Whittington Health
NHS Trust

# TRUST BOARD
# PUBLIC

14.00 – 16:00
Wednesday 6th December 2017

Whittington Education Centre
Room 7

NHS
Whittington Health
NHS Trust

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| **Meeting** | **Trust Board – Public** |
| **Date & time** | **06 December 2017 at 1400hrs – 1600hrs** |
| **Venue** | **Whittington Education Centre, Room 7** |

# AGENDA

**Members – Non-Executive Directors**
Steve Hitchins, Chair
Deborah Harris-Ugbomah, Non-Executive Director
Tony Rice, Non-Executive Director
Anu Singh, Non-Executive Director
Prof Graham Hart, Non-Executive Director
David Holt, Non-Executive Director
Yua Haw Yoe, Non-Executive Director

**Members – Executive Directors**
Siobhan Harrington, Chief Executive
Stephen Bloomer, Chief Finance Officer
Dr Richard Jennings, Medical Director
Philippa Davies, Chief Nurse & Director of Patient Experience
Carol Gillen, Chief Operating Officer

**Attendees – Associate Directors**
Dr Greg Battle, Medical Director (Integrated Care)
Fiona Smith, Communications Lead
Norma French, Director of Workforce

**Secretariat**
Kate Green, Minute Taker

**Contact for this meeting: fiona.smith19@nhs.net**

| Agenda Item | | Paper | Action & Timing |
|---|---|---|---|
| **Patient Story** | | | |
| | **Patient Story**<br>*Philippa Davies, Chief Nurse & Director of Patient Experience* | *Verbal* | *Note*<br>1400hrs |
| 17/160 | **Declaration of Conflicts of Interests**<br>*Steve Hitchins, Chair* | *Verbal* | *Declare*<br>1420hrs |
| 17/161 | **Apologies & Welcome**<br>*Steve Hitchins, Chair* | *Verbal* | *Note*<br>1425hrs |
| 17/162 | **Draft Minutes, Action Log & Matters Arising 1 November 2017** | 1 | *Approve*<br>1430hrs |
| 17/163 | **Chairman's Report**<br>*Steve Hitchins, Chair* | *Verbal* | *Note*<br>1435hrs |
| 17/164 | **Chief Executive's Report**<br>*Siobhan Harrington, Chief Executive* | 2 | *Approve*<br>1445hrs |
| **Patient Safety & Quality** | | | |
| 17/165 | **Serious Incident Report Month 07**<br>*Richard Jennings, Medical Director* | 3 | *Approve*<br>1455hrs |
| 17/166 | **Safer Staffing Report Month 07**<br>*Philippa Davies, Chief Nurse & Director of Patient Experience* | 4 | *Approve*<br>1505hrs |
| 17/167 | **Quality and Patient Safety Report Q2 (July to September)**<br>*Richard Jennings, Medical Director* | 5 | *Approve*<br>1515hrs |
| **Performance** | | | |
| 17/168 | **Financial Performance Month 07**<br>*Stephen Bloomer, Chief Finance Officer* | 6 | *Approve*<br>1525hrs |

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| 17/169 | **Performance Dashboard Month 07**<br>*Carol Gillen, Chief Operating Officer* | 7 | *Approve*<br>1535hrs |
| **Governance** | | | |
| 17/170 | **Section 75 Annual Report Islington LA**<br>*Janet Burgess, LA* | 8 | *Approve*<br>*1545hrs* |
| | | | |
| 17/171 | **Workforce Assurance Committee draft minutes**<br>*Prof. Graham Hart, Non-Executive Director* | 9 | *Note*<br>*1555hrs* |
| | | | |
| **AOB** | | | |
| | None notified to the Trust in advance | | |
| **Questions from the public** | | | |
| | None notified to the Trust in advance | | |
| **Date of next Trust Board Public Meeting** | | | |
| 31 January 2018 -1400hrs-1630hrs -Whittington Education Centre, Magdala Avenue, N19 5NF | | | |

**Register of Conflicts of Interests:**

The Register of Members' Conflicts of Declarations of Interests is available for viewing during working hours from Fiona Smith, Communications Lead, at Trust Headquarters, Jenner Building, Whittington Health, Magdala Avenue, London N19 5NF or Fiona.smith19@nhs.net

or www.whittingtonhealth@nhs.net

Whittington Health NHS

**ITEM: 17/162**
**Doc: 01**

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

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| Present: | Greg Battle | Medical Director, Integrated Care |
| | Stephen Bloomer | Chief Finance Officer |
| | Philippa Davies | Director of Nursing and Patient Experience |
| | Carol Gillen | Chief Operating Officer |
| | Deborah Harris-Ugbomah | Non-Executive Director |
| | Siobhan Harrington | Chief Executive |
| | Graham Hart | Non-Executive Director |
| | Steve Hitchins | Chairman |
| | David Holt | Non-Executive Director |
| | Richard Jennings | Medical Director |
| | 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 |
| | Lynne Spencer | Director of Corporate Affairs |

Patient Story

Philippa Davies introduced Chris Cooper, a 26 year old patient of the Trust from Finsbury Park. Chris explained that he suffered from autism, and lived in supported accommodation; he worked at an ad. agency, and part of his job involved carrying out 'mystery shopping' exercises. Chris had carried out such exercises at the Whittington, in order to gauge whether the Trust was autism friendly – this involved looking at signage, staff attitudes and noise. On the whole he had found staff to be friendly, and was pleased to note that changes which he had recommended following a previous visit had been implemented quickly. He spoke about local GPs, saying that some were very good, others less so.

Chris emphasised the importance of good communication, he said that he was proud to be present at the Trust Board, and spoke of other work he was involved in such as the Islington Autism Partnership Board and Healthwatch.

Colette Datt talked about the changes that had been implemented since Chris's first survey, including improvements to signage, reduction of noise on the wards, and training for reception staff. The organisation 'Ambitious for Autism' for which Chris worked would shortly be producing a report about their work with the Whittington.

Defend the Whittington Coalition

The Board meeting was suspended in order to allow representation from the Defend the Whittington Coalition and other interested parties who had attended to discuss the Trust's plans for its Strategic Estates Partnership. Siobhan Harrington assured the visitors that any questions not dealt with that day would be posted as part of a Q&A section on the Trust's intranet. She added that she had indicated her willingness to meet with the Coalition whenever convenient.

17/145 Declaration of Conflicts of Interest

145.01 No member of the Board declared any interest in any of the business to be transacted that afternoon.

17.146 Welcome and apologies

146.01 Steve Hitchins welcomed everyone to the meeting. Apologies for absence were received from Cllr. Janet Burgess.

17/147 Minutes, Matters Arising & Action Log

147.01 Referring to the fourth paragraph on page 2 of the public board minutes, Philippa Davies explained that there was to be a review of the staffing level rather than the report. On page three minute 132.05 the date in the fourth line should read the 16th rather than the 19th October. Other than these amendments, the minutes of the Trust Board meeting held on 4th October were approved. There were no matters arising other than those already scheduled for discussion.

147.02 Deborah Harris-Ugbomah asked to place on record her appreciation of how well the Chairman and Chief Executive had handled the Defend the Whittington Coalition's attendance that afternoon.

Action notes

147.03 The winter plan was scheduled for discussion as planned.

17/148 Chairman's Report

148.01 Steve Hitchins highlighted the following events and visits he had attended since the last meeting:

- an event to mark 50 years of emergency medicine
- a conference for those self-managing Type 2 diabetes
- a meeting with the CQC inspection team currently on site
- Myra Stern's retirement
- a visit from Professor Sir Bruce Keogh centred on the 'flu campaign
- community dental services in Ealing, Hounslow and Harrow
- an event to celebrate Black History Month with some inspirational speakers.

148.02 Steve drew particular attention to an event organised for young (largely teenage) carers, where he had been embarrassed to learn of the discrimination this group had experienced from hospital staff. Paediatric nurse consultant Colette Datt would be working with this group to draw up a young carers' policy.

148.03 Richard Jennings paid tribute to all that Myra Stern had achieved during her time at Whittington Health, describing her as a 'model of what good integrated care should look like', and saying that she would be returning to the Trust to carry out some specific pieces of work.

17/149 Chief Executive's Report

149.01 Siobhan Harrington began her report by confirming that the Secretary of State has now formally approved the Trust's change of name to Whittington Health, which she felt to be a significant celebration of its integrated care ethos.

149.02 Ryhurst had been named as preferred bidder for the Trust's Strategic Estates Partnership, and Siobhan acknowledged the concerns that some held about this appointment but remained confident these could be worked through.

149.03 Carol Gillen would be addressing performance issues in her report, and Siobhan stated that ED performance had reached 89.9% in September, meaning that the Q2 performance target had been missed by just 6 breaches. It had however since risen to 90%. The take-up of the 'flu vaccination had reached 49%, and an active campaign continued throughout the Trust. Completion of the national staff survey currently stood at 20.7%, and Norma French added that this had been achieved prior to either of two sets of reminders being issued. Whittington Health was currently in the middle range of performance, and surgeries were being held to brief and support staff.

149.04 Siobhan was pleased to announce the appointment of Rauri Hadlington as strategic lead for allied health professionals. She herself had continued to hold successful staff fora, and had widened the managers' briefing to include all rather than solely senior managers. The bank staff bonus scheme was due to be launched later in the month. David Holt requested that the key themes emerging from the staff fora were shared with the Board. On consideration of stress levels, he felt that staff in, for example, ED, might not be hugely impressed with some of the suggestions put forward, and asked that further work be carried out to make initiatives more relevant to the wider staff group. It was noted however that the Occupational Health & Wellbeing Team had been carrying out some popular and successful outreach work.

149.05 Siobhan concluded her report by expressing her congratulations to Yvonne Smith, Health Care Assistant with Islington district nursing team, on receiving that month's staff excellence award.

17/150 <u>Communications & Engagement Plan</u>

150.01 Fiona Smith introduced her paper, saying that it provided some initial ideas and suggestions for communications and outreach, but it remained very much a live document and could change according to responses received as work progressed. She added that she had looked at work carried out at Bart's and at other Trusts with strategic estates partnerships in order to see what worked best.

150.02 The work described was broken down into different phases, and the Trust was currently in Phase 1. Phase 2 was the development of the masterplan, Phase 3 the specific projects. The plan was also divided into different types of work; briefings (face to face and interactive wherever possible), and a digital approach involving the use of social media. A variety of activities had therefore been suggested, and Board members were invited to feedback their comments and suggestions to Fiona direct. The plan could be launched once contracts had been signed.

150.03 Stephen Bloomer enquired whether, given the number of possible routes available, there was confidence that a) there was sufficient resource to achieve this, and b) there would be no mixed messages. Fiona replied that a degree of control would certainly be necessary, as would consistency of approach. Siobhan added that Fiona was reviewing the overall communications resource as part of her brief; it was also noted that NHSI would be offering additional assistance as the work developed. Deborah Harris offered her advice and assistance in the effective channelling of social media.

150.04 Anu Singh made a distinction between transmission and engagement, and also pointed out the important difference between patients and stakeholders from the wider community. Norma French spoke about communications with staff and the staff side representatives, and Richard Jennings gave some examples of co-production including

the development of the ambulatory care and new pharmacy services. Norma added that she was also working with Leon Douglas to look at the use of microsites. Steve Hitchins reminded the Board that it was also useful to consider using other local fora such as council meetings and pensioners' groups.

17/151 Corporate Objectives

151.01 Helen Taylor introduced the Quarter 2 report of the Trust's corporate objectives, focusing particularly on those impacting on quality and safety. There were, she said, some 'red' areas, including falls and a never event, MRSA and ED performance. Areas where significant progress had been made included transport, a reduction in clinic cancellations, and a lessening of noise at night. Staff turnover had remained fairly static curing this reporting period.

151.02 Areas where considerable work needed to be carried out included CIPs and medical productivity; the Trust had an objective of increasing its market share, and Helen would be meeting with Carol Gillen and Stephen Bloomer to discuss this further.

151.03 David Holt said that this was a very useful report, but he would like to see the addition of trajectories so as to be able to gage whether there was confidence in moving from red to green and where the inherent risks lay. Helen would include this in the next iteration of the report, aiming to indicate which areas were expected to be red or green by the end of the year.

17/152 Safe Staffing Report

152.01 Philippa Davies informed Board colleagues that September had been a challenging month, with a high number of vacancies and unfilled shifts. Heads of Nursing had been actively managing all areas, and Philippa believed that it was now possible to see some indications of improvement.

152.02 The latest nursing recruits were currently arriving from the Philippines, and 92 offers of employment had been made so far during the current campaign in India, where the drop-out rate was believed to be far lower and the nurses already had their IELTS (English language certification).

152.03 The staff bank bonus scheme was scheduled to begin later that month, and there had already been a notable increase in the use of the 'employee on line' function. Norma French added that there had been a spike in the use of HCA agency staff, and work was in hand to skill up the Trust's own staff so they were able to special patients. A recruitment drive was also under way.

17/153 Financial Report

136.01 Stephen Bloomer reported that the Trust had achieved its Month 6 target, however this had been due to an increase in non-recurrent measures. He added that if the patterns seen at Months 4, 5 & 6 were to be repeated in future months then the Trust would not meet its control total. Month 7 was a long month, and it was crucial that the correct level of income was received, as otherwise it would be necessary to enter into discussions with the London office about changing the control total. The good news, however, was that activity had increased, and if this trend was to continue in Months 7 & 8 the sole focus would need to be on achieving the CIPs. Siobhan said that this was being actively addressed at this quarter's ICSU performance review meetings.

17/154 Performance Dashboard

154.01 Carol Gillen opened her report by talking about the ED target, reiterating that 89.9% had been achieved in September, with a subsequent rise to 90%. Mental health patients remained a key challenge in this area, and there were also difficulties in obtaining ED locum doctors. Development of the mental health recovery room was broadly on track. Time to treat was improving during the day but remained challenging at night.

154.02 There had been a fall in complaints response times performance, this was being addressed at the quarterly performance review meetings. Cancer targets and RTT had been achieved, and there had been some improvement in readmission rates. Discharge to assess was starting imminently and Carol was confident this would aid flow and reduce delayed discharges.

154.03 Stephen Bloomer raised the issue of performance around new-birth visits in Haringey, and it was noted that the commissioners had expressed concern that the decline in performance in this area was due to the Trust's holding vacancies. Carol was clear this was not the case, and said that this service (as part of the wider health visiting service) was being reviewed by the Children & Young People's performance improvement group.

17/155 Winter Plan 2017

155.01 Carol Gillen gave a presentation on this year's Winter Plan. The emphasis remained, she said, on keeping patients safe going into winter, and ensuring the correct workforce was in place to deliver the necessary services. She drew attention to the increase in acuity illustrated on page 3 of the plan, mentioning in particular the increase in attendance, the increase in patients over 75, and the increase in length of stay within cardiology and thoracic medicine.

155.02 Much of the winter resilience work took place over the summer months, and Carol highlighted the improvement work that had been carried out with ECIP. She also drew attention to the development of the full capacity protocol, saying that there were an additional nine beds which could be activated only under exceptional circumstances. Discharge to assess was expected to be a key enabler this winter, with considerable work undertaken with external partners and particularly the local authorities to achieve this initiative.

155.03 The team had also reviewed areas which had proved successful last winter, and a considerable amount of work had been undertaken with the performance team on management of patient flow. 'Flu vaccinations were being administered both within the community and on the wards. Social workers were also now on site for the winter. Workforce remained a key risk; a combination of factors had meant there was now a shortage of AAU consultants which needed to be addressed. Mental health patients also posed a risk particularly if there was any slippage to the opening of the mental health recovery room.

155.04 Carol concluded her report by indicating the table on page 9 which showed details of how the additional winter resilience funding was to be spent. Siobhan thanked Carol for the huge amount of work she and her team had put into the development of the plan; Carol replied that she was confident it was robust, and paid tribute to a great team who looked after one another. Richard Jennings echoed Siobhan's thanks, but reminded colleagues of factors beyond our control such as demand and the possibility of a 'flu epidemic.

17/156 NED lead for Cyber-Security

156.01 Steve Hitchins confirmed that Deborah Harris had been appointed lead for cyber-security rather than Tony Rice whose name had been mistakenly announced at a previous meeting.

17/157 Serious Incident Report

157.01 Richard Jennings informed the Board that the Trust continued to experience problems with lost handover sheets. There were plans for an electronic system to be introduced, but this would not happen immediately, and in the meantime Maria Barnard, as Caldicott Guardian, was working hard with targeted groups of staff to try to prevent incidents, and Richard was pleased to report that some progress had been made in that misplaced sheets were at least being found on the same day and on site. He was also pleased to inform the Board that there was an increasing culture of self-reporting. One suggestion made was that sheets were counted in the same way as swabs, but this was felt to be a slightly draconian measure. The ultimate solution, Richard said, was to reach a place where all such information was contemporaneously electronically recorded.

17/158 Healthy London Partnership Peer Review

158.01 Siobhan Harrington had brought this paper to the Board for interest, saying that Whittington Health's own report was a very positive one and would be discussed in more detail at the Quality Committee.

17/159 Assurance Reports

159.01 Anu Singh questioned whether this new way of presenting Board sub-committee reports was right, saying that she viewed it as a retrograde step in terms of transparency, and reduced information presented in this way to the lowest common denominator – as well as adding additional work for staff. It was agreed that this could be discussed at the forthcoming Board seminar.

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**Action Notes Summary**

| | | | |
|---|---|---|---|
| **Minute** | **Action** | **Date** | **Lead** |
| 159.01 | Board Assurance Reports / Draft Minutes - It was agreed to discuss format and content of sub-committee draft minutes versus assurance reports at a forthcoming Board seminar. | tbc | SH |

Whittington Health
NHS Trust

# Trust Board 6 December 2017

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| **Title:** | Chief Executive Officer's Report for the Trust Board | | |
| **Agenda item:** | **17/164** | **Paper** | **02** |
| **Action requested:** | For discussion and information | | |
| **Executive Summary:** | The purpose of this report is to highlight specific issues to the Trust Board and to update the Board on local, regional and national key issues facing the Trust | | |
| **Summary of recommendations:** | To note the report | | |
| **Fit with WH strategy:** | This report provides an update on key issues for Whittington Health's strategic intent | | |
| **Reference to related / other documents:** | Whittington Health's regulatory framework, strategies and policies | | |
| **Reference to areas of risk and corporate risks on the Board Assurance Framework:** | Risks captured in risk registers and/or Board Assurance Framework | | |
| **Date paper completed:** | 29 November 2017 | | |

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|---|---|---|---|---|---|---|---|
| **Author name and title:** | | **Lynne Spencer, Director of Corporate Affairs** | | **Director name and title:** | | **Siobhan Harrington, Chief Executive** | |
| **Date paper seen by EC n/a** | **n/a** | **Equality Impact Assessment complete?** | **n/a** | **Quality Impact Assessment complete?** | **n/a** | **Financial Impact Assessment complete?** | **n/a** |

## CHIEF EXECUTIVE OFFICER REPORT

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

### NHS Improvement Agency

Ian Dalton, has been appointed as the new Chief Executive Officer of NHS Improvement Agency and took over the role on 4 December.

### Care Quality Commission (CQC)

We are pleased to have been working with the CQC over the past few months as part of their inspection process for NHS providers. This has included announced and unannounced visits to our community and hospital services. At the end of November we were also assessed against the new CQC 'well-led' domain that looks at the quality of our leadership across all levels of the Trust. This process included Board members and senior staff meeting with CQC inspectors to discuss our strategy, business plan arrangements and corporate objectives. We will receive the results of our inspection in the spring of 2018.

### Quality Improvement

We are committed to continuous quality improvement by taking a whole organisation approach to how we undertake 'quality improvement'. We have introduced on-line quality improvement training levels that introduce helpful improvement methodologies focused on 'plan, do, study and act' cycles. We are also working with UCLP in embedding our quality improvement approach with the Trust Board and senior leaders and look forward to this month's Board seminar where we will discuss this in more depth to ensure all levels of the organisation are engaged and active in continuous quality improvement.

### Flu vaccine uptake

We are at 64% staff immunised against the flu and we continue to hold our position as the top London NHS Trust for the flu vaccine uptake. We will continue providing the vaccine up to the end of the year and hope to raise staff immunisation rates by at least another 10%. It is really important as many of our staff as possible are vaccinated in order to protect vulnerable patients and friends and family from a virus that can kill.

### MRSA Bacteraemia

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

### Clostridium Difficile

We have reported 10 cases of Clostridium Difficile up to the end of October. The target is for no more than 17 cases this year.

### Cancer Waiting Time Targets

We are pleased to exceed national standards for cancer waiting time targets achieving 89% for 62 days against a target of 85% and 94.36% for 2 week waits against the 92%

target. Reporting of waiting times is reported in arrears due to the national cancer data validation process

- 31 days to first treatment 100% against target of 96%
- 31 days to subsequent treatment (surgery)100% against target of 98%
- 31 days to subsequent treatment (drugs)100% against a target of 93%
- 62 days from referral to treatment 89.5% against a target of 85%
- 14 days cancer to be first seen 94.3% against a target of 93%
- 14 days to be first seen for breast symptomatic 98.1% against a target of 93%

### Community Access Targets

Our Improving Access to Psychological Therapies (IAPT) targets for the month of October recorded:

- 771 referrals – a 14% increase for patients entering treatment
- 328 patients entered treatment – 139 below target due to transitioning of staff but still reporting above target of 128 for year to date
- 17 days on average for first appointment (increased from 12 days average)
- 61 days on average wait time from first to second treatment – including out of hours
- 95% patients seen within 6 weeks
- 99.5% patients seen within 18 weeks
- 96% of patients reported they were satisfied with their overall experience

## OPERATIONAL

### Emergency Department

Performance against the 95% target continued to improve during October despite facing continued demand and increased attendances. We achieved 90.1% performance for October.

The improvements we are making reflect the implementation of continued changes within ED and across the hospital, and close system working.

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 most importantly will ensure our patients receive continued high quality and timely care.

## WORKFORCE

### Chief Nurse

Philippa Davies, Chief Nurse will leave the Trust at the end of December and Sarah Hayes, Deputy Director will act up from 1 January 2018 until Michelle Johnson commences on 12 February 2018.

### Staff Survey

We are pleased that 37.7% of staff have completed the staff survey to date. This means we are now above the average response against our peer group and this shows significant improvement on last year's response rate. We are aiming still higher with a

target of a 40% response rate and we will be further promoting the survey to staff in the last few days it remains open. We are keen to hear from as many staff as possible to find out what staff feel needs to change to make Whittington Health an employer of first choice.

## FINANCE MONTH 7 (April to October 2017)

We are reporting a breakeven position for October maintaining the year to date deficit of £1.1m. This is against the planned year to date deficit of £0.4m and planned in month surplus of 0.7m.

Income was £0.6m favourable for October against plan with expenditure; both pay and non-pay, adverse to plan.

Whist reporting a breakeven position up to the end of October we retain major risks to achieve our control total for year end 2017/18. The most significant challenges are the delivery of our cost improvements, currently £5.1m behind plan, and the delivery of activity and associated income.

We are still forecasting achievement of our control total by year end at Month 7 reporting but this is dependent upon managing key risks of cost improvements and improving activity and income. We will continue to focus through our project management office, the ICSUs and the financial team on identifying mitigating actions.

We will be discussing in detail our position and how best to address our financial risks over the forthcoming months with further information in our financial report to the Board.

## Monthly Staff Awards

Congratulations to Gurjit Mahil, Director of Operations for our Women's Health Integrated Clinical Service Unit. Gurjit has worked extremely hard over the past few years to achieve excellent results in service delivery and service improvements. Gurjit will be taking on leadership of the Children's and Young Persons ICSU during the winter until the new Director of Operations commences in early 2018.

**Siobhan Harrington**
**Chief Executive**

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

# Whittington Health

December 2017

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| **Title:** | Serious Incidents - Monthly Update Report | | |
| **Agenda item:** | **17/165** | **Paper** | **3** |
| **Action requested:** | For Information | | |
| **Executive Summary:** | This report provides an overview of serious incidents (SI) submitted externally via StEIS (Strategic Executive Information System) during October 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<br>2. Efficient and Effective care<br>3. Culture of Innovation and Improvement | | |
| **Reference to related / other documents:** | • Supporting evidence towards CQC fundamental standards (12) (13) (17) (20).<br>• Ensuring that health service bodies are open and transparent with the relevant person/s.<br>• NHS England National Framework for Reporting and Learning from Serious Incidents Requiring Investigation,<br>• Whittington Health Serious Incident Policy.<br>• Health and Safety Executive RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). | | |
| **Reference to areas of risk and corporate risks on the Board Assurance Framework:** | **Corporate Risk 636.** Create a robust SI learning process across the Trust. Trust Intranet page has been updated with key learning points following recent SIs and RCA investigations. | | |
| **Date paper completed:** | 27/11/2017 | | |

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|---|---|---|---|---|---|---|---|
| **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 October 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 five serious incidents during October 2017, bringing the total of reportable serious incidents to 26 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 |
|---|---|---|
| Delayed Treatment<br>Ref:22420 | Sept 17 | A patient with a critically ischaemic foot had a forefoot amputation following deterioration of a diabetic foot ulcer. |
| Information Governance Incident<br>Ref:23561 | Sept 17 | A ward handover sheet with patient details was found by hospital staff in a public area in the Hospital. |
| Unexpected death<br>Ref:24271 | Oct 17 | A patient died following an elective surgery for hepatic flexure cancer. Following complications during surgery the patient had an iatrogenic oesophageal perforation resulting in sepsis and pneumothorax and was transferred to a specialist Upper GI centre and subsequently died. |
| Unexpected admission to NICU<br>Ref:24280 | Oct 17 | A mother had an antepartum haemorrhage following an emergency caesarean section of twin babies. Twin 1 was born in poor condition and sadly died. |

| Category | Month Declared | Summary |
|---|---|---|
| Disruptive/ aggressive/ violent behaviour<br>Ref:24289 | Oct 17 | Staff member was assaulted by a patient on the ward. |
| Patient Fall<br>Ref:25566 | Oct 17 | A patient had an unwitnessed fall resulting in a fractured femur. |
| Delayed Diagnosis<br>Ref:26665 | Oct 17 | There was a delay in identifying a fractured femur following an unwitnessed patient fall. |

**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 |
| **Total** | 4 | 6 | 3 | 3 | 3 | 6 | 9 | **8** | **3** | **4** | **5** | **4** | **58** |

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

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

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Medical disposables incident meeting SI criteria | 1 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Medication Incident | 0 | | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| Nasogastric tube | 1 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Slip/Trips/Falls | 7 | | 0 | 1 | 0 | 0 | 2 | 0 | 1 | 4 |
| Sub optimal Care | 4 | | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Treatment Delay | 3 | | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 3 |
| Unexpected death | 10 | | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 3 |
| Retained foreign object | 1 | | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| HCAI\Infection Control Incident | 0 | | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| **Total** | **58** | | **2** | **4** | **4** | **3** | **6** | **2** | **5** | **26** |

## 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 October 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. The 'Big 4' is a weekly bulletin containing four key safety messages for clinical staff in theatres; this is emailed to all clinical staff in theatres, as well as being placed on notice boards around theatres. Learning from identified incidents is also published on the Trust Intranet making them available to all staff.

### 4.1 The Trust submitted four reports to NELCSU during October 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 October 2017.

| Summary | Actions taken as result of lessons learnt include; |
|---|---|
| Delayed Diagnosis<br>Ref:16865 | A delay in diagnosis following an elective procedure; a patient had to be returned to theatre for revisional surgery to address an anastomatic leak (a recognised complication of colorectal surgery).<br>• The risks and benefits of surgery and alternative options should always be discussed with the patient. The Trust are introducing PARQ (Procedure Alternative Risk Questions) as standard for patient consent to surgery which will be kept within the patient notes.<br>• New procedure specific consent forms in general surgery have been |

| Summary | Actions taken as result of lessons learnt include; |
|---|---|
| | developed that require both the patient and surgeon to sign, which will strengthen the evidence that consent has been agreed.<br>• This case has been shared with general surgeons as a reminder to consider the possibility of ileus and the timely placments of peri-operative nasogastric tubes (NGTS).<br>• A Standardised Operating Procedure has been developed to ensure there is a robust systematic process in general surgery where complications are shared, discussed and recorded timely and all learning disseminated. |
| Unexpected Death<br><br>Ref:14668 | A patient suffered a cardiac arrest and died 48 hours after presentation to the hospital.<br>• The Trust sepsis team are continuing to provide education and training of sepsis recognition and management focusing on recognition after initial presentation.<br>• The Trust continues to work to ensure bed occupancy is maintained below 100% to allow patient flow and prevent overcrowding in ED, ensuring full implementation of SAFER and Red to Green process as per recommendations from the Emergency Care Improvement programme (ECIP) review.<br>• Simulation based training is being delivered, using this patient story by the resus team for relevant staff including the clinical site practitioners. |
| Patient Fall<br><br>Ref: 19572 | A patient had a fall resulting in a fractured neck of Femur.<br>• A review of handover processes has taken place in relation to patient falls risk assessments to ensure the accurate ward to ward handover. The Trust transfer checklist now incorporates significant risks (including falls risk).<br>• The trust continues to increase awareness and training in the STOPfalls bundle across the Trust, including lying/standing BP and postural hypotension.<br>• An approach is being used 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 asked to be in the bay and on Baywatch until the nurse returns. |
| Delayed Diagnosis /Maternity<br><br>Ref:19650 | A delay in diagnosing a bladder dysfunction led to a bladder injury resulting in a patient having to return to theatre.<br>• The Trust guideline for Intrapartum and Postpartum Bladder Care to be amended and updated to ensure the guidance following removal of urine catheter when there has been a previous failed trial without catheter (TWOC) is clear.<br>• The Maternity service rolling education programme is being developed to include an in depth education session on intrapartum and postpartum bladder care and management. To specifically include trial without catheter management on first and subsequent occasions. |

## 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 trust wide patient safety newsletter. Themes from serious incidents are captured in an annual review, outlining areas of good practice and areas for improvement and trust wide 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.

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Whittington Health
NHS Trust

# Whittington Health Trust Board

6 December 2017

| | | | |
|---|---|---|---|
| **Title:** | Inpatient Safe Staffing - Nursing and Midwifery – October data | | |
| **Agenda item:** | 17/166 | **Paper** | 04 |
| **Action requested:** | For information | | |
| **Executive Summary:** | This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in October 2017. The key issues to note are:<br>1. The improved utilisation of Allocate 'Safe Care' and associated staffing levels to match the acuity and dependency needs of our patients<br>2. A slightly decreased fill rate in Registered Nurse shifts from 91.2% to 90.6% as detailed in the UNIFY report, due partly to patient acuity assessment and monitoring and the allocation of staff as described above.<br>3. An increase in shift requests to provide enhanced care to support vulnerable patients in October (n=287) compared to September (n=55)<br>4. 36 Registered Mental Health (RMN) nurses were booked for shifts to provide enhanced care for patients with a mental health condition in October.<br>5. There were 32 shifts in October which initially triggered 'Red' prompting a review of available staff. These shifts are regularly reviewed to mitigate any risks to patient safety.<br>6. The Care Hours Per Patient Day (CHPPD) measure during the month decreased marginally in October (8.13) compared to September (8.28)<br>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.<br>8. There was one Datix reports submitted in October where 'staffing' was highlighted as an issue which resulted in "Low / Minor (minimal harm)" | | |
| **Summary of recommendations:** | To note the October UNIFY return position and processes in place to ensure safe staffing levels in the organisation. | | |
| **Fit with WH strategy:** | Efficient and effective care; Francis Report recommendations. Cummings recommendations; NICE recommendations. | | |
| **Reference to related / other documents:** | | | |
| **Reference to areas of risk and corporate risks on the Board Assurance** | 3.4 Staffing ratios versus good practice standards. | | |

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

## Ward Staffing Levels – Nursing and Midwifery

### 1.0 Purpose

1.1 To provide the Trust Board with assurance in regard to the management of safe nursing and midwifery staffing levels for the month of October 2017.

1.2 To provide context for the Trust Board on the UNIFY safe staffing submission for the months of October 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 October data by ward please see section 4.2).

2.5 Staff fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st to 31st October for Whittington Hospital has 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 |
|---|---|---|
| **Patient safety is delivered though consistent, appropriate staffing levels for the service.** | Unify RN fill rate | Day – 85.2%<br>Night – 96.0% |
| | Care hours per Patient Day - CHPPD | Overall the CHPPD for October was 8.13 which is marginally lower than last month. |
| **Staff are supported in their decision making by effective reporting.** | Red triggered shifts | 32 shifts triggered 'Red' in October 2017 compared with 40 in September |

## 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 October. The number of level 1b patients remains static. 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 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 and other areas to ensure safe staffing levels across the

organisation. The staffing levels on all wards are reviewed each morning to ensure staffing levels are safe

3.2.2 Appendix 1 details a summary of 'actual' versus 'planned' fill rates in October. The average fill rate was **85.2%** for registered staff and **133.3%** for care staff during the day and **96%** for registered staff and **146.2%** for care staff during the night.

3.2.3 The Trust fill rate for October is outlined below:

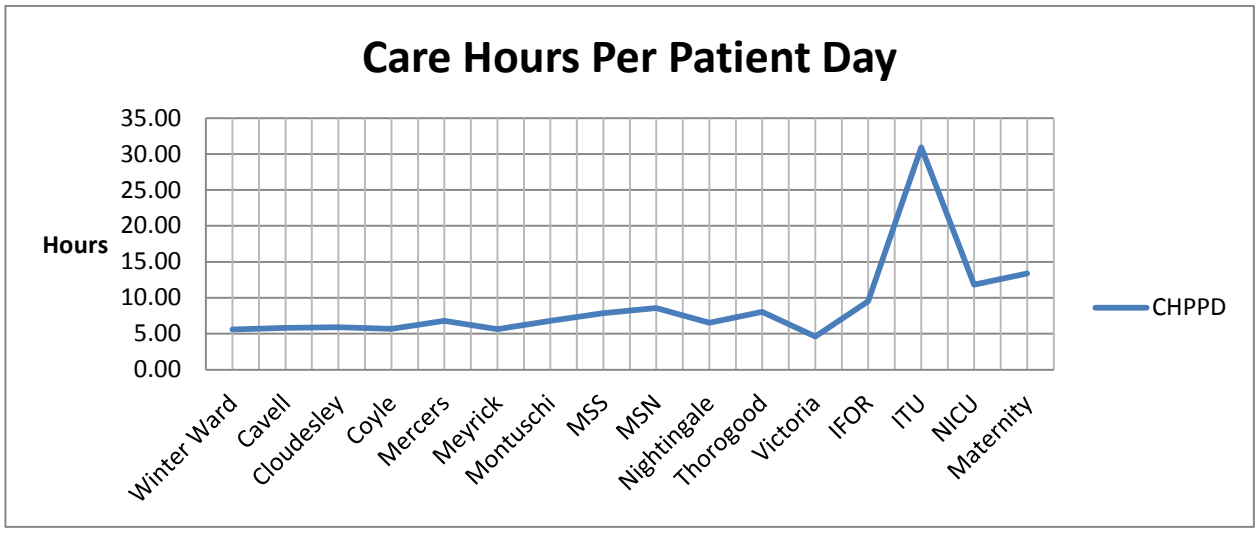
| **Day** | | **Night** | |
|---|---|---|---|
| Average fill rate registered Nurses /Midwives | Average fill rate Care Staff | Average fill rate registered Nurses/Midwives | Average fill rate Care Staff |
| **85.2%** | **133.3%** | **96.0%** | **146.2%** |

3.2.4 The UNIFY report shows some wards with unusually high percentage fill rates; for example, Montuschi, Mary Seacole North and South at above 200% for HCAs. In these areas a skill mix review has been completed and Band 4 Assistant Practitioners have been appointed to take on some tasks traditionally allocated to registered nurses. 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 and Head of Nursing depending on the needs of the specific patient group.

## 4. Care Hours per Patient Day (CHPPD)

Care hours per patient day 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). This indicator is not dependant on patient acuity.

The graph below shows the average individual CHPPD for each clinical area, in October. ITU have the most care hours (30.95) and Victoria ward have the least (4.61).




4.1 Across the Trust the average number of hours of Registered Nurse time spent with patients in October was calculated at 5.51 hours and 2.62 hours for care staff. This provides an overall average of 8.13 hours of care per patient day.

| | CHPPD (October) |
|---|---|
| **Registered Nurse** | **5.51** |
| **Care Staff** | **2.62** |
| **Overall hours** | **8.13** |

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.

| Ward Name | October | September | August | July |
|---|---|---|---|---|
| Cavell | 5.58 | 5.9 | | 7.18 |
| Bridges rehab ward | 5.82 | 6.44 | 7.12 | 6.67 |
| Cloudesley | 5.90 | 5.78 | 6.43 | 6.11 |
| Coyle | 5.67 | 5.65 | 6.25 | 6.23 |
| Mercers | 6.79 | 6.72 | 7.48 | 7.41 |
| Meyrick | 5.65 | 5.71 | 6.4 | 6.43 |
| Montuschi | 6.77 | 6.92 | 6.52 | 5.78 |
| Mary Seacole South | 7.86 | 7.88 | 7.69 | 8.32 |
| Mary Seacole North | 8.59 | 9.16 | 9.49 | 10.08 |
| Nightingale | 6.52 | 6.58 | 7.31 | 7.04 |
| Thorogood | 8.02 | 7.47 | 8.32 | 8.89 |
| Victoria | 4.61 | 5.57 | 6.01 | 6.61 |
| IFOR | 9.50 | 10.16 | 11.43 | 6.22 |
| ITU | 30.95 | 29.1 | 28.54 | 26.96 |
| NICU | 11.85 | 10.42 | 10.97 | 11.1 |
| Maternity | 13.37 | 13.14 | 16.14 | 13.27 |
| Total | 8.13 | 8.28 | 9.07 | 8.63 |

The overall CHPPD is marginally lower in October compared to September with fluctuations in both directions across all cost centres. Human resources and the nursing directorate are ensuring that proactive work is taking place to reduce unfilled shifts and increase recruitment into vacant posts.

Furthermore, refining of the process to update the Safecare system when staff are moved from one ward to another for clinical safety, improved during October.

## 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 08.30 bed meeting, the Deputy Chief Nurse and Heads of Nursing in conjunction with matrons, site managers and other senior staff review CHPPD and 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 for more than half an hour it 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. These KPI values continue to be under review.

5.3 A decision as to whether a ward staffing triggers red is taken once the review of staffing and dependency has taken place in addition. 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 32 red flags triggered in October. 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. This approach is still in its infancy and however it is anticipated that the number will reduce in November when the system is more robust. Heads of Nursing and matrons are working with ward staff to ensure that the system is accurately used. Frequency and trends will be regularly reviewed by the Deputy Chief Nurse throughout the winter and will be reported in the board reports.

The table below indicates which wards triggered the 32 red flags during October.

| Ward | Count |
|---|---|
| CAVELL | 2 |
| CLOUDESLEY | 1 |
| COYLE | 5 |
| MONTUSCHI | 4 |
| NIGHTINGALE | 6 |
| VICTORIA | 14 |

## 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 October there were 27 Datix reports submitted relating to staffing, one of the incidences relates to Low / Minor (minimal harm) to injury.

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

7.1 When comparing October 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 October there were 287 requests for 1:1 enhanced care provision compared to 55 requests in September. The requests made for this level of care were to ensure the safe management of particularly vulnerable groups of patients. There were 235 HCA shifts, 16 RN and 36 RMN shifts requested in October.

7.2 36 Registered Mental Health (RMN) nurses were booked for shifts, in October, to provide enhanced care for patients with a mental health condition.

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

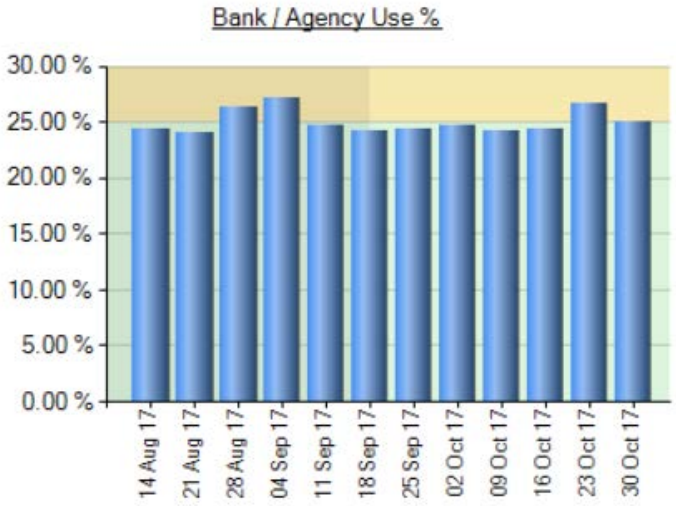
8.1 Temporary staff utilisation (nursing and midwifery) across the hospital is now monitored regularly by the Deputy Chief Nurse and Heads of Nursing, a member of the temporary staffing team also reports unfilled shifts to the site meeting. All requests for temporary staff (agency) on the wards are reviewed by the Head of Nursing/Midwifery. A further review and final authorisation is then made by the Deputy Chief Nurse.

8.2 Monitoring the requests for temporary staff in this way serves two purposes:

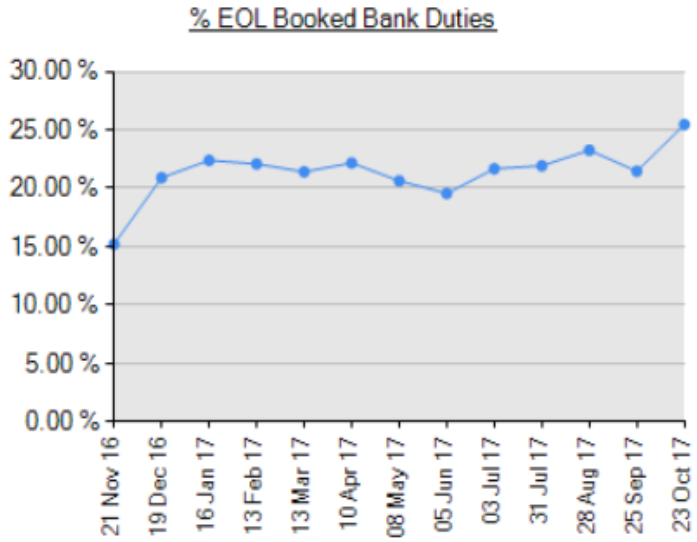
8.2.1 The system in place allows for the most appropriate use of high cost temporary agency staff across the organisation and provides a positive challenge mechanism for all requests.

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 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.

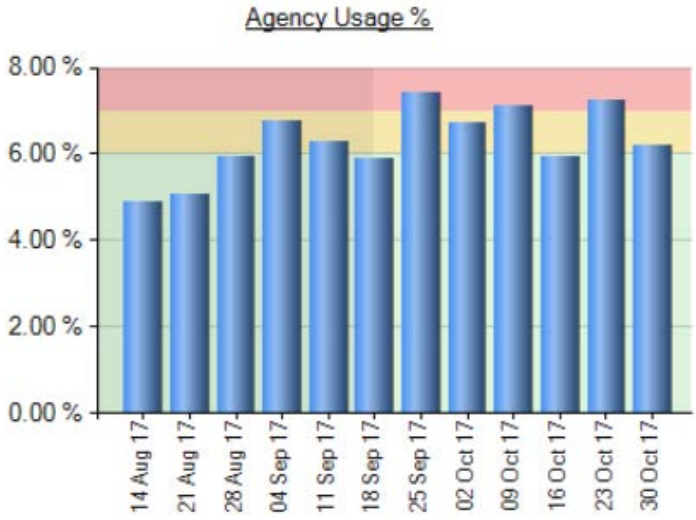



Whilst there is an upward trend in the direct booking process, less than 50% of bank shifts are booked by the staff themselves. This remains an area of service improvement.

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

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 October (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. This percentage continues to fluctuate.

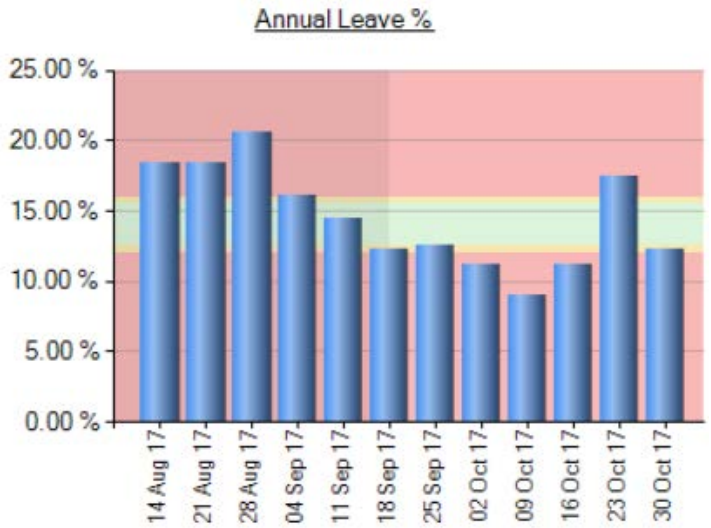



## Absence Management

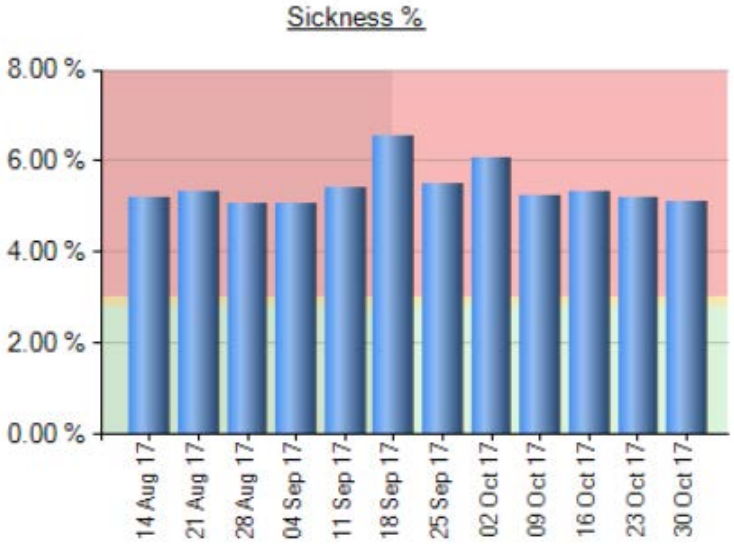
9.3 The management of absence is crucial to effective resource management. The key absences to track are annual leave and sickness. Annual leave taken from April to date varied over the month spanning the set tolerances of 14 -16%. These tolerance

levels ensure all staff are allocated leave appropriately and an even distribution of staff are available throughout the year.

9.4 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. As a result the annual leave percentage has been over-delivered to compensate for being under in the previous months. All areas have been appraised of the level of leave still to be taken by staff and this will be actioned to ensure that minimal leave is carried forward into 2018/19




10.3 Sick leave percentage continues to be above the 3% threshold month on month. Heads of Nursing ensure all individuals reporting back from sick leave undergo a sickness review which is being actively managed with the HR Business Partners for each ICSU.




## 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.

**Appendix 1**

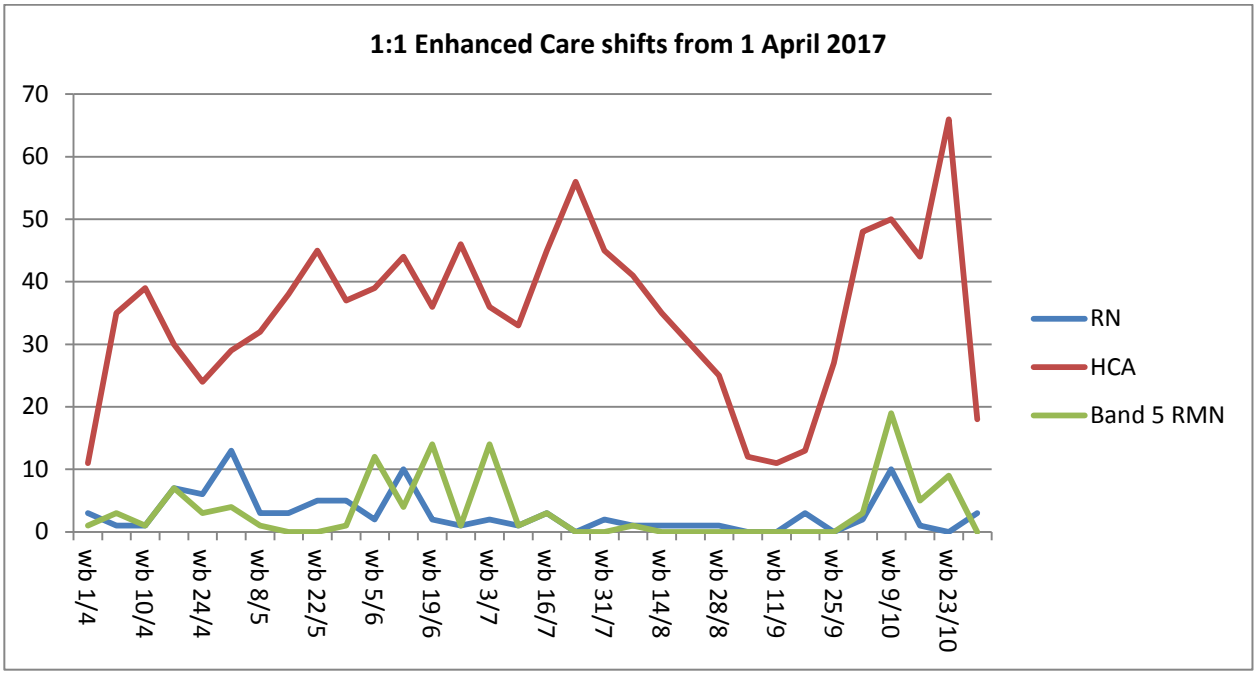
**Fill rate data - summary**
**October 2017**

| **Day** | | | | **Night** | | | | **Average fill rate data- Day** | | **Average fill rate data- Night** | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Registered nurses/ midwives | | Care staff | | Registered nurses/ midwives | | Care staff | | Registered nurses/ midwives | Care staff | Registered nurses/ midwives | Care staff |
| Planned (hrs) | Actual (hrs) | Planned (hrs) | Actual (hrs) | Planned (hrs) | Actual (hrs) | Planned (hrs) | Actual (hrs) | | | | |
| **10022** | **13358** | **25821** | **24795** | **7393** | **10810** | **10022** | **13358** | **85.2%** | **133.3%** | **96.0%** | **146.2%** |

**Care Hours per Patient Day**
**October 2017**

| Total Patients at Midnight/Month | CHPPD Registered staff | CHPPD Unregistered staff | Average CHPPD (all staff) |
|---|---|---|---|
| **9235** | **5.51** | **2.62** | **8.13** |

## Appendix 2: Enhanced Care requirement to date




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

| Oct - 17 | Day | | Night | |
|---|---|---|---|---|
| Ward Name | Nurses | Care Staff | Nurses | Care Staff |
| Cavell | 68.1% | 111.2% | 79.8% | 145.2% |
| Bridges | 67.3% | 104.1% | 106.6% | 106.7% |
| Cloudesley | 76.8% | 124.7% | 117.7% | 170.4% |
| Coyle | 80.9% | 148.6% | 123.2% | 127.3% |
| Mercers | 70.5% | 147.8% | 107.3% | 114.6% |
| Meyrick | 79.0% | 128.3% | 113.3% | 157.0% |
| Montuschi | 71.7% | 310.1% | 116.1% | NA |
| MSS | 57.9% | 273.1% | 76.5% | 269.5% |
| MSN | 72.0% | 141.0% | 106.7% | 236.8% |
| Nightingale | 96.9% | 119.4% | 81.5% | 136.3% |
| Thorogood | 93.3% | 71.5% | 122.8% | 0.0% |
| Victoria | 85.5% | 111.5% | 91.5% | 122.1% |
| IFOR | 87.8% | 100.0% | 74.9% | 100.0% |
| ITU | 100.0% | 0.0% | 100.0% | 0.0% |
| NICU | 84.5% | 0.0% | 85.2% | 0.0% |
| Maternity | 102.4% | 131.0% | 97.0% | 124.1% |
| Total | 85.2% | 133.3% | 96.0% | 146.2% |

# Whittington Health Trust Board

## 6 December 2017

| | | | |
|---|---|---|---|
| **Title:** | **Quarterly Safety and Quality Board Report<br>Quarter 2 2017/18 (01 July – 30 September 2017)** | | |
| **Agenda item:** | **17/167** | Paper | **05** |
| **Action requested:** | For the Board to discuss and make any additional recommendations. | | |
| **Executive Summary:** | This is the regular paper for the Trust Board to provide an overview of safety and quality in the organisation. | | |
| **Summary of recommendations:** | It is recommended that the contents are discussed | | |
| **Fit with WH strategy:** | To deliver consistent high quality, safe services. | | |
| **Reference to related / other documents:** | Quality Account 2015-16<br>Sign up to Safety Pledges<br>Clinical Strategy 2015-20<br>CQC standards<br>7 day services clinical standards | | |
| **Date paper completed:** | 23rd October 2017 | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Author name and title:** | | **Richard Jennings, Executive Medical Director** | | **Director name and title:** | | **Richard Jennings, Executive Medical Director** | |
| **Date paper seen by EC** | | **Equality Impact Assessment complete?** | **NA** | **Risk assessment undertaken?** | **NA** | **Legal advice received?** | **NA** |

## 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 the National Cardiac Arrest Audit.

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

## 2) Contents



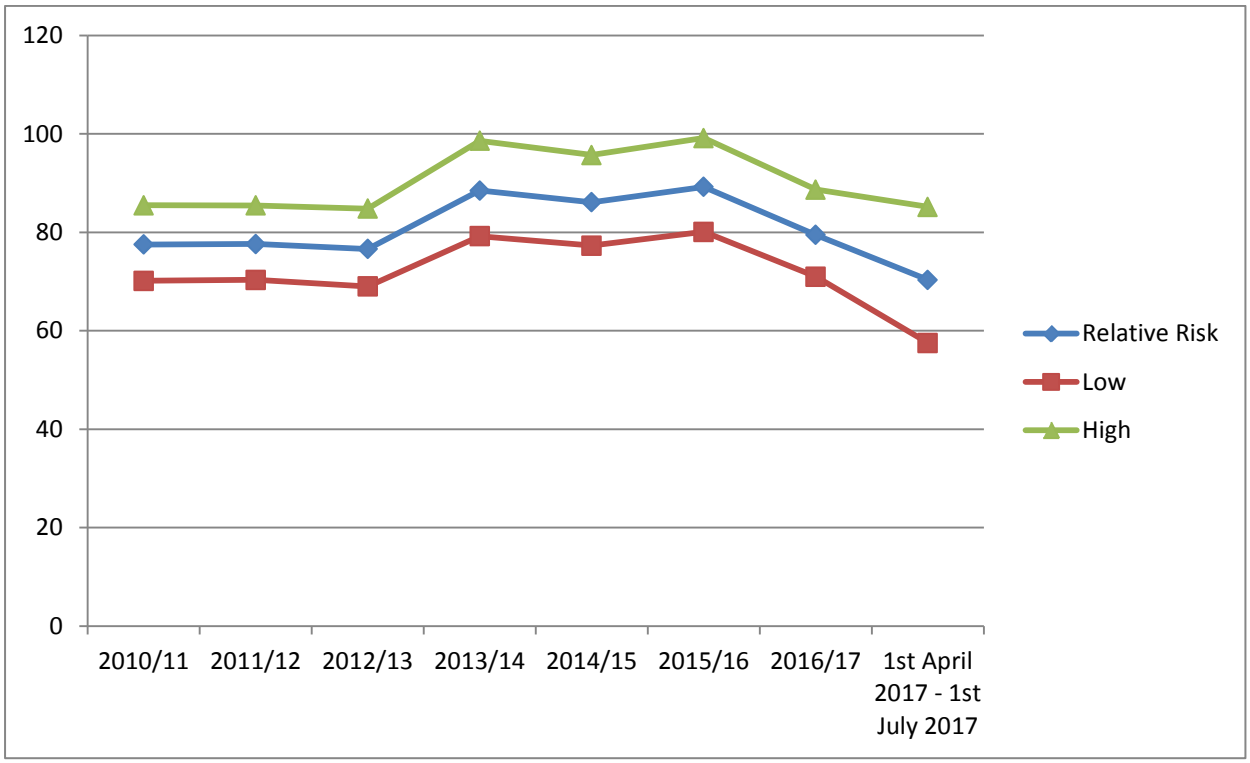
## 3. Mortality

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 – July 2017)**




The blue diamonds 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 that may suggest the need 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.

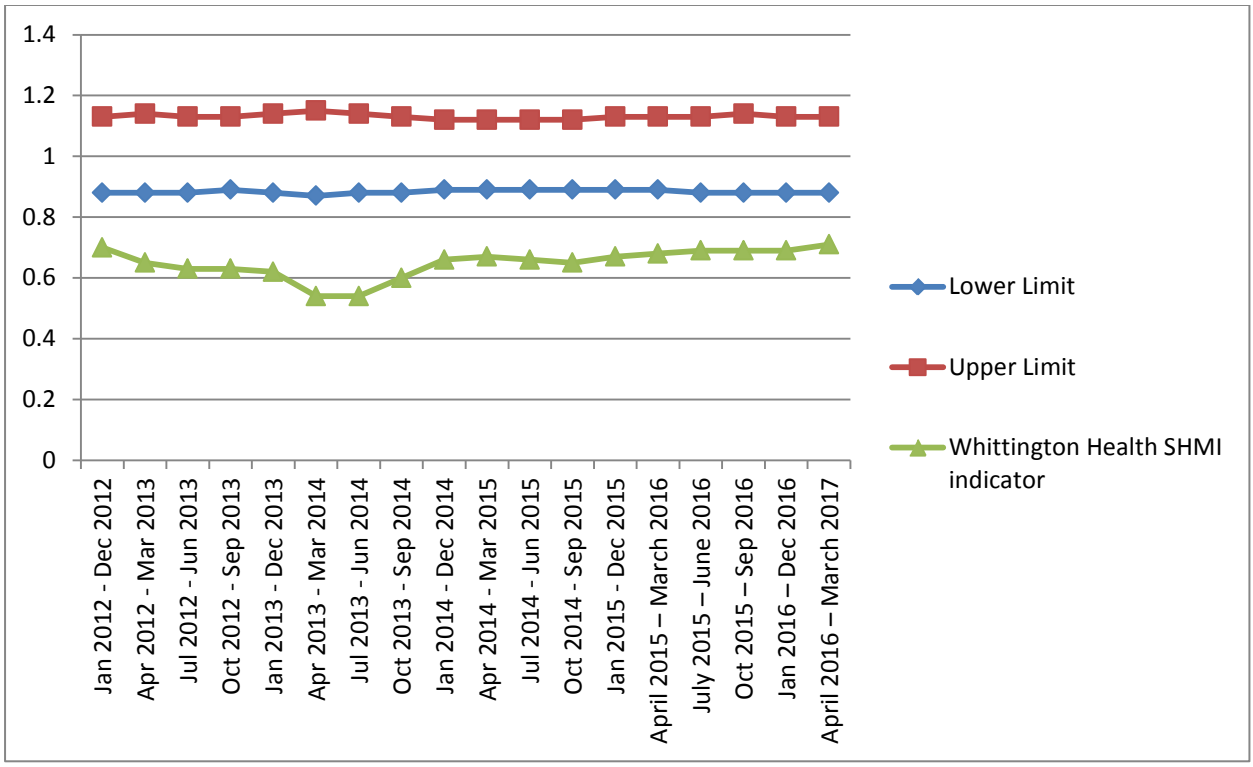
The most recent data available (released in September 2017) covers the period April 2016 – March 2017:

| | |
|---|---|
| **Whittington Health SHMI score** | **0.7075** |
| **National standard** | **1.00** |
| **Lowest national score** | **0.7075 (Whittington Health)** |
| **Highest national score** | **1.2123** |

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

| Data Period | Lower Limit | Upper Limit | Whittington Health SHMI indicator |
|---|---|---|---|
| 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 |
| April 2016 – March 2017 | 0.88 | 1.13 | 0.71 |

**Chart 2: Whittington Health Summary Hospital-level Mortality Indicator (SHMI) (January 2012 – March 2017)**




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. This was in June 2017 and was referred to in the previous *Quarterly Safety and Quality Board Report*. It is likely that it was a contamination rather than a real bacteraemia. The Department of Health final review and attribution is still awaited.

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-September 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 | 0 | 0 | | | | | | | 0 |
| **NICU** | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | | 0 |
| **SCBU** | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | | 0 |
| **Meyrick** | 0 | 0 | 0 | 1 | 2 | 0 | | | | | | | 3 |
| **Cloudesley** | 0 | 0 | 3 | 0 | 1 | 0 | | | | | | | 4 |
| **Bridges - Cavell rehab** | 0 | 3 | 0 | 0 | 0 | 0 | | | | | | | 3 |
| **Coyle #NOF** | 0 | 0 | 0 | 0 | 0 | 1 | | | | | | | 1 |
| **Cavell** | 0 | 0 | 0 | 1 | 0 | 0 | | | | | | | 1 |

### 4.2 *Clostridium difficile* diarrhoea

For 2017-18 there have been ten 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 | 0 | |
| September 2017 | 1 | Cloudesley |
| October 2017 | 3 | Cloudesley x 3 |

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.

Cases 7 (September 2017) to 10 (October 2017) shown in table 3 were all patients on Cloudesley Ward. An outbreak was declared. Following review, it was found that Case 7 was not a new infection, but was a relapse in a patient who had *C. difficile* in August 2017. Cases 8 and 9 were in a bay together, and as their ribotypes are the same, although this is not certain, it is likely that one case is due to cross-infection from the other. An *Clostridium difficile* outbreak is defined as any situation in which cross-infection from one patient to another has occurred. Cases 7 and 10 are of different ribotypes to cases 8 and 9, and therefore are not related.

The Infection Prevention and Control (IPC) nurses will continue to review all *Clostridium difficile* Toxin (CDT) requested samples daily. The IPC nurses update the JAC electronic prescribing system and the Medway electronic patient record with alerts to highlight patients who have previously been CDT positive.

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

There have been four Trust-attributable MSSA bacteraemia episodes since 1 April 2017. These all occurred in Quarter 2 – one occurred July and three occurred in August. There are no set national or local thresholds for MSSA bacteraemia.

There have been three *E.coli* bacteraemias episodes since 1 April 2017. Two of these occurred in Quarter 1 and one in Quarter 2. Short Post-Infection Reviews have been completed. Two of the three episodes were considered definitely unavoidable and learning has been shared from the third. 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 14 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 29 September 2017, 74% of Whittington Health staff have received IPC training within the last two years.

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 19 October 2017. Excellent feedback was received from attendees. The next study day is scheduled for April 2018. 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 *Quarterly Safety and Quality Board Report* there have been two new CPE cases at Whittington Health. Both patients were identified as positive for CPE before they were admitted to our Hospital, and this was highlighted in a timely way to clinical staff.

For the year 2017/18 none of the CPE cases 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 | **We will aim for all cases of Acute Kidney Injury to be promptly recognised and appropriately treated.** | 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 | **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.** | 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 | **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** | 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 *Care Of Older People* wards. |
| | | | We will reduce the number of avoidable falls resulting in serious harm to patients year on year. |

| | | | |
|---|---|---|---|
| | **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.** | | |
| Pressure Ulcers | **We will aim to eliminate avoidable grade 3 and 4 pressure ulcers within our integrated care organisation.** | Jane Preece | To achieve a year on year reduction in all grades of pressure ulcers across the ICO.<br><br>We are developing a cross borough target on the 'React to Red Initiative'. |
| Learning Disabilities | **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.** | Helen Odiembo | 75% of patients who present to the Emergency Department with learning disabilities are given a priority assessment.<br><br>We will introduce a care pathway for mothers with learning disabilities in the hospital. |

**5.1 Sign up to Safety progress update – Pressure ulcers**

The Tissue Viability team are constantly reviewing practice to reduce avoidable pressure ulcer and there has been significant reduction since April 2011.

**Sign up to safety pledge by 2018**

- We will have no avoidable grade 4 pressure ulcers. · ·
- We will reduce the number of avoidable grade 3 pressure ulcers in the community setting by 30%.
- We will reduce the number of avoidable grade 3 pressure ulcers in the acute setting by 50%.

**KPI Objective and quality account 2017/2018**

Acute:

- 20% reduction of Grade 2 and 3
- Continue zero avoidable Grade 4

Community:

- 20% reduction Grade 2 and Grade 3
- 30% reduction Grade 4

**Chart 3: Whittington Health avoidable pressure ulcers (April 2016 to July 2017)**

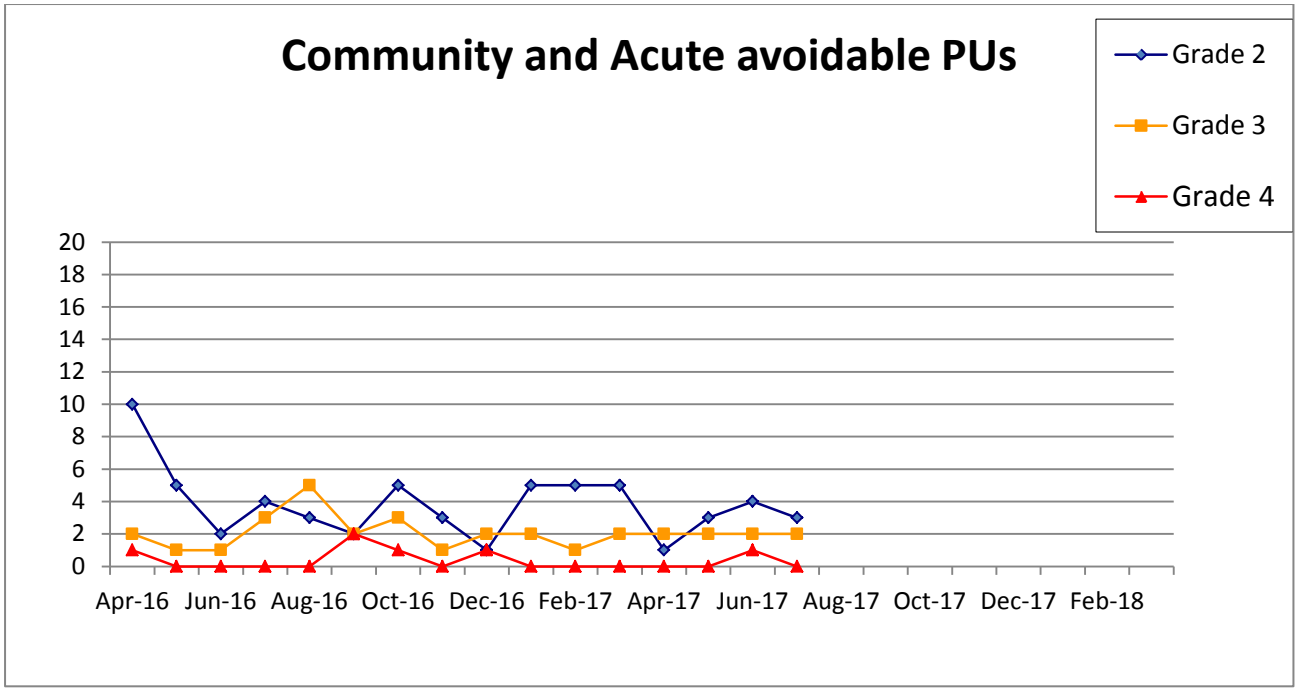



**Table 5: Number of avoidable pressure ulcer across Whittington Health April 2016 – July 2016 against the number of avoidable pressure ulcers across Whittington Health in the period April 2017 – July 2017**

| Grade | 2016/17 April - July | 2017/18 April - July | Percentage % |
|---|---|---|---|
| 2 | 21 | 11 | -48 |
| 3 | 7 | 8 | +13 |
| 4 | 1 | 1 | 0 |

As table 5 shows, there has been a decrease of 48% in the number of avoidable Grade 2 pressure ulcers across Whittington Health. However, there has been a small (13%) increase in the number of avoidable Grade 3 (n=1) pressure ulcers and no change in number of Grade 4 pressure ulcers. It should be noted that the overall numbers of avoidable Grade 3 pressure ulcers are small, and that the increase is due to just one more case in the second four month period.

**Chart 4: Community avoidable pressure ulcers April 2016 to July 2017**

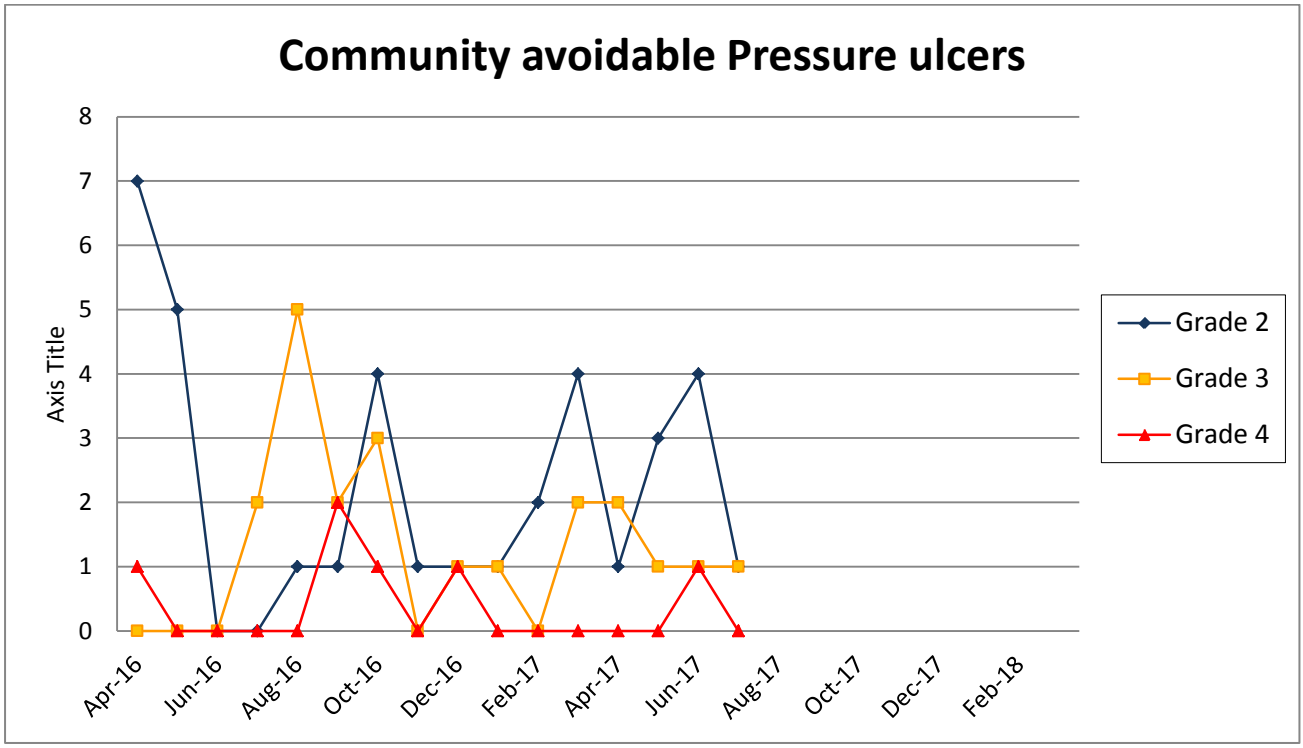
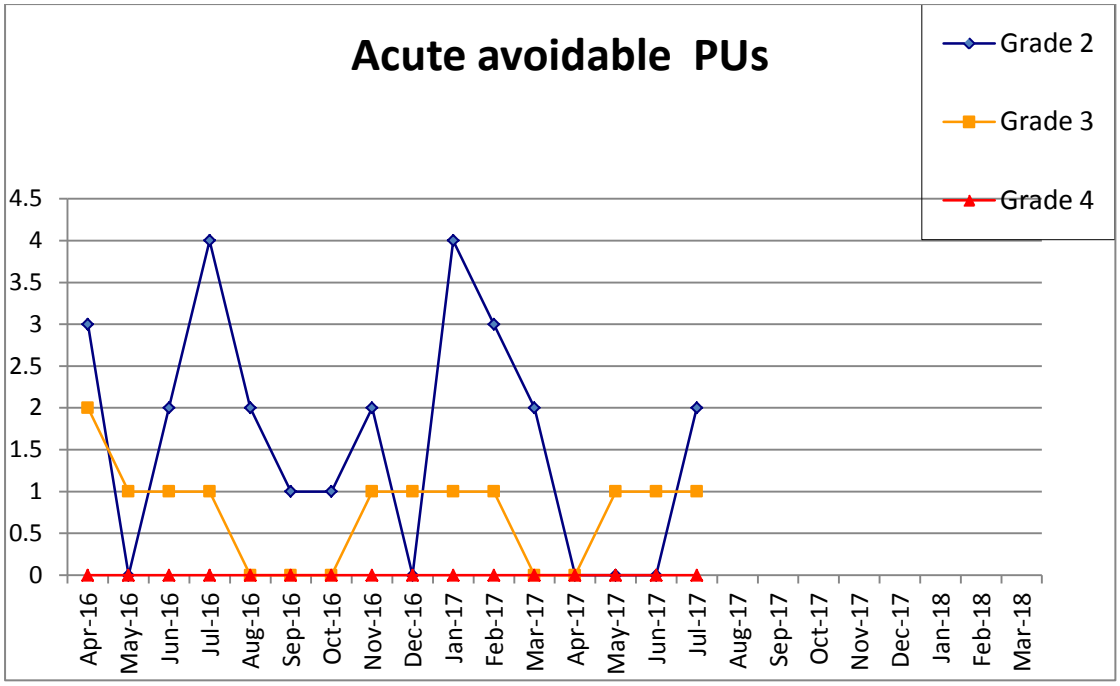



**Table 6: Number of avoidable pressure ulcers across the district nursing service April 2016 – July 2016 against the number of avoidable pressure ulcers across the district nursing service in the period April 2017 – July 2017**

| Grade | 2016/17 April - July | 2017/18 April - July | Percentage % |
|---|---|---|---|
| 2 | 12 | 9 | -25 |
| 3 | 2 | 5 | +60 |
| 4 | 1 | 1 | 0 |

As table 6 shows, there has been a 25% decrease in number of avoidable grade 2, an increase of 60% (n3) in Grade 3 pressure ulcers, but no change in the number of avoidable Grade 4 pressure ulcers.

**Chart 5: Whittington Hospital avoidable pressure ulcers April 2016 to July 2017**




As Chart 5 shows, Whittington Hospital has not had an avoidable Grade 4 since January 2015. There has been a 40% decrease (n2) in grade 3, with 78% decrease (n7) grade 2, when comparing timeframes.

**Table 7: Number of avoidable pressure ulcers across Whittington Hospital April 2016 – July 2016 against the number of avoidable pressure ulcers across Whittington Hospital in the period April 2017 – July 2017**

| Grade | 2016/17 April - July | 2017/18 April - July | Percentage % |
|---|---|---|---|
| 2 | 9 | 2 | -78 |
| 3 | 5 | 3 | -40 |
| 4 | 0 | 0 | 0 |

**Learning from the investigation of cases of avoidable Grade 3 pressure ulcers**

Examples of some of the care and service delivery problems that were found on investigation to have been associated with cases of avoidable Grade 3 pressure ulcers were:

- Incomplete or poor documentation reducing the ability of the clinical team to manage pressure ulcer prevention ultimately;

- Inadequate pain relief led to a patient being unwilling to be repositioned at a frequency that would have been appropriate for pressure ulcer prevention;
- Inaccurate clinical assessment and grading of skin leading to sub-optimal prevention or treatment measures.

## 6. Safety and Quality Review: National Cardiac Arrest Audit (NCAA) 2016/17

The National Cardiac Arrest Audit (NCAA) is the national, clinical, comparative audit for in-hospital cardiac arrest. The NCAA monitors and reports on the incidence of and outcome from, in-hospital cardiac arrests and aims to identify and foster improvements, where necessary, in the prevention, care delivery and outcome from cardiac arrest[1].

The NCAA is based on reported numbers (shown in table 5) of admissions to the hospital, in-hospital emergency 2222 calls, cardiac arrests attended by the team (where location of arrest is in-hospital and pre-hospital, and in-hospital only) and individuals (in relation to in-hospital arrests only).

The below information is selected analyses/data from the NCAA Report. The period of data covered by this Report is 01 April 2016 to 31 March 2017.

The NCAA report showed that our incidence of cardiac arrest on the wards is in the lower 6th compared to the national picture. The trust's survival to discharge is just below the national average (19.1% compared to 20%), but this is likely due to the number of patients who remained inpatients at the time the NCAA compiled the report.

**Table 8: NCAA reported numbers 2016/17**

| Period | Total number of admissions to your hospital^ | Total number of 2222 calls solely for cardiac arrest | Total number of reported cardiac arrests attended by the team that met the scope of NCAA | Total number of reported cardiac arrests attended by the team that met the scope of NCAA *(in-hospital only)* | Number of individuals *(in-hospital only)* |
|---|---|---|---|---|---|
| 01/04/2016 - 31/03/2017 | 43,847 | 110 | 77 | 50 | 47 |

**Chart 6: Rate of cardiac arrests attended by the team per 1000 hospital admissions 2013/14 – 2016/17**

[1] Whittington Health National Cardiac Arrest Audit 2017. Resuscitation Council (UK) & ICNARC

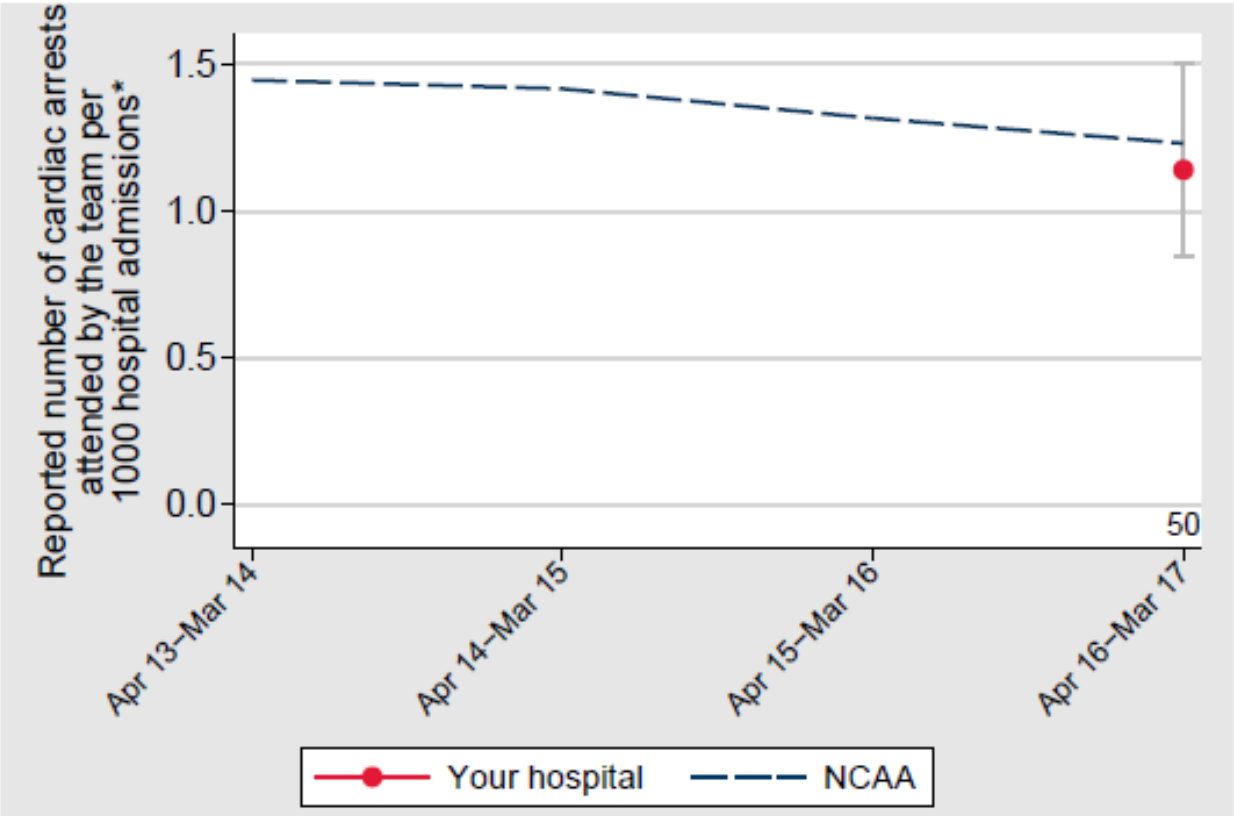



**Chart 7: Funnel plot of observed to predicted survival to hospital discharge 2016/17**

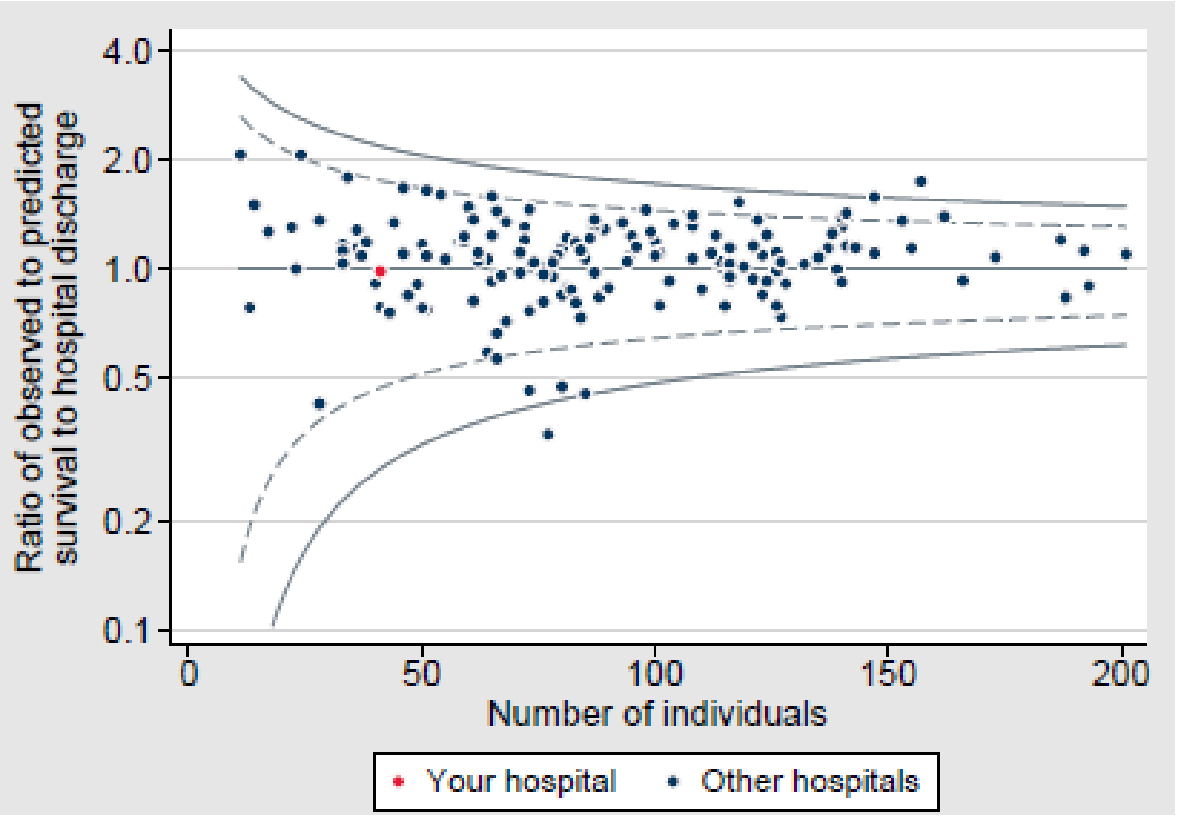



**Table 9: Observed to predicted survival to hospital discharge 2016/17**

| **Your hospital** | |
|---|---|
| Number of individuals | 41 |
| Number of observed survivors to hospital discharge | 9 |
| Number of predicted survivors to hospital discharge | 9.2 |
| Ratio of observed to predicted survival to hospital discharge | 0.98 |
| 95% confidence interval | (0.54,1.64) |

**Chart 8: Trend of observed to predicted survival to hospital discharge 2013/14 – 2016/17**

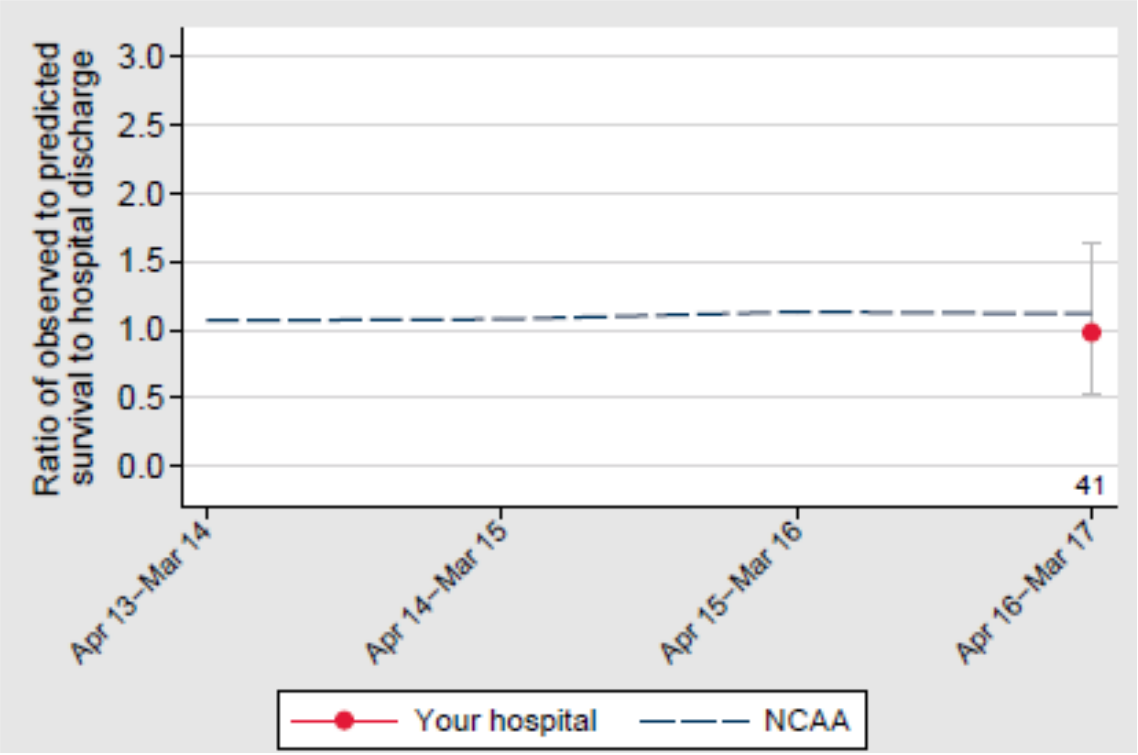
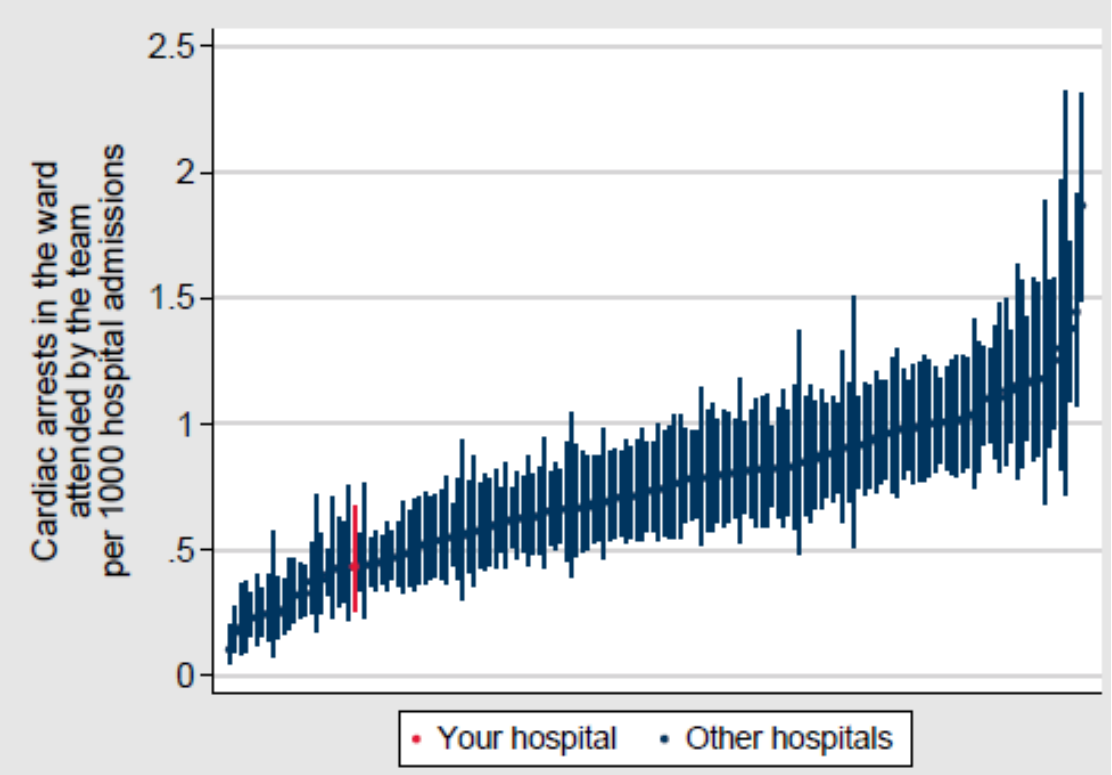



**Chart 9: Rate of cardiac arrests – hospital wards**



The key points to highlight with regards to the performance of this Trust in the National Cardiac Arrest Audit are;

1) This Trust performs very positively in terms of submitting a complete dataset to the audit.
2) The age profile of patients experiencing cardiac arrest (i.e. those patients aged between 16-64 versus patients aged 65 and over) is younger than the national picture. This is probably simply a reflection of the relatively younger local population in the part of London.
3) The rate of cardiac arrests per 1000 hospital admissions is not significantly different to the national average.
4) The number of cardiac arrests taking place on the inpatient wards (i.e. excluding those that occur in the emergency department) is considerably less (i.e. better) in the Whittington Hospital compared to the national average (see Chart 9).
5) The proportion of patients looked after on the Intensive Care Unit after their cardiac arrest is higher than the national average.
6) The rate of survival to hospital discharge is not significantly different from the national average.

The data for this Trust in the NCAA report provides assurance that our performance with regard to cardiac arrests is at least in line with the national performance, and that on our inpatient wards (see Chart 9) we have relatively few cardiac arrests compared to other hospitals nationally. The audit data does not in itself explain why we have fewer cardiac arrests on our inpatient wards than many other hospitals. A great deal of work has been done to prevent avoidable deterioration through the promotion of standardised safe patient pathways (for instance, for sepsis), to detect (for instance, through the improvement of the recording and reporting of vital signs), to proactively respond to deterioration (for instance, and through standardised protocols for the critical care outreach team to be involved, e.g. for acute kidney injury or sepsis.

A number of planned quality improvement initiatives may have a further positive affect on the reduction of the number of cardiac arrests on inpatient wards. Among these, a particularly important initiative is the forthcoming change to electronic documentation of vital signs (Care Flow Obs, formally known as Vitalpac) with a move to a protocolised rapid clinical response to vital sign evidence of patient deterioration (Care Flow Connect).

## 7. National Patient Safety Alert: Nasogastric tube misplacement: Continuing risk of death and severe harm (NHS/PSA/RE/2016/006)

In July 2016, NHS Improvement published a National Patient Safety Alert highlighting the continuing risk of death and severe harm as a result of nasogastric tube misplacement. Use of misplaced nasogastric and orogastric tubes was first recognised as a patient safety issue by the National Patient Safety Agency (NPSA) in 2005 and three further alerts were issued by the NPSA and NHS England between 2011 and 2013.The 2016 information was a stage two resource alert, calling all relevant NHS organisations to conduct a self-assessment against the national evidence-based resources available to ensure compliance with best practice. NHS Trusts were asked to develop and implement action plans to address any gaps in compliance and to present the findings to the Trust Board. Philippa Davies, Chief Nurse and Director of Patient Experience was nominated as the executive director responsible for overseeing delivery of the alert.

The self-assessment framework was divided into seven key areas; local policies, national safety guidance, equipment, competency-based training, clinical documentation, audit, and implementation of patient safety alerts. The Trust was compliant in all seven areas, however areas for improvement were identified with respect to procurement processes and maintaining an up to date competency database for naso-gastric training. These improvements are being monitored through the trust wide Patient Safety Committee. Full details of the self-assessment framework can be found in '*NHS/PSA/RE/2016/006: Nasogastric tube misplacement: continuing risk of death and severe harm: Self-Assessment framework to monitor compliance*'.

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

### Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) implementation and training project

We have been successful in bidding for funding from UCL Partners for 'ReSPECT – implementation and training' project.

The ReSPECT process is a new approach to encourage people to have an individual plan to try to ensure that they get the right care and treatment in an anticipated future emergency in which they no longer have the capacity to make or express choices. It is intended to respect both patient preferences and clinical judgement.

Nationally the ReSPECT process has been developed for the following aims:

- More conversations between people and clinicians
- More planning in advance
- Good communication
- Good decision-making
- Shared decision-making whenever possible
- Good documentation
- Better care

The primary local objective of this project will be to undertake a coordinated approach to embedding the ReSPECT process in the Islington area with a particular focus on nursing home staff and residents in three nursing homes in Islington. This will include the development of localised educational materials to support staff in adopting the ReSPECT process in Islington with a potential to adopt the same implementation and training model in Haringey.

Professionals who will be invited to participate:

- Ambulance service staff
- Community matrons
- Consultants, General Practitioners and Trainees in relevant areas
- Mental Health team members
- Multidisciplinary teams working in Emergency, Ambulatory care and Paediatric emergency settings
- Nurses – acute, district and GP based
- Nursing home staff and residents
- Voluntary sector staff

**UCL Partners Education Conference**

The trust is contributing to the University College London Partners (UCLP) Education Conference on Wednesday 6th December 2017. The trust will facilitate two workshops:

1) 'Using patient journeys to promote deep reflection that cuts across specialities and disciplines'. This is an experiential workshop facilitated by Caroline Fertleman (Paediatrician) and Rosemeen Stephenson (Children's Safeguarding Lead).

2) 'Getting to know you - the power of interprofessional patient focused education'. This workshop will introduce participants to each other actively using "speed dating" methodology focusing on appreciative inquiry, discussing bias and potential barriers to interprofessional education (IPE). Following this, four facilitators will host breakout discussion groups around experiences of "Learning Together from Patient Safety Incidents" workshops that the trust has been running in North Central London area for the previous 18 months.

**Learning Together Event – Learning disabilities**

The Learning Together from Patient Safety Incidents and Complaints for Learning Disability was held on 20th October 2017. 22 staff members attended the event and it was rated 4.75 by attendees (on a scale of 0 – 5, with 0 indicating a poor session and 5 indicating an excellent session).

**Grand Round**

Grand Rounds occur on Wednesday lunchtimes, each week is presented by a different team. On average the Grand Round attracts 42 attendees per session. Each week attendees are asked to complete an evaluation score rating the Grand Round from 0 (poor) – 5 (excellent). The average score for the seven Grand Rounds held 6th September – 18th October 2017 was 4.5. From 2016 the Grand Rounds have combined an academic and educational rigour with a renewed focus on the practical application of safety learning from individual clinical cases. Approximately one in four Grand Rounds are set aside for an explicit focus on learning from morbidity and mortality meetings that have been held in the Trust.

Over the same period Grand Rounds have shifted away from being an event for physician doctors and much more towards being a multi-disciplinary and multi-professional learning session. Grand Rounds are increasingly attended by nursing staff and allied-health professionals and pharmacists and other Trust workers as well as doctors, who are now attending from a wide-range of specialties.

## 9. References


1. NHS Digital Indicator Portal, (September 2017, NHS Digital), available from https://indicators.hscic.gov.uk/webview/
2. 'ReSPECT process', further information available from *http://www.respectprocess.org.uk/*
3. Whittington Health National Cardiac Arrest Audit (September 2017, Resuscitation Council (UK) & ICNARC)

Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

# Trust Board

## 6 December 2017

| | | | |
|---|---|---|---|
| **Title:** | October (Month 7) 2017/18 – Financial Performance | | |
| **Agenda item:** | **17/168** | **Paper** | **6** |
| **Action requested:** | To agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends. | | |
| **Executive Summary:** | The Trust reported a breakeven position for October (month 7) maintaining the year to date deficit of £1.1m. This is against the planned year to date deficit of £0.4m (and planned in month surplus of £0.7m).<br><br>Income was £0.6m favourable this month against plan with expenditure, both pay and non-pay, adverse to plan.<br><br>Whilst reporting a breakeven position at month 7, the Trust still faces significant risks in order to achieve its control total at year end. The most notable challenges remain the delivery of CIPs, currently £5.1m behind plan, and the delivery of activity and associated income. | | |
| **Summary of recommendations:** | The Trust Board is asked to:<br>• Note the financial results relating to performance during October 2017<br>• Grant delegated authority to the Finance & Business Development Committee to take the decision (at its December meeting) whether to change the end of year forecast, based on current performance, to show non-achievement of the Trust's annual Control Total | | |
| **Fit with WH strategy:** | Delivering efficient, affordable and effective services. Meet statutory financial duties. | | |
| **Reference to related / other documents:** | Previous monthly finance reports to the Finance & Business Committee and Trust Board. Operational Plan papers. Board Assurance Framework (Section 3). | | |
| **Date paper completed:** | 28 November 2017 | | |

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

# Financial Overview

The Trust is reporting a breakeven position in month 7 (October) against a planned surplus of £0.7m. This maintains the year to date deficit at £1.1m, which is against a planned deficit of £0.4m (for the year to date).

## Statement of comprehensive income

2017/18, Month 07 (October 2017)

| Statement of Comprehensive Income | In Month Budget (£000s) | In Month Actual (£000s) | Variance (£000s) | YTD Budget (£000s) | Ytd Actuals (£000s) | Variance (£000s) |
|---|---|---|---|---|---|---|
| NHS Clinical Income | 22,247 | 22,192 | (55) | 152,789 | 151,729 | (1,061) |
| *Sustainability & Transformation Funding (STF)* | *667* | *1,068* | 401 | *3,002* | *3,002* | *0* |
| | 22,914 | 23,260 | 346 | 155,791 | 154,731 | (1,061) |
| Non-NHS Clinical Income | 1,816 | 1,669 | (147) | 12,899 | 12,041 | (858) |
| Other Non-Patient Income | 1,950 | 2,321 | 371 | 13,650 | 15,225 | 1,575 |
| **Total Income** | **26,680** | **27,250** | **569** | **182,341** | **181,997** | **(344)** |
| | | | | | | |
| Pay | (18,010) | (18,621) | (611) | (127,053) | (126,950) | 103 |
| Non-Pay | (6,628) | (7,371) | (743) | (46,592) | (47,239) | (647) |
| **Total Operating Expenditure** | **(24,638)** | **(25,992)** | **(1,354)** | **(173,645)** | **(174,189)** | **(543)** |
| | | | | | | |
| **EBITDA** | **2,042** | **1,257** | **(785)** | **8,695** | **7,808** | **(887)** |
| | | | | | | |
| Depreciation | (721) | (668) | 53 | (5,047) | (4,676) | 372 |
| Dividends Payable | (345) | (346) | (1) | (2,420) | (2,422) | (2) |
| Interest Payable | (255) | (250) | 5 | (1,783) | (1,837) | (54) |
| Interest Receivable | 3 | 1 | (2) | 21 | 11 | (10) |
| P/L on Disposal of Assets | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **(1,318)** | **(1,263)** | **55** | **(9,229)** | **(8,924)** | **305** |
| | | | | | | |
| **Net Surplus / (Deficit) - before IFRIC 12 adjustment** | **724** | **(6)** | **(730)** | **(534)** | **(1,116)** | **(582)** |
| Add back impairments and adjust for IFRS & Donate | (13) | (8) | (5) | (91) | (55) | (37) |
| **Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments** | **737** | **2** | **(735)** | **(443)** | **(1,061)** | **(619)** |

The main driver for the breakeven position was an improvement in the level of income received compared to recent months. The income and activity section below provides further details regarding the improvement, but it should be noted that of the £0.6m favourable variance, £0.4m was linked to Sustainability & Transformation Funding (STF).

Originally it had been identified that as the Trust had not achieved all of the elements relating to the A&E target this would lead to a £0.4m reduction in the value of STF that could be claimed for quarter 2. However, the Trust has been advised by NHSI that subsequent validation and refinement of the calculation for the A&E delivery board target, indicates that the Trust does in fact qualify for the full STF payment for quarter 2. As a result the £0.4m reduction applied in Month 6 has been reversed, and included within the Month 7 position.

Expenditure (both pay and non-pay) is adverse to plan in-month, the main driver being delivery of CIPs, which across the Trust is at 46% of target.

At Month 7 the Trust is still forecasting achievement of its control total by year end, but this is dependent upon managing the key risks in relation to CIP delivery, and the delivery of activity and associated income. There is a continuing focus through the PMO, and ICSUs working with Finance, on identifying mitigating actions to offset the risks, and the impact this has on the Trust's ability to continue to forecast achievement of its control total.

# Income & Activity

Though overall income was £0.6m favourable against plan in Month 7, the Trust continues to be significantly under plan for NHS clinical income.

Year to date income is £0.3m adverse against plan, within which NHS clinical income is £1.9m adverse. This is offset by Other income being £1.6m favourable.

Points to note:

- Though Outpatient attendances improved in month, they continue to be below plan with an in month adverse variance of £0.1m and YTD adverse variance of £1.4m, the largest under-performances being in General Surgery, T&O and Dermatology. Though the ICSUs have plans in place to improve this under-performance they have failed to meet their recovery plans for the past two months.

- Elective and Outpatient Procedures continued to over perform though this was offset again by under performance in Day cases.

- Non electives improved in month with a £0.2m favourable variance, reducing the year to date adverse variance to £1.1m.

- Due to the nature of the contract signed, which has a 50% marginal rate applied to over or under-plan activity, the under-performance was offset by a favourable marginal rate adjustment of £0.1m

Month 07

| 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 | In Month Variance | YTD Activity | YTD Activity Actual | YTD Variance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Accident and Emergency | 893 | 961 | 68 | 6,166 | 6,343 | 177 | 5,123 | 6,099 | 976 | 35,898 | 39,838 | 3,940 |
| Adult Critical Care | 702 | 391 | (310) | 4,846 | 4,344 | (502) | 641 | 751 | 110 | 3,163 | 2,738 | (425) |
| Community Block | 5,858 | 5,859 | 0 | 41,037 | 41,037 | (0) | 0 | 0 | 0 | 0 | 0 | 0 |
| Day Cases | 1,238 | 1,176 | (62) | 8,281 | 7,742 | (540) | 1,809 | 1,617 | (192) | 12,247 | 11,022 | (1,225) |
| Diagnostics | 240 | 296 | 56 | 1,603 | 1,645 | 42 | 2,379 | 2,610 | 231 | 15,897 | 16,564 | 667 |
| Direct Access | 1,044 | 930 | (114) | 6,979 | 6,397 | (582) | 95,547 | 88,777 | (6,769) | 638,427 | 622,574 | (15,853) |
| Elective | 743 | 832 | 90 | 5,019 | 5,375 | 356 | 187 | 205 | 18 | 1,260 | 1,378 | 118 |
| Maternity - Deliveries | 1,110 | 1,142 | 33 | 7,665 | 7,538 | (127) | 334 | 339 | 5 | 2,304 | 2,224 | (80) |
| Maternity - Pathways | 801 | 773 | (29) | 5,354 | 5,105 | (249) | 750 | 716 | (34) | 5,013 | 4,788 | (225) |
| Non-Elective | 4,215 | 4,406 | 191 | 28,952 | 27,853 | (1,099) | 1,496 | 1,700 | 204 | 10,840 | 10,759 | (81) |
| OP Attendances - 1st | 999 | 958 | (41) | 6,679 | 5,917 | (762) | 5,253 | 5,127 | (126) | 36,626 | 33,164 | (3,462) |
| OP Attendances - follow up | 880 | 847 | (32) | 5,887 | 5,299 | (588) | 12,517 | 12,724 | 207 | 86,323 | 86,290 | (33) |
| Other Acute Income | 2,419 | 3,233 | 814 | 15,316 | 18,069 | 2,753 | 11,616 | 10,651 | (965) | 77,915 | 75,655 | (2,260) |
| Outpatient Procedures | 333 | 457 | 124 | 2,223 | 2,679 | 455 | 1,856 | 2,399 | 543 | 12,432 | 14,801 | 2,369 |
| **Total SLA** | **21,475** | **22,262** | **787** | **146,007** | **145,341** | **(666)** | **139,508** | **133,715** | **(5,793)** | **938,346** | **921,795** | **(16,551)** |
| **Marignal Rate** | 0 | (467) | (467) | 0 | 60 | 60 | | | | | | |
| | **21,475** | **21,795** | **320** | **146,007** | **145,401** | **(606)** | | | | | | |
| Other Clinical Income | 3,111 | 3,132 | 20 | 21,695 | 21,358 | (337) | | | | | | |
| Other Non Clinical Income | 2,094 | 2,322 | 228 | 14,638 | 15,238 | 600 | | | | | | |
| **Total Other** | **5,205** | **5,454** | **249** | **36,333** | **36,596** | **262** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Grand Total** | **26,680** | **27,250** | **569** | **182,340** | **181,997** | **(343)** | **139,508** | **133,715** | **(5,793)** | **938,346** | **921,795** | **(16,551)** |

# Monthly Run Rates – Expenditure

The Trust is reporting an adverse expenditure variance both in month and year to date. As previously reported the position includes the application of flexibilities as well as the benefit from the removal of booked agency shifts that were unfilled/not utilised.

In run rate the key highlights for pay are:

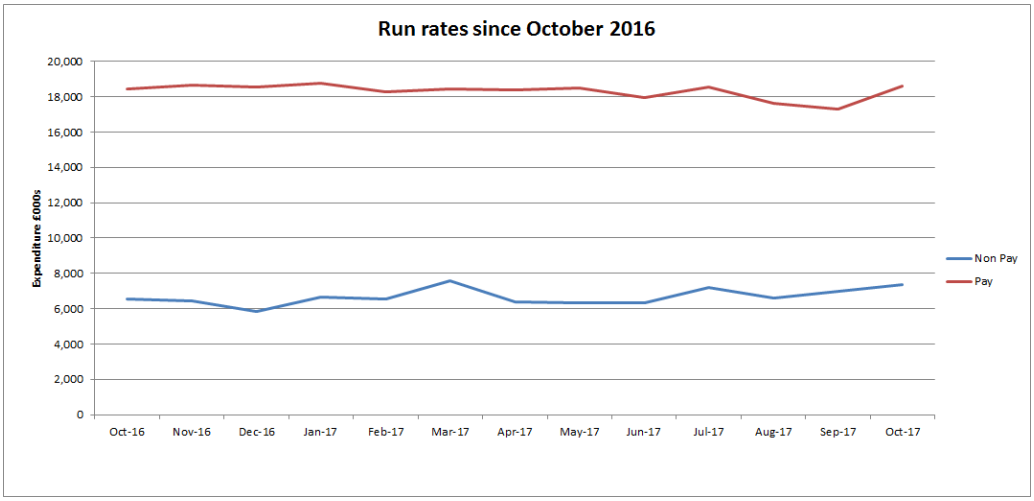
- Total pay expenditure for October was £18.6m, which is £1.3m more than the previous month and £0.3m more than the 12 months rolling average.

- As noted above, in comparison September's pay expenditure had included a one-off benefit from the removal of unfilled/non utilised agency shifts.

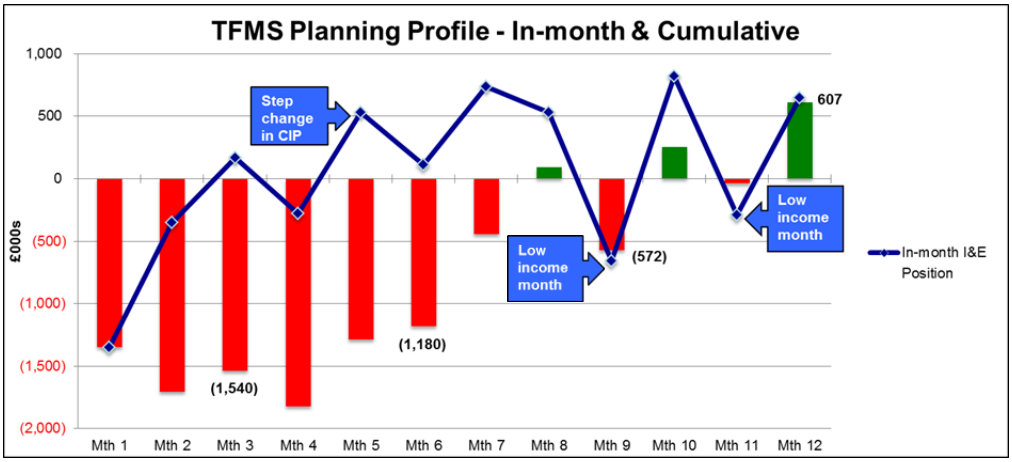
- Agency costs were £0.9m representing 4.8% of the October pay bill. The Trust has established a staffing taskforce led by the Director of HR to reduce the temporary staffing costs which includes a focus on agency spend.

Non pay expenditure for October was £7.3m, the highest it has been this financial year; the average for the first six months being £6.6m.

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




As can be seen from the chart above, in general terms there has been little variation in the pay and non-pay run rates, with non-pay showing an upward trajectory over the last 2 months and pay returning to its previous level in Month 7, following the one-off benefit in September (as mentioned above). In contrast the chart below shows that in terms of the Trust's annual planning submission, costs were expected to reduce from Month 5 following a step change in CIPs in order to achieve the annual control total.



# ICSU position

Table 1 below provides an analysis of the expenditure run rates by ICSU for 2017/18. When looking at ICSU trends it shows that cost is not falling at the rate required to achieve the CIP target. Table 2 provides an overview of each ICSUs position against budget.

## Table 1 – ICSU Expenditure Run Rates

**Pay**

| | Run Rate - Actual | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2017/18 Month 1 £'000 | 2017/18 Month 2 £'000 | 2017/18 Month 3 £'000 | 2017/18 Month 4 £'000 | 2017/18 Month 5 £'000 | 2017/18 Month 6 £'000 | 2017/18 Month 7 £'000 | Average for M1-6 | M7 variance from Avg |
| Children's & Young People | 3,896 | 3,955 | 3,945 | 3,941 | 3,862 | 3,941 | 3,804 | 3,923 | 119 |
| Clinical Support Services | 1,423 | 1,314 | 1,423 | 1,334 | 1,343 | 1,382 | 1,338 | 1,370 | 32 |
| Emergency & Urgent Care | 1,992 | 1,969 | 2,036 | 2,133 | 2,120 | 2,091 | 2,085 | 2,057 | -28 |
| Integrated Medicine | 2,953 | 2,926 | 2,820 | 2,779 | 2,780 | 2,963 | 2,999 | 2,870 | -129 |
| Patient Access, Prevention & Planned Care | 1,018 | 1,014 | 977 | 943 | 979 | 963 | 969 | 982 | 14 |
| Surgery & Cancer | 3,138 | 3,006 | 3,059 | 3,007 | 3,197 | 3,160 | 3,227 | 3,095 | -132 |
| Women's Health | 1,553 | 1,571 | 1,614 | 1,444 | 1,456 | 1,448 | 1,481 | 1,515 | 34 |
| Total Pay - ICSUs | 15,973 | 15,757 | 15,873 | 15,581 | 15,737 | 15,948 | 15,903 | 15,811 | -91 |

**Non Pay**

| | Run Rate - Actual | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2017/18 Month 1 £'000 | 2017/18 Month 2 £'000 | 2017/18 Month 3 £'000 | 2017/18 Month 4 £'000 | 2017/18 Month 5 £'000 | 2017/18 Month 6 £'000 | 2017/18 Month 7 £'000 | Average for M1-6 | M7 variance from Avg |
| Children's & Young People | 180 | 219 | 180 | 203 | 227 | 219 | 240 | 205 | -35 |
| Clinical Support Services | 1,506 | 1,563 | 1,543 | 1,522 | 1,602 | 1,356 | 1,632 | 1,515 | -117 |
| Emergency & Urgent Care | 223 | 234 | 327 | 277 | 281 | 276 | 252 | 270 | 18 |
| Integrated Medicine | 273 | 277 | 231 | 276 | 282 | 252 | 320 | 265 | -55 |
| Patient Access, Prevention & Planned Care | 154 | 134 | 187 | 220 | 201 | 194 | 280 | 182 | -98 |
| Surgery & Cancer | 973 | 836 | 858 | 874 | 874 | 1,063 | 832 | 913 | 81 |
| Women's Health | 163 | 197 | 193 | 119 | 112 | 128 | 94 | 152 | 58 |
| Total Non Pay - ICSUs | 3,472 | 3,461 | 3,519 | 3,490 | 3,579 | 3,488 | 3,650 | 3,501 | -149 |

**Combined Pay & Non Pay**

| | Run Rate - Actual | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2017/18 Month 1 £'000 | 2017/18 Month 2 £'000 | 2017/18 Month 3 £'000 | 2017/18 Month 4 £'000 | 2017/18 Month 5 £'000 | 2017/18 Month 6 £'000 | 2017/18 Month 7 £'000 | Average for M1-6 | M7 variance from Avg |
| Children's & Young People | 4,076 | 4,174 | 4,125 | 4,145 | 4,088 | 4,160 | 4,044 | 4,128 | 84 |
| Clinical Support Services | 2,929 | 2,877 | 2,965 | 2,856 | 2,945 | 2,738 | 2,970 | 2,885 | -85 |
| Emergency & Urgent Care | 2,215 | 2,203 | 2,363 | 2,410 | 2,402 | 2,366 | 2,337 | 2,326 | -11 |
| Integrated Medicine | 3,226 | 3,203 | 3,051 | 3,055 | 3,062 | 3,215 | 3,319 | 3,135 | -184 |
| Patient Access, Prevention & Planned Care | 1,172 | 1,148 | 1,164 | 1,163 | 1,180 | 1,158 | 1,249 | 1,164 | -85 |
| Surgery & Cancer | 4,111 | 3,843 | 3,917 | 3,882 | 4,071 | 4,223 | 4,058 | 4,008 | -50 |
| Women's Health | 1,716 | 1,768 | 1,808 | 1,563 | 1,568 | 1,576 | 1,575 | 1,666 | 91 |
| Total Spend - ICSUs | 19,445 | 19,217 | 19,392 | 19,072 | 19,316 | 19,436 | 19,553 | 19,313 | -240 |

## Cost Improvement Programme

Against the Trust's full year CIP target of £17.8m, to date £9.7m of plans have been agreed and recognised. As part of an ongoing process this value is being reconciled against the value of road-mapped schemes held by the Programme Management Office (PMO) to ensure that recognised schemes are still planned to deliver the values previously identified, with new schemes and opportunities being proposed and validated to address the gap compared to the target.

At Month 7, £4.4m has been recognised as delivered against the CIP programme, which is £5.1m adverse when compared to the Trust's planning submission. Originally it was expected that there would be a step change in delivery of savings from Month 5, which has not proven to be the case with accelerated delivery now expected later in the year.

Current performance by ICSU is:

| Integrated Clinical Service Unit | Annual Plan £'000 | Identified £'000 | Gap £'000 | YTD Target £'000 | YTD Actual £'000 | YTD Variance £'000 | YTD % achieved |
|---|---|---|---|---|---|---|---|
| Children's services | 3,065 | 1,559 | 1,506 | 1,639 | 594 | (1,045) | 36% |
| Clinical Support Services | 2,334 | 1,086 | 1,248 | 1,248 | 496 | (752) | 40% |
| Emergency & Urgent Care | 2,157 | 757 | 1,400 | 1,153 | 322 | (831) | 28% |
| Medicine, Frailty & Network Services | 2,132 | 1,160 | 972 | 1,140 | 520 | (620) | 46% |
| PPP | 874 | 368 | 506 | 467 | 445 | (22) | 95% |
| Surgery | 3,159 | 1,924 | 1,235 | 1,689 | 892 | (797) | 53% |
| Women's services | 1,498 | 882 | 616 | 801 | 334 | (467) | 42% |
| Estates & Facilities | 1,322 | 993 | 329 | 707 | 218 | (489) | 31% |
| Corporate | 1,236 | 1,010 | 226 | 661 | 591 | (70) | 89% |
| **Total** | **17,777** | **9,739** | **8,038** | **9,505** | **4,412** | **(5,093)** | **46%** |

As previously reported failure to achieve the required level of in-year cost reduction remains one of the key risks to delivering the Trust's control total. The PMO continues to lead on the work to address the current shortfall in plans, which includes:

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

At Month 7 the Trust has forecast that it will achieve its control total at year end. The identification of additional CIPs and other mitigating actions remains an important focus for the remainder of the financial year, and will continue to be assessed against operational financial risks to ascertain whether this will have an impact on the Trust's ability to continue to forecast achievement of its control total.

# Statement of Financial Position

| | As at 31 October 2017 £000 | Plan 31 October 2017 £000 | Plan variance 31 October 2017 £000 |
|---|---|---|---|
| Property, plant and equipment | 206,781 | 201,801 | 4,980 |
| Intangible assets | 3,108 | 1,823 | 1,285 |
| Trade and other receivables | 1,111 | 851 | 260 |
| **Total Non Current Assets** | **211,000** | **204,475** | **6,525** |
| | | | |
| Inventories | 1,768 | 150 | 1,618 |
| Trade and other receivables | 30,695 | 29,329 | 1,366 |
| Cash and cash equivalents | 6,751 | 3,930 | 2,821 |
| **Total Current Assets** | **39,214** | **33,409** | **5,805** |
| | | | |
| **Total Assets** | **250,214** | **237,884** | **12,330** |
| | | | |
| Trade and other payables | 44,541 | 40,803 | 3,738 |
| Borrowings | 944 | 4,144 | (3,200) |
| Provisions | 727 | 756 | (29) |
| **Total Current Liabilities** | **46,212** | **45,703** | **509** |
| | | | |
| **Net Current Assets (Liabilities)** | **(6,998)** | **(12,294)** | **5,296** |
| | | | |
| **Total Assets less Current Liabilities** | **204,002** | **192,181** | **11,821** |
| | | | |
| Borrowings | 59,364 | 63,825 | (4,461) |
| Provisions | 1,192 | 1,513 | (321) |
| **Total Non Current Liabilities** | **60,556** | **65,338** | **(4,782)** |
| | | | |
| **Total Assets Employed** | **143,446** | **126,843** | **16,603** |
| | | | |
| Public dividend capital | 62,404 | 62,404 | 0 |
| Retained earnings | (14,127) | (13,637) | (490) |
| Revaluation reserve | 95,169 | 78,076 | 17,093 |
| | | | |
| **Total Taxpayers' Equity** | **143,446** | **126,843** | **16,603** |
| | | | |
| **Capital cost absorption rate** | **3.5%** | **3.5%** | **3.5%** |

The key highlights for month 7 are:

**Cash:** The Trust is holding £6.8m in cash as at 31 October 2017. This is £2.8m higher than planned which includes £2.6m of STF monies that have been earmarked to spend on capital projects later in 2017/18. The Trust's cash position is being managed proactively and it is expected to return to plan later in the year as the capital programme accelerates.

**Receivables (Debtors)** are currently £1.4m above plan, which includes the raising of invoices for STF and resilience monies that are expected to be paid next month.

**Current Liabilities (Creditors and Borrowing)** are currently £0.5m above plan. During the year to date, the Trust has averaged 85% payment of creditors within 30 days, which is a significant improvement on 2016/17. As part of the annual planning process it was anticipated that cash support would be required from DH within the year. However, due to the strong cash position during the year this has not yet been required, and will be revisited in line with progress against the Trust's capital programme.

**Capital:** £1.5m of capital expenditure has been incurred in the year to date against a plan of £2.3m. The Trust still expects that capital expenditure will accelerate over the remaining months.

**Property, Plant & Equipment:** The value held at the end of October 2017 is £6.3m above plan. As previously reported the value will remain higher than plan due to the full valuation exercise undertaken as at 31 March 2017.

Executive Offices
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Whittington Health NHS

# Whittington Health Trust Board

## Wednesday 6th December 2017

| | | | |
|---|---|---|---|
| **Title:** | Trust Performance report November 2017 (October data) | | |
| **Agenda item:** | **17/169** | **Paper** | **07** |
| **Action requested:** | To receive assurance of Trust performance compliance | | |
| **Executive Summary:** | **Emergency Department (ED) four hours' wait**<br>Performance improved for the month ending at **90.1%** against the 95% target despite attendances up from previous month from **8053 to 8818.**<br>Steady progress has been made in implementing the SAFER bundle and FLOW which has improved overall bed occupancy. Median time to treat remains challenged at **82 minutes** against a target of 60 minutes and as part of ED improvement plan changes have been made to front of door assessment model which is expected to deliver improvement in this metric.<br><br>**Complaints:** Underachieving at 72.7%<br>**Cancer:** Overall achieved.<br>**RTT:** Overall achieved.<br>**DToC and Re-admission:** slight in both although expecting to see ongoing improvement in DTOCs as Discharge to Assess ( D2A) progresses. | | |
| **Summary of recommendations:** | That the board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan | | |
| **Fit with WH strategy:** | Clinical Strategy | | |
| **Reference to related / other documents:** | N/A | | |
| **Reference to risk and corporate risks on the BAF:** | N/A | | |
| **Date paper completed:** | 24th October 2017 | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Author name and title:** | | **Hester de Graag, Risk and Quality Manager** | | **Director name and title:** | | **Carol Gillen, Chief Operating Officer** | |
| **Date paper seen by EC** | | **Equality Impact Assessment complete?** | **n/a** | **Risk assessment undertaken?** | **n/a** | **Legal advice received?** | **n/a** |

Whittington Health NHS

# Integrated Performance Report

**November 2017**

**Month 7 (2017 – 2018)**

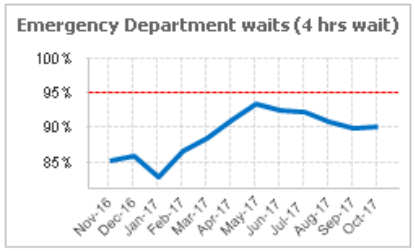


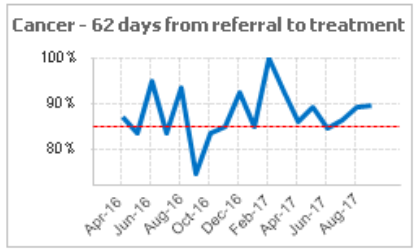
Date & time of production: 30/11/2017 10:45

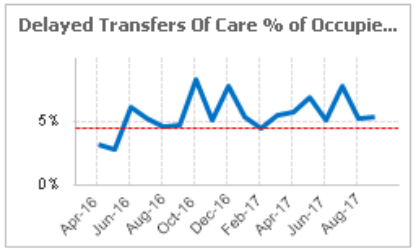
Date & time of production: 30/11/2017 10:45

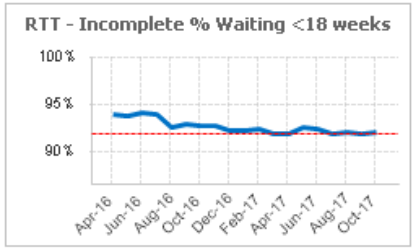
# Summary Page - Indicators

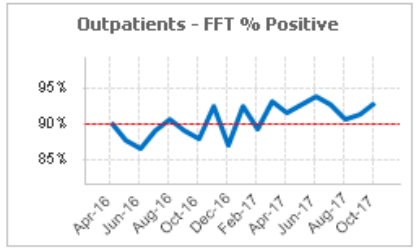
| Category | Indicator | 17_18 Target | Q3 Nov-16 | Q3 Dec-16 | Q4 Jan-17 | Q4 Feb-17 | Q4 Mar-17 | Q1 Apr-17 | Q1 May-17 | Q1 Jun-17 | Q2 Jul-17 | Q2 Aug-17 | Q2 Sep-17 | Q3 Oct-17 | 2017-2018 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ED | Emergency Department waits (4 hrs wait) | >95% | 85.1% | 85.8% | 82.9% | 86.6% | 88.4% | 91.1% | 93.5% | 92.4% | 92.3% | 90.9% | 89.9% | 90.1% | 91.5% |
| ED | ED Indicator - median wait for treatment (minutes) | <60 mins | 88 | 76 | 77 | 69 | 72 | 72 | 68 | 63 | 59 | 64 | 72 | 82 | 69 |
| Cancer | Cancer - 14 days to first seen | >93% | 95.5% | 93.4% | 94.8% | 96.8% | 94.6% | 93.2% | 93.2% | 95.3% | 95.7% | 94.7% | 94.3% | | 94.4% |
| Cancer | Cancer - 62 days from referral to treatment | >85% | 85.0% | 92.3% | 84.9% | 100.0% | 92.9% | 86.0% | 89.1% | 84.4% | 86.4% | 89.4% | 89.5% | | 87.4% |
| Admitted | Non Elective Re-admissions within 30 days | <5.5% | 5.9% | 6.0% | 4.8% | 5.7% | 6.3% | 6.1% | 6.0% | 5.8% | 6.8% | 7.1% | 6.4% | 7.0% | 6.5% |
| Admitted | Delayed Transfers Of Care % of Occupied Bed Days | <4.5% | 5.1% | 7.7% | 5.3% | 4.5% | 5.5% | 5.8% | 6.9% | 5.0% | 7.8% | 5.2% | 5.3% | | 6.0% |
| Access | RTT - Incomplete % Waiting <18 weeks | >92% | 92.8% | 92.2% | 92.2% | 92.4% | 92.0% | 92.0% | 92.6% | 92.4% | 92.0% | 92.1% | 92.0% | 92.1% | 92.2% |
| Outpatients | Outpatients - FFT % Positive | >90% | 92.6% | 87.0% | 92.5% | 89.4% | 93.1% | 91.6% | 92.8% | 93.9% | 92.8% | 90.8% | 91.5% | 93.0% | 92.5% |
| Community | Community - FFT % Positive | >90% | 98.2% | 98.7% | 98.0% | 96.8% | 96.0% | 98.5% | 94.9% | 93.9% | 94.8% | 96.7% | 96.5% | 95.3% | 95.6% |
| Staff | Staff - FFT % Recommend Care | >70% | | | | | 74.6% | | | 69.0% | | | 69.4% | | 69.2% |

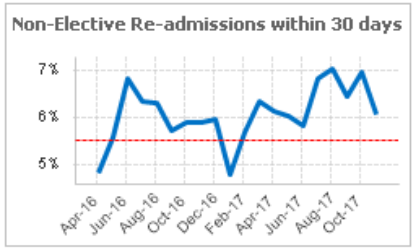





Date & time of production: 30/11/2017 10:45

# Safe Services - Indicators and Performance

| Category | Indicator | 17_18 Target | 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 | Q2 Aug-17 | Q2 Sep-17 | Q3 Oct-17 | 2017-2018 | Performance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Admitted | Admissions to Adult Facilities of pts under 16 yrs of age | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |  |
| Admitted | HCAI C Difficile | <17 | 0 | 0 | 0 | 1 | 1 | 2 | 3 | 0 | 1 | 0 | 1 | 3 | 10 |  |
| All Areas | CAS Alerts Outstanding | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |  |
| All Areas | Actual Falls | 400 | 30 | 45 | 56 | 45 | 31 | 31 | 44 | 45 | 34 | 31 | 27 | 34 | 246 |  |
| All Areas | Avoidable Grade 3 or 4 Pressure Ulcers | 0 | 1 | 3 | 2 | 1 | 2 | 2 | 2 | 3 | 2 | 2 | 3 | 3 | 17 |  |
| All Areas | Harm Free Care % | >95% | 92.6% | 93.2% | 94.3% | 92.9% | 92.5% | 93.2% | 93.9% | 96.6% | 93.5% | 93.8% | 95.1% | 94.1% | 94.3% |  |
| Maternity | Non Elective C-Section % Rate | <15% | 21.6% | 17.4% | 20.5% | 18.0% | 21.4% | 19.2% | 18.9% | 19.7% | 22.5% | 18.8% | 19.8% | 20.6% | 19.9% |  |
| All Areas | Medication Errors causing serious harm | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |  |
| Admitted | MRSA Bacteraemia Incidences | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |  |
| Admitted | Never Events | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |  |
| All Areas | Proportion of reported Patient Safety Incidents Causing Harm | N/A | 20.1% | 21.1% | 21.3% | 19.5% | 22.4% | 18.1% | 16.6% | 18.3% | 17.3% | 21.7% | 17.1% | 16.5% | 17.9% |  |
| All Areas | Serious Incidents | 0 | 8 | 3 | 4 | 5 | 4 | 2 | 4 | 4 | 3 | 6 | 2 | 5 | 26 |  |
| Admitted | VTE Risk Assessment % | >95% | 96.4% | 95.9% | 96.1% | 96.0% | 96.5% | 95.2% | 95.4% | 95.6% | 95.3% | 96.7% | 96.0% | | 95.7% | |



Date & time of production: 30/11/2017 10:45

## Safe Services - Commentary

**Avoidable pressure ulcers**

There were 2 in total both within the District Nursing Team one of which was a one category 4 and the other a category 3 avoidable pressure ulcer

Category 4 to sacrum: Rapid deterioration of a moisture lesion to a category 4 pressure ulcer as the patient's condition deteriorated rapidly. Patient nutritional input decreased over time. The team did not complete the appropriate documentation and assessments as the patient's condition deteriorated which may have reduce the degree of pressure ulceration.

Category 3 to the patient's hip. The team did not complete the correct documentation on admission to the case load and develop a preventative plan.

**Non Elective C-section rate**

20.6% - Slight increase from previous month (19.8%). The service has seen an increase in induction of labour rates and a proportion of these patients would then go ono to have an emergency section.  Working group has been developed to review the induction pathway.

**HCAI C.difficile**

There have been 3 Trust attributable Clostridium difficile infections within Whittington Hospital in October 2017. These were three of five patients on Cloudesley Ward with confirmed C. difficile infection and an outbreak was declared. Following an outbreak meeting/Post Infection Review and ribotyping of the specimens it was determined that three of the cases were not connected. Two patients, who were in the same bay, had the same ribotype and it was likely that they are due to cross-infection.

**HCAI MRSA Bacteraemia**

There have been no new MRSA bacteraemias reported in October 2017.

## Safe Services - Commentary

**Medication Errors causing serious harm**
Investigation underway as patient was readmitted as a result of medication error causing high harm. Root cause analysis being carried out in order to conclude investigation.

**Falls**
In January 2017, the trust launched the STOPfalls Quality Improvement project on the Seacoles units, in response to a number of serious harm falls. A STOPfalls bundle was developed in line with the Royal College of Physicians guidelines and PDSA (Plan, Do, Study, Act) methodology was used to implement a series of changes designed to embed the STOPfalls bundle in practice. These included ward-based training, STOPfalls assessment tool being embedded within standardised patient admission booklet, and the 'baywatch' initiative. Collectively these measures have resulted in a reduction in falls with harm on the Seacoles, and the project is now being rolled out trust-wide starting with the Care of Older Peoples Units.

**Serious Incidents**
The trust reported 5 Serious Incidents in October 2017.
Two serious incidents were reported for Integrated Medicine
Two serious incidents were reported for Surgery and Cancer ICSU
One serious incident was reported for Women Health ICSU
All serious incidents are being investigated using the Root Cause Analysis tool.

# Caring Services - Indicators and Performance

| Category | Indicator | 17_18 Target | 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 | Q2 Aug-17 | Q2 Sep-17 | Q3 Oct-17 | 2017-2018 | Performance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ED | ED - FFT % Positive | >90% | 82.1% | 83.8% | 83.4% | 83.9% | 83.0% | 84.0% | 87.4% | 84.0% | 85.5% | 83.0% | 80.4% | 81.6% | 83.9% | |
| ED | ED - FFT Response Rate | >15% | 16.6% | 16.6% | 14.6% | 16.0% | 14.6% | 16.9% | 15.6% | 13.8% | 13.1% | 13.7% | 12.6% | 13.2% | 14.2% | |
| Admitted | Inpatients - FFT % Positive | >90% | 92.7% | 95.8% | 92.1% | 96.1% | 94.1% | 98.0% | 94.2% | 97.0% | 95.8% | 95.2% | 97.7% | 98.3% | 96.5% | |
| Admitted | Inpatients - FFT Response Rate | >25% | 18.0% | 12.6% | 7.2% | 17.1% | 26.8% | 21.6% | 22.7% | 19.8% | 20.9% | 14.9% | 16.0% | 18.0% | 19.1% | |
| Maternity | Maternity - FFT % Positive | >90% | 93.8% | 94.8% | 88.0% | 89.4% | 92.4% | 93.6% | 90.2% | 88.1% | 92.7% | 89.4% | 92.4% | 94.9% | 91.9% | |
| Maternity | Maternity - FFT Response Rate | >15% | 12.8% | 24.6% | 30.4% | 24.0% | 27.8% | 24.7% | 22.2% | 20.1% | 23.5% | 30.1% | 18.5% | 37.4% | 25.3% | |
| Outpatients | Outpatients - FFT % Positive | >90% | 92.6% | 87.0% | 92.5% | 89.4% | 93.1% | 91.6% | 92.8% | 93.9% | 92.8% | 90.8% | 91.5% | 93.0% | 92.5% | |
| Outpatients | Outpatients - FFT Responses | 400 | 516 | 193 | 481 | 407 | 551 | 357 | 623 | 537 | 485 | 338 | 433 | 569 | 3342 | |
| Community | Community - FFT % Positive | >90% | 98.2% | 98.7% | 98.0% | 96.8% | 96.0% | 98.5% | 94.9% | 93.9% | 94.8% | 96.7% | 96.5% | 95.3% | 95.6% | |
| Community | Community - FFT Responses | 1500 | 880 | 549 | 697 | 1095 | 1169 | 725 | 1192 | 970 | 1224 | 858 | 940 | 731 | 6640 | |
| Staff | Staff - FFT % Recommend Care | >70% | | | | | 74.6% | | | 69.0% | | | 69.4% | | 69.2% | |
| All Areas | Complaints responded to within 25 working day | >80% | 100.0% | 89.3% | 66.7% | 90.0% | 100.0% | 100.0% | 83.3% | 93.9% | 76.0% | 81.0% | 72.2% | 72.7% | 82.4% | |
| All Areas | Complaints (including complaints against Corporate division) | N/A | 19 | 32 | 22 | 34 | 38 | 22 | 24 | 38 | 32 | 24 | 25 | 26 | 191 | |



Date & time of production: 30/11/2017 10:45

## Caring Services - Commentary

**FFT**

The response rate for ED adults was 17% in October 2017, however, ED paediatrics collected 1% of FFT feedback that month. The patient experience manager is currently working with the Head of Nursing to ensure that the surveys are available and in an appropriate format.

The inpatient wards achieved a 33% response rate in October. However, day cases achieved only a 7% response rate resulting in an overall rate of 18%. It is not clear why the response rate for day cases has reduced throughout this quarter. The patient experience manager is currently exploring the reason for the low response rate with the department and will agree actions as appropriate.

Feedback from community services continues to be below the required 1500 responses. It has been identified that some services have a backlog of feedback that has not been entered onto the patient survey database in a timely manner. The patient experience manager is working with services to identify what support is needed and can be provided to ensure feedback is entered on time each month. Some community services are collecting a very low level of feedback and are currently exploring options for collection (including SMS).

**Complaints**

During October 2017 the Trust closed 26 complaints; 22 required a response within 25 working days and 4 complaints were allocated 40 working days for investigation.

In regards to the 25 working day target, the Trust achieved a performance of 73%, falling short of its 80% target for the second month in a row. One complaint allocated 25 working days remains outstanding i.e. Surgery & Cancer. Of the 4 complaints allocated 40 working days, only one hit its target (25%).

The majority of the complaints were allocated to Surgery & Cancer 50% (13), Integrated Medicine 15% (4) and Women's' Health 15% (4). 8% (2) were designated 'high', 42% (11) were designated 'moderate' risk and 50% (13) were designated 'low'.

**Complaints cont..**

A review of the complaints for October shows that ‘medical care’ 23% (6) continues to be the main issue in the majority of patient complaints, followed by ‘communication’ 23% (6) and ‘appointments’ 11% (3).

In regard to ‘medical care,’ 33% of patients (2) felt that ‘inadequate treatment’ had been provided; in regard to ‘communication,’ 33% of patients (2) stated that a ‘lack of information’ had been provided; and in regard to ‘appointments’, 66% (2) patients raised issues around the ‘cancellation of appointments’ and/or ‘long wait for an appointment’.

Of the complaints that have closed, (including those allocated 40 working days), 24% (6) were ‘upheld’, and 48% (12) were ‘partially upheld’, meaning that at present 72% have been upheld in one form or another.

# Effective Services - Indicators and Performance

| Category | Indicator | 17_18 Target | 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 | Q2 Aug-17 | Q2 Sep-17 | Q3 Oct-17 | 2017-2018 | Performance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Maternity | Breastfeeding Initiated | >90% | 90.2% | 91.5% | 93.1% | 90.3% | 91.6% | 90.2% | 91.6% | 93.3% | 94.5% | 92.3% | 93.2% | 91.7% | 92.4% | |
| Maternity | Smoking at Delivery | <6% | 5.1% | 4.8% | 3.6% | 5.6% | 3.0% | 5.4% | 3.4% | 5.7% | 7.5% | 4.8% | 7.1% | 6.2% | 5.7% | |
| Admitted | Non Elective Re-admissions within 30 days | <5.5% | 5.9% | 6.0% | 4.8% | 5.7% | 6.3% | 6.1% | 6.0% | 5.8% | 6.9% | 7.1% | 6.4% | 7.0% | 6.5% | |
| Trust | Hospital Standardised Mortality Ratio rolling 12 months | 100 | 93.6 | 62.4 | 82.0 | 85.7 | 60.9 | 72.9 | 77.2 | 66.1 | 64.4 | | | | 70.3 | |
| Trust | Hospital Standardised Mortality Ratio rolling 12 months - weekend | 100 | 91.9 | 23.3 | 109.3 | 31.1 | 63.7 | 67.2 | 66.2 | 92.4 | 62.9 | | | | 72.8 | |
| Trust | Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 mont... | 1.14 | | 0.69 | | | 0.71 | | | | | | | | | |
| Admitted | Mortality rate per 1000 admissions in-months | 14.4 | 7.9 | 7.2 | 11.7 | 9.1 | 7.9 | 7.2 | 7.6 | 6.5 | 6.4 | 7.2 | 2.6 | 8.6 | 6.6 | |
| Community | IAPT Moving to Recovery | >50% | 47.1% | 52.4% | 50.4% | 49.1% | 48.4% | 50.3% | 53.0% | 56.4% | 52.3% | 56.5% | 55.1% | | 54.0% | |
| Community | % seen <=2 hours of Referral to District Nursing Night Service | >80% | | | | | | | | | | | 84.2% | 88.2% | 87.1% | |



Date & time of production: 30/11/2017 10:45

## Effective Services - Commentary

**Non Elective re-admission within 30 days**

The Trust has seen an increase in re-admission rates above the overall average performance in month 7. Integrated Medicine ICSU is carrying out 3 audits on readmissions rates, frailty discharges and the use of virtual ward/ambulatory care (results expected in January 2018 ), overall impact of discharge to assess (ongoing audit) and impact on speech and language services (completed). Results to date have shown when additional resource for speech and language has been made available there is correlation in the reduction of readmissions.

**Smoking at Delivery**

6.2% decrease from previous month 7.1%. The service continues to offer screening for all pregnant women for carbon monoxide levels at booking and at 28 weeks and refer women when necessary to the appropriate smoking cessation support.

# Responsive Services - Indicators and Performance

| Category | Indicator | 17_18 Target | 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 | Q2 Aug-17 | Q2 Sep-17 | Q3 Oct-17 | 2017-2018 | Performance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ED | Emergency Department waits (4 hrs wait) | >95% | 85.1% | 85.8% | 82.9% | 86.6% | 88.4% | 91.1% | 93.5% | 92.4% | 92.3% | 90.9% | 89.9% | 90.1% | 91.5% | |
| ED | ED Indicator - median wait for treatment (minutes) | <60 mins | 88 | 76 | 77 | 69 | 72 | 72 | 68 | 63 | 59 | 64 | 72 | 82 | 69 | |
| ED | Ambulance handovers waiting more than 30 mins | 0 | 45 | 68 | 113 | 68 | 60 | 28 | 14 | 40 | 27 | 23 | 35 | | 167 | |
| ED | Ambulance handovers waiting more than 60 mins | 0 | 4 | 22 | 37 | 13 | 3 | 1 | 0 | 7 | 4 | 2 | 1 | | 15 | |
| ED | 12 hour trolley waits in A&E | 0 | 1 | 0 | 2 | 3 | 2 | 5 | 4 | 3 | 2 | 4 | 3 | 0 | 21 | |
| Cancer | Cancer - 14 days to first seen | >93% | 95.5% | 93.4% | 94.8% | 96.8% | 94.6% | 93.2% | 93.2% | 95.3% | 95.7% | 94.7% | 94.3% | | 94.4% | |
| Cancer | Cancer - 14 days to first seen - breast symptomatic | >93% | 98.2% | 100.0% | 93.4% | 98.7% | 92.9% | 96.0% | 94.1% | 100.0% | 100.0% | 95.9% | 98.1% | | 97.2% | |
| Cancer | Cancer - 62 days from referral to treatment | >85% | 85.0% | 92.3% | 84.9% | 100.0% | 92.9% | 86.0% | 89.1% | 84.4% | 86.4% | 89.4% | 89.5% | | 87.4% | |
| 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% | |
| Cancer | Cancer - 62 Day Upgrade | | | | | | | | | | | | | | | |
| Access | DM01 - Diagnostic Waits (<6 weeks) | >99% | 99.8% | 99.1% | 99.1% | 99.6% | 99.2% | 99.0% | 99.1% | 99.1% | 99.0% | 99.0% | 99.1% | 99.1% | 99.1% | |
| Access | RTT - Incomplete % Waiting <18 weeks | >92% | 92.8% | 92.2% | 92.2% | 92.4% | 92.0% | 92.0% | 92.6% | 92.4% | 92.0% | 92.1% | 92.0% | 92.1% | 92.2% | |
| Access | Referral to Treatment 18 weeks - 52 Week Waits | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 1 | 1 | 0 | 5 | |

## Responsive Services - Commentary

| Tumour Type | Oct 2016 | Nov 2016 | Dec 2016 | Jan 2017 | Feb 2017 | Mar 2017 | Apr 2017 | May 2017 | Jun 2017 | Jul 2017 | Aug 2017 | Sep 2017 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breast | 100.0% | 100.0% | 100.0% | 92.3% | 100.0% | 90.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Gynaecological | - | - | 100.0% | 40.0% | 100.0% | 100.0% | 100.0% | 100.0% | - | 50.0% | 66.7% | 100.0% |
| Haematological (Excluding Acute Leukaemia) | 100.0% | 100.0% | - | - | 100.0% | 100.0% | 100.0% | 50.0% | 100.0% | - | - | - |
| Lower Gastrointestinal | 100.0% | 100.0% | 100.0% | 85.7% | - | 100.0% | 100.0% | 100.0% | - | 87.5% | 50.0% | 100.0% |
| Lung | 80.0% | - | 50.0% | 66.7% | - | 66.7% | 83.3% | - | 100.0% | 100.0% | 100.0% | - |
| Other | - | 100.0% | - | 50.0% | - | - | - | - | - | - | - | - |
| Skin | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Testicular | 100.0% | 100.0% | 100.0% | - | - | - | 100.0% | 100.0% | 100.0% | - | 100.0% | - |
| Upper Gastrointestinal | - | 66.7% | 100.0% | - | - | - | - | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Urological (Excluding Testicular) | 61.5% | 60.0% | 75.0% | 85.7% | 100.0% | 100.0% | 54.5% | 80.0% | 61.5% | 57.1% | 50.0% | 57.1% |
| **Total** | **83.3%** | **85.0%** | **92.3%** | **84.9%** | **100.0%** | **92.9%** | **86.0%** | **89.1%** | **84.4%** | **86.4%** | **89.4%** | **89.5%** |

# Responsive Services - Indicators and Performance

| Category | Indicator | 17_18 Target | 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 | Q2 Aug-17 | Q2 Sep-17 | Q3 Oct-17 | 2017-2018 | Performance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Theatres | Hospital Cancelled Operations | 0 | 6 | 2 | 15 | 7 | 5 | 6 | 9 | 9 | 2 | 6 | 8 | | 40 | |
| Theatres | Cancelled ops not rebooked < 28 days | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 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 | 267 | 348 | 236 | 192 | 255 | 245 | 300 | 210 | 334 | 250 | 252 | | 1591 | |
| Admitted | Delayed Transfers Of Care % of Occupied Bed Days | <4.5% | 5.1% | 7.7% | 5.3% | 4.5% | 5.5% | 5.8% | 6.9% | 5.0% | 7.8% | 5.2% | 5.3% | | 6.0% | |
| Maternity | Women seen by HCP / midwife within 10 weeks | >50% | 67.2% | 67.8% | 54.1% | 57.5% | 50.9% | 45.8% | 52.8% | 48.7% | 58.0% | 61.4% | 59.0% | 56.8% | 54.8% | |
| Community | IAPT Waiting Times for Treatment (% < 6 wks) | >75% | 94.3% | 97.2% | 97.2% | 93.6% | 93.3% | 97.5% | 96.5% | 94.7% | 94.7% | 97.3% | 98.8% | | 96.7% | |
| Community | Haringey New Birth Visits - % seen within 2 weeks | >95% | 92.2% | 91.6% | 91.3% | 93.3% | 87.5% | 88.6% | 93.8% | 91.9% | 88.7% | 89.3% | 89.4% | | 90.3% | |
| Community | Islington New Birth Visits - % seen within 2 weeks | >95% | 94.1% | 94.6% | 94.8% | 93.3% | 90.7% | 90.3% | 94.1% | 96.1% | 91.7% | 94.6% | 94.8% | | 93.6% | |
| Community | Haringey - HR1 % carried out before child aged 15 months | | | | | | | 43.8% | 37.5% | 45.1% | 44.7% | 41.2% | 32.9% | | 40.8% | |
| Community | Haringey - HR2 % carried out before child aged 30 months | | | | | | | 36.5% | 34.6% | 32.6% | 48.9% | 30.5% | 42.5% | | 37.5% | |
| Community | Islington - HR1 % carried out before child aged 15 mths | | | | | | | 70.6% | 67.3% | 71.0% | 60.9% | 69.0% | 73.2% | | 68.6% | |
| Community | Islington - HR2 % carried out before child aged 30 mths | | | | | | | 78.1% | 74.7% | 72.6% | 82.3% | 73.4% | 72.7% | | 75.7% | |
| Community | Haringey - 8wk Review % carried out before child aged 8 weeks | | | | | | | | 34.8% | 33.5% | 42.4% | 29.9% | 34.0% | | 34.9% | |
| Community | Islington - 8wk Review % carried out before child aged 8 weeks | | | | | | | | 42.1% | 43.1% | 46.2% | 48.5% | 39.1% | | 44.2% | |



Date & time of production: 30/11/2017 10:45

## Responsive Services - Commentary

**Emergency Department (ED) four hours' wait and Ambulance handover time**

Performance against the 95% target increased to 90.1% in October 2017 compared to the previous month, this was despite a continued increase in the acuity of patients. The improvement can be attributed to a strong focus on flow coordination throughout Whittington Health and onto other organisations through close working relationships particularly with Mental Health. The staffing position in both ED and across the wards was also improved. However the median time to treat remained challenged at 82 minutes against a target of 60. In order to improve the median time to treat improvements have been made to the front door assessment model which will embed over the next few weeks.

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

There were 0 12 hour trolley waits reported in October which is a significant improvement from previous months and reflects the ongoing work to streamline the pathway for MH patients as part of the work to embed the recommendations set out by ECIP.

**Cancelled Operations**

4 urgent/target patients were cancelled on the day in September 2017
3 urology patients were cancelled as there was no operating theatre nurses as we were unable to cover a gap in the rota. All patients were treated two days later. The issue regards covering gaps in the theatre rota and payment has been escalated to the executive team and this has been resolved recently.
1 urology patient not treated as notes were not available. Patient was treated within 28 days. Staff have been allocated to make sure that all notes are in place prior to day of surgery.

5 routine patients were cancelled on the day in September 2017
4 urology patients were cancelled as there was no surgeon. Currently there are a number of vacancies on the urology SpR rota which we are filling with bank/agency staff. On this occasion the bank/agency staff was booked but did not arrive. Therefore the list did not go ahead. Issues with covering junior doctor rotas in surgery is on the risk register as one of the ICSUs highest risks. All patients have been treated.
1 T&O patient was cancelled due to a previous case overrunning. This patient has been treated.

**Delayed Transfer of Care**

This indicator has maintained its overall performance. Impact of Discharge to Assess, on site social workers from local authorities and overall flow improvements has been positive. Bed capacity at St Pancras Hospital continues to be challenging, however a working group between key stakeholders has been set up to review capacity and flow improvement in December.

**Haringey and Islington New Birth Visits**

**New Birth Visit (NBV):** September 2017 births

**Islington:** 3.5% new births later than 10-14 days
Islington performance improved from 94.6% in August to 94.8% in September.

**Haringey:** 7.5% new births later than 10-14 days
Haringey's performance increased slightly from 89.3% in August to 89.4% in September.
Reasons given for late visits across both boroughs:
- in hospital (only acceptable exception)
- late notification/incorrect address
- interpreter unavailable
- HV error/cause

**Newly added indicators for Health Visiting, 8 weeks review and Health Review 1 and 2**

**8 week review**
Slight progress made in Haringey (34% from 29.9%) whereas there was a fall in coverage in Islington (39.1% from 48.5%); this review is a work in progress and is still largely targeted, in Islington this is in part due to current HV vacancies and in Haringey because the focus has been on 1 & 2 year reviews.

**Health Review 1 and 2 years**

**Islington:** increased coverage at 73.2% for 1 year review - highest performance to date this year. 2 year review is down slightly at 72.7% but consistent.

**Haringey:** significant fall from 41.2% to 32.9% for 1 year review - this is due to the cumulative backlog for children seen in June 2017 (this was cleared in July and improvement will be seen in next month's reporting)
Good improvement for 2 year review from 30.5% to 42.5%

# Well Led Services - Indicators and Performance

| Category | Indicator | 17_18 Target | 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 | Q2 Aug-17 | Q2 Sep-17 | Q3 Oct-17 | 2017-2018 | Performance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HR | Appraisals % Rate | >90% | 66% | 67% | 72% | 75% | 80% | 80% | 79% | 79% | 78% | 78% | 75% | 71% | | |
| HR | Mandatory Training % Rate | >90% | 81% | 82% | 81% | 82% | 82% | 82% | 82% | 82% | 82% | 82% | 79% | 80% | | |
| HR | Permanent Staffing WTEs Utilised | >90% | 88.1% | 87.7% | 87.7% | 87.8% | 87.8% | 88.7% | 88.9% | 87.4% | 86.1% | 87.4% | 87.3% | 87.9% | 87.7% | |
| HR | Staff FFT % recommended work | >50% | | | | | 60.5% | | | 54.5% | | | 53.3% | | 53.8% | |
| HR | Staff FFT response rate | >20% | | | | | 24.4% | | | 18.2% | | | 21.6% | | 19.9% | |
| HR | Staff sickness absence % | <3.5% | 3.9% | 3.7% | 3.8% | 3.7% | 3.2% | 3.4% | 3.3% | 3.6% | 3.3% | 3.5% | 3.4% | 3.7% | 3.4% | |
| HR | Staff turnover % | <10% | 14.9% | 15.4% | 15.3% | 15.1% | 14.3% | 14.8% | 14.4% | 14.0% | 14.7% | 15.0% | 14.4% | 14.1% | 14.5% | |
| HR | Vacancy % Rate against Establishment | <10% | 11.9% | 12.3% | 12.3% | 12.2% | 12.2% | 11.3% | 11.1% | 12.6% | 13.9% | 12.6% | 12.7% | 12.1% | 12.3% | |

| Category | Staff Type | 17_18 Target | 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 | Q2 Aug-17 | Q2 Sep-17 | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medical | Average staff cost per patient | | 88 | 101 | 94 | 89 | 125 | 107 | 91 | 95 | 96 | 97 | 97 | |
| Nursing | Average staff cost per patient | | 160 | 186 | 182 | 174 | 237 | 190 | 169 | 169 | 171 | 171 | 164 | |
| Other | Average staff cost per patient | | 178 | 200 | 188 | 194 | 256 | 217 | 198 | 194 | 209 | 205 | 209 | |



Date & time of production: 30/11/2017 10:45

## Well Led Services - Commentary

**Human Resources**

Mandatory training compliance has improved very slightly by 1% to 80%. Unfortunately appraisal compliance has dropped to 71%. Each of the ICSUs presented a department by department action plan on both these key indicators to at their Performance Review Meetings in October. Sickness absence is slightly over at 3.7% from the previous month at 3.4%. There is a slight improvement in turnover at 14.1%.

Vacancy rate has reduced against lightly to 12.01% - which is encouraging. However it is important to note that there continue to be high vacancy rates in registered nursing and midwifery.

# Activity - Indicators and Performance

| Category | Indicator | 17_18 Target | 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 | Q2 Aug-17 | Q2 Sep-17 | Q3 Oct-17 | Activity |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ED | ED Attendances | **8285** | 8271 | 8238 | 8254 | 7430 | 8527 | 8285 | 8699 | 8239 | 8537 | 7853 | 8052 | 8816 | |
| ED | ED Admission Rate % | | 16.6% | 17.5% | 17.2% | 17.1% | 16.9% | 17.2% | 17.3% | 17.3% | 16.4% | 17.4% | 17.5% | 18.0% | |
| Community | Community DNA Rate % | **<10%** | 7.6% | 7.9% | 7.6% | 7.5% | 6.9% | 7.1% | 7.0% | 7.6% | 7.3% | 7.8% | 7.7% | 8.2% | |
| Community | Community Face to Face Contacts | | 63805 | 53867 | 60460 | 56364 | 66462 | 52657 | 62772 | 61220 | 59676 | 51638 | 57147 | 58188 | |
| Admissions | Elective and Daycase | | 1876 | 1714 | 1879 | 1686 | 1850 | 1618 | 1790 | 1931 | 1904 | 1830 | 1827 | 1906 | |
| Admissions | Emergency Inpatients | | 2124 | 2110 | 2067 | 1926 | 2200 | 2117 | 2212 | 2131 | 2163 | 2136 | 2242 | 2455 | |
| Referrals | GP Referrals to an Acute Service | | 7648 | 6394 | 7098 | 6567 | 8314 | 6304 | 7614 | 7064 | 6911 | 7239 | 7107 | 7768 | |
| Referrals | % of GP Referrals that were completed via ERS | | 18.9% | 20.4% | 21.5% | 20.5% | 18.9% | 20.5% | 19.7% | 21.6% | 23.1% | 28.9% | 30.3% | 32.9% | |
| Referrals | % ERS Slot Issues | **<4%** | | | | | 36.1% | 35.1% | 32.7% | 39.1% | 35.7% | 25.0% | 22.4% | 17.3% | |
| Maternity | Maternity Births | **333** | 324 | 300 | 312 | 274 | 309 | 301 | 331 | 321 | 313 | 320 | 344 | 346 | |
| Maternity | Maternity Bookings | **377** | 365 | 319 | 323 | 308 | 382 | 309 | 414 | 304 | 337 | 335 | 293 | 370 | |
| Outpatients | Outpatient DNA Rate % - New | **<10%** | 11.3% | 12.7% | 12.4% | 11.8% | 12.0% | 12.3% | 11.9% | 11.2% | 11.9% | 12.6% | 11.3% | 11.0% | |
| Outpatients | Outpatient DNA Rate % - FUp | **<10%** | 10.0% | 11.7% | 12.5% | 12.1% | 11.9% | 11.6% | 11.7% | 10.2% | 11.6% | 12.0% | 11.1% | 10.4% | |
| Outpatients | Outpatient New Attendances | | 9638 | 7966 | 8839 | 8439 | 9207 | 7565 | 9402 | 9111 | 8620 | 8707 | 8796 | 9476 | |
| Outpatients | Outpatient FUp Attendances | | 19877 | 17244 | 18670 | 17067 | 18955 | 15634 | 18610 | 18978 | 17796 | 17309 | 17168 | 18475 | |
| Outpatients | Outpatient Procedures | | 6186 | 5628 | 5956 | 5244 | 5793 | 4980 | 6097 | 6355 | 5748 | 5785 | 6469 | 6987 | |
| Theatres | Theatre Utilisation | **>85%** | 83.7% | 83.5% | 72.8% | 81.1% | 82.7% | 84.9% | 85.9% | 82.7% | 83.4% | 80.8% | 81.2% | 86.1% | |



Date & time of production: 30/11/2017 10:45

# Average Tariff by Point of Delivery (POD)

| Category | Staff Type | 17_18 Target | 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 | Q2 Aug-17 | Q2 Sep-17 | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medical | Average staff cost per patient | | 88 | 101 | 94 | 89 | 125 | 107 | 91 | 95 | 96 | 97 | 97 | |
| Nursing | Average staff cost per patient | | 160 | 186 | 182 | 174 | 237 | 190 | 169 | 169 | 171 | 171 | 164 | |
| Other | Average staff cost per patient | | 178 | 200 | 188 | 194 | 256 | 217 | 198 | 194 | 209 | 205 | 209 | |

## Activity - Commentary

**Maternity Bookings**

Bookings have increased again, as per normal trends seen in the last three years

**DNA Rate**

DrDoctor has been implemented within Imaging for one month now, and first performance reviews show a reduction in DNA rates but we will be further reviewing all KPIs over the next few months. Children and Young People Services will be rolled out in November training across all booking staff will be taking place on the 22nd and 24th November. The full implementation plan across all ICSUs is running to plan.

**Average cost per patient**

The numbers of patients attending Whittington Hospital has been similar month on month. The Trust has a target to reduce staffing spend and this has not yet been achieved due to Agency CIPs not delivering.
Work programmes include increasing productivity to reduce the cost per 1,000 patients.

**Average tariff by POD**

The tariff changes each financial year based on national guidance and is affected by the type of treatment and complexity of patients treated. The activity has remained broadly flat. Day Case & Non-Elective average tariff increased from July to August, indicating a richer casemix, whilst Elective reduced, but all were broadly in line with previous months overall.

Item 17/170
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ISLINGTON

In partnership with

Whittington Health NHS

# Report on Section 75 (National Health Service Act 2006) Partnership Working between

# London Borough of Islington and Whittington Health NHS Trust

## 1. INTRODUCTION

This report covers the main achievements of during the financial year of 2016/17 in the provision of integrated services for adults and older people, and identifies the key priorities for 2017/18.

## 2. KEY AREAS OF ACHIEVEMENT 2016-17

### 2.1 Integrated Locality Team Working - Where we are now

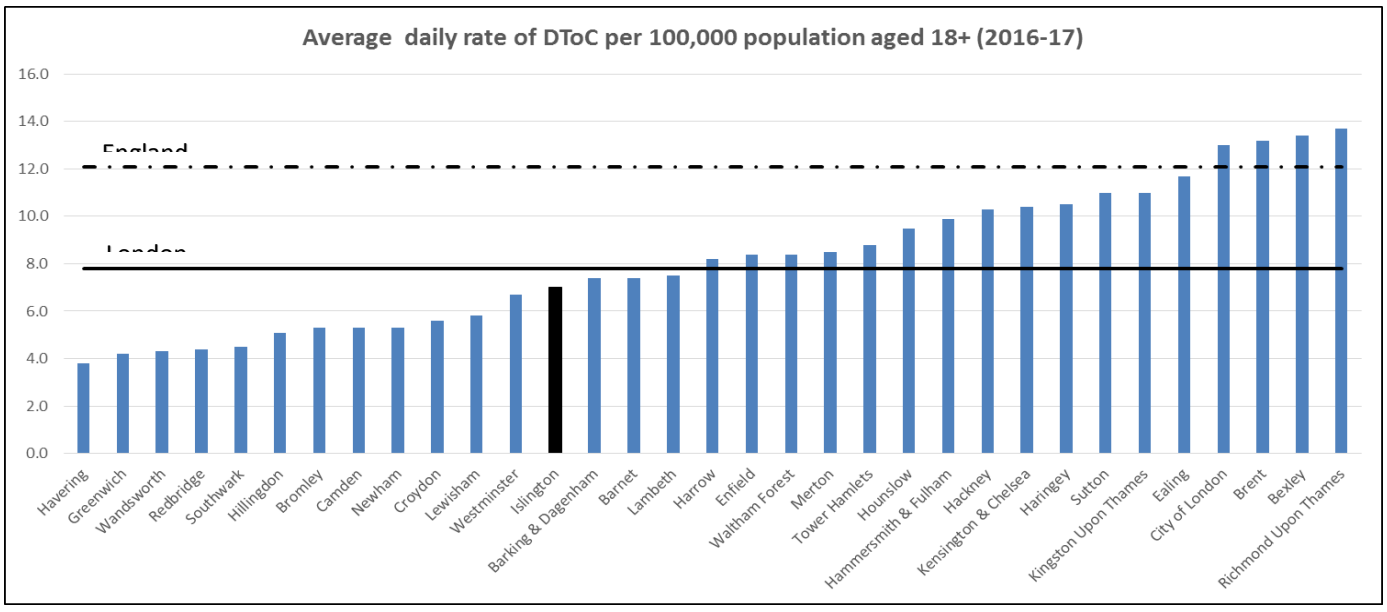
The service has updated its name to 'Integrated Community Services'. This is as a result of the implementation of the integrated GP networks and to prevent any confusion around referral pathways. The North and South integrated community teams continue to be co-located with the REACH services. The teams continue to work together to ensure that the services are delivered in partnership and are sustainable and able to respond to the increasing number of people being supported to remain in their own homes and independent for as long as possible.

Collaboration between Whittington Health and Islington continues in the following areas:

- Integration in line with healthcare priorities
- Development of discharge to assess pathways
- Retain co-location between health and social care staff in the community setting
- Integrate team meetings across community health and social care
- Ongoing work on admissions avoidance
- Growth in the use of Enhanced Telecare services

### 2.2 Care Closer to Home – reducing the time people have to spend in hospital

**Delayed Transfers of Care**




Islington continues to perform well in maintaining a low number of Delayed Transfers of Care (delays to people leaving hospital). This has been supported by: -

- Daily teleconferencing to discuss people with complex needs, and to agree actions across hospital and community teams towards discharge day and social work service over the winter period.
- The development of a "virtual ward" which enables patients to be discharged with reablement packages of care over the weekend.

- Prompt access to necessary equipment via TCES (community equipment service)
- A support worker (employed by Age UK) continues to carry out practical tasks necessary for hospital discharge, in a timely way e.g. getting keys cut, enabling essential work to prepare people's home for them to return to being carried out whilst they are still in hospital.
- Links to the voluntary sector, particularly Age UK, to support people on return home, for example following an attendance at accident and emergency.
- Continue review of whole system concerns with the Discharge Lead to monitor Delayed Transfers of Care for Islington residents and to escalate issues around delays.

Islington perform well when benchmarked with other providers and have consistently been a highly performing authority in London for the past 5 years. Performance has improved slightly in 2016-17 from 7.2 to 7.0 delayed transfers of care per 100,000 of the population. It is worth noting however that Islington rates of delay are still significantly lower than the London average of 7.8 delays per 100,000 of the population, and the England average of 12.1 delays per 100,000 of the population.

**2.3 Avoiding Hospital Admission**

Evidence shows that older people 'decompensate' and lose their independence during an extended hospital stay. Hospitals are an unfamiliar environment and patients lose their routine impacting on their ability to keep active and maintain muscle strength. There is a continued focus on supporting and caring for people at home in line with current clinical best evidence if they do not need an admission for acute medical care.

The **Facilitating Early Discharge Service (FEDs)** team changed their name this year to the **Specialised Therapy and Rapid Treatment Team (START)** to better reflect their role in admission avoidance in the Emergency Department, Clinical Decision Unit, Acute Assessment Units and Ambulatory Care. The service is covered every day from 08.30 to 20.30.

The aim of the team is to screen all patients who require therapy intervention as part of a full MDT assessment within 12 hours of admission. The assessment will determine the needs of the person and if they can be supported to return home safely thus avoiding admission to hospital. Early intervention and rapid assessment can also significantly reduce the time the person is in hospital for reducing the risk of decompensation and hospital acquired infection.

The team work closely with the Virtual Ward service, Social Services and Reablement to ensure a seamless link from hospital to home. Equipment that is required to promote independence, maintain function or improve safely can be rapidly accessed through a loan provider or via local pharmacy's using a prescription system.

The team also includes a technician who can undertake further assessment in the home environment immediately post discharge, for example, to complete a home safety check, practice with new equipment in the home setting, assess for non-urgent equipment such as bathing aids or outdoor mobility equipment and make onward referrals to both statutory and voluntary sector services when required.

A social worker is linked to the team on weekdays to provide assistance and support with assessing the more complex patients who present for example with, a higher level need or safeguarding concerns. At the weekends the team link closely with the duty social worker based in EDT for the same purpose.

These initiatives are successfully minimising the time people spend in hospital, supporting them to remain as independent as possible and providing the support they need to remain in their own homes.

Currently we are progressing to the Discharge to Assess Pathway working with colleagues in

Social care and Reablement to ensure when people are medically optimised they can leave the acute setting with the appropriate care and therapy provision they require to continue their recovery at home.

The work of **the Lead Nurse for Quality and Assurance**; a jointly funded post that sits in the Older Adults Commissioning Team within the Council, continues to improve the quality of care and clinical competency within the care homes, to prevent hospital admissions and to support reductions in hospital lengths of stay.

Currently, all of the homes have permanent home managers in post and for the exception of one home, good clinical leads, this has enabled effective working relationship with the GP and the wider MDT to manage the increasingly frail and complex residents and support the sustainability of the training and input being provided into the homes.

A number of actions identified in the 2015 -16 report have been completed whilst others remain in development. The achievements for the year includes:-

- Engagement of care home staff in cross sector training, in particular the Health Education England funded Care Certificate training.
- The development of the nursing audit tools.
- Embedding the process and systems for care home management of residents requiring PEG feeding.
- The move from the use of blister packs on care home nursing floors.
- Engagement of ICAT pharmacist to improved medicine management.
- The introduction of defibrillators into the care homes in support of London Ambulance Service response time.
- With the support of a Darzi fellow, the introduction of Treatment Escalation Plan guidance and template
- Full implementation of the pan London based Quality Performance Monitoring (QPM).

There is ongoing work required around the introduction of the 'Standard Operating Procedure for the management of deteriorating residents. This is being progressed in 2017 -18.

**The Home Managers Clinical Care Improvement Group (HMCCIG)**

This group set up in 2014 continue to meet bimonthly and work collaboratively to sustain clinical changes that have been implemented as well as those being proposed by specialist groups. The group is represented by a broad spectrum representation and include community based specialist teams (SALT, Dietician, OT, Physiotherapist Team), TVN, SAMH, DN, and other relevant resources. It remains the forum through which clinical concerns are highlighted and clinical improvements progressed.

The Lead Nurse continue to provide a monthly update of current and potential clinical risks and concerns to the RADAR group, which monitors the quality of care or service provided within the care homes and other care providers. The purpose of the group is to monitor areas of concern as well, engaged the wider MDT and share intelligence. The group is made up of operational and commissioning leads from both Health and Social Care including both the Council and CCG Safeguarding leads and key members of the HMCCIG i.e., SALT.

This collaborative approach has ensured that safeguarding concerns or investigations following complaints or feedback from the wider MDT with a clinical practice component are addressed quickly and effectively.

As a result of the quality monitoring, a number of quality improvement initiatives have been implemented during 2015 -16. These initiatives have been developed in part to address gaps in the delivery of effective and safe care, hospital avoidance and primarily to continue to improve the experience of residents in the homes.

The 2016-17 focus of the HMCCIG, in support of the relevant Sustainability Transformation Plans (STP), whole system thinking and approach is to sustain previous initiatives as well as develop the following:

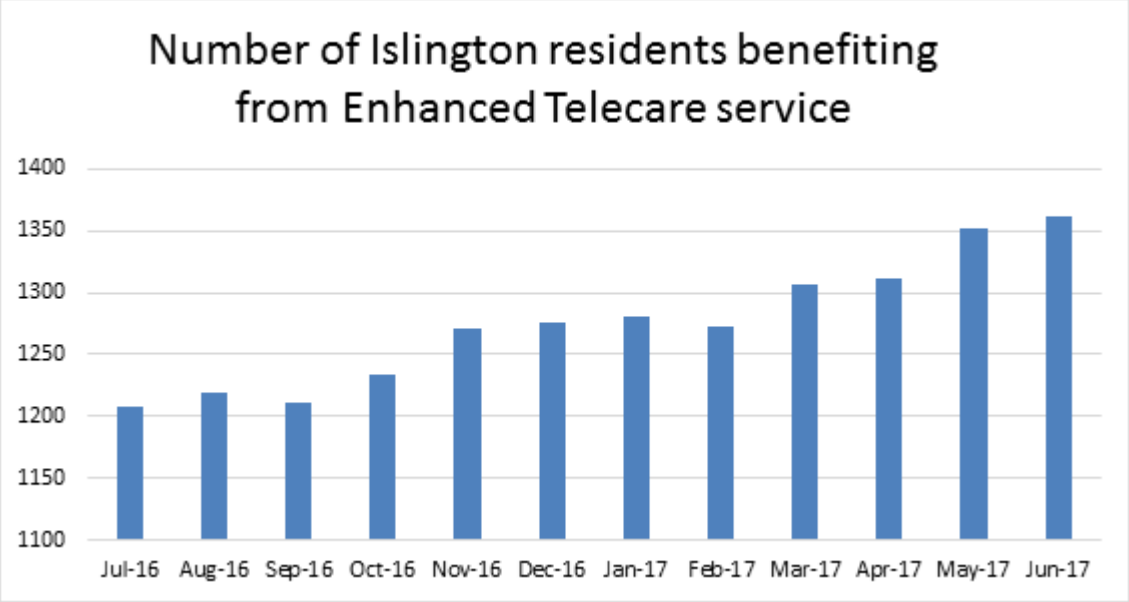
- A more skilled qualified and unqualified workforce in care homes who are well able to utilise the resources available to manage long term conditions within the home.
- Inclusion of care homes in integrated workforce planning within the local health and social care system
- With representation from the Lead Nurse, the Community Provide Education Network (CPEN) continues to engage care homes in cross sector training.
- Through recent transformation plan funding, the care homes will be in the position to access secondary sector training to gain extended clinical skills in support of Advance Care Planning and Treatment Escalation Plan e.g., management of syringe drivers and catherisation.
- Three Islington care homes, Bridgeside Lodge, Highbury New Park and Muriel Street will be supporting the UCLP pilot of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT). The pilot will start in September 2017 and is expected to add to achievements made to date around hospital avoidance.
- There is ongoing commitment to engage the care home providers in the various initiatives and projects designed to prevent unnecessary hospital admissions and improve experience of care within the care homes. Two of the home managers were invited and have made successful applications to take part in the Capital Nurse Senior Leadership programme. Alongside the Lead Nurse, the home managers will be focussing their project on 'Care homes internal infrastructure which will in turn support the 'Trusted Assessor' and secondary sector care clinical training objectives. There will also be the potential to develop clinical pathways that extends to care within the care home setting.

### 2.4 Telecare

The Enhanced Telecare team continue to provide support focussed on keeping Islington residents safer and more independent at home, as well as delaying admission into care homes and preventing hospital admissions. Telecare is available to residents in private dwellings as well as to people living in supported accommodations and sheltered schemes to assist onsite staff in managing their residents' needs and keeping people independent for longer.

In 2017/18 Islington is committed to further cementing telecare as a central part of our universal preventive offer. We have streamlined the referral process for enhanced telecare services, removing the requirement for a full social care assessment to trigger access to the service in line with the principles of the Care Act. To support and embed this process change, a mainstreaming training programme will be delivered in Autumn 2017 to ensure staff across adult social services are confident in using this new referral process and understand telecare's role as a universal preventive service for all residents who stand to benefit from the support it offers.

As a result of this shift, we expect to see a continued upward trend in the number of people receiving the service and we will be monitoring this closely.




## 3 PLANNED DEVELOPMENTS

### 3.1 Developing the locality-based model with GPs

There is a commitment to participation in the locality-based multi-disciplinary team working within GP localities. The participation of staff from both social services, and community health teams, e.g. therapists, district nurses and community matrons, and hospital consultant geriatricians, in a fortnightly primary care led teleconference brings together information and expertise from a wide range of professionals, and from acute and community care. This supports development of a coordinated care plan to support better management of people's well-being within a community setting. Whittington operationally manages the integrated networks (multiagency teams wrapped around primary care) through the Integrated Network Coordination (INC) infrastructure.

The development of locality based teams of health and social care staff will support effective links with the primary care localities, and development of multidisciplinary work to support management of patients most at risk of hospital admission or premature entry in to long term care.

Whittington Health has been a central part to the implementation of the Integrated Networks across Islington so far. The roll out of the programme began in February 2016 and Whittington Health have operationally managed and provided the ongoing infrastructure for the Integrated Networks. There are now 12 Integrated Networks running across Islington with 97% of GP practices part of a Network as of July 2017. In 2016/17, a total of 1440 patients were discussed via the Integrated Networks.

The relationships and ways of working that have been developed across health and social care organisations across Islington will be key to the successful delivery of the CHIN's as part of the STP. The Integrated Networks will be the foundation of the CHIN model and the Whittington Health admin, management and community matron teams involved will continue to work with partners to support the development. There will be a focus this year in strengthening links between the Integrated Networks and secondary care to ensure that they are embedded into business as usual and the relationships already created will be extended to acute clinical teams.

## 3.2 Discharge to assess

### 3.2.1 The approach

'Discharge to assess' is a new approach to hospital discharge which supports people who are medically ready to be discharged from hospital to get home more quickly by having their social care needs assessed at home rather than on the ward. This approach to discharge will help to improve patient flow through the hospital, ease demand on hospital beds and staff, and make better use of our community services and deliver better outcomes for patients.

Patient outcomes the approach supports include the following examples:

- They will have a much lower risk of getting a hospital acquired infection;
- They will keep their independence for longer
- They will rely less on long term care and receive care that is most appropriate to their needs
- They are likely to live longer.

### 3.2.2 The pilot

Discharge to assess has been piloted on a small scale to date for residents living in Islington through a partnership with The Whittington Hospital, University College London Hospital (UCLH) and Islington Adult Social Services. As of July 2017, a pilot pathway has been developed based on the Medway model for patients in pathway 1 (those who have additional care needs but can have these safely met at home).

The pilot has facilitated 3 discharges from the Whittington to date and 1 from UCLH. A further 6 discharges (5 from each hospital) will be delivered through the pilot, each building on learning from the previous example to ensure continued improvements.

Upon completion of the pilot, evaluation data will be reviewed and overall learnings considered ensuring the delivery of a sustainable pathway using discharge to assess as the primary discharge route for pathway 1 discharges going forward. Work is underway to scope requirements to deliver a pilot for pathway 2 and 3 patients in the coming months.

### 3.2.3 Upcoming priorities for delivery

Delivering effective discharge to assess pathways relies on safe and effective community services which are able to respond to referrals rapidly to facilitate same day discharge for medically fit patients. In particular, a strong therapeutic and reablement offer in the community is essential.

Priorities development areas for delivering these requirements in the coming months include;

- Ensuring accurate data is available from both acute and community partners to support well informed understanding of capacity requirements of the discharge pathways
- Delivering improvements in the efficiency, flexibility and capacity of our reablement service to support same day discharges as standard
- Developing a sustainable and robust single point of access for acute referrals to adult social care
- Securing additional resources required to fully staff this single point of access
- Developing a coherent admissions avoidance strategy which supports the discharge to assess approach.
- Ensure services are embedded for Winter 2017/18.
- Implementation timetable includes CHC beds from September 2017.

## 4 CONCLUSION

The strong partnership working between Islington Social Services and the health services within Whittington Health NHS Trust continues to move in a positive direction. Ongoing work such as Discharge to Assess will further develop local and locality services that are truly 'joined up' and delivered in a way that offers integrated care and support, to the benefit of Islington residents.

It is important to preserve the benefits of integrated working, and to use the opportunities to develop further integration of front-line teams over the coming year, as this will provide a better coordinated service to vulnerable people, and ensures that opportunities to share expertise and specialist knowledge are maximised, and that any duplication of work is minimised.

Carole MacGregor, Head of Islington Community Rehabilitation Service

Paul Attwal, Director of Operations, Integrated Medicine

August 2017

DRAFT

Whittington Health NHS

**WORKFORCE ASSURANCE COMMITTEE**

Minutes of meeting held on Wednesday 8th November 2017

ITEM 17/171
Doc 09

| | | |
|---|---|---|
| Present: | Jason Burn | Operational Director of Finance |
| | Carol Gillen | Chief Operating Officer |
| | Norma French | Director of Workforce |
| | Helen Gordon | Deputy Director of Workforce |
| | Graham Hart | Non-Executive Director (WAC Chair) |
| | Sarah Hayes | Deputy Chief Nurse |
| | Steve Hitchins | Trust Chairman |
| | Helen Kent | Assistant Director of Learning & OD |
| In attendance: | Lawrence Anderson | Medical Staffing Manager |
| | Kate Green | PA to Director of Workforce (minutes) |

17/28 Welcome and Introductions

28.01 Graham Hart welcomed everyone to the meeting.

28.02 Apologies for absence were received from Helen Taylor, Caroline Fertleman, Lisa Smith, Graeme Muir and Jana Kristienova.

17/29 Minutes of the meeting held on 2nd August

29.01 It was noted that some brief amendments had been made to the minutes of the August meeting, and Helen Gordon explained these were largely points of clarification. The minutes of the meeting held on 2nd August were therefore approved.

17/30 Matters arising

30.01 In answer to a question from Norma French about the migration of information from the finance ledger onto ESR, Helen Gordon replied that significant progress had been made during the summer, with both finance and ESR staff working extremely hard on this project. Although there were some additional steps to go through prior to completion data was considerably improved and Helen expected the majority of this to have been completed by 1st December.

30.02 Danielle Morrell had been invited to attend that day but had already booked annual leave; she was keen however to attend the next meeting. Graeme Muir had had insufficient time to complete his report therefore the GMC survey results would also be presented at a future meeting.

30.03 Graham Hart asked about the inclusion of benchmarking data within the review of ward nursing establishments. It was noted that this had been promised for the February meeting, and Sarah Hayes offered to follow this up with Lisa.

17/31 2017/18 Quarter 2 Workforce Report

31.01 Helen Gordon introduced the workforce report for the second quarter of 2017/18. She highlighted the following issues:

31.02 There had been no significant change in the vacancy factor but a great deal of activity was being undertaken around the recruitment and retention of nursing and midwifery staff.

31.03 Turnover remained a concern, it was known that some staff were unhappy, and retention was therefore an issue. Progress was being made however with mitigating initiatives such as improved career management and better support for new starters.

31.04 Utilisation of bank and agency staff had increased during the quarter. Norma had established an agency reduction taskforce to further address this via a series of 'deep dives' into individual ICSUs. In addition, the bank bonus scheme was due to start up again later that month and work was in hand to make it easier for staff to join the bank and generally to make bank working a more attractive option. In answer to a question from Graham about how usage had increased while costs appeared to have reduced, Jason explained that this was connected to the need to accrue for all shifts logged onto the system; a subsequent clean-up exercise conducted in December had brought about the reduction in spend seen. The overall position of both doctors and HCAs was static rather than improving so more radical steps were needed to address this.

31.05 Moving to recruitment, Helen explained that the report remained a little cumbersome but work was in hand to improve the data. Norma French informed the committee that she took weekly pipeline reports to the Executive Team.

31.06 Helen had established a new team to focus on nursing . Portuguese and Greek nursing staff were already arriving at the Trust, and around forty staff recruited from the Philippines were due to arrive from November onwards. Norma added that the team was now looking at the position on a ward by ward basis; she and Philippa had attended a recent meeting of senior nursing staff at which it had rapidly become clear that, though there was a great deal of recruitment activity being undertaken, front line staff were unaware. Communications had subsequently been improved including the establishment of a joint Recruitment/Temporary Staffing Office bulletin and staff were beginning to appreciate that work is ongoing to fill vacancies as swiftly as possible.

31.07 The nursing recruitment campaign currently taking place in India proved a success, with 138 offers having been made. Subject to acceptance of these offers, staff would be in place from next spring. The complex aspect of the process was the support required for bringing overseas staff into post including accommodation, visas, GP registration, banking arrangements etc. If arrangements went smoothly however this would have an extremely positive effect on existing staff morale. In answer to a question from Graham about retention of such staff groups, Sarah Hayes said that she had created a retention plan for nursing and midwifery staff, which could be circulated to committee members. Helen Gordon added that the nursing recruitment team was arranging a contract with a local housing association. A decision had also been made to offer financial support to existing overseas staff already in post who needed to renew their visas via ICSU budgets.

31.08 The Trust's sickness rate had reduced but remained over target, and Helen said that she would expand upon this later in the meeting under a connected agenda item.

31.09 There had been a slight decrease in compliance rates for appraisal and mandatory training, and it was not currently possible to gauge whether this was attributable to a seasonal factor or to a 'post CQC inspection' reduction.

It was noted however that both ICSUs and corporate directorates were setting clear trajectories for improvement in areas where particular problems had been noted.

31.10 Helen expressed her disappointment at the reduction of response rates to exit interviews, and would be researching why this had occurred. The main reasons for leaving related to promotion, and negative indicators relating to feeling under-valued and instances of bullying.

17/32 Employee Relations Activity

32.01 Helen Gordon explained that although the report had been presented in its usual format there was some under-reporting, which was largely down to staff shortage within the ER Team). This had caused a combination of data not being entered on the tracker and a reduction in the speed with which cases were resolved. There were however start dates confirmed for new members of staff.

32.02 Helen was clear that what this demonstrated was the need to move to an electronic casework management system, and this was something which Norma had already discussed with Richard Jones. . Jason Burn offered his assistance with the procurement of a system, emphasising that quotes would be needed in order to fulfill governance requirements. He would arrange to discuss this further with Richard Jones.

32.03 The management of formal sickness cases had also been affected by staff shortages within the team, however Helen stressed that the actual management of sickness remained the responsibility of line managers within the ICSUs and corporate directorates. With regard to the apparent lack of employee relations activity within the Integrated Medicine ICSU, Helen replied that there were live cases but these had not been entered on to the tracker, hence the lack of reported cases in this quarter.

32.04 Graham enquired whether it would be possible to break down cases by ethnicity, and Helen suggested that this was better analysed annually rather than quarterly which was agreed. Norma French referred to the presentation on WRES data given that morning by Yvonne Coghill at the Board seminar which had, she said, been unsettling in parts particularly concerning the proportion of ER cases involving staff from a minority ethnic background. It was noted that Bart's and the Royal Free have an independent fair treatment panel for cases which had proved very effective in reviewing such issues. Yvonne would be returning to the Trust to carry out further work related to the nine WRES standards.

32.05 Norma French described a piece of work on bullying and harassment carried out by Professor Duncan Lewis at Barts which had resulted in a significant improvement in their indicators. Together with Siobhan Harrington she had met with Professor Lewis, who was now working on a similar proposal for Whittington Health. Norma would share this proposal with Graham Hart once complete.

17/33 Report from the Guardian of Safe Working

33.01 Lawrence Anderson explained that the report presented contained an additional month's data in order to bring the report in line with other quarterly reporting cycles.

33.02 A total of 134 exception reports had been received during this period, mostly from FY1s. Whittington Health is not an outlier in this respect, the picture appears the same across

London and possibly nationally. There is evidence to support the fact that the more senior doctors in training become the less likely they are to report, and particularly when reaching senior registrar level and looking for consultant posts. The report has also been broken down to show the relative positions of existing staff and new starters, with the latter reporting more, although Lawrence would expect this to tail off over the coming months. The majority of reports came from the Integrated Medicine ICSU; this is to be followed up both through the next ICSU Board (which Lawrence will attend) and the Clinical Director.

33.03 One diary card exercise had been outstanding but had now been completed. This had involved SHOs in ED and had been returned as a Band 3 due to insufficient breaks having been taken. Lawrence was however clear that colleagues in ED had put a great deal of work into encouraging doctors to take breaks, including instigating a distinct piece of work led by Heidi Edmundson.

33.03 From 4th October 2017 all doctors in training at Whittington Health were on the new contract.

33.04 Norma enquired how this report was circulated to the ICSUs. Lawrence replied that Caroline Fertleman wished to create an intranet page, and Norma said that in the meantime she would personally send it to the ICSU 'triumvirates' after checking this with Caroline in case any further amendments needed to be made prior to circulation.

33.05 Helen Gordon had recently attended a session on engagement of doctors in training, and said that a key issue had been the transition from medical school to the workplace and treating patients and how Trusts could best support them in making this transition. This was particularly important given the legacy of the new contract negotiations. Graham Hart said that Julie Andrews had recently run a very successful session for the new doctors in training who had shown themselves to be an extremely bright and able group.

17/34 <u>Employment & Inclusion Annual Report</u>

34.01 It was noted that this report had already been to the Trust Board and to Trust Management Group therefore those present had already had opportunity to read it.

17/35 <u>Next steps on Equality & Inclusion</u>

35.01 Introducing this item, Helen Kent reported that over 100 people had attended the recent inclusion event, and a number of workstreams had subsequently been highlighted. There was a need to work on improving data, but the main priority was to be the establishment of networks to support people and help them to progress. The video of the day would be shared in due course.

35.02 No additional inclusion champions had been identified at the event, but it was hoped to further engage people once there was a greater understanding of how people wanted to be supported. Helen Gordon pointed out that there was a range of different models, and described a self-managed LGBT network which had worked very successfully at Guy's & St Thomas's. There was a need to review what was most needed at the Trust and then present the available options. Norma added that there also needed to be a clear timeline for the work.

35.03 Steve Hitchins said that there was a clear need to demonstrate commitment from the top as this was an area of work which had not been progressed as swiftly as he would have liked, and the Board had assured Yvonne Coghill that morning that action would be taken on inclusion; this would include a focus on the nine WRES indicators. Norma French would pick this up with Charlotte Johnson.

17/36 Date of next meeting

36.01 The next meeting of the Workforce Assurance Committee would take place on 12 February.

Action log

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| 22.09 | Danielle Morrell to be invited to the next meeting which would look in more detail at the Emergency & Urgent Care ICSU | NF | February WAC |
| 25.02 | Benchmarking data from other Trusts to be included in future nursing establishment reports | LS | February WAC |
| 27.01 | Report setting out results of GMC survey to be commissioned for next meeting | KG | February WAC |
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| 32.02 | JB to meet with RJ to assist with the procurement of an electronic casework management system | JB/RJ | November |
| 32.05 | Norma to share details of Prof. Lewis proposal on dealing with bullying in the workplace once complete | NF | Pending |
| 35.03 | Norma to discuss next stage of the inclusion work with Charlotte Johnson | NF | November |