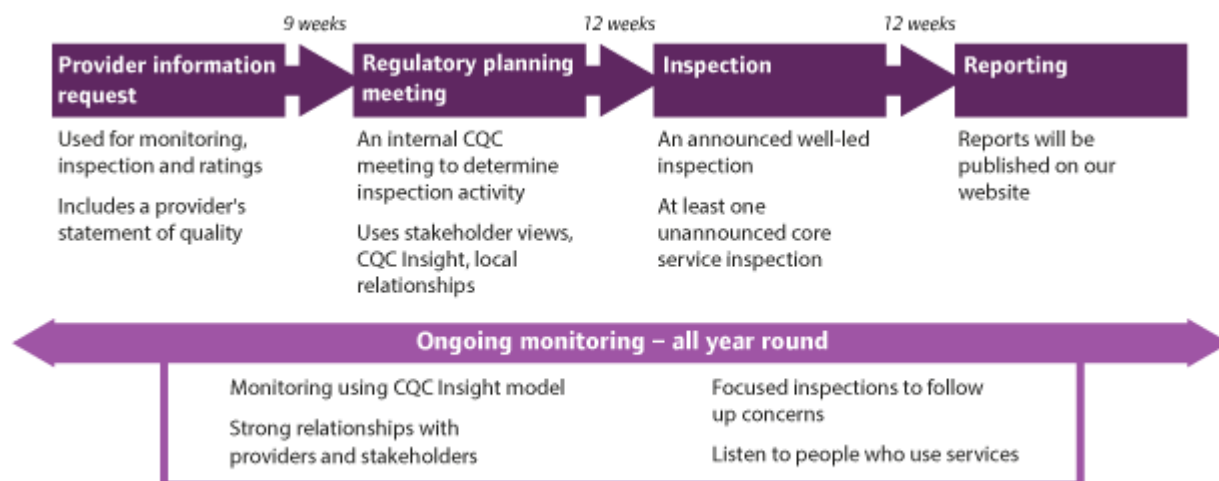
The CQC will use trusts' previous ratings as a guide to setting maximum intervals for re-inspecting its core services alongside its inspection of the well-led key question. However, these are maximum timeframes and the CQC will return more frequently depending on the information received from CQC Insight and key stakeholders. The maximum intervals for inspection are set as follows;

- one year for core services rated as inadequate
- two years for core services rated as requires improvement
- three and a half years for core services rated as good
- five years for core services rated as outstanding.

### **Schedule for Inspection**

The CQC send a provider information request (PIR) to trusts approximately once a year. This is a detailed information request for the trust including performance data, policy documents, and a self-assessment against all core services.

This request triggers the start of the inspection process, as outlined below.



## Whittington Health CQC Inspection 2017: Status Update

Whittington Health received a Provider Information Request (PIR) on 4<sup>th</sup> August 2017.

The CQC have asked the Trust to arrange a series of Staff Focus Groups on the 7<sup>th</sup> September 2017 with hospital and community staff, and the CQC will also be visiting hospital and community clinics to speak to patients about the quality of care at the trust, throughout this period.

Following receipt of the PIR and feedback from staff and patients, the CQC will hold a regulatory planning meeting to determine the level and areas for inspection. A date for the inspection of the well-led question at trust level will be announced and interviews with Board members and senior staff arranged.

In addition to the announced well-led inspection, the CQC will carry out at least one unannounced core service inspection based on information from the PIR, focus groups and CQC Insight. The ratings of each core service from the inspection in 2015 are outlined in Appendix B. Three services were rated as 'Requires Improvement'; critical care, outpatients, and community health services for children, young people and families. (Appendix A)

## CQC Insight July 2017: Overview

CQC Insight replaces the previous Quality and Risk Profiles and Intelligent Monitoring reports produced by the CQC. For all NHS trusts, CQC Insight gives inspectors:

- Facts and figures: contextual and descriptive information such as levels of activity, staffing and financial information.
- A ratings overview: the trust's latest CQC ratings with information about the direction of potential change suggested by the performance monitoring indicators.
- Intelligence overview: a summary of the analysis of the indicators selected to monitor performance. It is presented at provider, key question and, where available, core service level.
- Performance monitoring indicators: show a trust's performance compared with national standards or with other providers. They also indicate changes in a trust's performance over time, and whether its latest performance is an improvement, decline or about the same as

the equivalent period 12 months before. All indicators are mapped to CQC's five key questions and key lines of enquiry (KLOEs).

- Featured data sources: for example, the findings from national surveys, incident reports, mortality ratios and outliers.

The CQC Insight report published in July 2017 rated the trust as stable, and suggested no change to the ratings from the December 2015 inspection.

Of the 77 trust wide indicators, 2 (3%) are categorised as much better, 2 (3%) as better, 0 (0%) as worse and 0 (0%) as much worse than the national average. 37 indicators have been compared to data from 12 months previous, of which 4 (11%) have shown an improvement and 3 (8%) have shown a decline.

<b>Much better compared nationally</b>	<b>Worse compared nationally</b>	<b>Improved</b>	<b>Declined</b>
<ul style="list-style-type: none"> <li>Sick days for medical and dental staff (%)</li> <li>Summary Hospital-level Mortality Indicator (SHMI)</li> </ul>	<p><b>Maternal readmissions –</b> update report sent to CQC showing improvements</p>	<ul style="list-style-type: none"> <li>Confidence and trust in the nurses</li> <li>Flu vaccination uptake (63% to 80%)</li> <li>NRLS - Proportion of reported patient safety incidents that are harmful (35% to 26%)</li> <li>Patient-led assessment of environment for dementia care (76% to 91%)</li> </ul> <p><b>Core service areas:</b> <b>Urgent and Emergency Care</b></p> <ul style="list-style-type: none"> <li>Admissions waiting 4-12 hours from the decision to admit (Improved from 17% to 7%)</li> <li>Patients spending less than 4 hours in major A&amp;E (improved from 86% to 94%)</li> </ul>	<p>Hospital Standardised Mortality Ratio (Weekday) However, this is still better compared with the national average. (Reduced from 82% to 87%; Fractured NOF, pneumonia, AKI and UTI highlighted as areas of decline, improvements noted in acute bronchitis and acute myocardial)</p> <ul style="list-style-type: none"> <li>Never Events (2015/16 1 reported, 2016/17 2 reported)</li> </ul> <p><b>Core service areas:</b> <b>Surgery and Urgent and Emergency Care</b></p> <ul style="list-style-type: none"> <li>Referral to treatment within 18 weeks (Medicine 92% to 84%; Surgery 71% to 61%)</li> </ul> <p><b>Urgent and Emergency care</b></p> <ul style="list-style-type: none"> <li>Patients recommending the trust (Reduced from 93% to 84%)</li> <li>A&amp;E attendees spending more than 12 hours from decision to admit to admission (increased from 2% to 4%; rated as 'much worse' than national average)</li> </ul>

## Conclusion

- The Trust Board is asked to note; the recent changes to the CQC methodology and inspection framework, the current CQC inspection schedule for Whittington Health and the CQC Insight profile for Whittington Health, published in July 2017.

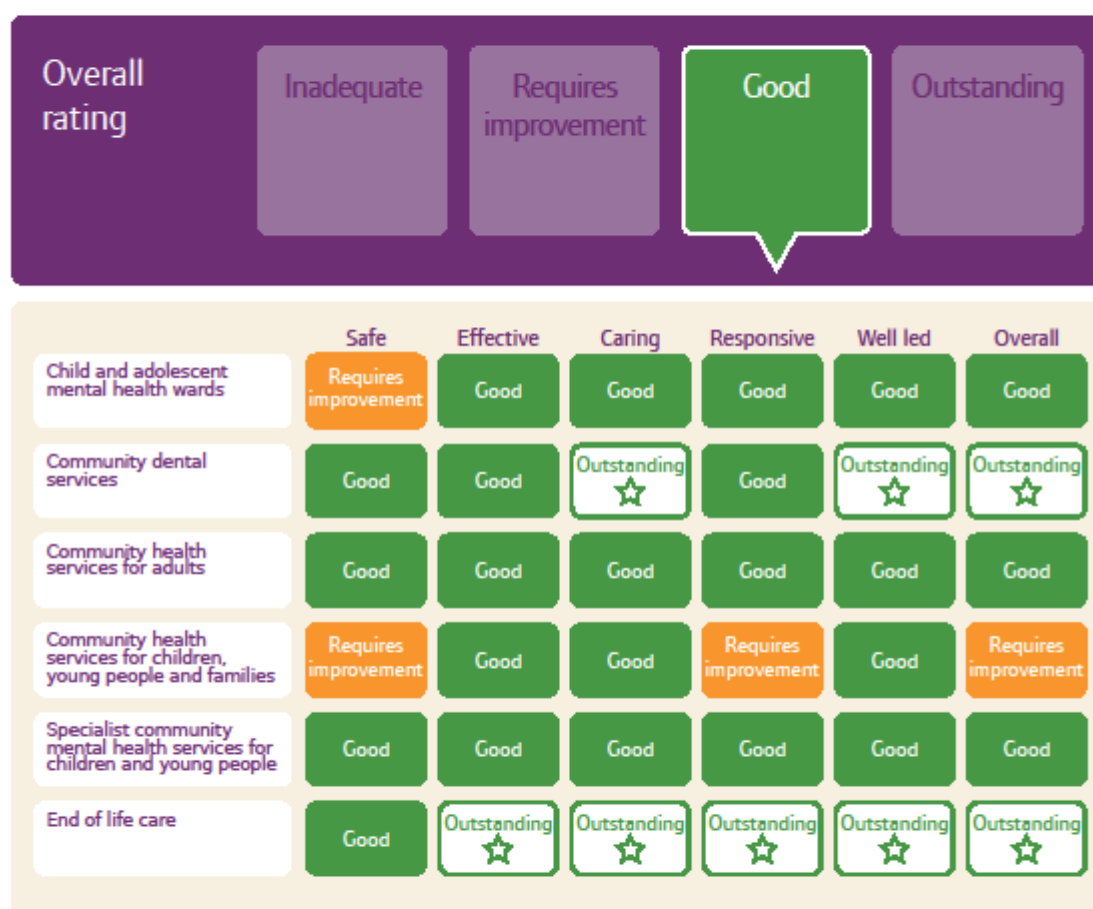
## Appendix A: CQC ratings broken down by core service (July 2016, following inspection in December 2015)

### 1. Community Services



Last rated  
8 July 2016

The Whittington Hospital NHS Trust



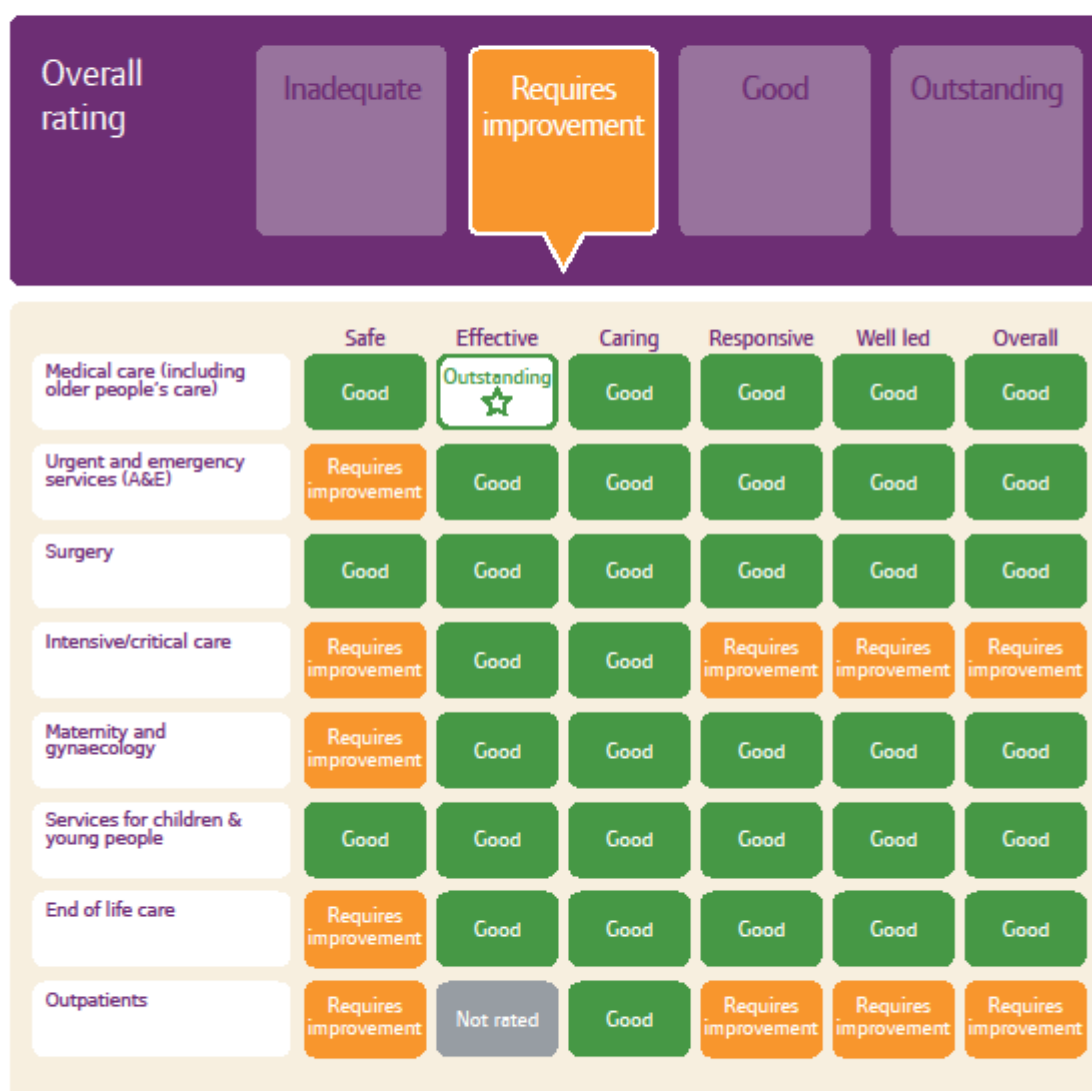
## 2. Hospital Services



Last rated  
8 July 2016

The Whittington Hospital NHS Trust

The Whittington Hospital



## Trust Board

2017

<b>Title:</b>		July (Month 4) 2017/18 – Financial Performance					
<b>Agenda item:</b>		<b>17/115</b>		<b>Paper</b>		<b>08</b>	
<b>Action requested:</b>		To agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends.					
<b>Executive Summary:</b>		<p>The Trust reported a £0.4m deficit for July (month 4) leading to a year to date deficit of £1.9m. This is against the planned year to date deficit of £1.8m (planned in month deficit £0.3m).</p> <p>Whilst income exceeded plan in month the Trust continued to overspend driven largely by the failure to achieve its cost improvement target which is now £2.3m behind plan. Whilst enhanced financial controls and non-recurrent measures have helped to bridge the gap it is becoming increasingly difficult.</p>					
<b>Summary of recommendations:</b>		To note the financial results relating to performance during July 2017					
<b>Fit with WH strategy:</b>		Delivering efficient, affordable and effective services. Meet statutory financial duties.					
<b>Reference to related / other documents:</b>		Previous monthly finance reports to the Finance & Business Committee and Trust Board. Operational Plan papers. Board Assurance Framework (Section 3).					
<b>Date paper completed:</b>		25 August 2017					
<b>Author name and title:</b>		<b>Anis Choudhury, Head of Financial Planning and Analysis</b>		<b>Director name and title:</b>		<b>Stephen Bloomer, Chief Financial Officer</b>	
<b>Date paper seen by EC</b>	<b>n/a</b>	<b>Equality Impact Assessment complete?</b>	<b>n/a</b>	<b>Quality Impact Assessment complete?</b>	<b>n/a</b>	<b>Financial Impact Assessment complete?</b>	<b>n/a</b>



## Financial Overview

The Trust is reporting a £0.4m deficit at the end of July (month 4) against a planned deficit of £0.3m. Actual performance therefore represents an adverse variance of £0.1m in month with the year to date position £0.1m adverse against plan.

Whilst income exceeded plan in month (£0.7m) the Trust continued to overspend (£0.9m) driven largely by the failure to achieve its cost improvement target which is now £2.3m behind plan for the year to date. Whilst enhanced financial controls and non-recurrent measures have helped to bridge the gap it is becoming increasingly difficult. The CIP was a challenging target but opportunities were identified to achieve it and it is the conversion of opportunity into road mapped plans which has created slippage in year and a number of opportunities have fallen away which is creating a gap. Forecasts suggest that in-year recurrent cost improvement is likely to be between £9-£12m with a most likely return being £11m meaning that mitigations of circa £6.5m would be required.

The year to date income position is £0.5m behind plan however current forecasts taking account of recovery plans suggest that the Trust will achieve its overall income plan but there remain a number of risks particularly on non-activity based commissioner income. It should be noted that first outpatient attendances are down materially which given referrals are broadly on trend waiting lists are increasing and there could be issues with operational targets as well as income in the coming months.

To respond to the predicted CIP shortfall the PMO is leading work on cross cutting initiatives and helping ICSUs to complete the final detail and quality impact assessment for schemes which are still in planning stage. In addition to this ICSUs are working with Finance to look at non-recurrent actions that can be taken to ensure that the agreed budgets are achieved.

The pressures above means that the Trust does not have reserves available to support new initiatives that do not have an in year pay back.

Statement of Comprehensive Income	In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	YTD Budget (£000s)	YTD Actual (£000s)	YTD Variance (£000s)
Nhs Clinical Income	22,367	22,921	553	87,710	87,410	(300)
Non-Nhs Clinical Income	1,943	1,567	(376)	7,727	7,275	(452)
Other Non-Patient Income	1,581	2,138	557	7,764	8,038	274
<b>Total Income</b>	<b>25,891</b>	<b>26,626</b>	<b>734</b>	<b>103,201</b>	<b>102,723</b>	<b>(478)</b>
Pay	18,210	18,554	(344)	73,016	73,400	(384)
Non-Pay	6,656	7,219	(563)	26,784	26,293	491
<b>Total Operating Expenditure</b>	<b>24,866</b>	<b>25,773</b>	<b>(907)</b>	<b>99,800</b>	<b>99,693</b>	<b>107</b>
<b>EBITDA</b>	<b>1,025</b>	<b>853</b>	<b>(173)</b>	<b>3,401</b>	<b>3,030</b>	<b>(371)</b>
Depreciation	722	668	54	2,884	2,672	212
Dividends Payable	346	346	0	1,384	1,384	0
Interest Payable	258	277	(19)	1,018	950	68
Interest Receivable	(3)	(1)	(2)	(12)	(6)	(6)
<b>Total</b>	<b>1,323</b>	<b>1,290</b>	<b>33</b>	<b>5,274</b>	<b>5,000</b>	<b>274</b>
<b>Net Surplus / (Deficit) - before IFRIC 12 adjustment</b>	<b>(298)</b>	<b>(437)</b>	<b>(140)</b>	<b>(1,873)</b>	<b>(1,970)</b>	<b>(97)</b>
Add back impairments and adjust for IFRS & Donated assets	(1)	(8)	(7)	(52)	(31)	21
<b>Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments</b>	<b>(297)</b>	<b>(430)</b>	<b>(132)</b>	<b>(1,821)</b>	<b>(1,939)</b>	<b>(118)</b>

## Income & Activity

In month, income improved against plan with a positive variance of £0.7m reducing the year-to-date underperformance to £0.5m.

The in month improvement was driven by the following key factors

- Other non-contract income (£0.4m) which is primarily dental mobilisation and offset by expenditure; and
- The commissioner QIPP plans should have begun to reduce activity from month 4 and are reflected in the in-month plan but to date there has been little evidence of success.

Other points of note are:

- Non-elective income and critical care income continued on trend and is behind plan in M4 is expected to be closer to plan by the year-end due to the phasing of QIPP schemes within agreed commissioner plans
- Outpatients have a year-to-date adverse variance of £0.7m this continued to deteriorate in month. First outpatients are 60% of the variance which is a major concern as this could indicate future issues with operational targets as well as income. The largest under performances are in General Surgery & Dermatology where waiting lists have risen and the affected ICSUs have recovery plans in place to return to planned activity levels.
- Whilst Day Cases continue to underperform it is offset by over-performance in outpatient procedures, predominantly in Urology.
- Other Clinical income is below plan due to reduced call to action Health Visiting income and the termination of the sexual health contract.

Month 04

Category	In Month Income Plan	In Month Income	In Month Variance	YTD Income Plan	YTD Income Actual	YTD Variance	In Month Activity Plan	In Month Activity Actual	In Month Variance	YTD Activity Plan	YTD Activity Actual	YTD Variance
Accident and Emergency	893	945	52	3,515	3,650	134	5,193	5,757	564	20,614	23,017	2,403
Adult Critical Care	702	181	(521)	2,763	2,224	(539)	715	496	(219)	2,818	1,973	(845)
Community Block	5,865	5,865	0	23,459	23,459	0	0	0	0	0	0	0
Day Cases	1,183	1,127	(56)	4,622	4,390	(231)	1,753	1,641	(112)	6,885	6,224	(661)
Diagnostics	229	238	9	894	865	(29)	2,271	2,133	(138)	8,870	8,646	(224)
Direct Access	997	901	(96)	3,893	3,646	(247)	91,201	86,524	(4,678)	356,159	352,447	(3,712)
Elective	717	832	115	2,816	3,123	307	180	214	34	707	816	109
Maternity - Deliveries	1,105	1,038	(67)	4,367	4,194	(173)	332	308	(24)	1,313	1,241	(72)
Maternity - Pathways	765	702	(63)	2,988	2,979	(9)	737	646	(91)	2,880	2,812	(68)
Non-Elective	4,183	4,013	(170)	16,446	15,807	(639)	1,557	1,646	89	6,230	6,119	(111)
OP Attendances - 1st	954	867	(87)	3,727	3,322	(406)	5,271	4,486	(785)	20,694	18,653	(2,041)
OP Attendances - follow up	841	796	(45)	3,287	3,029	(257)	12,446	11,656	(790)	48,833	48,778	(55)
Other Acute Income	2,212	3,685	1,474	8,505	9,641	1,135	12,075	10,975	(1,100)	47,309	46,159	(1,150)
Outpatient Procedures	318	415	97	1,240	1,503	263	1,778	2,158	380	6,963	8,367	1,404
<b>Total SLA</b>	<b>20,964</b>	<b>21,605</b>	<b>641</b>	<b>82,524</b>	<b>81,833</b>	<b>(691)</b>	<b>135,512</b>	<b>128,639</b>	<b>(6,872)</b>	<b>530,273</b>	<b>525,251</b>	<b>(5,022)</b>
<b>Marignall Rate</b>	<b>0</b>	<b>(200)</b>	<b>(200)</b>	<b>0</b>	<b>500</b>	<b>500</b>						
	<b>20,964</b>	<b>21,405</b>	<b>441</b>	<b>82,524</b>	<b>82,333</b>	<b>(191)</b>						
Other Clinical Income	3,204	3,081	(123)	12,770	12,346	(425)						
Other Non Clinical Income	1,723	2,139	416	7,907	8,045	138						
<b>Total Other</b>	<b>4,927</b>	<b>5,220</b>	<b>293</b>	<b>20,677</b>	<b>20,390</b>	<b>(287)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Grand Total</b>	<b>25,891</b>	<b>26,626</b>	<b>734</b>	<b>103,201</b>	<b>102,723</b>	<b>(478)</b>	<b>135,512</b>	<b>128,639</b>	<b>(6,872)</b>	<b>530,273</b>	<b>525,251</b>	<b>(5,022)</b>

## Monthly Run Rates – Expenditure

As noted above, the Trust is reporting an adverse expenditure position against plan. When comparing actual to plan the key driver is the failure to achieve CIP and whilst the enhanced financial control environment is offsetting part of this, the Trust is overspending and a step change is required to reduce expenditure.

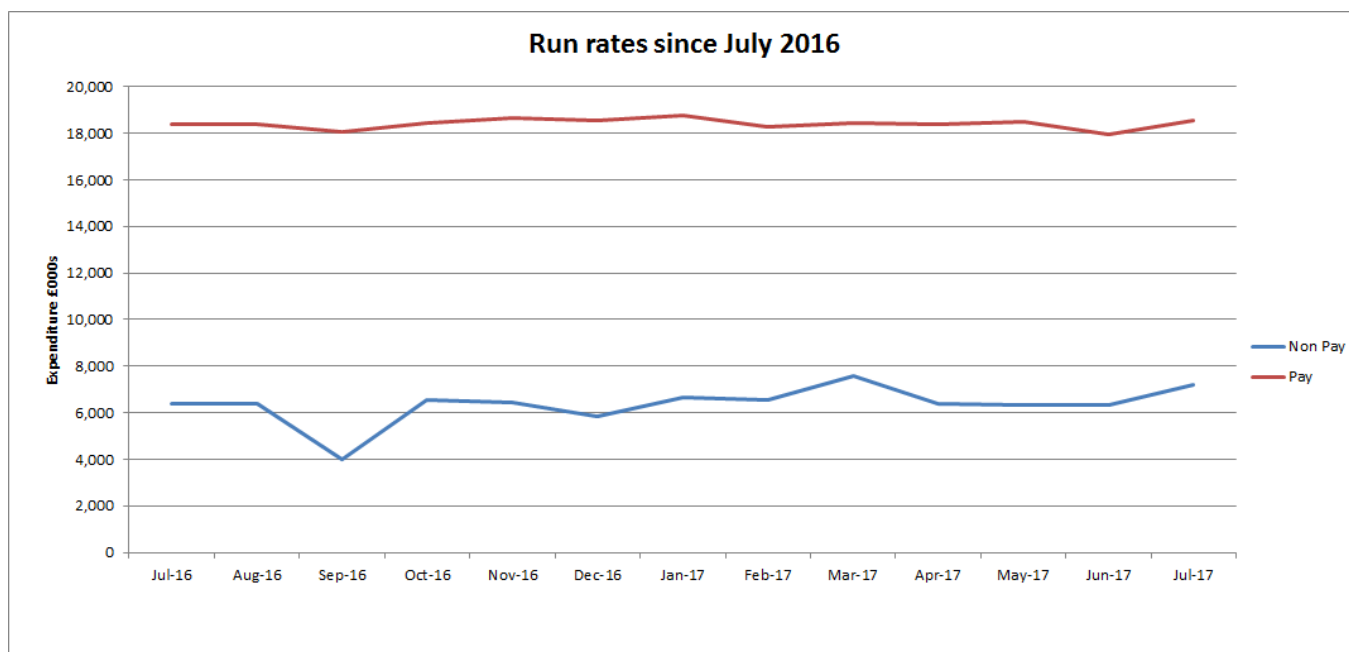
In run rate the key highlights for pay are:

- Total pay expenditure for July was £18.5m, which is £0.6m more than the previous month and £0.1m more than the 12 months rolling average.
- In month there was an increase in the staffing spend linked to dental mobilisation which is non-recurrent and backed by income (£0.4m). It is expected that the mobilisation will be delivered within the agreed funding limit.
- Agency staff related costs were £1.0m representing 5.5% of the June pay bill and is £0.1m more than each of the first three months of this financial year. The increased agency costs compared to month 3 were mainly in Children's and Emergency ICSUs. The Trust has established a staffing taskforce led by the Director of HR to reduce the staffing costs which will include a focus on agency spend. The Trust is currently exceeding the NHSI agency ceiling.

Non pay expenditure for July was £7.2m, which £0.9m greater than each month this financial year. This was due to

- the non-recurrent recognition of the majority of the third element of the FIP2 cost (£0.5m),
- increased expenditure in clinical supplies across the clinical ICSUs;
- child care packages has seen an increase in expenditure without a corresponding increase in income which is now creating a pressure for the Trust;
- establishment costs such as advertising and transport have increased which suggests financial controls have been less successful in month four than in the first quarter; and
- there has also been a step change in education and training expenditure.

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



## ICSU position

The table below provides an analysis of the expenditure run rates within clinical ICSUs from the end of 2016/17 through to the end of the first quarter (2017/18). When looking at ICSU trends it shows that cost is not reducing as required to achieve the CIP target.

<b>Pay</b>						
	Run Rate - Actual					
	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18
	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4
	£'000	£'000	£'000	£'000	£'000	£'000
Children's & Young People	3,975	3,934	3,896	3,955	3,945	3,941
Clinical Support Services	1,334	1,352	1,423	1,314	1,423	1,334
Corporate	2,246	2,449	2,431	2,714	2,097	2,973
Emergency & Urgent Care	2,036	2,042	1,992	1,969	2,036	2,133
Integrated Medicine	3,239	2,936	2,953	2,926	2,820	2,779
Patient Access, Prevention & Planned Care	1,025	1,038	1,018	1,014	977	943
Surgery & Cancer	2,796	3,124	3,138	3,006	3,059	3,007
Women's Health	1,619	1,565	1,553	1,571	1,614	1,444
<b>Total Pay - Clinical ICSUs</b>	<b>18,270</b>	<b>18,440</b>	<b>18,404</b>	<b>18,470</b>	<b>17,971</b>	<b>18,554</b>

### Non Pay

	Run Rate - Actual					
	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18
	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4
	£'000	£'000	£'000	£'000	£'000	£'000
Children's & Young People	142	215	180	219	180	203
Clinical Support Services	1,214	1,580	1,506	1,563	1,543	1,522
Corporate	3,949	3,844	2,918	2,863	2,840	3,729
Emergency & Urgent Care	203	265	223	234	327	277
Integrated Medicine	199	393	273	277	231	276
Patient Access, Prevention & Planned Care	172	287	154	134	187	220
Surgery & Cancer	555	797	973	836	858	874
Women's Health	131	223	163	197	193	119
<b>Total Non Pay - Clinical ICSUs</b>	<b>6,565</b>	<b>7,604</b>	<b>6,390</b>	<b>6,324</b>	<b>6,358</b>	<b>7,219</b>

### Combined Pay & Non Pay

	Run Rate - Actual					
	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18
	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4
	£'000	£'000	£'000	£'000	£'000	£'000
Children's & Young People	4,117	4,149	4,076	4,174	4,125	4,145
Clinical Support Services	2,548	2,932	2,929	2,877	2,965	2,856
Corporate	6,195	6,294	5,349	5,577	4,937	6,701
Emergency & Urgent Care	2,239	2,307	2,215	2,203	2,363	2,410
Integrated Medicine	3,438	3,329	3,226	3,203	3,051	3,055
Patient Access, Prevention & Planned Care	1,197	1,325	1,172	1,148	1,164	1,163
Surgery & Cancer	3,351	3,921	4,111	3,843	3,917	3,882
Women's Health	1,750	1,788	1,716	1,768	1,808	1,563
<b>Total Non Pay - Clinical ICSUs</b>	<b>24,835</b>	<b>26,045</b>	<b>24,794</b>	<b>24,794</b>	<b>24,329</b>	<b>25,773</b>

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. Corporate includes the dental mobilisation income and expenditure which has a net nil effect on the Trust bottom line but is material in run rate

## Cost Improvement Programme

The Trust has a £17.8m CIP target for 2017/18. To date £9.1m of plans have been agreed and recognised as road mapped within the Programme Management Office (PMO), leaving a balance of £8.6m to be confirmed as schemes from additional initiatives.

The Trust's planning submission identified a delivery target of £4.6m by month 4. Actual delivery is £2.2m resulting in a shortfall of £2.3m against plan. Those schemes with full road mapped status are to date delivering in line with the PMO expectation. The two critical issues for the Trust are

- a) The gap where schemes are not fully signed off as road mapped; and
- b) The phasing of the road mapped schemes is creating further slippage.

The PMO is therefore leading the work to close the gap on CIP by

1. Working with ICSUs to complete the planning on schemes so that they have rigorous and detailed delivery plans, are quality impact assessed and be committed as road map status schemes
2. Working with ICSU leadership teams to convert opportunity and draft plans in to full schemes
3. Taking forward cross cutting initiatives e.g. community productivity, procurement and staffing taskforce to create savings that will count towards the targets; and
4. Working on non-recurrent schemes to plug the gap created in-year through slippage

Failure to achieve in-year cost reduction is now the key financial risk to the Trust and current forecasts put the shortfall in the region of £6.5m creating a material mitigation challenge.

Current performance by ICSU is:

Integrated Clinical Service Unit	Annual Plan £'000			YTD		
		Identified £'000	Gap £'000	Target £'000	Actual £'000	Variance £'000
Children's services	3,065	1,559	1,506	794	397	(397)
Clinical Support Services	2,334	1,086	1,248	604	134	(470)
Emergency & Urgent Care	2,157	525	1,632	559	166	(393)
Medicine, Frailty & Network Services	2,132	1,160	972	552	279	(273)
PPP	874	368	506	226	215	(11)
Surgery	3,159	1,894	1,265	818	498	(320)
Women's services	1,498	882	616	388	205	(183)
Estates & Facilities	1,322	993	329	342	111	(231)
Corporate	1,236	637	599	320	251	(69)
<b>Total</b>	<b>17,777</b>	<b>9,104</b>	<b>8,673</b>	<b>4,603</b>	<b>2,256</b>	<b>(2,347)</b>

# Statement of Financial Position

## THE WHITTINGTON HEALTH NHS TRUST

### Statement of Financial Position

	Year to Date		
	As at 31 July 2017 £000	Plan 31 July 2017 £000	Plan variance 31 July 2017 £000
Property, plant and equipment	207,949	201,748	6,201
Intangible assets	3,541	2,255	1,286
Trade and other receivables	1,352	851	501
<b>Total Non Current Assets</b>	<b>212,842</b>	<b>204,854</b>	<b>7,988</b>
Inventories	1,575	150	1,425
Trade and other receivables	23,465	28,533	(5,068)
Cash and cash equivalents	7,128	4,030	3,098
<b>Total Current Assets</b>	<b>32,168</b>	<b>32,713</b>	<b>(545)</b>
<b>Total Assets</b>	<b>245,010</b>	<b>237,567</b>	<b>7,443</b>
Trade and other payables	39,882	42,743	(2,861)
Borrowings	1,787	2,812	(1,025)
Provisions	443	756	(313)
<b>Total Current Liabilities</b>	<b>42,112</b>	<b>46,311</b>	<b>(4,199)</b>
<b>Net Current Assets (Liabilities)</b>	<b>(9,944)</b>	<b>(13,598)</b>	<b>3,654</b>
<b>Total Assets less Current Liabilities</b>	<b>202,898</b>	<b>191,256</b>	<b>11,642</b>
Borrowings	58,257	63,866	(5,609)
Provisions	1,647	1,513	134
<b>Total Non Current Liabilities</b>	<b>59,904</b>	<b>65,379</b>	<b>(5,475)</b>
<b>Total Assets Employed</b>	<b>142,994</b>	<b>125,877</b>	<b>17,117</b>
Public dividend capital	62,404	62,404	0
Retained earnings	(14,579)	(14,603)	24
Revaluation reserve	95,169	78,076	17,093
<b>Total Taxpayers' Equity</b>	<b>142,994</b>	<b>125,877</b>	<b>17,117</b>
<b>Capital cost absorption rate</b>	<b>3.5%</b>	<b>3.5%</b>	<b>3.5%</b>

The key highlights for the month four are

**Cash:** The cash balance is £3.1m above plan at the end of month 4. This is due to the receipt of debt settlements as mentioned above from NHS England, NHS and non-NHS partners.

**Receivables (Debtors)** are currently £5.1m below plan. As described above a number of material debtors have been settled including NHS (particularly Royal Free) and non-NHS (particularly London Borough of Haringey).

**Payables (Creditors)** are currently £2.8m below plan which is driven by movement towards the better payments guidance by using higher cash balances to drive improved performance in payment of creditors (particularly non-NHS) during 2017/18 to date.

**Capital:** £0.7m of capital expenditure has been incurred year to date against a plan of £1.0m. Within the June 2017 plan resubmission, the Trust increased its capital plan by £2.6m to recognise the re-investment of incentive and bonus STF into the Trust's capital programme. It has been noted that this has not yet been reflected as an increase to the capital resource limit by DH.

**Property, Plant & Equipment:** As previously reported the value held for assets is and will remain high than plan (£7.4m) as full valuation exercise undertaken as at 31 March 2017 created a higher value than the planning expectation.



## Whittington Health Trust Board

6<sup>th</sup> September 2017

<b>Title:</b>	Trust Board Report May 2017 (July data)		
<b>Agenda item:</b>	<b>17/116</b>	<b>Paper</b>	<b>09</b>
<b>Action requested:</b>	For discussion and decision making		
<b>Executive Summary:</b>	<p><b>Highlights</b></p> <p><b>Emergency and Urgent Care</b></p> <p>Performance against the 95% target remained at 92% in July, whilst the medium time to treat target fell to 59% against a target of 60%. The sustained improvement is a result of the ED improvement plans embedding into practice.</p> <p>In June the Department had seven '<b>black</b>' <b>breaches</b> which occurred during the heatwave (19<sup>th</sup> - 25<sup>th</sup> June ) when the system was challenged with an increase in ED attendances and admissions</p> <p>Improving LAS handovers is part of the ongoing ED improvement plan.</p> <p>There were two <b>12 hour trolley waits</b> in July both of which were mental health patients requiring mental health bed transfers. ECIP have now completed the Mental Health System review and there are a number of key recommendations include – mental health CNS triage, consideration of recovery room to reduce long waits and improvement in flow at mental health trust. Whittington Health are working closely with Camden &amp; Islington Mental Health trust I to embed these into practice. We also continue to work closely with the trust to ensure that timely and robust escalation processes are embedded in practice both in an out of hours.</p> <p><b>Cancer</b></p> <p>Cancer <b>62 day</b> performance fell short of the target for June 2017 with a total of 3.5 breaches.</p> <p>There were 2 x 0.5 breaches for gynaecology. And 2.5 in urology</p> <p>We continue to work with partners around speciality pathways to achieve compliance with the 62 day target.</p>		

	<p><b>RRT 18 week waits – 52 weeks</b></p> <p>There were 3 x 52 week breaches reported in July with the clock incorrectly stopped in all three cases. The specialities where these breaches occurred were in vascular, general surgery and spinal.</p> <p>Two patients – general surgery and vascular have been booked for procedures, the third patient has declined. None of these patients have come to any harm as confirmed by the respective clinical teams.</p> <p>A refreshed training and audit programme is now in place to address any shortfall in training and monitoring.</p> <p><b>Delayed Transfer of Care</b></p> <p>The reported month saw an overall improvement in numbers with ongoing work to ensure that DTOCs are maintained at a manageable number.</p> <p>Additional capacity is now in the Discharge team to support ward teams and are aligned with flow co-ordinators with daily reviews of medically optimised patients.</p> <p><b>Complaints</b></p> <p>The trust standard of 80% of complaints responded to within 25days was not met in July (76%) but we are confident that the target will be achieved for August.</p> <p><b>Human resources</b></p> <p>Both Appraisal and Mandatory Training compliance remain static at 80% and 82% respectively. With the appointment of the new Assistant Director of OD and investment in the learning and development team, objectives have been set to support managers in ensuring both mandatory training and appraisal compliance is improved. All subject matter experts are involved in reviewing how training is delivered.</p>
<b>Summary of recommendations:</b>	That the board notes the performance.
<b>Fit with WH strategy:</b>	All five strategic aims
<b>Reference to related / other documents:</b>	N/A
<b>Reference to areas of risk and corporate risks on the Board Assurance Framework:</b>	N/A

<b>Date paper completed:</b>		30 <sup>th</sup> August 2017					
<b>Author name and title:</b>		<b>Carol Gillen</b>		<b>Director name and title:</b>		<b>Carol Gillen, Chief Operating Officer</b>	
<b>Date paper seen by EC</b>		<b>Equality Impact Assessment complete?</b>		<b>Quality Impact Assessment complete?</b>		<b>Financial Impact Assessment complete?</b>	





Whittington Health **NHS**

**Integrated Performance Report**

**August 2017**

**Month 4 (2017 – 2018)**

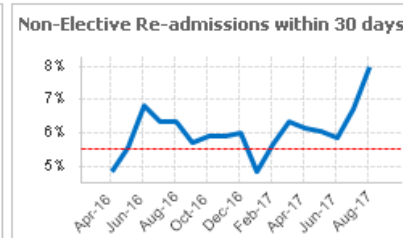
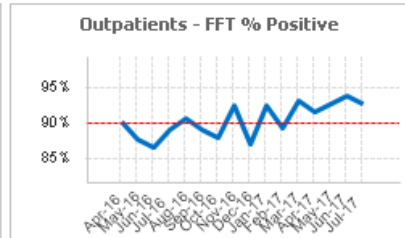
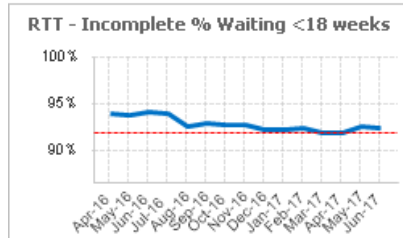
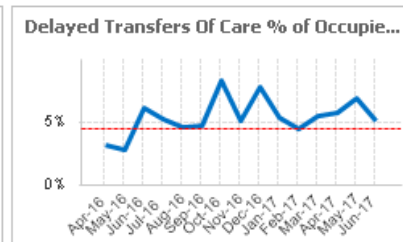
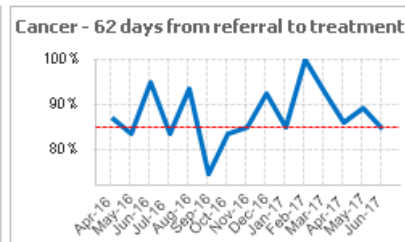
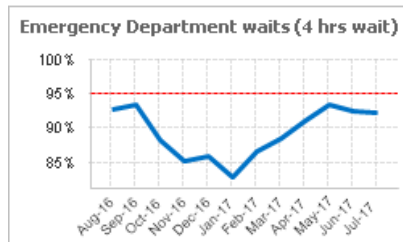


Section	Page
Performance Summary	
Safe Services	
Caring Services	
Effective Services	
Responsive Service	
Well Led Services	
Activity	



## Summary Page - Indicators

Category	Indicator	17_18 Target	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	Q1 May-17	Q1 Jun-17	Q2 Jul-17	2017-2018
ED	Emergency Department waits (4 hrs wait)	>95%	92.7%	93.4%	88.1%	85.1%	85.8%	82.9%	86.6%	88.4%	91.1%	93.5%	92.4%	92.2%	92.3%
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	60	62	75	88	76	77	69	72	72	68	63	59	65
Cancer	Cancer - 14 days to first seen	>93%	97.7%	96.6%	97.8%	95.5%	93.4%	94.8%	96.8%	94.6%	93.2%	93.2%	95.3%		93.9%
Cancer	Cancer - 62 days from referral to treatment	>85%	93.5%	74.5%	83.3%	85.0%	92.3%	84.9%	100.0%	92.9%	86.0%	89.1%	84.4%		86.6%
Admitted	Non Elective Re-admissions within 30 days	<5.5%	6.3%	5.7%	5.9%	5.9%	6.0%	4.8%	5.7%	6.3%	6.1%	6.0%	5.8%	6.7%	6.2%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	4.5%	4.6%	8.2%	5.1%	7.7%	5.3%	4.5%	5.5%	5.8%	6.9%	5.0%		5.9%
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.7%	93.1%	92.9%	92.8%	92.2%	92.2%	92.4%	92.0%	92.0%	92.6%	92.4%	92.0%	92.3%
Outpatients	Outpatients - FFT % Positive	>90%	90.8%	89.2%	88.0%	92.6%	87.0%	92.5%	89.4%	93.1%	91.6%	92.8%	93.9%	92.8%	92.9%
Community	Community - FFT % Positive	>90%	97.5%	98.4%	98.1%	98.2%	98.7%	98.0%	96.8%	96.0%	98.5%	94.9%	93.9%	94.8%	95.3%
Staff	Staff - FFT % Recommend Care	>70%		76.2%						74.6%					





## Safe Services - Indicators and Performance

Category	Indicator	17_18 Target	Q2	Q2	Q3	Q3	Q3	Q4	Q4	Q4	Q1	Q1	Q1	Q2	2017-2018	Performance
			Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17		
Admitted	Admissions to Adult Facilities of pts under 16 yrs of age	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Admitted	HCAI C Difficile	<17	0	0	0	0	0	0	1	1	2	3	0	1	6	
All Areas	CAS Alerts Outstanding	0	0	0	0	0	0	0	3	0	0	0	0	0	0	
All Areas	Actual Falls	400	31	38	45	30	45	56	45	31	31	44	45	34	154	
All Areas	Avoidable Grade 3 or 4 Pressure Ulcers	0	5	5	5	1	3	2	1	2	2	1	2		5	
All Areas	Harm Free Care %	>95%	91.9%	90.8%	93.3%	92.6%	93.2%	94.3%	92.9%	92.5%	93.2%	93.9%	96.6%	93.5%	94.3%	
Maternity	Non Elective C-Section % Rate	>15%	17.4%	20.2%	17.7%	21.6%	17.4%	20.5%	18.0%	21.4%	19.2%	18.9%	19.7%	22.5%	20.1%	
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	1	0	0	0	1	0	0	0	1	0	1	
Admitted	Never Events	0	1	0	1	0	0	0	0	0	0	0	0	0	0	
All Areas	Proportion of reported Patient Safety Incidents Causing Harm	N/A	21.6%	21.8%	19.9%	20.1%	21.1%	21.3%	19.5%	22.4%	18.1%	16.6%	22.5%	17.3%	18.4%	
All Areas	Serious Incidents	0	4	6	9	8	3	4	5	4	2	4	4	3	13	
Admitted	VTE Risk Assessment %	>95%	96.2%	96.6%	97.3%	96.4%	95.9%	96.1%	96.0%	96.5%	95.2%	95.4%	95.6%		95.4%	



## Safe Services - Commentary

### **Avoidable pressure ulcers**

July 2017 there was 2 avoidable grade 3 pressure ulcers reported.

1. South East Islington DN team, patient sustained a grade 3 pressure ulcer to the right buttock from prolonged sitting in a wheelchair. The patient was not assessed for appropriate pressure relieving equipment for bed or chair, the patient was not being repositioned frequently as no information had been provided.
2. Cavell ward, patient acquired a grade 3 to the lateral aspect of the right foot as the patient was not repositioned frequently enough due to inadequate pain relief for the patient to allow staff to reposition the patient. The Waterlow risk assessment was incomplete and inaccurate so no prevention plan was implemented.

### **C. difficile associated diarrhoea**

As of the 29 August, there have been six Trust attributable C. difficile infections at Whittington Health for the year 2017-18. Two of these were in the same patient. Post Infection Reviews (PIR) have been performed on all of these cases and all have been determined as not avoidable. During the PIR for the patient with two positive results, it was determined that the initial infection had been treated appropriately but that the second infection was likely to be due to a continuing infection.

### **Non Elective C-section rate**

There is an increasing induction of labour (gap/grow reduced foetal movement (RFM)) which is similar across all NCL trusts. The Trust dashboard (unlike NCL) also includes premature and multiple pregnancies.

WH are continuing to run a vbac for women to aim for vaginal birth following previous Cs – they are also using cooks balloon for some women to increase chances of women going into labour



## Caring Services - Indicators and Performance

			Q2	Q2	Q3	Q3	Q3	Q4	Q4	Q4	Q1	Q1	Q1	Q2		
Category	Indicator	17_18 Target	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	2017-2018	Performance
ED	ED - FFT % Positive	>90%	92.4%	95.6%	89.9%	82.1%	83.8%	83.4%	83.9%	83.0%	84.0%	87.4%	84.0%	85.5%	85.3%	
ED	ED - FFT Response Rate	>15%	3.4%	4.1%	4.1%	16.6%	16.6%	14.6%	16.0%	14.6%	16.9%	15.6%	13.8%	13.1%	14.9%	
Admitted	Inpatients - FFT % Positive	>90%	96.0%	95.1%	95.8%	92.7%	95.8%	92.1%	96.1%	94.1%	98.0%	94.2%	97.0%	95.8%	96.2%	
Admitted	Inpatients - FFT Response Rate	>25%	15.4%	20.4%	18.3%	18.0%	12.6%	7.2%	17.1%	26.8%	21.6%	22.7%	19.8%	20.9%	21.2%	
Maternity	Maternity - FFT % Positive	>90%	93.2%	91.1%	91.6%	93.8%	94.8%	88.0%	89.4%	92.4%	93.6%	90.2%	88.1%	92.7%	91.3%	
Maternity	Maternity - FFT Response Rate	>15%	18.9%	24.2%	23.1%	12.8%	24.6%	30.4%	24.0%	27.8%	24.7%	22.2%	20.1%	23.5%	22.6%	
Outpatients	Outpatients - FFT % Positive	>90%	90.8%	89.2%	88.0%	92.6%	87.0%	92.5%	89.4%	93.1%	91.6%	92.8%	93.9%	92.8%	92.9%	
Outpatients	Outpatients - FFT Responses	400	229	305	408	516	193	481	407	551	357	623	537	485	2002	
Community	Community - FFT % Positive	>90%	97.5%	98.4%	98.1%	98.2%	98.7%	98.0%	96.8%	96.0%	98.5%	94.9%	93.9%	94.8%	95.3%	
Community	Community - FFT Responses	1500	609	621	645	880	549	697	1095	1169	725	1192	970	1224	4111	
Staff	Staff - FFT % Recommend Care	>70%		76.2%						74.6%						
All Areas	Complaints responded to within 25 working day	>80%	85.3%	85.7%	100.0%	100.0%	89.3%	66.7%	90.0%	100.0%	100.0%	83.3%	93.9%	76.0%	87.4%	
All Areas	Complaints (including complaints against Corporate division)	N/A	38	32	25	19	32	22	34	38	22	24	38	32	116	



## Caring Services - Commentary

### FFT

The patient experience manager is working with services to increase response rates and ensure that the devices and paper surveys are available as required. Volunteers are also being utilised to support survey collection with a particular focus in outpatients.

The recommended rate for the emergency department continues to be slightly below the target of 90%. The department recently undertook a detailed analysis of their FFT responses and developed an action plan to address themes. Actions taken to improve staff attitude and quality of care have included: 1. Leadership study day for all Band 6 nurses (who often work in triage) focussing on standards, communication and developing a culture of quality, safe care. 2. Customer care training for all ED reception staff and all new starters. 3. Quality checks conducted by matrons

All other areas achieved a recommend rate of 90% or more.

### Complaints

During July 2017 the Trust closed 32 complaints; 25 required a response with 25 working days and 7 complaints were allocated 40 working days for investigation. The Trust achieved a performance of 76%, falling slightly short of its 80% target against 25 working day target, Of the 7 complaints allocated 40 working days, only 1 (14%) has hit its target. 6 complaints are currently still outstanding and overdue i.e. IM (3), EUC (1) and S&C (2).

The majority of the complaints had been allocated to IM 25% (8), WH 19% (6) and S&C 16% (5). 53% (17) were designated 'moderate' risk and 44% (14) complaints were designated 'low with one complaint risk assessed as 'high'.

A review of the complaints for July shows that, as in Q1 (April – June), 'medical care' 41% (13) was cited as the main issue in the majority of complaints, followed 'attitude' 19% (6).

In regard to 'medical care' most patients 46% (6) felt that 'inadequate treatment' had been provided (as in June) and in regard to 'attitude' the issues related primarily to staff being 'rude and/or disrespectful' 50% (3). Of the complaints that have closed, (including those allocated 40 working days), 31% (8) were 'upheld', and 31% (8) were 'partially upheld', meaning that at present 62% have been upheld in one form or another.



## Effective Services - Indicators and Performance

			Q2	Q2	Q3	Q3	Q3	Q4	Q4	Q4	Q1	Q1	Q1	Q2	2017-2018	Performance
Category	Indicator	17_18 Target	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17		
Maternity	Breastfeeding Initiated	>90%	91.5%	90.6%	94.2%	90.2%	90.1%	90.1%	90.6%	91.6%	90.2%	91.6%	93.6%	93.2%	92.2%	
Maternity	Smoking at Delivery	<6%	4.4%	4.8%	3.2%	5.1%	4.8%	3.6%	5.6%	3.0%	5.4%	3.4%	5.7%	7.5%	5.5%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	6.3%	5.7%	5.9%	5.9%	6.0%	4.8%	5.7%	6.3%	6.1%	6.0%	5.8%	6.7%	6.2%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	92.3	61.7	83.2	93.2	61.4	77.9	80.0	56.5						
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	96.7	90.1	81.6	91.2	22.7	104.4	28.9	59.2						
Trust	Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 months	1.14		0.69			0.69									
Admitted	Mortality rate per 1000 admissions in-months	14.4	5.8	4.2	6.5	7.9	7.2	11.7	9.1	7.9	7.2	7.6	6.5	6.4	6.9	
Community	IAPT Moving to Recovery	>50%	51.7%	52.3%	45.7%	47.1%	52.4%	50.4%	49.1%	48.4%	50.3%	53.0%	56.4%		53.3%	



## Effective Services - Commentary

### **Smoking at delivery**

Smoking cessation provider's services have changed since April 2017 with Solutions for Health providing the service for Camden and Islington. - and One You Haringey – previously there was one provider (Whittington Health)  
Out of area women are referred to their GP or local pharmacy for support which proves challenging in terms of referrals and in ting smoking data. Solutions for health now run a clinic hospital site (Camden and Islington women only).  
In order to reduce DNAs text reminders are sent to encourage attendance and screening is offered to all pregnant women for carbon monoxide (CO) levels at booking and at 28 weeks which is compliant with NICE guidance.



## Responsive Services - Indicators and Performance

			Q2	Q2	Q3	Q3	Q3	Q4	Q4	Q4	Q1	Q1	Q1	Q2	2017-2018	Performance
Category	Indicator	17_18 Target	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17		
ED	Emergency Department waits (4 hrs wait)	>95%	92.7%	93.4%	88.1%	85.1%	85.8%	82.9%	86.6%	88.4%	91.1%	93.5%	92.4%	92.2%	92.3%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	60	62	75	88	76	77	69	72	72	68	63	59	65	
ED	Ambulance handovers waiting more than 30 mins	0	13	16	26	45	68	113	68	60	28	14	40		82	
ED	Ambulance handovers waiting more than 60 mins	0	1	0	1	4	22	37	13	3	1	0	7		8	
ED	12 hour trolley waits in A&E	0	0	1	1	1	0	2	3	2	5	4	3	2	14	
Cancer	Cancer - 14 days to first seen	>93%	97.7%	96.6%	97.8%	95.5%	93.4%	94.8%	96.8%	94.6%	93.2%	93.2%	95.3%		93.9%	
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	100.0%	100.0%	97.2%	98.2%	100.0%	93.4%	98.7%	92.9%	96.0%	94.1%	100.0%		96.6%	
Cancer	Cancer - 62 days from referral to treatment	>85%	93.5%	74.5%	83.3%	85.0%	92.3%	84.9%	100.0%	92.9%	86.0%	89.1%	84.4%		86.6%	
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%		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%		100.0%	
Cancer	Cancer - 31 days to subsequent treatment - drugs	>93%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	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%		100.0%	
Cancer	Cancer - 62 Day Upgrade															
Access	DM01 - Diagnostic Waits (<6 weeks)	>99%	99.5%	99.7%	99.5%	99.8%	99.1%	99.1%	99.6%	99.2%	99.0%	99.1%	99.1%	99.0%	99.1%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.7%	93.1%	92.9%	92.8%	92.2%	92.2%	92.4%	92.0%	92.0%	92.6%	92.4%	92.0%	92.3%	
Access	Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	0	0	0	0	0	0	0	0	3	3	



## Responsive Services - Commentary

### **Cancer 62 day performance for June 2017**

#### **Total of 3.5 breaches**

There were 2 x 0.5 breaches for gynaecology. One was sent on time to UCLH for treatment, and second had a number of delays in diagnostics at WH and was a late referral to UCLH

There were 2.5 breaches for urology. 1 was due to delay in timing for CT and Bone scan as early pathway was very timely, 0.5 breach was due to complex pathway where patient was referred as a suspected upper GI cancer, and the 1.0 breach was due to problems with equipment not available and also a clinic had to be cancelled due to lack of Registrar cover.

#### **RRT 18 week waits – 52 weeks**

There were 3x 52 week breaches reported in July with the clock incorrectly stopped in all three cases. The specialities where these breaches occurred were in vascular, general surgery and spinal.

Two patients – general surgery and vascular have been booked for procedures, the third patient has declined. None of these patients have come to any harm as confirmed by clinical team.

#### **Actions taken:**

All 2583 patients on the 'stopped clock' list were validated following the discovery of the first 52 week breach with 2 further confirmed (within the 3 reported in July)

Clock stop list included on the Patient Tracker Level (PTL) list and reviewed at weekly PTL meeting.

Implementation of revised training programme over seen by in-house validation team – targeting specific pathways

Clock stop audits included in ICSU data quality audit -



## Responsive Services - Indicators and Performance

			Q2	Q2	Q3	Q3	Q3	Q4	Q4	Q4	Q1	Q1	Q1	Q2	2017-2018	Performance
Category	Indicator	17_18 Target	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17		
Theatres	Hospital Cancelled Operations	0	6	1	4	6	2	15	7	5	6	9	9		24	
Theatres	Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	0	0	0	2	0	0		2	
Theatres	Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0	0	0	0		0	
Admitted	Delayed Transfers Of Care - Days Lost	N/A	191	199	364	267	348	236	192	255	245	300	210		755	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	4.5%	4.6%	8.2%	5.1%	7.7%	5.3%	4.5%	5.5%	5.8%	6.9%	5.0%		5.9%	
Maternity	Women seen by HCP / midwife within 10 weeks	>50%	69.1%	72.8%	69.4%	67.2%	67.8%	54.1%	57.5%	50.9%	45.8%	52.8%	48.7%	58.0%	51.6%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%	93.8%	94.6%	94.4%	94.3%	97.2%	97.2%	93.6%	93.3%	97.5%	96.5%	94.7%		96.2%	
Community	GUM - Appointment Offered within 2 days	>98%	97.8%	99.2%	99.9%	99.6%	99.8%	99.3%	99.5%	99.3%	98.7%	99.3%	99.1%		99.0%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	94.6%	94.2%	91.8%	92.2%	91.6%	91.3%	93.3%	87.5%	88.6%	93.8%	91.9%		91.4%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	93.7%	88.3%	93.3%	94.1%	94.6%	94.8%	93.3%	90.7%	90.3%	94.1%	96.1%		93.5%	
Community	Haringey - HR1 % carried out before child aged 15 months		52.4%	48.4%	38.8%	41.2%	35.4%	33.1%	35.2%	41.8%	42.2%	38.8%	43.8%		41.6%	
Community	Haringey - HR2 % carried out before child aged 30 months		15.2%	14.4%	45.6%	50.8%	46.6%	46.6%	41.8%	44.1%	40.6%	31.1%	36.1%		35.8%	
Community	Islington - HR1 % carried out before child aged 15 mths		61.4%	55.2%	55.2%	55.6%	66.4%	56.2%	61.2%	66.0%	70.0%	69.0%	69.8%		69.6%	
Community	Islington - HR2 % carried out before child aged 30 mths		60.7%	68.6%	70.1%	72.9%	70.9%	78.7%	73.3%	76.7%	77.1%	70.1%	67.3%		71.6%	
Community	Haringey - 8wk Review % carried out before child aged 8 weeks		0.5%	1.0%	3.4%	3.8%	11.3%	10.7%	13.9%	17.2%	20.8%	27.2%	32.6%		26.9%	
Community	Islington - 8wk Review % carried out before child aged 8 weeks		5.5%	5.3%	4.6%	4.8%	3.9%	5.6%	4.1%	2.1%	15.2%	29.4%	42.2%		29.8%	



## Responsive Services - Commentary

**Cancelled operations-**There were 9 cancelled operations for June 2017 of which one was urgent which was one of two patients who had been scheduled for a Hickman line insertion, both of which were cancelled as an emergency case ran over which took priority.

1 urology patient was cancelled due to equipment failure.

2 T&O patients were cancelled as the trauma cases ran over into the elective time, and as such had to be cancelled

3 T&O patients were cancelled as on the day there was not enough staff to cover the list.

1 gynae patient was cancelled due to a patient who was scheduled to take 40 minutes took 2 hours instead and therefore there was no theatre time left.

All cancelled operations were re-booked within 28 days

### **Delayed Transfer of Care-**

June saw an improvement in overall numbers with ongoing work to ensure that DTOCs are managed which includes escalation as per agreed protocol.

Additional capacity is now in the Discharge team to support ward teams and is aligned with flow co-ordinators with regular review of medically optimised patients and patients over length of stay (LOS) over 7 days.

### **New Birth visits:**

95% standard achieved for Islington however drop to 91.9% for Haringey - due to late births –( Late births due to: 5x in hospital, 8x parent unavailable/uncontactable, 1x late notification, 6x out of borough/transferred.)

**HCP 10 weeks** -The National Screening Committee set a KPI of 50% of women who refer before 10 completed weeks are booked and have a result available for Haemaglobinopathies by 10weeks and 0 days. We have achieved more than 50% for five out of seven months from January 2017 to July 2017. All referrals are prioritised with aim to offer booking appointment by 9 weeks. The service works closely with labs to ensure that results are available in a timely manner.



## Well Led Services - Indicators and Performance

			Q2	Q2	Q3	Q3	Q3	Q4	Q4	Q4	Q1	Q1	Q1	Q2	2017-2018	Performance
Category	Indicator	17_18 Target	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17		
HR	Appraisals % Rate	>90%	66%	63%	66%	66%	67%	72%	75%	80%	80%	79%	79%	78%		
HR	Mandatory Training % Rate	>90%	81%	80%	81%	81%	82%	81%	82%	82%	82%	82%	82%	82%		
HR	Permanent Staffing WTEs Utilised	>90%	87.1%	87.0%	88.1%	88.1%	87.7%	87.7%	87.8%	87.8%	88.7%	88.9%	87.4%		88.4%	
HR	Staff FFT % recommended work	>50%		59.7%						60.5%						
HR	Staff FFT response rate	>20%		24.9%						24.4%						
HR	Staff sickness absence %	<3.5%	3.2%	3.6%	3.8%	3.8%	3.7%	3.7%	3.6%	3.2%	2.7%	2.4%	3.4%		2.8%	
HR	Staff turnover %	<10%	15.5%	15.7%	15.4%	14.9%	15.4%	15.3%	15.1%	14.3%	14.8%	14.4%	14.0%	14.7%	14.5%	
HR	Vacancy % Rate against Establishment	<10%	12.9%	13.0%	11.9%	11.9%	12.3%	12.3%	12.2%	12.2%	11.3%	11.1%	12.6%		11.6%	

			Q2	Q2	Q3	Q3	Q3	Q4	Q4	Q4	Q1	Q1	Q1	Trend
Category	Staff Type	17_18 Target	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	
Medical	Average staff cost per patient		96	92	98	88	101	94	89	125	107	91	95	
Nursing	Average staff cost per patient		180	171	173	160	186	182	174	237	190	169	169	
Other	Average staff cost per patient		196	174	191	178	200	188	194	256	217	198	194	



## Well Led Services - Commentary

### Human Resources

All key workforce indicators remain static in month.

With the appointment of the new Assistant Director of OD and investment in the learning and development team, objectives have been set to support managers in ensuring both mandatory training and appraisal compliance is improved. All subject matter experts are being involved in reviewing how training is delivered.

The Performance Review Groups in July allowed each ICSU the opportunity to present in depth analysis of sickness absence across their teams. Assurance was given on all those who required being managed in accordance with Trust policy and procedures.

Vacancy rates are high in nursing across the Trust. The overseas appointments will begin to have an impact from October onwards. The appointment of a Clinical Nurse Manager within the Recruitment and Temporary Staffing Offices is going to provide additional focus and impetus in nurse recruitment as we move towards the winter months



## Activity - Indicators and Performance

			Q2	Q2	Q3	Q3	Q3	Q4	Q4	Q4	Q1	Q1	Q1	Q2	Activity
Category	Indicator	17_18 Target	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	
ED	ED Attendances	8285	7513	8020	8253	8271	8238	8254	7430	8527	8285	8699	8239	8538	
ED	ED Admission Rate %		17.8%	16.7%	16.2%	16.6%	17.5%	17.2%	17.1%	16.9%	17.2%	17.3%	17.3%	16.4%	
Community	Community DNA Rate %	<10%	5.6%	5.5%	5.2%	5.4%	5.5%	5.3%	5.5%	5.1%	4.8%	5.2%	5.7%	5.2%	
Community	Community Face to Face Contacts		56844	62907	62175	67370	56605	63709	59274	69974	55461	66093	62694	61168	
Admissions	Elective and Daycase		1769	1937	1948	1876	1714	1879	1686	1850	1618	1790	1930	1897	
Admissions	Emergency Inpatients		2117	2078	2036	2124	2110	2067	1926	2200	2117	2212	2131	2161	
Referrals	GP Referrals to an Acute Service		5903	6341	5976	6314	5165	5823	5416	6742	5168	6317	5979	5780	
Maternity	Maternity Births	333	299	337	315	324	301	312	274	309	301	332	321	313	
Maternity	Maternity Bookings	377	299	301	353	365	319	323	308	382	309	414	304	337	
Outpatients	Outpatient DNA Rate % - New	<10%	11.9%	12.3%	11.1%	11.3%	12.7%	12.4%	11.8%	12.0%	12.4%	11.9%	11.3%	11.9%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	9.8%	11.2%	10.1%	10.1%	11.7%	12.5%	12.2%	11.9%	11.7%	11.8%	10.3%	12.1%	
Outpatients	Outpatient New Attendances		8362	8908	8660	9575	7910	8771	8364	9153	7499	9323	9000	8451	
Outpatients	Outpatient FUp Attendances		18091	18524	18666	19769	17109	18506	16880	18851	15492	18411	18655	16707	
Outpatients	Outpatient Procedures		6258	6014	6265	6181	5628	5957	5239	5793	4973	6099	6357	5743	
Theatres	Theatre Utilisation	>85%	78.2%	81.8%	81.5%	83.7%	83.5%	72.8%	81.1%	82.7%	84.9%	85.9%	82.7%	83.4%	



## Average Tariff by Point of Delivery (POD)

			Q2	Q2	Q3	Q3	Q3	Q4	Q4	Q4	Q1	Q1	Q1
Category	Point of Delivery (POD)	17_18 Target	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Average Tariff	Daycases		588	616	663	694	664	682	664	657	739	727	709
Average Tariff	Elective		3601	4027	3831	4099	4402	2522	3785	4214	3772	2701	3726
Average Tariff	Non-Elective		2107	2117	2153	2196	2132	2383	2180	2165	1790	1883	2356





## Responsive Services - Commentary

### **ED four hours' wait and Ambulance handover time**

Performance against the 95% target remained at 92% in July, whilst the medium time to treat target fell to 59% against a target of 60%. The sustained improvement is a result of the ED improvement plans embedding into practice and improved flow through the system.

### **LAS handovers**

The 7 breaches occurred during the heatwave over 19<sup>th</sup> - 25<sup>th</sup> June

The heatwave in June saw a spike in ED attendance, admissions to hospital, and over the same period an increase in DTOCs.

During this time the ED team continued to work closely with LAS colleagues to ensure quick turnaround times but at some points this did lead to hand overs taking longer than usual resulting in 7 60 hour breaches.

In order to support the continued improvement of LAS handover times, WH are engaged in a number of initiatives including; having a dedicated LAS triage nurse who greets the ambulance crew and takes handover, increasing the consultant numbers to speed senior decision making and in turn hand over times and exploring an IT function to facilitate a 'fast triage'.

### **12 hour trolley waits in A&E**

Both 12 hour trolley waits in July were informal mental health patients requiring mental health bed transfers. ECIP completed the Mental Health System review and the report and recommendations are currently being signed off,

The key recommendations include – mental health CNS triage, consideration of recovery room to reduce long waits and improvement in flow at mental health trust. Whittington Health will work closely with Camden and Islington Mental Health Trust to implement these changes. The organisation also continues to work closely with the trust to ensure that timely and robust escalation processes are embedded in practice both in an out of hours.

<b>MEETING:</b>	WH Trust Board
<b>AGENDA: 17/ 118</b>	Paper 11
<b>DATE:</b>	6 September 2017
<b>TITLE:</b>	North London Partners in Health & Care - Sustainability and Transformation Plan
<b>AUTHOR:</b>	NCL STP Lead David Stout
<b>PRESENTER:</b>	Simon Pleydell, Chief Executive Officer

## Introduction

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

## Background

Following publication of the *Case for Change* in September 2016, the draft STP was submitted to NHS England on 21<sup>st</sup> October 2016 and was published in November 2016. The draft plan was described as a 'work in progress' and we invited comments from the public and other stakeholders while we continued to develop the more detailed delivery plans.

An updated version of the draft STP was published in February 2017 to reflect the more detailed work that had taken place in advance of agreeing NHS contracts at the end of December 2016 for 2017/18 and 2018/19. A commitment was made to publish a more complete update of the STP, including an updated financial analysis by the end of April 2017.

## Updated plan

The updated plan confirms the overall vision we put forward in October 2016 and reflects the detailed more granular planning which has been undertaken over the last six months. All comments received on the draft plan have been responded to and where applicable addressed in the updated plan.

The plan sets out:

- Our vision: A place where no-one gets left behind
- Our strategic framework for change covering prevention; service transformation; productivity; and enablers
- The programme governance to achieve the change
- Detailed plans for prevention; health & care closer to home; urgent & emergency care; planned care; mental health; cancer; maternity; children & young people; workforce; estates; and digital
- An updated financial analysis, including investment plans
- Our approach to communications and engagement
- Equalities analysis and impact assessment
- Conclusion and next steps

Although we are committed to publication of the STP as part of our commitment to openness and transparency, it remains a technical planning document. We will therefore

also produce an updated plain English public facing summary of the plan.

In line with national thinking as set out in the *Next Steps on the Five Year NHS Forward View* document published at the end of March 2017, we have reframed the STP as a partnership of health & care organisations: *North London Partners in Health & Care*. Other London STPs have adopted a similar approach. The Communications & Engagement workstream proposed the move away from 'North Central London' as North London better reflects the identity of the area we cover. In the future we hope to be able to widen the partnership to include for example the voluntary and community sector.

## **Financial position**

We have worked hard to identify opportunities to deliver efficiencies in the way in which we deliver health and care. This plan sets out the impact we believe we can achieve. However the plan does not yet balance the finances, either next year or by 2020/21. There are significant pressures on budgets particularly in 2017/18. We will continue to look for opportunities for further efficiencies, including one-off measures that can improve the financial position in the short run pending full implementation of the transformational changes which we plan to deliver over the next few years.

We know that this is probably not be enough to bring our plan into financial balance. To support our plan, we will continue to work with NHS England and NHS Improvement to help us to produce a set of affordable NHS plans 2017/18 as part of the *Capped Expenditure Process*. This aims to help us deliver the best possible clinical outcomes for local people within the funding available. Commissioners and providers will work together on this process through our existing STP partnership arrangements in agreeing plans, engagement, undertaking impact assessments and delivery

Any proposals from the Capped Expenditure Process will be need to be fully assured they are consistent with constitutional rights for waiting times and patient choice and to ensure that patient safety and quality is safeguarded. If any proposals are developed in relation to service reconfiguration these will be subject to full public consultation in line with our legal duties. As proposals are developed we will ensure that patients and staff are engaged throughout the planning and implementation stages of CEP.

## **Next Steps**

Bringing health and care together in a way that is sustainable, while also making improvements to how we deliver services is challenging. The environment in which we work is constantly changing and we must be ready to respond when it does. While we are fully committed to implement the STP as set out, we know our plan will continue to evolve. There may be new opportunities we can embrace, or decisions to be made about the viability of some of the things we currently do. We will work closely with local people and communities and our staff deciding what further changes are needed and in how we implement these changes. At the heart of every decision is our commitment to deliver the health and care the people of North London expect and deserve.

**RECOMMENDED ACTION:**

The Board is asked to:

- NOTE the reframing of the STP partnership of health & care organisations: *North London Partners in Health & Care*
- ENDORSE the *North London Partners in Health & Care* Sustainability and Transformation Plan
- NOTE the intention to produce a plain English public summary of the plan
- NOTE the commitment to continue to work with NHS England and NHS Improvement to produce a set of affordable NHS plans for 2017/18 as part of the Capped Expenditure Process
- DISCUSS the next steps

**SUPPORTING PAPERS:**

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

- North London partners in health and care – our sustainability and transformation plan;





**NORTH LONDON  
PARTNERS**  
in health and care


June 2017

**Working together for  
better health and care:**  
our sustainability and  
transformation plan



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## Foreword

Welcome to our plan for health and care in North London.

Health and social care services in North London have become 'partners in health and care' to improve the access and quality of services, and to make the system more efficient. As partners, we serve a population of more than 1.5 million people from the London boroughs of Barnet, Camden, Enfield, Haringey and Islington.

This is our plan for changing the way the health and social care services in North London work, to bring them together to provide the entire local population with access to the best possible health, care and wellbeing services, and to make North London a place where no-one is left behind.

We have a proud history of providing high quality health and care services. We have an important role to play in delivering the **NHS Five Year Forward View** and other national health and social care policy. We need to ensure our services can adapt to meet future needs and are financially sustainable against a backdrop of increasing demand. In particular, we need to support services work better together, both in hospital and the community, to keep people well and independent and to help them recover when they are unwell.

On 31 March, NHS released the **Five Year Forward View Next Steps**. This update provides us with an opportunity to relook at our local plan and to make some adjustments so that our focus remains aligned to the national priorities while delivering at local level.

Our current system is unsustainable. The health and social care needs of our local people are changing and the way we are currently organised means that waiting times for some services, as well as the health outcomes vary. As our population ages, we now need to consider how people will receive care and what that care may look like. We believe there is the scope to provide more services closer to people's homes. Working alongside local authorities, we can design and deliver the right care in the right setting so that everyone can live and age with dignity. We need to do more to recognise the mental health as well as the physical health needs of our population. We want the standard of care and people's experience of health and social services to be of the highest quality.

Our financial situation remains challenging as the demand for health and social care continues to grow year on year, exceeding any increase in funding.

We have worked hard to identify challenging but achievable opportunities to deliver efficiencies in the way in which we deliver health and care. This plan sets out the impact we believe we can make. However, the plan does not yet balance the finances, either next year or by 2020/21. There are significant pressures on budgets particularly in 2017/18. We will continue to look for opportunities for further efficiencies, including one-off measures that can improve the financial position in the short run pending full implementation of the transformational changes that we plan to deliver over the next few years.

We know that this is probably not be enough to bring our plan into financial balance. To support our need to achieve financial balance, we will continue to work with NHS England and NHS Improvement as part of the Capped Expenditure Process to help us to produce a set of affordable NHS plans 2017/18, which potentially includes difficult choices. This aims to help us deliver the best possible clinical outcomes for local people within the limited funding available.

Bringing health and care together in a way that is sustainable, while also making improvements to how we deliver services, is challenging. The environment in which we work is constantly changing and we must be ready to respond when it does. Our plan will continue to evolve. There may be new opportunities we can embrace, or decisions to be made about the viability of some of the things we currently do. We will work closely with local people, communities and our staff when deciding what further changes are needed and in how we implement these changes. At the heart of every decision is our commitment to deliver the health and care the people of North London expect and deserve.



## Executive summary

It has been over a year since we came together as a partnership of 21 health and social care organisations in North London. During this time, we have invested time, energy and resources into building strong relationships with each other and developing a shared vision for a health and care system that can deliver high quality services to our community where and when they need, while becoming more sustainable.

We have undertaken significant work to identify, articulate and quantify the specific gaps in health and wellbeing; care and quality; and our baseline financial position. We agree on the nature and scale of the challenge described in our **Case for Change** (published September 2016).

Creating a healthier population is at the heart of our plan. Our vision is for our community to be happier, healthier and to live longer in good health. To do this we must embrace the opportunities that working together can deliver. We must look to emerging technologies and finding new and better ways of working that can eliminate duplication and waste and we must develop and support a motivated, highly skilled and professional workforce to serve North London.

As partners we have a shared vision, a collective agenda and the commitment to transform the health and care services of North London.

Every day the media report on the pressure experienced by the health and social care system. We know that to meet the demands of our population now and into the future we must do things differently. We have already invested time and resources into finding new ways of working. Our community has told us they want a more joined up and integrated health and care system, they want care closer to where they live and work, delivered by professional and compassionate health and care workforce. Some of our boroughs, such as Islington and Haringey, already have a strong history of working together and we know there some similarities in the health and care profile of the North London populations. We want to use this collective knowledge to deliver better health and care services to the North London community and to ensure we have a system that is efficient, effective and sustainable.

To build a better health and care system we must also look at the social determinants of health and wellbeing. There are high levels of poverty, mental ill health and employment insecurity. In general, life expectancy is increasing, but for many people, the last 20 years of their life is lived in poor health. As a result, older people often require a lot of support from health and care services.

Working together presents an opportunity for our health and care services to focus on the people we commission and provide services for. We want to share the collective responsibility for meeting the mental and physical health and care needs of the North London community and to help make our community more resilient.

Our greatest aim is to help people to be, stay or regain good health and wellbeing. To do this we must take a preventative approach, build strong community services and improve health and care outcomes for people. Working together in this way will allow us to look across the system at how services are provided and identify opportunities to add value, improve outcomes and eliminate duplication and reduce costs.

Our vision is for North London to be a place where our people experience the best possible health and wellbeing. North London is a place where no-one is left behind.

To achieve our vision, this plan must result in real and demonstrable improved health and care outcomes for the people. Our community will experience the benefits of improved health and wellbeing, better services delivered within the available resources for our health and care system.

We currently project a financial deficit across the NHS organisations in North London of £234m in 2016/17. If we do nothing, by 2020/21 we project this financial deficit in health will rise to £811m plus a funding gap across North London councils on social care and public health of a further £247m. Our plans reduce this financial deficit across the NHS organisations to £75m by 2020/21 but we clearly need to continue to work to identify further opportunities for efficiencies to ensure that we have financially sustainable services.

In respect of the 2017/18 financial position specifically, current plans fall short of the 'control total' targets set by NHS England and NHS Improvement for the CCGs and NHS Trusts across North London. Currently North London CCGs and Trusts are assessed as c£60m away from delivering the 2017/18 target, with further risks of delivering already challenging savings plans on top of this

We will therefore continue to work to identify additional efficiencies that will help to reduce this residual gap and this includes working with NHS England and NHS Improvement as part of the Capped Expenditure Process to help the NHS produce a set of affordable plans for 2017/18.

We have in place a governance structure to enable NHS and local government organisations to work together in a new way to deliver our plan. It is crucial that whole system is aligned and committed to the delivery of this Sustainability and Transformation Plan (STP) and we have ensured the two year health contracts that are in place for 2017/18 - 2018/19 are consistent with the plan's strategic framework (outlined below).

Much work and effort has taken place to provide more detail about our proposals. We have begun to engage with those who use health and care services and we invite the public to work with us to test our thinking and validate that our plans truly reflect their needs.

We are committed to being innovative in our approach; to focusing on improving the health and wellbeing of our community and delivering the best care not only in London, but nationally. Local people deserve to be supported to live happier, healthier and longer lives, and we are fully committed to making this vision a reality.



# Our vision: A place where no-one is left behind

We want to transform North London into a place where no-one is left behind. We are united in our commitment to transforming care to deliver the best possible health outcomes for our local population. This will be done by shifting our model of care so that more people are cared for in 'out of hospital' settings, and through prevention, more proactive care, and new models of care delivery, we can reduce the reliance on secondary care and improve the way people access and receive care.

To deliver on our bold vision, we have designed a programme of transformation with four fundamental elements:

- **Prevention:** We know that many of the health challenges facing our population arise from preventable conditions. We will increase our efforts on prevention and early intervention to improve health and wellbeing outcomes for our whole population;
- **Service transformation:** We know that there are emerging technologies and new and better ways to deliver services. To meet the changing needs of our population we will transform the way that we deliver services;
- **Productivity:** We know that there is duplication and waste that can be eliminated by working together. We will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies, including working together across organisations to identify opportunities to deliver better productivity at scale;
- **Enablers:** We know that there may be untapped resources that can be put to work to improve our capacity. We will build capacity in digital, workforce, estates and new commissioning and delivery models to enable transformation.

Developing our vision in North London has taken time. We have harnessed high quality clinical and practitioner leadership at every stage of the process. The vision for North London initially drew on existing local engagement work which was underway before the STP process started – putting the needs and expectations of the public at the heart of the plan. Leaders across the system agreed the vision in September 2016. This process, alongside more local engagement events, has ensured that our vision is collectively owned across the health and care partnership. We will continue to engage with our population and develop the plan with them throughout the process.

By establishing North London 'Partners in health and care' we will work together to deliver our Sustainability and Transformation Plan (STP) and realise our vision for North London. Our core principles to support our ambition are:

## Our core principles

- We will put the health and wellbeing of our population at the heart of our plan;
- We will work in a new way as a whole system; sharing risk, resources and reward. Health and social care will be integrated as a critical enabler to the delivery of seamless, joined-up care;
- We will move from pilots and projects to interventions for whole populations built around communities, people and their needs. This will be underpinned by research-based delivery models that move innovation in laboratories to frontline delivery as quickly as possible;
- We will make the best the standard for everyone, by reducing variation across North London;
- In terms of health, we will give children the best start in life and work with people to help them

remain independent and manage their own health and wellbeing;

- In terms of care we will work together to improve outcomes, provide care closer to home, and people will only need to go to hospital when it is clinically essential or economically sensible;
- We will ensure value for tax payers' money through increasing efficiency and productivity, and consolidating services where appropriate;
- To do all of this we will do things radically differently through optimising the use of technology;
- This will be delivered by a unified, high quality workforce for North London.

We are continuing to include staff and residents in the development of our plan. We will continue to engage with people and groups throughout the process so that our conversation with our local community continues to develop and mature alongside our proposals. Each organisation in the partnership is committed to delivering the right service, at the right time, in the right place.

Further detail about how we plan to engage with our patients and residents can be found in the [Communications and Engagement](#) section of this document.



# Our Strategic Framework

To deliver on our vision and achieve an increase in health and wellbeing; meet the highest standards of care and quality; and improve productivity and efficiency, we have designed our five year programme of transformation with four elements:

- **Prevention:** Much of the burden of ill health, poor quality of life and health inequalities in North London is preventable. We will increase our efforts on prevention and early intervention to improve both the physical and mental health and wellbeing of our whole population. This will reduce health inequalities, and help reduce the demand for more expensive health and care services in the longer term. Best of all, we can improve the quality of life of our residents and build a more resilient community;
- **Service transformation:** To meet the changing needs of our population and to respond to what people have told us they want from health and care services, we will transform the way that we deliver services. This involves taking a “population health” approach: giving children the best possible start in life; strengthening the offers and provision in the local community to ensure that where possible care can be provided out of hospital and closer to home – reducing pressure on hospital services; rethinking the relationships between physical and mental health to ensure that mental health care is holistic and person-centred; and, reducing variation in services provided in hospital. Working in partnership with local authorities, together we can provide a better health and care experience for people when they need it, and in a place that more conducive to recovery or longer term care, supported by caring and compassionate professionals;
- **Productivity:** In order to ensure sustainability, we will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies. For providers, this includes implementing recommendations from the **Carter Review** and working together across organisations to identify opportunities to deliver better productivity at scale;
- **Enablers:** To increase our ability to provide health and care services for the future we have identified key areas that will support the delivery of transformed care across North London. To do this we must have the necessary architecture in place. This includes digital, workforce, estates, and new commissioning and delivery models.

Exhibit 1: The North London STP strategic framework

Social Care	<b>Service Transformation</b> <b>Improves population health outcomes; reduces demand; improves the quality of services</b> <ul style="list-style-type: none"><li>• Health and Care closer to home</li><li>• Urgent and Emergency Care</li><li>• Children and Young People</li><li>• Specialised Commissioning</li><li>• Planned Care</li><li>• Mental Health</li><li>• Maternity</li><li>• Cancer</li></ul>	<b>Productivity</b> <b>Reduces non value-adding costs</b> <ul style="list-style-type: none"><li>• Commissioner savings</li><li>• Provider savings</li><li>• System-wide productivity</li></ul>	Prevention
	<b>Enablers</b> <b>Facilitates the delivery of key workstreams</b> <ul style="list-style-type: none"><li>• Digital</li><li>• Workforce</li><li>• Estates</li><li>• New Commissioning and delivery models</li></ul>		



## Programme governance to deliver the plan

In coming together as a collaborative, we have developed a governance structure, which enables NHS and local government partners to work together in new ways. The objectives of the North London STP governance arrangements are to:

- Support effective collaboration and trust between commissioners, providers, political leaders and the general public to work together to deliver improved health and care outcomes more effectively and reduce health inequalities across the North London system;
- Provide a robust framework for system level decision making, and clarity on where and how decisions are made on the development and implementation of the North London STP;
- Provide greater clarity on system level accountabilities and responsibilities for the North London STP;
- Enable opportunities to innovate, share best practice and maximise sharing of resources across organisations in North London; and
- Enable collaboration between partner organisations to achieve system level financial balance over the remaining 3 years of the Five Year Forward View timeframe and deliver the agreed system control total, while safeguarding the autonomy of organisations.

A detailed governance handbook including the terms of reference for all of the governance groups is available [here](#). A summary of the programme governance is provided below.

The delivery of the plan is overseen by the North London Programme Delivery Board. This is an executive steering group made up of a cross section of representatives from across North London. This group is specifically responsible for providing accountability for the implementation of the workstream plans. Membership includes the Senior Responsible Officers (SRO) of each workstream and SRO leads for CCGs, Providers and Local Authorities. Two subgroups provide advice to the Programme Delivery Board: the Health and Care Cabinet (formerly the Clinical Cabinet) and the Finance and Activity Modelling Group.

The Health and Care Cabinet meets monthly to provide clinical and professional steer, input and challenge to each of the workstreams as they develop. Membership consists of the five CCG Chairs, the eight Medical Directors, clinical leads from across the workstreams, three nursing representatives from across the footprint, Pharmacy and Allied Health Professions representatives, a representative for the Directors of Public Health and representatives for the Directors of Adult Social Services and the Directors of Children's Services respectively.

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

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

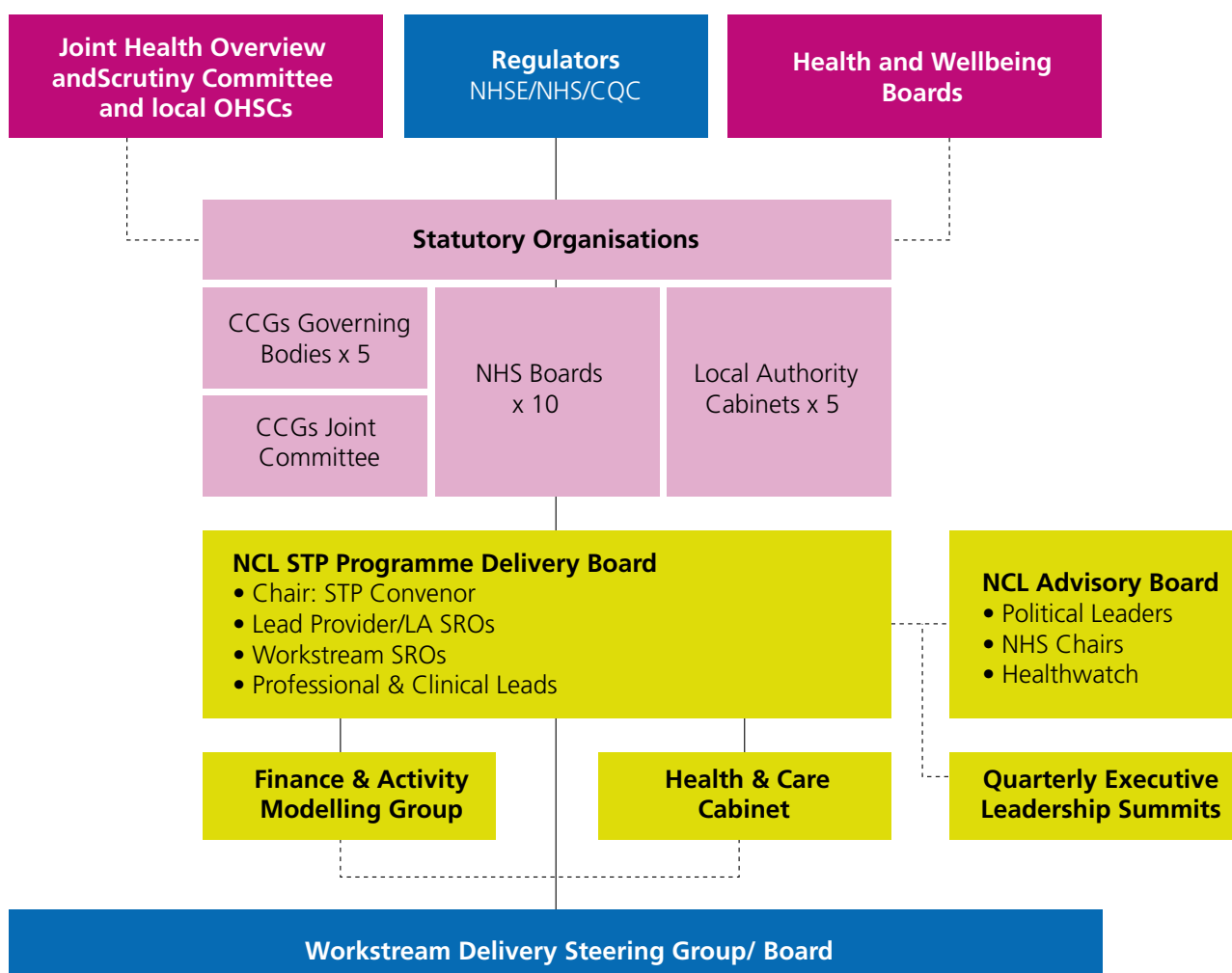
A new STP Advisory Board was established established in June 2017. This group will have an advisory role, enable a collective partnership approach, and act as the 'sounding board' for the implementation of the STP plans. The membership of this group includes Local Authority leaders, NHS Chairs, and Healthwatch. This will go some way to address the democratic deficit and representation of views of the local population, and ensure a better connection with the independent members of NHS boards/governing bodies, local authority leadership, patients, and residents. This group will meet quarterly and a decision whether or not to appoint an Independent Chair will be discussed in due course.

In addition to the above governance groups, CEOs and other relevant executive directors and stakeholder representatives will meet quarterly for executive leadership events to enable continued engagement and momentum, regular communication, and to assist with resolving any programme delivery issues identified by the programme delivery board.

There has been the appointment of a single Accountable Officer for the five CCGs across North London. This will ensure a more collaborative commissioning approach across North London. The Governing Bodies of the five CCGs agree to establish a Joint Committee for some elements of commissioning in North London including:

- All acute services core contracts and other out of sector cute commissioning
- All learning disabilities contracting associated with the Transforming Care programme
- All integrated urgent care (through the Urgent & Emergency Care Boards including NHS 111/ GP Out-of-Hours services)

## Exhibit 2: Agreed programme governance structure



## **Programme resourcing**

The implementation of the STP is regarded as business as usual, so the majority of the capacity required to implement the plan will be found from within existing management and clinical capacity within the health & care organisations in North London. In addition we have established a Project Management Office (PMO) which facilitates and coordinates the meetings of the main governance groups, liaises with each of the workstreams to monitor and track delivery plans, as well as delivering communications and engagement support to the programme.

Each workstream has a Senior Responsible Officer (SRO). Some workstreams have shared leadership, where a mixed skillset is required. All of these individuals are senior Executive level - Chief Executives, Medical Directors or Finance Directors - ensuring leadership of the highest quality.

## **Health and wellbeing boards**

CCGs are required to involve their local Health and Wellbeing Board (HWB) when preparing their commissioning plan so that HWBs can consider whether their draft plans take proper account of the local health and wellbeing strategy. As CCG commissioning plans will be set within the context of the STP, CCGs have engaged with HWBs as we developed the plan and will continue to do so as it is implemented.

## **Overview and scrutiny committees**

Local authorities have a role in reviewing and scrutinising matters relating to the planning, provision and operation of health and care services in their local area. Local authorities themselves are scrutinised on the delivery of health and social care services for which they are directly responsible and accountable, but commissioners and providers of NHS services must also consult the local authority where they are considering any proposal for a substantial development or variation of the health service in the area. Providers of public health services commissioned by the local authority are also required to consult the local authority in the same way as commissioners and providers of NHS services.

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

We have a Joint Health Overview and Scrutiny Committee (JHOSC) in place for North London. The JHOSC undertook a review of the draft STP during November and December 2016. The JHOSC heard verbal and written evidence from local residents and a range of other stakeholders at specially convened meetings. This review has generated a report from the JHOSC setting out a number of key principles and recommendations across eight themes, which aim to support and inform the further development and delivery of the STP going forward. The JHOSC also reviewed governance and communications & engagement proposals in March 2017. We continue to work constructively with the JHOSC as the proposals are developed so we can plan ahead for any potential public consultation. In addition, we will discuss plans with any relevant local authority overview and scrutiny committees as we move towards local implementation.

To meet the changing needs of our population we must transform the way that we deliver services and shift the nature of care from reactive to proactive. We will embed prevention in everything we do. This starts with giving children the best start in life and helping people stay healthy and well throughout their lives. We will develop our care closer to home model, and we will create a holistic approach to mental health services. We will improve urgent and emergency care, optimise the planned care pathway, consolidate specialties where appropriate and transform cancer services to improve the treatment and care experience for patients and their families.

## **Implementing our plans**

This work began as an NHS directive. However, we are all committed to ensuring integrated health and social care is what we provide our population. Now health and social care are working together to join up the system. Our collaboration means more joined up health and social care services, this integration is a key success factor in the realisation of our plan.

A robust delivery plan has been developed for each of our workstreams, setting out the scope; objectives; financial and non-financial impact with trajectories; any investment requirements, communication and engagement plans and the key risks to successful delivery.

The delivery plans are live documents and will continue to be reviewed and revised as the programme develops. Each workstream has developed a detailed delivery plan which will provide a reference point for the relevant governance structures and the central PMO to keep planned delivery on track, and to support the effective management of interdependencies between workstreams.

## **Social Care**

Social care plays a crucial role in our plan and is reflected throughout this document. Sufficient, high quality and sustainable social care delivered directly by local authorities (e.g. via social workers) or commissioned through external providers (e.g. in the residential, nursing and home care markets) can deliver excellent outcomes for residents in North London and reduce the burden on health and care services.

However, adult social care faces similar funding challenges to the NHS, as the ageing population with more long term conditions begin to draw on adult social services in the same way they do the NHS. Put together with recruitment and retention issues and a social care provider market under significant pressure, it is important that we invest time and effort in social care and the NHS in equal measure.

Recent measures announced by the Government have begun to ease the financial pressure, but a significant financial gap remains.. In the 2017 Spring Budget, the Chancellor of the Exchequer announced an additional £2bn investment into adult social care from 2017/18 to 2019/20. This is on top of the £2.4bn announced as part of an improved Better Care Fund in the 2015 Spending Review and separately, powers for Councils to raise additional revenue for adult social care through applying a precept of up to 6% over the next three years. The additional £2bn investment equates to £28m for North London Councils in 2017/18 and £55.5m by the end of 2019/20. This is to be spent specifically on adult social care for the purposes of meeting adult social care needs, reducing pressures on the

NHS, including supporting more people to be discharged from hospital when they are ready, and stabilising the social care provider market. North London Councils will be working closely with NHS organisations to implement these measures during 2017/18, using guidance in the new Better Care Fund Policy Framework and Planning Requirements 2017-19. More detail on the financial position of local authorities on adult social care is reflected in the 'Addressing the financial gap' chapter.

Since the publication of the draft plan in October 2016 NHS organisations and local authorities in North London have continued to work together to ensure the STP addresses the challenges across health and social care. As such, many workstream delivery plans now seek to deliver benefits and outcomes from both a health and social care perspective. Directors of Children's Services (DCS) and Directors of Adults Services (DASS) across all five North London Councils have been contributing to the development of the delivery plans where there is an opportunity to work as a system across health and social care.

We have also undertaken some further analysis across North London to understand the nature and scale of the local social economy and pinpoint areas where the NHS and local authorities need to work together closely to deliver better health and care. These areas are summarised below.

### **Hospital admission avoidance and discharge**

Councils' ability to arrange social care packages for adults in North London is a major contributing factor to delays in hospital discharge, albeit it is not the biggest cause. Latest data from NHS Digital shows that 55% of delays are caused by the NHS, 42% by social care and the remainder attributable to both parts of the system. Each Council in North London has a different approach to arranging packages of care and ensuring timely discharge from hospital, therefore there are variations in the length of wait to be discharged from hospital depending on where you live in North London. There are similar variations in the way each Council supports people to avoid unnecessary admission to hospital.

We will be working closely with NHS colleagues as part of the Urgent and Emergency Care workstream to ensure variation is minimised across North London.

### **The social care 'market'**

Under the Care Act 2014, upper tier local authorities have a responsibility to manage and shape their local social care market to ensure the needs of users and carers are met. A significant proportion of social care packages are purchased from an external marketplace of large and small, profit-making and not-for-profit organisations some of which operate nationally and/or locally. Analysis shows that the 42% of delays transfers of care attributable to social care, the majority of these relate to difficulties in sourcing a suitable package of care in a residential or nursing home or in the person's own home with homecare. Analysis of 2016 data from NHS Digital suggests a growing trend in delays attributable to the sourcing of suitable home care vs bedded care, suggesting pressure on homecare market capacity. Local authorities in North London also pay different prices for residential, nursing and home care, even when purchasing the same package of care from the same provider.

High quality, sustainable capacity in these markets are critical to achieving the aims of the STP, both in order to prevent admission to hospital and help with timely discharge, but also in ensuring care can be delivered closer to home and in the community. North London local authorities will be working together to shape and manage the market, working closely with NHS colleagues to ensure shared ambitions are achieved.

## The social care workforce

The social care workforce ranges from social workers directly employed by Councils to care workers employed in the independent sector and family carers who provide care on a paid for or voluntary basis. A study by Skills for Care in 2016 showed that 78% of employed carers in North London worked in the independent sector. Employment terms and conditions can be challenging, with care workers being paid near the National Minimum Wage or London Living Wage (depending on the terms and conditions of the Council in North London) with variances in their contractual terms. Whilst many new starters (73%) in the independent care sector have previous experience of working in adult social care in North London (suggesting we retain our workforce well), the average turnover rate in the region is 21% with some boroughs seeing as many new starters as those leaving the sector. The care sector in North London also employs a large number of non-British nationals (42%), with some boroughs seeing more non-British national employed vs British nationals. Uncertainty on the future of non-British workforce creates additional pressure and anxiety in the marketplace, which is a challenge shared in other public services including the NHS.

North London Councils will be working together with NHS colleagues under the STP workforce workstream to develop capacity and skills in the care workforce.

## Prevention

Much of the burden of ill health, poor quality of life, and health inequalities in North London is preventable. Between 2012 and 2014, an estimated 20% (4,628) of deaths in our community were from preventable causes. By focusing on helping people to stay well we will improve health and wellbeing outcomes for our whole population, reduce health inequalities, and help manage demand for health and care services in both the immediate and longer term.

We will embed evidence-based prevention and early intervention across the whole health and care system. This will include council services, social care and the voluntary and community sector. We will build upon the individual strengths that each part of the public sector in North London can bring to preventing disease and ill health. As well as traditional 'health professionals' this also means working with local authority housing officers and other organisations such as the London Fire Brigade in preventing falls.

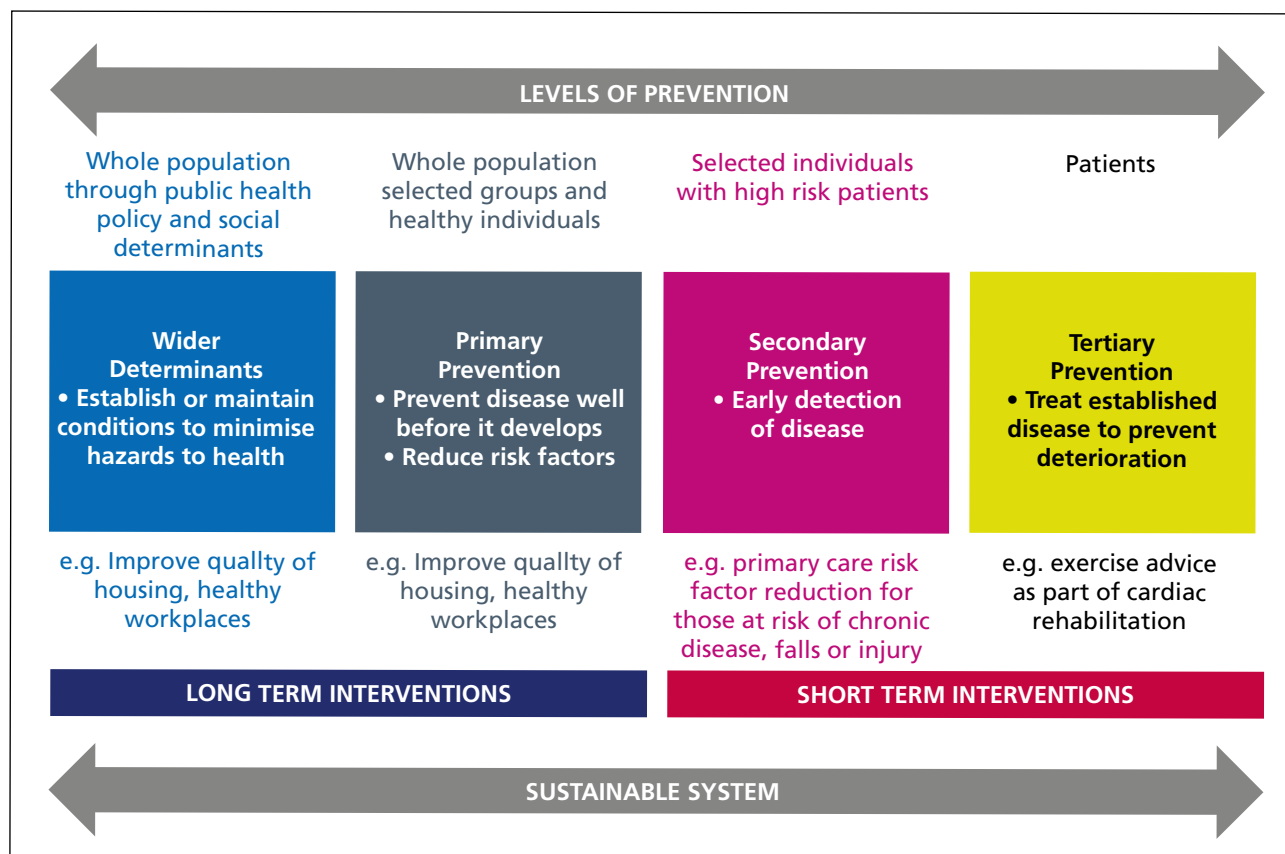
Afrin lives in hostel accommodation and is dependent on alcohol. He experiences seizures almost daily. Afrin has in the past, with support from treatment, managed to gain abstinence but had a relapse which is due to depression brought on by unstable housing and economic circumstances. Afrin has had many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

We also recognise the important contribution that voluntary and community sector organisations can make in achieving disproportionately greater improvements in health for residents with mental ill

health and learning disabilities, specific BME groups, and those in the most deprived communities, and we are committed to working more collaboratively with these organisations.

Our prevention plan focuses on interventions and system change across the whole spectrum of prevention (exhibit 3), where there is strong evidence of effectiveness. We have identified opportunities where we could quickly build upon successful local initiatives across North London to achieve economies of scale.

### Exhibit 3: Approach to prevention



We will concentrate our efforts on three priority areas with different initiatives:

Workstream	Initiative	Description	Deliverable
Workforce for prevention	Making Every Contact Count (MECC)	Residents will be appropriately directed to services that might be of benefit to them, including lifestyle interventions and those addressing the social determinants of health e.g. debt, employment, housing. The 'brief advice' and signposting given as part of the MECC programmes will increase the numbers of referrals into preventative services.	Increase the number of staff across the health and care system and the wider public sector participating in online MECC training.
		Residents with mental health issues, including dementia, will be identified more quickly and guided towards the right support service to address their needs.	Increase the number of frontline health and care staff participating in face-to-face MECC training.
	Mental Health First Aid (MHFA)		Increase the number of non-medical frontline staff (NHS and LA) trained in MHFA.
	Dementia awareness		Increase the number of NHS and social care staff trained in basic dementia awareness.  Commence training for dementia friendly GP practices.
Healthy environments	Haringey devolution pilot	Pioneer new approaches to tackling problem gambling, alcohol misuse and smoking to secure the sustainability of the NHS, and reduce demand on social care by creating a supportive environment where it is easier to make healthy choices.  Prevent people with mental health difficulties from becoming long-term unemployed and claiming ESA benefits by providing effective early help and job retention support.	Rapid application of learning across North London.
	Child Obesity	Reduce levels of childhood obesity, reduce the negative impacts on children's physical and mental health over the short and longer term through ensuring that the settings where children spend their time are recognised as healthy, and promote healthy eating and physical activity.  Reduce the health and wellbeing gap by targeting settings in our most deprived communities and those with a high proportion of children from some BAME groups who are more likely to be overweight / obese.	Increase the number of early years' settings and schools in North London accredited as healthy schools or early years settings.
	Workplace Wellbeing	Build on existing momentum and commitment to promote a culture that improves health and wellbeing of employees, by working with the North London Health Education England lead, North London healthy workplace leads and Healthy London Partnerships to promote a culture that improves health and wellbeing of employees and leads to healthy and productive workplaces.	All North London NHS and local government organisations sign up to and attain at least achievement standard of the Healthy Workplace Charter.

Healthier choices	Obesity	Develop and up-scale the delivery of weight management programmes which include integrated physical and wellbeing activities. Specifically reduce the health and wellbeing gap by targeting those living with a mental illness and a physical condition and those from Black and South Asian minority ethnic groups living in the most deprived areas.	Increase the percentage of overweight/obese residents accessing support. Increase the number of overweight and obese residents losing $\geq 3\%$ of their body weight
	Smoking	Radically up-scale the delivery of smoking cessation activities across North London, and in all parts of the system, as well as increasing the options available to residents who want to quit smoking. This includes: the use of digital (smartphone) apps being developed at a pan London level; increasing community support through the use of the voluntary and community sector; and providing more specialist addiction support for those with highly addictive behaviours.  To reduce the detrimental health impacts on foetuses and young children, there will also be additional support for pregnant women to quit smoking, including the expansion of CO monitoring.  To specifically close the health and wellbeing gap, we will target disadvantaged groups for intervention, including people with serious mental health problems, learning disabilities, specific BAME groups, and those from the most deprived communities.	Reduce smoking prevalence Increase the number of 4-week smoking quitters per year. Reduce smoking related hospital admissions
	Alcohol	Increase in the capacity and reach of alcohol liaison teams, alcohol outreach teams, as well as an increase in alcohol screening rates across North London, to identify and proactively manage via and intensive support programme a complex cohort of high risk and dependent drinkers so that their health needs are stabilised. This will reduce the number of people in crisis and help to avoid repeat hospital admissions and call-outs for blue light services. To reduce the health and wellbeing gap, interventions will be targeting high risk and dependent drinkers who are disproportionately from the most deprived communities.	Reduce alcohol-related hospital admissions  Increase in alcohol screening rates
	Falls	Falls-related hospital admissions will be reduced through the use of a multifactorial intervention combining regular exercise (including strength and balance), modifications to people's homes and regular review of medications, delivered in collaboration across the local public sector organisations and with the voluntary and community sector. This will include collaboration with London Fire Brigade (in Camden and Islington initially) as part of their 'Safe and Well' initiative, as well as identifying people who have had minor falls for early intervention.	Reduce falls-related hospital admissions
	Sexual health - contraception	There will be an increase in the offer and uptake of long acting reversible contraceptives to achieve national average expenditure. Residents will have increased choice and convenience of access of contraceptive methods, including via primary care, maternity, abortion, and early pregnancy loss services. There will also be training and skills development for health professionals and awareness raising and outreach in the community.	Increase the offer and uptake of long acting reversible contraceptives to achieve national average expenditure.  Reduce unwanted pregnancies
	Sexual health – late HIV diagnoses	There will be an increase in the offer and uptake of HIV testing to diagnose people with HIV earlier across the system. New regional on-line services will also help increase access to HIV testing, as will outreach and promotion with higher risk and more vulnerable groups.	Reduce late HIV diagnoses.

We will know we have been successful when:

- Every member of the public sector workforce in North London is a champion for prevention and taking proactive steps to close the health and wellbeing gap;
- Our residents, families and communities are supported to look after their health: smoking and drinking less, eating more healthily, and being more active, as well as looking after their sexual health and mental health wellbeing;
- There are fewer hospital admissions from preventable causes such as smoking, alcohol, and falls, and reductions in associated ill health and early deaths;
- We close the health inequalities gap, through disproportionately greater improvements in health for people with mental health problems and learning disabilities, specific BAME groups, and those in the most deprived communities;
- We start to reverse the trend in childhood obesity, by proactively working across different settings to promote healthier eating and more physical activity among children and young people, as well as using our regulatory powers;
- Those working in North London become healthier, through increased levels of active travel, supporting positive mental health wellbeing, supporting employees to quit smoking and to eat more healthily, leading to reduced absences and increased productivity.

#### **In 2017/18 we will:**

- Ensure that a prevention focus is effectively embedded in all the other clinical workstreams in the plan.
- Seek to identify investment funding to take forward early implementation of the prevention priorities set out in the plan.

## **Health and care closer to home**

Working closely with all system partners, including hospitals, GPs, Community and Social Care, as well as with Patients/Residents and the voluntary sector, we will deliver the right care at the right time to the whole population.

Health and care will be available closer to home for all, ensuring that people receive care in the best possible setting at a local level and with local accountability. At the heart of the care closer to home model is a 'place-based' population health system of care delivery which draws together social, community, primary and specialist services underpinned by a systematic focus on prevention and supported self-care, with the aim of reducing demand on the system over time. Social care and the voluntary sector will play a key role in the design, development and expansion of the future model.

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

North London has good services, the health and care closer to home model will focus on scaling these services up, reducing variation and making the care closer to home integrated network model the default approach to care and place based commissioning of services. We will address the sustainability and quality of general practice, including workforce and workload issues. It is recognised that for

some people, health and care being delivered closer to their home is not always the best choice, and therefore high quality hospital-based and care home services will continue to be available when needed. The model will make sure services are focused on the care of people within neighbourhoods.

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

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

- **Developing 'Care Closer to Home Integrated Networks'** (CHINs<sup>1</sup>): These may be virtual or physical, and will potentially cover a population of c.50,000 people. They will be home to a number of services including the voluntary and community sector to provide a more integrated and holistic, person-centred community model, including health and social care integrated multi-disciplinary teams (MDTs), care planning and care coordination for identified patients;
- **Quality Improvement Support Teams** (QIST) will also operate from CHINs, to reduce unwarranted variation by providing hands-on practical help for individual GP practices to ensure a consistent quality standard and offer to all patients which will include support for case finding and proactive management of high blood pressure, atrial fibrillation and diabetes;
- **Extended Access:** Patients will be able to access consultations with GPs or other primary care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm 7 days a week. Telephone triage, virtual consultations and online booking systems will be available for all patients;
- **Social Prescribing:** In line with our prevention agenda, the care closer to home model will include upscaling our smoking cessation activities by nine-fold to reduce prevalence and hospital admissions; increasing alcohol screening and the capacity of alcohol liaison services and alcohol assertive outreach teams across North London; scaling up weight management programmes with integrated physical and wellbeing activities; reducing unplanned pregnancies by increasing the offer and uptake of long acting reversible contraception. The care closer to home model will include a greater emphasis on social prescribing and patient education. Support will be available for patients, carers and professionals to be confident users of information and IT solutions that enable self-management and care, as well as care navigation support to direct patients to the right services.

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<sup>1</sup> CHINS is a working title only – name to be co-designed with patients and residents

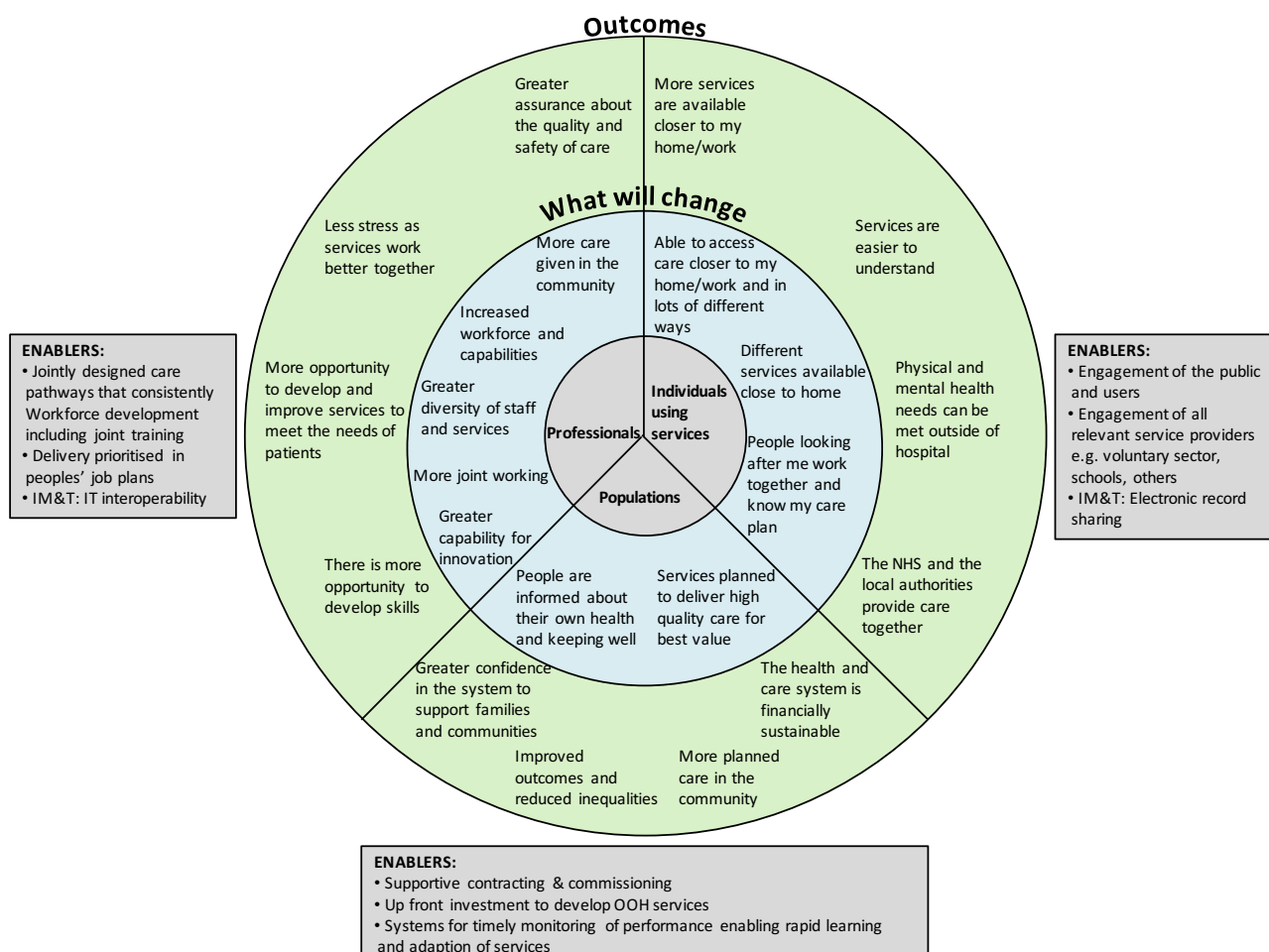
The impacts of three main strands of this workstream are detailed below:

Initiative	Description	Deliverable
<b>Improved access</b>	Patients will be able to access consultations with GPs or other primary care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm 7 days a week. Patients will be able to access a GP through a variety of different methods such as telephone and e-consultations as well as book appointments and access their records online.	<ul style="list-style-type: none"> <li>• Improved patient satisfaction with access to primary care</li> <li>• Reduced number of patients with a primary care appropriate problem seen in A&amp;E or Urgent Care</li> <li>• A health and care system that is more resilient</li> </ul>
<b>Quality Improvement Support Teams</b>	Improving quality in primary care; and reducing unwarranted variation will also operate from CHINs, including Quality Improvement Support Teams (QIST) to provide hands-on practical help for individual GP practices to ensure a consistent quality standard and offer to all patients. This will include support for case finding and proactive management of high blood pressure, atrial fibrillation and diabetes.	<ul style="list-style-type: none"> <li>• Reduction in unwarranted clinical variation</li> <li>• Reduction in activity and cost of secondary care services</li> <li>• Preventing people from dying prematurely</li> <li>• Enhancing quality of life for people with long-term conditions</li> <li>• Reduction in inequalities in health</li> <li>• Ensuring people have a positive experience of care</li> </ul>
<b>Care closer to Home Integrated Networks (CHINs)</b>	CHINs may be virtual or physical, and will most likely cover a population of c.50,000 people. They will be home to a number of services including the voluntary and community sector to provide a more integrated and holistic, person-centred community model, including health and social care integrated multi-disciplinary teams (MDTs), care planning and care coordination for identified patients. Interventions focused on the strengths of residents, families and communities	<ul style="list-style-type: none"> <li>• Reduction in clinical variation</li> <li>• Reduction in activity and cost of secondary care services</li> <li>• Preventing people from dying prematurely</li> <li>• Enhancing quality of life for people with long-term conditions</li> <li>• Reduction in inequalities in health</li> <li>• Ensuring people have a positive experience of care</li> </ul>

Improving outcomes will be the crucial measure of success of the care closer to home model. The benefits of our health and care closer to home model include:

- Improved patient satisfaction with access to primary care
- Reduced unwarranted clinical variation
- Prevention of people from dying prematurely
- Reduced inequalities in health
- Enhanced quality of life for people with long-term conditions
- More people have a positive experience of care and support to self-care
- Shared learning across CHINs and QISTs and ability to roll out best practice, new technology and new ways of working more quickly across North London

## Exhibit 4: Delivery of the Better Health for London outcomes through the health and care closer to home model



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

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

The Integrated Personal Commissioning site will:

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

## **In 2017/18 we will:**

- Offer improved access to Primary Care across the whole of North London: Patients will be able to access consultations with GPs or other primary care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm 7 days a week.
- Implement the first wave of 'Care Closer to Home Integrated Networks' (CHINs) in each of the boroughs and invest in the corresponding Quality Improvement Support Teams. We aim to achieve comprehensive coverage of these networks during 2018/19

## **Urgent and emergency care<sup>2</sup>**

We are all aware of the pressures faced in A&E departments throughout the country. Every year we hear about breaches of waiting times and ever-increasing the winter pressures. We know the system is overburdened and cannot meet expectations for performance and patient experience.

Over the next five years, we will deliver urgent and emergency care (UEC) services that are reliable, work well together and are easily understood. Our services will be consistent and inspire confidence in patients and professionals; supported by the use of an integrated digital care record that can be accessed across organisations.

The Health and Social Care services within our five boroughs will be working collectively to solve problems that affect a person's care. We will explore new ways of delivering our services to provide the best quality services for the resources we have available. This will span from the moment somebody identifies that they have an urgent or emergency need through to when they return home.

The focus on urgent and emergency care services will reduce confusion about which service people should access, will reduce the number of unplanned admissions to hospital and will support people to return home from hospital as soon as possible. This will improve people's experience of the care they receive when unwell or in crisis and make sure that people have their care on a planned basis wherever possible.

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

In the future when Mary falls, her husband will dial 999, and a paramedic will be dispatched. When the clinical assessment does not suggest any fractures, the crew will access the local directory of services whilst on scene and electronically refer Mary to the falls response part of the community based admission avoidance team. Mary will then be visited at home by the falls team on the same day, who will design a package of care to support Mary to stay at home. The falls team will be able to make a rapid appointment with her GP or a hospital specialist if they think that Mary would benefit from a medical opinion. Mary will then get the treatment and support that she needs, quickly, to help support her.

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<sup>2</sup> This workstream includes all aspects of Urgent and Emergency Care provision delivered in the acute setting, including support for people to leave hospital. Also in scope is the development of a high quality, integrated urgent care system

To do this we need to work with local people to understand the urgent and emergency care services that they need and would choose to access. We will work with local people in designing our services to better understand the way they want to use services for an urgent or emergency need.

### Our top priorities are:

- To create a consistent and reliable Urgent and Emergency Care service by 2021 that is accessible to the public and easy to navigate, inspires confidence, promotes consistent standards in clinical practice and leads to a reduction in variation of patient outcomes
- To review current Urgent and Emergency Care services and compare them against the defined national and London-wide standards
- To implement a high quality Integrated Urgent Care model which complies with IUC 'top 8' requirements set nationally
- To develop high quality, responsive 7 day community services, enabling more care to be provided closer to a person's home
- To develop an enhanced community based, admission avoidance model to support care being provided closer to a person's home and to reduce the number of avoidable hospital admissions
- To develop high quality ambulatory care services across North London, supporting people to receive acute care on an outpatient/ day case basis and thereby reducing the number of avoidable hospital admissions

The projects that we will be starting with first will focus on:

Workstream	Description	Initiatives	Impact
<b>Enhanced Community Based Admission Avoidance &amp; Ambulatory Emergency Care</b>	Developing high quality, responsive community-based services that work 7 days a week, and support someone to have their care closer to home and therefore not requiring admission to hospital or the need to attend an emergency department.	<p>This focuses on:</p> <ul style="list-style-type: none"> <li>• joining up of all community-based admission avoidance services to support patients to receive their acute care at home, supported by a single point of access ;</li> <li>• developing services in acute trusts to provide same day emergency care to patients to support assessment, diagnosis and treatment; and</li> <li>• developing admission avoidance models to support ambulatory / short stay community based care for paediatrics.</li> </ul>	Key benefits to be achieved include reductions in admissions and readmissions and improved patient experience

Workstream	Description	Initiatives	Impact
<b>Acute Frailty Pathway</b>	Developing the care we provide for frail older people who become unwell to support them to be assessed and treated quickly, so they can remain in their home for as long as possible	<p>This focuses on:</p> <ol style="list-style-type: none"> <li>1. enabling rapid, early, risk-based assessments of elderly people by senior geriatricians and the provision of diagnostic support, therapy, mental health teams, access to care in the community 7 days a week and access to rehabilitation teams through a single point of access;</li> <li>2. enabling rapid treatment of frail older people by standardising services, processes and pathways across North London to ensure that only those requiring admission are admitted to hospital;</li> <li>3. enabling rapid discharge of medically optimised frailty patients.</li> </ol>	Key benefits to be achieved include reducing variation, improving patient outcomes and improving patient flow
<b>Last Phase of Life</b>	Improving the quality of peoples' care within the last phase of their life, to support them to die in their place of choice	<p>This focuses on:</p> <ol style="list-style-type: none"> <li>1. improving the care of care home patients in the last 12 months of life by embedding practice facilitators / case finders in the relevant local community palliative care service to identify, support and record care planning information for care and nursing home residents in their last year of life;</li> <li>2. Specialist Palliative Care (SPC) services working together to reorganise services around two hubs (north and south) to provide SPC advice 7/7 a week, enable Single Points of Access and to reduce inequity of provision;</li> <li>3. Telemedicine - remote Band 7 nurses will support 3-5 Band 5 nurses who visit patients and provide care in community and 'eSHIFT' technology will provide remote access to electronic patient records, enabling Band 5 nurses to communicate key clinical findings centrally, and be given expert advice on next steps.</li> </ol>	Key benefits to be achieved include reducing A&E admissions and non-elective activity, improving end of life care, improving patient experience, and improving the knowledge and care of the social care workforce.

Workstream	Description	Initiatives	Impact
<b>Integrated Urgent Care</b>	Improving and standardising access to Urgent Care across North London to avoid the need to attend an emergency department	This focuses on implementing a high quality Integrated Urgent Care model which brings together current urgent care services such as 111, GP out of hours, Pharmacy, Urgent Care Centres and Minor Injury Units to create a single, unified approach to urgent care in line with the London UEC designation standards	Key benefits to be achieved include a reduction in A&E activity and an increase access to a locality GP/ Primary Care clinician
<b>Simplified Discharge</b>	Addressing the multiple different reasons that mean somebody's discharge from hospital back to their home is delayed	<p>This involves:</p> <ol style="list-style-type: none"> <li>1. establishing a Trusted Assessor Model wherein health and social care professionals complete a single assessment of patients' needs, which can be shared, reducing duplication;</li> <li>2. developing 7 day community services to support discharge processes through the development of single access points, including a North London discharge referral form;</li> <li>3. improving patient flow through the hospital, ensuring the right care can be delivered at the right place at the right time through the implementation of the 'SAFER' patient flow rules;</li> <li>4. supporting shorter hospital stays by ensuring that, where appropriate, an assessment of on-going care and community support needs takes place in an environment familiar to an individual, either at home or using 'step down' beds;</li> <li>5. stroke - transformation of service delivery to implement a consistent approach to the management and delivery of stroke pathways across North London.</li> </ol>	Key expected benefits include reduction in delayed transfers of care, improved patient flow, reduction in readmissions, reduction in excess bed days and improved patient experience results.

#### In 2017/18 we will:

- Join up all community based admission avoidance services to support patients to receive their acute care at home, supported by a single point of access
- Develop services in all acute trusts to provide same day emergency care to patients to support assessment, diagnosis and treatment on a same day basis with no overnight stay
- Develop admission avoidance models to support ambulatory/ short stay/ community based care for Paediatrics

- Implement simplified discharge for stroke patients
- Begin design work to improve and standardise access to Urgent Care across North London to avoid the need to attend an emergency department

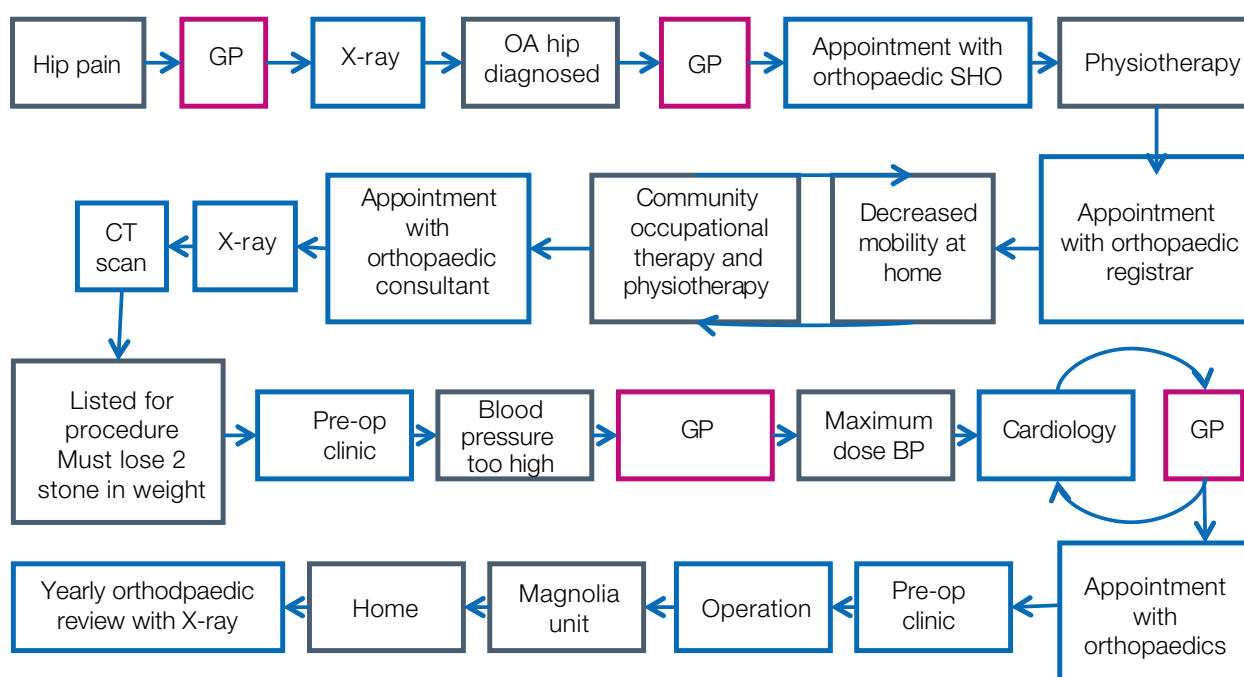
## Planned care

Building on the opportunities identified through RightCare<sup>3</sup>, we will deliver the best value planned care services across North London to reduce unwarranted variation in planned care across providers in North London. This will include;

- Reducing variation in the length of stay in hospital
- Reducing variation in the number of outpatient appointments received by patients with similar needs.
- Optimising pathways to ensure patient safety, quality and outcomes, and efficient care delivery.
- Standardising Procedures of Limited Clinical Effectiveness (PoLCE), consultant to consultant (C2C) referrals and referral threshold policy across North London to ensure parity of care regardless of patient's postcode.

Below is an example of a journey from a patient who was suffering from hip pain. Due to handoffs, inefficiencies and suboptimal advice and information transfers, this patient's pathway continued for more than three years.

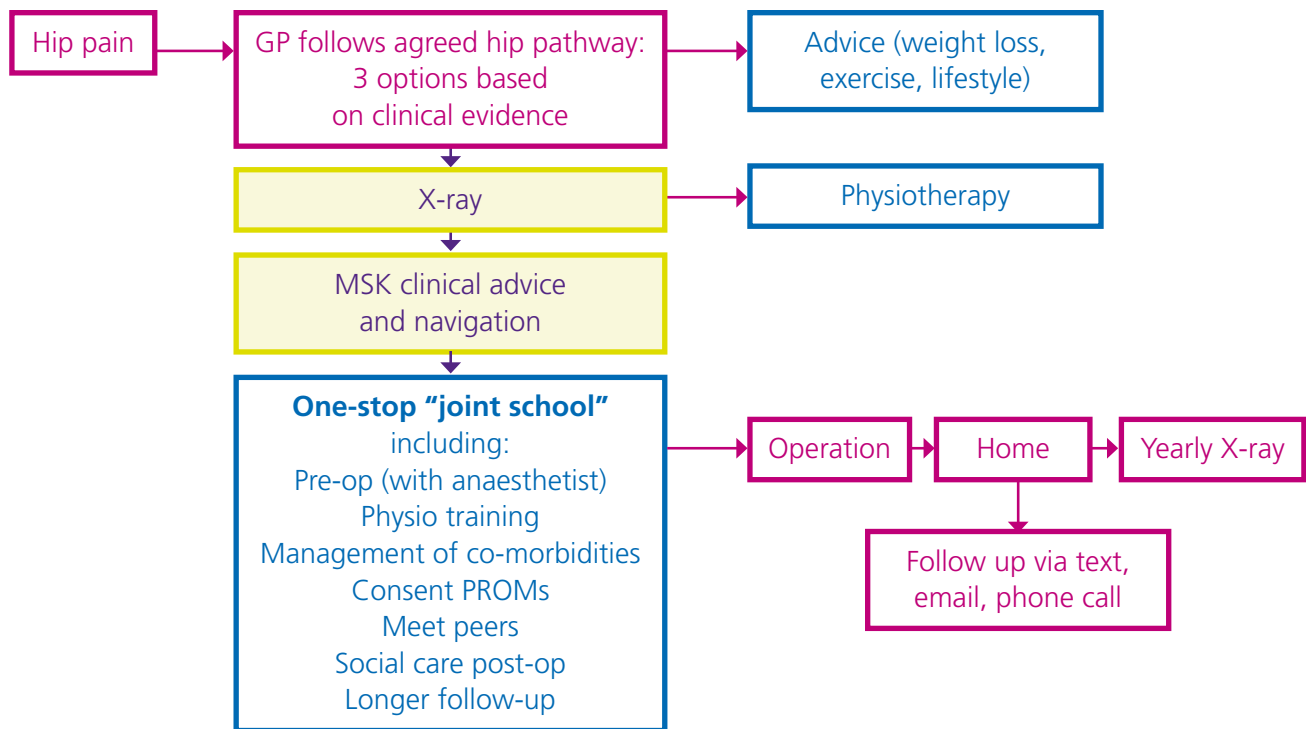
### Exhibit 5: Example of previous patient journey



Moving forward the planned care workstream will seek to create a system where patient journeys are as efficient, safe and well managed as possible. As a result the new pathway will look more like the below and last a much shorter amount of time.

<sup>3</sup> RightCare Atlas of Variation in Healthcare, September 2015

## Exhibit 6: Example of revised patient journey



As well as delivering efficiency savings, reducing variation in planned care will improve patient outcomes and experience. In order to deliver this the workflow will adopt the following principles:

- Standardised approach to pathway delivery across CCGs and hospitals
- Senior clinical triage and advice with access to multidisciplinary triage where appropriate
- Majority of outpatients managed within a community or primary care based service
- Community services supervised by senior clinicians
- Diagnostics ordered once and only when clinically necessary – reduce over ordering
- One stop service/co-location to improve patient experience
- Follow-up once, and only when necessary
- Patient centred, safe services
- Payment mechanism based on whole system management and clinical outcomes
- Quality of GP referrals and clinical thresholds improved – protocol driven
- Educational support for primary care through training and development led by senior clinicians
- Provision of health and advice telephone lines for clinicians
- Integrated IT/information portal
- Use of technology to deliver virtual services
- Standardised approach to Procedures of Limited Clinical Effectiveness (POLCEs)
- Standardised approach to consultant to consultant referrals

Drawing on local and global examples of best practice and building on the evidence, we will redesign pathways with local clinicians and patients, responding to local needs and opportunities. We will initially focus on areas with high volume or high variability, where there is opportunity to achieve high impact by making changes, such as orthopaedics. A key enabler to the work will be the provision of enhanced advice, based on competency to make sure everyone within the system, including patients, have the right access in order to manage their conditions.

We will leverage the following opportunities for improvement to planned care pathways:

- clinical advice and navigation: ensuring competency based advice and navigation for patients so they are managed in the most optimal way for their condition
- standardised POLCE and consultant to consultant policies: ensuring parity of care and reduction in

handoffs and unnecessary procedures

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

Below is an outline of the eight areas of focus and the resulting benefits for the system:

Workstream	Initiatives	Description	Impact
<b>Group 1 'High volume'</b>	MSK	High volume referrer where extensive work is already being undertaken across North London	<ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved staff experience</li> <li>• Delivery of associated financial savings with the workstream</li> <li>• Reduction in the number of secondary care attendances</li> <li>• Improved utilisation of inpatient services</li> </ul>
	Dermatology		
<b>Group 2 'Integrated CAN'</b>	Clinical Advice and Navigation	Single point of access for advice and navigation and referral management	<ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved staff experience</li> <li>• Delivery of associated financial savings with the workstream</li> <li>• Reduction in the number of secondary care attendances</li> </ul>
<b>Group 3 'Work in train'</b>	Neurology	Service that already has work being done within North London that could be adopted using 'follow the fastest' principle	<ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved staff experience</li> <li>• Delivery of associated financial savings with the workstream</li> <li>• Reduction in the number of secondary care attendances</li> <li>• Improved utilisation of inpatient services</li> </ul>
	Urology		
	Ophthalmology		
<b>Group 4 'Fastest First'</b>	Gynaecology	Service that already has work being done within North London that could be adopted using 'follow the fastest' principle	<ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved staff experience</li> <li>• Delivery of associated financial savings with the workstream</li> <li>• Reduction in the number of secondary care attendances</li> <li>• Improved utilisation of inpatient services</li> </ul>
	Gastroenterology		
	Colorectal Surgery	High volume service, identified as priority through stocktake and/or Right Care data	
<b>Group 5 'Avoiding the postcode lottery'</b>	PolCE	Standardisation of thresholds and policy across North London to ensure parity of care provision.	<ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved staff experience</li> </ul>
	Consultant to consultant referral		
<b>Group 6</b>	Diagnostics	Standardisation of diagnostics thresholds and ordering across North London	<ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved staff experience</li> <li>• Improved utilisation of diagnostics</li> </ul>

Workstream	Initiatives	Description	Impact
<b>Group 7 'Phase 2'</b>	Vascular Surgery	High volume service, identified as priority through stocktake and/or Right Care data	<ul style="list-style-type: none"> <li>• Integrated pathways and services</li> <li>• Reduction in variation in length of stay</li> <li>• Standardisation of service and pathways across North London</li> <li>• New financial models based on whole system design</li> <li>• Improved patient experience</li> </ul>
	Breast Surgery		
	Hepatobiliary & pancreatic surgery, Upper GI surgery		
	General Surgery		
	ENT	Service that already has work being done within North London that could be adopted using 'follow the fastest' principle	
<b>Group 8 'Local schemes'</b>	Local Schemes	Local CCG specific schemes that do display any initial benefit to North London level work	<ul style="list-style-type: none"> <li>• New local models based on the need of borough or area specific population</li> </ul>

To deliver on the above, a series of interventions will be put in place at each stage of the planned care pathway. These are illustrated and detailed below.

#### Exhibit 7: Interventions that support optimised planned care pathways

Pre-primary care	Primary care	Outpatient care	Inpatient pre-operative care	Surgery	Inpatient post-operative care	Follow-up post discharge
<ul style="list-style-type: none"> <li>• Non-medical support and education</li> </ul>	<ul style="list-style-type: none"> <li>• Expert first point of contact</li> <li>• Only when ready</li> <li>• Structured referral template</li> <li>• Diagnostic protocols</li> <li>• Shared protocols</li> <li>• Monitoring and transparency</li> </ul>	<ul style="list-style-type: none"> <li>• One-stop outpatient clinics</li> <li>• MDT clinic</li> </ul>	<ul style="list-style-type: none"> <li>• Preoperative assessment</li> <li>• Re-check prior to surgery</li> <li>• Short-notice reserve list</li> </ul>	<ul style="list-style-type: none"> <li>• Consultant-level feedback</li> <li>• Ring-fenced elective beds</li> <li>• Theatre utilisation</li> </ul>	<ul style="list-style-type: none"> <li>• Enhanced recovery</li> <li>• Effective planning for discharge</li> </ul>	<ul style="list-style-type: none"> <li>• Nurse led or virtual follow up</li> </ul>

Implementation of these high level interventions includes:

- **Better use of non-medical support and education:** promoting non-medical support staff as the first line for minor concerns (e.g. at gyms), greater use of pharmacists, and giving patients access to more information online.
- **Expert first point of contact:** the first person the patient comes into contact with would be a GP with special interest or experienced physiotherapist, who would know the full range of treatment options available. As a consequence of this, more outpatient referrals would have diagnostics already performed and patients would be supported by the right information when they are making decisions about onward treatment.
- **Use of a structured referral template:** allowing all information to be available at the

first clinic appointment. Ideally, this would be an electronic form which would reduce the risk of unnecessary follow up appointments as all relevant diagnostics and information are readily available to clinicians at the initial appointment. Structured referral templates are currently used by some providers and commissioners in North London to good effect, but would be used more widely as part of the optimised planned care pathway.

- **Improved diagnostic protocols:** administrative protocols would be ordered to ensure that the appropriate tests are being conducted to diagnose patients. This would limit repetitive tests being ordered, which is better for patients and optimises resource use.
- **Use of NCL-wide shared protocols:** would ensure that patients are being managed in a consistent way. It would build relationships and teams across the whole system, fostering trust and reducing duplication in tests, appointments and treatments as a result.
- **Only when ready:** patients are only referred when they are ready and available for treatment. This avoids a second GP appointment and re-referral.
- **Better monitoring and transparency:** peer review and support would be established to ensure referrals are appropriate, enabling clinicians to have an open dialogue regarding the quality of referrals and continuously improve their own referral practices.
- **One-stop outpatient clinics:** access to simultaneous pre-assessment and additional diagnostics in a single place, reducing the need for unnecessary follow ups.
- **Multi-disciplinary team (MDT) clinics:** clinics which consist of multiple different people working together to triage to the most appropriate clinician. Consultants, extended scope physiotherapists and GPs with special interests would all working together in a single setting to form the MDT.
- **Pre-operative assessments conducted at the first outpatient appointment:** if patients are not found to be fit, then their plan is reviewed the same day. This would be supported by greater use of e-self assessment by patients in their home. Rehab and post-operative packages of care would be arranged prior to referral, enabling patients who are at risk of staying for long lengths of time in hospital to be proactively identified.
- **Re-check prior to surgery:** patients will be contacted 48-72 hours before their surgery to reduce the risk of late cancellations. This check will ensure patients are still well enough for surgery, and want to go ahead with the planned procedure.
- **Short-notice reserve list:** to ensure that gaps caused by late cancellation can be filled by patients who are ready for treatment which allows theatres to be used most efficiently.
- **Consultant-level feedback:** transparency of list utilisation and case volumes per list. This allows for peer challenge to take place between consultants, to ensure the highest quality and most efficient practices are being maintained.
- **More effective planning for discharge:** discharge planning services will be offered earlier in the process, before patients are admitted to hospital. This will give greater access to community support services, and reduce delays in discharge.
- **Enhanced recovery pathways will be consistently applied:** patients will have a greater understanding of their expected length of stay when they are admitted, and be advised on the best course of action to avoid staying for longer.
- **Ring fenced planned care beds will be available:** to reduce wasted theatre time, and diminish the risk of infection for planned care patients.
- **Theatre utilisation will be optimised:** by scheduling cases and ensuring that critical equipment is properly scheduled to maintain the order and running of lists.

## In 2017/18 we will:

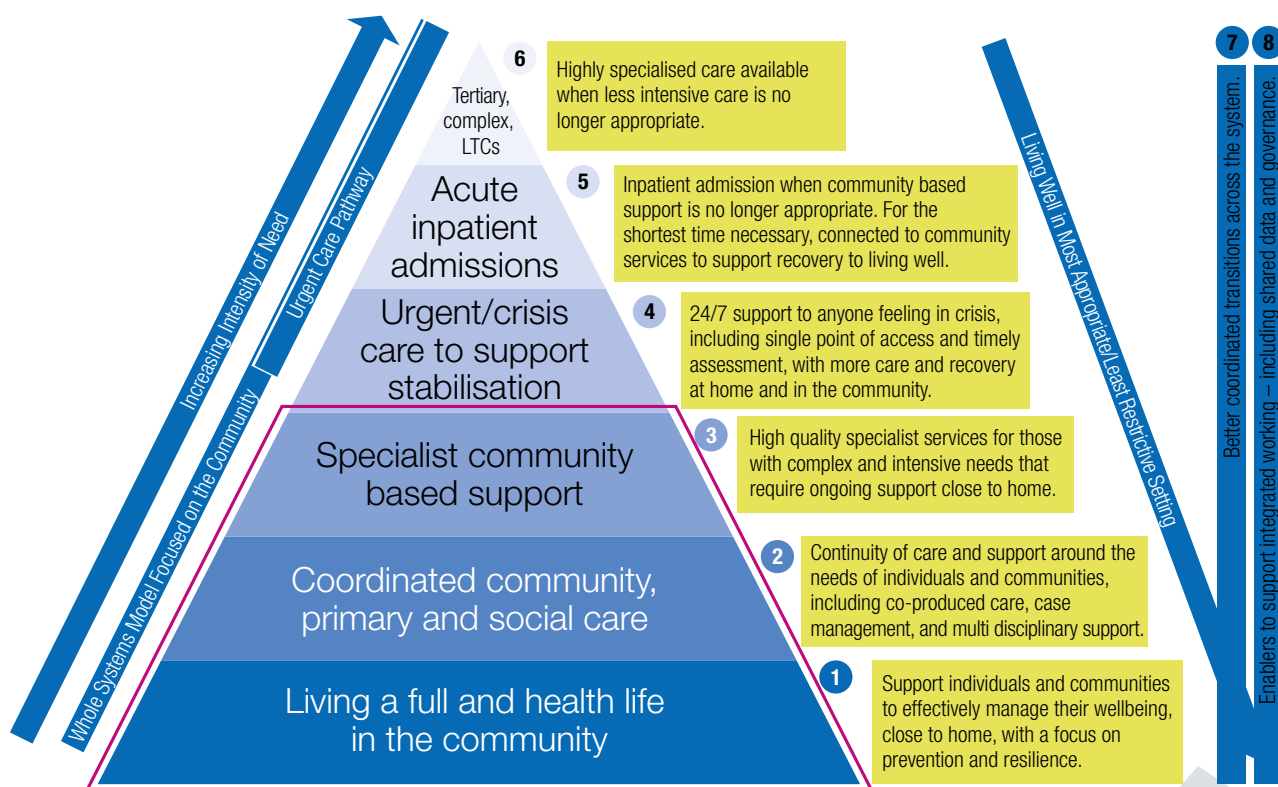
- Work with local clinicians and patients, responding to local needs and opportunities to redesign pathways in:
  - > MSK and Dermatology
  - > Urology, Neurology and Ophthalmology
  - > Gynaecology, Gastroenterology and Colorectal Surgery
- Design a single point of access for advice and navigation and referral management
- Standardise thresholds and policy across North London to ensure parity of care provision through a review of Policies of Limited Clinical Effectiveness and Consultant to Consultant referrals
- Standardise diagnostics thresholds and ordering across North London

## Mental health

Our ambition is that unless someone requires highly specialised care, they will be able to receive the care they need with North London, and not require an out of area placement. By investing in community based care, we aim to reduce demand on the acute sector and mitigate the need for additional mental health inpatient beds.

We will develop a 'stepped' model of care supporting people with mental ill health to live well, enabling them to receive care in the least restrictive setting for their needs. The provision of appropriate social care is a key success factor for people with long-standing mental ill health and this will be central to the success of the stepped model.

**Exhibit 8: The mental health 'stepped' model of care**



We aim to reduce demand on the acute sector and mitigate the need for additional mental health inpatient beds. We want to improve overall mental health outcomes across North London and reduce

inequalities for those with mental ill health, enable more people to live well and receive services closer to home and ensure that we are treating both physical and mental ill health equally. We will work towards achieving the key mental health access standards:

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

Through this work we aim to bring all of North London up to the same level of care quality. No matter where in North London you live, you can expect to receive the same high quality care. This includes:

- increase mental health basic awareness, reduce stigma and increase mental health self-awareness
- support at risk population to stay well
- provide more accessible mental health support delivered at locality level
- increased alternatives to admission and support for discharge to enable more people to live well in the community, with better crisis support
- eliminate the need for out of area placement for female service users who require psychiatric intensive care via the female PICU initiative
- give more women access to specialist perinatal mental health services
- make sure more children have access to mental health support and unless highly specialised care is required, eliminate out of area placements for children requiring inpatient support
- more people in A&E and on physical health inpatient wards to have their mental health needs supported
- support more people to spend more time at home, rather than in hospital
- For North London to become more dementia friendly

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

Broadly the programme covers mental health support for all age groups and the current identified initiatives include:

- Community resilience
- Primary care mental health
- Acute pathway – including Health Based Place of Safety, S136, alternatives to admission
- Female psychiatric intensive care unit (PICU)
- Child and adolescent mental health services (CAMHS) and Perinatal mental health
- Mental health liaison
- Dementia

Over time other areas may be identified which have the potential to deliver savings. Currently out of scope are specialist commissioned mental health services (excluding Tier 4 CAMHS) although this may be reviewed over time.

In the development of this model of care we are committed to coproducing with those who have lived experience. We have established an 'experts by experience' group, the EbyE Board, with representation from across our 5 boroughs. The group formed in December 2016, and going forward will be involved in all of our areas of work, and support us in further engagement and coproduction across North London.

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

Workstream	Description	Impact
<b>Improving Community Resilience</b>	<p>Both for the general population, and those at risk of developing mental ill health or of becoming more severe.</p> <p>For the general population this includes a health promotion campaign aimed at increasing basic mental health awareness including self-awareness, normalising mental health needs and reducing stigma.</p> <p>For the at-risk population focus will be given to improving access and support through training of non-mental health specialists to recognise mental ill health symptoms, improving service navigation, development of open resources, and provision of individual and group therapies; employment support to help people to maintain and get back into work including through Individual Placement Support<sup>4</sup>; and suicide prevention work to strengthen referral pathways for those in crisis, linked to the local multiagency suicide prevention strategies<sup>5</sup>. This will be delivered in conjunction with other regional and national schemes such as the London digital wellbeing platform. We will continue to build upon current work; for example Barnet CCG and local authority are already working towards a dementia friendly borough by providing lunch clubs, reminiscence therapy and engaging with local shops to raise awareness.</p>	<ul style="list-style-type: none"> <li>• 3% reduction sick days</li> <li>• 165 new jobs via IPS scheme</li> <li>• Reduction in suicide rate</li> <li>• Improved well-being for the general and at-risk population</li> </ul>

<sup>4</sup> Five Year Forward View - 29,000 more people living with mental ill health should be supported to find or stay in work (~725 within North London)

<sup>5</sup> Five Year Forward View - Reduce suicide by 10%

Workstream	Description	Impact
<b>Increasing access to primary care mental health services</b>	Ensuring more accessible and extensive mental health support is delivered locally within primary care services. This will be developed as part of the Care and Health Integrated Networks ; enabling physical health and mental health needs to be treated and supported together <sup>6</sup> . We will offer support directly to patients and support to GPs and other professionals; enabling more people to access evidenced based mental health services <sup>7</sup> , with more care to be offered through Care and Health Integrated Networks rather than requiring referral to secondary care mental health services. Services will include increasing the IAPT offer to reach 25% of need <sup>8</sup> with a focus on supporting people with long term conditions. In 2017/18 the Primary Care Based Mental Health service is being rolled out to all Islington CCG practices. This service provides assessment and support within primary care, as well as training for GPs, so that more people can have their mental health supported in primary care rather than secondary care.	<ul style="list-style-type: none"> <li>• 30% reduction in secondary care MH referrals</li> <li>• Delivery of national IAPT targets</li> </ul>
<b>Improving the acute mental health pathway</b>	Building community capacity to enable people to stay well and reduce acute presentations. This includes developing alternatives to hospital admission by strengthening crisis and home treatment teams; reviewing Health Based Place of Safety (HBPoS) provision with the view to reduce the number of units and to have a sector wide provision that meets all requirements; and investing in longer term supported living arrangements to provide more effective discharge, enabling people to live well in the community. In the southern part of North London a plan is being developed to close the A&E HBPoSs, and move to a purpose built suite at Highgate Centre for Mental Health, this is expected to open in 18/19. In the north section of North London there is the potential to develop a complex rehab ward.	<ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved stakeholder satisfaction</li> <li>• Reduced LoS</li> <li>• Avoidance of need for additional inpatient beds.</li> <li>• Bed occupancy maintained at 95%</li> <li>• HBPoS provision to meet North London needs</li> </ul>
<b>Developing a female Psychiatric Intensive Care Unit (PICU):</b>	It is important to facilitate local provision of inpatient services to female patients requiring psychiatric intensive care. There is currently none available in North London. Patients will be able to remain close to their communities, with a more streamlined and effective pathway with the focus on recovery. A potential site within North London has been identified, and work is underway to develop the plan further.	<ul style="list-style-type: none"> <li>• Eliminate out of area placements</li> <li>• Improved quality of provision and patient experience</li> <li>• Reduced LoS</li> <li>• Financial savings.</li> </ul>

6 FYFV – at least 280,000 people with severe mental ill health have their physical health needs met (~7,000 within North London)

7 Five Year Forward View - more adults with anxiety and depression have access to evidence based psychological therapies (~15,000 within North London)

8 Five Year Forward View – increased IAPT to reach 25% of need by 2020/21

Workstream		Description	Impact
<b>Investing in mental health liaison services</b>		By scaling up 24/7 all-age comprehensive liaison to more wards and Emergency Departments (EDs), we can ensure more people in Emergency Departments and on inpatient wards being treated for their physical health problems will also have their mental health needs assessed and supported.	<ul style="list-style-type: none"> <li>• Improved patient experience</li> <li>• Improved A&amp;E performance</li> <li>• Average of 1 day reduction in length of stay</li> <li>• Reduction in readmissions</li> </ul>
<b>Investing in a dementia friendly North London</b>		Looking at prevention and early intervention, supporting people to remain at home longer and supporting carers. This will be delivered in line with national standards around dementia.	<ul style="list-style-type: none"> <li>• A dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.</li> </ul>
<b>Focusing on perinatal and child and adolescent mental health services (CAMHS)</b>	Shared dataset	Develop shared dataset to enable comparison and shared learning across North London	<ul style="list-style-type: none"> <li>• 32% of children with a diagnosable condition being able to access evidence-based services by April 2019</li> <li>• Reduction in LoS and admissions</li> <li>• Elimination of OOA placements</li> <li>• Investment in outreach offer</li> </ul>
	Eating Disorders	Invest in eating disorders	
	Workforce	Planning for a workforce that meets the mental health and psychological well-being needs of children and young people in North London, including CYP IAPT workforce capability programme	
	Transforming Care	Supporting children and young people with challenging behaviour in the community, preventing the need for residential admission	
	Perinatal	Develop a specialist community perinatal mental health team so that more women have access to evidence based specialist perinatal mental health care	
	Child House Model	Following best practice to support abused children in North London	
	Crisis Pathway	Develop an North London crisis pathway that includes 24/7 urgent and emergency mental health service for children and young people with care delivered as close to home as possible for children in crisis, this includes local commissioning of Tier 4 CAMHS, and review of S136 provision	
	Youth Justice	Work with NHS England to develop co-commissioning model for youth justice	

### **Focusing on perinatal and child and adolescent mental health services (CAMHS):**

We know 50% of all mental illness in adults begins before 14 years of age and 75% by 18<sup>9</sup>. There is significant financial cost associated with perinatal mental ill health along with negative social/emotional impacts on a child's life, health and wellbeing<sup>10</sup>, Focusing on children and young peoples' mental health and wellbeing and perinatal mental health as key priorities we can improve the long term mental health outcomes for our population. The eight priority areas identified above form

<sup>9</sup> Cavendish Square Group

<sup>10</sup> Centre for Mental Health and London School of Economics

the joint aspect of the North London Children and Young People (CYP) Transformation Plans. The principles of THRIVE<sup>11</sup> will be used as an overarching approach with the aim of at least 32% of children with a diagnosable condition being able to access evidence-based services by April 2019 as set out in the Mental Health Taskforce.

There are a number of interdependencies across the North London mental health workstream and the other elements of our programme of work. Other areas of work such as workforce are crucial in identifying the future workforce we need in order to deliver these initiatives, which includes new roles and developing new skills.

The Estates workstream is another important enabler of a number of our initiatives. This includes the redevelopment of the Barnet, Enfield and Haringey Mental Health Trust, St Ann's site and the Camden and Islington Foundation Trust St Pancras site in conjunction with the proposed relocation of Moorfields Eye Hospital Foundation Trust to the St Pancras site.

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

- Transform the current inadequate acute mental health inpatient environments on both sites
- Provide more therapeutic and recovery focussed surroundings for patients and staff
- Improve clinical efficiency and greater integration of physical and mental health care
- Release estates across the trusts, to enable development of community-based integrated physical and mental health facilities
- Develop world class research facilities for mental health and ophthalmology enabling practice to reflect the best evidence
- Provide land for both private and affordable housing, as well as supported housing for service users and housing for key workers.

The delivery of these initiatives, and the realisation of the proposed benefits, is critically dependent on increased investment. For 2017/18 to date we have identified investment of an additional £1.3m and have succeeded in accessing a further £2.5m from national transformation funding.

Priorities for mental health are being taken forward in line with available funding at this stage and with a focus on the ability to test new models of provision and strengthen the evidence base for effectiveness. The STP remains committed to expanding the pace of transformation in mental health care as resources, including national transformation funding become available.

### **In 2017/18 we will:**

- Roll out primary care mental health services in Islington
- Establish integrated IAPT capacity in Haringey and Islington
- Map and design the acute care pathway
- Establish a specialist community perinatal mental health teamBid for local commissioning of Tier 4 CAMHS
- Develop core 24 hour mental health liaison services at UCLH and North Middlesex
- Plan the development of a local female PICU to be put in place in 2018/19
- Seek to identify further investment funding to take forward implementation of other priorities in line with the plan

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<sup>11</sup> THRIVE is a population approach to children and young people's mental health developed by the Tavistock and Portman Foundation Trust and Anna Freud Centre which aims to replace the traditional tiered model with one which tailors the response of services to the presenting needs and expressed preferences of young people.

## Cancer

Working in partnership as the UCLH Cancer Collaborative, Commissioners and providers across north central and north east London and west Essex joined together in late 2015 to form the national Cancer Vanguard, in partnership with Manchester Cancer and Royal Marsden Partners, under the auspices of NHS England's new care models programme.

We aim to save lives and improve patient outcomes and experience for those with cancer in North London and beyond by driving changes in delivery of cancer care across a whole health system that will save hundreds of lives, reduce variation and improve quality of care.

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

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

Our top priorities are to:

- **Improve survival:** through earlier diagnosis, implementation of best practice and improved access to novel diagnostics and therapeutics
- **Improve patient experience:** by reducing pathway delays (sustainable delivery of 62 day standard), supporting care closer to home and developing integrated patient pathways across primary and secondary care, physical and mental health, health and social care
- **Reduce cost:** using new models of care, reducing variation in pathways and closer integration between providers and across the commissioning landscape
- **Generate new income:** by capitalising on our position of natural competitive advantage in translational and clinical cancer research

Faster diagnosis will be delivered at pace and scale through a range of approaches including the use of decision support tools mobilising primary care in the early detection of cancer, driving the straight to test agenda and effective modelling to focus diagnostic capacity most efficiently on areas of need. Quality of care, variation in treatment and outcomes and improved cancer waits will be tackled through implementing agreed whole pathways of care through diagnosis and treatment to living with and beyond cancer and end of life care. Efficiencies can be further consolidated through innovative service delivery models and partnerships to deliver personalised cancer care from diagnosis to living with cancer and beyond.

Our cancer workstream builds on the platform established by the National Cancer Vanguard and encompasses a breadth of priorities, primarily the recommendations from the National Cancer Taskforce. The key areas of focus include:

- **Early diagnosis:** to address impact of late diagnosis on survival outcomes across North London, we will target specific causes of late diagnosis and poor detection rates. Targeting colorectal and lung pathways are a particular focus given the high percentage of patients receiving late stage diagnoses, often in Emergency Departments. We will roll out the Multi-disciplinary Diagnostic Clinic model for vague abdominal symptoms, promote adoption of straight to test models, implement interventions to increase screening uptake rates, lead innovation in cancer diagnostics and deliver a programme to improve awareness of cancer symptoms in primary care.
- **Pathway improvement:** across the region there is an on-going challenge to ensure that patients' rights under the NHS constitution concerning waiting times for cancer diagnostics and treatments are consistently realised. We are working together as a whole system to understand where the 'pinch points' are that cause delays in pathways, and to be able to 'flex' diagnostic capacity and workforce. We have already enabled reconfiguration of some small volume MDTs to improve diagnostic pathway and workforce efficiency and resilience.
- **Living with and beyond cancer:** working with patients, hospitals and GP practices to support long term self-management, increase care in community settings and improve both understanding and communication of patients' holistic needs between healthcare professionals and with patients.
- **End of life care:** evidence indicates a need for service improvement to ensure that patients are better supported to choose the location for their last days of life. There is also growing evidence indicating a need for better informed clinical and patient decision making concerning the value of therapeutic interventions in the last days of life.
- **New models of care:** we are developing the case for a single provider model for radiotherapy in North London, to help achieve financial sustainability, reduce variation in clinical protocols and improve patient access to research and clinical innovations. This is being explored between the North Middlesex University Hospitals NHS Trust, the Royal Free NHS Foundation Trust and University College London Hospitals NHS Foundation Trust and links the hospital chains Vanguard led by the Royal Free. We will increase provision of chemotherapy closer to home, establishing a quality standard for chemotherapy and supporting self-management. The first patient treatment in the home for breast cancer took place in September 2016.
- **Centre for Cancer Outcomes (CCO):** to deliver robust outcomes data, improve pathway intelligence and address important population health research questions we are developing balanced scorecards which can be made available to MDTs, providers and commissioners through a free to access web-based platform. A project on interventions in the last three months of life is about to launch in conjunction with PHE.
- **Cancer Academy:** a new Academy is being launched to provide infrastructure and expertise to develop programmes for patients, primary care, multidisciplinary teams, cancer professionals and staff working in cancer clinical research. The Academy is working closely with partners across London as well as with UCL to collaborate effectively in programme design and delivery.
- **Research and commercialisation:** we will leverage our unique position nationally in cancer to improve care for people with cancer, generate additional revenues across the system, and generate efficiencies by avoiding unnecessary interventions.

We are focused on achieving a step change in key patient outcomes including:

- Deliver Cancer Taskforce aspiration for proportion stage 1 & 2 diagnoses by 2020
- Reduce to the national average or below the proportion of patients diagnosed in an emergency setting
- Achieve and sustain delivery of the 62 day access standard from the 2nd quarter of 2017/18
- Improve patient experience to achieve or exceed national average performance
- Reduce variation in these outcomes across NCEL and close the gap with the best performing regions, aiming for no CCG to be in the lowest quartile for any of these outcomes by the end of 2018/19

- Aiming to improve overall one year survival rate and reduce the current large variation seen across North and East London

#### **In 2017/18 we will:**

- Achieve a shift in the stage at which patients receive a cancer diagnosis, through a range of access and awareness improvements.
- Agree new care models in chemotherapy and radiotherapy to reduce variation in quality, improve financial sustainability and support care closer to home
- Work to define and capture the outcomes that matter to patients along their pathway from diagnosis to living with and beyond cancer so that this information can be fed back to patients, clinicians, providers and commissioners
- Undertake analysis that will improve patient experience and informed decision on therapeutic interventions during the last days of life.
- Define and implement best practice cancer pathways and service delivery models.
- Reduce wastage and improve value for money from cancer drugs spend

## **Maternity**

In 2014-15 there were approximately 20,000 babies born to North London residents and 24,000 births delivered by the local Trusts. In North London there are specialist maternity services centred on a single tertiary level neonatal unit, as well as obstetric, midwifery led-units and home births taking place. The population is diverse and growing and experiences significant fluctuations as people using health and care services move in and out of the city. North London has significant areas of deprivation as well as older women, more likely to be overweight or obese and likely to experience medical complications in pregnancy such as gestational diabetes, when compared with the national averages.

Across North London, fewer women access services in midwifery-led settings, within birth centres and at home than would be clinically indicated. While community midwifery antenatal care is offered by all providers, more care can be provided close to home or work. Women are not being offered choice of care setting or receiving continuity of antenatal or postnatal care. There is a lower than national average score for experience during the antenatal, intrapartum and postnatal periods and perinatal mental health support is varied.

In November 2016, North London was successful in a bid to become an early adopter of the National Maternity Transformation Programme. This programme sets out to achieve the ambitions of the Better Births report - the output from the National Maternity Review conducted earlier in 2016.

Based on the Better Births report, the primary objectives for their Maternity Programme are:

- To improve the experience of women accessing maternity services in North London
- To provide increased community-based choice across the pathway of care and greater access to midwifery-led care within birth centres and for home birth
- To improve continuity of maternity care, including continuity of carer
- To improve the safety of maternity care provided to women
- To improve the quality of information offered during pregnancy so that women can be supported to make choices that are most appropriate for their needs
- To develop a single point of access or centralised booking service

The key areas of transformation have been identified and summarised into three main categories:

**Personalisation** – We will redesign maternity provision so that women and their families will be able to choose maternity care in a variety of settings and by the most appropriate clinicians. This will be achieved through the development of innovative models of care, advice and education

which, where possible, will take place outside of the acute hospital setting. This will require staff development, process improvement and the development of appropriate early information around risk to choice and continuity. The gap between the actual and desired place of care will be reduced and births in midwifery-led settings (where appropriate) will be increased. Women will have an engaged professional advocate (usually their midwife) to provide unbiased support and advice. Maternity teams will work closely with the emerging perinatal mental health services to develop improved services for women affected by mental ill health.

**Continuity** - The majority of care will be provided in community hubs by midwives working in partnership with other agencies including:

- Social Services
- Health Visiting
- Family Nurse Partnership
- Housing
- Contraception
- Mental health
- Neonatal outreach with classes offered to all (antenatal, breastfeeding, parenting, pre-conceptual care for next pregnancies)

Autonomous teams of midwives will be supported by named obstetricians with the governance, training, protocols and processes to work in any facility within the North London system. There will be continuity from the initial booking visit through the availability of a centralised booking service offering appointments, information and advice. Maternity information will be shared across North London organisations through the implementation of electronic medical records. Continuity of postnatal care will be improved through revised models of care and care plans.

**Safer Care** – Governance and training will be centralised so the system becomes more responsive and learns from events. Duplication will be reduced with prompt response to abnormal results achieved through equal access to all systems partners (with a woman's permission). We will continue to reduce perinatal deaths through the Still Birth Care Bundle, investigating deaths using a standardised review process, increasing utero transfers to L3 units, reviewing capacity and escalating 'red' outcomes for peer review. Benchmarking and driving improvement plus ensuring the Maternity Services dataset is completed by all providers. Care will be delivered by a multi-profession workforce which is able to work across organisations to support new models of care and improve staff safety levels.

The programme will be delivered through four workstreams, which address different elements of the transformation plan. However, because of the interdependencies between the workstreams, the working groups will need to be cross cutting. For example, the work on improving community care through the establishment of community hubs is dependent on the work to establish systems for collaborative working. The establishment of a single point of access is dependent upon the work on choice.

Those elements of work on safer care, which don't fall specifically into one of the four workstreams, will be picked up within a Quality and Safety Subgroup of the Local Maternity Services Board.

Furthermore, given the considerable body of research suggesting that foetal exposure to an adverse environment in-utero sets the trajectory for child and adult health in terms of congenital malformations, obesity, diabetes and cardiovascular disease, the Partnership will explore ways to link primary care, public health and maternity services to optimise maternal health before, during and after pregnancy.

In particular, smoking cessation, weight reduction, optimisation of blood sugar control in diabetics and improving the diet of women of reproductive age has the potential to reduce the health needs of both women and children in the longer term.

Below is an outline of our plans in more detail:

Workstream	Initiative	Description/Deliverable	Impact
<b>Ensuring equality of choice for all North London women regarding place and type of care</b>	Identify current birth settings and which are chosen at present	Detailed mapping of current offer for birth, antenatal and postnatal care by each Trust has been completed.	<ul style="list-style-type: none"> <li>• Improvement in patient satisfaction in relation to choice and information offered.</li> <li>• Increased score within CQC survey relating to choice questions. More women say they are offered choice of place of antenatal, birth and postnatal care.</li> <li>• Improved and streamlined systems for clinical staff.</li> </ul>
	Determine factors impacting choice of birth setting	Engage service users to understand the factors that impact choice.	
	Identify current antenatal and postnatal settings and which are chosen	Map key blockers to ensuring choice is offered and perceived as such by women.  Map the current processes and how staff and women perceive them.	
	Determine factors impacting choice of antenatal and postnatal settings	Engage women to understand what choice means to them.	
	Standardise the process for offering choice of care setting at referral	Engage staff to understand how these systems could improve.	
	Ensure women have equal access to a range of antenatal, birth and postnatal settings whichever Trust they choose	Review information available and standardise.  Consider a North London wide website for information.  Produce standardised decision making tools, linking to single point of access work.  Review guidelines, milestones and workforce to ensure able to implement new models of care.	

Workstream	Initiative	Description/Deliverable	Impact
Improving community services	Mapping of existing community services	Detailed mapping of current service locations and activity has been completed. Further mapping to identify other co-located services to follow.	<ul style="list-style-type: none"><li>• More care available closer to home or work for women outside an acute setting.</li><li>• Clear pathways of care across geographical boundaries.</li><li>• Improved continuity of carer for women.</li><li>• Improved satisfaction for staff in being able to provide continuity.</li><li>• Improved postnatal care, demonstrated through improved CQC survey scores and London continuity audits.</li><li>• Reduced blood spot screening Sis.</li></ul>
	Identification of maternity activity at community sites		
	Mapping of existing processes underpinning services	Detailed mapping of antenatal and postnatal pathways including for out of area women and those from in area who birth outside to be completed.	
	Development of North London wide community model of care	A new vision for community services, including models of care and pathways to be developed in conjunction with stakeholders.	
	Development of North London wide antenatal pathway		
	Development of North London wide postnatal pathway	Develop a plan for the configuration of hubs and other locations, including staffing, IT etc.	
	Implementation of community hubs		
	Reconfiguration and training of North London workforce	Develop policies, a training plan and materials.	
	Communication of change		
Implementation of single point of access	Determine existing access models	Mapping to identify current booking patterns is complete.	<ul style="list-style-type: none"><li>• Increased level of informed choice about type and location of care at beginning of pregnancy.</li><li>• Increased rates of early booking to meet screening target at 10+0 weeks.</li><li>• Reduced levels of DNAs, reduced levels of multiple appointments and bookings.</li><li>• Streamlined systems within maternity services.</li></ul>
	Determine preferred future model	In-depth review of referral processes to be undertaken.	
	Ensure staff equipped to transition to new model	Work with women and families to map factors, which shape choices made at booking.	
	Refine literature offered to women	Develop vision for new model by examining what is available elsewhere and engaging with stakeholders to determine the most appropriate for North London.	

Workstream	Initiative	Description/Deliverable	Impact
<b>Implementation of collaborative working approach</b>	Implementation of shared processes and procedures	Working closely with work stream 2 this work stream is about enabling the establishment of community hubs and the ability for staff to work across the system.	<ul style="list-style-type: none"> <li>• A mobile workforce that can be flexed across the system.</li> <li>• Improved demand management at times of increased activity.</li> <li>• More efficient use of maternity services across North London.</li> <li>• Improved continuity of care for women with the greatest medical and social need.</li> </ul>
	Implementation of shared communication approach	Governance and indemnity systems and processes will be reviewed and changes required enabling staff to work across the system.	
	Implementation of a mobile workforce	Pathways and models of care into and out of acute care to the community will need to be mapped.	
	Enabling shared access to patient data / IT	Along with current training systems and materials so that a new models of education and training can be developed (As per work stream 2).	

#### In 2017/18 we will:

- Standardise the process for offering women a choice of care setting at referral in North London
- Ensure women have equal access to the different birth settings and antenatal care/postnatal care settings at whichever North London Trust they book with
- Improve Community Services through a review of current pathways and provision that will lead to the design of community hubs
- Work with relevant partners to design a single point of access for maternity services

## Children and Young People

Children and young people are a significant proportion of the total population of North London (approximately 25% to 30%). The health and wellbeing of our children and young people today will determine the health and wellbeing of all future generations. Our service transformation therefore must include a specific focus on our younger population.

Our simple aim is to ensure children and young people are as happy, safe and healthy as possible and have access to opportunities that allow them to achieve their full potential.

We are committed to reducing health inequalities with a focus on prevention and early intervention. We believe that we need to work across health, education and social care in North London to do this, particularly maximising the potential of nurseries and schools to improve health and wellbeing of our children and young people.

We know that poverty, deprivation and inadequate housing are the greatest determinants of poor health and wellbeing outcomes in children and young people and we face significant demographic challenges. We also know that issues such as domestic violence can impact negatively on the mental

health and wellbeing of children. Our case for change demonstrated that 30% of local children grow up in child poverty, with 6% living in households where no one works. Four of our five boroughs are in the top 10% of areas in England for the number of homeless households with a priority need, and all five are in the top 10% or number of households in temporary accommodation.

In response to these challenges, we have established a North London-wide Children and Young People's Network which will champion children and young people's service development and drive up quality and efficiency. Our priority areas are:

**Paediatric elective and emergency surgery** - Children & Young people should have equal access to surgery based on clinical need. Surgery should be undertaken as close to home as possible by staff with the requisite training and skills. There is opportunity to commission and deliver surgery differently across the footprint to achieve high quality care whilst at the same time realising economic benefits.

**School readiness by five** - Supporting children to have the very best start in life is very important to their future health and life opportunities. However, we know a third of our children in North London do not reach a good level of development in preparation for school. We will explore how to work together to have the biggest impact on this area, in particular by improving oral health of children (tooth extraction is the biggest cause of hospital admission nationally in school aged children five to nine years of age) and by improving children and young people's speech, language and communication.

**Long term conditions** - Asthma is the most common long term condition in the UK and, on average, affects three pupils in every school classroom. We will draw on the London paediatric asthma standards to ensure children and young people are routinely followed up by their GP practice after an asthma related A&E attendance or admission; to ensure every registered asthmatic has a written asthma management plan and an annual health review, which will include correct inhaler technique and medication review; and to extend the Asthma Friendly Schools Initiative successfully piloted in Islington.

**Reducing emergency attendances and admissions** - The network will play a pivotal role in supporting the delivery of reduced paediatric A&E attendances and emergency hospital admissions by 20% by March 2021. This will mean new models of care will be tested and developed across the footprint.

In addition to the areas above, the network will promote an all age, life course approach across all other workstreams within this plan.

To tackle obesity and the number of children who are overweight, we will promote active travel, sport and play for children in schools, encouraging schools to deliver the Take 10, Active 15, Walk a daily mile initiatives that have been successfully adopted in other parts of the country. By 2020/21, our aim is that four out of five early years' settings and schools in North London will be accredited as part of the healthy schools, healthy early years or similarly accredited programme for promoting healthy lives.

Working with the Mental Health workstream of this plan, we will address mental ill health in children as early as possible: developing antenatal and postnatal interventions for mothers with mental ill health; improving services for parenting support, health visiting, and signposting; and creating targeted services that focus on vulnerable high risk families.

We will capitalise on the universal services of MIND, Place2Be and established voluntary sector initiatives like **Hope Tottenham** that are already working directly with families and young people.

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

We will work collaboratively with the mental health workstream to deliver the Child and Adolescent Mental Health Services (CAMHS) and perinatal initiatives as detailed above. We will explore ways to develop the Partnership and link primary care, public health and maternity services to optimise maternal health before, during and after pregnancy and to reduce the health needs of children in the longer term.

#### **In 2017/18 we will:**

- Engage with the other workstreams in the partnership to support the delivery of their plans to improve the lives of children
- Develop a more detailed delivery plan for work that falls outside of the remit of the other workstreams ready to implement in 2018/19

### **Specialised commissioning**

The London Specialist Planning Board has set out the scope of its work, and established four workstreams on clinical pathways, in Renal, Cardiovascular, Cancer and Paediatrics. We are actively participating in the groups which held their first meetings at the end of January: it is too early to know how these workstreams will impact on North London which has already undertaken significant reconfiguration in three of these. We also understand that NHS England is driving a number of initiatives through commissioning, to control expenditure on high cost drugs and devices. We will incorporate information on these, together with further refinement of additional priorities and North London-driven activity in due course.

### **New commissioning and delivery models**

As part of the development process of this plan, and in response to the changing healthcare landscape in North London, the five CCGs have agreed to establish new ways of working more collaboratively together whilst also seeking to strengthen joint commissioning with local authorities. The establishment of a more formalised degree of cooperation between the five CCGs will improve health commissioning, particularly in response to:

- the development of new models of care, including larger provider organisations such the Royal Free Group model which aims to bring together a network of hospital providers
- increasing financial risk
- stretched capability and capacity

We have agreed to establish a joint committee across the five CCGs to enable joint governance of some key commissioning decisions; the development of a common commissioning strategy and financial strategy; and the establishment of some shared CCG management arrangements, with a view to shaping new ways of commissioning. With a focus on population health systems and

outcomes and the transition to new models to deliver these, our objective is to further strengthen strategic commissioning over the next two years. We have agreed that any new commissioning arrangements need to balance the importance of local relationships and existing programmes of work with the need to commission at scale.

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

These new leadership positions will work with each of the CCGs, as well as the new shared governance structure described above, to ensure that health commissioning in North London delivers the best possible health and wellbeing for the local population whilst ensuring value for money. The arrangements were agreed by governing bodies in November 2016 and a single Accountable Officer is now in place. The remaining new post holders will start early in 2017/18.

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

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

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

We recognise that the health & care landscape in London is particularly complicated, so we do not expect to implement any significant changes in the short term but will keep our approach under review.

## **Consolidation of specialties**

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

We are not starting from scratch in this area: considerable service consolidation and specialisation has already taken place in North London. We have successfully done this across:

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

We recognise that there are other service areas which are currently or may become vulnerable in the future. There are many reasons why consolidation of services might be considered as a possible opportunity for improvement. We agree that improving quality should always be the key driver for exploring consolidation, particularly where there is clear evidence of patients achieving better outcomes.

This work is at an early stage. No decisions have been made. Over the next year we will review whether these or any other services would benefit from consolidation or networking. Consideration of any requirements for consolidation of services will be undertaken within each of our clinical workstreams as they develop more detailed delivery plans. The Health and Care Cabinet will retain oversight of this work to maintain a whole system perspective.

## **Enablers**

As well as making the changes outlined above in prevention and service transformation, we need to ensure the infrastructure and resources we have are redesigned and aligned to deliver these transformed services - these workstreams are known as enablers. To achieve this, we will work as a sector to share and transform the vehicles that underpin delivery.

## **Workforce**

Our vision is to support North London health and social care organisations to be excellent employers, committed to supporting the wellbeing of staff whilst also preparing them to deliver the new care models in a range of settings. We will work with North London organisations across all health and care settings to support their collaborative efforts to achieve this whilst ensuring that everything we do contributes to the following aims:

1. Improve patient experience and outcomes through improved staff experience and engagement
2. Define and adopt new ways of working, including working across health and care settings
3. Maximise workforce efficiency and productivity
4. Create a reputation where North London is recognised as a great place to work aiding recruitment and retention
5. Promote and provide an excellent learning environment
6. Develop, implement and embed a systematic approach to leadership development.

To support these aims we are committed to co-creating, communicating and collaboratively delivering plans to address capacity, quality, cost and capability of our workforce. As leaders, we will encourage a culture of networking, collaborating and educational asset sharing, as we believe that strong relationships between our staff are the best way of achieving change. The 'Breaking Down the Barriers' programme (a collaboration between Health Education England, UCL Partners and a number of our Trusts that aims to improve mental and physical health through education and training) is a positive example of an initiative which will be taken forward through developing such a culture.

We will achieve efficiencies in employment by:

- connecting employment services and processes collectively across the footprint
- enabling North London organisations to recruit and retain staff, particularly where employee turnover rates are high or where there are staff shortages
- facilitating the implementation of new models of care, providing a framework for the deployment of staff to new settings and areas of greatest need

We will develop initiatives to equip the existing workforce with new skills and ways of working, ensuring that our people are working to the best of their ability as well as adapting roles to meet the changing requirements of our services. We will implement plans emerging from the workstreams to equip people currently working in hospital settings with the skills and confidence to work across the care pathway, reaching out into community care settings and delivering the care closer to home model.

Since the inception of the STP, we have commissioned 446 postgraduate career development programmes and rotations for our nurses to develop the skills required to fulfil our vision of an agile, highly skilled, North London workforce. This work will continue over the life of the plan through initiatives such as the Capital Nurse programme (for which we have already affirmed our commitment to deliver) and through a single implementation plan for the sector, boroughs and organisations.

We have five successful Community Education Provider Networks (CEPNs) in North London who are starting to focus their work to the following core themes:

- Retention
- Clinical skills
- Widening participation
- Carers and communities
- New ways of working and new roles
- Building a stronger interface with secondary care to enable skills transfer

Our CEPNs are an example of a network/asset sharing based approach to improvement. Delivering improvements to primary and community care through initiatives such as Care Closer to Home Integrated Networks (CHINs) is fundamental to achieving the service ambitions set out in our plan.

**A note on mitigating the potential risks of Brexit:** We do not currently know how the process of the UK leaving the EU will impact on health and care services but we do know North London is a cosmopolitan area with many people from the EU settled here as workers and residents. We know Brexit it is a real concern to staff, patients and residents – both in terms of who will provide their care, who will run their services and what it will mean for the livelihoods of friends and family. In the current political and economic climate, a safe supply of workers to meet the needs of our patients in North London. Our retention strategies are aimed at continuing to attract and retain the right people, thus reducing the reliance on overseas staff. Our HR community is working closely with the Mayor of London to ensure that overseas workers, who are vital to our health economy, remain part of our health economy.

Health, social care and public health delivery is not limited to employees of our traditional employers, and our notion of working with the 'wider workforce' extends to the numerous carers, volunteers and citizens who improve the life of our population but are employed outside of the public sector, including home care workers and personal assistants. In order to improve the general wellbeing of our population and make use of the substantial social capital across our footprint, we will educate and support patients, carers and those in their communities in areas such as self-care, self-management, dementia and mental health awareness.

We will implement initiatives to equip existing and future staff with motivational and coaching skills, competence in promoting self-care and prevention, and enhancing emotional resilience in themselves, their teams and their patients. We have developed a health coaching competency framework which has now been rolled out across each of our Trusts, with each Trust now leading a specific person-centred conversation initiative.

We will support the Prevention workstream in training all frontline NHS and social care staff in Making Every Contact Count (MECC). Similar work will be undertaken to ensure that all non-medical frontline staff receive training in Mental Health First Aid (MHFA) and basic dementia awareness. We have created a Dementia Awareness programme in North London, which we will continue to develop and ramp-up to focus on Tiers 1, 2 and 3. This programme, developed by Health Education England and UCL Partners, has been nationally acclaimed.

While most of the people who will be engaged in delivering the North London vision are already with us, working in roles which will need to adapt or change in some way, we will also help to establish a number of new roles such as physician associates, care navigators and advanced clinical practitioners. We will support strategic workforce planning and redesign and commission training for skill enhancement, role diversification and new role implementation. Much of this work has begun, but others will be contingent on the definition of new clinical models.

To enable transformation, we will deliver system-level organisational development, supporting leaders and teams through the transformation journey. In addition, we will train everyone in a single approach to continuous quality improvement to deliver sustained clinical excellence and high quality care.

As part of our Delivery Plan we have brought together the health and social care workforce community under the strategic leadership of the LWAB (Local Workforce Action Board) and initiated a programme of work in the following areas that help deliver the six aims outlined earlier:

- Resourcing and integrated employment (aim 4)
- Learning and development (aim 5)
- Enabling new models of care (aim 2)
- Enabling productivity and back office rationalisation (aim 3)

We have launched collaborative work programmes to improve staff retention, manage temporary staff rates of pay, procure a shared bank and reduce levels of agency expenditure. We have already identified significant savings against these initiatives which we are committed to achieving. Building the brand of North London as a place of choice to train and work is a pivotal enabler to these ambitions; where permanent or temporary employment is deemed much more attractive than agency work; whilst remaining flexible.

We recognise the benefits of collaborating on learning and development and our delivery plan includes work on shared leadership, Organisational Development programmes and a review of Learning and Development capacity and delivery, as well as a joint approach to new arrangements for apprenticeships.

These initiatives, together with work on creating common employment policies and procedures, will improve employment portability and further the aim of achieving more integrated employment across North London.

#### Exhibit 9: Integrated model of employment



The Workforce workstream is a key enabler for the new models of care emerging from the workstreams. We will lead workshops and task and finish projects to facilitate agreed workforce plans. The NHS provider HR community is also collaborating on a review of back-office HR processes; shared HR systems and policies will facilitate this work.

For the next stage of the Workforce workstream, we will turn our focus to the clinical workstreams to accelerate the pace at which they develop new service models and define the workforce they require.

Engagement and the development of close working with the clinical workstreams has been a key element of our initial work and this now needs to progress into the delivery of workforce plans to transform services. We will support scenario modelling to assess the financial benefits of the new models and the impact of new roles and changing settings for providing care.

Below is an outline of the different areas we are working on:

Work package	Initiative	Description	Deliverable
<b>New Models of Care (Workforce as an enabler)</b>	Package of work for each of the clinical work streams	Support the new models of care leads in understanding changes to workforce resulting from the new models of care covering capacity changes, new roles, changed roles, skills, training, competencies, recruitment and professional and career development. Bring together professional expertise in pathway designers with HR expertise to ensure credible plans for implementation	<ul style="list-style-type: none"> <li>• Workforce modelling and analysis</li> <li>• Workforce design</li> <li>• Education &amp; Training design and delivery</li> <li>• Develop change management skills and capacity to support new models of care</li> </ul>
<b>Primary Care</b>	Recruitment & Retention  Training & Development  New Roles	Review and re-alignment of GP Training across London/ North London. Implementation of new role programme.  Implementation of retention schemes and training of existing workforce	<ul style="list-style-type: none"> <li>• Workforce design to take place concurrently with CHIN development timelines</li> <li>• Delivery of workforce aspects of the GP Forward View</li> </ul>
<b>Resourcing</b>	Recruitment & Retention  Temporary Staffing  Bank	To reduce turnover across North London and retain existing skills  To consolidate temporary resourcing activity across North London and to provide attractive and comparable rates and reduce agency spend  Single procurement for a shared bank platform/service	<ul style="list-style-type: none"> <li>• Stage one qualitative “deep dive” assessment</li> <li>• Reward Assessment</li> <li>• Common Recruitment Policy and Processes</li> <li>• Pay data report to LWAB</li> <li>• Platform for one provider that enables Trusts to join the bank</li> </ul>
<b>Learning &amp; Development</b>	Statutory and Mandatory  Shared provision  Apprenticeships	Standardise and streamline and extend one approach to statutory and mandatory training  Pooling resources across North London and developing shared capabilities for in house delivery of education, training and workforce development  Collaborative approach to apprenticeships	<ul style="list-style-type: none"> <li>• Standard common approach , content, topics and standards implemented to delivery models for statutory training</li> <li>• Initial phase provides an in depth review of learning centres, e-learning platforms, library services, simulation facilities and current provision</li> <li>• Shared policies including pay, terms and conditions</li> <li>• Co-ordinated approach to capabilities</li> <li>• Joint procurement of providers</li> <li>• Joint planning of shared cohorts</li> </ul>

Work package	Initiative	Description	Deliverable
<b>Integrated Employment Model</b>	Branding  Employment portability  Career frameworks	To encourage employment flexibility across the health and social care system. To implement employment portability and career frameworks that supports the new models of care.	<ul style="list-style-type: none"> <li>• Employment Concordat</li> <li>• Shared Vision</li> <li>• Programme of work</li> </ul>
<b>Productivity</b>	HR Administration	Future HR operating models that consolidates HR transactional activity	<ul style="list-style-type: none"> <li>• Standardisation and streamlining of policies and processes and procedures and an operating model for future delivery</li> </ul>

Our Local Workforce Action Board has matured into a dynamic forum for improvement, bringing together the workforce community from across all our stakeholders as a key vehicle for developing, approving and assuring our plans. It will continue to provide oversight and challenge to current programmes, ensuring that benefits are realised while extending the reach of these programmes and bringing new ones on-stream.

Key challenges for 2017/18 will be to support the service in:

- Breaking down the boundaries that exist between hospitals and primary care, health and social care and between generalists and specialists
- Building the future workforce to tie in with the implementation of new service models, where there is a significant lead time in training new staff
- Investing, developing and deploying support staff to become a more flexible and cost-effective resource that reduces pressure on highly qualified staff
- Extending skills of registered professionals and training advanced practitioners to fill gaps in the medical workforce, provide rewarding clinical career options and mentoring for less experienced staff

#### **In 2017/18 we will:**

- Work with the Care Closer to Home workstream to ensure the required staffing mix is available
- Work with Primary Care colleagues to support the transformation of access to Primary Care seven days a week
- Work to reduce turnover across North London and retain existing skills to support delivery of the above
- Roll out a collaborative approach to learning and development and apprenticeships

## **Estates**

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

The priorities for development of our estates strategy are:

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

There are a number of barriers to achieving this including:

- in North London, there are a significant number of organisations and the differences in governance, objectives and incentives between each organisation, can result in organisations working in silos
- misaligned incentives, which do not encourage optimal behaviour
- lack of affordability, specifically the inability for non- foundation trusts to retain capital receipts, budget “annuality” and the difficulty of accessing capital investment for re-provision, especially in the constrained fiscal environment for the NHS
- the complexity of developing business cases in terms of getting the right balance of speed and rigour, and the different approvals processes facing different organisation types (for example, there are different capital approval regimes operating across the NHS and local government)
- the primary and community estate requires development to create ‘care closer to home’, improved access and to meet the needs of significant population growth. Capital funding to develop this estate is scarce and significant proportion of the community and primary estate is not owned by the partners in the Partnership

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

- local prioritisation and investment of capital receipts, including those that would otherwise be retained nationally
- NHS capital business case approval to be accelerated and consolidated through the implementation of a jointly owned and collaborative North London / national process (or devolved to sub-regional or London-level)
- developing local flexibilities in terms and conditions for the primary and community health estate to improve quality and utilisation

It is anticipated that the London devolution agreement for health and care will be agreed in Spring 2017. In the currently agreed London timetable, North London expects to be able to use devolved powers in shadow form initially, moving to full use of devolved powers after 2017/18. We want to use devolution as an opportunity to accelerate the development of the estate needed for care closer to home, securing greater utilisation of community estate and capital for redevelopment from disposals of surplus estate. We also want to ensure that devolved powers enable us to address the need for better quality mental health in-patient facilities at greater pace.

A London Estates Board has been established to oversee the implementation of estates devolution in London. An early priority for North London in 2017/18 is to develop its legally constituted governance for devolved powers.

We anticipate the following benefits from the estates workstream and devolution:

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

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

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

The three trusts are currently refining their outline business cases, with outputs due mid-2017. Subject to consultation, further testing of economic viability and planning permission, the specific benefits of the work will include:

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

The schemes are planned at a total capital cost of c. £400m with joint provider engagement under the umbrella of the estates devolution pilot driving completion of the final scheme by 2023. It is planned that around £325m of this is financed by sale proceeds with the remainder funded from a variety of sources, including philanthropy.

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

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

- development of CHINs to enable the delivery of the care closer to home model
- expansion and development of primary care facilities to ensure registration for a significantly expanding population and extended hours access
- our modelling indicates that development of the estate required for care closer to home will need capital investment of circa £111m. North London has been successful in securing some investment from NHS England's Estates and Technology Transformation Fund and an allocation from the NHS Information Governance Fund. However, the funding secured, in common with other STP footprints, will not meet the full cost of development.

**In 2017/18 we will:**

- develop detailed business cases for the care closer to home estate to support the developing CHIN framework by working closely with the Care Closer to Home and the Planned Care workstreams
- use devolved powers and other avenues to secure capital to deliver these much needed improvements and reduce the running costs of this estate

## Digital

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

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

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

Our digital programme proposes the creation of a North London Population Health Management System (exhibit 10) which supports prevention, service transformation and productivity, and would assist in meeting the national mandate of operating paper free at the point of care by 2020. Through this system we will move from a landscape of diversity and variation to one of shared principles, consolidation and joint working for the benefit of the population.

### Exhibit 10: North London Population Health System Management

<b>Activate</b>	<b>Digitally activated population</b> Personal Health Record; Self management; remote monitoring; digital transactions	<b>Information Governance</b>	<b>Data Quality and Validation</b>	<b>NCL Digital Delivery Model</b>
<b>Analyse</b>	<b>Insights driven health system</b> Health system benchmarking; cohort stratification; patient tracking; case management; whole pathway decision support; predictive modelling			
<b>Share</b>	<b>Integrated care</b> Shared health and care records; care plans			
<b>Link</b>	<b>Integration and messaging</b> Health Information Exchange; information and messaging standards; document, image and data exchange			
<b>Digitise</b>	<b>Applications</b> Electronic health records; clinical documentation; ePrescribing and closed loop medication management; orders and results; device integration; alerts and decision support	<ul style="list-style-type: none"><li>• CCGs</li><li>• Primary care Social care</li><li>• Acute, community, mental health and specialist providers</li><li>• Care homes</li></ul>		
<b>Enable</b>	<b>Infrastructure</b> Network; wifi; unified comms; email; collaboration tools; end user technology; virtual care services			

The six elements that make up our digital strategy are:

- **Activate:** We will provide our citizens with the ability to transact with healthcare services digitally, giving them access to their personal health and care information and equipping them with tools which enable them to actively manage their own health and wellbeing.

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

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

#### **In 2017/18 we will:**

- Develop and adopt a common Information Sharing Agreement
- Develop a connectivity strategy for North London
- Develop a system-wide approach for Integration and Data Platform
- Review the opportunities for the consolidation of the ICT services across providers
- Identify digital maturity investment objectives across providers
- Scope of Universal Capabilities reporting



## Addressing the financial gap

Not only do we aspire to provide the best services that improve outcomes and reduce inequalities, we need to make the system financially sustainable.

The financial analysis that we have undertaken (exhibit 11) shows the significant gap between anticipated growth in demand (and therefore cost growth) for the NHS in North London and the growth in funding that the NHS expects to receive over the five years of the STP.

**Exhibit 11: The 'do nothing' financial gap for North London**

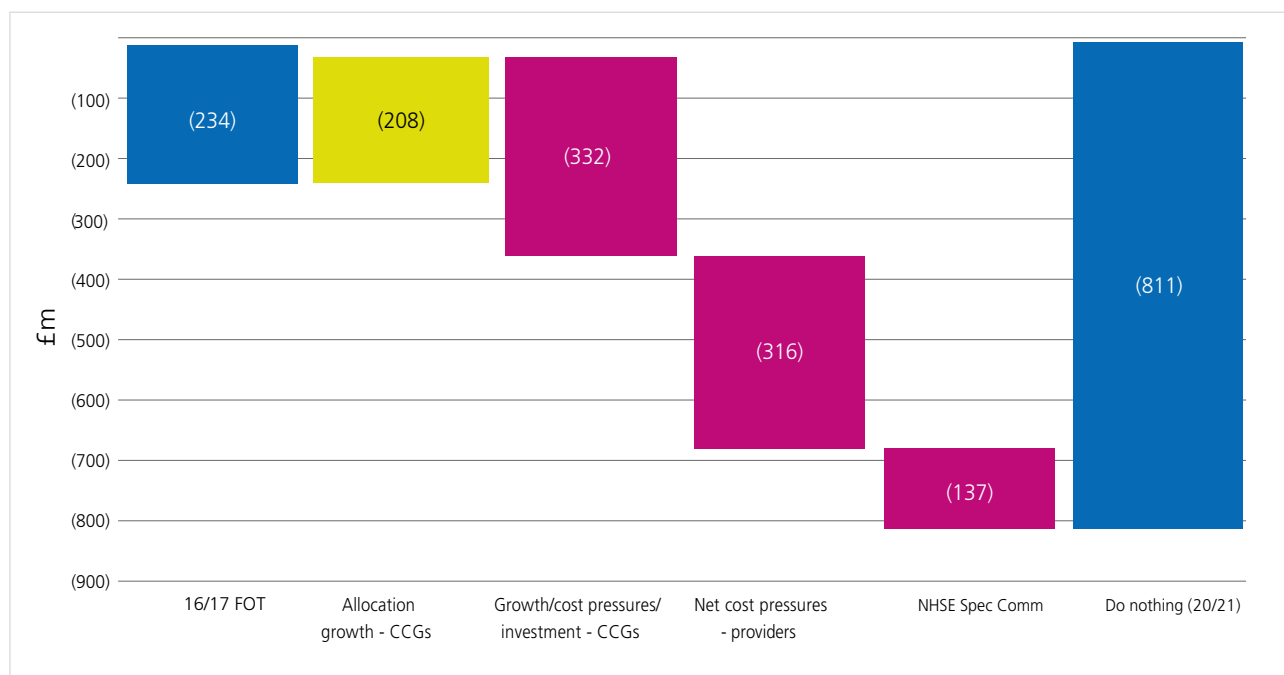
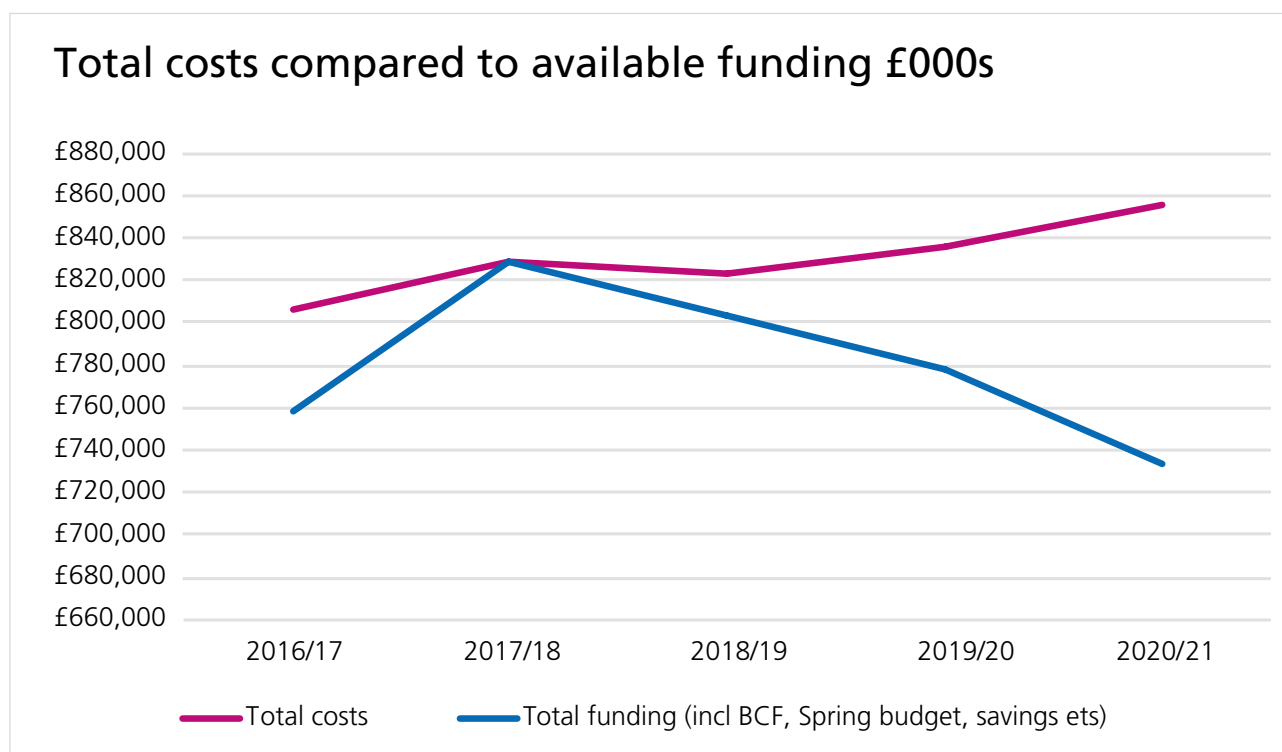


Exhibit 12 shows the financial pressure facing Councils in North London (for children's and adult social care and public health), which includes additional funding announced in the 2015 Spending Review, 2016 Autumn Statement and 2017 Spring Budget.

**Exhibit 12 – North London Council pressure budget pressure 2016/17 – 2020/21**



Without changing the way that we work together as a system to provide a more efficient, joined up service across organisations, we will have an estimated £811m deficit across the NHS in North London in 2020/2021. North London Councils will face a budget pressure of £247m for social care and public health by 2020/21, even when all additional funding announced by the Government has been taken into account. Local government finance legislation states that Councils must deliver a balanced budget each year, so North London Councils are using a variety of measures to offset this financial pressure, including increasing the pace on the delivery of transformation programmes, using savings from elsewhere in the organisation, and drawing from financial reserves accrued in previous years.

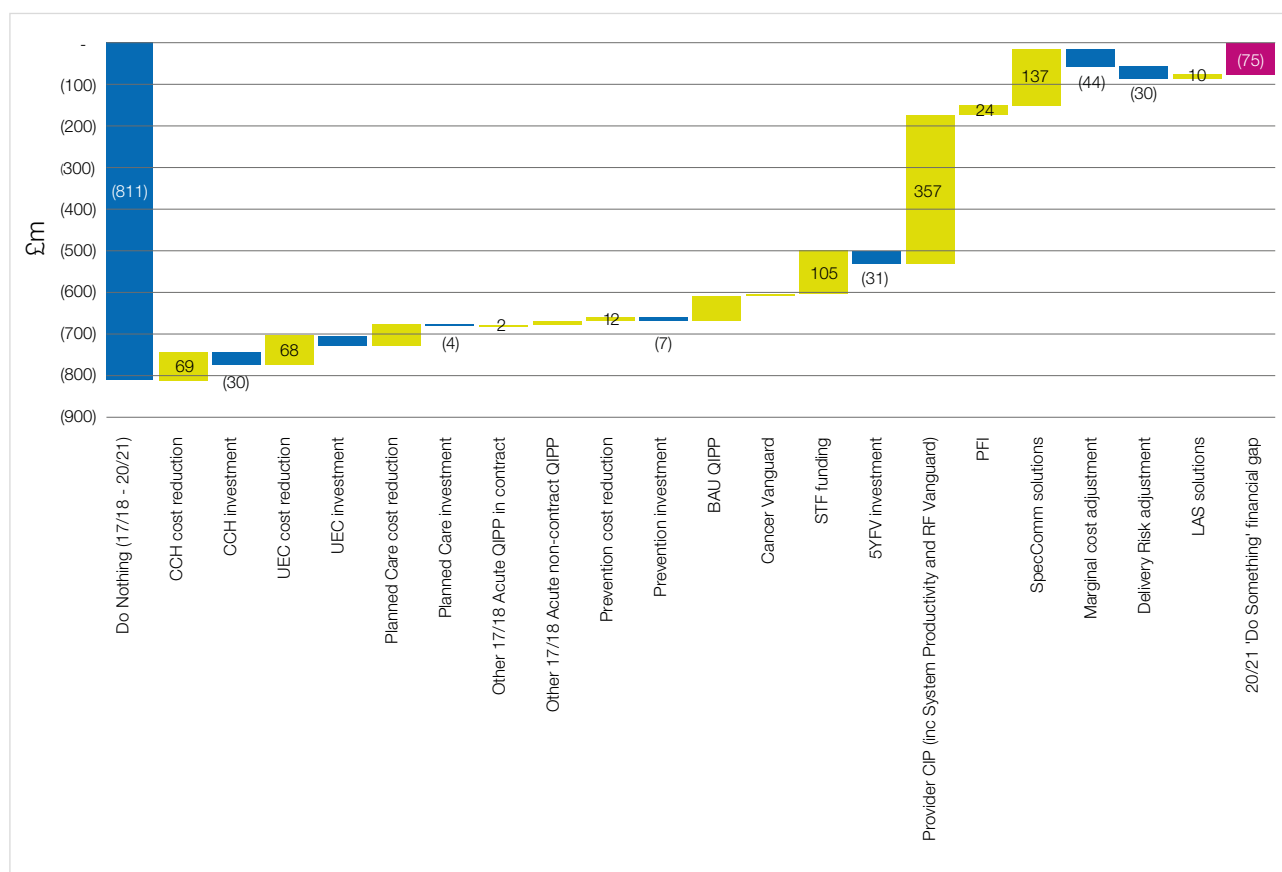
Further work is being undertaken to develop a full understanding of the financial pressures on North London Councils, particularly in adult social care, with a view to working closely together in 2017/18 to understand how we can jointly address the financial gap we face as a system. In particular, the NHS within North London is seeking to learn from local authority colleagues' best practice in relation to reducing cost whilst improving the experience of service users and the public.

As such, the rest of this section refers to plans to address the financial gap across the NHS in North London.

This 'do-nothing' financial gap has been calculated on a normalised recurrent basis (i.e. excluding one-off items) in accordance with NHS England and NHS Improvement guidance. The main drivers of the financial gap are the increased projected demands on the NHS as a result of the increasing population, and within this the demographic changes of an increasing elderly population in particular, as well as the increasing costs of providing healthcare, e.g. due to inflation. Although the NHS in North London is receiving additional resources, the combined impact of the projected increase in demand and cost increases are forecast to be greater than the increase in resources. This therefore results in the 'do-nothing' recurrent projected deficit in 2020/21 increasing to £811m, from the forecast 2016/17 outturn of £234m.

The STP in North London has brought together organisations across health and social care to jointly discuss how we can address this financial challenge as well as making progress in improving the quality of, and access, to services. Based on the plans and analysis set out in this STP, which have been developed with and by local clinical experts, we will reduce the annual deficit over the next five years to £75m (exhibit 13) whilst this addresses more than 90% of the financial gap, we recognise that further work is needed to close it entirely.

**Exhibit 13: The 'Do something' financial gap to 2020/21**



The key elements of the plan are set out in detail earlier in this document. Exhibit 13 shows how these contribute to the improvement in the annual financial position of the North London system over 5 years. The savings that will be delivered from the key areas of transformation are:

- **Care closer to home:** savings of £69m have been estimated from improving access to primary care and providing community-based care (with £30m of investment);
- **Urgent and Emergency care:** savings of £68m (with £20m of investment) to proactively identify early intervention to avoid crisis; rapid response to urgent needs to prevent hospital admissions; provide ambulatory-based care; and reducing delays to discharge.
- **Optimising the planned care pathway:** savings of £49m (with £4m of investment) through redesigning outpatient and planned care pathways.
- **Prevention and the support of healthier choices:** this is estimated to result in savings of £12m, with £7m investment.
- **UCLH Cancer Vanguard**, savings of £4m and Royal Free Hospital Chain Vanguard, included in the provider CIP section below.
- **Productivity** savings are planned to be achieved, including both 'business as usual' cost

improvements across providers, and wider system savings through working together of £357m in total. Business as usual QIPP schemes (non-acute) total £57m. Further details of the productivity savings projected are set out below.

## **BAU productivity**

Significantly improving provider productivity is an essential part of the work to address our financial challenge. Our plans assume significant delivery of CIP (Cost Improvement Programmes), improving provider productivity. Lord Carter's report on hospital productivity has shown that there is variation in how productive different NHS services are, and provides a "model hospital" website to help providers to understand where productivity improvements can be made. In addition to specific Carter initiatives within providers, each organisation will also have an intensive programme of cost improvement opportunities. The assumed levels of provider CIP in each year for 2017/18 and 2018/19 are based upon providers' detailed operating plans. Beyond this, a general assumption of 2% per year productivity improvement is made – this is a "net" figure as trusts usually experience additional external cost pressures each year (for example, PFI charges, rates increases and education funding losses) which must be offset with new savings first, before delivering an overall productivity improvement.

Analysis by NHS Improvement, provided by an independent firm, has indicated that a figure of around 2% per year is a reasonable maximum expectation in relation to annual productivity improvement for NHS providers. In an environment of reducing activity growth, for example as a result of the STP's work to provide patient care in more appropriate and less acute settings, it becomes more challenging to deliver a higher level productivity improvement.

## **System-wide productivity**

Notwithstanding the above, we know from the Carter work that we have opportunities to improve productivity further without detriment to the service we provide our patients and service users. Much of this comes from working more closely across different organisations within the STP in addition to work within organisations. North London has already consolidated many services across organisations, both clinically (such as cardiac, cancer and neurosurgery) and non-clinically (such as payroll, pathology laboratory services and procurement) which means there are fewer opportunities remaining.

However, we have identified a number of additional opportunities for system productivity (defined as those areas where CIP delivery is dependent on trusts working together rather than in isolation) to deliver financial savings whilst maintaining or improving quality. Our plans also assume savings from more efficient contracting between CCGs and trusts. As the STP has developed, it has become the norm for organisations to work together in realising savings, and these savings are incorporated within the CIP plans of each provider.

Specific initiatives to improve productivity are described in the sections below.

### **Workforce**

The Delivery Plan for Workforce includes a range of initiatives that have the effect of sharing back office workforce activity. These include:

- Standardising and streamlining statutory and mandatory training to deliver a standard common approach
- Pooling training resources across North London and developing shared capabilities in the delivery of education, training and workforce development

- Developing a common approach to Apprenticeships including joint procurement of providers with the aim of maximising the benefit from the levy
- Reviewing and standardising rates of pay for temporary staff across North London with an initial focus on locum medical pay
- A integrated review on workforce supply and reward to inform a new North London specific pay and non-pay benefit strategy for our permanent workforce
- Developing a platform for one staff bank which enables trusts to join at a time of their choosing. UCLH is leading a collaborative procurement to appoint a new provider not just for UCLH but for all other provider organisations within the STP who wish to join. This will reduce administrative costs and increase the number of temporary staff that are paid through a “staff bank” rather than through more expensive agency arrangements

These initiatives will help improve the efficiency of our HR functions as well as improving retention of current staff and upskilling the health and social care workforce to enable delivery of new models of care. We also commit to complying with the maximum total agency spend and hourly rates set out by NHS Improvement.

## Digital and ICT Consolidation

There are two main themes in relation to the use of digital technology across the STP – firstly the transformational ICT initiatives that will help improve the way in which organisations communicate with each other and their patients (which is described elsewhere in this document), and secondly reducing the costs of providing existing technology such as PCs, telephony, networks and other IT infrastructure. This second area is being addressed through a new digital technology partnership with Atos, a large IT company, which has the potential to significantly reduce costs across STP organisations by consolidating expenditure whilst also improving the resilience and quality of services. UCLH have already signed a contract with Atos that will reduce costs by c. £30m over ten years, and this was procured in such a way that other STP organisations can readily join.

## Other Workstreams for System-wide Productivity Improvement

- **Procurement:** we will reduce purchasing unit costs with increased volume and scale across all providers by reducing clinical variation in product choice and undertaking joint action on drugs and medicines management. This will be driven through the procurement shared service that already exists for 5 of our North London providers, with further collaborative work across the Shelford Group and the London Mental Health network augmenting this work.
- **Back office:** We have worked over the last 4 months to review opportunities for back office consolidation, centralisation and outsourcing, supported by external consultancy and internal project management. Although in many areas the external work suggested limited opportunities for further productivity improvement in the short term, we are actively seeking to reduce our overheads and improve service resilience across the footprint and are progressing with the following key workstreams in addition to those highlighted above:
  - o Enhance and extend the existing shared procurement arrangements (which serve most NHS providers within North London) to reduce non-pay costs; maximise use of wider procurement networks for large teaching trusts and mental health trusts.
  - o Review with HR Directors and our workforce workstream the opportunities and enthusiasm for HR transaction consolidation.
  - o Review with Finance Directors opportunities for process alignment, resource sharing and cost reduction across organisations’ finance directorates.
  - o Progress further outsourcing of payroll functions and take opportunities to consolidate contracts where feasible to do so.

- **Contract and transaction costs:** Releasing savings from streamlining transactions and contracting. This will be delivered through implementing new commissioning arrangements (which may facilitate joint procurement of services from the Commissioning Support Unit (CSU), for example) and leveraging the opportunities associated with joint commissioning between local authorities and CCGs.
- **Other:** Additional existing provider productivity schemes: estates, clinical admin redesign, service transformation, income etc.
- **Operational and clinical variation:** all acute providers are actively progressing plans in relation to the Carter productivity work. Reducing variation is a key part of the Royal Free's Group model, and we will also be working collectively to reduce average length of stay, maximise theatre utilisation and streamline clinical processes, in addition to the changes proposed through the planned care workstream.

### **Commissioner business as usual efficiencies (QIPP)**

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

- **Mental health:** this includes ongoing non-transformational efficiencies, consistent with parity of esteem requirements. Examples of mental health QIPP are the management of out of sector placements and streamlining the pathways with specialist commissioning across forensic and mental health services.
- **Community:** spend on community services includes an assumption of increased efficiency equivalent supported by benchmarking work and transition to new models of care.
- **Continuing care:** spend on continuing care assumes increased efficiency supported by existing framework agreements.
- **Primary care prescribing:** spend on primary care prescribing assumes increased efficiency including the adoption of generic drugs where possible, the adoption of local quality schemes to improve consistency and effectiveness.
- **Programme costs (including estates):** this includes measures to reduce void costs and better alignment of health and care services to reduce the overall estate footprint whilst maintaining and improving service quality.
- **Private Finance Initiatives (PFIs)** – whilst we recognise the role that PFI projects have had on modernising the NHS's buildings, we also believe that they don't represent value for money for individual NHS Trusts. We have modelled a conservative estimate of the saving (£24m per year) that could be made from terminating these contracts and bringing management of these facilities back within the public sector. We will continue to work with the Department of Health and others to develop these plans, or alternatively to seek additional central funding for these schemes if terminating them is not possible, recognising that there are a number of constraints.
- **Other** - Although detailed plans have not yet been developed, we have been advised by NHS England to assume that the North London proportion of the **London Ambulance Service (LAS)** financial gap of £10m and the estimated **specialised commissioning** pressure of £137m will be fully addressed by LAS and NHS England respectively. North London hospitals provide a very significant amount of specialist care and it is therefore essential that NHS England works together with the STP on how these services can flourish whilst also addressing the financial pressures associated with the growth in specialist activity (which in most developed economies is higher than growth in other services due to new technologies, drugs and clinical interventions).

These improvements cannot be achieved without investment. The plan is based on investment of £20m in urgent and emergency care, £7m in prevention, £30m in care closer to home, and £4m in planned care. We have also assumed that £31m of our indicative £105m share of the Sustainability and Transformation Fund will be required to fund national policy priorities over and above these investments, in addition to that already assumed within the 'do nothing' scenario.

The savings set out above are predicated strongly upon reducing significant activity in acute hospitals, in particular reducing demand for inpatient care. We know that realising such savings can be difficult in practice and are contingent upon removing or re-purposing capacity within acute hospitals. As such, through working with the Health and Care Cabinet within North London we have assumed that the cost savings that will be realised from each avoided day of acute hospital care will be significantly lower than the average tariff that is currently paid to providers by commissioners for this care. This is reflected in a £44m marginal cost (i.e. stranded costs) and £30m 'delivery risk adjustment' in the financial analysis.

## **Delivery through 2 year contracts in North London**

Delivering the STP is a priority for health and care commissioners and providers in North London - and our commissioning intentions, operating plans and contracts reflect this. All NHS contracts within the STP incorporate the impact of the STP's planned initiatives, particularly those that seek to provide care to our patients in a more appropriate, less acute setting. This strategic alignment, working as a system, will help support delivery. Whilst we recognise that implementation will look different in different local areas, we know that it will only be possible to deliver on the STP if we are all pulling in the same direction. Having two year contracts based around our STP delivery plans will help these plans to be implemented quickly, as well as supporting a longer term move to new relationships between commissioners and providers, reducing transactional costs and building the foundation for working more closely as a system between commissioners and providers in the future.

We have also ensured that organisations' operating plans are strategically consistent with the STP. In the current context of the financial position and management capacity across the system, we will ensure in the first 2 years of the STP that we are prioritising our efforts in the areas which will add the most value in terms of increasing health and wellbeing for people; improving the quality of care people receive; and ensuring value for tax payers' money.

Recognising that we have still not achieved financial balance in the current plan to 2020/21, we will continue to look for further opportunities for further efficiencies, in line with the Five Year Forward View Next Steps document, published recently by NHS England.

## **2017/18 position**

In respect of the 2017/18 financial position specifically, current plans fall short of the 'control total' targets set by NHS England and NHS Improvement for the CCGs and NHS Trusts across North London.

Although there are plans in place to reduce the recurrent deficit in 2017/18, the targets set for 2017/18 are for an in-year surplus. Currently North London CCGs and Trusts are assessed as c£60m away from delivering the 2017/18 target, with further risks of delivering already challenging savings plans on top of this. Recognising this, we are continuing to work on reducing the risks of delivering existing plans for 2017/18, as well as looking for further immediate opportunities for further efficiencies, beyond those set out above, including one-off non-recurrent measures that could improve the financial position in 2017/18, pending the full implementation of the transformational changes planned over the period to 2020/21.

To support our plan, NHS England and NHS Improvement have initiated a Capped Expenditure Process, to help the NHS produce a set of affordable plans for 2017/18. This aims to help us deliver the best possible clinical outcomes for local people within the funding available.

## Capital expenditure

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

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

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

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

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

- Estates redevelopment relating to our St Pancras/St Ann’s/Moorfields proposals - £404m, assumed to be funded through disposals (£326m), DH loans (£39m) and Donations (£37m), of which £272m (including short term bridging loans and repayments) occur within the period covered by this STP (i.e. before 2020/21) and is included above;
- Primary Care for Care Closer to Home and Five Year Forward View investment (£111m – assumed to be funded predominantly through ETTF (£60m – all bids submitted), s106/CIL/GP contributions (£26m), grants and other sources.
- IT investment (£159m with a further £21m in 2021/22) – all assumed to be funded by ETTF (circa £10m – bids submitted for the Person Held Record/IDCR) or through the central Digital Transformation fund.

We recognise that further work is needed to develop full business cases for the above, and at present these figures are estimated - particularly in relation to primary care and digital investment. In developing these schemes we will seek to maximise the use of existing buildings and other assets, and minimise the need for new capital investment, together with applying a robust requirement for return on investment for each scheme. However, we fundamentally believe that investment in primary care and digital technology is central to the transformation of services that is needed in North London to address the gaps in service quality, access and finance, and wholly consistent with the Five Year Forward View and requirement to be paper-free at the point of care by 2023. It would be wrong to

assume that such investment is not required and won't deliver value simply because of the stage in development of these plans that North London is currently in.

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

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



# Communications and Engagement

Since November 2016, we have been working with the NCL Joint health oversight and scrutiny committee (JHOSC). We have presented at the JHOSC and shared with the committee and members of the public our draft plan and introduced some of the areas of work. In January, the committee presented a report which included a number of recommendations to the NCL STP. We have responded to these recommendations and will continue to attend the JHOSC meetings to share our progress and respond to questions and feedback with a commitment to transparency and collaboration. As part of our work with the JHOSC, we have agreed a number of principles to guide the NCL process:

- Put the needs of individual patients, carers, residents and communities truly at the centre;
- Recognise that local patients, carers, residents and communities themselves are a resource for knowledge, for information, for understanding and for change; work with patients, residents and communities to harness their strengths;
- Trust and empower local patients, carers, residents and communities to drive change and deliver sustainable improvements;
- Co-design, co-produce and co-deliver services and programmes with local patients, carers, residents and communities;
- Focus on building resilient patients, carers, residents and communities -and on where resources can have the biggest sustainable impact.

The full report responding to the JHOSC recommendations can be found at <http://democracy.camden.gov.uk/documents/s57037/response%20to%20JHOSC%20report%20January%202017%20-%20final.pdf>

We have come a long way since being asked to come together as 21 health and social care organisations with disparate views in December 2015. It takes time to build trust and develop shared a shared vision of the future between people and organisations, and to get everyone working towards the same goals. We are now all aligned behind a collective agenda and are ready to share it more widely, seeking input and feedback on our draft plans to date.

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

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

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

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

## Our future plans

To help us meet our communication and engagement commitments we have formed a communications and engagement workstream. Membership of this group includes representatives from the 21 partner organisations, Healthwatch, voluntary sector representatives and lay people.

Working together as partners, we have established an evidence based engagement model and drawn of the expertise of communications leads from our CCG's, local authorities and provider organisations. We have identified key population groups and those members of your community that can at times be hard to reach. Working alongside Healthwatch and the voluntary sector we are now taking our proposals to the community for input and advice.

- In partnership with CCGs and Healthwatch we will participate in pan-NCL events on the overall plan and any specific issues that may arise at pan North London or individual borough level.
- Each workstream area has an engagement plan and will hosting meetings and events with patients, service users, carers and with the public on focussed topics such as urgent and emergency care, primary care, and mental health. This will help us to get more in-depth input from the community about their needs and how they expect services to be delivered.
- Our website will provide opportunities for online surveys and an online FAQ which will be kept current
- Our website will feature animations, infographics and relevant resources that will help people better understand the plan.
- We will link our website to social media and to promote our public engagement programmes and share information. We will also use these channels push residents and stakeholders to our website to test ideas and share progress on local priorities.

### **To do this, we will:**

- Work alongside Healthwatch and the voluntary sector, to identify representative groups, resident associations and other interest groups, local authority engagement networks and the many other networks available to the 21 partner organisations to reach out to the public and share proposals.
- We work in partnership with the communications and engagement teams across North London health and care organisations and together access their community activities and channels to share information about our proposals and progress and invite feedback and participation when appropriate.
- We will use existing online engagement tools used by partners to engage specific audiences and reach those who may be unable to attend our events.

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

- planning regular face to face meetings between the STP leadership team and local councillors and MPs, along with Ministers in the Department for Health if required to seek their regular advice on all proposed changes
- continuing to submit our work to the Joint Health Overview and Scrutiny Committee (JHOSC) ensuring that all political channels through CCGs, local authorities and providers are kept fully briefed on the STP as it develops and any public concerns for the regular engagement they undertake with elected leaders
- logging all FOI requests, public enquiries, media stories and providing an update to the Transformation Board and meeting with elected members.

The health and care workforce is a significant stakeholder in the STP process. We have been providing a weekly update from the convenor of news and important meeting dates.

To engage more fully with our health and care workforce we are developing a staff engagement strategy in partnership with the workforce workstream. This will include identifying and training workplace champions, well versed in the priority areas of work who can speak at staff forums and events on the STP programme and articulate the implications and benefits of a more sustainable health and care system.

- the weekly STP newsletter that we have set up for those working within the organisations of the STP
- providing people working within our organisations with regular updates on progress through internal newsletters and bulletins, weekly / monthly updates from Chief Executives
- face-to-face meetings with professional organisations (e.g. Royal College of Physicians) to seek advice on communicating and engaging with specific cohorts within the health and care workforce and the most relevant issues.
- participating in or hosting sessions with a wider set of clinicians and social care practitioners to get their input into the priorities and delivery areas. This includes joint commissioners and working with our GP Federations to engage primary care providers to ensure our workforce is a driver and owner of change
- working with membership organisations to showcase the range of work which is happening across North London and share with staff the proposals and what the future health and care workforce will look like and how changes to how health and care is delivered may affect them.

We will continue to build our communications and engagement capabilities across the system. The Communications and engagement workstream meets monthly to develop and co-design the communications and engagement strategy. This forum is designed to build skills and expertise in engagement and brings together communication and engagement practitioners, clinical expertise, Healthwatch, voluntary sector and layperson representative in one room with a commitment to best practice in engagement.

There are many stakeholders in this programme of work. The most important is the residents of the five North London boroughs. Communicating with such a large and diverse audience is challenging. We will utilise the existing communications channels available through the 21 partner organisations and our network of voluntary sector organisations, Healthwatch and professional colleges and bodies.

The workstreams will identify specific key audiences appropriate to their proposals and engage with these groups of patients, service users, carers and other interested parties. It is through this work we can make sure that services meet the needs of people rather than the current system that is often disparate and disjointed for the person accessing.

## **Public consultation**

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

Each of the partner organisations has conducted numerous engagement activities over past two years. This has included events, resident and staff surveys, forums, public meetings as well as input and feedback via organisational channels.

This data has helped us build a comprehensive picture of local views and concerns about health and care services. We know that people expect:

- People want more joined up health and care services

- People want health and care closer to where they live or work
- Services that are flexible, that adapt to people's differing needs
- People want to tell their story once
- Good signposting and information
- Access to services for a diverse population including interpreting services
- Simple, effective admin process which support patients to access the right service
- Compassionate healthcare professionals
- Access to a wide range of community support
- To not forget about carers and family

The launch of our North London Partners in health and care website (July 2017) will provide a single platform for information of the STP for residents, staff and other stakeholders.

On the website we will provide the most up to date information about our plan and the progress we are making to improve the health and wellbeing of the people of North London.

It is on our website where we will share stories of real local people and how the changes we are proposing make a difference to how they access care but also improving their health and care outcomes. It will also be our platform for inviting local people to participate in activities and events to help as co-design and co-produce services.



# Equalities analysis and impact assessment

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

The analysis has considered the effect on different groups protected from discrimination by the Equality Act to ensure any changes are fully effective for all target groups and mitigate any unintended consequences for some groups. The analysis of the plans to date found that no groups will suffer a negative impact from the plan, rather the plans will have a broadly positive impact on health inequalities. Exhibit 11 summarises these impacts, indicating for each workstream, what is the expected impact on health inequalities for each protected characteristic. Detailed impact assessments for each workstream and each protected characteristic are available by emailing us at [nclstppmo@nhs.net](mailto:nclstppmo@nhs.net).

**Exhibit 11: summary of impacts by workstream**

Protected characteristic \ Workstream	Disability	Sex	Race	Age	Gender reassignment	Sexual orientation	Religion or belief	Pregnancy and maternity	Other groups
Care closer to home	Positive impact	Positive impact	Positive impact	Positive impact	Positive impact	Positive impact	Positive impact	Positive impact	Positive impact
Urgent & Emergency Care	Positive impact	Positive impact	Positive impact	Positive impact	Positive impact	Positive impact	Positive impact	Positive impact	Positive impact
Mental Health	Positive impact	Positive impact	Positive impact	Positive impact	No impact	No impact	No impact	Positive impact	Positive impact
Cancer	Positive impact	No impact	Positive impact	No impact	No impact	No impact	No impact	No impact	Positive impact
Planned Care	Positive impact	No impact	Positive impact	No impact	No impact	No impact	No impact	No impact	No impact
Productivity	Positive impact	No impact	No impact	No impact	No impact	No impact	No impact	Positive impact	Positive impact
Prevention	Positive impact	Positive impact	Positive impact	Positive impact	No impact	No impact	No impact	Positive impact	Positive impact
Digital	No impact	No impact	No impact	No impact	No impact	No impact	No impact	No impact	No impact
Estates	Positive impact	No impact	No impact	Positive impact	No impact	No impact	No impact	Positive impact	No impact
Workforce	Positive impact	Positive impact	Positive impact	Positive impact	No impact	Positive impact	No impact	Positive impact	Positive impact
Maternity	Positive impact	Positive impact	Positive impact	Positive impact	Positive impact	No impact	No impact	Positive impact	Positive impact
Communications and Engagement	Positive impact	Positive impact	Positive impact	Positive impact	Positive impact	Positive impact	No impact	Positive impact	Positive impact

No impact  Positive impact

## Disability

Most workstreams will have a positive impact on inequalities associated with disabilities, which include physical, visual, and sensory impairment, and mental health problems or learning difficulties.

Some workstreams specifically aim to reduce health inequalities experienced by residents with disabilities. For example, the **Prevention workstream** will develop smoking cessation services that specifically target people with learning disabilities, including a payment to incentivise providers to

target this population group.

Patients with disabilities and their carers frequently experience disjointed health and care provision that fails to consider their needs in the round, or put the patient at the centre. Multiple workstreams, such as **Urgent and Emergency Care**, **Planned Care**, and **Care Closer to Home**, will seek to develop better integrated care to enable people with complex needs to have their needs more proactively assessed and met and to experience more joined up care.

Physical access to facilities and the availability of suitable equipment to meet the specific needs of people with different disabilities also figures prominently as a concern. The work by the **Estates workstream** is particularly relevant for this, as the review, re-purposing and reinvestment in estate will be done in the context of ensuring access for residents and patients with disabilities, e.g. in terms of level access/ramps, and in terms of ensuring premises are located at places that are most accessible by public transport etc. The work of the **Communications and Engagement workstream** will also aim to ensure that all venues used for events are assessed for accessibility for people with disabilities. Additionally, the review of office space and flexible working arrangements planned by the **Productivity workstream** and enabled by the **Digital workstream** may result in encouraging more flexible working opportunities for staff with disabilities.

As an overarching programme, the **Mental Health workstream** will have a positive impact for people suffering from mental ill health. For example, building community resilience will increase mental health basic awareness, reduce stigma, and increase mental health self-awareness. The **Workforce workstream** will also contribute to reducing stigma by ensuring that staff recruitment, training and retention practices are fully compliant with best practice.

Some ways of delivery of these projects will further facilitate access to services for people with disabilities. For example, the new care model proposed by the **Cancer workstream** has a strong emphasis on care closer to home, which has the potential to improve access for patients with disabilities. The **Workforce workstream** will also contribute to facilitating access by promoting a workforce that is better able to deliver care in appropriate settings, closer to home.

The **Maternity workstream** expects to have a positive impact on inequalities related to disability. Specific work is being planned to engage service users and community organisations to help ensure the needs of residents with disabilities are firmly built into workstream plans and implementation.

## Sex

Men and women do experience different health outcomes. However, these differences are difficult to isolate as being caused by gender alone, as gender interacts with other characteristics such as ethnicity and age, leading to considerable differences in the determinants of health for each population group.

However, some differences can be identified. For example, men are typically underserved by mental health services. The **Mental Health workstream** will target men in its community resilience, primary care mental health, and acute pathway projects, in order to address this inequality. Men may also be less likely to engage with preventive services delivered in 'traditional' healthcare services and settings, e.g. general practices. The **Prevention workstream** will use voluntary and community sector organisations to provide services to harder to reach groups, hopefully increasing the uptake of those services by men.

Some workstreams have identified other differences between men and women that will be addressed during the implementation phase. For example, men are generally more likely to die prematurely from

chronic diseases than women. In the **Care Closer to Home workstream**, the Care Closer to Home Integrated Networks (CHINs) will need to redesign services to make them more accessible to men and to find ways of engaging them earlier and to build resilience and self-care more effectively. Additionally, data from the recent Urgent and Emergency Care stocktake demonstrates that women use some services, such as walk-in centres, more than men. Resident engagement work by the **Urgent and Emergency Care workstream** will ensure that both genders are engaged in the design of Urgent and Emergency Care services across North London.

Men and women still carry significantly different burdens of work, caring, and other responsibilities. The **Workforce workstream** will seek to improve access to flexible employment arrangements, providing North London workers with a wider variety of work options.

The **Maternity workstream** also expects to have a positive impact on male partners as well as on women, although this needs to be further explored as these plans develop.

## Race

Language and cultural factors can determine health inequalities in groups defined by race and ethnicity.

The focus on healthier environments and settings as part of the **Prevention workstream** is fundamental to the reduction of health inequalities. By promoting positive changes in the settings where people grow, live, and work, we will be positively impacting on equality of opportunities, helping to reduce the health inequalities experienced by groups with certain characteristics, such as race and ethnicity.

One important determinant of different health outcomes between ethnic groups is differences in health service use. Greater involvement of and working with voluntary and community sector services and organisations at a local level in the planning and delivery of care and support should help professionals to become more responsive to the diverse needs of the communities they serve. This should enable more people to access advice and services that they might otherwise not access or use. The focus on working with and engaging the community is an important focus of the work of the **Prevention, Care Closer to Home, Cancer, Planned Care, and Mental Health workstreams**.

The investment and strengthening of primary care, expected through the **Care Closer to Home workstream**, should impact positively on inequalities in health and in particular improve the health of people from ethnic minorities.

The **Urgent and Emergency Care workstream** aims to improve the monitoring of ethnicity data within Urgent and Emergency Care services and is working alongside Healthwatch to develop a co-production strategy to engage harder to reach communities. Ensuring services are accessible and reach key population groups, including recognising language as a key determinant of access, will be a key consideration for this workstream.

The population served by maternity services is diverse, with high immigrant populations and in particular those who do not have English as their first language. Services can be difficult to navigate, with greater choice available to those best able to work their way through the system. The **Maternity workstream** aims to improve information regarding women's choices and the services that are available, and will equip staff to better signpost and guide women and their families through their maternity journey.

The **Workforce workstream** will ensure the recruitment, retention and development of underrepresented groups in North London, thus improving equality of opportunities.

The **Communications and Engagement workstream** will ensure opportunities for engagement are accessible to people from different cultural or ethnic groups, and will ensure all communication are made available in easy read or key community language.

## Age

Age is a major determinant of health and care needs, health outcomes, and service utilisation. The services provided by each workstream will seek to benefit different age groups and tackle age-related inequalities.

A major goal of the **Care Closer to Home workstream** is to provide better integrated care. This will enable frail older people to have their needs more proactively and holistically assessed and met, and to experience more joined up care.

There is a growing population of older people in North London. The **Urgent and Emergency Care workstream** has developed a frailty pathway project to address the specific needs of an ageing population. This will be considered in a range of areas, such as relationships with staff, accessibility of buildings, accessibility and cost of transport, and their overall experience of local healthcare. Additionally, future service design within this workstream will consider accessibility to specific facilities by target age group.

The **Prevention workstream** will maintain a focus on supporting children and young people to have healthy lives, ensuring that the settings in which they spend much of their time – early years' childcare and nurseries, and schools – give them the opportunity to be healthy. Additionally, it will make use of digital technologies and analytics to deliver interventions (e.g. apps), in order to promote access to services to young people. This workstream will also ensure that working age adults have the best chance to be healthy at work, by ensuring that the North London workforce (in its widest sense) is supported by organisational environments and opportunities that encourage and enable them to lead healthy lives and make choices that support their wellbeing.

The **Mental Health workstream** also includes projects that target specific population age groups, such as developments in children and adolescent mental health services, to better meet the needs of children and young people with mental health needs. This workstream will also invest in developing a dementia friendly North London, to better support older people living with dementia.

Experiences of maternity services can be very different according to maternal age. The **Maternity workstream** will link into existing services for young people under twenty. There are greater numbers of women over forty having babies in London than in other parts of the country. This workstream will examine the specific needs of this group and will create appropriate pathways of care for them.

The **Estates workstream** will ensure that the transformation of services and premises will be carried out in such a way as to consider the needs of the old and young, and target improvements in service provision. The **Workforce workstream** will guarantee that staff recruitment, training and retention practices would be fully compliant with best practice. The **Communications and Engagement workstream** will look to ensure that venues for engagement events are accessible for older people, who more frequently have mobility needs.

## Transgender

People who experience their body to be different from their assigned gender at birth remain a vulnerable group that suffers from an array of health inequalities. Some people may choose not to access services because their assigned gender on clinical records does not match how they personally experience their gender, which could cause distress and anxiety for the individual having to explain this to staff.

The **Care Closer to Home workstream** will aim to provide this group with the same quality and accessibility of services as for the rest of the population: improved access to more proactive and integrated care and the services better tailored to the needs of diverse local communities.

Under the **Urgent and Emergency Care workstream**, each service will develop its own policy regarding transgender and transsexual service users to ensure there is no discrimination and they are treated considerately and with respect. Regional or national organisations that represent individuals who are / have undergone gender reassignment will be invited to share their perspective within the formal consultation process.

Although the potential impact is not fully known, greater personalisation of care and improved choice provided by the **Maternity workstream** should have a positive impact on this population group.

The **Communications and Engagement workstream** will ensure all communications and engagement activities use inclusive language and venues are welcoming and consider the needs of all, including bathroom facilities that are trans-friendly.

## Sexual Orientation

There are clear differences in health outcomes between people of different sexual orientations. These differences will be addressed by the **Care Closer to Home** and **Urgent and Emergency Care workstreams** by improved access to more proactive and integrated care, by providing adequate training for all staff and by gathering further evidence and insight from local residents, organisations and groups to better understand their experiences of services and care. The **Workforce workstream** will further contribute by guaranteeing adequate staffing and skill mix, which should promote positive outcomes for all patients. Staff recruitment, training and retention practices will be fully compliant with best practice. The **Communications and Engagement workstream** will ensure all communications and engagement activities use inclusive language.

Furthermore, several workstreams plan to use voluntary and community sector organisations to deliver their interventions. This approach is intended to facilitate access to services by groups of people who are traditionally harder to reach.

## Religion or belief

The **Care Closer to Home** and the **Urgent and Emergency Care** workstreams will ensure there is no discrimination of service users according to their religion or belief, by providing improved access to more proactive and integrated care, delivering services that are better tailored to the needs of diverse local communities, and giving consideration to physical, cultural or behavioural barriers in the design of new services. The **Communications and Engagement workstream** will consider days of worship and cultural holidays or festivities.

The use of voluntary and community sector organisations to deliver interventions by several workstreams will also further facilitate access to and engagement in services by groups of people who are typically harder to reach.

## Pregnancy and Maternity

The **Care Closer to Home** and the **Urgent and Emergency Care** workstreams will ensure that, when designing new services, access and mobility issues will be considered for visitors and the ability for mothers to breastfeed and for parents to change babies as part of providers' consideration of service use.

The **Mental Health workstream**, through greater mental health support in primary care, will raise awareness of mental ill health in the perinatal period. Additionally, through the perinatal mental health programme, this workstream will support more women with their mental health in the perinatal period.

The **Productivity, Estates, Communications and Engagement, and Workforce workstreams** will all contribute to increasing opportunities for pregnant women and people with parental duties by reviewing flexible and remote working arrangements, encouraging more flexible working opportunities.

The **Prevention workstream** will develop projects with a specific focus on pregnant women. For example, smoking cessation services will specifically target pregnant women, including a payment to incentivise providers to target this particular population group. This will ensure that appropriate treatment is available to pregnant women, as traditionally not all services offer support for this group.

This is a particularly important group for the **Maternity workstream**, whose major impact is likely to be on pregnant women and parents. In terms of women and families using the services, increased access to care closer to home, improved choice and personalised care should improve access during pregnancy.

## Other Groups

The eight protected characteristics defined by the 2010 Equality Act do not exhaust all determinants that can lead to health inequalities. One major determinant is socioeconomic circumstance – income, education, employment, occupation, among others, can have significant impacts on an individual's health. Several workstreams will have an impact on socioeconomic health inequalities.

The **Prevention workstream** aspires to follow a model of proportionate universalism, which seeks to offer a universal service that is accessible to all but also target communities and groups where additional needs exist. Accordingly, it is not anticipated that a specific group of residents would be discriminated against, and this active approach will likely lead to a decrease in health inequalities. Some actions that will be suggested to guarantee this include:

- Setting specific targets for communities that carry a disproportionate weight of ill-health, in order to guarantee that their increased need is met with adequate services;
- Working with a variety of organizations, such as public, voluntary, and community sector, will allow a wider reach, ensuring residents of many social groups have the opportunity to be involved;
- Working in a variety of formats, such as the better use digital technologies, will facilitate this wide reach of North London residents;
- Maintaining a focus on contextual determinants – such as opportunities to eat a balanced diet, to exercise, or to work in a health-promoting environment – as key to guaranteeing equality

of opportunities, absence of discrimination, and promotion of good relationships between communities.

The **Care Closer to Home workstream** also explicitly seeks to address inequalities. Each Care Closer to Home Integrated Network (CHIN) will be provided with public health information showing where there are inequalities in health in their population which need to be addressed and they will be monitored on how effectively they deliver this outcome. Investing in primary care services is shown to reduce inequalities in health, reduce costs, improve access to more appropriate services, reduce in-hospital mortality, and reduce hospital admission rates. This is particularly important in North London, as there are high levels of A&E attendances across North London compared to national and peer averages, and also very high levels of first outpatient attendances.

Homelessness is of particular interest to the **Urgent and Emergency Care workstream**, as homeless people attend A&E more often than the general population, are admitted more often, and once admitted tend to stay longer. These and other issues regarding other vulnerable groups will be taken into consideration and addressed through local engagement groups and the co-production of Urgent and Emergency services.

The prevalence of severe mental illness varies amongst the North London boroughs, but is high across all areas. North London lies in the bottom quartile nationally, with varying outcomes across the boroughs. The **Mental Health workstream** will aim to reduce inequalities across the five boroughs so that no matter where someone lives in North London they can expect to receive the same high quality of care.

The **Cancer** and **Maternity workstreams** will also support work to understand where inequalities to access exist and will look to build evidence based solutions to address these. For example, the Cancer Vanguard includes a project to review the relative effectiveness of different types of invite to participate in screening.

The **Productivity** and the **Workforce workstreams** will also contribute to reducing health inequalities by encouraging more flexible working opportunities.

The **Communications and Engagement workstream** will seek to have a positive impact by ensuring that all communications and engagement activities use inclusive language.

Based on work previously done by the Islington CCG in building their personal health record, the **Digital workstream** will consult extensively with the public and patients to ensure that design, data presentation and access mechanisms are inclusive and support accessibility good practice.

We will continue to build on local regular equality audits of residents, patients and staff to ensure good engagement with protected groups and others, so that we can better understand the actual or potential effect of changes to functions, policies or decisions of the plan. This will help us to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

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



## Conclusion and next steps

We have made significant progress in developing our specific ideas for how we will achieve this. We have worked hard over the last few months to further develop our thinking, building on the evidence and by involving hundreds of members of staff from each of the provider and commissioning organisations and local authorities within North London. We held public meetings in each of the boroughs in September 2016 as the starting point to an ongoing conversation with the local community. We recognise there is more work to be done to engage with the community in the months ahead.

We have also worked proactively with the Joint Health Overview & Scrutiny Committee in North London to ensure that our developing plans are scrutinised and the robustness of our plan is challenged.

The STP has been developed to deliver the vision we have set out, the vision that the public has told us they want. As a sector, we have committed to the development and implementation of the delivery plans within each of the areas outlined above that can achieve the much wanted and much needed change. At the same time, we are clear that we will not lose focus on the longer term transformation and prevention work that will support sustainability.

Our work to April 2018 will focus on:

- taking steps to stabilise our financial position
- implementing our priorities as set out in this document in to ensure that we focus initially on the improvements which will make the most impact on our triple aims most quickly
- build on the early engagement with the public and staff

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

For further information or to contact us please email [\*\*nclstppmo@nhs.net\*\*](mailto:nclstppmo@nhs.net).



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## Whittington Health Trust Board

6th September 2017

<b>Title:</b>	Equality & Inclusion Report 2016/17		
<b>Agenda item:</b>	<b>17/119</b>	<b>Paper</b>	<b>12</b>
<b>Action requested:</b>	For Board approval		
<b>Executive Summary:</b>	<p>Whittington Health serves a diverse population, delivering services from over 40 sites across London. The implementation of the Trust's Clinical and Workforce Strategies plus the Health &amp; Wellbeing Strategy articulate the Trust's commitment to providing an infrastructure for improving health, wellbeing and development opportunities for the workforce in order to support the provision of excellent patient experience.</p> <p>The Trust recognises the importance of incorporating equality and diversity, embedding inclusion within a complex and multifaceted climate of daily operational activities. This Annual Equality and Inclusion Report outlines work undertaken during 2016/2017. Going forward, activities should implement equalities and inclusion as a 'golden thread' throughout the Trust's everyday and strategic business.</p> <p>This report compares our inclusion performance across three years' of data (2014-17) where available; with data from the North Central London STP (10 Trusts), and with London STPs (35 Trusts) for the year 2015-16.</p>		
<b>Summary of recommendations:</b>	Recommendations for 2017/18 show what is required to create and further embed a more inclusive culture that supports the Trust's ICARE values and corporate objectives. This will need to include consideration of available research and feedback from a variety of sources including the National Staff Survey 2016 and NHS Workforce Race Equality Standard 2016.		
<b>Fit with WH strategy:</b>	Clinical, Workforce and Health & Wellbeing Strategies		
<b>Date paper completed:</b>	August 2017		
<b>Author name and title:</b>	<b>Charlotte Johnson</b> Head of Development & Inclusion	<b>Director name and title:</b>	<b>Norma French</b> Director of Workforce







**Whittington Health**  
NHS Trust

**Equality and Inclusion Report**  
**2016 – 2017**



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Appendix 1 - Whittington Health WRES data – 2014/15 to 2016/17

Appendix 2 - London STP WRES data – 2015-16

## Executive Summary

Whittington Health serves a diverse population delivering services from over 40 sites across London. The implementation of the Trust's Clinical Strategy underpinned by the six strategic objectives outlined in the Workforce Strategy, plus the Health & Wellbeing Strategy articulate the Trust's commitment to continuing to provide an infrastructure for improving health wellbeing and development opportunities for the workforce in order to support the provision of excellent patient experience

The Trust recognises the importance of incorporating equality and diversity, embedding inclusion within a complex and multifaceted climate of daily operational activities. The Trust takes an integrated approach in order to enhance the high quality work undertaken to improve patients' experiences and the health and wellbeing of the workforce.

The Annual Equality and Inclusion Report outlines the work undertaken during the period of 2016 – 2017. Going forward, activities should implement equalities and inclusion as a 'golden thread' throughout the Trust's everyday and strategic business.

The recommendations for 2017/18 reflect and underscore what is needed to begin to create and further embed a more inclusive culture that supports the Trust's ICARE values, and the Trust's corporate objectives. This will need to include consideration of the wealth of research available and feedback from a variety of resources such as the National Staff Survey 2016 and NHS Workforce Race Equality Standard: 2016 Data Analysis Report for NHS Trust.

This report compares our inclusion performance across three years' of data (2014-15, 2015-16 and 2016-17) where data is available; with data from North Central London (NCL) sustainable transformation partners (STP) (10 trusts), and with London STPs (35 trusts) for the year 2015-16.

### 1.0 Introduction

Whittington Health employs a staff of over 4,300 that reflects the diverse population in the local communities it supports.. The Trust delivers services to more than 500,000 people in the boroughs of Haringey, Islington, Barnet, Camden, Enfield, Hackney, and since the acquisition of the Dental Service, Harrow, Ealing, Hounslow and Brent across over 40 sites

The Trust's Clinical Strategy provides a framework and direction for the organisation to be a national leader in delivering safe, integrated care to our local community. 'Helping local people live longer, healthier lives', continues to be the overall mission and strategic vision. The Trust employs a diverse workforce which enables the Trust to proactively meet the needs of our patients and service users.

The Trust continues to be committed to the promotion of equality of opportunity for all its employees. The Equality Policy 2015-18: Promoting Equality, Diversity and Human Rights provide guidance and direction for all staff as outlined under the Public Sector Equality Duty of the Equality Act 2010.

The organisation values reinforce the value of equality, equity and inclusion. The 5 core values that produce the acronym, ICARE (Innovation, Compassionate, Accountable, Respectful and Excellence) supports the principles of celebrating diversity, kindness, being respectful and inclusive as an Integrated Care Organisation (ICO).

The Equality Plan 2015-18 and previous reports relating to equality, diversity and inclusion can be accessed through the Trust's website: [www.Whittington.nhs.uk](http://www.Whittington.nhs.uk)

## 2.0 Equalities Legislation

The introduction of the Equality Act 2010 made it unlawful to discriminate against people on the basis of any one or more of nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, sexual orientation, and pregnancy and maternity. As a public sector organisation, Whittington Health has a duty under Section 149 of the Act known as the 'Public Sector Equality Duty ' (PSED). This requires Whittington Health to have due regard to:

- a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by the Act
- b) Advance equality of opportunity between individuals who share a relevant characteristic and individuals who do not share it.
- c) Foster good relations between individuals who share a relevant protected characteristic and individuals who do not share it.

This legislation is applicable to all services, functions and contractors that are commissioned to provide a service or services on behalf of Whittington Health.

## 3.0 NHS Standard Equality Requirements

The Workforce Race Equality Standard (WRES) was first introduced during 2015 and is a requirement of the NHS Standard Contract. From April 2016 the Care Quality Commission (CQC) included the WRES as part of its inspection regime for NHS Trusts. The Trust's WRES data is considered under the 'well led ' domain with the Equality Delivery System (second iteration: EDS2) as indicated within the NHS Standard Contract for 2017/18 and 2018/19<sup>1</sup>.

The Trust's first WRES report was published in December 2015 providing benchmark data for future publications. The second WRES report was published in September 2016. The data from that published report contributed to the 2016 Data Analysis Report for NHS Trusts published in April 2017. Key findings and other detailed benchmarking information can be found in the report: <https://www.england.nhs.uk/wp-content/uploads/2017/03/workforce-race-equality-standard-data-report-2016.pdf>

The WRES data for 2016-17 and comparisons with data gathered since the introduction of the WRES can be found in appendix 1. Some of the data highlight the progress that has been made over the past two years, whilst elsewhere it is possible to identify areas that require further work to better understand the gaps and issues, identify the steps necessary to close them, and take action to make improvements in order to implement the PSED of the Equality Act 2010.

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<sup>1</sup> NHS England, 'NHS Standard Contract 2017/18 to 2018/19: Service Conditions (full length)', November 2016.

## 4.0 Data Sources

The following data and information sources were used to compile this report:

- i. Clinical Strategy
- ii. Workforce Strategy
- iii. Health and Wellbeing Strategy
- iv. Workforce Assurance Committee
- v. Workforce Race Equality Standard data extracted for the Whittington Health's Electronic System Record
- vi. NHS Workforce Race Equality Standard: 2016 Data Analysis Report for NHS Trusts
- vii. Workforce Race Equality Standard Data for London STP areas (2016)

## 5.0 Workforce Strategy

There are six strategic objectives outlined in Trust's Workforce Strategy 2016-20 designed to support the delivery of the Clinical Strategy with a complex and multifaceted agenda to achieve, while taking an integrated approach through workforce development and effective leadership. They are:

- i. Performance management, maximise productivity and maintain quality
- ii. Workforce planning and design
- iii. Education, training and learning
- iv. Employee engagement and wellbeing
- v. Model employment practice
- vi. Rewarding and recognising staff

The Trust's Workforce Health and Wellbeing Strategy 2015-2020 further underpins the Workforce Strategy through the following priorities and their associated outcomes:

- Priority 1: Improving health life expectancy
- Priority 2: Improving mental health and wellbeing
- Priority 3: Improving psychosocial working conditions

These objectives and priorities support the strategic goal within the NHS EDS2 of having 'empowered, engaged and well supported staff ', as stipulated in the NHS Standard Contract.

## 6.0 Workforce Profile

The table below illustrate the breakdown of all ethnic groups working at Whittington Health in comparison with our local population and with the NHS workforce as a whole. The data shows that Whittington Health employ forty five per cent of the workforce from a Black and Minority Ethnic (BME) background.

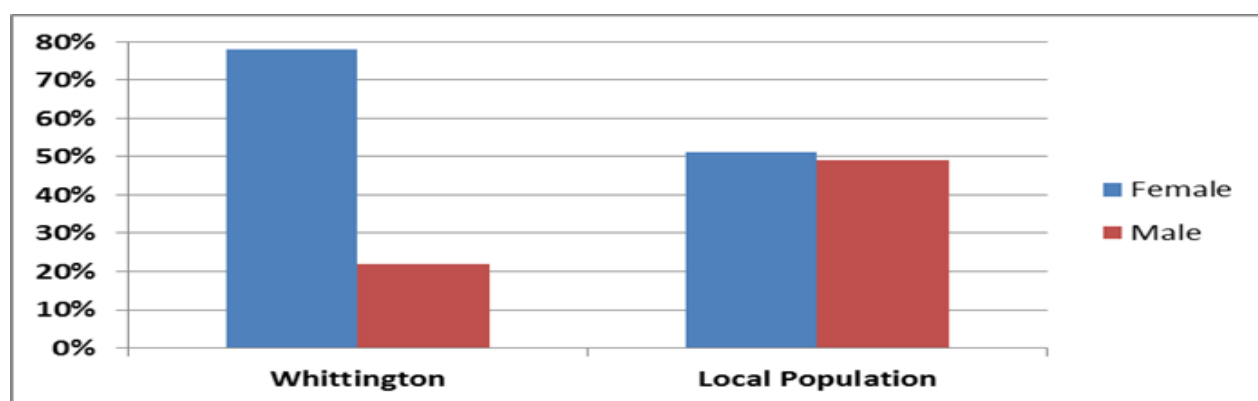
**Table: Breakdown of all ethnic groups**

Breakdown of Ethnic group	Whittington Health %	Local Population %	NHS Workforce %*
White	48	64	78
Black or Black British	23	16	5
Asian or Asian British	13	9	9
Mixed	3	7	1
Any other ethnic group	6	4	2
Not stated/Unknown	7	-	4

\* Source: NHS Digital – December 2016 Data

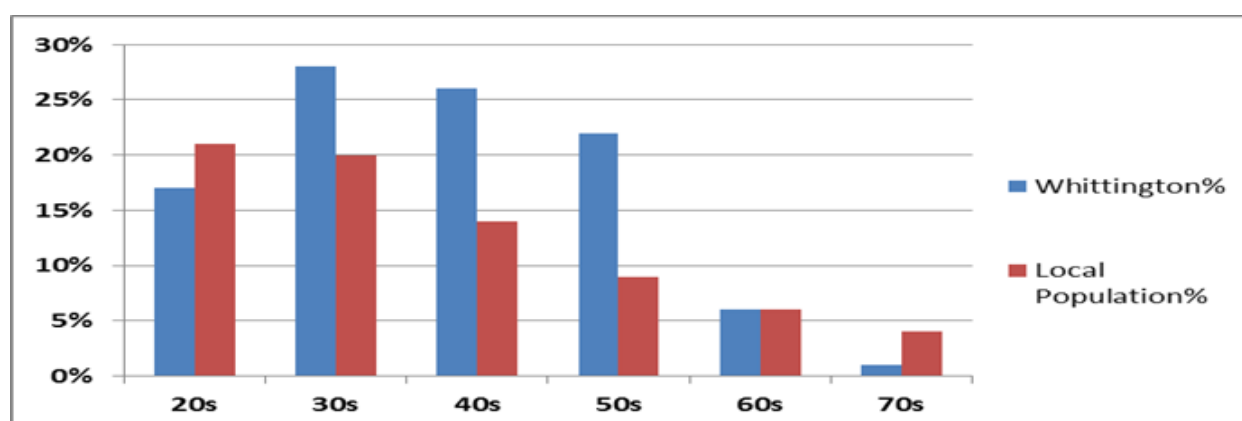
The current workforce appears to reflect the local population when taken as a whole across the Trust. Work is being carried out to improve the quality of the data about the workforce to improve the robustness of the information for making comparisons, to establish trends and to identify emerging themes.

### 6.1 Graph: Staff profile by gender



As a National Health Service organisation it is not unusual for the workforce to have a high percentage of female staff. The graph shows that 78% of the workforce is female with male staff representing 22%. In comparison 49% of the local population.

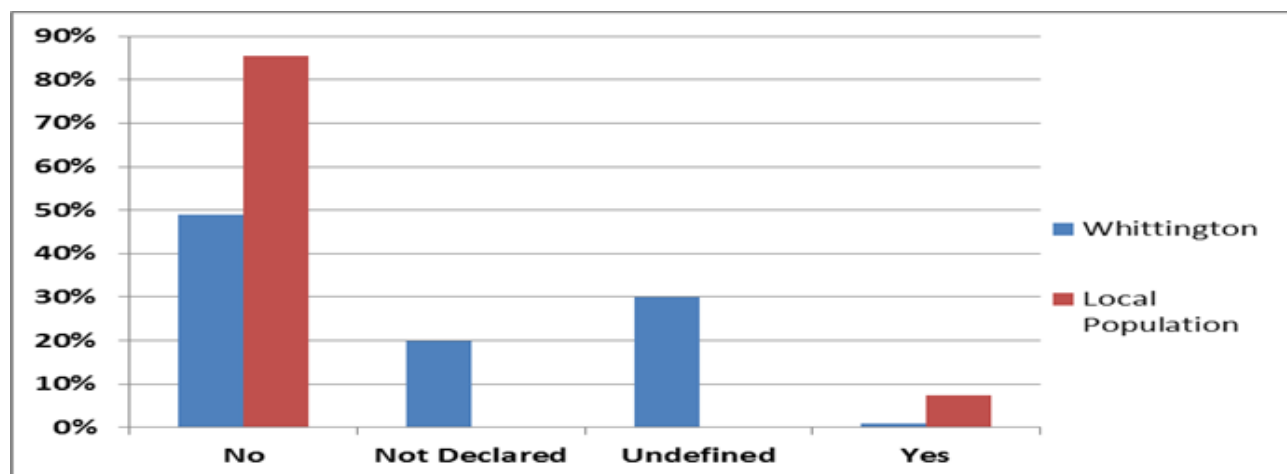
### 6.2 Graph: Staff profile by age



The table above demonstrate the data known about the age demographics of the workforce.

The highest numbers of staff are in their thirties (28%). Whittington Health has a lower percentage of staff in their twenties (17%) compared to the local population (21%) although there is a good representation of staff aged in their sixties (6% staff and community).

### 6.3 Graph: Breakdown of Disability

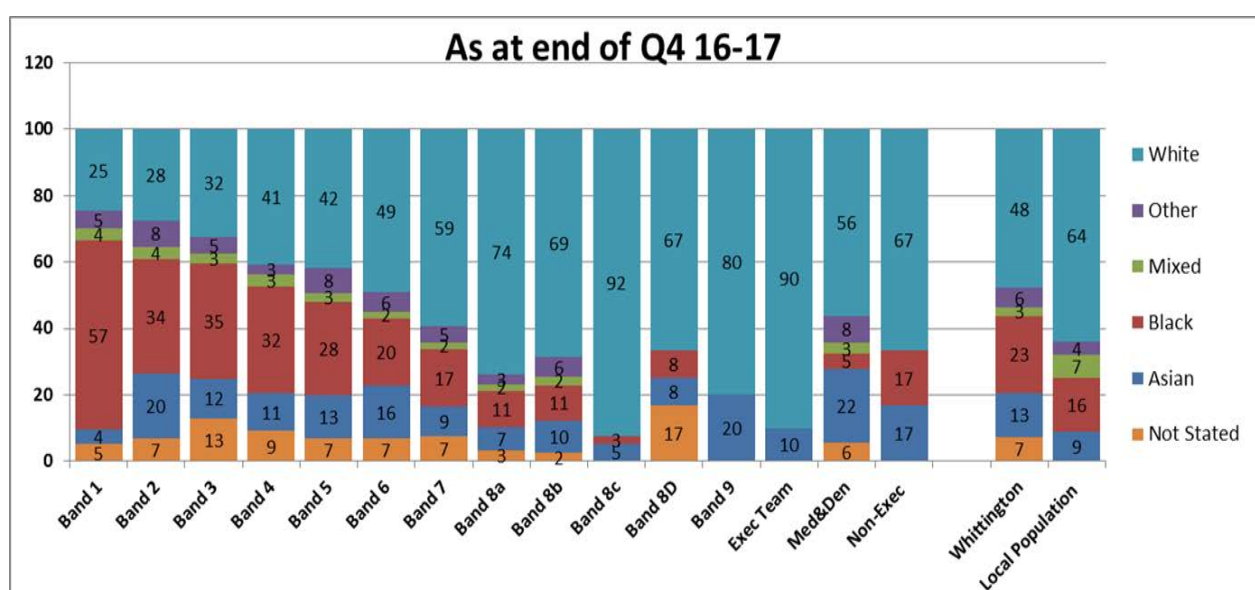


The table above shows that 8% of the local population has declared a disability that limits their day to day activity, with 7% indicating they have a long term condition. Whittington's figure (1%) of those who have declared a disability appears low in comparison. However, it should be noted that a total of 50% is either not declared or undefined.

Measures are being implemented at recruitment stage to ensure disability data is recorded on the electronic staff record (ESR) for all new staff.

The Learning Disability Employment Pledge was signed in 2016 declaring the Trust's commitment, which will be further reinforced by becoming a 'Disability Confident Employer' during 2017. The following link provides more information on the Employment Pledge: <http://www.nhsemployers.org/your-workforce/plan/building-a-diverse-workforce/need-to-know/creating-a-diverse-workforce-learning-disability>

### 1.4 Graph: Staff profile by Band and Ethnicity



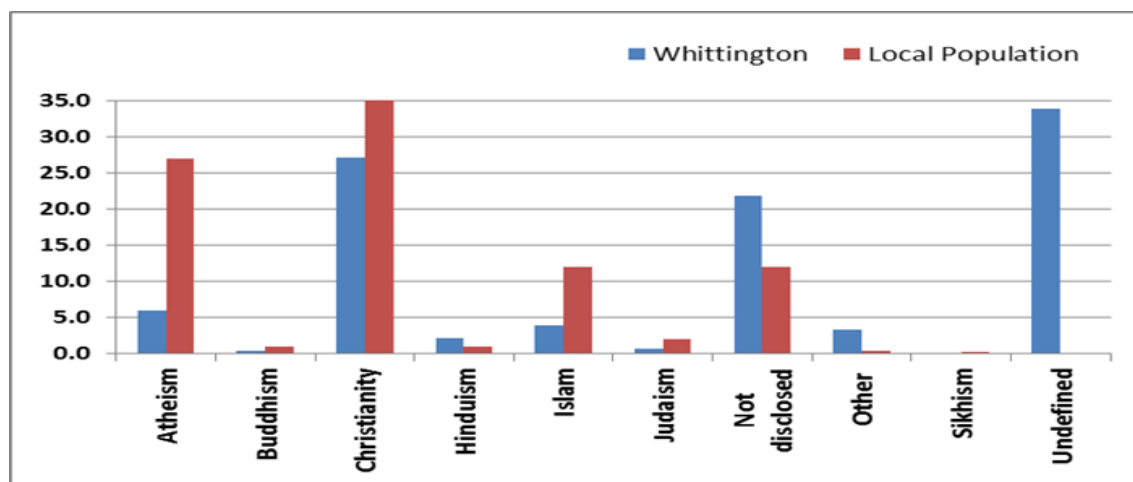
The table above shows the race profile of Trust's workforce: 45% are BME staff compared with 48% White staff (and 7% not stated).

Of all staff banded 8 and above, 31% are BME staff (29% in Q4 15-16) and 65% are White staff (67% in Q4 15-16). There are 4% of staff who did not state their ethnicity (no change from Q4 15-16). On average the majority of staff in bands 1-6 are BME staff (52%) while the majority of band 7 staff are White staff (59%), although 8% across Bands 1-7 did not state their ethnicity. In comparison, 36% of the local population (Haringey and Islington population from the Census 2011) are from Black and ethnic minorities while 64% are White.

Whittington Health has an overall higher proportion of BME staff as compared to the local population. The proportion of BME staff in Bands 8 and above, including Executive, Medical and Board level staff, has increased by 2% (to 31%), 5% short of total BME proportion of the local population.

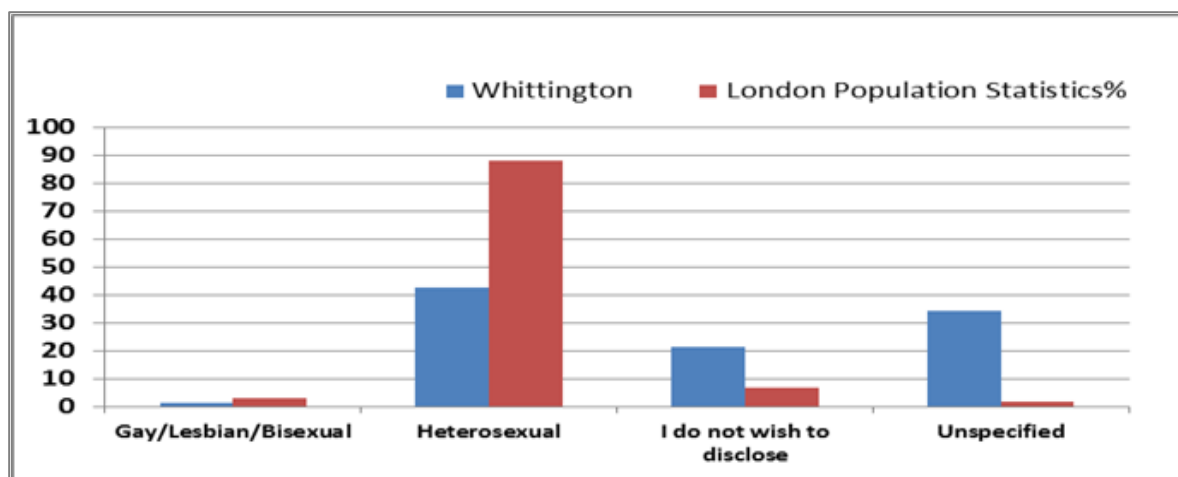
The WRES data (Indicator 1) for London sustainable transformation partnerships (STP) (Appendix 2) shows that Whittington Health is one of three out of the ten trusts in the North Central London (NCL) STP who report that 100% of their very senior managers (VSM) are White; and one of ten out of the 35 trusts in all-London STPs who report that 100% of VSM are White. This highlights the need to focus on the career development of BME staff.

## 6.5 Graph: Staff profile by Religious Belief



The table above show the breakdown of staff profile by religious belief in comparison with the local population. The highest number of staff reporting a religion are Christian (27%) compared with the local population (43%). Atheists are the second highest category in Whittington (6%). This follows the trend of the local population. The third highest reported religious belief system in Whittington is Islam (4%%). However, Whittington Health has a lower representation in comparison with the local population. There is a small but significant proportion (3%) who disclosed 'other' religious beliefs.

## 6.6 Graph: Staff profile by Sexual Orientation



\*ONS Integrated Household Survey, January – December 2014). Benchmark used is at London level, no borough data is available.

The table on Staff profile by Sexual Orientation show 43% of Whittington staff are heterosexual, which reflects the trend of the London population. The Trust has a slightly lower representation of bisexual, gay and lesbian categories (2%) as compared to the London population (3%) and a significantly higher rate of those who do not wish to disclose and those who have not been asked, or answered the question (>20%).

## 6.7 Table: Breakdown of six of the Protected Characteristics – Equality Act 2010.

Protected Characteristics (Demographics)	Known/ Indicated 'Yes'	Indicated 'No'	Indicated 'Did not want to say'	Undefined/Not declared
Gender	100%	-	-	-
Disability	1%	33%	-	66%
Sexual Orientation	35%	-	31%	34%
Religious Belief	38%	-	29%	33%
Ethnicity	94%	-	3%	3%
Age	100%	-	-	-

The table above provide a detailed breakdown of known and unknown information for six of the nine Protected Characteristics under the Equality Act. Work is already underway to address the gaps in information.

## 7.0 Recruitment

Recruitment of new external and internal appointments is one of the most significantly important stages in Workforce activities and includes ensuring that employees are employed to reflect the Trust's organisational values and provide excellent healthcare. The results of the data collected for the WRES (indicator 2), have identified that the relative likelihood of White staff being appointed to BME staff was 2.17 greater during 2016-17. This is a slight improvement on 2015-16 when the rate was 2.28: a slight decrease of 0.11 over a 12 month period. The data for the period of 2014-15 was unavailable. See appendix 1, Indicator 2 for a breakdown of data.

The STP WRES data for Indicator 2 (Appendix 2) shows that, in spite of the improvement, we have the highest likelihood for appointing White candidates in NCL, and the third highest across London, again highlighting the need to focus on the career development of BME staff including the management of the recruitment, application and interview process.

A working group will be set up during 2017-18 to review this data and relevant practices and processes, and will make recommendations to improve parity at the recruitment and appointment stages. Additionally, a request will be added to all contract cover letters sent to new starters asking that they log in to employee self-service to ensure personal data is complete and accurate, including protected characteristics.

## 8.0 Employee Relations

The Trust began capturing and monitoring employee relations cases 18 months ago. Data gathered for WRES showed the relative likelihood of BME staff entering the formal disciplinary process compared to that of their White counterparts were 2.67 times greater during 2015/16. During 2016/17 the figure has slightly decreased to 2.41 times greater. During 2017/18 action will be taken to capture more detailed equality data to facilitate a more detailed analysis of employee relations cases, this will include a review of the system currently collating and reporting the data. For a breakdown of the WRES data, see appendix 1, indicator 3.

The London STP data (Appendix 2) for Indicator 3 shows that Whittington Health has the 5<sup>th</sup> highest likelihood of BME staff entering the disciplinary process in NCL and joint 13<sup>th</sup> highest in London STP.

## 9.0 Workforce Assurance Committee

The Trust's Workforce Assurance Committee, In line with the Trust's corporate objectives, Workforce Strategy, national and local standards, and policies, and compliance with relevant equality legislation, diversity and inclusion practices, works to ensure an effective structure, process and system of control for workforce governance and risk management. The Workforce Assurance Committee, chaired by a Non- Executive Director met four times during 2016-17 and was quorate in line with its terms of reference. Plans and activities in relation to the equalities agenda, will be reported to and guided by this committee.

## 10.0 2016 Staff Survey Results

Whittington Health as an Integrated Care Organisation (ICO) conducted its sixth national staff survey in 2016. For 2016 the Trust opted to select a random sample of 1,227 staff to complete the staff survey. Whittington Health's overall response rate was 36% against the national community acute Trust average of 40%, equating to 441 responses. This was an increase of 6% since the 2015 survey. Demographic characteristics of respondents were:

- **Age:** Between 16 - 30, 19%. Between 31 - 40, 26%. Between 41 - 50, 27%. 51 and over, 29%.
- **Gender:** Male respondents 26%, female respondents 74%.
- **Ethnicity:** White responses 60%, BME responses 40%.
- **Disabled:** Responses from staff declaring a disability 13%, responses from staff not declaring a disability 87%

The survey results noted improvements in areas such as communication between senior managers and staff and the quality of appraisals. However, areas which related to bullying and harassment, often experienced as related to protected characteristics and therefore linked to the equality agenda, showed scores ranked among the bottom five results. Examples include The table below shows the areas:

#### 10.1 Table: Three Indicators comparing our Trust results against National results.

	Indicator	Our Trust	National
1	Staff experiencing harassment, bullying or abuse from staff	30%	23%
2	% of staff experiencing discrimination at work in the last 12 months	19%	10%
3	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	31%	26%

The three bottom ranking scores also appeared amongst the bottom five results in the Trust's 2015 results and have shown little improvement in the year. The percentage of staff experiencing harassment, bullying or abuse from service users has been highlighted as a concern and will require attention through action planning for 2017-18 and beyond. Each ICSU has agreed an action plan which underpins the corporate plan for staff survey priorities.

Four of the staff survey indicators will be used to carry out comparisons of the outcomes of responses for BME and White staff. The results will be incorporated into the WRES Indicator 5-8 for 2017 WRES-analysis and is likely to be published in 2018. See appendix 1, Indicators 5-8.

Whilst the level of harassment and bullying is of concern, the local WRES data (Appendix 1) Indicators 5 and 6, shows that is little difference in race profile of those reporting it, either from patients and public, or from colleagues and managers. The London STP WRES data (Appendix 2) Indicators 5 and 6 shows those trusts (Tavistock and Portman in NCL, and 4 more trusts in other London STP) which have achieved lower levels (below 20%) from which we could learn.

London STP WRES data (Appendix 2) Indicator 8 shows the percentage of Whittington Health BME staff who report experiencing discrimination is 6<sup>th</sup> highest of the ten trusts and 16<sup>th</sup> highest of 35 trusts in London. Of more concern is that it is almost double that of White staff reporting discrimination. The WRES data in Appendix 1 shows this gap has increased in the last year from 7% to 10%. More information is needed on the nature of discrimination to support focused action.

### 11.0 Anti-Bullying and Harassment Scheme

The Anti-Bullying & Harassment Scheme was launched in June 2016 with 17 externally trained in-house Anti-Bullying and Harassment Advisors. The Advisors reflect the diversity of the Trust in terms of professions, bandings and representation of the directorates. The purpose of the Scheme is to provide a resource of trained advisors to signpost individuals to a selection of supportive assistance to counter the experiences of bullying and harassment. The Scheme provides a 24 hour service through a confidential referral system to safeguard all parties.

Whittington Health's senior leadership have taken a zero-tolerance approach to bullying and harassment. The Scheme was audited within the first six months of being set up and was deemed to be a robust system, although it was found that it required increased publicity to raise its profile. It is recognised that bullying is a complex issue and will require sustained efforts over a longer period to embed the culture of non-bullying behaviours.

During 2017/18 more work will be undertaken utilising data from the WRES and Staff Survey with the focus on eliminating discrimination and promoting better working relationships. This will also include recruiting additional Anti-Bullying and Harassment Advisors.

## 12.0 Equality, Diversity and Inclusion Training

A range of equality, diversity and inclusion training, some mandatory, has been delivered throughout 2016-17 to continuously increase knowledge, understanding and encourage inclusive behaviours to underpin the Trust's organisational values. Courses offered through the Capital People programme hosted by the London Leadership Academy have been regularly publicised for managers and leaders to attend.

A number of training sessions took place during 2016-17. The figures indicates the number of staff who attended during the course of the 12 month period.

Course Name	Total
Equality, Diversity and Human Rights – Level 1 (e-learning)	742
Becoming an Inclusive Organisation (Unconscious Bias)	114
Customer Care for a Diverse Client Group	274
Equality & Diversity – workbook	737
Equality and Diversity (Refresher and Induction)*	704
<b>Grand Total</b>	<b>2571</b>

\*Refresher training is required very three years for existing staff.

We are one of three trusts in NCL, and one of ten trusts in London, which do not have data on the uptake of non-mandatory training by ethnic profile. A systematic review and revision of collection and monitoring is required to improve consistent and accurate reporting.

The London STP WRES data (Appendix 2) Indicator 7 ranks the Trust as 5<sup>th</sup> highest of ten trusts in NCL for the percentage of BME staff believing that the Trust provides equal opportunities for career progression or promotion. This is 20% below the percentage of White staff. However, more recent local WRES data (Appendix 1) shows an increase of almost 3% for BME staff slightly closing the gap.

The WRES data on the race profile of staff at different levels of seniority; the recruitment data on likelihood of appointing BME staff on interview; and Indicator 7 discussed above, all highlight the need for appropriate action to support career development for BME staff. Examples of programmes include the NHS Leadership Academy 'Ready Now' programme for senior BME staff typically for Bands 8A and above, and the 'Stepping Up' programme for lower Bands.

## 13.0 Summary of Actions

There are a number of gaps in this report as evident from the information that is presented, which is based on what is currently available. For example, only 6 of the 9 protected characteristics have been reported upon.

The recent (2017-18) restructure of Organisational Development and the strengthening of the staffing resource to focus on inclusion will allow for more focussed attention on workforce data in the first instance. Disability is an example of where disclosure rates need to be improved with only 1% of the workforce declaring a disability which is much lower that disclosed in the local census or in the anonymised staff survey. More concerted focus is required in the coming months

to prepare for the forthcoming Disability Workforce Equality Standard (DWES) which is due to be published in April 2018.

## 14.0 Recommended Actions

The report provides a clearer picture of the Trust's equality data than previously, although the information is far from comprehensive, and it will take time to develop robust systems for ascertaining quantitative and qualitative information that will contribute to making informed decisions. In order to further cultivate and embed the 'golden thread' of inclusion throughout all levels and areas of the Trust it is recommended that:

1. Action points stemming from the Staff Survey and the 2015-16 WRES Improvement Plan should be reviewed and consolidated to ensure a more holistic approach to addressing gaps is identified.
2. The equalities objectives under the Well-Led domain of the EDS2 are refreshed in line with the six strategic goals articulated in the Workforce Strategy and are reflected in the Trust's Corporate Objectives for 2017/18 and beyond.
3. Develop and implement initiatives following the Staff Equalities Engagement Event (scheduled to take place on 27 September 2017) to address, once identified, the top three priorities for the Trust. These should cover the period of 2017-2020 to ensure sustainability.
4. This report is presented at ISCU Boards and Directorate management meetings to raise awareness and facilitate embedding of equalities and inclusion as a 'golden thread' at local and operational level.
5. The national framework for action on improvement and leadership development in NHS-Funded services, 'Developing People – Improving Care' is applied to the Trust's current leadership initiatives to reinforce a focus on inclusive leadership, including the promotion of the London Leadership Academy programmes 'Ready Now' and 'Stepping Up'.
6. Review and create a plan to improve collection and monitoring of equalities data for non-mandatory learning and development opportunities.
7. Set up a working group to review recruitment processes.

## 15.0 Conclusion

Whittington Health as a London based healthcare service with a good reputation for delivering services employs an increasingly diverse workforce who will be serving a growing and increasingly diverse population with a variety of multifaceted needs. The changing landscape in terms of the Sustainable Transformation Plans (now 'Partnerships': STP) agenda plus Health and Wellbeing Boards will provide opportunities for more inclusive working across services within and outside the Trust. Therefore, work to set up robust systems to generate intelligence data on the workforce and patients and service users, including a focus on equality and health inequalities is imperative, and can only serve to help the Executive Leadership to make informed decisions that will positively impact the health of the whole workforce, and in turn improve patients' and services users experience. Continued work on the equality and inclusion agenda within Whittington Health will help the Trust to fulfil its statutory duties, and will work towards the development of a workforce who are more productive as a result of being 'able to bring their whole selves to work'.

The main data below covers the period April 2016 to March 2017 to meet the Trust's responsibility to prepare and publish WRES data for 2017. The information below should be viewed as comparable data from 2014/15 and 2015/16, where applicable, to demonstrate the Trust's progress since publishing its first report in December 2015.

The WRES data commented on throughout this report is based on equality data captured at the end of March 2017. The previous WRES template was completed in September 2016. The information from that year contributed to the NHS Workforce Race Equality Standard: 2016 Data Analysis Report for NHS Trust published in April 2017. The research within the document gives a comprehensive picture of some of the experiences and impact faced by BME staff across the whole NHS system. Data for Indicators 5 to 8 will be data gathered directed from the results of NHS Staff Survey 2016.

#### INDICATOR 1: Compare the data for BME and White staff

BME					White				
	Band 1-4	Band 5 – 7	Band 8a – 9	VSM	Band 1-4	Band 5-7	Band 8a – 9	VSM	Total
2014/15			8%						*
2015/16			146 (25%)				429 (75%)		4210
2016/17	63.86	46.3	22.83		36.14	53.7	77.17		4284

\*total number of BME staff in overall workforce was 23%.

Graph: Staff profile by band and ethnicity provides a detailed breakdown of the number of staff from different ethnic backgrounds within all the bands in comparison with the local population. Whittington Health has a higher population of staff from BME background in comparison to the local population with a significantly higher proportion of the BME staff working in bands 1-4 and 5-7.

#### INDICATOR 2: Likelihood of staff being appointed

2015/16 - Indicator 2.1

Descriptor	BME	White
Number of shortlisted applicants	996	623
Number of appointed from shortlisting	63	90
Ratio shortlisted/appointed	0.06	0.14

2016/17 - Indicator 2.2

Descriptor	BME	White
Number of shortlisted applicants	584	295
Number of appointed from shortlisting	102	112
Ratio shortlisted/appointed	0.17	0.37

Indicator 2.3	2014/15	2015/16	2016/17
Relative likelihood of White staff being appointed from shortlisting compared to BME staff:	Data not available.	2.28	2.17

Information in Indicator 2.3 shows a fall by 0.11 of the relative likelihood of White individuals being appointed from shortlisting compared to BME counterparts. A key finding from the 2016 Data Analysis report showed that White shortlisted applicants are 1.57 times more likely to be appointed from shortlisting than BME shortlisted applicants, a difference of 0.71<sup>2</sup> in comparison to 2.17 for 2016/17.

<sup>2</sup> NHS Workforce Race Equality Standard: 2016 Data Analysis Report for NHS Trusts, page11.

**INDICATOR 3: Relative Likelihood – formal disciplinary process**

2015/16 - Indicator 3.1

Descriptor	BME	White
Number of staff in workforce	1857	2038
Number of staff entering the formal disciplinary process	34	14

2016/17 - Indicator 3.2

Descriptor	BME	White	Unidentified
Number of staff in workforce	1931	2033	320
Number of staff entering the formal disciplinary process	32	14	14

Indicator 3.3	2014/15	2015/16	2016/17
Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary investigation.	Data not available.	2.67 times greater	2.41 times greater

Note: This indicator will be based on data from a two year rolling average of the current year and the previous year.

There are significant variations between regions and Trusts across the NHS system. In London BME staff are 2.0 times more likely to enter the formal disciplinary process than their White counterparts<sup>3</sup>. Community provider Trusts performed work with BME staff more likely to enter the formal disciplinary process. Table 3.3 show a small decrease from 2.76 times greater in 2015/16 to 2.41 in 2016/17, a difference of 0.26.

**INDICATOR 4: Relative likelihood of BME staff accessing non-mandatory training and CPD compared to White staff.**

The current recording processes for reporting non-mandatory training and CPD related development opportunities has not been consistently used. A systematic review and revision of collection and monitoring is required to improve consistent and accurate reporting of data before it can be relied upon for making informed decisions.

<sup>3</sup> NHS Workforce Race Equality Standard: 2016 Data Analysis Report for NHS Trusts. page 52.

**INDICATOR 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relative or the public in last 12 months.**

It should be noted that the sample survey for the NHS Staff Survey was accessible to 1240 staff of which on 35.6% of respondents completed the survey.

Year	BME	White	All staff
2014/15	30%	27%	
2015/16	28.53%	28.75%	
2016/17	28.57%	30.33%	

The table above shows a small decrease from 30% in 2014/15 to 28.57% in 2016/17 for BME staff. The figures for White staff saw an increase from 27% in 2014/15 to 30.33% in 2016/17 for White staff. In comparison with other Trusts within the North Central London region 7 out of 10 Trusts have a higher percentage of White staff experiencing bullying or abuse from patients, relatives or the public in the last 12 months.<sup>4</sup>

**INDICATOR 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.**

Year	BME	White
2014/15	33%	25%
2015/16	27.25%	26.97%
2016/17	31.88%	24.59%

The above table shows an overall decrease or be less than 2% for BME staff and less than 0.5% for White staff this shows downward trend albeit very small. In comparison with North Central London Trusts in the region 8 out of 10 Trusts show that BME staff are experiencing a higher percentage of bullying, harassment, or abuse from colleagues in the last 12 months. The WRES Data Analysis note that 'Significant and sustained differences between BME responses on WRES indicators 5 and 6 reflects real and lived experiences.'<sup>5</sup>

**INDICATOR 7: Percentage believing that Trust provides equal opportunities for career progression or promotion.**

Year	BME	White
2014/15	62%	87%
2015/16	67.29%	87.28%
2016/17	70%	86.56%

The above table show a distinctive difference between BME and White staff believing that the Trust provides career progress. During 2014/15 62% of BME staff believed that the trust provided equal opportunities for career progression in comparison to 87% of White staff, a difference of 25%. The information for 2016/17 shows a reduction in the gap of 8% over a two cycle. The gap between BME and White is still in double figures of over 16%.

<sup>4</sup> Workforce Race Equality Standard Data (2016)

<sup>5</sup> NHS Workforce Race Equality Standard: 2016 Data Analysis Report for NHS Trusts. page 75.

**INDICATOR 8: Percentage – In the last 12 months you have you experienced discrimination at work from management/team.**

Year	BME	White
2014/15		
2015/16	22% (14.59%).	11.00% (7.40%)*
2016/17	16.56%	6.61%

Comparison of the last two years has shown a decrease by both BME and White staff. The difference between BME staff and White for 2016/17 is 10%. With the exception of one Trust in the North Central London region there is a wide variance between the experiences of BME staff experiencing discrimination at work from management than White counterparts.

**INDICATOR 9: The difference between the organisation's Board voting membership and its overall workforce.**

The definition for indicator 9 has changed from 2016 whereby the data will be asking fro non-executive directors to be distinguished from executive directors. There is a very that much of any increase in BME Board membership tend to be among non-executive members not executive members.

Year	BME	White	Unknown
2014/15			
2015/16	3	10	
2016/17	2 (13.3%)	8 (53.3%)	5 (33.3%)

The table above show that the column 'unknown 'indicate a percentage of over 33% which is high for the sample size.

## WORKFORCE ETHNICITY

			Total Headcount (Mar-16)	% BME	% White	% Unknown / Null
RRP	North Central London	Barnet, Enfield And Haringey Mental Health NHS Trust	2925	47.6%	46.5%	5.8%
TAF	North Central London	Camden And Islington NHS Foundation Trust	1544	40.8%	57.5%	1.7%
RP4	North Central London	Great Ormond Street Hospital For Children NHS Foundation Trust	4161	27.3%	71.3%	1.4%
RP6	North Central London	Moorfields Eye Hospital NHS Foundation Trust	2063	48.7%	42.8%	8.5%
RAP	North Central London	North Middlesex University Hospital NHS Trust	2995	54.9%	34.6%	10.6%
RAL	North Central London	Royal Free London NHS Foundation Trust	9447	45.5%	52.4%	2.1%
RAN	North Central London	Royal National Orthopaedic Hospital NHS Trust	1505	42.9%	54.7%	2.4%
RNK	North Central London	Tavistock And Portman NHS Foundation Trust	612	25.7%	74.3%	0.0%
<b>RKE</b>	<b>North Central London</b>	<b>The Whittington Hospital NHS Trust</b>	<b>4190</b>	<b>44.3%</b>	<b>48.6%</b>	<b>7.0%</b>
RRV	North Central London	University College London NHS Foundation Trust	8245	41.5%	51.5%	6.9%
RF4	North East London	Barking, Havering And Redbridge University Hospitals NHS Trust	6266	43.6%	54.7%	1.7%
R1H	North East London	Barts Health NHS Trust	14688	50.6%	41.2%	8.2%
RWK	North East London	East London NHS Foundation Trust	4878	49.8%	47.7%	2.5%
RQX	North East London	Homerton University Hospital NHS Foundation Trust	3732	50.1%	46.9%	3.0%
RAT	North East London	North East London NHS Foundation Trust	5742	32.1%	64.7%	3.2%
RV3	North West London	Central And North West London NHS Foundation Trust	6405	38.2%	57.4%	4.4%
RYX	North West London	Central London Community Healthcare NHS Trust	2749	40.6%	54.2%	5.2%
RQM	North West London	Chelsea And Westminster Hospital NHS Foundation Trust	5512	40.3%	53.8%	5.8%
RYJ	North West London	Imperial College Healthcare NHS Trust	10876	46.5%	44.9%	8.6%
R1K	North West London	London North West Healthcare NHS Trust	8930	57.3%	37.1%	5.6%
RT3	North West London	Royal Brompton And Harefield NHS Foundation Trust	3578	30.4%	60.3%	9.3%
RAS	North West London	The Hillingdon Hospitals NHS Foundation Trust	3962	44.5%	53.1%	2.3%
RKL	North West London	West London Mental Health NHS Trust	3311	46.8%	48.1%	5.1%
RJ1	South East London	Guy's And St Thomas' NHS Foundation Trust	14375	38.0%	49.6%	12.4%
RJZ	South East London	King's College Hospital NHS Foundation Trust	11657	43.0%	53.7%	3.3%
RJ2	South East London	Lewisham And Greenwich NHS Trust	6000	45.8%	52.8%	1.5%
RPG	South East London	Oxleas NHS Foundation Trust	3674	35.0%	61.6%	3.3%
RV5	South East London	South London And Maudsley NHS Foundation Trust	4737	39.8%	57.5%	2.7%
RJ6	South West London	Croydon Health Services NHS Trust	-	-	-	-
RVR	South West London	Epsom And St Helier University Hospitals NHS Trust	4827	31.9%	60.8%	7.3%
RY9	South West London	Hounslow And Richmond Community Healthcare NHS Trust	1062	31.3%	61.9%	6.9%
RAX	South West London	Kingston Hospital NHS Foundation Trust	2965	32.2%	66.5%	1.3%
RQY	South West London	South West London And St George's Mental Health NHS Trust	2118	44.3%	52.9%	2.8%
RJ7	South West London	St George's University Hospitals NHS Foundation Trust	8972	41.1%	54.5%	4.4%
RPY	South West London	The Royal Marsden NHS Foundation Trust	4275	27.1%	70.6%	2.2%

## 2016 STAFF SURVEY RESPONSE RATES

Percentage that responded from total recipients	Base (total number of recipients with ineligible staff removed)	Estimated respondents as % of workforce
52.9	2815	50.9%
55.4	1495	53.6%
60.2	1157	16.8%
49.7	1901	45.8%
34.1	2963	33.7%
41.9	9042	40.1%
55.4	1358	50.0%
57.7	556	-
<b>35.6</b>	<b>1240</b>	<b>10.5%</b>
43.5	7529	39.7%
43.1	5880	40.5%
46.1	14557	45.7%
44.9	4610	42.4%
54.8	3410	50.1%
38.4	5192	34.8%
41.1	5534	35.5%
44.1	2833	45.5%
48.2	5160	45.1%
42.3	1198	4.7%
34.9	8180	31.9%
39.2	3520	38.6%
46.3	3117	-
47.0	3183	45.2%
38.2	13427	35.7%
36.1	10569	32.7%
29.6	5876	29.0%
44.4	3396	41.1%
40.4	4537	38.7%
33.4	3499	-
56.2	4513	52.5%
68.7	1039	67.2%
50.7	2793	47.7%
50.0	2023	47.8%
40.2	8621	38.6%
48.5	3744	42.5%

			INDICATOR 1							
			WHITE %				BME %			
			SUPPORT Band 1-4	MIDDLE Band 5-7	SENIOR Band 8a-9	VSM	SUPPORT Band 1-4	MIDDLE Band 5-7	SENIOR Band 8a-9	VSM
RRP	North Central London	Barnet, Enfield And Haringey Mental Health NHS Trust	42.2%	45.8%	75.3%	100.0%	57.8%	54.2%	24.7%	0.0%
TAF	North Central London	Camden And Islington NHS Foundation Trust	42.4%	56.7%	85.6%	92.3%	57.6%	43.3%	14.4%	7.7%
RP4	North Central London	Great Ormond Street Hospital For Children NHS Foundation Trust	54.3%	78.4%	89.3%	91.7%	45.7%	21.6%	10.7%	8.3%
RP6	North Central London	Moorfields Eye Hospital NHS Foundation Trust	40.1%	43.7%	70.8%	90.0%	59.9%	56.3%	29.2%	10.0%
RAP	North Central London	North Middlesex University Hospital NHS Trust	33.4%	35.9%	61.7%	84.6%	66.6%	64.1%	38.3%	15.4%
RAL	North Central London	Royal Free London NHS Foundation Trust	47.4%	52.6%	76.7%	100.0%	52.6%	47.4%	23.3%	0.0%
RAN	North Central London	Royal National Orthopaedic Hospital NHS Trust	53.7%	52.8%	71.4%	85.7%	46.3%	47.2%	28.6%	14.3%
RNK	North Central London	Tavistock And Portman NHS Foundation Trust	57.4%	75.0%	79.5%	90.0%	42.6%	25.0%	20.5%	10.0%
<b>RKE</b>	<b>North Central London</b>	<b>The Whittington Hospital NHS Trust</b>	<b>36.7%</b>	<b>54.2%</b>	<b>77.5%</b>	<b>100.0%</b>	<b>63.3%</b>	<b>45.8%</b>	<b>22.5%</b>	<b>0.0%</b>
RRV	North Central London	University College London NHS Foundation Trust	33.8%	57.3%	81.7%	92.6%	66.2%	42.7%	18.3%	7.4%
RF4	North East London	Barking, Havering And Redbridge University Hospitals NHS Trust	69.3%	49.3%	66.7%	87.5%	30.7%	50.7%	33.3%	12.5%
R1H	North East London	Barts Health NHS Trust	32.4%	43.7%	72.9%	80.0%	67.6%	56.3%	27.1%	20.0%
RWK	North East London	East London NHS Foundation Trust	41.0%	45.6%	75.8%	14.3%	59.0%	54.4%	24.2%	85.7%
RQX	North East London	Homerton University Hospital NHS Foundation Trust	31.8%	50.4%	76.4%	100.0%	68.2%	49.6%	23.6%	0.0%
RAT	North East London	North East London NHS Foundation Trust	73.9%	62.6%	77.1%	91.7%	26.1%	37.4%	22.9%	8.3%
RV3	North West London	Central And North West London NHS Foundation Trust	55.3%	58.8%	79.3%	87.5%	44.7%	41.2%	20.7%	12.5%
RYX	North West London	Central London Community Healthcare NHS Trust	44.2%	59.9%	77.4%	100.0%	55.8%	40.1%	22.6%	0.0%
RQM	North West London	Chelsea And Westminster Hospital NHS Foundation Trust	47.0%	58.3%	77.4%	88.9%	53.0%	41.7%	22.6%	11.1%
RYJ	North West London	Imperial College Healthcare NHS Trust	36.9%	44.0%	77.6%	88.0%	63.1%	56.0%	22.4%	12.0%
R1K	North West London	London North West Healthcare NHS Trust	31.8%	39.4%	66.0%	89.5%	68.2%	60.6%	34.0%	10.5%
RT3	North West London	Royal Brompton And Harefield NHS Foundation Trust	64.0%	65.2%	76.9%	100.0%	36.0%	34.8%	23.1%	0.0%
RAS	North West London	The Hillingdon Hospitals NHS Foundation Trust	56.0%	54.0%	71.5%	88.9%	44.0%	46.0%	28.5%	11.1%
RKL	North West London	West London Mental Health NHS Trust	47.7%	46.2%	77.1%	91.7%	52.3%	53.8%	22.9%	8.3%
RJ1	South East London	Guy's And St Thomas' NHS Foundation Trust	37.2%	61.5%	80.5%	100.0%	62.8%	38.5%	19.5%	0.0%
RJZ	South East London	King's College Hospital NHS Foundation Trust	49.4%	55.6%	76.6%	89.5%	50.6%	44.4%	23.4%	10.5%
RJ2	South East London	Lewisham And Greenwich NHS Trust	54.9%	49.3%	77.2%	88.2%	45.1%	50.7%	22.8%	11.8%
RPG	South East London	Oxleas NHS Foundation Trust	69.8%	58.0%	82.1%	81.8%	30.2%	42.0%	17.9%	18.2%
RV5	South East London	South London And Maudsley NHS Foundation Trust	46.6%	57.4%	81.6%	92.0%	53.4%	42.6%	18.4%	8.0%
RJ6	South West London	Croydon Health Services NHS Trust	45.9%	47.4%	68.8%	68.4%	54.1%	52.6%	31.2%	31.6%
RVR	South West London	Epsom And St Helier University Hospitals NHS Trust	73.8%	61.3%	82.2%	81.8%	26.2%	38.7%	17.8%	18.2%
RY9	South West London	Hounslow And Richmond Community Healthcare NHS Trust	59.8%	69.0%	79.7%	66.7%	40.2%	31.0%	20.3%	33.3%
RAX	South West London	Kingston Hospital NHS Foundation Trust	65.4%	68.6%	83.9%	100.0%	34.6%	31.4%	16.1%	0.0%
RQY	South West London	South West London And St George's Mental Health NHS Trust	36.6%	53.0%	81.3%	100.0%	63.4%	47.0%	18.7%	0.0%
RJ7	South West London	St George's University Hospitals NHS Foundation Trust	43.7%	59.0%	71.0%	100.0%	56.3%	41.0%	29.0%	0.0%
RPY	South West London	The Royal Marsden NHS Foundation Trust	66.8%	72.8%	84.4%	85.0%	33.2%	27.2%	15.6%	15.0%

			INDICATOR 2	INDICATOR 3	INDICATOR 4
			Relative likelihood of White staff being appointed from shortlisting compared to BME staff:	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff:	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff
RRP	North Central London	Barnet, Enfield And Haringey Mental Health NHS Trust	1.20	6.18	0.91
TAF	North Central London	Camden And Islington NHS Foundation Trust	1.43	1.75	0.58
RP4	North Central London	Great Ormond Street Hospital For Children NHS Foundation Trust	2.02	3.37	1.07
RP6	North Central London	Moorfields Eye Hospital NHS Foundation Trust	1.09	3.51	0.86
RAP	North Central London	North Middlesex University Hospital NHS Trust	1.63	2.10	-
RAL	North Central London	Royal Free London NHS Foundation Trust	1.49	1.23	0.80
RAN	North Central London	Royal National Orthopaedic Hospital NHS Trust	1.26	1.62	1.50
RNK	North Central London	Tavistock And Portman NHS Foundation Trust	1.89	0.00	-
<b>RKE</b>	<b>North Central London</b>	<b>The Whittington Hospital NHS Trust</b>	<b>2.28</b>	<b>2.67</b>	<b>-</b>
RRV	North Central London	University College London NHS Foundation Trust	1.34	3.00	0.65
RF4	North East London	Barking, Havering And Redbridge University Hospitals NHS Trust	1.54	1.26	0.63
R1H	North East London	Barts Health NHS Trust	1.84	1.82	-
RWK	North East London	East London NHS Foundation Trust	1.32	2.74	0.86
RQX	North East London	Homerton University Hospital NHS Foundation Trust	1.96	2.81	1.05
RAT	North East London	North East London NHS Foundation Trust	3.12	2.02	0.81
RV3	North West London	Central And North West London NHS Foundation Trust	1.38	2.93	-
RYX	North West London	Central London Community Healthcare NHS Trust	1.86	3.07	1.56
RQM	North West London	Chelsea And Westminster Hospital NHS Foundation Trust	1.76	2.34	0.80
RYJ	North West London	Imperial College Healthcare NHS Trust	1.51	2.03	0.90
R1K	North West London	London North West Healthcare NHS Trust	1.10	1.32	0.95
RT3	North West London	Royal Brompton And Harefield NHS Foundation Trust	1.80	0.50	0.79
RAS	North West London	The Hillingdon Hospitals NHS Foundation Trust	1.39	1.17	-
RKL	North West London	West London Mental Health NHS Trust	1.17	2.15	-
RJ1	South East London	Guy's And St Thomas' NHS Foundation Trust	-	2.58	0.97
RJZ	South East London	King's College Hospital NHS Foundation Trust	1.84	2.25	1.00
RJ2	South East London	Lewisham And Greenwich NHS Trust	1.85	2.92	0.96
RPG	South East London	Oxleas NHS Foundation Trust	1.78	3.30	0.98
RV5	South East London	South London And Maudsley NHS Foundation Trust	1.90	3.06	0.98
RJ6	South West London	Croydon Health Services NHS Trust	-	-	-
RVR	South West London	Epsom And St Helier University Hospitals NHS Trust	1.09	2.67	0.95
RY9	South West London	Hounslow And Richmond Community Healthcare NHS Trust	1.99	2.51	2.04
RAX	South West London	Kingston Hospital NHS Foundation Trust	2.74	1.19	0.84
RQY	South West London	South West London And St George's Mental Health NHS Trust	0.77	3.60	1.81
RJ7	South West London	St George's University Hospitals NHS Foundation Trust	1.98	2.41	-
RPY	South West London	The Royal Marsden NHS Foundation Trust	1.91	2.20	-

RRP	North Central London	Barnet, Enfield And Haringey Mental Health NHS Trust
TAF	North Central London	Camden And Islington NHS Foundation Trust
RP4	North Central London	Great Ormond Street Hospital For Children NHS Foundation Trust
RP6	North Central London	Moorfields Eye Hospital NHS Foundation Trust
RAP	North Central London	North Middlesex University Hospital NHS Trust
RAL	North Central London	Royal Free London NHS Foundation Trust
RAN	North Central London	Royal National Orthopaedic Hospital NHS Trust
RNK	North Central London	Tavistock And Portman NHS Foundation Trust
<b>RKE</b>	<b>North Central London</b>	<b>The Whittington Hospital NHS Trust</b>
RRV	North Central London	University College London NHS Foundation Trust
RF4	North East London	Barking, Havering And Redbridge University Hospitals NHS Trust
R1H	North East London	Barts Health NHS Trust
RWK	North East London	East London NHS Foundation Trust
RQX	North East London	Homerton University Hospital NHS Foundation Trust
RAT	North East London	North East London NHS Foundation Trust
RV3	North West London	Central And North West London NHS Foundation Trust
RYX	North West London	Central London Community Healthcare NHS Trust
RQM	North West London	Chelsea And Westminster Hospital NHS Foundation Trust
RYJ	North West London	Imperial College Healthcare NHS Trust
R1K	North West London	London North West Healthcare NHS Trust
RT3	North West London	Royal Brompton And Harefield NHS Foundation Trust
RAS	North West London	The Hillingdon Hospitals NHS Foundation Trust
RKL	North West London	West London Mental Health NHS Trust
RJ1	South East London	Guy's And St Thomas' NHS Foundation Trust
RJ2	South East London	King's College Hospital NHS Foundation Trust
RJ2	South East London	Lewisham And Greenwich NHS Trust
RPG	South East London	Oxleas NHS Foundation Trust
RV5	South East London	South London And Maudsley NHS Foundation Trust
RJ6	South West London	Croydon Health Services NHS Trust
RVR	South West London	Epsom And St Helier University Hospitals NHS Trust
RY9	South West London	Hounslow And Richmond Community Healthcare NHS Trust
RAX	South West London	Kingston Hospital NHS Foundation Trust
RQY	South West London	South West London And St George's Mental Health NHS Trust
RJ7	South West London	St George's University Hospitals NHS Foundation Trust
RPY	South West London	The Royal Marsden NHS Foundation Trust

INDICATOR 5		
Key Finding 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months		
All Staff	White	BME
35.8%	25.8%	30.9%
38.4%	37.7%	41.2%
22.5%	26.8%	21.2%
22.9%	24.9%	22.5%
37.7%	33.7%	33.0%
30.0%	31.4%	32.2%
22.8%	25.2%	25.1%
20.7%	19.0%	18.4%
<b>30.3%</b>	<b>28.8%</b>	<b>28.5%</b>
32.1%	32.2%	28.4%
29.9%	33.3%	32.5%
29.6%	30.9%	33.8%
32.5%	31.9%	35.6%
27.9%	25.3%	29.8%
28.9%	31.1%	37.6%
29.6%	26.6%	34.0%
25.4%	26.8%	23.2%
38.5%	42.5%	33.8%
32.6%	25.2%	31.8%
34.0%	33.6%	24.4%
19.7%	21.3%	13.2%
29.3%	31.3%	23.7%
35.5%	33.6%	37.3%
26.6%	27.7%	23.5%
36.7%	35.4%	32.0%
31.3%	33.3%	26.3%
32.9%	25.1%	36.9%
34.1%	33.3%	38.1%
31.3%	35.9%	33.3%
29.1%	27.0%	26.5%
23.9%	22.8%	23.8%
30.2%	29.6%	28.2%
34.6%	31.5%	37.0%
30.0%	32.2%	29.9%
17.0%	17.2%	14.6%

INDICATOR 6		
Key Finding 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months		
All Staff	White	BME
26.9%	22.4%	26.2%
20.4%	20.5%	21.4%
25.9%	22.9%	32.7%
26.9%	24.2%	30.0%
34.8%	32.6%	35.6%
32.0%	32.2%	35.9%
28.1%	26.2%	28.8%
23.8%	16.5%	10.5%
<b>28.0%</b>	<b>27.0%</b>	<b>27.2%</b>
31.2%	29.6%	33.8%
29.8%	30.7%	31.0%
32.7%	36.8%	36.8%
23.2%	24.5%	22.5%
22.6%	22.0%	28.6%
22.9%	24.1%	28.3%
23.0%	20.8%	22.7%
22.8%	23.1%	24.2%
27.5%	26.2%	28.3%
31.8%	28.1%	35.2%
30.8%	25.6%	27.7%
29.9%	28.8%	25.9%
23.2%	23.6%	22.4%
30.3%	28.0%	29.2%
24.2%	23.8%	24.2%
32.3%	29.3%	30.7%
27.9%	27.3%	27.1%
20.2%	19.2%	15.7%
25.1%	23.3%	32.4%
27.5%	30.1%	26.1%
26.1%	24.8%	29.1%
19.9%	15.5%	26.3%
26.9%	28.0%	31.6%
23.7%	21.8%	24.5%
32.3%	32.2%	35.3%
23.9%	20.8%	24.4%

INDICATOR 7		
Key Finding 21. Percentage of staff believing that trust provides equal opportunities for career progression or promotion		
All Staff	White	BME
77.8%	86.1%	68.5%
78.7%	87.9%	64.6%
84.4%	90.0%	77.8%
81.7%	91.5%	72.1%
69.1%	86.8%	66.7%
77.5%	83.7%	64.9%
82.8%	88.4%	70.7%
78.8%	83.1%	0.0%
<b>80.4%</b>	<b>87.3%</b>	<b>67.3%</b>
78.9%	84.6%	66.3%
78.6%	82.4%	64.3%
72.6%	79.7%	58.6%
79.1%	90.7%	68.8%
78.3%	88.7%	63.6%
83.2%	87.3%	71.6%
83.0%	91.0%	75.2%
82.3%	91.1%	65.6%
82.2%	91.8%	76.2%
81.1%	85.6%	64.8%
73.4%	77.8%	68.7%
84.2%	87.9%	79.8%
82.7%	90.1%	73.2%
76.3%	76.8%	66.1%
83.2%	91.2%	71.5%
76.8%	81.7%	86.5%
82.5%	88.5%	72.4%
85.8%	95.5%	81.2%
79.3%	85.0%	62.9%
78.6%	90.4%	75.9%
80.1%	87.1%	70.7%
85.8%	90.6%	78.6%
83.0%	88.0%	68.7%
76.4%	80.0%	67.4%
76.1%	82.8%	59.5%
86.8%	90.5%	75.6%

			INDICATOR 8		INDICATOR 9	
			Q17b. In the last 12 months have you personally experienced discrimination at work from any of the following? - Manager / team leader or other colleagues		NHS Trust Board Representation by Ethnicity	
			White	BME	% BME	% White
RRP	North Central London	Barnet, Enfield And Haringey Mental Health NHS Trust	5.3%	14.6%	0.0%	100.0%
TAF	North Central London	Camden And Islington NHS Foundation Trust	6.2%	12.7%	-	-
RP4	North Central London	Great Ormond Street Hospital For Children NHS Foundation Trust	5.8%	14.6%	23.1%	76.9%
RP6	North Central London	Moorfields Eye Hospital NHS Foundation Trust	5.5%	11.6%	17.6%	82.4%
RAP	North Central London	North Middlesex University Hospital NHS Trust	6.6%	14.0%	10.0%	90.0%
RAL	North Central London	Royal Free London NHS Foundation Trust	8.4%	18.5%	-	-
RAN	North Central London	Royal National Orthopaedic Hospital NHS Trust	7.8%	15.7%	0.0%	100.0%
RNK	North Central London	Tavistock And Portman NHS Foundation Trust	5.7%	5.0%	9.1%	90.9%
<b>RKE</b>	<b>North Central London</b>	<b>The Whittington Hospital NHS Trust</b>	<b>7.4%</b>	<b>14.5%</b>	<b>23.1%</b>	<b>76.9%</b>
RRV	North Central London	University College London NHS Foundation Trust	7.9%	18.4%	0.0%	100.0%
RF4	North East London	Barking, Havering And Redbridge University Hospitals NHS Trust	8.5%	17.8%	45.5%	54.5%
R1H	North East London	Barts Health NHS Trust	10.3%	19.7%	33.3%	66.7%
RWK	North East London	East London NHS Foundation Trust	7.4%	16.7%	33.3%	66.7%
RQX	North East London	Homerton University Hospital NHS Foundation Trust	7.0%	13.8%	0.0%	100.0%
RAT	North East London	North East London NHS Foundation Trust	8.6%	16.4%	0.0%	100.0%
RV3	North West London	Central And North West London NHS Foundation Trust	5.1%	12.4%	16.7%	83.3%
RYX	North West London	Central London Community Healthcare NHS Trust	4.1%	13.4%	0.0%	100.0%
RQM	North West London	Chelsea And Westminster Hospital NHS Foundation Trust	5.1%	12.3%	9.1%	90.9%
RYJ	North West London	Imperial College Healthcare NHS Trust	5.1%	21.6%	8.3%	91.7%
R1K	North West London	London North West Healthcare NHS Trust	6.2%	15.0%	-	-
RT3	North West London	Royal Brompton And Harefield NHS Foundation Trust	6.8%	11.7%	-	-
RAS	North West London	The Hillingdon Hospitals NHS Foundation Trust	6.1%	11.0%	18.2%	81.8%
RKL	North West London	West London Mental Health NHS Trust	7.6%	13.8%	13.3%	86.7%
RJ1	South East London	Guy's And St Thomas' NHS Foundation Trust	5.9%	12.3%	21.1%	78.9%
RJZ	South East London	King's College Hospital NHS Foundation Trust	6.1%	5.5%	7.1%	92.9%
RJ2	South East London	Lewisham And Greenwich NHS Trust	7.5%	13.7%	6.7%	93.3%
RPG	South East London	Oxleas NHS Foundation Trust	3.9%	12.2%	23.1%	76.9%
RV5	South East London	South London And Maudsley NHS Foundation Trust	7.0%	15.5%	8.3%	91.7%
RJ6	South West London	Croydon Health Services NHS Trust	7.6%	15.7%	-	-
RVR	South West London	Epsom And St Helier University Hospitals NHS Trust	6.5%	11.2%	16.7%	83.3%
RY9	South West London	Hounslow And Richmond Community Healthcare NHS Trust	4.5%	13.7%	18.2%	81.8%
RAX	South West London	Kingston Hospital NHS Foundation Trust	6.0%	15.2%	-	-
RQY	South West London	South West London And St George's Mental Health NHS Trust	6.6%	12.9%	8.3%	91.7%
RJ7	South West London	St George's University Hospitals NHS Foundation Trust	8.5%	22.8%	0.0%	100.0%
RPY	South West London	The Royal Marsden NHS Foundation Trust	4.6%	11.7%	0.0%	100.0%

**Whittington Health****Trust Board****6<sup>th</sup> September 2017**

<b>Title:</b>		Medical Appraisal and Revalidation: Annual Board Report					
<b>Agenda item:</b>		<b>17/120</b>		Paper		<b>13</b>	
<b>Action requested:</b>		To approve					
<b>Executive Summary:</b>		<p>This is the annual Medical Appraisal Board Report in the format required by NHS England as part of the quality assurance process for medical appraisal and revalidation.</p> <p>Medical revalidation was introduced in November 2012 as a means of improving the ways in which doctors are regulated. It is not a means of addressing concerns about doctors, for which there are existing policies and procedures, but instead is designed to improve quality of care, while simultaneously increasing public confidence in the medical system.</p> <p>This report reviews appraisals completed and revalidation recommendations submitted in the financial year 2016-17.</p>					
<b>Summary of recommendations:</b>		The Board is asked to approve this report.					
<b>Fit with WH strategy:</b>		This report is a requirement under NHS England Framework of Quality Assurance for Responsible Officers and Revalidation (FQA). It is designed to provide the Board with oversight and assurance of its local medical appraisal and revalidation processes.					
<b>Reference to related / other documents:</b>		Medical Appraisal and Medical Revalidation Policy Conduct, Performance and Ill-Health Procedures for Medical and Dental Staff Maintaining High Professional Standards in the Modern NHS Responsible Officer Regulations					
<b>Date paper completed:</b>		17 <sup>th</sup> August 2017					
<b>Author name and title:</b>		Ashleigh Soan Medical Director Portfolio Manager		<b>Director name and title:</b>		Richard Jennings, Executive Medical Director	
<b>Date paper seen by EC</b>		<b>Equality Impact Assessment complete?</b>	NA	<b>Risk assessment undertaken?</b>	NA	<b>Legal advice received?</b>	NA

# Medical Appraisal and Revalidation: Annual Board Report

August 2017

## 1. Executive Summary and Background

This is the fifth of the Trust's Medical Appraisal Annual Board Reports in the format required by NHS England as part of the quality assurance process for medical appraisal and revalidation.

Medical revalidation was live in November 2012 as a means of improving the ways in which doctors are regulated. It is not a means of addressing concerns about doctors, for which there are existing policies and procedures, but instead is designed to improve quality of care, while simultaneously increasing public confidence in the medical profession.

All provider organisations known as Designated Bodies have a statutory obligation to support their Responsible Officer in fulfilling his or her duties under the Responsible Officer Regulations<sup>1</sup>. For this reason, this report has been designed to ensure that the Board has oversight of the following areas:

- monitoring the frequency and quality of medical appraisals within the Trust;
- checking there are effective systems in place for monitoring the conduct and performance of the Trust's doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for the Trust's doctors; and
- ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work that they perform.

Dr Richard Jennings, the Trust's Executive Medical Director, was appointed to the role of Responsible Officer and has been in post since June 2014.

Mr Robert Sherwin, the Trust's Associate Medical Director for Revalidation, was appointed to the role on 1<sup>st</sup> February 2016.

## 2. Terminology

**'Revalidation'**: the process whereby the General Medical Council (GMC) renews a doctor's license to practise every five years, based on a recommendation from the doctor's Responsible Officer.

**'Designated body'**: an organisation recognised by the GMC as responsible for submitting revalidation recommendations. Every designated body must have a Responsible Officer.

**'Responsible Officer' (RO)**: a senior doctor, usually the Medical Director, who is responsible for medical appraisal and revalidation within the organisation and who makes recommendations to the GMC about doctors' fitness to practise. The revalidation recommendations submitted by the RO are considered by the GMC when they make the final decision with regards to a doctor's revalidation. The RO's responsibilities are laid out

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<sup>1</sup> The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (License to Practice and Revalidation) Regulations Order of Council 2012'

in the Responsible Officer Regulations, and in additional documents provided by the GMC such as the Responsible Officer Framework.

**‘Prescribed Connection’:** the term used to indicate the link with a doctor and their designated body. The prescribed connection is determined by law in the Responsible Officer Regulations and cannot be chosen, though it can be altered in exceptional circumstances. For doctors in a formal training programme, their prescribed connection is with the relevant region for Health Education England (HEE) that administrates their course. All GPs on performers’ lists have a prescribed connection to their Area Team for NHS England. Doctors who only work privately have a prescribed connection to the private organisation for which they do most work, and doctors employed only by an agency will usually have a prescribed connection to that agency. For all other doctors, including those with honorary contracts or on the bank, their prescribed connection is to the organisation for which they do most work, or, in the case of doctors who do an equal amount of work at two different NHS Trusts, to the organisation which is closest to their GMC registered address.

**‘Medical Appraisal’:** the evidence to inform revalidation recommendations is based on annual medical appraisals. Medical appraisals are performed by trained appraisers, and include a process whereby the doctor must provide a portfolio of evidence regarding their practice, including six kinds of information which are considered mandatory by the GMC. These should relate to:

1. Continuing Professional Development
2. Quality improvement activity
3. Significant events (including but not limited to Serious Incidents)
4. Colleague feedback (Completed through a formal 360)
5. Patient feedback (Completed through a formal 360)
6. Review of complaints and compliments

## Revalidation recommendations

Responsible Officers are only able to submit one of three revalidation recommendations about a doctor to the GMC<sup>2</sup>:

1. **‘Positive recommendation’:** a recommendation from the Responsible Officer to the GMC that in his/her opinion a doctor is up-to-date, fit to practise, and without unaddressed concerns.
2. **‘Deferral request’:** a request from the Responsible Officer to the GMC to delay a doctor’s revalidation submission date to allow for additional information to be considered (for example, if the doctor has not completed a 360 Multi-Source Feedback exercise, or if they are in a local HR process that has not yet come to a conclusion). Deferral of revalidation is neutral and has no impact on a doctor’s practice; however, more than one request for deferral of revalidation date for an individual will lead to the GMC requesting further information as to the reasons for the deferral.
3. **‘Recommendation of non-engagement’:** a recommendation of non-engagement is made by the Responsible Officer to the GMC where a doctor is failing to engage with the processes that support revalidation (for example, where a doctor has repeatedly failed to complete an appraisal). A recommendation of non-engagement can be made at any point in the revalidation cycle.

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<sup>2</sup> Revalidation Statements, accessible at <http://www.gmc-uk.org/doctors/revalidation/12394.asp>

### **3. Prescribed connection and appraisal completion rate**

It should be noted that due to the nature of the prescribed connection, which includes doctors on honorary contracts, as well as doctors on short term contracts and doctors employed via the Trust Bank if they have no other NHS employment, these figures fluctuate. For this reason it is expected that the appraisal completion rate will fall short of 100%. At 31<sup>st</sup> March 2017, there were 257 doctors with a prescribed connection to Whittington Health.

Between 1<sup>st</sup> April 2016 and 31<sup>st</sup> March 2017 211 medical appraisals (82%) were completed, between 1<sup>st</sup> April 2017 and 31<sup>st</sup> May 2017 a further 8 doctors have completed a late 2016-17 medical appraisal. 38 doctors had an agreed postponement of appraisal with the RO. 3 doctors are now significantly past their appraisal due dates and the Associate Medical Director for Revalidation is in contact with these doctors to support them to meet their appraisal obligations.

### **4. Governance Arrangements and Responsibilities**

The Responsible Officer is supported by the Associate Medical Director for Revalidation, Medical Director Portfolio Manager and the Project Support Officer. The responsibilities of the Medical Director Portfolio Manager and Project Support Officer include:

- Maintaining the Trust's prescribed connection list on GMC Connect;
- Monitoring revalidation submission dates;
- Responding to revalidation information requests from other organisations on behalf of the Responsible Officer;
- Storing information relating to revalidation recommendations;
- Maintaining and monitoring the annual appraisal list, including providing reminders to doctors that their appraisals are due and escalating missed appraisals appropriately to Clinical Directors and the Responsible Officer;
- Supporting the Clinical Directors in allocating appraisers to the Trust's doctors, and keeping records of appraisal pairings in order to ensure that these are in line with the policy;
- Monitoring the Trust's online Revalidation Management System and liaising with the provider (Equiniti360Clinical) on improvements and development;
- Providing training for doctors with regard to using the online system, as well as more generally about the requirements of appraisal and revalidation;
- Providing refresher training to appraisers;
- Ensuring that Trust-held data on complaints, incidents and registered audit is entered onto the Revalidation Management System;
- Assisting the Director of Postgraduate Medical Education with the completion of the Trainee Revalidation Portal, as required;
- Monitoring new advice from the GMC and NHS England and providing advice on process to individual doctors and to the Responsible Officer as necessary;
- Reviewing and updating the Medical Appraisal Policy in line with new guidance as necessary;
- Managing appraisal reporting, including locally to the Responsible Officer, and the completion of quarterly reports to NHS England;
- Completing the Annual Organisational Audit;

- Completing first stage quality assurance audit of annual appraisals.

The responsibilities of the Associate Medical Director for Revalidation include:

- Oversee the medical appraisal process to help ensure that all non-training grade doctors employed by the trust have an annual appraisal.
- With the day to day support of the Medical Director Portfolio Manager and Project Support Officer, agree a strategy to ensure improvements in the medical appraisal and medical revalidation processes.
- Develop reviews of medical appraisal outputs to ensure the inclusion of all required documentation and to use regular reviews to set a standard for medical appraisals in the trust.
- To offer bespoke advice and support to colleagues who have complex issues around evidencing performance and quality.
- To support the Responsible Officer in ensuring the evidencing of recommendations made to the GMC about the fitness to practise of doctors employed by the trust.
- To oversee the continuous quality review and improvement of training and guidance for trust medical appraisers.
- To assist the Medical Director in overseeing the trust's process for responding to correspondence from the GMC.
- Refer concerns about a doctor to the Responsible Officer (Medical Director) for further investigation and support the Responsible Officer in ensuring that appropriate timely action is taken, in accordance with trust procedures, when a concern is raised about a doctor's performance or conduct.
- Oversee existing processes to ensure that the trust complies with the external reporting related to medical revalidation and medical appraisals.
- Subject to agreement between the post holder and the Medical Director, the post-holder may deputise for the Medical Director.
- Chair appropriate meetings relating to the role.

The Trust has a process for maintaining an accurate list of prescribed connections via Electronic Staff Record (ESR) reports and updates provided by the recruitment team.

## **5. Medical Appraisal**

### **a) Policy and Guidance**

The Trust's Medical Appraisal and Revalidation Policy has been updated this year, in discussion with our Local Negotiating Committee (LNC), to reflect the new requirements in the Framework of Quality Assurance, the change in the trust's organisational structure and revalidation arrangements.

### **b) Appraisal and Revalidation Performance Data**

As at 31<sup>st</sup> March 2016 211 appraisals had been completed and a further 8 appraisals were completed between 1<sup>st</sup> April 2017 – 31<sup>st</sup> May 2017. The audit of missed or incomplete appraisals (Appendix A) provides detail on the reasons for those appraisals not completed in the window within which they were due.

### **Completion of medical appraisals in 2016-17 by grade of doctor (n = 257)**

#### **Consultants (n = 191)**

- 171 completed appraisals in line with policy (90%)
- 7 with late appraisals (appraisals completed between 1<sup>st</sup> April 2017 – 31<sup>st</sup> May 2017)
- 13 with previously agreed and acceptable reasons for not completing




#### **Specialty Doctors/Associate Specialists (SASG)/Doctors on Performers Lists (n = 24)**

- 21 completed appraisals in line with policy (88%)
- 0 with late appraisals (appraisals completed between 1<sup>st</sup> April 2017 – 31<sup>st</sup> May 2017)
- 3 with a previously agreed and acceptable reason for not completing

#### **Trust grade doctors or doctors on short term contracts (including non-training grade junior doctors) (n= 42)**

- 19 completed appraisals in line with policy
- 1 with a late appraisal (appraisals completed between 1<sup>st</sup> April 2017 – 31<sup>st</sup> May 2017)
- 21 with previously agreed and acceptable reasons for not completing
- 1 with no previously agreed or acceptable reason for not completing

**Table 1: Appraisals in-line with policy in 2015/16 and 2016/17 by grade of doctor**

<b>Appraisals in-line with policy (%)</b>	<b>Consultants</b>	<b>SASG doctors</b>	<b>Trust grade doctors</b>
<b>2015/16</b>	77	77	25
<b>2016/17</b>	90	88	45
<b>Difference</b>	13 	11 	20 

### **c) Appraisers**

The Trust had 63 active appraisers for the 2016-17 appraisal period (an active appraiser is defined as having performed at least one appraisal in the year). This represents approximately one quarter of the total number of doctors with a prescribed connection. All appraisers have received revalidation-ready training from approved external providers.

Additional half-day refresher training for the 2016-17 appraisal period was provided by an specialist external training company; 43 of the trust's appraisers attended the training. Refresher training is important and is recommended at least every 3 years to ensure our medical appraisers are up to date with the latest developments in appraisal and revalidation. This training was developed using the audit of a sample of medical appraisals completed in 2015-16 and the feedback we have received from doctors, and included:

- Reviewing medical appraisal supporting information, knowing what to look for and when it would be appropriate to postpone an appraisal
- Reviewing structures for reflective comments
- Practice of using assertive techniques in discussions with doctors, including when the doctor's supporting information is not adequate
- Personal Development Plans (PDPs) and how appraisers can help support doctors to write good quality PDPs
- Recognising the different ways in which doctors can develop their clinical and interpersonal skills

## Appraiser feedback 2016-17

Following each completed appraisal doctors are invited to complete a short survey to give feedback to their appraiser. The below Table 3 represents the feedback received for appraisals completed between 28<sup>th</sup> June 2016 and 9<sup>th</sup> May 2017. As Table 2 and Table 3 (below) show, we have improved our appraiser feedback received last year

**Table 2: 2015/16 appraiser feedback**

Combined appraiser feedback for all our 58 active appraisers in 2015/16. This is based on the responses of 205 doctors who were surveyed straight after their appraisal	Unable to Comment	Poor	Borderline	Satisfactory	Good	Very Good
Establishing rapport	0%	0%	0%	2%	19%	79%
Demonstrating thorough preparation for your appraisal	0%	0%	1%	2%	23%	74%
Listening to you and giving you time to talk	0%	0%	0%	20%	18%	80%
Giving constructive and helpful feedback	0%	1%	0%	3%	22%	74%
Supporting you	0%	0%	2%	3%	21%	74%
Challenging you	0%	1%	0%	4%	31%	64%
Helping you to review your practice	0%	1%	0%	3%	28%	68%
Helping you to identify gaps and improve your portfolio of supporting information for revalidation	1%	1%	0%	4%	30%	64%
Helping you to review your progress against your Personal Development Plan (PDP)	0%	0%	1%	3%	28%	68%
Helping you to produce a new PDP that reflects your development needs	0%	1%	0%	2%	26%	71%

**Table 3: 2016/17 appraiser feedback**

Combined appraiser feedback for all our 63 active appraisers in 2016/17. This is based on the responses of 215 doctors who were surveyed straight after their appraisal	Unable to Comment	Poor	Borderline	Satisfactory	Good	Very Good
Establishing rapport	0%	0%	0%	1%	17%	82%
Demonstrating thorough preparation for your appraisal	0%	0%	0%	3%	13%	84%
Listening to you and giving you time to talk	0%	0%	0%	3%	17%	80%
Giving constructive and helpful feedback	0%	0%	0%	2%	19%	79%
Supporting you	0%	0%	0%	2%	17%	80%
Challenging you	0%	0%	0%	4%	28%	68%
Helping you to review your practice	0%	0%	0%	2%	27%	71%
Helping you to identify gaps and improve your portfolio of supporting information for revalidation	1%	0%	0%	3%	25%	71%
Helping you to review your progress against your Personal Development Plan (PDP)	0%	0%	0%	2%	18%	80%
Helping you to produce a new PDP that reflects your development needs	0%	0%	0%	2%	22%	75%

The written feedback received about medical appraisals has been overwhelmingly positive. This list provides examples of anonymous written feedback received for medical appraisers in 2016/17:

“Far better than you’d expect appraisal to be.”

“Well beyond a simple tick-box exercise.”

“I had a deep reflection on my current medical practice and I was guided through this review of my practice in a very supportive and professional way.”

“I found the appraisal process very helpful to progress in my career and voice any concerns. My appraisers have been thoroughly professional and never patronising.”

“I felt [my appraiser] gave me the right advice and has motivated me to complete what is agreed in the PDP.”

“I came out with excellent ideas for further service development. [My appraiser] has challenged me to think about other, more flexible ways of working to balance out the work load. [My appraiser] helped me to reflect on difficult events in the last year – and likewise on positive achievements.”

“[My appraiser] had gone through my portfolio in advance and was familiar with all my work. [My appraiser] gave me time to discuss certain relevant matters and gave me valuable advice.”

“Despite the hassle of accumulating all the information, it is definitely a worthwhile process.”

“I can speak to [my appraiser] openly about anything work related or otherwise.”

#### **d) Quality Assurance**

##### ***Quality assurance of appraisals***

Individual appraisal portfolios and output documents are reviewed at two stages. An audit is conducted by the RO’s team on at least 10% of completed appraisals following the completion of the appraisal cycle. For the most recent cycle, the audit was conducted using the NHS England Appraisal Summary and PDP Audit Tool Template (ASPAT). The results of this audit are included in Appendix B.

An individual doctor’s appraisal output documents and some key pieces of evidence from the appraisal portfolio are then reviewed again by the Responsible Officer and a member of his team prior to a revalidation recommendation being made.

##### ***Quality assurance for appraisers***

All Trust appraisers have undertaken revalidation-ready training in order to provide a level of assurance that they have the skills and knowledge appropriate for the role. In addition, the Trust collects anonymous feedback on individual appraisers via the online Revalidation Management System; this feedback is collated by the RO’s team and provided to individual appraisers so that they can reflect on it at their own appraisal. In cases where an appraiser consistently scores very low in a number of areas, where multiple doctors have requested not to be appraised by one individual, or where audits have identified substandard appraisals

conducted by one appraiser, the RO's team will escalate this to the Responsible Officer and this appraiser may be asked to undertake further training. The Trust also keeps records of appraiser attendance at refresher training events which can be used in the appraiser's portfolio as evidence of ongoing professional development.

#### **e) Access, security and confidentiality**

In line with GMC requirements that all medical appraisals be performed electronically, the Trust uses the Revalidation Management System (RMS) provided by software company Equiniti. The system is part of the G-cloud programme, which provides a very high level of data security and assurance. A doctor's appraiser only has access to the appraiser's portfolio once it has been submitted to them, and loses access once the appraisal is signed off. The Responsible Officer has access to a doctor's information in order to be able to make revalidation recommendations, and the RO's team have administrative access in order to be able to provide IT and technical support, as well as conducting audits.

#### **f) Clinical Governance Data**

The Trust maintains certain corporate data which is issued to doctors prior to their annual appraisals. This data includes:

- Complaints and PALS;
- Incidents, including but not limited to Serious Incidents and high risk incidents, and including incidents that the doctors reported even if they were not themselves responsible;
- Information on legal claims;
- Participation in registered local or national audit and contribution to clinical guidelines.

Complaints, PALS, claims, incidents and audit data is uploaded to a doctor's portfolio by the RO's team in order to ensure that it is included in the portfolio.

We are working to be able to provide details of surgical activity for all operating clinicians.

In 2017/18 the Trust will be appointing to the role of Associate Director for Quality Improvement; the new post-holder will work with the Clinical Governance department to develop of all doctors involved in quality improvement projects, which will then feed into annual medical appraisals.

### **6. Revalidation Recommendations**

The audit of revalidation recommendations (Appendix C) details recommendations made for the year 1<sup>st</sup> April 2016 to 31<sup>st</sup> March 2017. Since revalidation went live in November 2012, the Trust has made 322 recommendations for doctors with a prescribed connection to the Whittington, of which 206 were positive recommendations, and 125 were requests for deferrals. So far there have not been any recommendations of non-engagement. Between the 1<sup>st</sup> April 2016 and 31<sup>st</sup> March 2017 the Trust has made 15 positive recommendations, and 19 doctors had their revalidation dates deferred pending further information, for 4 of these doctors this was due to their being in a formal MHPS process. In this time period 4 recommendations were submitted later than the requested submission dates, these were due to administrative error, and the longest delay was 2 days. To prevent late submissions revalidations are now reviewed up to four months in advance by the Medical Appraisal and Revalidation Decision Group. There have been no late submissions so far since the beginning of 2017-18.

## **7. Recruitment and engagement background checks**

Pre-employment checks for doctors on permanent or fixed term contracts are performed by the Recruitment Team and Occupational Health. These include:

- Verification of identity
- Health clearance checks
- Criminal records checks and the signing of a Criminal Convictions Declaration form
- Verification of right to work in the UK, where this is necessary
- Verification of license to practise and other relevant qualifications
- Filing of references and CVs

Honorary contracts are issued by the recruitment team. Where a doctor applies for an honorary contract with Whittington Health, but also holds a substantive role at another organisation, verification of employment checks from their substantive employer is sought from the other NHS employing body.

With regard to doctors working at the Trust via an agency, the Trust has framework agency agreements which are used to secure the majority of agency bookings for medical staff. However, when the trust uses non-framework agencies, where there is no such agreement, there is no assurance that the agency is following NHS mandated recruitment standards.

## **8. Responding to Concerns and Remediation**

The Trust has a local policy for 'Conduct, Performance and Ill-Health Procedures for Medical and Dental staff'. All conduct, performance and health concerns relating to doctors are managed by a Case Manager, and if investigation is necessary, are investigated by a Case Investigator with oversight from a nominated Non-Executive Director, as required by the national framework 'Maintaining High Professional Standards in the Modern NHS'<sup>3</sup> and by local policy. Should the Executive Medical Director have any concerns regarding a doctor's conduct, performance or health the Trust may initially discuss this on an anonymous basis with the National Clinical Assessment Service (NCAS) or with the Trust's GMC Employer Liaison Advisor.

## **9. Risk and Issues**

There is a risk that the percentage of recommendations that are for deferral is higher than it needs to be because of short-falls that are in fact avoidable in the assembly of relevant information by individual doctors in preparation for their appraisals. This is being addressed through the Medical Appraisal and Revalidation Decision Group, which anticipates possible short-falls in relevant appraisal evidence for individual doctors, and then works with those doctors to prospectively address these.

There is a risk that through administrative error, revalidation recommendations will be made late. This has been addressed through the strengthened processes associated with the Medical Appraisal and Revalidation Decision Group.

To safeguard the quality of appraisals, we envisage reducing the number of appraisers and stipulating that there is a minimum number of appraisals completed per annum. At present,

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<sup>3</sup> Department of Health, *Maintaining High Professional Standards in the Modern NHS*, accessible at [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4103586](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103586)

appraisers receive no additional remuneration or allowance within their job plan. However, the trust is implementing new job planning guidance that recommends remuneration for medical appraisers through formal recognition of appraising as a Supporting Professional Activity (SPA) in a doctor's job plan.

## 10. Action Planning and Next Steps

**Table 4: Agreed actions for 2016/17**

Action	Progress
Reducing the number of potentially avoidable revalidation deferral recommendations	The majority of deferrals are due to the lack of information provided by the appraisee. We have re-issued appraisal guidance and have pro-actively contacted doctors returning from long-term absence to support their collection of relevant supporting information.
Reducing the number of late revalidation submissions to the GMC	The formation of the Medical Appraisal and Revalidation Decision Group has achieved the aim of reducing the number of late revalidation submissions. Since 9 <sup>th</sup> February 2017 there have been no late submissions to the GMC.
Facilitating Follett Principle appraisals for all clinical academics	We have achieved this and have been in discussion with UCL regarding joint appraisal for our clinicians that have substantive appointments with UCL.
Increasing the number of suitably trained senior members of staff to conduct MHPS case investigations	A number of senior clinicians have attended case investigator training provided through the National Clinical Assessment Service (NCAS). We have called upon these individuals to perform preliminary fact-finding investigations, which form part of the initial MHPS investigations.

### For 2017-18 we will focus on:

- Work with educational supervisors to offer appraisal for all newly-appointed trust grade doctors; thereby reducing the number of late appraisals due to 'new starter more than 3 months from appraisal due date (within 6 months)' (see appendix A).
- We will focus on the incorporation of surgical volume data for operating clinicians and anaesthetists. This will allow appraisal discussions regarding outcomes and complications. We will endeavour to work with colleagues in Theatres and other service areas to provide this information for Consultants and other grades.
- Work with Clinical Directors to implement formal recognition of medical appraiser roles in individual doctor's job plans. We will also work with Clinical Directors to develop a selection process for medical appraisers.
- Complete a benchmarking exercise with two other local trusts to identify areas for further development.

The trust will be receiving a visit from the Higher Level Responsible Officer's team on the 13<sup>th</sup> December 2017.

## **11. Recommendations**

The Board is asked to accept the report, which will be shared (along with the Annual Organisational Audit or AOA) with the higher level Responsible Officer for NHS England, London Region.

The CEO is asked to approve the 'statement of compliance' (Appendix E) confirming that the organisation, as a designated body, is in compliance with the regulations.

## Medical Appraisal Annual Board Report Appendix A

**Table 5: Audit of all missed or incomplete appraisals audit**

Please note that this relates only to doctors due for an appraisal within the year 1<sup>st</sup> April 2016 – 31<sup>st</sup> March 2017

Acceptable or not acceptable	Doctor factors (total)	37
Acceptable	Maternity leave during the majority of the 'appraisal due window'	6
Acceptable	Sickness absence during the majority of the 'appraisal due window'	7
Acceptable	Prolonged leave during the majority of the 'appraisal due window'	0
Acceptable	Exclusion during the majority of the 'appraisal due window'	0
Acceptable	New starter within 3 month of appraisal due date	0
Acceptable	New starter more than 3 months from appraisal due date (within 6 months)	22
Unacceptable	Postponed due to incomplete portfolio/insufficient supporting information	0
Unacceptable	Appraisal outputs not signed off by doctor within 28 days	0
Unacceptable	Doctor cited insufficient time and capacity	0
Unacceptable	Lack of engagement of doctor*	1
Acceptable	Other doctor factors: Doctor completed appraisal through junior doctor training portfolio, not through the trust system	1
Acceptable	Carers' leave	0
	<b>Appraiser factors (total)</b>	<b>0</b>
	Unplanned absence of appraiser	0
	Appraisal outputs not signed off by appraiser within 28 days	0
	Lack of time of appraiser	0
	Other appraiser factors (describe):	0
	<b>Organisational factors (total)</b>	<b>1</b>
	Administration or management factors – Requirement to change appraiser	1
	Failure of electronic information systems	0
	Insufficient numbers of trained appraisers	0
	Other organisational factors (describe)	0

*\*The doctor has now engaged with the appraisal process.*

## Medical Appraisal Annual Board Report Appendix B - Quality assurance audit of appraisal inputs and outputs

**Table 6: Audit of 2015/16 appraisals using ASPAT tool**

Audit appraisal reference	Setting the scene (out of a possible 18 marks)	Reflection (out of a possible 6 marks)	PDP (out of a possible 16 marks)	Revalidation Ready (out of a possible 10 marks)	Total (out of a possible 50 marks)
1	11	2	10	6	29
2	5	2	10	6	23
3	8	3	9	6	26
4	5	0	10	6	21
5	7	0	11	6	24
6	8	1	12	6	27
7	4	0	7	4	15
8	9	0	9	6	24
9	10	4	11	6	31
10	11	4	11	6	32
11	18	6	12	9	45
12	4	0	8	8	20
13	15	6	16	8	45
14	17	6	14	7	44
15	17	6	16	9	48
16	16	6	15	7	44
17	18	6	15	6	45
18	16	6	14	7	43
19	14	6	14	6	40
20	17	6	15	7	45
21	17	6	13	6	42
22	13	4	11	7	35
23	13	6	12	9	40
24	14	0	13	9	36
25	4	1	3	7	15
<b>Average</b>	<b>11.64 / 18</b>	<b>3.48 / 6</b>	<b>11.64 / 16</b>	<b>6.8 / 10</b>	<b>33.56 / 50</b>

**Table 7: Audit of 2016/17 appraisals using ASPAT tool**

Audit appraisal reference	Setting the scene (out of a possible 18 marks)	Reflection (out of a possible 6 marks)	PDP (out of a possible 16 marks)	Revalidation Ready (out of a possible 10 marks)	Total (out of a possible 50 marks)
1	17	5	14	8	44
2	5	1	12	8	26
3	18	6	15	10	49
4	12	5	15	10	42
5	3	2	13	8	26
6	18	6	16	10	50
7	13	5	15	9	42
8	7	5	12	8	32
9	8	5	13	9	35
10	13	2	15	8	38
11	7	4	14	9	34
12	4	3	14	8	29
13	8	3	10	8	29
14	5	4	12	8	29
15	14	4	11	9	38
16	16	4	16	10	46
17	2	4	10	8	24
18	16	5	12	10	43
19	7	2	10	9	28
20	12	5	14	5	36
21	15	4	16	10	45
22	14	5	16	6	41
23	14	3	10	10	37
24	12	6	15	8	41
25	12	5	11	6	34
<b>Average</b>	<b>11 / 18</b>	<b>4 / 6</b>	<b>13 / 16</b>	<b>8 / 10</b>	<b>37 / 50</b>

Although there has been a small improvement in the overall audit score for 'Reflection' between 2015/16 and 2016/17, the improvement has not been sufficient. The Associate Medical Director for Revalidation will be meeting with the Medical Director and Associate Medical Director for Patient Safety to review how this can be addressed.

## Medical Appraisal Annual Board Report Appendix C

**Table 8: Audit of revalidation recommendations**

<b>Revalidation recommendations between 1 April 2016 to 31 March 2017</b>	
Recommendations completed on time (within the GMC recommendation window)	51
Late recommendations (completed, but after the GMC recommendation window closed)	4
Missed recommendations (not completed)	0
<b>TOTAL</b>	<b>55</b>
<b>Primary reason for all late/missed recommendations</b> For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	4
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	0
Describe other	
<b>TOTAL [sum of (late) + (missed)]</b>	<b>55</b>

## Medical Appraisal Annual Report Appendix D

### Employment relation cases concerning the Trust's medical & dental staff for the period 1<sup>st</sup> April 2015 – 31<sup>st</sup> March 2017

The purpose of this paper is to provide a numerical breakdown of the employment relations casework relating to the Trust's Medical & Dental staff. This is in accordance with the requirement under the NHS England Annual Organisational Audit and the Trust Conduct, Performance & Ill-Health Procedures for Medical & Dental Staff, to provide this information to the Trust Board. Please note this information is based on all cases notified and managed by Medical HR.

#### 1. Number of formal cases by grade

2016/17		2015/16	
Grade	Numbers	Grade	Numbers
Consultant	5	Consultant	10 cases (involving 7 consultants)
SASG*	0	SASG*	1
GPs	0	GPs	0
Dentists	1	Dentists	0
Trainee Doctors	1	Trainee Doctors	1
Total	7	Total	9

#### 2. Number of informal cases by grade

2016/17		2015/16	
Grade	Numbers	Grade	Numbers
Consultant	1	Consultant	3
SASG*	0	SASG*	0
GPs	0	GPs	0
Dentists	0	Dentists	1
Trainee Doctors	0	Trainee Doctors	0
Total	1	Total	4

### 3. Number of medical & dental staff excluded by grade

2016/17	
Grade	Numbers
Consultant	0
SASG*	0
GPs	0
Dentists	0
Trainee Doctors	1
Total	1

2015/16	
Grade	Numbers
Consultant	0
SASG*	0
GPs	0
Dentists	0
Trainee Doctors	1
Total	1

### 4. Number of medical & dental staff restricted from clinical practice or with restrictions on their clinical practice but not excluded from work.

2016/17	
Grade	Numbers
Consultant	3
SASG*	0
GPs	0
Dentists	0
Trainee Doctors	1
Total	4

2015/16	
Grade	Numbers
Consultant	1
SASG*	0
GPs	0
Dentists	0
Trainee Doctors	0
Total	1

\*SASG: Includes all doctors in the following grades: Associate Specialist, Specialty Doctor, Staff Grade & Trust Grade

## Medical Appraisal Annual Board Report Appendix E

### Designated Body Statement of Compliance

The board/executive management team of Whittington Health has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

Comments: Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

Comments: Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

Comments: Yes

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

Comments: Yes

5. All licensed medical practitioners<sup>4</sup> either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

Comments: Yes

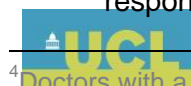
6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners<sup>1</sup>, which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

Comments: Yes

7. There is a process established for responding to concerns about any licensed medical practitioners<sup>1</sup> fitness to practise;

Comments: Yes

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;



<sup>4</sup> Doctors with a prescribed connection to the designated body on the date of reporting.

Comments: Yes

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licensed medical practitioners<sup>5</sup> have qualifications and experience appropriate to the work performed; and

Comments: Yes

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments: Yes

Signed on behalf of the designated body

Name:

Signed: \_\_\_\_\_

[chief executive or chairman a board member (or executive if no board exists)]

Date:



<sup>5</sup> Doctors with a prescribed connection to the designated body on the date of reporting.



Established as The Whittington Hospital NHS Trust

Chairman: Mr Steve Hitchins

Chief Executive: Mr Simon Pleydell

OFFICIAL



## Appraisal Summary and PDP Audit Tool Template

Appraiser identifier	<a href="#">Click here to enter text.</a>
Doctor identifier	<a href="#">Click here to enter text.</a>
Date of appraisal	<a href="#">Click here to enter a date.</a>
Organisation	<a href="#">Click here to enter text.</a>
Auditor (usually the senior appraiser)	<a href="#">Click here to enter text.</a>

### Scale:

0 Unsatisfactory

1 Needs improvement

2 Good

Score each item out of two

### 1.1.1 Setting the scene and overview of supporting information

a) The appraiser sets the scene summarising the doctor's scope of work	Choose an item.
b) The evidence discussed during the appraisal is listed (not all senior appraisers feel that this is necessary, so if not required score 2)	Choose an item.
c) There is documentation of whether the supporting information covers the whole scope of work	Choose an item.
d) Specific evidence is summarised with a description of what it demonstrates	Choose an item.
e) Objective statements about the quality of the evidence are documented	Choose an item.
f) All statements made by the appraiser are supported by evidence	Choose an item.
g) Appraiser comments about evidence refer/fit in to the four GMC domains and associated attributes set out in the GMC guidance <i>Good medical practice framework for appraisal and revalidation</i>	Choose an item.
h) Reference is made to whether speciality specific guidance for appraisal has been followed e.g. college recommendations for CPD and quality improvement activity (this is not a GMC requirement so if the senior appraiser does not feel that this is necessary, score 2)	Choose an item.
i) Reference to completion of locally agreed required training (e.g. safeguarding training, basic life support training) is made (please insert agreed requirements, score 2 if none agreed)	Choose an item.

*This form has been extracted from, and should be used in accordance with, the NHS England Medical Appraisal Policy, version 2, April 2015, MAPS Annex J: Routine Appraiser assurance tools (<http://www.england.nhs.uk/revalidation/appraisers/app-aol/>).*



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**Comments:** Click here to enter text.

### 1.1.2 Reflection and effective learning

a) There is documentation of evidence showing that reflection on learning has taken place or that the appraiser has discussed how the doctor should document their reflection	Choose an item.
b) There is documentation of evidence showing that learning has been shared with colleagues or that the appraiser has challenged the doctor to do so	Choose an item.
c) There is documentation of evidence showing that learning has improved patient care/practice or that the appraiser has explored how this might be taken further with the doctor	Choose an item.
<b>Comments:</b> Click here to enter text.	

### 1.1.3 The PDP and developmental progress

a) There is positive recording of strengths, achievements and aspirations in the last year	Choose an item.
b) There is documentation of appropriate challenge in the discussion and PDP e.g. significant issues discussed and new suggestions made	Choose an item.
c) The completion (or not) of last year's PDP is recorded	Choose an item.
d) Reasons why any PDP learning needs that were not followed through are stated (if the PDP was completed then score 2)	Choose an item.
e) There are clear links between the summary of discussion and the agreed PDP	Choose an item.
f) The PDP has SMART objectives (specific, measurable, achievable, relevant, timely)	Choose an item.
g) The PDP covers the doctor's whole scope of work and personal learning needs and goals	Choose an item.

*This form has been extracted from, and should be used in accordance with, the NHS England Medical Appraisal Policy, version 2, April 2015, MAPS Annex J: Routine Appraiser assurance tools (<http://www.england.nhs.uk/revalidation/appraisers/app-pol/>).*

2



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h) The PDP contains between 3-6 items	Choose an item.
<b>Comments:</b> <a href="#">Click here to enter text.</a>	

#### 1.1.4 General standards and revalidation readiness

a) The documentation is typed and uploaded onto an electronic toolkit in clear and fluent English	Choose an item.
b) There is no evidence of appraiser bias or prejudice or information that could identify a patient/third party information	Choose an item.
c) The stage of the revalidation cycle is commented on	Choose an item.
d) There is documentation regarding revalidation readiness relating to supporting information (e.g. states that feedback and satisfactory QIA are already done). Any outstanding supporting information/other requirements for revalidation are commented on with a plan of action to address them	Choose an item.
e) Appraisal statements (including health and probity) have been signed off or if not, an explanation given (if signed off score 2)	Choose an item.
<b>Comments:</b> <a href="#">Click here to enter text.</a>	

<b>TOTAL SCORE (OUT OF 50)</b> <a href="#">Click here to enter text.</a>
--

#### General comments from the senior appraiser:

<a href="#">Click here to enter text.</a>
---

The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

*This form has been extracted from, and should be used in accordance with, the NHS England Medical Appraisal Policy, version 2, April 2015, MAPS Annex J: Routine Appraiser assurance tools (<http://www.england.nhs.uk/revalidation/appraisers/app-pol/>).*

3



Established as The Whittington Hospital NHS Trust

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## **The Medical Appraisal and Revalidation Decision Group**

### **Terms of Reference**

**Version 0.2 14/09/2016**

#### **1. Authority and Scope**

- 1.1 The Medical Appraisal and Revalidation Decision Group has been established by the executive authority of the Executive Medical Director.
- 1.2 The Medical Appraisal and Revalidation Decision Group shall meet no fewer than 10 times per year.
- 1.3 The Group is authorised by the Executive Medical Director to act within its terms of reference and to provide advice to the Trust's Responsible Officer as to individual medical doctors' fitness to be recommended for revalidation by the General Medical Council (GMC).
- 1.4 The revalidation recommendation is made by the Trust's Responsible Officer and the Responsible Officer is not obliged to take the advice of the Medical Appraisal and Revalidation Decision Group.
- 1.5 The Group is authorised by the Executive Medical Director to obtain such internal information as is necessary to exercise its functions and discharge its duties.

#### **2. Membership**

- 2.1 The Group will be chaired by the trust's Associate Medical Director for Revalidation and administered by the Medical Director Portfolio Manager or appropriate nominated officer.
- 2.2 The Group will comprise of the Medical Staffing Manager, Head of Integrated Risk Management, Responsible Officer, Executive Medical Director, Medical Director Project Officer, and Associate Medical Director for Patient Safety.
- 2.3 If the Medical Staffing Manager and Head of Integrated Risk Management are not able to attend meetings then a summary document detailing the relevant information for each individual doctor may be sent to the Chair in advance of the meeting.
- 2.4 The Responsible Officer, Executive Medical Director, and Medical Director Project Officer are members of the Group, but attendance by these members or their nominated officers is not required for the Group to be quorate.

#### **3. Purpose and role**

- 3.1 The purpose of the Group is to provide advice to the Trust's Responsible Officer as to individual medical doctors' fitness to be recommended for revalidation to the GMC.



- 3.2 The Group will provide scrutiny of the medical appraisal documentation and information from Trust governance and risk systems to inform the recommendations made to the Responsible Officer.
- 3.3 The Group will make one of three recommendations to the Responsible Officer for each individual doctor linked to the Trust for the purposes of revalidation. The three recommendations the Group can make are: revalidate, defer, or non-engagement.
- 3.4 A recommendation by the Group that a doctor should be positively recommended for revalidation will act to provide the Responsible Officer with assurance that all information required by the GMC has been appropriately considered and is deemed by the Group to be sufficient for a positive revalidation recommendation to be made by the Responsible Officer.

#### **4. Duties**

- 4.1 Ahead of the meeting a list of all medical doctors to be considered will be circulated to members. Members of the Group are required to review and interrogate all relevant information in their area of expertise for all doctors to be considered at the meeting. Members are required to bring summary information for each doctor to the meetings.
- 4.2 The Head of Integrated Risk Management is required to review information from the Trust's risk management systems and information highlighted to them through patient safety.
- 4.3 The Medical Staffing Manager is required to review information all employee relation and human resourcing matters.
- 4.4 The Associate Medical Director for Patient Safety will bring to the attention of the group patient safety concerns relating to the practice of doctors considered.
- 4.5 The Associate Medical Director for Revalidation is required to review appraisal output documentation, colleague and patient feedback and external information received or sent by the trust relating to the doctor (e.g. correspondence with other employers, correspondence from the GMC).
- 4.6 The Group will decide on the recommendation to make to the Responsible Officer for each doctor considered by the Group. If a consensus between members cannot be reached then the Chair will decide on the recommendation.
- 4.7 The Group will ensure a completed summary form (Appendix A) is made available to the Responsible Officer in good time to ensure that revalidation recommendations can be submitted to the GMC.

#### **5. Review**

- 5.1 The terms of reference of the Group will be reviewed annually by the Trust's Executive Medical Director.





## Trust Board 6 September 2017

<b>Title:</b>		<b>Modern Slavery</b>					
<b>Agenda item:</b>		<b>Item 17/121</b>		<b>Agenda 14</b>			
<b>Action requested:</b>		Trust Board Approval					
<b>Executive Summary:</b>		<p>The Trust is required to produce a statement setting out compliance with the provisions of the Modern Slavery Act ('the Act'), namely the prevention of modern slavery and human trafficking in its business and supply chains. The Act applies to every organisation in the UK with a total turnover in excess of £36m.</p> <p>The statement must be agreed by the Trust Board and published within six months following the financial year end. The Trust will publish this statement on the Whittington Health website in accordance with the Act.</p> <p>The Act does not require organisations to introduce new policies, or amend existing policies if they are deemed to be adequate.</p> <p>The Trust Executive and Trust Management Group have agreed that our existing policies, procedures and controls are fit for purpose and that a regular cycle of review and amendment is in place through the Trust Board governance framework and structures for strategies, policies and standard operating procedures.</p>					
<b>Fit with WH strategy:</b>		Aligns with the Trust regulatory framework, corporate governance,					
<b>Reference to relate documents:</b>		Standing Orders and Standing Financial Instructions  Trust Board Committee Terms of Reference					
<b>Date completed:</b>		24 August 2017					
<b>Author name and title:</b>		Lynne Spencer, Director Communications and Corporate Affairs, Mick Corti, Director of Partners Procurement Service		<b>Director name and title:</b>		Lynne Spencer, Director Communications and Corporate Affairs	
<b>Date paper seen by EC</b>	<b>4/9/17</b>	<b>Equality Impact Assessment complete?</b>	<b>N/A</b>	<b>Risk assessment undertaken?</b>	<b>n /a</b>	<b>Legal advice received?</b>	<b>N/A</b>



## **Modern Slavery Act**

### **Whittington Health NHS Trust Board Statement**

Whittington Hospital NHS Trust is committed to upholding the provisions of the Modern Slavery and Human Trafficking Act 2015, and we expect our staff and suppliers to comply with the legislation.

The Trust has updated relevant Trust policies to highlight obligations where any issues of modern slavery or human trafficking might arise, particularly in our guidelines on safeguarding adults and children, tendering for goods and services, and recruitment and retention.

The procurement process has been reviewed to ensure that human trafficking and modern slavery issues are considered at an early stage, with certification for potential suppliers that their supply chains comply with the law.

We procure many goods and services under frameworks endorsed by the Cabinet Office and Department of Health, under which suppliers adhere to a code of conduct on forced labour.

We uphold professional practices relating to procurement and supply, and ensure procurement staff attend training on changes to procurement legislation. The Trust requires all new staff to complete a safeguarding course, which covers obligations under the Act. We also require external agencies supplying temporary staff to demonstrate compliance with the legislation.

All clinical and non-clinical staff have a responsibility to consider issues regarding modern slavery and incorporate their understanding of these into their day-to-day practices.

The Trust Board believes that the Trust is following good practice in implementing steps to prevent slavery and human trafficking.

Draft minutes of  
**The Whittington Health Charitable Funds Committee**  
**5<sup>th</sup> July 2017**

Item:17/122

Doc: 15.1

Present:	Tony Rice	TR	Non-Executive Director, Chair
	Stephen Bloomer	SB	Chief Finance Officer
	Graham Brogden	GB	Head of Fundraising
	Simon Pleydell	SP	Chief Executive Officer
	Naomi Scott	NS	Charitable Funds Accountant
	Lynne Spencer	LS	Director of Communications
	Jonathan Ware	JW	Head of Financial Services
	Vivien Bucke	VB	Business Support Manager, Finance

**17/001 Welcome, Apologies for Absence & Declarations of Interest**

- 1.1 No Declarations of Interest were received. Apologies were given from Philippa Davies, Siobhan Harrington and Steve Hitchins.

**17/002 Approval of Minutes of the meeting held on 7<sup>th</sup> January 2017**

- 21 The minutes were agreed as an accurate record. GB raised the issue of event sponsorship and SB stated the the Director of PPS had sent Department of Health guidance to the Chairman and SB would forward this to the members. The committee discussed the latest sponsorship guidance.  
**Action: SB**

**17/003 Fund Balances and their usage Paper 2a**

- 3.1 The paper was brought to the Committee for information and agreement. JW described the breakdown of fund balances shows a total balance of £4.2m; an increase of £405k since the last committee report. The key movements are receipt of the final instalment of the Joyce Edith Layton legacy, Gains on investments of £125k for 2017-17 financial year and £17k of donation income for the 2017 London Marathon.
- 3.2 After the £1m maternity monies there remained £270k from the legacy and as there was no designated special purpose it was recommended transferring this balance to the general funds. This was agreed.
- 3.3 JW said he expected another legacy to be received, estimated at £25k. After discussion GB and TR agreed the link with local solicitors should be continued with a possible event in the future to be set up. **Action: GB**

**Financial Report Month 9 2016/17 Paper 2b**

- 3.4 JW said that since the last Committee year end had passed and the report gave the headlines of the final accounts. Audit would be visiting the Whittington on the 7<sup>th</sup> August. Audited financial statements will be reported along with the external audit report to the November Committee. The Committee noted the report.

#### **17/004 Fund Plan for Spending Balances for 2017/18 Paper 3**

- 4.1 TR thanked JW stating this was a very explanatory paper. Fund holders and directors had been asked to provide a forecast for the use of their funds. The number of funds had grown organically over the years and there were quite a lot of funds with no movement, or with a low (less than £1,000) or nil balance. However, the vast majority of those staff contacted did have plans and Finance would be working with them to ensure the plans are more specific than just comments of 'use for staff training'.
- 4.2 Where there is no response from fund holders, Finance will merge funds and will classify from restricted to unrestricted. SB emphasised that as this paper clearly shows there are a number of funds that did not have any activity in the last 12 months and there was a need for the Committee to give a clear message that managers must either move forward with the plans or trustees must consider how the balances are dealt with to comply with donor wishes and Charities Committee guidance. It was agreed that staff will have the opportunity to use their funds and action plans for a period of 6 months and if there is no progress the CFO will pull together proposals for the following committee. SP felt there is a need to engage with the Clinical Directors in this process.
- 4.3 The Committee discussed the need to consolidate funds with a low balance to be used appropriately and SP suggested anything below £1k be closed if not used by a particular date. In addition members agreed consolidation as ICSU funds or research/education/environment funds etc. which will support the culture change required moving away from holding onto funds for a rainy day. All agreed if funds were pooled this would allow the Charity to undertake more exciting projects. The paper was approved to consolidate.

#### **17/005 Major Fundraising Scheme for Ifor ward Paper 4**

- 5.1 GB reported that £7,234 had been raised so far. Bright Horizons had started their fund raising also and staff there had climbed the O2. However the project had been proceeding with the view that the dividing wall was not structural and now it seemed the lower part of the wall is a supporting steel beam. The request was for structural engineer survey costs of £1,710+vat to be agreed. In addition GB stated the area is currently part of the PFI but the Director of the Environment would like to remove this. SP said there will be a cost to that suggestion. The Committee agreed that the Director of the Environment (Adrien Cooper) & GB to talk to SB to confirm what can be done and AC bring a further update to the September committee. It was noted that if the steel beam cannot be removed there could be ways to work around this.

#### **17/006 Applications for Funding Paper 5**

- 6.1 JW stated there were currently two items for approval in relation to Kanitz (£11k for a moto med machine and £9k for rehabilitation equipment that allows staff to move ITU patients more easily.) He noted they have an expansive list of items they want to fund and at the next committee they should be bringing much larger cost items. The Committee agreed the two items.

- 6.2 SB drew the Committee's attention to Appendix 1 – Bids under £5k. This list had been brought for information as the bids were signed off by himself and he asked if the Committee had any questions. The Committee discussed bid and themes where SB explained the most difficult theme is training requests as is it not possible to always differentiate between those that should be funded by exchequer and those that are charitable. The committee agreed that team events were the most likely to be charitable. TR felt that the process for spending under £5k looks like it is working well.

## **17/007 Fundraising Update Report**

39.1 GB highlighted:

- The London Marathon had been very successful and the number of social hits was exceptional. 18 staff were interested in the marathon for next year.
- 50 staff/supporters were running the 10k this Sunday.
- The Rotary quiz night raised £2k for Ifor Ward.
- Fair in the square was very well attended.
- In addition to fund raising at the Tough Mudder event, the team that attended fed back that it had successfully brought the team together and so had a positive organisational development outcome.
- LS spoke of the possibility in the future of a fashion show to raise funds.

39.2 Maternity Update:

GB reported there was a possible £3m donation to the maternity project and the Deputy CEO was producing an overview of the scheme to be passed on to the potential donor. The Committee discussed the maternity development and potential for charitable support. **Action: DCEO**



**Minutes**  
**Quality Committee, Whittington Health**

Item: 17/122  
 Doc: 15.2

**Date & time:** 12<sup>th</sup> July 2017 at 1230 - 1400

**Venue:** Room 6 Whittington Education Centre, Whittington Hospital

**Chair:** Anu Singh (AS), Non-Executive Director

**Members Present:** Yua Haw Yoe (YHY), Non-Executive Director

Philippa Davies (PD), Director of Nursing and Patient Experience  
 Carol Gillen (CG), Chief Operating Officer

**In attendance** Debbie Clatworthy (DC), Head of Nursing, Surgery and Cancer  
 Dorian Cole (DCo), Head of Nursing, PPP  
 Lynne Spencer (LS), Director of Communications and Corporate Affairs  
 Helen Taylor (HT), Clinical Director, CSS  
 Russell Nightingale (RN), Director of Operations CYP  
 Manjit Roseghini (MR), Head of Midwifery  
 Clarissa Murdoch (CM), Clinical Director IM  
 Angel Bellot (AB), Complaints Manager

**Apologies:** Deborah Harris-Ugbomah (DHU), Non-Executive Director  
 Richard Jennings (RJ), Medical Director  
 Sarah Hayes (SH), Deputy Chief Nurse  
 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  
 James Connell, Patient Experience Manager  
 Neeta Patel, Clinical Director CYP  
 Daniele Morrell, Director of Operations, EUC  
 Alison Kett, Head of Nursing (IM)

**Agenda items**

<b>1.1</b>	<b>Welcome &amp; Apologies</b>	<b>Chair</b>
	Apologies noted as above. Anu Singh noted that no deputy was available for RJ as the Associate Medical Directors were both on leave at the same time.	
<b>Actions</b>	<b>Deadline</b>	<b>Owner</b>



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<b>1.2</b>	<b>Declarations of Conflicts of Interests</b>	<b>Chair</b>
	No Conflicts of Interests were noted.	
<b>Actions</b>		<b>Deadline</b>
None		

<b>1.3</b>	<b>Minutes of the previous meeting (May 2017) and Action Log</b>	<b>Chair</b>
	Approved with no amendments. See Action Tracker for updates on actions.	
<b>Actions</b>		<b>Deadline</b>
None		

<b>1.4</b>	<b>Matters Arising</b>	<b>Chair</b>
	The Committee congratulated GL on her new role as Head of Governance and Risk	
<b>Actions</b>		<b>Deadline</b>

<b>2.</b>	<b>Strategy</b>	
2.1	No item to discuss	
<b>Actions</b>		<b>Deadline</b>

<b>3.</b>	<b>ICSU Quality Performance Dashboards (ICSU Leads)</b>
<b>3.1</b>	<p>The <b>Women's Services Quality Report</b> was approved by the Quality Committee.</p> <p>Key points were highlighted as follows:</p> <ul style="list-style-type: none"> <li>The Sexual Health Service is no longer part of Whittington Health; Staff have been TUPED over to the new provider CNWL</li> </ul>

	<ul style="list-style-type: none"> <li>• 100% compliance with complaint responses, robust process with patients involved</li> <li>• High Risk incidents, but no serious incidents reported in Q1</li> <li>• Key themes emerging from Maternity Dashboard – induction of labour, caesarean section, 3/4<sup>th</sup> degree tears and MOH.</li> <li>• Induction of labour increase linked to early screening as part of safer babies bundles. London randomised trial in place to compare new screening process against old process.</li> <li>• 3/4<sup>th</sup> degree tears higher than expected. Trust invested in epi-scissors to reduce chances of tear. Reviewing training of student midwives emphasising evidence based practice.</li> <li>• MOH is increasing nationally; this may be linked to co-morbidities and age of mothers.</li> <li>• Full risk register included in Dashboard</li> <li>• MJ highlighted the ongoing work with security team to reduce violence and aggression towards maternity staff. PD asked if staff were up to date with conflict resolution, MJ responded staff were up to date.</li> <li>• PD and CM noted error with target figure on c-section rate</li> <li>• NCL Dashboard currently doesn't match ICSU dashboard, however NCL dashboard under review. Both dashboards are currently reviewed at Women's ICSU governance meeting. Whittington Health benchmarks with NCL average.</li> <li>• 7 runners from maternity completed 10k which was a good staff morale boost</li> <li>• MJ provided an update on the recent high risk incident; blue light ambulance emergency, mother with MOH and 2litre blood loss. Maternity teams worked very well together, mother had successful emergency c-section with healthy baby, mother then had a cardiac arrest and 'Code Red' instigated. Mother transferred to St Thomas' Hospital and is making good progress. Good communication with St Thomas' maternity team throughout. "Hot Debrief" to support staff at the time of the incident.</li> </ul>
<b>3.2</b>	<p><b>The IM Quality Report</b> was approved by the Quality Committee.</p> <p>Key points were highlighted as follows:</p> <ul style="list-style-type: none"> <li>• Ongoing issue with falls, which is part of a major improvement programme led by Jo Eardley. STOPfalls bundle launched which focuses on assessment and identification, Baywatch initiative launched with focuses on interventions to reduce falls.</li> <li>• Medication errors increasing but no themes emerging. CM added it was good practice to report medication errors and an increase in reporting no harm incidents was a sign of open safety culture.</li> <li>• Serious incidents relating to delayed diagnosis discussed</li> <li>• Top 3 risks; Victoria Ward particularly around effective discharge; staffing levels for nursing and with registrar rotas; Holter analysis (cardiology reporting on Anglia ICE)</li> <li>• CM noted that staffing issues were not unique to IM and were a problem across the Trust.</li> <li>• Trialling Victoria ward with smaller bed-base over summer to allow for</li> </ul>

	<p>more dedicated speciality ward base for sickle-cell patients</p> <ul style="list-style-type: none"> <li>• Work is ongoing to map beds to patient need; Victoria and Cavell wards kept open to accommodate patient need but CM emphasised the staffing pressures and patient safety concerns associated with keeping excess beds open.</li> <li>• AS commented on the progress made in the IM ICSU but highlighted concerns at the number of reds on dashboard – e.g. delayed transfers, readmission rates- and asked where these risks were managed.</li> <li>• CM noted Perfect Week was a good mechanism for managing issues around discharge management</li> <li>• LS noted a detailed discussion had been led by Simon Pleydell at TMG around these challenges with a plan for improvement</li> </ul>		
<b>3.3</b>	<p>The <b>CYP Quality Report</b> was approved by the Quality Committee.</p> <p>Key points were highlighted as follows:</p> <ul style="list-style-type: none"> <li>• Increase in response rates for F&amp;F</li> <li>• All complaints managed within timeframe, theme around SLT funding, complex care and health visiting communication breakdown</li> <li>• Serious Incident around information governance breaches; unencrypted memory stick lost and patient handover sheet found in public area</li> <li>• Top risks highlighted;               <ol style="list-style-type: none"> <li>1) Junior doctor rota, currently three doctors short to operate safe service. RN noted the mitigating action the ICSU was taking through locum cover.</li> <li>2) Complex care high vacancy rates with big agency spend. RN met with commissioners to discuss upgrading job bands to make jobs more attractive and provide different package of care for children;</li> <li>3) Northern health centre lift issue ongoing. CG noted for Northern Health Centre actions had been taken to ensure fire safety, and mitigating action taken to ensure children with disabilities are seen on lower floors.</li> <li>4) Simmons house window risk re-opened as estates only addressed first floor risks and ground floor to be fixed as well.</li> </ol> </li> </ul> <p>AS asked what the Trust appetite was for estates related risks. PD noted Strategic Estates Plan is long-term plan to manage risk, mitigating actions taken on a case by case basis.</p>		
		<b>Deadline</b>	<b>Owner</b>

<b>4.</b>	<b>Quality governance</b>		
<b>4.1</b>	Patient Experience Report		

4.1	<p>The <b>Patient Experience Report</b> was approved by the Quality Committee.</p> <p>Key points were highlighted as follows:</p> <ul style="list-style-type: none"> <li>• PD noted the September report would include any themes emerging from NHS Choices comments and progress against the Quality Account targets</li> <li>• AS noted national strategy to shift in how volunteer roles are used; PD confirmed that the use of volunteers was being reviewed at the trust</li> </ul>		
<b>Actions</b>		<b>Deadline</b>	<b>Owner</b>
<ul style="list-style-type: none"> <li>• Quality Account targets to be reported as part of report</li> <li>• Plan for Volunteers to be brought back to next committee</li> </ul>		Sept 17	Phillipa Alston

4.2	<b>Nursing Quality Indicators</b>		PD
	<p>PD noted SH was currently working with Heads of Nursing to refine the Nursing Quality Indicators report presentation. The report format in future will be in line with performance reports including sections on interrogation and analysis</p> <p>DC noted work was in progress to develop dashboards for other areas like community, outpatients, theatres not just inpatient wards</p> <p>AS asked what the burden was for collecting this data. DC noted the information team pulled together report from a variety of sources including DATIX reports.</p> <p>AS noted this report should be used as an improvement tool for wards, and asked how the dashboard was currently monitored and used to drive improvement. DC noted this was managed at local level by ward teams and through the ICSU governance structure. Any exceptions are highlighted at the Nursing and Midwifery Executive Committee.</p>		
<b>Actions</b>		<b>Deadline</b>	<b>Owner</b>
None			

4.3	<b>Patient Safety and Quality Report</b>		RJ
	<p>AS commented on the rhythm for reports, and stressed the need to ensure the Quarterly Patient Safety Report was presented to the Quality Committee before Trust Board.</p> <p>LS noted the new change to Board cycle should improve this process.</p>		

<b>Actions</b>	<b>Deadline</b>	<b>Owner</b>
Quality Account targets to be included in next report, Q2 report due September 2017	Sept 17	RJ

<b>4.4</b>	<b>Quality and Safety Risk Register</b>	<b>GL</b>
	<p>GL provided an update on the changes made to improve the Quality Committee Risk Register. GL noted that the Risk Register module on DATIX has been revised and a data cleansing exercise completed. GL noted that an SOP had been drafted to support staff in using the Risk Register and ensure there is a standardised approach across the Trust. Work is ongoing to update the Facilities and Estates related risks and to add IT risks to DATIX.</p> <p>There have been three new risks added to the Quality Committee Risk Register since May 2017;</p> <ul style="list-style-type: none"> <li>• 797 – AAU consultant provision</li> <li>• 778 – GE holter analysis MARS</li> <li>• 779 - Risk to patients due to inadequate SHO doctor grade on rota</li> </ul> <p>Workforce issues remain the top risk across the trust, with an increasing risk around junior doctor grade rotas. DCo noted pressures on staffing had knock-on effects on training and supervision, which was not always picked up in the risk register</p> <p>PD noted the important role the Quality Committee played in providing fresh eyes and ensuring services were not building up a tolerance for certain risks</p> <p>DC noted there were regular meetings between ICSUs and corporate teams with the Head of Risk and Governance to keep the register up to date</p>	
<b>Actions</b>	<b>Deadline</b>	<b>Owner</b>

<b>4.5</b>	<b>Quality Assurance Report</b>	<b>GL</b>
	<p>GL provided an update on the peer review programme and patient safety huddle initiative.</p> <p>GL noted comments from patients during peer reviews were overwhelmingly positive and this provided a good morale boost for staff. Theme emerging across trust where staff reported feeling under pressure when working with temporary staff who may not be aware of local processes.</p> <p>GL outlined the changes planned to the patient safety huddle model, which will link closely in future with Freedom to Speak Up through DCo. The opportunities</p>	

	<p>for Board to ward engagement will be widened through 'Back to the Floor' initiatives and involvement in peer reviews.</p> <p>Work is ongoing to continue to improve practice following the CQC recommendations in a number of areas, specifically emergency pathway and bed management, palliative care, autism pathway and the Strategic Estates Partner.</p>		
Actions		Deadline	Owner
None			

4.6	Complaints Annual Report	AB	
	<p>AB presented the annual Complaints report. AS complimented AB for the comprehensive report.</p> <p>Key points were highlighted as follows:</p> <ul style="list-style-type: none"><li>• There has been an increase in the number of unhappy complaint responses. In response, AB has launched a complaints training programme to focus on the quality of complaint responses. Training will be provided in small bite-size pieces to facilitate busy staff schedules.</li><li>• AB noted that many action plans were not SMART and improvement in action planning would form part of the new complaints training.</li><li>• AB reported that the number of compliments has increased while complaints have gone down. AB noted this was very positive, suggesting early resolution at local level, where managers are closing down issues before they escalate to formal complaint level</li></ul> <p>AS asked when the aggregated incident, complaints and claims report would next be presented. GL noted this was currently being revamped, to be prepared for September 2017.</p> <p>DC thanked complaints staff for circulating the compliments to ICSUs. DC noted this is really appreciated and is useful for revalidation and appraisal.</p>		
Actions		Deadline	Owner
None			

4.7	Trust policies	GL
	The Trust Policy update paper was approved by the Quality Committee.	

<b>Actions</b>	<b>Deadline</b>	<b>Owner</b>
None		

<b>5.0</b>	<b>Minutes from reporting groups</b>	<b>For information only</b>
	The minutes were taken as read.	
<b>Actions</b>	<b>Deadline</b>	<b>Owner</b>
None.		

<b>6.0</b>	<b>For information only</b>	
	The papers were taken as read.	
<b>Actions</b>	<b>Deadline</b>	<b>Owner</b>
None		

<b>7.</b>	<b>AOB</b>	<b>Lead</b>
	None	
<b>Actions</b>	<b>Deadline</b>	<b>Owner</b>
None.		

**Next meeting:** Wednesday 13<sup>th</sup> September 2017, Room 6, Whittington Education Centre

**Whittington Health  
Remuneration Committee  
Wednesday 12 July 2017  
0900 in Whittington Education Centre**

Present:	Steve Hitchins	SH	Chairman
	Anu Singh	AS	Non-Executive Director
	David Holt	DH	Non-Executive Director
	Deborah Harris-Ugbomah	DHU	Non-Executive Director
	Yua Haw Yoe	YY	Non-Executive Director
Attendees as required:	Simon Pleydell	SP	Chief Executive
	Norma French	NF	Director of Workforce

01.	Welcome and Apologies	
	Apologies were received from Graham Hart, Non-Executive Director	
02.	Minutes of the last meeting	
	The minutes of the Remuneration held on 13 July 2016 were agreed as correct.	
03.	Terms of Reference	
	The Terms of Reference were presented for review and remain accurate.	
04.	Executive Director Remuneration	
	The Committee agreed to award the national 1% pay increment for all 7 directors. It was agreed that this would be backdated to 1 <sup>st</sup> April 2017.	
05.	Review of the year 2016-17 – Team and Individuals	
	SP presented the team and individual review. The Committee noted and discussed the performance of the executive directors, which was supported by the documentation used in the appraisals of each individual director.	
06.	Medical Pay and Increments	
	The committee voted to settle the pay dispute over back pay, agreeing options 1, for individuals placed on the wrong pay point and 2, for individuals having not received an incremental rise in 2008 but re-instated in 2009. No further action will be taken for option 3, for individuals requesting to be paid on a high pay point to take account of previous experience after being in post for some time. They would remain on the pay scale agreed when appointed.	
07.	Fit and Proper Persons Test Policy	
	NF presented the policy for approval and included a 2017 checklist for the current directors. David Holt and Deborah Harris both had queries about the DBS process. NF confirmed these were reviewed on an annual basis.	

08.	Forward Look Discussion	
	The chief executive briefly summarised the key challenges for 2017-18 and included outcomes of the Operational Plan for 16/17.	
09.	CEO recruitment update SH gave a brief outline of the candidates shortlisted. He confirmed that the presentation and focus groups were being held on 17 July and the interviews on 18 July. The appointment will thereafter need to be confirmed by NHSI.	
10.	Any Other Business	
	Notes of the meeting would be presented to the trust board in September. No other business was requested.	

**WORKFORCE ASSURANCE COMMITTEE**Minutes of meeting held on Wednesday 2<sup>nd</sup> August 2017

Item 17/122

Doc: 15.4

Present:	Stephen Bloomer	Chief Finance Officer
	Carol Gillen	Chief Operating Officer
	Norma French	Director of Workforce
	Helen Gordon	Deputy Director of Workforce
	Graham Hart	Non-Executive Director (WAC Chair)
	Steve Hitchins	Trust Chairman
	Helen Kent	Assistant Director of Learning & OD
	Jana Kristienova	Assistant Director for Integrated Care Education
	Lisa Smith	Assistant Chief Nurse

In attendance:	Lawrence Anderson	Medical Staffing Manager
	Kate Green	PA to Director of Workforce (minutes)

17/19 Welcome and Introductions

19.01 Graham Hart welcomed everyone to the meeting, and in particular Helen Kent, newly-appointed Assistant Director of Learning & OD, present at this meeting for the first time.

19.02 Apologies for absence were received from Ian Bates and Siobhan Harrington.

17/20 Minutes of the meeting held on 26<sup>th</sup> April

20.01 It was noted that Carol Gillen had sent her apologies for the April meeting. Other than this, the minutes of the Workforce Assurance Committee held on 26th April were approved.

17/21 Matters arising

21.01 The secretariat was reminded that it had been agreed that all meeting papers should be clearly numbered and an action log added in order to more easily identify actions and issues to follow up; this would be completed for the following meeting.

20.02 Norma French informed the committee that an annual equalities report was currently being prepared; this would be brought to the Trust Board and to the next meeting of this committee in the autumn.

20.03 Referring to minute 16.07 (NC London HR Directors' STP meetings) Norma said that she was now dialing in to these regular meetings which saved considerable time. She added that she had taken the lead on the redeployment register but progress on this had slowed down slightly over the summer holiday period. Julia Tybura had been appointed to support the group's activities, and Norma was scheduled to meet with her in the next few days.

17/22 2017/18 Quarter 1 Workforce Report

22.01 Introducing this item, Helen Gordon informed the committee that a major piece of work was progressing to migrate information from the finance ledger onto ESR. This would enable the production of far more accurate and timely data so that future reports would flow in a more iterative way. The aim was to have the two systems reconciled by 1st October.

- 22.02 Moving on to temporary staffing, Helen began by saying that she would welcome the committee's views on this section of the report and how helpful they found it. Slide 1 showed the Bank & Agency staffing analysis by staff group in terms of agency hours. The overall trend was one of reduction, although usage still remained too high. The key work for ICSUs was to continue to move away from agency towards bank; there was also now a pan-London workstream on agency rates.
- 22.03 In answer to a question from Steve Hitchins about the high use of agency staff in Emergency & Urgent Care, Helen explained that this was chiefly caused by the need to bring in agency district nurses (extremely difficult to recruit) and medical staff for ED. Norma was writing a paper for the following week's Executive Meeting on nurse recruitment which would show the results of the successful recruitment campaign in the Philippines as well as a further 26 appointments in the pipeline. The Trust advertised constantly for nurses, and there was some pressure from the Heads of Nursing to return to the Philippines, however this had to be carefully considered as such campaigns were resource-expensive.
- 22.04 Helen was also in discussion with Deputy Chief Nurse Sarah Hayes about the relaunching of flexible working for substantive staff. Norma briefed the committee on the agency reliance task force, which was carrying out focused work with the Heads of Nursing, Finance and HR Business Partners to look at staffing by ICSU and by ward area – this group was scheduled to meet for the second time the following day. Steve Hitchins asked whether the planned £3.5m reduction in spend was achievable; Helen replied that this was indeed a challenging ask, however some of the ICSUs had made excellent progress in this area albeit others could achieve more.
- 22.05 Table 5 on page 16 showed vacancy projection by ICSU, and illustrated where the run rate exceeded the budgeted establishment; there was, for example, overspending within Integrated Medicine. Not all vacancies were nursing; there were significant problems also with the recruitment and retention of AHPs. Helen would also welcome feedback on this section of the report.
- 22.06 Stephen Bloomer praised the quality and content of the report which he felt highlighted key workforce issues, adding that the challenge for the executive team now was how the information contained therein could be used to change things. Helen replied that the agency reliance task force was likely to be the first enabler for change.
- 22.07 Looking at the figures for sickness absence across the Trust, Helen commented that there were no surprises within this section of the report and little change from the previous quarter, other than an emerging trend of improvement as sickness was better managed; this included support from the HR Business Partners in holding case reviews and bespoke training sessions for managers. There had also been a reduction in turnover, and consideration was being given to how best to illustrate trends in this area.
- 22.08 There had been a reduction in the number of exit interviews generated this quarter, and Helen explained that this was unfortunately attributable to the absence, during April, of a member of staff who had been responsible for ensuring these were sent out automatically once terminations of employment were processed.

Measures would be introduced to ensure there were contingency arrangements in place in future. There remained however a wealth of information available from the exit interviews which had been received, and some challenges for the ICSUs to address.

- 22.09 Graham Hart reminded committee members that at the previous meeting there had been mention of conducting a 'deep dive', perhaps into the Emergency & Urgent Care ICSU; he felt it would be instructive to look at an ICSU which contained both outstanding areas of practice and challenges and hoped that Danielle Morrell would be able to attend the meeting. Carol Gillen agreed this was a good idea, but reminded the committee that the ICSUs had just concluded the latest round of quarterly performance reviews and hoped the same methodology could be used for any supporting papers required.
- 22.10 Referring back to the information generated through exit interviews, Steve wondered how this could be used to best purpose, perhaps being able to intervene in cases of stress sooner, or to examine promotion prospects. The next stage of this work would be to focus down to ICSU level so as to be able to spot trends and clusters. She added that there was also a case for bringing in some sort of route for 'rising stars', and to this end it would be beneficial to have Helen Kent and Eleanor Clarke consider what form this might take. It was noted that it would be vital to be able to demonstrate equality of access to such opportunities, which might also include secondments. Both Norma and Carol commended the Stepping Stones programme.
- 22.11 It was noted that this data is collected by ethnicity, and this was noted on page 28/29.

17/23 Employee Relations Activity

- 23.01 Helen Gordon informed the committee that since it had last met the Trust had engaged the services of Richard Jones as Employee Relations Manager, and he was rapidly getting to grips with this agenda and making notable improvements. There was still some way to go, however, and as an example Helen said that there had been an improvement in the number of cases closed (over twice as many as in the previous quarter) but cases were still taking too long to resolve.
- 23.02 Helen mentioned the training her team had arranged for Trust staff on the management of sickness, saying that she hoped this would have a tangible effect on numbers. She also mentioned the increase in referrals to the NMC, which the regulator itself felt was largely attributable to an increased use of social media.
- 23.03 In answer to a question about the recording of protected characteristics, Helen replied that the annual report being produced by Charlotte Johnson and Harri Weeks would give a comprehensive picture of this information. Professor Hart asked for clarification on the denominators used. Helen replied that this was a point well made and she would ask for it to be reflected in the next iteration of this report. It was agreed there was no 'right' level, but such information could be an indicator of issues in specific areas, however in the absence of trend data little could be achieved. The next challenge, Helen said, was to include the medical casework within the report.

17/24 Guardian of Safe Working Report

- 24.01 Lawrence Anderson introduced this item, explaining that the paper had been produced more to a local specification than the previous report, which had been produced using the template devised jointly by NHS Employers and the BMA. A total of 69 exception reports had been filed, the majority of which had come from general medicine.
- 24.02 August 2<sup>nd</sup> was the national changeover day for junior doctors (now referred to as doctors in training) and the Trust now had 200 doctors on 2016 terms and conditions, a sharp rise from 98 previously. Most of the new intake would remain with the Trust for at least a year and in some cases for two years.
- 24.03 As of June, all exception reports had been resolved. In respect of diary card monitoring, there were two outstanding claims, one in surgery and the other in trauma and orthopaedics. The claim in surgery was to be settled as a 2A (a cost pressure of around £60k); the claim in trauma and orthopaedics remained as a Band 3 and would give a cost pressure of around £75k. It had been acknowledged that there were some issues within trauma and orthopaedics which needed to be addressed. Claims showed that some doctors in training were working rotas which were not sustainable, and as there was little opportunity for them to attend teaching sessions and regional training days this was impacting on their education. Lawrence was helping the ICSUs to find ways to address this.
- 24.03 A diary card exercise had just been completed for emergency doctors; this had also come out at Band 3 due to breaks not being met. It was clear however that the doctors had been instructed to take breaks therefore the Trust's position was defensible. No fines had yet been issued to ICSUs however there was likely to be one in the next quarter and this would relate to statutory rules such as the European Working Time Directive. Lawrence felt that exception reporting may have reduced due to trainees undergoing their ARCP reviews. Graham Hart added that this would be interesting to monitor over the summer as the new intake came on board.
- 24.04 Jana Kristienova asked whether comparative data was available for other Trusts and if so how Whittington Health's performance compared. Norma replied that very little information was available centrally as yet. Anecdotally however it appeared that UCLH had received far fewer exception reports, but this had a positive aspect, i.e. that WH trainees felt able to report.

17/25 Six Monthly Review of Ward Nursing Establishments

- 25.01 Lisa Smith informed the committee that there was a requirement to make a report to the Trust Board twice yearly, and the next Board meeting would receive the second of these reports. Moving on to the highlights, she said that there had been a significant improvement in retention in the last six months, also in fill rates. In March wards had had an extremely high occupancy rate of well over 95% and in some cases 100%, yet the Trust had not had inadequate or unsafe staffing levels. Some changes had been recommended, and these would be reviewed in October.
- 25.02 In answer to a question from Stephen Bloomer about how Whittington Health benchmarked with other Trusts, Lisa replied that the position was quite variable, but the Trust was broadly in the middle of the pack. Stephen asked whether such comparisons might be included in future reports; Lisa assured him they would be for the more comprehensive report produced

in October. Carol Gillen remarked that comparative data should be straightforward for those Trusts using the same tools.

- 25.03 Graham Hart enquired about the extent to which the nursing associates would have an impact on the position. Lisa informed the committee that Professor Griffith from Southampton University was conducting a national study on whether there was (for example) any correlation between the arrival of the nursing associates and reduction in falls. Whittington Health had 20 nursing associates who were doing extremely well. Graham thanked Lisa for her report.

17/26 Date of next meeting

- 26.01 The next meeting of the Workforce Assurance Committee would take place in November, and Kate would canvas for dates for both this and the February meeting.

17/27 Any other business

- 27.01 Norma French informed the committee that the results of the GMC survey (both trainees and trainers) had now been received by the Trust. She would ask Graeme Muir to produce a report on these for the next meeting.

Action log

20.02	Annual equalities report to be scheduled for discussion at the November meeting	KG	November WAC
22.09	Danielle Morrell to be invited to the next meeting which would look in more detail at the Emergency & Urgent Care ICSU	NF	November WAC
25.02	Benchmarking data from other Trusts to be included in future nursing establishment reports	LS	February WAC
26.01	Dates to be set for the next two WAC meetings (to be held in November and February)	KG	August
27.01	Report setting out results of GMC survey to be commissioned for next meeting	KG	November WAC

