Whittington Health
NHS Trust

TRUST BOARD
PUBLIC

14.00 – 17:00
Wednesday 25th April 2018

Whittington Education Centre
Room 7

NHS
Whittington Health
NHS Trust

Meeting	**Trust Board – Public**
Date & time	**25th April 2018 at 1400hrs – 1700hrs**
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
Carol Gillen, Chief Operating Officer
Michelle Johnson, Chief Nurse & Director of Patient Experience

Attendees
Helen Taylor, Deputy Director of Strategy
Juliette Marshall, Communications Lead
Norma French, Director of Workforce

Secretariat
Susan Sorensen, Interim Corporate Secretary
Kate Green, Minute Taker

Contact for this meeting: susan.sorensen@nhs.net

Agenda Item		Paper	Action & Timing
Patient Story			
18/049	**Patient Story** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	*Verbal*	*Note* 1400hrs
18/050	**Declaration of Conflicts of Interest** *Steve Hitchins, Chair*	*Verbal*	*Declare* 1420hrs
18/051	**Apologies & Welcome** *Steve Hitchins, Chair*	*Verbal*	*Note* 1425hrs
18/052	**Draft Minutes, Action Log & Matters Arising 28 March 2018** *Steve Hitchins, Chair*	1	*Approve* 1430hrs
18/053	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Note* 1440hrs
18/054	**Chief Executive's Report** *Siobhan Harrington, Chief Executive*	2	*Discuss* 1450hrs
Patient Safety & Quality			
18/055	**Serious Incident Report Month 12** *Richard Jennings, Medical Director*	3	*Approve* 1500hrs
18/056	**Quarterly Safety and Quality Board report** *Richard Jennings, Medical Director*	4	*Note* *1510hrs*
18/057	**Annual Safeguarding Children Declaration** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	5	*Approve* *1530hrs*

18/058	**Improving mental health care in the emergency department; an external review by Verita, and the Trust response** *Richard Jennings, Medical Director*	6	*Discuss 15500hrs*
Operational Performance and Planning			
18/059	**Financial Performance Month 12** *Stephen Bloomer, Chief Finance Officer*	7	*Approve 1600hrs*
18/060	**Performance Dashboard Month 12** *Carol Gillen, Chief Operating Officer*	8	*Approve 1615hrs*
18/061	**Risk Register Summary Report** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	9	*Discuss 1630hrs*
18/062	**Annual Operational Plan** *Helen Taylor, Deputy Director of Strategy* *Stephen Bloomer, Chief Finance Officer*	10	*Approve 1625hrs*
Strategy and Governance			
18/063	**Trust Operational Objectives** *Helen Taylor, Deputy Director of Strategy*	11	*Note 1635hrs*
18/064	**Risk Management Strategy** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	12	*Note 1640hrs*
18/065	**Register of Deed of Execution and Seal** *Siobhan Harrington, Chief Executive*	13	*Approve 1645hrs*
18/066	**Sub-Committee Minutes:** (as available) 14.1 Quality (14 March) 14.2 Charitable Funds (21 March)	14	*Note 1650hrs*
AOB			
	None notified to the Trust in advance		
Questions from the public on matters covered on the agenda			
	None notified to the Trust in advance		
Date of next Trust Board Public Meeting			
30 May 2018 -1400hrs-1700hrs -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 Susan Sorensen, Interim Corporate Secretary at Trust Headquarters, Jenner Building, Whittington Health, Magdala Avenue, London N19 5NF or susan.sorensen@nhs.net or www.whittingtonhealth@nhs.net

Whittington Health
NHS Trust

ITEM: 18/052
Doc: 1

The minutes of the meeting of the Trust Board of Whittington Health held in public at 14.00hrs on Wednesday 28th March 2018 in the Whittington Education Centre

Present:	Greg Battle	Medical Director, Integrated Care
	Stephen Bloomer	Chief Finance Officer
	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
	Michelle Johnson	Chief Nurse
	Tony Rice	Non-Executive Director
	Anu Singh	Non-Executive Director
	Yua Haw Yoe	Non-Executive Director
In attendance:	Janet Burgess	London Borough of Islington
	Norma French	Director of Workforce
	Kate Green	Minute Taker
	Susan Sorensen	Interim Corporate Affairs Lead
	Julie Andrews	Consultant/Associate Medical Director

Defend the Whittington Coalition

A delegation from the Defend the Whittington Coalition was present to protest against the Board's decision to enter into a strategic estates partnership with the company Ryhurst.

18/29 Welcome and apologies

29.01 Steve Hitchins welcomed everyone to the meeting. No apologies for absence had been received.

18/30 Patient Story

Michelle Johnson introduced James Connell, Patient Experience Manager, and Janet Edwards, Service Manager for endoscopy. The patient at the centre of the story had been unable to attend, so Janet was to recount her story on her behalf.

Janet introduced the story by explaining to Board members that she frequently visited the endoscopy unit to check that all was well, and on this occasion had found the patient prepared for her procedure in a hospital gown, cold, and with little knowledge about why she had been kept waiting. Her daughter had been with her as the hospital had been unable to book an interpreter. It had turned out that the reason the patient had been kept waiting was because she had requested a female clinician and the composition of the day's lists had meant she had been forced to wait longer than usual.

Janet had immediately arranged for blankets to be placed in the waiting area for patients to use should they need them. She was also arranging for 'you said, we did', notice boards to be put up, and had asked for a volunteer who could monitor patients' waits and the information given to

them. The patient had been contacted a number of times since her appointment, and had expressed satisfaction with the procedure, describing the consultant who had treated her as 'amazing'.

In answer to a question from Deborah Harris, Janet explained that once patients were in the waiting area, they were safe, but not in the immediate view of staff so on occasion not immediately provided with sufficient information about waiting times or what was to happen next should someone's procedure take longer than expected. She had presented at the Endoscopy Users' Group the previous week, and feedback had been exceptional.

The Board discussed having information available in different languages, but given the multiplicity of languages spoken in the boroughs served by the Trust it was understood that this was difficult; visual images had worked well in ED and Janet favoured this approach. James added that information in different languages could be made available for patients on the internet.

Greg Battle said that this was a good example of where clinical care was excellent but the overall patient experience had failed through faults in supporting areas. He cited the use of DrDoctor, where reminders were sent through to patients as text messages and backed up with additional information showing procedures and illustrations. Janet confirmed this had been installed and so far was running well. Richard Jennings commented that he had not recently seen a formal complaint about the endoscopy service, and asked Janet what, in her view, was the biggest area of risk; she replied that appointments scheduling was probably her greatest concern. Janet Burgess had this week received a letter about the service and would forward it to Richard, who confirmed that if this was an issue which had been resolved locally and informally he might not have been made aware of it.

18/31 Declaration of Conflicts of Interest

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

18/32 Draft Minutes, Matters Arising & Action Log

32.01 The minutes of the Trust Board meeting held on 28th February were approved.

32.02 Action log

13.02: Stephen Bloomer confirmed that 270 fire marshals had been trained against a target of 300. In answer to a question from Deborah Harris about the team's monitoring of whether all these staff remained within the organisation, Stephen confirmed that they did, and all these staff remained in place to date

32.03 All other items on the action log were scheduled for discussion on the agenda.

18.33 Chairman's Report

33.01 Steve Hitchins began his report by saying he was pleased to inform the Board that the Trust had been awarded the top grade in baby initiatives run by Unicef; the event had been attended by Dominic West. Discussions had also been held with the Cloudesley Trust (connected to the ward of the same name) and the Cripplegate Foundation. It was noted that both Susan Sorensen and Janet Burgess were on the Board of the former.

33.02 Other visits and events attended by Steve in the month since the last meeting had included:

- the heart failure patients' progress group
- an event on thalassaemia services in Tottenham, where the Trust had been commended for having the only weekend service available in the area
- the London Metropolitan University's employers day
- the Rotary Club quiz
- the TB awareness day held the previous Monday
- the celebration of the 'massive' improvements to the outpatient service.

33.03 Within the last two days spring daffodils donated by the Queen had been distributed to hospital and community services across the Trust. There had also been generous donations of Easter Eggs from staff and other stakeholders and companies included a very generous donation from Transport for London. Norma French added that she had personally taken delivery of 4000 cream eggs for staff which had been arranged through the Occupational Health Department. Members of the Arsenal football team had also visited the hospital.

33.04 Looking forward, Steve informed the Board that the annual London Mayors' Walk from the Whittington Stone to Mansion House would take place on 8th April – all were welcome to attend – and there were plans to commemorate the 70th anniversary of the NHS on 5th July.

33.05 Moving on to goodbyes, Steve had attended Director of Social Care Sean McLoughlin's leaving event at Islington. He also noted that this was Greg Battle's last Board meeting prior to his retirement the following day, and the Board joined with him in expressing a huge thank you to all that Greg had contributed to the Trust and particularly to its integrated care agenda.

18/34 Chief Executive's Report

34.01 Introducing her report, Siobhan began by informing the Board of two pieces of news which had happened since its production. The first was the announcement, the previous day, that there were plans for NHSE and NHSI to work more closely together from September and would be having an integrated structure. The second was Theresa May's announcement that that a longer-term funding strategy for the NHS was required.

34.02 Siobhan echoed Steve's thanks to Greg Battle, who would be greatly missed. A GP replacement had been appointed, Dr Sarah Humphery, a partner from the Goodinge Practice in Islington. She also expressed her thanks to Julie Andrews, who was standing down after eleven years as DIPC, saying that Julie had made a remarkable contribution in this area. Michelle Johnson would be taking over this role from 1st April.

34.03 In terms of quality and safety the Trust had remained extremely busy over the past month and it had been a very challenging time. Siobhan had observed that staff were tired, and expressed her thanks to everyone, on behalf of the Board, for their hard work. Michelle had submitted the Trust's response to the CQC report and this would be circulated to Board members. The Trust had met all the regulatory actions apart from patient flow through ITU, which would take longer to implement.

34.04 Turning to the ED pathway, Siobhan said that the Trust had hoped to achieve a 90% performance against the 95% target, but had not managed this and was likely to end the year having achieved an overall performance of 89.5%. This however still placed Whittington Health amongst the top 5/6 highest performers in London. The Trust had failed to meet the cancer standard for 62 days.

34.05 Siobhan announced that Dr Jo Sauvage had been appointed Chair of the Haringey & Islington Wellbeing Partnership Sponsor Board.

34.06 Stephen Bloomer would be giving a full report on the Trust's financial position later in the meeting, but Siobhan was pleased to announce that the Trust was on track to meet its control total by the year end. Other positive news included:

- Siobhan's being given the opportunity to chair the first hour of the recent Capital Nursing conference
- two of the Trust's nurses having attended a reception for frontline nurses at Buckingham Palace
- the Trust's having been shortlisted for the HSJ value awards.

Norma French added that Whittington Health had also been shortlisted for the HPMA awards in recognition of the portability agreement with UCLH.

34.07 Richard Jennings echoed his thanks to Julie Andrews for all that she had achieved in her years as DIPC, saying that he had observed at first hand the many positive changes that she and her team had brought about.

18/35 Serious Incident Report

35.01 Richard Jennings informed the Board that the Trust had declared one serious incident during February, and this remained under investigation. He also reported on a child safeguarding incident which had concerned the very sad death of a 23 week old baby who had been seen by the Trust's health visiting service. There was learning to be had, he said, around the way that communications could be improved when families moved across sectors and care was transferred.

35.02 Richard would be providing the Board with a report on 'flu deaths, but advised that this would come at the end of the 'flu season. To date there had been 327 cases this season.

35.03 Richard had seen the draft RCA report on the surgical death from sepsis described in table 3.2. He commented that this incident reminded staff that although the Trust had achieved a huge amount of improvement work in this area – and had been nationally commended for doing so – there were still times that things could go wrong and the service could never afford to stand still. There was much learning from the incident that would be acted on.

35.04 In answer to a question from Steve Hitchins about the prevalence of 'flu this season, Richard said that this winter had proved particularly challenging, and Julie Andrews added that the Trust had seen 20% more cases than usual to date. She added that resource constraints had made it necessary to cut down on testing. It was acknowledged that some staff had refused the vaccination due to its having proved ineffective the previous year, and Julie said that it was not possible to know until the end of the season how efficacious this year's vaccination had proved. David Holt enquired whether there was a case for the Trust to be more proactive in vaccinating its local population wherever contact provided opportunity; Richard replied that in his view the most important contribution the Trust could make was to promote the national approach as well as to liaise well with primary care colleagues in support of the 'flu campaign. Julie added that at risk groups such as those in nursing or care homes and pregnant women would always be targeted.

35.05 Greg Battle reminded the Board of the hugely successful Grand Round which had been held on sepsis and enquired, in the light of the latest tragic death, whether there were plans to repeat it. Julie confirmed that this would be taking place on 2nd May and that many GPs had already booked to attend. Considerable background preparation work was required given the sensitivities of the incident, particularly around the Trust's duty of candour to relatives and friends.

18/36 Hospital Nursing Establishment Review

36.01 Introducing this item, Michelle Johnson informed Board colleagues that six monthly reviews of nursing establishments had been one of the recommendations from the national Quality Board. The data presented was from October, and Michelle apologised for its late presentation to the Board, saying that the next review was already planned for April. Going forward, community services would also be included. Philippa Davies had used three different tools to measure establishment figures, in addition to the professional judgement of senior nurses.

36.02 Michelle was satisfied that most areas felt safe and right, although she acknowledged that the challenge of nurse recruitment did mean that the position on the wards felt harder. Two wards in particular felt challenged, Cavell and Victoria, and in both of these an additional HCA post had been brought in and nursing leadership strengthened. Thorogood was also complex to manage from a nursing perspective, and some work was being carried out through skill mix. The position would be reviewed in April then again in October. Cavell ward should close by the end of April.

36.03 Within maternity services the Birthrate Plus tool exercise was to be repeated; it was noted however that this was the one tool that was not free to Trusts; there was some national lobbying being undertaken to alter this. A paper had also been to TMG about the possibility of changing the establishment in ED.

36.04 Michelle recommended that a lighter touch review would be carried out in April, with a report coming to the Board in June. In October a more robust exercise would be carried out, with findings then being available to underpin budget-setting for 2019/20.

36.05 David Holt was pleased to note that community services were to be included in future such reviews, and asked for more detail on how this was to be done. Michelle replied that there was an established view for district nursing, although not as yet for school nursing. David felt that the test for such reports was whether nursing staff on the wards would recognise them as giving an accurate picture of the position in their areas; the same test could be used for the monthly safer staffing report. Siobhan commented that recruitment – and retention – remained the biggest challenge, with Stephen Bloomer adding that as a Trust Whittington Health remained expensive, and consideration should be given to what might be done differently. Michelle confirmed that new scales were being introduced, but there were issues with the pace at which changes could be made.

18/37 Nursing Safer Staffing Report

37.01 Michelle informed the Board that this was the last time the report would be seen in this format; from next month there were plans to merge it with the performance dashboard. Moving to the report itself, she said there had been a reduction in HCA shifts in February, which was positive. The use of RMNs remained high, and it was possible to see a trajectory that showed having the necessary capacity to care for mental health patients would continue to be an issue for the Trust. Introduction of mental health practitioners was under consideration.

37.02 There had been a number of red shifts declared during February, but Michelle had been reassured by the fact that no Datix reports had been submitted and concluded that no harm had been caused.

37.03 David Holt commented on the rise in agency usage by month, and Carol confirmed that this had indeed been the case as a result of winter pressures and extra funding received in December. Community MSK had also been an issue. Norma added that she had noted a spike in AHP usage during January, which was attributable to 'flu. Some ICSUs had however reduced their use of agency staff considerably, and maternity services in particular had been particularly impressive in this respect.

37.04 Turning to CIPs, David reminded the Board of the crucial importance of starting CIP programmes as early as possible. The executive team did review the position regularly, especially in respect of quality and safety implications. The Audit & Risk Committee had also held a discussion on the CIP programme that morning in respect of the additional pressures the Trust was likely to face this year and the need to push schemes through as early as possible. Siobhan explained the different approach to be taken this year, with all ICSUs and Directorates needing to make 2% savings then additionally some broader transformation schemes which would affect services across the board. Deborah asked a question on Quality Impact Assessments and how they aligned with CIP decisions; Richard replied that there was a robust process in place to ensure this ran as smoothly as possible supported by regular QIA meetings and ensuring the right people were in the room to ensure decisions were made in a timely and efficient way and supported by accurate reliable information.

18/40 <u>NHS National Staff Survey Results 2017</u> (Item brought forward)

40.01 Head of Learning & Organisational Development Eleanor Clarke introduced her paper setting out the staff survey results for 2017, saying that this was now the seventh year the Trust had participated as an ICO. She was pleased to report that the response rate had risen again – from 36% the previous year to 42% for 2017.

40.02 Eleanor had attended an NHS Employers conference to talk about the overall national findings and to look at some case studies. The conference leaders had recommended looking at areas where Trusts could see the most significant changes, and Eleanor took the Board through the local results in relation to these areas explaining the key findings illustrated by the charts on page 4.

40.03 Turning to action plans to be produced in response to the findings, Eleanor advised that it was generally best to focus on a few key areas that could be done really well rather than trying to do everything and consequently risking failure. The HR, OD and Inclusion teams planned to run four events in May, one in the hospital and three in the community, in order to gather staff views on what they would like to see. OD had also started to offer support in 'hotspots' and in particular the hard to reach parts, e.g. Health & Wellbeing for Women's Health.

40.04 Steve Hitchins commented that page 6 bore more resemblance to a list of problems rather than an action plan, and Eleanor replied that each ICSU would be developing its own individual action plan. Norma confirmed that each ICSU had been given its own detailed data, and that the action plans they developed would be reviewed by the quarterly ICSU performance review meetings.

40.05 Siobhan added that the cultural survey being carried out by Professor Duncan Lewis had now closed. 1,200 responses had been received, and there had been around 80 requests for individual or group meetings with Professor Lewis. Tony Rice wondered whether any work had been done to review staff surveys from Trusts where there were

quality concerns. Michelle spoke of the importance of supporting students; from September, Whittington Health was to have its own students, and this message would be widely communicated across the Trust, including new badging. The Board discussed communications, and Norma spoke about an initiative she was developing with Leon Douglas and the new Interim Communications Director Juliette Marshall to produce a series of short films to support the Trust's clinical strategy. Anu spoke of the importance of local accountability for action plans. In answer to a request from Steve Hitchins about the Board being given more detail on plans, Norma replied that this would be discussed in more detail at the next Workforce Assurance Committee prior to being brought back to the Board.

18/38 Financial Report

38.01 Stephen Bloomer introduced the financial report covering Month 11. He began by explaining that the Trust had planned for lower income in February due to its being a shorter month, however performance had in fact been higher than expected. Temporary staffing and agency usage had however contributed to high pay costs in month.

38.02 CIP performance had improved in month although remained some way off plan for the year. Stephen remained confident that the Trust would achieve its forecast control total at year end. In answer to a question about what would happen to any surplus STF monies not allocated, Stephen said that they were likely to be used to support incentive schemes.

38.03 Good progress had been made on staffing and plans to close winter escalation beds now that winter pressures were beginning to subside. There had also been continued improvement in outpatient attendances. Carol confirmed that it was proposed to close Cavell ward by the end of April and then begin to reduce the use of Victoria and Coyle wards. She acknowledged that closing winter pressure beds always presented a challenge, as did bank holidays in their overall impact on the month. In answer to a question about the improved functioning of the PMO, Carol replied that things were moving in the right direction, i.e. to support the ICSUs.

18/39 Performance Dashboard

39.01 Introducing this item, Carol Gillen began by reporting on ED performance, which during February had come in at 86.1%. She went on to say that during the month there had been a significant number of 'flu cases and generally a high level of acuity on the wards. Things were now starting to recover, and there was considerable focus on flow. Quality improvements achieved in ED had been encouraging. Mental health patients however remained an issue, contributing to breaches and long delays. The new mental health suite was looking very nice and would shortly be open and hopefully making a positive contribution to length of stay.

39.02 There had been some improvement to the cancer performance though the 62 day target had not been met for January. Moving on to the HR targets, Carol said there had not been a great deal of improvement in either Mandatory Training or Appraisal rates and both would be looked at in earnest at the ICSU quarterly performance review meetings. Some had already developed plans to improve their position.

39.03 On April 16th the E-referral system would be fully implemented and paper systems switched off. From this date the Trust would no longer be paid for paper referrals. Clinical teams would therefore need to be very clear what was in the directory. A paper on the Electronic Referral System was to be taken to TMG on 10th April. In answer to a question about whether any contingency plans existed, Carol replied there were not, she was confident this must be made to work.

18/41 LUTS: Proposed next steps

41.01 Introducing his paper, Richard Jennings said that it summarised progress made to date and highlighted the steps that needed to be taken moving forward. Good progress had been made on safety and governance, a local MDT had been established, and a service specification had been produced. The job description for the joint post was currently being written, and the next steps that needed to be taken were quite clear. Siobhan added that a meeting with service users (some of whom were present at the Board) had taken place the previous day, and representatives from the commissioners had been present. The Board hoped to achieve two things today, the first being to agree the progression of the recruitment for the appointment of the new consultant, and the second to agree a phased approach to the opening of the clinic to new patients.

41.02 The date for re-opening the clinic was not specified by the Trust Board, and would be determined by Rob Sherwin, the Trust's Associate Medical Director, after discussion with the lead consultant from the LUTS clinic. The phased re-opening of the clinic must ensure that new patients are managed in line with the service specification criteria that new referrals would be received through secondary care with treatment agreed through the multi-disciplinary team.

41.03 Service users read out a prepared statement setting out their views and wishes. They began by focusing on the recently published research, the result of ten years of study, which had been received with 'massive acclaim'. 84% of patients interviewed had said their symptoms were much better, and 64% 'very much better'. They asked whether the Trust felt able to give a date when the clinic would open to new patients. Siobhan felt unable to stipulate a precise date, but reiterated that Rob Sherwin would be determining this following discussion with Professor Malone-Lee. Service users also wished for an assurance that a good flow of new patients would be seen in order to alleviate any backlog which had built up.

41.03 The Board formally agreed the recommendations as set out in the paper, and also agreed :

- the progression of the recruitment process for the appointment of the new consultant
- that there should be a phased approach to the opening of the clinic to new patients.

The Commissioning Director of Performance across the five local CCGs, who was present at the meeting, confirmed that this approach had commissioner support.

41.04 Deborah Harris thanked the service users and their representatives for attending the Board meeting to express their sentiments. The Board was, and had always been, keen to hear the views of its service users and to involve local people in relation to the provision of services.

18/42 Clinical Strategy Review

42.01 Greg Battle reminded Board colleagues that Siobhan had led on the production of the Trust's clinical strategy when she was the Trust's Director of Strategy, supported by him. The Trust was now two and a half years in to the period covered by the strategy, and Greg had sent it to all ICSUs asking whether, in their view, it remained fit for purpose, he had also invited them to comment on their achievements. He had received responses from all but one ICSU.

42.02 A common theme throughout responses was that the Trust was not good at communicating its successes. It had however made good progress in its thinking in an integrated way across services, and it had made great strides in its collaboration with social care and the voluntary sector. Greg felt that amongst the Trust's many successes particularly noteworthy were some outstanding work with children, progress in the treatment of sepsis, achieving good inspection results, and developing as an ICO although there was still more work to do in this area.

42.03 There had been broad agreement that the mission statement required no change, and that the Trust's vision remained fit for purpose, as did the six strategic goals supporting it. There needed however to be a greater emphasis on quality improvement as a methodology, a greater focus on population health, and more celebrating of successes, e.g. through being more visible at conferences and seminars. There also needed to be a more scientific evaluation of changes, with more thought given to how we assess what had been done well.

42.04 In summary then there was a broad consensus that the strategy did not require any major overhaul although some suggestions had been made around empowering staff and being an exemplary employer. Taking this forward would now be the responsibility of his successor, and it would, Greg said, be up to the Board to ensure the strategy remained dynamic and evolved further over the next two years. Siobhan added that there was also a piece of work being carried out by the Haringey & Islington Health & Wellbeing Partnership which involved looking at local strategies. It was noted that both the new Director of Strategy, Development & Corporate Affairs and the new Medical Director for Integrated Care were due to start at the Trust in May.

42.05 Richard Jennings suggested that the Trust should be further involving public health colleagues in such work; they were the real experts in this field and staff should be working more closely with them. He also pointed out that success should be celebrated not just through publications and conferences but also more locally in teams, citing as one example the excellent newsletter produced by the TB team which could be emulated.

18/43 <u>Whittington Pharmacy CIC – Appointment of Director</u>

43.01 Carol Gillen recommended, and the Board formally agreed, the appointment of Mr Patel to the Whittington Pharmacy CIC Board and noted the Articles of Association which had been circulated with the Board papers.

18/44 <u>Fast Follower – System C contract change approval</u>

44.01 Stephen Bloomer said that he would take this paper as read; in summary the paper asked the Board to authorise a contract extension to the value of £4.8m. There had been no progress as yet since the contract had not been agreed. There were however programme plans, and Leon Douglas was getting teams in place to work on this.

44.02 Siobhan informed the Board that she had met the Chief Executive of United Hospitals Bristol the previous week, who had been generous enough to comment on how much Bristol was learning from Whittington Health.

44.03 Deborah Harris asked whether developments in technology arising from this programme might be used to further engage staff, e.g. through the use of video conferencing enabling multi-site communications. Stephen replied that the fundamental drive for this was about clinical improvements and safety, and less on meeting systems requirements. Deborah pointed out that staff would need training, and that any contribution that would assist this was valuable.

She also commented on the range of free tools widely available, but it was noted that if tools were free, it was likely they were open access and therefore did not protect confidentiality.

18/45 Draft Trust Board Meeting Plan 2018/19

45.01 Susan Sorensen asked for Board views on the draft meeting plan, saying that it would of necessity be an evolving document, and there were some things to be added such as the timetable for the production of the annual accounts and the self-certification provider license. Both Steve Hitchins and Siobhan Harrington commented that the layout and format of the document were greatly improved.

18/46 Board Sub-Committee minutes: Quality Committee

46.01 Anu Singh pointed out that the January minutes had been circulated instead of draft March ones, but in any case commented on the high quality of the March meeting.

18/47 Board Sub-Committee minutes: Finance & Business Development Committee

47.01 The minutes of the Finance & Business Development Committee held on 26th February 2018 were received by the Board.

18/48 Register of Conflicts of Interest 2018/19

48.01 The Trust Board and senior staff Register of Conflicts of Interest, together with supporting guidance, was received by the Board. Michelle pointed out the Codes of Conduct and Accountability were out of date, however they were acknowledged to be the latest guidance available.

Any other business

There being no other business, the meeting concluded at 4.45pm.

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Action Log

Minute	**Action**	**Date**	**Lead**
05.04	Report to Board on hospital-acquired 'flu and 'flu deaths in hospital as part of the quarterly monitoring	April 2018	RJ
13.02	Training need – to increase number of fire marshals in appropriate locations across the Trust. Assurance report to Board within six months and annually thereafter.	July 2018	SB
20.03	Review role of Director of Infection Prevention & Control (DIPC) following Julie Andrews' stepping down	April 2018	MJ
25.03	Board to review performance on appraisal and mandatory training rates especially within the ICSUs	April 2018	NF/CG
34.03	To circulate the Trust's response to the CQC report to Non-Executive Directors	a.s.a.p.	MJ

35.04	“Light touch” Nursing Establishment Review to be carried out in April with report to Board in June.	June 2018	MJ
37.01	Nursing Safer Staffing data to be merged in future with the Performance Dashboard	Complete	MJ
40.05	Action plans arising from the Staff survey to be brought back to the Board following discussion at the Workforce Assurance Committee	Sept 2018	NF

Whittington Health
NHS Trust

Trust Board
25 April 2018

Title:	**Chief Executive Officer's Report for the Trust Board**		
Agenda item:	**18/054**	**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 receive 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:	20 April 2018		

Author name and title:		**Fiona Smith Communications & engagement**		**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.

WELCOME

Dr Sarah Humphery joins the Trust as Medical Director for Integrated care on 8 May. Dr Humphery is a practicing GP in Islington and a partner from the Goodinge Practice.

Jonathan Gardner joins the Trust as Director for Strategy, Development and Corporate Affairs on 14 May. Jonathan currently works at UCLH as Deputy Director of Strategic Development.

QUALITY AND SAFETY

Emergency Pathway

The Trusts performance against the 4-hour Emergency Department target was 89.3% at the end of the financial year. This is a 3% improvement on the year-end performance in 2016/17 and places the Trust as a top performer in North Central London.

Performance against the 95% standard for March 2018 was 83.15%.

Attendance activity to the Emergency Department increased from 8527 in March 17 to 9217 attendances in March 18. Ambulance activity increased by 15% compared to the same time last year; 1929 (March 18) compared to 1639 (March 17)

Delayed transfers of care

There was a slight improvement in delayed transfers of care (DTOCs) in March, however DTOCs continue to be challenging. Islington Social Services capacity is challenged and individual cases are escalated through to directors to reduce number of delays.

The trust has implemented weekly MADE (Multiple Discharge Events), attended by senior representatives from both Haringey and Islington to focus on improving patient flow through the emergency pathway, and in the community.

Nursing vacancies

Following the targeted nurse recruitment campaign, the nursing and midwifery vacancy rate has fallen between December 2017 and Feb 2018 from 21% to 19%, with Band 5 vacancy rate reducing by 6%. HCA vacancy rate has reduced from 23% to 19%.

Safer Staffing

Nursing staff average percentage fill rate of nurses and HCA, split by day and night shifts, has been added to the Performance Report. The number of “Red” staffing alerts per month has also been added, and these have been reducing each quarter – see page 20 of the Performance Report.

FINANCIAL

March and year-end Financial Position

The Trust has achieved its financial control total for 2018/19. Further detailed information will be presented to the Board through the Finance Report.

The Trust Board will also be updated on the final settlement in relation to the STF bonus.

INFORMATION TECHNOLOGY

E Referral System

Whittington Health is a "Wave 1 – Early Adopter" site for the NHS e-Referral System.

Moving to ERS is a requirement of the NHS England 208/19 Contract for all GP referrals to Consultant Led First Outpatients Appointments that states that all referrals must be made via the NHS e-Referral System (eRS) by Monday 1st October 2018.

As a wave 1 site the Trust has been allocated an early Paper Switch Off date and since 16th April Whittington Health now accepts GP referrals to and Consultant Led Outpatients Services via the NHS e-Referral System. Any referrals made, via paper or email, are returned to the referrer with a request to re-referred via eRS.

Whittington Health runs a weekly implementation group represented by all services with support from:

- Local and regional NHS Digital
- eRS leads in Haringey and Islington CCG

Cyber security

The Department of Health and Social Care, NHS Digital, NHS England and NHS Improvement have developed technical guidance to assist Trust's IT security teams to be more cyber resilient in the heightened threat landscape. The guidance gives information on how building simple security practices into our Information Governance work, helps to mitigate these threats and avoid unintended disclosure.

Cyber Security is monitored through the Trust's Information Governance Committee. Key roles in the organisation include;
Carol Gillen – Senior Responsible Risk Owner
Leon Douglas – Chief Information Officer
Ali Kapasi – assistant Director for Information Governance.
Maria Barnard – Caldicott Guardian

The information governance committee reports to the Audit and Risk Committee

Information Governance

The Trust has achieved Level 2 Information Governance Compliance against the Information Governance Toolkit.

The Information Governance Toolkit is a Department of Health (DH) Policy delivery vehicle that the Health and Social Care Information Centre (HSCIC) is commissioned to develop and maintain. It draws together the legal rules and central guidance set out by DH policy and presents them in in a single standard as a set of information governance requirements.

Organisations are assessed for

- Management structures and responsibilities (e.g. assigning responsibility for carrying out the IG assessment, providing staff training, etc).
- Confidentiality and data protection.
- Information security.

All NHS Trusts are required to achieve 66% compliance at level 2 of the Information Governance Toolkit. Whittington Health has achieved 77% for 2017/18, improving from 74% in 2016/17.

WORKFORCE

Integrated care Units (ICSUs) restructure

Whittington Health has had seven integrated clinical service units for the last three years. Following our CQC report and NHS Improvement reviews, and considering what the Trust must deliver over the next two years, we launched a staff consultation on 11 April on our proposal to move from seven to five integrated clinical service units.

The ICSU restructuring is seen as very much an evolution of the existing structure. Indeed it is essential that we retain much of what is in place in terms of people and practice. The Executive believe there are potentially better synergies between services if they are managed in an even more integrated way. The restructure will help to further empower staff to deliver some of the service pathway changes needed over the next two to three years including: delivering new models of care for frail elderly; improved working with primary care; strengthened surgical services; improved success in the community services market and developing a new maternity and neonatal unit.

NEWS THIS MONTH:

Chris Hopson visit

Chris Hopson, Chief Executive of NHS Providers, visited the Trust on 12 April. He spent time with staff in community and acute settings and discussed with them the progress they are making in delivering integrated care. Following his visit he tweeted:

“Great visit to @WhitHealth to see the team delivering some great, innovative, integrated care to the people of North London. The power of a genuinely integrated acute/community trust in action!”

#End PJ Paralysis

Whittington Health has been in the local and national news following the launch of our #End PJ Paralysis campaign. As part of a national 70-day campaign to help patients regain strength and get home faster, staff at the Whittington Hospital are pledging to help patients get dressed and out of bed while they are in hospital.

While staff are encouraging patients who are able to get dressed and get out of bed for some of the day, the hospital is appealing to friends and family who come to visit to support their loved ones in boosting their recovery by taking home clothes that need a wash and bringing in fresh clothing so that patients have clean clothes to wear.

Mayors' Association walk

The Trust took part in the Mayors' Association Walk on Sunday 8 April 2018. 27 of the 32 Borough of London Mayors and the Lord Mayor of the City of London assembled at Whittington Hospital in their full robes and regalia before heading off for Mansion House.

Setting off at 9.30am, the 5 mile sponsored walk follows the route that Richard 'Dick' Whittington, one of London's most famous Mayor's, took some 600 years ago to Mansion House in the City of London.

Siobhan Harrington
Chief Executive

Twitter: @S_HarringtonNHS

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NHS
Whittington Health
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Trust Board

25th April 2018

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	**18/055**	**Paper**	**3**
Action requested:	It is recommended that the Board recognises the assurances contained within this report that the serious incident process is managed effectively and lessons learnt as a result of serious incident investigations are shared widely.		
Executive Summary:	This report provides an overview of serious incidents (SI) submitted externally via StEIS (Strategic Executive Information System) during March 2018. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.		
Fit with WH strategy:	1. Integrated care 2. Efficient and Effective care 3. Culture of Innovation and Improvement		
Reference to related / other documents:	• Supporting evidence towards CQC fundamental standards (12) (13) (17) (20). • Ensuring that health service bodies are open and transparent with the relevant person/s. • NHS England National Framework for Reporting and Learning from Serious Incidents Requiring Investigation, • Whittington Health Serious Incident Policy. • Health and Safety Executive RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013).		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	**Corporate Risk 636.** Create a robust SI learning process across the Trust. Trust Intranet page has been updated with key learning points following recent SIs and RCA investigations.		
Date paper completed:	11/04/2018		

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 March 2018. 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 one serious incident during February 2018, bringing the total of reportable serious incidents to 38 since 1st April 2017. In 2016/17 the Trust declared 58 serious incidents.

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

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

3.2 The table below details the Serious Incidents currently under investigation

Category	Month Declared	Summary
Unexpected Death - influenza Ref:1986	Jan 18	Patient acquired influenza in hospital and subsequently died.
Unexpected Death - influenza Ref:1980	Jan 18	Patient acquired influenza in hospital and subsequently died.
Environment Incident meeting SI criteria Ref: 2655	Jan 18	A fire broke out in the Whittington hospital which was contained in the basement area of the PFI Building storage room. The smoke was distributed into the ventilation system resulting in the evacuation of the affected areas. No staff or members of the public were harmed.
Sub-optimal Care of deteriorating patient (Unexpected death) Ref:4863	Feb 18	On reinserting a feeding tube that the patient had pulled out, the patient had a cardiac arrest. The patient subsequently died.
Patient Fall Ref:6532	March 18	Patient had a witnessed fall on the ward, resulting in a fractured neck of femur.

Category	Month Declared	Summary
Unexpected Death - influenza Ref:7161	March 18	Patient acquired influenza in hospital and subsequently died.
Unexpected Admission to NICU Ref:8303	April 18	Term baby born in poor condition and admitted to NICU and subsequently transferred to a tertiary unit. Possible hypoxic injury, prognosis unknown at present.
Unexpected Admission to NICU Ref:8308	April 18	Full term baby born in very poor condition, admitted to NICU and subsequently died.
Confidential Information Breach Ref:8308	April 18	Staff member's medical record inappropriately accessed by another staff member.

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 – March 2018

STEIS 2017-18 Category	2016/17 Total		Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Total 17/18 ytd
Safeguarding	5		0	0	0	0	0	0	0	1	0	0	0	0	1
Attempted self-harm	1		0	0	0	0	0	0	0	0	0	0	0	0	0
Confidential information leak/loss/IG Breach	6		0	0	1	1	0	1	0	0	0	0	0	0	3
Diagnostic Incident including delay	8		0	1	1	1	1	0	1	1	0	1	0	0	7
Disruptive/ aggressive/ violent behaviour	0		0	0	0	0	0	0	1	0	0	0	0	0	1
Environment Incident meeting SI criteria	0		0	0	0	0	0	0	0	0	0	1	0	0	1
Failure to source a tier 4 bed for a child	1		0	0	0	0	0	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	0	0	0	0	0
HCAI/Infection control incident meeting SI criteria	0		0	0	0	0	0	0	0	0	0	2	0	1	3

Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	7		0	1	0	0	0	0	1	0	0	0	0	0	2
Maternity/Obstetric incident mother only	2		0	0	0	0	1	0	0	0	0	0	0	0	1
Medical disposables incident meeting SI criteria	1		0	0	0	0	0	0	0	0	0	0	0	0	0
Medication Incident	0		0	0	0	1	0	0	0	0	0	0	0	0	1
Nasogastric tube	1		0	0	0	0	0	0	0	0	0	0	0	0	0
Slip/Trips/Falls	7		0	1	0	0	2	0	1	0	0	1	0	1	6
Sub Optimal Care	4		0	0	1	0	0	0	0	0	0	0	1	0	2
Treatment Delay	3		1	1	0	0	0	1	0	0	0	1	0	0	4
Unexpected death	10		1	0	1	0	0	0	1	0	0	1	0	0	4
Retained foreign object	1		0	0	0	0	1	0	0	0	0	0	0	0	1
HCAI\Infection Control Incident	0		0	0	0	0	1	0	0	0	0	0	0	0	1
Total	**58**		**2**	**4**	**4**	**3**	**6**	**2**	**5**	**2**	**0**	**7**	**1**	**2**	**38**

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 did not have any reports scheduled to be submitted in March 2018 and therefore no DoC was required.

Lessons learnt following the investigation are shared with all staff and departments involved in the patient's care through various means including the Trust wide Spotlight on Safety Newsletter, '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.

5. Shared learning

The learning from the serious incidents references 1986 and 1980 declared in January 2018 is described in the April 2018 Public Trust Board paper "Quarterly Safety and Quality Board Report Quarter 4 2017/18 (01 January 2018 – 31 March 2018)" and not reported here.

6. Summary

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

Whittington Health

Trust Board

25th April 2018

Title:	**Quarterly Safety and Quality Board Report** **Quarter 4 2017/18 (01 January 2018 – 31 March 2018)**				
Agenda item:	**18/056**	**Paper**	**4**		
Action requested:	It is recommended that the assurances contained within this paper are recognised and that the Board discusses potential opportunities for further improvement.				
Executive Summary:	This is the regular paper for the Trust Board to provide an overview of safety and quality in the organisation. This report provides an update on mortality, and the Trust's HSMR and SHMI figures. On this occasion this report provides an overview of the flu season in 2017/18 summarising the impact and learning.				
Fit with WH strategy:	To deliver consistent high quality, safe services.				
Reference to related / other documents:	Quality Account 2016-17 Sign up to Safety Pledges Clinical Strategy 2015-20 CQC standards 7 day services clinical standards				
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Quality and safety category risks on risk register.				
Date paper completed:	17th April 2018				
Author name and title:	**Richard Jennings, Executive Medical Director**	**Director name and title:**		**Richard Jennings, Executive Medical Director**	
Equality Impact Assessment complete?	**N/A**	**Quality Impact Assessment complete?**	**N/A**	**Financial Impact Assessment complete?**	**N/A**

1) Executive Summary

This is the regular paper for the Trust Board to provide an overview of safety and quality in the organisation.

This report provides an update on mortality and the Trust's HSMR and SHMI figures remain assuring. On this occasion this report provides an overview of the flu season in 2017/18 summarising the impact and learning.

2) Contents

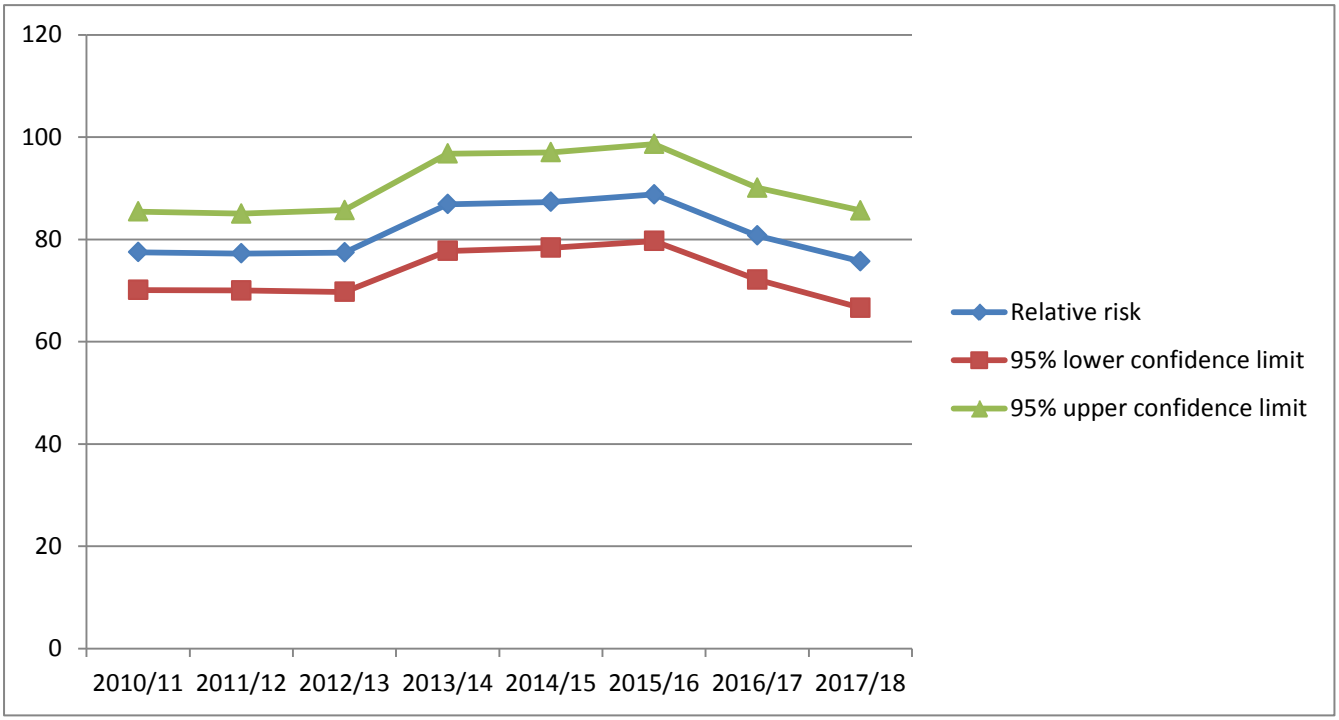
3. Mortality

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 – September 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.

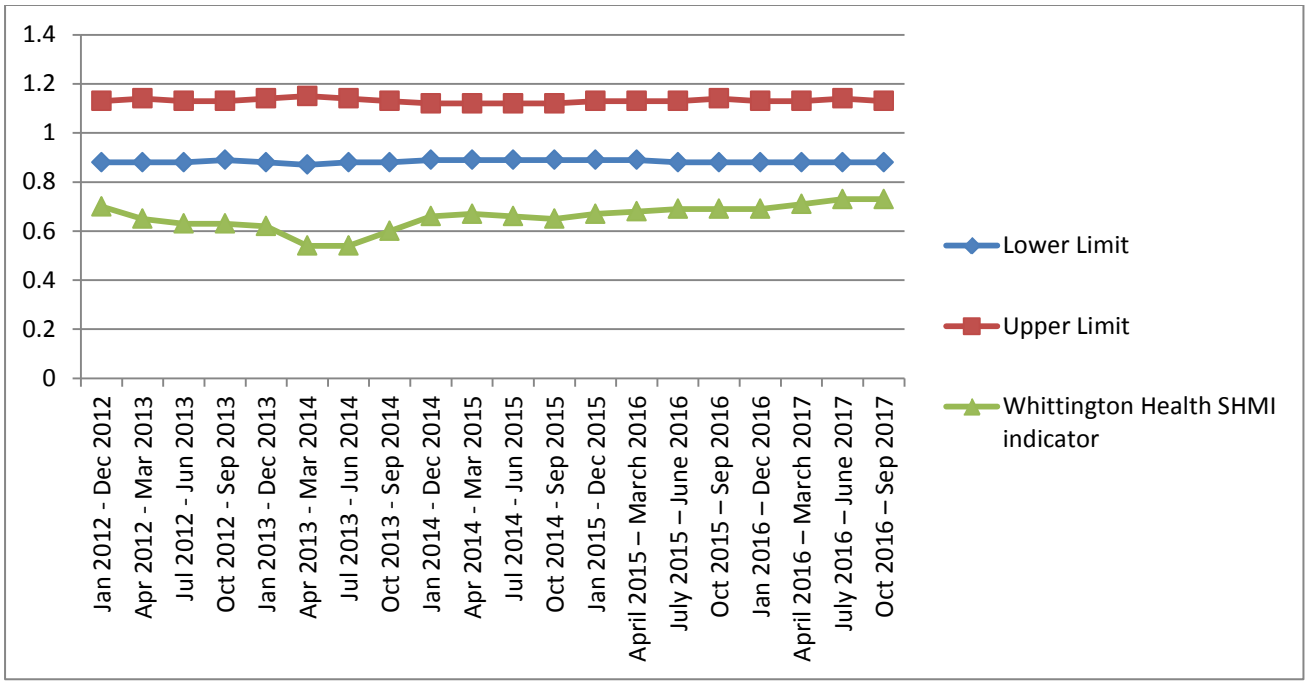
The most recent data available (released in March 2018) covers the period October 2016 – September 2017:

Whittington Health SHMI score	**0.7271**
National standard	**1.00**
Lowest national score	**0.7271 (Whittington Health)**
Highest national score	**1.2277**

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
July 2016 – June 2017	0.88	1.14	0.73
Oct 2016 – Sep 2017	0.88	1.13	0.73

Chart 2: Whittington Health Summary Hospital-level Mortality Indicator (SHMI) (January 2012 – September 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 have been three Trust-attributable MRSA bacteraemias since 1 April 2017 and Post Infection Reviews (PIR) have taken place. The first was found in June 2017 and is likely to be a contamination rather than a true bacteraemia. We have asked the Department of Health to review this case and remove it from our numbers as the patient had MRSA and a long-standing skin condition.

The second, which was found in November 2017, has been determined as avoidable. The final PIR report has been completed and it was decided that it was likely to have been cannula related. An action plan has been devised and is part of the open actions arising from PIR of HCAI.

The third, from January 2018, has been determined as a contaminant. We are hoping to have cases 1 and 3 removed from our total and are awaiting confirmation

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 1 documents MRSA colonisation events.

Since mid-March 2018, there has been an increase in acquired MRSA colonisation on Cavell Ward. There are seven patients that have acquired MRSA colonisation, i.e. they had a negative specimen followed by a positive. All specimens have been sent for typing with six coming back as the same type. Initially there were three new cases from one weekly screening. All patients were swabbed, including previously positive patients and the four new positives sent for typing. All of the positive patients have been isolated and started on MRSA suppression. Due to the number of patients, cohort isolation is being used. An outbreak has been declared and an outbreak meeting is being convened to ensure that all appropriate steps are being taken promptly to prevent further MRSA colonisation acquisition on this ward, both now and in the future.

Table 2: Whittington Health MRSA colonisation acquisition events April 2017- January 2018

MRSA acquisition April 2017 - March 2018													
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Running total**
ITU	0	0	0	0	0	0	0	0	0	0	0	0	0
NICU	0	0	0	0	0	0	0	1	1	0	0	0	2
SCBU	0	0	0	0	0	0	0	0	0	0	0	0	0
Meyrick	0	0	0	1	2	0	0	0	0	0	0	1	3
Cloude-sley	0	0	3	0	1	0	0	1	1	1	0	0	6
Bridges rehab	0	3	0	0	0	1	1	0	0	0	0	0	5
Coyle #NOF	0	0	0	0	0	2	0	0	0	0	0	0	2
Cavell	0	0	0	1	0	1	0	1	1	0	0	7	11

4.2 *Clostridium difficile* diarrhoea issues

For 2017-18 there have been eleven Trust-attributable 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 was set as 17. The breakdown of cases by ward is shown in table 3. The tolerance for 2018/19 has been set as 16.

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
November 2017	0	
December 2017	0	
January 2018	0	
February 2018	1	ITU
March 2018	0	

There has been one new case since the last report. A Post Infection Review (PIR) has taken place and it has been determined as not avoidable. The patient had been admitted from a hospital of another trust.

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

There was one issue during the year with an increased incidence of *C*. *difficile* associated diarrhoea on Cloudesley Ward with five cases. Following the Post Infection Reviews, it was noted that ribotyping showed that three of the five cases had different types and two had the same. It was noted that these two patients were in the same bay and that cross-infection was likely, but it was not possible to determine how this had happened. All of the other 9 cases were determined to be unavoidable. There was no key learning from these cases except to continue ensuring that patients with diarrhoea are isolated and a specimen taken as soon as possible from the start of diarrhoea or admission.

4.3 MSSA / *E. coli* Bacteraemia episodes

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

Table 4: Whittington Health Trust-attributable MSSA bacteraemia cases by ward

Date	No. of Cases	Ward
April 2017	0	
May 2017	0	
June 2017	0	
July 2017	1	Nightingale
August 2017	3	Mercers, Cloudesley, NICU
September 2017	0	
October 2017	0	
November 2017	0	
December 2017	1	Montuschi
January 2018	0	
February 2018	0	
March 2018	0	

There have been nine Trust-attributable *E.coli* bacteraemias and short Post Infection Reviews have been completed. We are attempting to reduce the number of *E.coli* bacteraemias by 20% this year to be on target for the national reduction by 50% by 2021. In 2016/17 there were 14 Trust-attributable *E.coli* bacteraemia episodes, therefore for 2017/18 our local trajectory was 11, which we have achieved and for 2018/19 our local trajectory will be 8. The Trust has produced a *E. coli* recovery plan for 2017/18 in conjunction with the local Clinical Commissioning Group. This is being updated for 2018/19.

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 31 March 2018, 81% of Whittington Health staff has received recent (within the last 2 years) IPC training. This is the same as the previous report.

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 next study day is to be held on 19 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)

For the year 2017/18 there have been 12 new CPE positive patients, none of these are Trust-attributable.

All patients admitted should be reviewed to determine if they are liable to be suspected cases and the reviewing questions are part of the paperwork for the pre-admission clinic as well as the Emergency Department. The IPCT review the ongoing screening of patients through the surgical site infection surveillance scheme for orthopaedics. Each of the patients on the scheme have their paperwork reviewed to ensure the questions have been asked and specimens taken, if required. For most quarters, around 90% of patients have been asked the questions. Most missed patients are the fractured neck of femur patients in ED. Screening for suspected cases can be low, at 75% and the patients with issues are again the fractured neck of femur patients from whom specimens cannot be taken due to their injury.

5. Influenza - Winter 2017-18

Introduction

This report describes the impact that the 2017/18 winter influenza (flu) season has had nationally, and for patients treated by this Trust. It describes the Trust's response to the annual influenza season, the way in which learning is gathered, the ways in which learning from previous influenza seasons is being implemented, and the lessons for the Trust to prepare for the influenza season of 2018/19.

Influenza is an important patient safety issue for all acute trusts, and the importance of optimising our response to it can only increase as demand rises locally and nationally and winter challenges rise alongside demand.

National context; Influenza in England and Wales 2017/18

Influenza (flu) is a highly infectious and common disease caused by a virus. It can lead to serious complications and death, particularly for patients at higher risk (e.g. pregnant women, people over 65, children). An average of 600 people a year die from complications of flu every year across the UK[1]. Influenza viruses are sub-divided two types, influenza A and influenza B.

Every year, the influenza vaccine is varied in anticipation of the sub-types of influenza A and B that are thought most likely to be prevalent in the influenza season. Because the influenza sub-types change from year to year and because their relative prevalence varies, it is not

[1] University of Oxford Centre for Clinical Vaccinology and Tropical Medicine, Oxford Vaccine Group, available from http://vk.ovg.ox.ac.uk/inactivated-flu-vaccine

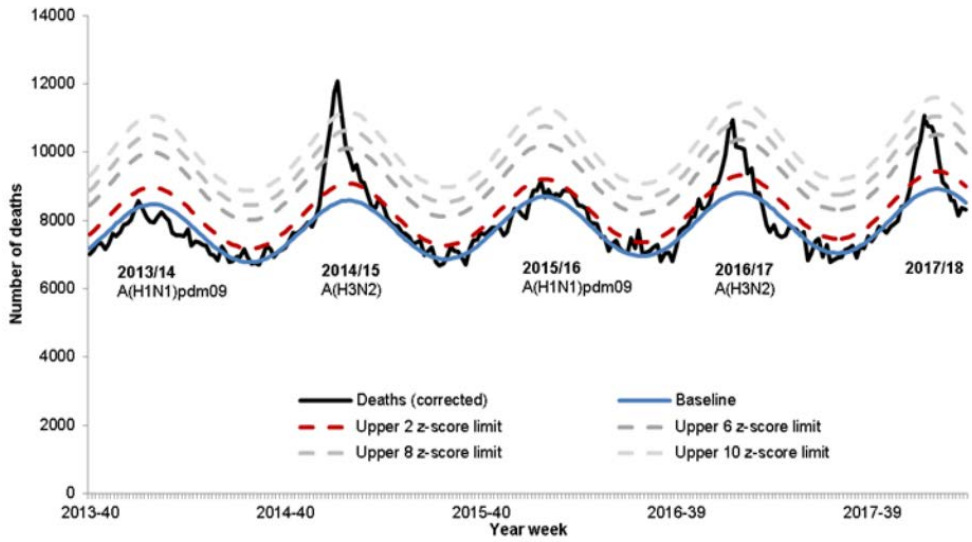
possible to match the vaccine precisely to the forthcoming circulating influenza viruses, and for this reason, vaccine efficacy can vary from year to year. Nevertheless influenza immunisation is one of the most effective interventions immunisers can provide to reduce both the risk of death and serious illness from flu, and the pressures on health and social care services during the winter[2].

The provisional proportion of people in England who had received the 2017/18 influenza vaccine in targeted groups was: 48.7% in under 65 year olds in a clinical risk group, 47.1% in pregnant women and 72.4% in 65+ year olds.[3]

The flu vaccine works better in some years than others. Across all age groups including children, the flu vaccine prevented 52.4% of flu cases in 2015-16[4], and 39.8% of flu cases in 2016-17.[5]

The chart labelled as chart 3, which is taken from the Public Health England *Weekly National Influenza Report* of 12 April 2018, illustrates the yearly season variation in all-cause deaths in people over 65 years old. The nature and extent of the annual rise in influenza in winter is a significant contributor to the variation in the number of deaths that are observed.

Chart 3: Weekly observed and expected number of all-cause deaths in 65+ year olds, with the dominant circulating influenza A subtype, England, 2013 to week 12 2018[6]



[2] Public Health England, Flu immunisation programme e-learning, available from https://www.e-lfh.org.uk/programmes/flu-immunisation/

[3] Public Health England, Weekly National Influenza Report, 12 April 2018 – Week 15 report, available from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/699521/Weekly_report_current_12_April_2018.pdf

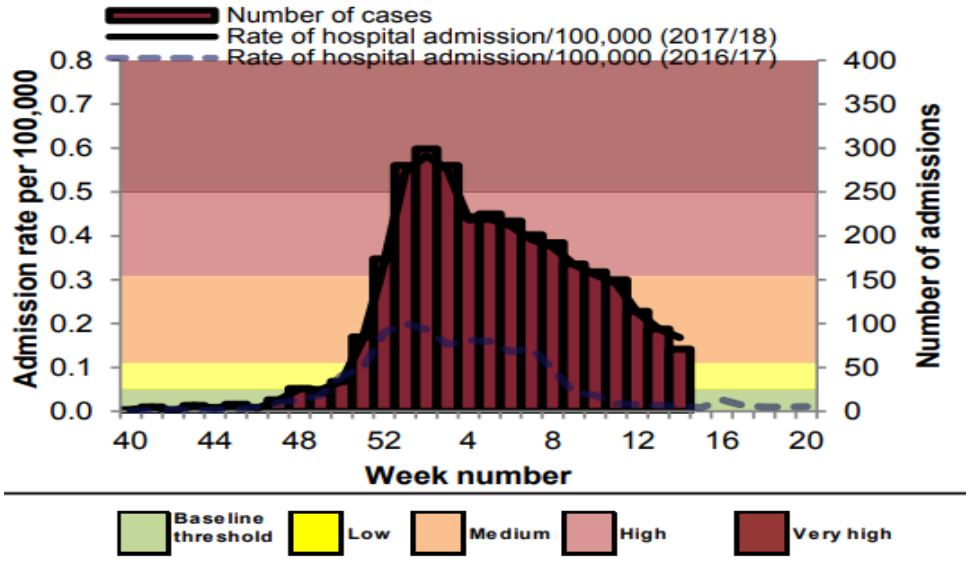
[4] Pebody Richard, Warburton Fiona, Ellis Joanna, Andrews Nick, Potts Alison, Cottrell Simon, Johnston Jillian, Reynolds Arlene, Gunson Rory,Thompson Catherine, Galiano Monica, Robertson Chris, Byford Rachel, Gallagher Naomh, Sinnathamby Mary, Yonova Ivelina, Pathirannehelage Sameera, Donati Matthew,Moore Catherine, de Lusignan Simon, McMenamin Jim, Zambon Maria. *Effectiveness of seasonal influenza vaccine for adults and children in preventing laboratory-confirmed influenza in primary care in the United Kingdom: 2015/16 end-of-season results*. Euro Surveill. 2016. Available from https://doi.org/10.2807/1560-7917.ES.2016.21.38.30348

[5] Pebody Richard, Warburton Fiona, Ellis Joanna, Andrews Nick, Potts Alison, Cottrell Simon, Reynolds Arlene, Gunson Rory, Thompson Catherine,Galiano Monica, Robertson Chris, Gallagher Naomh, Sinnathamby Mary, Yonova Ivelina, Correa Ana, Moore Catherine, Sartaj Muhammad, de Lusignan Simon,McMenamin Jim, Zambon Maria. End-of-season influenza vaccine effectiveness in adults and children, United Kingdom, 2016/17. (2017, Euro Surveill). Available from https://doi.org/10.2807/1560-7917.ES.2017.22.44.17-00306

[6] Public Health England, Weekly National Influenza Report, 12 April 2018 – Week 15 report, available from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/699521/Weekly_report_current_12_April_2018.pdf

The chart labelled chart 4 provides a graphical illustration of the start, sharp up rise, and gradual decline of proven influenza cases that were admitted to intensive care / high dependency units in England in the influenza season that is now coming to a close.

Chart 4: Weekly ICU/HDUinfluenza admission rate per 100,000 trust catchment population , England, since week 40 2017 to week 12 2018[7]



Influenza in the Whittington Hospital 2017/18

There is no formal definition of the beginning and the end of seasonal influenza, but for the purposes of this report the season has taken as stretching from the first confirmed case of a hospital patient with influenza, which was on 18th September 2017, until 16th April 2018.

Within this period there have been a total of 336 positive influenza cases found at Whittington Health, as compared to 235 in 2016/17. After the first flu case of the season was diagnosed in September 2017, there were only three more cases before the end of November and a further 32 before the end of December 2017. The number of cases of influenza then peaked in Quarter 4 of 2017/18.

There were 172 cases of Influenza A, and 159 cases of influenza B. 122 of these cases were acquired in the community before admission to the hospital, 50 of these cases (16%) were classified as having been acquired after admission to the hospital, this classification is based on the incubation period for influenza (i.e. the time it takes from being infected to first showing symptoms), and if the first symptoms of a patient's influenza begin more than 72 hours after admission to hospital, we infer that the influenza has been contracted in hospital.

As in previous years, the hospital policy has been to prescribe Oseltamivir empirically (i.e. based on the clinical picture before laboratory confirmation of infection) as soon as the patient shows symptoms or signs that are thought likely to be due to influenza. This empirical prescribing of Oseltamivir has been used since December 2017.

As in previous years, if influenza is suspected, standard infection control procedures are instituted, including where possible the isolation of the patient in a side room.

[7] Public Health England, Weekly National Influenza Report, 12 April 2018 – Week 15 report, available from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/699521/Weekly_report_current_12_April_2018.pdf

This 2017/18 influenza season had, as might be expected, an impact on the management of in-patients in general, adding to the challenge of making sure that each patient is in the right place at the right time and that patient flow is appropriately maintained. At the beginning of the season it was possible to isolate potential influenza patients in side rooms whilst influenza swabs were pending. Once the numbers of cases being admitted via the Emergency Department increased, this was no longer possible and this meant that on frequent occasions, symptomatic patients had to be admitted into bays of non-symptomatic patients. As in previous years, the hospital policy was to prescribe oseltamivir prophylaxis (i.e. treatment intended to prevent a patient from acquiring influenza) to the non-symptomatic patients in the same bay.

In this 2017/18 influenza season there were two occasions on which there was cross-infection within bays on particular wards (i.e. patients who did not have influenza who caught influenza from patients in the same bay who did have influenza). These two instances became apparent when all the patients in the same bay were screened and multiple patients were found to have influenza. In these instances, it is not possible to determine how influenza was introduced to the bays – it could have been introduced by patients or their visitors or by staff.

Whenever there is an increased incidence of patients with signs of influenza, the Infection Prevention and Control Team (IPCT) review the situation and will close bays or wards as soon as possible to reduce the risk of cross infection. They will also contact the Bed Managers to ensure that the Bed Managers understand that new patients cannot be admitted to empty beds in that area.

As in previous years serious incidents were declared and root cause analysis were undertaken to investigate the care given to any patient who died in hospital, where influenza was thought to have been the direct cause or a contributory cause of the death, and where that influenza had been hospital-acquired. The reason for this approach is that these deaths may offer the best opportunity for learning as to how to minimise the risks to our patients from influenza during their hospital admission.

In 2017/18 there have been eight patients who have died in the hospital and who have had influenza recorded on part I of their death certificates. In five of these cases, the acquisition of influenza has been determined as unavoidable because the evidence indicates that the influenza was community acquired before the patient was admitted to the hospital. Three of the patients who died who had influenza recorded on part I of the death certificate are presumed to have acquired influenza within the hospital as they had all been in-patients for more than 72 hours before developing symptoms. All three of these cases were declared as serious incidents; root cause analyses have been completed for two of the cases and the third root cause analysis is currently underway. The initial learning from these is discussed below. In keeping with the well-recognised epidemiology of influenza, all three of these patients were elderly with significant co-morbidities.

There have been eight patients who have died in the hospital and who have had influenza recorded on part 1 of their death certificates. Five of these deaths have been determined as unavoidable as they either were admitted to the hospital with active influenza symptoms or had symptoms that may have disguised influenza. Three patients died with influenza on part I of their death certificate and they are liable to have caught influenza within the hospital as they had all been in-patients for more than 72 hours before developing symptoms. These cases are undergoing further investigation as serious incidents.

Lessons from 2016/17 that were implemented in 2017/18

From the root cause analyses that were undertaken in 2016/17, a number of learning points were highlighted, and one of these led to a change in the way that the IPCT intervene with individual cases of influenza.

In this 2017/18 influenza season, the IPCT has been labelling notes, which is a new initiative that we did not do last year. For patients found to be influenza positive, a label has been placed into all in-patient notes stating the type of influenza, that they need to start on treatment and that the patient has been informed and given an information leaflet about influenza. If there are any contacts in the bay, they also have labels put into their notes which state that they have been in contact with influenza and that if they become symptomatic they need to be swabbed. At the time the notes are labelled, the IPCT also discuss the case with the doctors on the ward, asking them to commence treatment and recommend prophylaxis for contacts. On a daily basis, the IPCT have been sending out an email record of all new cases as well as in-patients remaining. Because of a substantial increase in the number of positive influenza cases in 2017/18 (336, as compared to 235 in the previous year) oseltamivir prophylaxis was indicated in a large number of inpatients. Although it is not possible to demonstrate conclusively the benefits of labelling the case and contact notes, it seems likely that the IPCT labelling the notes, visiting the wards and speaking to the doctors to remind them of the need for treatment and prophylaxis was of great benefit in preventing cases of hospital-acquired influenza that would have otherwise occurred.

Lessons from 2017/18 and preparation for 2018/19

The lessons that have been learnt locally so far in this Trust from the 2017/18 influenza season, and from the root cause analysis that have been completed so far are;

1) It continues to be important to remind front-line staff to consider the diagnosis of influenza at the earliest possible opportunity, and if it appears likely, to immediately test for influenza and to immediately commence oseltamivir treatment whilst the result of the test is pending. This message will be given to front-line staff at regular intervals from the beginning of the next influenza season, and we will continue with the regular communications to all front-line staff updating them on how many influenza cases are being diagnosed.

2) In common with almost every hospital, we do not have enough side rooms to isolate every patient with suspected influenza at height of a flu season, and we will therefore continue the proactive labelling of notes of positive patients and contacts, and the IPCT will carry out individual risk assessments in each case with the clinical team to make the best possible pragmatic decision about which patients should be in which side rooms or bays. To achieve this, it will important to ensure that the IPCT is staffed to full capacity.

3) We will consider the potential risks and benefits to moving to a system of near-patient diagnosis, whereby an influenza swab is taken and tested in the emergency department, providing a real-time immediate result to indicate whether they have influenza or not. Although there are obvious potential benefits to this there are also significant challenges in its implementation, which would be in the clinical environment that is under the greatest real-time pressure during peak activity in the winter.

4) It will be important for us to continue our efforts to ensure that as many front-line staff as possible are vaccinated against influenza, and we will review the best approach to this. While the overall vaccination rate for Whittington Health staff in 2017/18 was

good (by both London and national standards) with 78.6% staff receiving the vaccination, individual investigations this year has highlighted considerable vaccination in the percentage of staff vaccinated in the different inpatient environments, and it will be appropriate to tailor our approach to promoting vaccination in order to take this into account.

The national learning/response to the 2017/18 influenza season has included a call from the outgoing National Medical Director, Sir Bruce Keogh, for a "serious debate on mandatory flu vaccination[8]". The incoming National Medical Director, Professor Stephen Powis, and Dr Kathy McLean, Executive Medical Director and Chief Operating Officer, has written to all healthcare providers advising that the quadrivalent vaccine should be used prior to the 2018/19 influenza season as this offers better protection against influenza B (which was unusually prominent in the 2017/18 season) than the trivalent vaccine.

Conclusion

This report on the 2017/18 influenza season aims to give assurance to the Board that the Trust is taking very active steps to minimise the risk to our patients from influenza, and is using the tools of serious incident investigation to proactively learn and continually improve in managing clinical risk. This report must remind us, however, that it is not possible to absolutely prevent inpatient influenza transmission, and that (as is well-recognised) inpatient hospital admission is not without risk, and while it should certainly be used when it is indicate, it should certainly be avoided when it is not. While this report necessarily focusses on hospital inpatients, one of the key aspects of this Integrated Care Organisation's clinical strategy is to make the best use of the integration of our community and hospital services, and of our strong relationships with primary care, to support our local population to receive their care in their own homes or in the community wherever possible.

[8] Twitter. @DrBruceKeogh. 5 Jan 2017.

6. 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 within three years**.** In March 2015 the Trust devised our own local Sign Up to Safety priorities. There 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: Update on progress against Whittington Health Quality Account priorities and 'Sign up to Safety' pledges for 2017/18

Domain	Whittington Health Quality Account priorities and 'Sign up to Safety' pledges for 2017/18	Progress in Quarter 1, 2 and Quarter 3 2017/18
AKI	At least 75% of patients with AKI include an AKI diagnosis in their discharge letter	Q1 92% Q2 79% Q3 67%
	At least 90% of patients with grade 3 AKI are seen by Critical Care Outreach Team within 24 hours.	Q1 96% Q2 97% Q3 98 %
	90% of patients that develop grade 3 AKI have a medicine safety review within 24 hours	Q1 50% Q2 40% Q3 51%
Sepsis	We will achieve the national CQUIN for sepsis (**90% of eligible patients in ED screened for sepsis**) with a particular focus on sepsis developing during inpatient stay.	Q1 88% Q2 95% Q3 96%
	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 to relevant local healthcare provider centres.	• Sepsis awareness day attended by 263 community and Hospital staff. • All community nurses now receive sepsis awareness training in their induction. • '*Could it be sepsis*' leaflets distributed to 26 community sites (the Trust has 46 community sites in total).

<table>
<tr><td rowspan="2">Falls</td><td>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 (COOP)</td><td><u>AAU</u>
Q3 100%
<u>COOP</u>
Q2 83%; Q3 92%</td></tr>
<tr><td>We will reduce the number of avoidable falls resulting in SERIOUS HARM to patients year on year</td><td>2016/17: 6
2017/18: 4</td></tr>
<tr><td rowspan="2">Pressure Ulcers</td><td>To achieve a year on year reduction in all grades of pressure ulcers across the ICO</td><td><table><tr><th>Q1 – Q3</th><th>Community</th><th>Acute</th><th>% Change</th></tr><tr><td>Grade 4</td><td>5</td><td>0</td><td>0</td></tr><tr><td>Grade 3</td><td>18</td><td>7</td><td>12% increase</td></tr><tr><td>Grade 2</td><td>28</td><td>20</td><td>17% increase</td></tr></table></td></tr>
<tr><td>We are developing a cross borough target on the ‘React to Red Initiative’</td><td>Awareness events through attendance at Islington carer hub and Islington Adult Safeguarding Group.
Training session provided to Islington GPs on PU recognition.
Article published in Islington newsletter.
Information distribution to pharmacists, care agencies, practice nurses and GPs, including on the GP portal for Islington.</td></tr>
<tr><td>LD</td><td>75% of patients who present to the Emergency Department with learning disabilities are given a priority assessment (i.e. seen in <2 hours)</td><td>Q1 65%
Q2 75%
Q3 66%</td></tr>
</table>

	We will introduce a care pathway for mothers with learning disabilities in the hospital	LD draft protocol in final stages and on target to be approved, ratified and in circulation by 31/03/2018
	All children and young people entering CAMHS for a choice appointment will be screened for Learning Disabilities	Q1 - 100% Q2 – 100% Q3 – 100%

7. New initiatives to disseminate learning from serious incidents, near misses, inquests, complaints and claims

BMJ Open Quality

The Trust has purchased access to BMJ Open Quality and this is now available to Whittington Health staff. BMJ Open Quality has an ever-expanding collection of peer reviewed quality improvement reports. The journal is dedicated to publishing high quality, peer reviewed healthcare improvement work and as we are now subscribers Whittington authors can submit their own reports for publication. The BMJ Open Quality website also provides a wide range of resources to support quality improvement work such as learning modules blogs, podcasts and templates to help staff run and write up quality improvement projects.

Reflective reading club

We have begun a new round of our Reflective Reading Club aimed at supporting nurses going through revalidation. Each session provides 3 hours of CPD towards the revalidation requirement. Topics recently covered include clinical supervision and radicalisation.

8. References

1. NHS Digital Indicator Portal, (September 2017, NHS Digital), available from https://indicators.hscic.gov.uk/webview/
2. University of Oxford Centre for Clinical Vaccinology and Tropical Medicine, Oxford Vaccine Group, available from http://vk.ovg.ox.ac.uk/inactivated-flu-vaccine
3. Public Health England, Flu immunisation programme e-learning, available from https://www.e-lfh.org.uk/programmes/flu-immunisation/
4. Public Health England, Weekly National Influenza Report, 12 April 2018 – Week 15 report, available from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment data/file/699521/Weekly_report_current_12_April_2018.pdf
5. Pebody Richard, Warburton Fiona, Ellis Joanna, Andrews Nick, Potts Alison, Cottrell Simon, Johnston Jillian, Reynolds Arlene, Gunson Rory,Thompson Catherine, Galiano Monica, Robertson Chris, Byford Rachel, Gallagher Naomh, Sinnathamby Mary, Yonova Ivelina, Pathirannehelage Sameera, Donati Matthew,Moore Catherine, de Lusignan Simon, McMenamin Jim, Zambon Maria. *Effectiveness of seasonal influenza vaccine for adults and children in preventing laboratory-confirmed influenza in primary care in the United Kingdom: 2015/16 end-of-season results*. (2016, Euro Surveill). Available from https://doi.org/10.2807/1560-7917.ES.2016.21.38.30348
6. Pebody Richard, Warburton Fiona, Ellis Joanna, Andrews Nick, Potts Alison, Cottrell Simon, Reynolds Arlene, Gunson Rory, Thompson Catherine,Galiano Monica, Robertson Chris, Gallagher Naomh, Sinnathamby Mary, Yonova Ivelina, Correa Ana, Moore Catherine, Sartaj Muhammad, de Lusignan Simon,McMenamin Jim, Zambon Maria. End-of-season influenza vaccine effectiveness in adults and children, United Kingdom, 2016/17. (2017, Euro Surveill). Available from https://doi.org/10.2807/1560-7917.ES.2017.22.44.17-00306

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Whittington Health Trust Board

25th April 2018

Title:	**Annual Safeguarding Children Declaration 2018**		
Agenda item:	**18/057**	**Paper**	**5**
Action requested:	For Approval		
Executive Summary:	• Whittington Health NHS Trust (WH) is committed to achieving and maintaining compliance with national safeguarding children standards and guidance to ensure that children and young people are cared for in a safe, secure and caring environment. • Safeguarding and promoting the welfare of children is embedded across every part of the Trust and in every aspect of our work. The Trust has clear controls and arrangements in place through regular audit, review and quality improvement led by skilled and competent named professionals, supported and challenged by the Trust Board and Clinical Commissioning Groups. • The Board Director responsible for safeguarding is the Chief Nurse & Director of Patient Experience. Bi-monthly Safeguarding Children Committee meetings are held with accountability to the Trust Board through the Quality Committee. • The Trust has systems and processes in place that ensure that it meets its statutory requirements to keep children safe.		
Summary of recommendations:	To approve the annual statement of assurance		
Fit with WH strategy:	To ensure that the Trust deliver consistent, high quality, safe services		
Reference to related / other documents:	Fits with Local Safeguarding Children Boards procedures and the Pan London Safeguarding Children Procedures		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	There are not any risks associated with this annual statement		
Date paper completed:	16th April 2018		

Author name and title:		**Karen Miller Head of Safeguarding Children**		**Director name and title:**		**Michelle Johnson Chief Nurse & director of Patient Experience**	
Date paper seen by EC	**NA**	**Equality Impact Assessment complete?**	**NA**	**Quality Impact Assessment complete?**	**NA**	**Financial Impact Assessment complete?**	**NA**

Annual Safeguarding Children Declaration 2018

1. SUMMARY DECLARATION

1.1. Whittington Health NHS Trust (WH) is committed to achieving and maintaining compliance with national safeguarding children standards and guidance to ensure that children and young people are cared for in a safe, secure and caring environment.

1.2. The WH Safeguarding Children team works closely with the Safeguarding Adults lead to ensure a 'joined up' approach exists to safeguard the entire population the Trust serves. This includes fully embedding strategies linked to protection from domestic abuse, child sexual exploitation and adhering to the PREVENT strategy in protecting vulnerable groups from radicalisation.

1.3. Safeguarding and promoting the welfare of children is embedded across every part of the Trust and in every aspect of our work. The Trust has clear controls and arrangements in place through regular audit, review and quality improvement led by skilled and competent named professionals, supported and challenged by the Trust Board and Clinical Commissioning Groups.

1.4. The Board Director responsible for safeguarding is the Chief Nurse & Director of Patient Experience. Bi-monthly Safeguarding Children Committee meetings are held with accountability to the Trust Board through the Quality Committee.

2. SYSTEMS AND PROCESSES

2.1. Disclosure and Barring Service (DBS) checks (formally known as CRB) are carried out on all staff commencing employment. Staff working with children and/or vulnerable adults requires an enhanced level of check.

2.2. A Designated Officer (currently the Head of Safeguarding Children post holder) is employed to investigate and advise regarding safety within the workforce.

2.3. The Designated Officer works closely with Local Authority Designated Officers (LADO) in Local Authorities Children's Social Care to escalate concerns regarding staff behaviour in respect of potential risks posed by their behaviour in relation to their employment.

3. POLICIES

3.1. The Trust has clear up-to-date child protection and safeguarding policies and systems which are reviewed regularly. These are overseen by our Quality Committee and Safeguarding Children's Committees, both of which report into Trust Board.

3.2. The Trust has a process in place for following up children who miss appointments and systems for identifying children where there are

safeguarding concerns. A policy called the 'Was not Brought' Policy supports staff in this area.

3.3. Safeguarding training is a priority for all staff, with different levels of training depending on their role. Training is provided in accordance with the Safeguarding Intercollegiate Document (2014 revision expected in 2018). This is designed to ensure our staff possess the correct knowledge, skills and competencies to carry out their duties in relation to safeguarding children. Whittington Health is working towards CQC compliance at 90% at levels 1-3 with a robust training programme in place to ensure this is achieved.

4. ASSURANCE

4.1. The Chief Nurse holds the position as Executive Lead for safeguarding children and the Head of Safeguarding professionally reports to the Chief Nurse.

4.2. Safeguarding Children Annual Report is produced which is reviewed by the Trust Board.

4.3. Whittington Health is an active member of three local LSCB's in Haringey, Hackney and Islington. Local Safeguarding Board Section 11 audits into safeguarding compliance across the Trust are completed as required.

4.4. The Safeguarding Children Committee meets quarterly to discuss all matters pertaining to child protection including serious case review recommendations.

5. DECLARATION

5.1. This summary provides the trust Board with assurance that the trust is meeting its statutory requirements in relation to safeguarding children in its care.

Whittington Health

Trust Board

25th April 2018

Title:	**Improving mental health care in the emergency department; an external review by Verita, and the Trust response**		
Agenda item:	18/058	**Paper**	6
Action requested:	The Board is asked to recognise the steps taken and the assurances contained within this paper, and to discuss any further improvements that might be made.		
Executive Summary:	Between November 2014 and December 2016 seven patients who had contact with the Emergency Department at the Whittington Hospital, and had presentations related to possible or confirmed mental health issues, subsequently died unexpectedly. Although not all the subsequent coroner's inquests recorded a verdict of suicide, all the deaths were related to apparent acts of self-harm. In each of these seven cases, Whittington Health (WH) undertook a full root cause analysis (RCA) investigation. Four of these deaths were declared as serious incidents (SIs) by Whittington Health, three were declared as serious incidents by Camden and Islington Mental Health Trust (C&I), and one was declared as a serious incident by Barnet and Enfield Mental Health Trust (BEH). Although these investigations provided a number of important individual learning points, WH and C&I did not feel that there was any clear overarching common theme emerging from these separate investigations that would account for the unexpected number of tragic incidents in a relatively short period of time. WH and C&I agreed that it was very important to seek an independent external overview to test the quality of the investigations and to see if there might have been any additional learning or themes that our investigations had not identified. For this reason, WH, in conjunction with C&I, commissioned Verita to conduct an external review of our Emergency Department with respect to the experience and safety of patients with mental health conditions. Verita is a consultancy specialising in the management and conduct of investigations, reviews and inquiries. This paper describes the terms of reference and methodology of the Verita review, the conclusions that Verita came to and the formal recommendations that Verita made. This paper also describes Whittington Health's response to each of Verita's recommendations. This paper also describes additional actions that have been taken by Whittington Health to improve the safety and experience of patients with mental health conditions in the emergency department, including substantial changes that have been made to the physical environment.		

	Appendix 1 of this paper contains the executive summary and recommendations of the Verita report itself, from February 2018.				
Fit with WH strategy:	To deliver consistent high quality, safe services.				
Reference to related / other documents:	Quality Account 2016-17 Sign up to Safety Pledges Clinical Strategy 2015-20 CQC standards				
Reference to areas of risk and corporate risks on the Board Assurance Framework:	BAF14: Failure to deliver safe and high quality urgent and emergency pathway resulting in patients waiting for care and treatment with risk identified in care of people with mental health care needs.				
Date paper completed:	17th April 2018				
Author name and title:	**Richard Jennings, Executive Medical Director**	**Director name and title:**		**Richard Jennings, Executive Medical Director**	
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Improving mental health care in the emergency department; an external review by Verita, and the Trust response

Background to the commissioning of the Verita report

Between November 2014 and December 2016 seven patients who had contact with the Emergency Department at the Whittington Hospital, and had presentations related to possible or confirmed mental health issues, subsequently died unexpectedly. Although not all the subsequent coroner's inquests recorded a verdict of suicide, all the deaths were related to apparent acts of self-harm.

In each of these seven cases, Whittington Health (WH) undertook a full root cause analysis (RCA) investigation. Four of these deaths were declared as serious incidents (SIs) by Whittington Health, three were declared as serious incidents by Camden and Islington Mental Health Trust (C&I) and one was declared, and one was declared as a serious incident by Barnet and Enfield Mental Health Trust (BEH).

Although these investigations provided a number of important individual learning points, WH and C&I did not feel that there was any clear overarching common theme emerging from these separate investigations that would account for the unexpected number of tragic incidents in a relatively short period of time.

WH and C&I agreed that it was very important to seek an independent external overview to test the quality of the investigations and to see if there might have been any additional learning or themes that our investigations had not identified.

For this reason, WH, in conjunction with C&I, commissioned Verita to conduct an external review of our Emergency Department with respect to the experience and safety of patients with mental health conditions. Verita is a consultancy specialising in the management and conduct of investigations, reviews and inquiries.

This paper describes the terms of reference and methodology of the Verita review, the conclusions that Verita came to and the formal recommendations that Verita made.

This paper also describes Whittington Health's response to each of Verita's recommendations.

This paper also describes additional actions that have been taken by Whittington Health to improve the safety and experience of patients with mental health conditions in the emergency department, including substantial changes that have been made to the physical environment.

Appendix 1 of this paper contains the executive summary and recommendations of the Verita report itself, from February 2018.

Terms of Reference for the Verita Report

The terms of reference for Verita were:

WH, in conjunction with C&I, commissioned Verita to conduct an external review of our Emergency Department with respect to the experience and safety of patients with mental health conditions. Verita is a consultancy specialising in the management and conduct of investigations, reviews and inquiries.

This review was commissioned in response to serious incidents between November 2014 and December 2016, where seven patients who had contact with the Emergency Department at WH subsequently died unexpectedly. The aim of the review was two-fold, as set out in the terms of reference;

1. Evaluate the investigative process and reports of the service users who committed suicide between 2014 – 2016 to establish whether the investigations are robust and all relevant learning has been identified
2. Examine and evaluate the systems and processes in place for the management of patients at risk of suicide to check that they are fit for purpose. This will include those of the Camden and Islington Mental Health Liaison Team working in the Emergency Department.

The Verita methodology

In undertaking this review, Verita carried out interviews with key staff across Whittington Health, Camden and Islington and Haringey Clinical Commissioning Group, as well as reviewing copies of the investigation reports and relevant Trust policies, national guidance and observing practice within the Whittington Hospital Emergency Department.

Key findings

In summarising the key findings of the Verita review, this paper will be divided into the two key sections as set out in the terms of reference, and then provide an overview of any actions taken in relation to the comments or recommendations highlighted by Verita. It is important to note that this report should be reviewed in the wider national context of increasing demand for mental health beds. Much of the work outlined had already been undertaken, not in response to the Verita report, but as part of the local strategy for managing mental health patients in conjunction with our neighbouring mental health trusts.

Quality assurance of investigation reports for serious incidents

Verita reviewed seven serious incident investigation reports from incidents that occurred between November 2014 and December 2016, the last five occurring over three months in late 2016. These investigations were completed by WH, C&I and in one case, BEH. The findings are therefore not solely focused on WH's investigative process.

Verita confirmed that the WH *Serious Incident Policy* is based on national guidance, with a Serious Incident Executive Assurance Group (SIEAG) made up of the Medical Director (chair), Chief Nurse and Chief Operating Officer. The Trust met local and national standards by using root cause analysis as the preferred method of incident investigation; however Verita raised concerns that not all investigators understood how to use these tools effectively.

The report acknowledged that while WH used a standard template based directly on the national serious incident framework, Verita felt it was restrictive and not intuitive due to the repetitive nature of the executive summary. However, it should be recognised that the template had already been amended with the executive summary removed by October 2017.

Verita identified a number of areas for improvement with respect to the investigative process which are outlined in the recommendations section, including training for investigators. These recommendations are not specific to WH, and the majority were already in place at WH and required no further action. More integrated working on investigations where patients have had care from multiple providers was highlighted as a key are for focus.

The overall conclusion of the report highlighted the commitment of staff in the Whittington Health Emergency Department to the welfare of mental health patients. Verita commented on the ambition of staff to learn from incidents, noting that many staff spoken to could describe previous incidents and the improvement actions introduced as a result. Verita also commended the commitment of both trust leadership teams on working together in the best interest of patients.

Systems and processes in place for the management of patients at risk of suicide in Whittington Health Emergency Department (ED)

No common themes were identified from the seven cases reviewed. However, Verita highlighted a number of underlying issues including the interaction between three factors – the level of demand for the service, the length of time people have to wait and the physical environment in which they wait.

The report outlined that many staff had commented on the increase in mental health activity, in particular the number of sectioned patients. Staff felt a contributory factor to this was the reduction in the availability of alternative services for patients with mental health issues, such as access to community services. In addition, the length of time that patients are spending in the emergency department is increasing, which is driven by the lack of available mental health beds nationally.

While the report acknowledged that rising number of people presenting at the ED and the shortage of mental health beds were mainly out of the control of both trusts, the physical environment in Whittington ED was poor and needed to be improved. Verita noted that the trust had plans in place to address this, including the immediate renovation of Rooms 12 and 12A and longer-term plans to provide alternative facilities for patients detained under the Mental Health Act (Section 136) in C&I.

The location of the liaison team was another area of focus in the report. Verita acknowledged that there were benefits and disadvantages to having the Mental Health Liaison Team based within the ED and did not make a specific recommendation. However, the report did highlight that the nurse-led Mental Health Liaison Team would benefit from more senior input from psychiatrists in the ED. Verita further noted that the service would benefit from more dual qualified nurses (i.e. both Registered General Nurse and Registered Mental Health Nurse).

Verita acknowledged the existing work which had already taken place following the incidents including the introduction of a mental health pro-forma and care plan. While no specific recommendations were made in relation to the processes in the ED, the final section of this summary highlights the actions taken by the trust to improve the physical environment of the ED, as well as changes to processes to improve patient safety.

In the overall conclusion, Verita commented that the treatment of mental health patients within ED of hospitals is a difficult and complex area of practice. In particular the report acknowledged that decisions on whether to hold patients against their will are inherently complex, and there is no simple solution. The report highlighted the benefits of enhanced staff training, including awareness of the use of the Mental Capacity and Mental Health Acts, as well as scenario-based roleplays across the multi-disciplinary team, including security staff.

Recommendations

R1: Commissioners of investigations should meet with investigators face-to-face at the beginning of the process to discuss what is expected

> WH response: Previously Lead Investigators presented the Terms of Reference in person at a SIEAG Panel meeting (commissioners of SIs); this was the practice in place during the period covered in the Verita review. However, following review of clinician time this is now done virtually and this new process has been well received by investigators. In place of the face to face meeting between Panel and the investigator, the SI timeline now has two face-to-face meetings with the Integrated Clinical Service Unit (ICSU) risk manager at day 15 and day 30 to review progress and provide support.

R2: The executive team that commissions a serious incident should ensure that members of the investigation team have the appropriate knowledge and skills to undertake the investigation and write the report.

> WH response: WH works to ensure that all lead investigators have had adequate training in RCA methodology before undertaking an investigation. Four RCA training sessions have been held since October 2017 to increase the number of staff trained in RCA methodology. There are plans to develop in-house training in 2018 to expand the opportunity to provide training to staff. However, it should be noted that if a lead investigator did not have RCA training, they would be mentored through the process by the ICSU risk manager, ICSU Head of Nursing (HoN) and Quality and Risk Team.

R3: The commissioners of the service should ensure that the investigation report template meets the needs of the trusts, the commissioners and those affected by an incident (i.e. the family) to ensure that investigation reports are sound, accessible and focused.

> WH: Since the Verita review commenced, the WH SI template has been revised. It is standard practice, where possible to invite those affected by an incident (often the patients' families) to contribute to the terms of reference of the investigation by adding any questions that they wish to have answered. It is also standard practice, in accordance with the Trust's *Being Open Policy* and in line with the statutory Duty of Candour, to discuss the findings of investigations with those affected. The new template is a simplified version which removed the duplicate entries that had been a cause of frustration for staff. The feedback from staff on the new template has been positive and since its introduction there have been no complaints about the SI template

R4: Those who commission serious incident investigations must ensure that the terms of reference focus on the purpose of the investigation rather than the process and that all relevant lines of enquiry are explicitly stated.

WH: As described above, the terms of reference for all serious incident investigations must be signed off by the Serious Incident Executive Approval Group (SIEAG) panel. This ensures that all relevant lines of enquiry are explicitly stated and provides direction for the investigation.

R5: Investigation reports should demonstrate that benchmarks relevant to the incident and surrounding circumstances are identified and these are analysed to find any underlying systems issues so that recommendations can be made to reduce the chances of the same thing happening again.

WH: A standard Term of Reference question in all SI reports is to refer back to any similar serious incidents which have happened in the past. The investigator must address whether there were any common themes and confirm if the actions from the previous serious incident had been adequately addressed. This process ensures that the SIEAG panel has oversight of recurring issues and can identify where actions have either not been completed, or were inadequate at resolving the root cause of the incident.

R6: Both trusts should ensure that recommendations outlined in investigation reports are clearly linked to the issues, contributory factors and evidence so that recommendations can be made that eliminate or reduce risk

WH: All recommendations and associated action plans are signed off by the SIEAG Panel before they are submitted to commissioners. This process ensures that the recommendations are specifically linked to the contributory factors and root cause identified in the report. The SIEAG Panel further reviews all actions to ensure they are Specific, Measurable, Achievable, Realistic, and Timed Bound (SMART) and will adequately address the problem identified. It is commonplace for actions to be revised or new actions added to the report during the SIEAG Panel discussion.

R7: Both trusts should ensure that recommendations are SMART so that there is a clear description of what is required, who is responsible for taking action and for measuring its effectiveness

WH: As above

R8: WH and C&I work together to establish a memorandum of understanding to facilitate joint investigations of SIs.

WH: The Clinical Directors and Heads of Nursing from WH and C&I have met following the receipt of the draft Verita report in December 2017. The Heads of Governance and Risk at both trusts have also met to discuss the findings of the report. An informal agreement is already in place to support joint investigations and WH has hosted a joint learning workshop relating to one of the serious incident investigations which was attended by neighbouring mental health trusts, social care, and commissioners. A formal memorandum of understanding is currently being developed to reflect the informal arrangement already in place.

In addition to the specific recommendations highlighted in the report, Whittington Health has taken the following actions to improve the safety and experience of patients with mental health conditions in the Emergency Department:

1. **ED environment**

    a. Short term plan: The 136 suite rooms have been renovated, including new vinyl flooring, new windows, new furniture, and the rooms were re-painted. Work has also been completed to improve the air-conditioning unit and clock.
    b. Medium term plan: A section of ambulatory care has now been comprehensively re-fitted as an experience-friendly mental health recovery lounge for low-risk patients. This area will include an assessment room, lounge, office, bathroom and shower and can accommodate up to four service users. The area will be staffed by Camden and Islington Mental Health Trust (C&I) Integrated Liaison Assessment Team (ILAT). However, the funding to staff the area is awaiting confirmation from the CCG. This recovery lounge will become operational very shortly, and represents a significant investment in the environment to improve the experience of local people with mental health concerns who access our emergency service.
    c. Long-term plan: The longer term plan is to provide an alternative facility for mental health patients on Section 136 of the Mental Health Act. The 136 suites locally would be located at C&I Highgate Wing, where service users will be managed by C&I staff. This is due for completion by December 2018.

2. **Safe observations for mental health patients**

    a. Emergency Department Assistants (EDAs) who carry out observations of mental health patients undertake a departmental training day provided by the C&I liaison team and WH staff. This includes training on how to carry out observations.
    b. EDA carrying out mental health observations now wear yellow coloured tabards with the words 'DO NOT DISTURB' to make it clear to staff that the EDA must not be called away by other staff members to undertake any other duty.
    c. There is now a tag card watch system in place to ensure that the observations of mental health patients are carried out effectively without gaps or interruptions. This system involves the person carrying out the observation carrying a tag card, which they have to hand over to any colleague taking over the observation role before they can leave the patient.
    d. Laminated prompt cards are in place to remind staff of their responsibilities when undertaking observation duties.
    e. Refresher training is provided on the ward by the psychiatric liaison service as required.
    f. The Seclusion Policy has been renewed, and includes specific advice for secluding patients and performing arm's length observations, and is applicable to C&I ILAT and WH staff.
    g. The existing mental health 4 hour review pro-forma has been added to electronic system, Medway. C&I ILAT staff complete this form and conduct reviews every four hours for service users that stay for longer periods of time in ED, creating a robust, retrievable and auditable record of these reviews.

3. **Co-location of psychiatric liaison service within ED**
    a. The psychiatric liaison service has a hot desk and office space in the ED. In addition to this, work is in progress to provide a team base for the liaison service closer to ED, which will include larger office space and a breakout area.

Appendix 1

VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent review of suicides and deaths of mental health patients who attended the Whittington Health emergency department

A report for

Whittington Hospitals NHS Trust

February 2018

1. Executive summary and recommendations

1.1 Between November 2014 and December 2016 seven patients who had contact with the emergency department at the Whittington hospital subsequently died unexpectedly. As well as being treated by emergency department staff, they also received an assessment from the mental health liaison team from the local provider of mental health services Camden & Islington NHS Foundation Trust (the 'mental health trust').

1.2 Whittington Health NHS Trust ('Whittington Health'), with the support of the mental health trust and the local clinical commissioning group asked Verita to carry out an independent review. The aim of the review is to look the trusts' investigation into the deaths and also the processes that are in place to manage patients with mental health needs as part of their commitment to learning and development.

1.3 We interviewed a total of 18 staff across Whittington Health, the mental health trust and the Clinical Commissioning Group (CCG). We reviewed documentation including national guidance, local policies and serious incident reports.

Background

1.4 Whittington Health provides hospital and community care services from 30 community locations as well as from the Whittington hospital ('the Whittington').

1.5 The mental health trust provides care and treatment for patients in the community, in their homes or in hospital. The mental health trust also provides mental health liaison services at hospitals including the Whittington. These services are provided by the integrated liaison assessment team (the liaison team) and include emergency assessment for people with mental health conditions who present to the emergency department. The Whittington liaison team is based at the Highgate Mental Health Centre across the road from the hospital.

1.6 Patients with mental health issues may arrive at the emergency department in a number of ways – by themselves, with friends or family, in an ambulance or accompanied by the police. On arrival at the emergency department, they go through a triage process which is carried out by emergency department nurses with training in triage. The

completion of the triage is usually the point where the triage nurse would make a referral to the mental health team if necessary.

1.7 Patients presenting with mental health concerns are assessed by a nurse using a mental health pro forma which guides them though questions about the patient including issues such as the risk of absconding. The second half of the pro forma is then used by a doctor to carry out further assessment. The pro forma is used for stratifying patents according to risk. Where relevant the patient will be referred to the mental health team.

1.8 The mental health team are required to carry out an assessment of a patient within one hour of the patient being referred to them. Assessments are carried out using the risk assessment model included in CareNotes, the mental health trust's electronic patient record system. If a patient is sectioned under the Mental Health Act and physical restraint of patients is needed, the Whittington security team are contacted as they are responsible for carrying out the restraint.

1.9 In the emergency department interventions are mainly focussed on medication rather than providing therapy as patients are often in a crisis state and the priority is to keep them safe. If the decision is made to admit a mental health patient (either formally or informally), the mental health team will begin the process of finding a bed. Patients waiting for a mental health bed is a major bottleneck in the system.

1.10 The facilities in the Whittington emergency department consist of two rooms (12 and 12a) within the main emergency department area. There is a general agreement that these facilities are not well suited to mental health patients because of their poor physical environment. There are also two secure rooms in the Majors area.

1.11 Everyone that we spoke to described the relationship between the emergency department staff and mental health liaison team as good. Although they are not located on the same site as the emergency department, the mental health team are generally viewed as being accessible and normally meet the one-hour target for seeing patients.

The seven cases

1.12 We considered seven cases that that occurred between November 2014 and December 2016, the last five occurring over three months in late 2016. The cases are summarised in the report, including a reference to the coroner's inquests, where relevant.

Investigations

1.13 We considered the process of the investigations that were carried out as a result of these events. Investigations were carried out by staff in Whittington Health, the mental health trust and, in one case, Barnet, Enfield & Haringey Mental Health Trust. The commissioners, Islington and Haringey CCGs review them. The commissioners told us that they expected the investigations to adhere to the national guidance around reporting. The commissioners want to ensure that the quality of the investigation is high, that the duty of candour requirements with family members are fulfilled and that there is learning from what happened.

Whittington Health investigations

1.14 Whittington Health's serious incident policy is based on national guidance. When an incident has been identified it is escalated and reaches a serious incident panel chaired by the medical director if sufficiently serious. The panel gives a steer on the terms of reference of an investigation, although they are carried out within the relevant directorate, rather than by a central team.

1.15 Some investigators told us that they were commissioned to carry out an investigation by email. The initial steps in an investigation are a crucial part of the process. Face to face meetings with investigators to talk through with them what is expected would be desirable.

1.16 Reports are written using a standard template, based on the national serious incident framework provided by the Clinical Commissioning Group. The investigation template is restrictive and not intuitive. It does not encourage authors to begin by clearly setting out a description of the events leading up to the incident. As a result, there is a tendency for reports to be unclear and repetitive, with the same facts appearing a number of times.

1.17 Whittington Health provides a training programme for investigators. It was not always clear that the investigators had received the training.

Camden and Islington Investigations

1.18 Investigations are carried out jointly by a lead investigator from outside the division where the incident occurred, working alongside a clinical expert from within the division. Investigators are nominated from staff on a central trust rota and tend to carry out investigations every two or three years.

1.19 The question of whether to have a specialist team to carry out investigations, or getting staff throughout the organisation is a dilemma for all trusts. The approach of spreading investigations amongst staff members has benefits in sharing learning. However, having to carry out an investigation is a burden for already busy staff. Providing adequate support is therefore important.

1.20 A central serious incident team carries out a preliminary review of incidents. A decision on what level of investigation is needed is taken by the mortality review group, chaired by the medical director. The terms of reference are decided by the investigator, who involves the family. They are then fed back to the mortality review group. Investigators are usually sent a 72-hour report and a template by email at the start of their investigation.

1.21 We saw plenty of examples of good practice, particularly in relation to family engagement. However, there was a feeling among trust investigators that they were given little guidance and left to 'get on with it'. At times, this made them feel anxious about the process.

1.22 Time pressure was raised as an issue by many investigators. The investigation process described to us was the same for all serious incidents. However, some investigations are more complex and sensitive than others. Extra resources, whether in terms of support

for making time for the investigator should be provided for the most significant investigations.

1.23 Investigators in both trusts told us that they received little feedback after completion of their investigation reports. It would be good to ensure adequate engagement with those who complete reports, to thank them for their work, to get learning for the trust

about the investigation process and to give investigators feedback on learning about the work that they have done.

Joint investigations

1.24 The circumstances of some serious incidents will call for investigations to be undertaken jointly with other NHS trusts, local authorities or other organisations. However, there is no guidance on carrying out joint investigations with other trusts in the Whittington health policy.

1.25 Interviewees had differing views as to who was responsible for managing incidents and therefore investigations - not necessarily a simple question where patients have been involved with multiple organisations. One might argue that it is only possible to be completely certain who is responsible for an incident AFTER the investigation has been completed. Spending a lot of time arguing between NHS organisations about who is responsible beforehand is unlikely to generate any value. Besides, the technical responsibility with regards to serious incident reporting procedures does not necessarily have to determine who actually carries out the investigation - "responsibility" is not necessarily the same as "best placed to input".

Evaluation of serious incident investigation reports

1.26 We evaluated the seven investigation reports supplied to us to establish whether the investigations were robust and whether all relevant learning was identified. The main issues identified were:

- Investigation template – a number of interviewees had concerns about the usability of the template
- Terms of reference – while all the reports included terms of reference and there were some examples of good practice, there was a lack of focus on specific lines of inquiry
- Clinical risk management – there was a lack of analysis of risk management processes
- Benchmarks – none of the reports provided a comprehensive, organised approach to using benchmarks
- Analysis – some reports lacked clarity about the central issues
- Recommendations – some key issues raised in the reports were not carried through into recommendations and some recommendations did not result from the issues highlighted in the report. Many of the

recommendations were not 'SMART'

- Duty of candour – the reports demonstrate in broad terms that duty of candour was adhered to but they could be further improved if the reports were more explicit about when families were told about the incident and when and how an apology was offered. Some of the reports were not as generally accessible as they could be.

1.27 The following common themes emerged from the investigative reports:

- Improving record keeping and handovers, so that accurate information including risks is shared
- The sharing of patient records between emergency department and mental health staff
- Ensuring that risk assessment and risk management plans are up to date and that plans are put in place for when patients leave the emergency department or face long waits to be transferred to non-local mental health trusts
- Improving the physical environment at the Whittington emergency department for patients suffering from mental health problems.

1.28 We were told that the investigation process focusses on learning. However, a pre-requisite for learning is understanding. If the conclusions of investigations are not firmly based on good understanding and analysis of what happened, they are more likely to be prejudices or clichés rather than genuine learning. There is also a danger in focussing on the "quantity" of learning. It may be that there is only one important thing to be learnt from a particular investigation, so having more recommendations weakens, rather than strengthens the report. A report that clearly sets out what happened is a resource which can be used in the future. A report that jumps to conclusions and learning without sufficient analysis may tell the reader little.

1.29 Carrying out investigations is challenging, particularly when authors also have their day jobs to do. While this report focusses on where improvements can be made, this should not be taken as a criticism that the reports we read where particularly sub-standard, or that they were very different from most investigation reports we read from across the country.

1.30 A number of people we spoke to in told us that improvements had been made since the incidents. We were told that there is now much more awareness of the use

of the mental health crisis proformas and that the assessment is now more objective and better focussed on identifying and predicting which patients are at high risk or likely to be at high risk (risk stratification).

1.31 The staffing structure of an emergency department with two providers working so closely together makes it inevitable that in any incident concerning a mental health patient will involve staff from both organisations. Looking from the outside, the case for integrated investigations between acute and mental health trusts is strong. Administrative distinctions within the NHS should not be allowed to get in the way of what is best for the patient or their family. That the medical directors of both organisations share this view and are very closely aligned on this issue, is welcome.

1.32 Formalising the relationship between the two trusts so that it is clear to staff how a joint investigation should work would be welcome as it would avoid most of the issues that arose in these investigations. This approach would be re-enforced by a joint training event to further embed good practice. It is important to note that joint working does not necessarily mean always having to carry out an investigation jointly or agree about all findings. The key issue is dialogue - that the respective investigators and teams meet together at the beginning of the process to agree a way forward. That could result in a single report, two separate reports or some combination of the two.

Themes and issues

Overarching theme

1.33 The conclusion from our review of the seven cases is that while there are a number of underlying factors which lie behind the cases, there is no single factor or issue with the care provided that links together all the cases. We did however identify a number of contributory issues which are relevant.

Contributory issues

1.34 A number of important issues have emerged from our investigation. One issue results from the interaction between three factors – the level of demand for the service, the length of time people have to wait and the physical environment in which they wait. We were told that the number of patients attending the emergency department has grown in recent years due to wider societal issues. The volume of patients creates delays and also increases the length of time that patients have to spend in the emergency department.

Bed availability is the major factor in very long delays for mental health patients as the length of time it takes to find a bed leads to mental health patients having to spend many hours, and sometimes days in the department.

1.35 Emergency departments are generally not good places for people with mental health problems who would ideally be seen in calm, quiet environments. The physical environment for mental health patients in the Whittington in particular is very poor. Whittington Health told us that plans have been developed to improve the rooms used by mental health patients. The news that Whittington have a programme to improve them are welcome.

1.36 Overall it is clear that a rising number of people presenting at the emergency department and the shortage of mental health beds for them to go to will mean that long waits are likely to continue. While this is mainly out of control of the Whittington and Camden & Islington trusts, the best that can be made of this situation is to ensure that the facilities that are provided are as fit for purpose as possible.

Absconding

1.37 For some patients, it is necessary to ensure that they stay in the emergency department even if they do not want to remain. Interviewees told us of their understanding of the balance between allowing patients their dignity and freedom, but also acting to protect them when necessary. Decisions on whether to hold patients against their will are inherently complex. There will never be a simple answer to them, all that trusts can do is ensure that staff are properly trained and that the issues are kept in the forefront of the minds of staff.

1.38 A number of interviewees made reference to the importance of security guards in these issues. They should be included in any training initiatives that are carried out to reinforce awareness of mental health legislation.

Location of the liaison team

1.39 While we were told that the emergency department team work well together with the mental health liaison team, a number of interviewees noted that the liaison team is not based within the emergency department. There are pros and cons to having the mental health liaison team based within the emergency department. The main issues about the

proposal, however, appear to relate to concerns about there being enough space within the emergency department for the needs of the liaison team. If the team is to be moved into the emergency department it will be important to ensure that they have allocated time and space to do the aspects of their job that do not involve interaction with emergency department staff – reviewing patient histories, writing up assessments and making calls to other services.

1.40 The mental health liaison team is nurse-led. There is no settled view amongst those we spoke to about whether or not the level of input into the emergency department by senior psychiatrists (consultants and trainees) is right. However, interviewees report that the highest risk and greatest workload is in the emergency department and that appears to be supported by the data. We think therefore it would sensible for the two trusts to discuss how the time of senior psychiatrists is divided between the emergency department and the wards.

Changes in practice

1.41 There have been a number of changes in practice that have followed the incidents described in this report such as the introduction of a mental health pro-forma and care plan. There remain; however, areas where staff felt further improvements can be made. One of these was around 4-hour observations of patients in the emergency department by the mental health team. The quality of record keeping was an issue that was highlighted in a number of the investigation reports. This continues to be a concern for commissioners.

Overall conclusion

1.42 The treatment of mental health patients within emergency departments of hospitals is a difficult and complex area of practice. Emergency departments, with their noisy and busy atmosphere are not good places for vulnerable people. Ideally there should be adequate facilities in the community to meet their needs. Nevertheless, supporting people in these circumstances is an important role for an emergency department.

1.43 We saw many areas of good practice amongst the staff that we spoke to. They demonstrated a commitment to the welfare of mental health patients and to improving services to them. There was also a commitment from staff to learn from these incidents. Time and again we spoke to front line staff who knew the details of the individual cases and who had spent time thinking about what changes need to be made in the light of them. We

see this as a very encouraging aspect of our investigation.

1.44 We also saw the commitment of the leadership of both the Whittington and Camden & Islington mental health trusts to work together in the best interests of patients, leaving aside the administrative barriers. The staff in the emergency department – from both the Whittington and the mental health trust – also displayed a commitment to working together to deliver the best services possible, despite the issues we identified with past investigations. Joint working on investigations should be cemented through a memorandum of understanding between the two trusts.

1.45 We make a number of recommendations relating to conduct of investigations in the two trusts, including ensuring that there a good template is provided and staff carrying out investigations are properly supported. Everyone who carries out investigations should be fully trained (particularly with challenging issues such as engagement with families). It would be helpful if briefing meetings were held at the outset of investigations and that feedback about the quality of investigations is given to those who have carried them out.

1.46 Training more generally is also a key theme. Staff are expected to make difficult decisions about when to allow patients to go and when to keep them in the department. Both the Mental Capacity and Mental Health Acts are complex and even the most experienced staff find their application difficult. Enhanced training, which could include roleplay using scenarios around which patients are sufficiently 'at risk' so they should be denied their freedom, should be considered. Such training should include the security teams who play and important role in several of the cases we looked at.

1.47 The greater availability of dual qualified nurses – i.e. both Registered General Nurse and Registered Mental Nurse would be of benefit to the department.

1.48 Legal highs appear to be a growing problem. We heard that use of these substances is regularly a causal factor behind people presenting to the emergency department with mental health issues. More information should be provided to staff and patients about the risks.

1.49 The quality of physical facilities is also important, notwithstanding the point we have made about the inherent difficulty of providing mental health services from within an emergency department. Whittington acknowledge that the facilities currently available

within the emergency department are inadequate and we welcome the plans that they have to upgrade them.

1.50 Ensuring that sectioned patients do not abscond is also an important theme. Again, staff are aware of the need to strike a balance. A number told us that they do not see themselves as "jailors" and while it is always an option to lock sectioned patients into a room, their reluctance to do so is understandable. If a non-stigmatising identification system for sectioned patients could be designed, e.g. by putting a flag on the door of rooms 12/12a, that may prove helpful.

1.51 Physical constraints also mean that the mental health liaison team is not currently based on the Whittington site. The closer that they could be located to the emergency department, the better this would be for improving day-to-day communication between the teams. Almost everyone that we spoke to acknowledged the benefits of such a move. Given the nature of their work following an assessment, the team need a properly equipped room.

1.52 The trust may want to consider whether volunteer 'befrienders' working in the emergency department with mental health patients would help alleviate the pressure on professional staff and provide companionship to patients who are waiting.

1.53 Mental health patients in emergency departments is an area where there are few simple solutions. We have found compelling evidence that practice has improved greatly in the Whittington since these incidents occurred. Work should continue until all the lessons are fully incorporated into practice.

Recommendations

R1 Commissioners of investigations should meet with investigators face-to-face at the beginning of the process to discuss what is expected.

R2 The executive team that commissions a serious incident investigation should ensure that members of the investigation team have the appropriate knowledge and skills to undertake the investigation and write the report.

R3 The commissioners of the service should ensure that the investigation report

template meets the needs of the trusts, the commissioners and those affected by an incident i.e. the family, to ensure that investigation reports are sound, accessible and focused.

R4 Those who commission serious incident investigations must ensure that the terms of reference focus on the purpose of the investigation rather than the process and that all relevant lines of enquiry are explicitly stated.

R5 Investigation reports should demonstrate that benchmarks relevant to the incident and surrounding circumstances are identified and these are analysed to find any underlying systems issues so that recommendations can be made to reduce the chances of the same thing happening again.

R6 Both trusts should ensure that recommendations outlined in investigation reports are clearly linked to the issues, contributory factors and evidence so that recommendations can be made that eliminate or reduce risk.

R7 Both trusts should ensure that recommendations are SMART so that there is a clear description of what is required, who is responsible for taking the action and for measuring its effectiveness.

R8 That Whittington Health and Camden & Islington Foundation Trust work together to establish a memorandum of understanding to facilitate joint investigations of serious incidents.

Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board

25 April 2018

Title:	March (Month 12) 2017/18 – Financial Performance		
Agenda item:	**18/059**	**Paper**	**7**
Action requested:	To agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends.		
Executive Summary:	In-month the Trust is reporting a £0.4m surplus, with a full-year surplus of £0.8m. As a result the Trust has bettered both its original and revised control total requirement for the year. As the Trust has bettered its control total it will be eligible for both incentive and bonus STF payments. These are to be recognised in 2017/18 and so the Trust's Annual Accounts will reflect an additional £4.7m income, and a revised surplus of £5.4m. March continued to see improved income performance, leading to a £1.7m favourable variance. Whilst pay costs reduced compared to Month 11 they are adverse against plan. Non-pay costs increased compared to the previous month, but include recognition of costs associated with a previous capital development project which were to be charged to I&E at year end. CIP performance has improved across the final quarter, but actual full year delivery (£11.7m) is significantly short of the Trust's target (£17.8m).		
Summary of recommendations:	The Board is asked to note: • the financial results for the month of March 2018 • the Trust has bettered its control total and is therefore eligible for both incentive and bonus STF payments • the on-going risks to delivering the 2018/19 control total as a result of performance against the Trust's annual CIP programme		
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:	23 April 2018		

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

In-month & Full Year

Prior to the application of incentive and bonus STF payments the Trust is reporting a £0.4m surplus in Month 12 (March) leading to an overall surplus of £0.8m for the financial year. Against both the original and revised control totals this represents a favourable variance of £0.2m.

Statement of comprehensive income

2017/18, Month 12 (March 2018)

Statement of Comprehensive Income	Original Control Total In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	Original Control Total YTD Budget (£000s)	YTD Actuals (£000s)	Variance (£000s)
NHS Clinical Income	22,117	22,872	756	260,888	264,624	3,736
Sustainability & Transformation Funding (STF)	*778*	*78*	(700)	*6,670*	*5,970*	*(700)*
STF - Incentive & Bonus Funding	*0*	*4,670*	4,670	*0*	*4,670*	*4,670*
	22,895	27,620	4,726	267,558	275,264	7,706
Non-NHS Clinical Income	1,815	1,544	(272)	21,979	19,913	(2,066)
Other Non-Patient Income	1,940	3,846	1,906	23,390	28,237	4,847
Total Income	**26,650**	**33,010**	**6,359**	**312,927**	**323,414**	**10,487**
Pay	(18,064)	(18,203)	(140)	(217,281)	(219,061)	(1,780)
Non-Pay	(6,594)	(7,720)	(1,126)	(79,334)	(82,429)	(3,095)
Total Operating Expenditure	**(24,658)**	**(25,924)**	**(1,266)**	**(296,615)**	**(301,490)**	**(4,875)**
EBITDA	**1,992**	**7,086**	**5,094**	**16,312**	**21,924**	**5,612**
Depreciation	(726)	(1,054)	(328)	(8,661)	(8,467)	194
Dividends Payable	(344)	(467)	(123)	(4,146)	(4,757)	(611)
Interest Payable	(293)	(295)	(2)	(3,096)	(3,191)	(95)
Interest Receivable	3	20	17	36	44	8
P/L on Disposal of Assets	0	(29)	(29)	0	(29)	(29)
Total	**(1,360)**	**(1,825)**	**(465)**	**(15,867)**	**(16,399)**	**(532)**
Net Surplus / (Deficit) - before IFRIC 12 adjustment	**632**	**5,261**	**4,629**	**445**	**5,524**	**5,079**
Add back impairments and adjust for IFRS & Donate	(15)	160	(175)	(162)	92	(254)
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**647**	**5,100**	**4,454**	**607**	**5,433**	**4,826**

The Trust continued to see improved income performance in March. Excluding the incentive and bonus STF payments the favourable variance against plan was £1.7m. As a result the full-year favourable variance has increased to £5.8m, which includes both A&E Tranche 1 and Tranche 2 funding (awarded by NHSI/NHSE), recognition of additional education monies, additional audiology new-born screening income, and takes into account a reduction to the Core STF (Sustainability & Transformation Funding) payment linked to A&E performance in Quarter 4.

Pay expenditure in Month 12 reduced compared to Month 11, and was slightly below the rolling 12-month average. However, actual costs are higher than budget both in-month and for the year as a whole and so further work will be required in 2018/19 to reduce costs, particularly those in relation to temporary staffing.

Non-pay expenditure increased compared to Month 11, but within this were the costs of a previous capital development project (£1.1m) that the Trust needed to recognise at year-end. As with Pay, Non-pay costs are adverse to budget both in-month and for the year as a whole with the key drivers being expenditure on supplies & services (clinical and general) and consultancy, together with underperformance against CIP schemes.

CIP performance has generally improved in the final quarter of the year, with a full year delivery of £11.7m savings. However, despite the improvements seen in Quarter 4 the Trust was still significantly short of its target (£6.1m) and its original planning assumption (£5.6m), and therefore delivery of CIPs will remain a key risk for the Trust to manage as we head into the new financial year.

Annual performance against Control Total

The Trust's original control total requirement for 2017/18 was to deliver a surplus of £0.6m. During the course of the financial year this was increased, and subsequently reduced, to take into account additional funding to support seasonal pressures within A&E and Quarter 4 A&E performance respectively.
See Table 1 below.

Table 1 – Control Total 2017/18

Control Total Requirement 2017/18	£000s
Original Control Total - Surplus	607
Increase for additional A&E funding	686
Revised Control Total	**1,293**
Adjustment for Quarter 4 A&E performance	(700)
Final Control Total - Surplus	**593**
Actual I&E Surplus - Month 12	**763**
Improvement on Control Total	**170**

The final control total requirement for the Trust was to deliver a surplus of £0.6m, taking into account the adjustments described above, against which the Trust actually delivered a surplus of £0.8m.

As a result of bettering the control total, the Trust is eligible for both incentive (£3.0m) and bonus (£1.7m) STF payments. The payments are to be recognised in 2017/18, and therefore the Trust's Annual Accounts will reflect an additional £4.7m in income, compared to the I&E statement above, and a revised year end surplus of £5.4m. Discussions are due to be held with NHSI to explore how the additional cash received can be utilised to improve services and infrastructure during 2018/19.

Income & Activity

Month 12 was a high-income month for the Trust. Excluding incentive & bonus STF payments the in-month favourable variance against plan was £1.7m, leading to a cumulative favourable income variance of £5.8m.

Points to note:

- Outpatient attendances (controllable income) fell in month for first attendances, resulting in a £0.1m adverse variance in-month, and £0.8m adverse variance for the year. Follow ups continue to be below plan (£0.1m adverse in month and £1.0m adverse full year). The largest under-performances continue to be in General Surgery, T&O and Dermatology.

- Elective and Outpatient Procedures were on plan in month with OP procedures continuing to over perform for the year (£0.8m).

- Non electives were slightly below plan making the overall, full-year, adverse variance £0.9m.

- Due to the stable activity performance, there is a marginal rate reduction of £0.4m for Month 12, similar to Month 11.

- Other Income, overall, is £3.2m favourable for the year.

Month 12

Category	In Month Income Plan	In Month Income Actual	In Month Variance	YTD Income Plan	YTD Income Actual	YTD Variance	In Month Activity Plan	In Month Activity Actual	In Month Variance	YTD Activity Plan	YTD Activity Actual	YTD Variance
Accident and Emergency	893	901	8	10,518	10,953	435	5,044	6,271	1,227	60,492	69,222	8,730
Adult Critical Care	702	1,058	356	8,265	7,856	(409)	580	382	(198)	5,221	4,758	(463)
Community Block	5,858	5,859	0	70,329	70,329	0	0	0	0	0	0	0
Day Cases	1,238	1,065	(174)	14,086	13,247	(839)	1,807	1,599	(208)	20,819	18,960	(1,859)
Diagnostics	240	280	40	2,726	2,925	200	2,379	2,766	387	27,036	29,606	2,570
Direct Access	1,044	1,091	47	11,869	11,271	(599)	95,547	98,267	2,720	1,085,760	1,075,749	(10,011)
Elective	743	745	2	8,552	8,522	(31)	129	197	68	1,919	2,227	308
Maternity - Deliveries	1,110	1,047	(62)	13,076	12,617	(459)	334	312	(22)	3,931	3,722	(209)
Maternity - Pathways	801	674	(127)	9,105	8,606	(500)	750	624	(126)	8,526	8,128	(398)
Non-Elective	4,215	4,198	(17)	49,373	48,454	(919)	1,430	1,594	164	17,903	18,557	654
OP Attendances - 1st	999	935	(64)	11,361	10,604	(756)	4,765	5,015	250	59,520	58,840	(680)
OP Attendances - follow up	880	732	(148)	10,015	8,994	(1,021)	11,661	11,235	(426)	142,000	146,317	4,317
Other Acute Income	2,531	2,535	5	27,777	34,384	6,607	11,401	10,561	(840)	132,036	132,628	592
Outpatient Procedures	333	358	25	3,781	4,547	765	1,856	2,445	589	21,115	26,253	5,138
Total SLA	**21,586**	**21,476**	**(110)**	**250,834**	**253,309**	**2,475**	**137,682**	**141,268**	**3,586**	**1,586,279**	**1,594,967**	**8,688**
Marginal Rate	0	0	0	0	(374)	(374)						
	21,586	**21,476**	**(110)**	**250,834**	**252,935**	**2,101**						
Other Clinical Income	2,989	3,016	28	37,002	37,565	564						
Other Non Clinical Income	2,076	3,847	1,771	25,091	28,244	3,153						
Total Other	**5,064**	**6,864**	**1,799**	**62,092**	**65,809**	**3,717**	**0**	**0**	**0**	**0**	**0**	**0**
Grand Total	**26,650**	**28,340**	**1,689**	**312,927**	**318,744**	**5,817**	**137,682**	**141,268**	**3,586**	**1,586,279**	**1,594,967**	**8,688**

In addition to the key points noted above, it should also be noted that the end of year position includes:

- both A&E Tranche 1 (£0.7m) and Tranche 2 (£0.5m) funding

- recognition of additional education monies (£1.8m).

- audiology new-born screening income. As previously reported a review of the contractual position indicated that the Trust is following the correct billing procedure and therefore the income has been fully recognised.

Monthly Run Rates – Expenditure

The Trust is reporting an adverse expenditure variance both in month (£1.3m) and year to date (£4.9m). 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 March was £18.2m, £0.6m lower than the previous month and £0.1m lower than the 12 months rolling average. However, it should be noted that whilst pay expenditure was lower in Month 12, total spend for the year is adverse to budget.

- Bank and agency costs in month totalled £3.3m, £1.1m more than average with CYP, Integrated Medicine and PPP services having the largest increased compared to Month 11.

- Agency costs this financial year have been averaging £0.8m per month representing 3.9% of the average monthly pay bill. However for Quarter 4 (months 10, 11 and 12) they were £1.1m, £1.0m and £1.1m respectively representing 5.6%, 5.1% and 6.2% of the pay bill.

- Reducing the level of pay expenditure, particularly that associated with temporary staffing, together with maintaining the strong income performance seen in the second half of the financial year and delivery of CIPs will be the key focuses of financial performance in 2018/19.

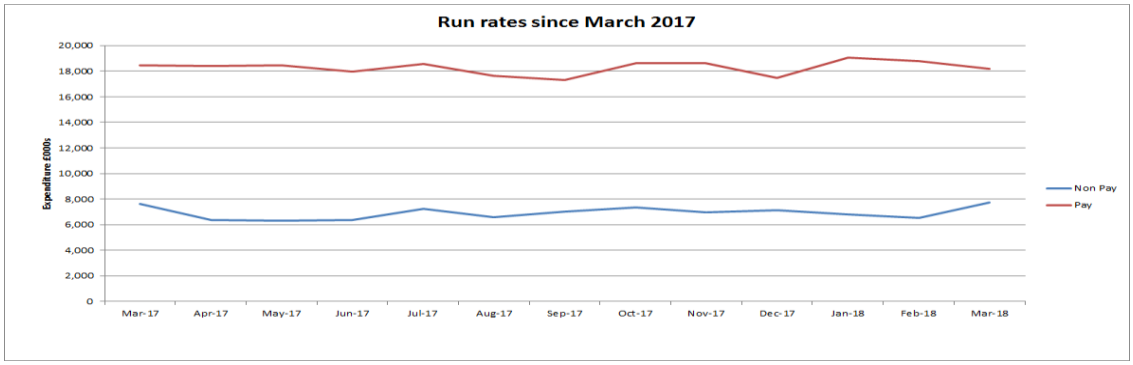
  Whilst the Trust has finished the year just inside the NHSI agency ceiling, this has included the non-recurrent benefit from the removal of booked agency shifts. Without it, the Trust would have exceeded the agency ceiling and as a result further work is required to continue to reduce costs associated with agency in 2018/19, particularly as the ceiling has been reduced from £9.5m to £8.8m (full-year).

  It should be noted that there are certain areas that have performed better than others. For example, within Surgery & Cancer even though Nursing has experienced high levels of vacancies, to add to the complexity of the service requirements, they have still managed agency/temporary staffing effectively and kept costs within budget. The Trust will be seeking to learn from the approach adopted within Surgery & Cancer and to apply this more widely.

Non pay expenditure for March was £7.7m, which is £1.1m adverse against plan in-month, and £0.9m more than the monthly average for this financial year. Cumulatively non-pay is £3.1m adverse to plan, with key drivers being expenditure on supplies & services (clinical and general) and consultancy, together with underperformance against CIP schemes. Comparing Month 12 to Month 11, notable increases in non-pay expenditure included:

- The impact of costs associated with a previous capital development project that needed to be recognised at year-end £1.1m;
- Increased expenditure on clinical tests sent to other provider organisations £0.2m; and
- The impact of the revaluation of assets on depreciation and Public Dividend Capital £0.2m.

The graph below provides the pay and non-pay expenditure trend over a 13-month period from March 2017 to March 2018.



Cost Improvement Programme

Against the Trust's full year target of £17.8m, £12.5m of plans had been agreed and recognised. As part of an ongoing process this value continued to be reconciled against the value of road-mapped schemes held by the Programme Management Office (PMO), with new schemes and opportunities proposed and validated to address the gap compared to the target.

Current performance by ICSU:

Integrated Clinical Service Unit	Against Target		Month 12 - Full Year			
	Identified £'000	Gap £'000	Plan £'000	Actual £'000	Variance £'000	% achieved
Children's services	2,787	278	2,985	1,985	(1,001)	66.5%
Clinical Support Services	1,333	1,001	2,273	1,428	(845)	62.8%
Emergency & Urgent Care	705	1,452	2,101	642	(1,459)	30.5%
Integrated Medicine	1,918	214	2,077	1,168	(908)	56.3%
PPP	674	200	851	1,122	271	131.8%
Surgery	2,161	998	3,077	2,124	(953)	69.0%
Women's services	990	508	1,459	677	(782)	46.4%
Estates & Facilities	836	486	1,288	1,063	(225)	82.5%
Corporate	1,114	122	1,204	1,449	245	120.4%
Total	**12,518**	**5,259**	**17,315**	**11,657**	**(5,658)**	**67.3%**

At Month 12, £11.7m had been recognised as delivered against the CIP programme, which is £5.6m adverse when compared to the Trust's original planning submission. Whilst the expected step change in delivery of savings at Quarter 3 didn't occur, actual delivery over the final 3 months of the financial year has improved.

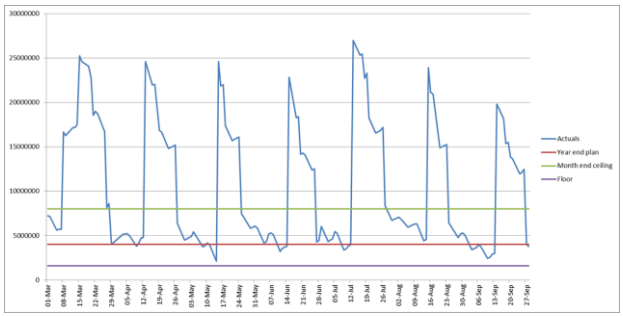
Against the Month 11 full-year forecast (£10.5m) the final position has shown an improvement of £1.1m. Included within this improvement is the recognition of increased Audiology activity which has led to increased (recurrent) income £0.7m, together with the conclusion of an exercise examining where budgetary underspends were recurrent and therefore could be removed as a CIP.

As we head into the new financial year, the Trust has made structural changes to its PMO as it seeks to improve the identification and support for scheme delivery.

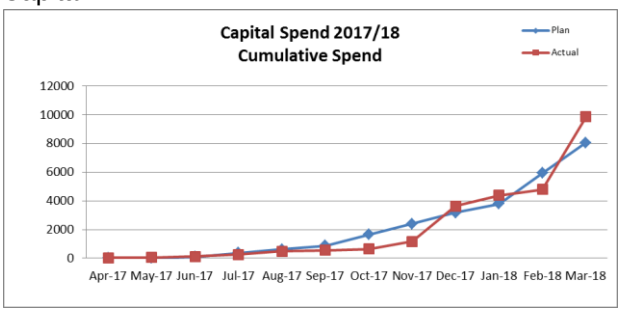
Statement of Financial Position

	As at 31 March 2018 £000	Plan 31 March 2018 £000	Plan variance 31 March 2018 £000
Property, plant and equipment	216,498	204,291	12,207
Intangible assets	4,274	1,395	2,879
Trade and other receivables	656	851	(195)
Total Non Current Assets	**221,428**	**206,537**	**14,891**
Inventories	1,355	150	1,205
Trade and other receivables	28,814	27,863	951
Cash and cash equivalents	4,051	4,030	21
Total Current Assets	**34,220**	**32,043**	**2,177**
Total Assets	**255,648**	**238,580**	**17,068**
Trade and other payables	37,139	38,045	(906)
Borrowings	18,996	7,020	11,976
Provisions	1,391	756	635
Total Current Liabilities	**57,526**	**45,821**	**11,705**
Net Current Assets (Liabilities)	**(23,306)**	**(13,778)**	**(9,528)**
Total Assets less Current Liabilities	**198,122**	**192,759**	**5,363**
Borrowings	39,647	63,515	(23,868)
Provisions	842	1,513	(671)
Total Non Current Liabilities	**40,489**	**65,028**	**(24,539)**
Total Assets Employed	**157,633**	**127,731**	**29,902**
Public dividend capital	64,679	62,404	2,275
Retained earnings	(5,620)	(12,749)	7,130
Revaluation reserve	98,573	78,076	20,497
Total Taxpayers' Equity	**157,633**	**127,731**	**29,902**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**

Cash Flow



Capital



The key highlights for month 12 are:

Property, Plant & Equipment (PPE): The value held at the end of March 2018 is £15.1m above plan. This reflects increased expenditure on PPE and intangibles in Month 12, together with an end of year revaluation (£5m).

Receivables (Debtors) at month 12 are currently £0.8m above plan. Included within the Month 12 position is the STF incentive and bonus payment that will be physically in the next financial year.

Payables (Creditors) are currently £0.9m below plan. During the year, the Trust has averaged 86.2% payment of creditors within 30 days, which is a significant improvement on 2016-17 (67.8%). The Trust also planned for cash support from the DH, but due to the favourable cash position throughout the year, this was not required during 2017-18.

Capital: £9.9m of capital expenditure has been incurred year to date against the initial plan of £8.1m (excluding commitments on PFI and finance lease arrangements). The Trust has exceeded its plan following an additional allocation of £2.3m from DH for Fast Follower (£1.3m) and A&E Primary Care Streaming (£1.0m) projects. Spend on the capital programme more widely also accelerated. In particular, some IT projects were brought forward from 2018-19 to meet shortfalls elsewhere in the programme.

Cash Flow: As at 31 March 2018 the Trust is holding £4.1m in cash, which is in line with plan. Month 12 saw increased payments linked to the acceleration of the capital programme (in the latter part of the year), and the Trust has made an advance payment of its National Insurance liability. The Trust's cash position has been managed proactively throughout the year, and as expected returned to plan in the final month of the financial year.

Appendix 1 – ICSU I&E Position

	Month 12			Year to date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Children's & Young People						
Income	2,061	2,466	**405**	24,268	25,887	**1,619**
Pay	3,745	4,077	**(332)**	44,900	47,290	**(2,390)**
Non Pay	178	222	**(44)**	2,137	2,541	**(404)**
	1,862	**1,833**	**29**	**22,769**	**23,944**	**(1,175)**
Clinical Support Services						
Income	1,949	2,047	**98**	22,620	22,458	**(162)**
Pay	1,240	1,207	**33**	14,810	16,198	**(1,389)**
Non Pay	1,286	1,654	**(369)**	15,367	18,348	**(2,981)**
	577	**814**	**(237)**	**7,557**	**12,089**	**(4,531)**
Emergency & Urgent Care						
Income	1,393	1,492	**99**	15,885	16,962	**1,077**
Pay	2,212	2,395	**(183)**	22,439	25,220	**(2,782)**
Non Pay	245	325	**(80)**	2,782	3,259	**(476)**
	1,063	**1,228**	**(165)**	**9,336**	**11,517**	**(2,181)**
Integrated Medicine						
Income	3,980	4,482	**502**	46,502	45,637	**(865)**
Pay	2,823	3,157	(334)	33,168	35,494	(2,325)
Non Pay	194	270	(76)	2,238	3,010	(771)
	(963)	**(1,055)**	**93**	**(11,095)**	**(7,134)**	**(3,961)**
PPP						
Income	222	243	**20**	2,442	2,345	**(96)**
Pay	1,048	1,078	(30)	12,453	11,930	523
Non Pay	190	197	(7)	2,256	2,526	(270)
	1,016	**1,032**	**(16)**	**12,267**	**12,111**	**157**
Surgery						
Income	4,651	4,362	**(289)**	54,202	52,220	**(1,982)**
Pay	3,062	3,290	(228)	36,526	37,705	(1,179)
Non Pay	766	992	(225)	9,146	10,458	(1,312)
	(823)	**(80)**	**(742)**	**(8,530)**	**(4,056)**	**(4,473)**
Women's						
Income	2,440	2,185	**(255)**	29,132	28,026	**(1,106)**
Pay	1,298	1,431	(132)	16,454	17,877	(1,424)
Non Pay	99	82	17	1,408	1,534	(126)
	(1,043)	**(672)**	**(371)**	**(11,271)**	**(8,615)**	**(2,656)**
Facilities						
Income	152	154	**2**	1,672	1,651	**(21)**
Pay	635	576	**59**	6,990	7,550	**(560)**
Non Pay	1,457	1,639	**(182)**	16,403	16,691	**(288)**
	1,941	**2,062**	**(121)**	**21,722**	**22,590**	**(868)**
Corporate (Excl Facilities)						
Income	568	1,243	**675**	7,067	8,838	**1,771**
Pay	1,869	1,592	**277**	22,552	20,703	**1,849**
Non Pay	1,575	2,213	**(638)**	18,999	19,196	**(197)**
	2,876	**2,562**	**314**	**34,484**	**31,061**	**3,423**

Operations
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Whittington Health NHS Trust

Trust Board
25th April 2018

Title:	Trust Performance report April 2018 (March 2018 data)		
Agenda item:	**18/060**	**Paper**	**8**
Action requested:	To receive assurance of Trust performance compliance		
Executive Summary:	**Emergency Department (ED) four hours' wait:** Performance against the 95% target for March was 83.15%. This was unfortunately lower than March 2017 which was at 88.39%. Q4 performance (17/18) was 85.19% which was slightly lower than the same quarter the year previous (85.96%). Overall performance against the 95% target for 17/18 improved in comparison to 16/17, where we reported 89.43%, an increase of 3% on 16/17. Activity was up on last year, 9217 attendances (March 18) against 8527 (March 17). **Community waiting times** As part of the Community Improvement Programme a revised community dashboard is expected to be made available for the May Board. **Safer Staffing** For approval of the board: Nursing staff average percentage for day and night staff, split by nurses and HCA has now been added to the Performance report. The number of staffing Alerts per month has also been added. **eRS** In line with the National 'Paper Switch Off' Project and as a requirement of the NHS England 2018/19 Contract all GP referrals to Consultant Led First Outpatient Appointments will be made via the NHS e-Referral System (eRS) by **1st October 2018.** Whittington Health is a wave 1 early adopter site and from 16th April 2018 are accepting all GP referrals to Consultant Led Outpatients Services via the NHS e-Referral System. The Trust has a weekly task group represented by all services in place to oversee the implementation.		
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:		18th April 2018					
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 Trust

April 2018

Month 12 (2017 – 2018)

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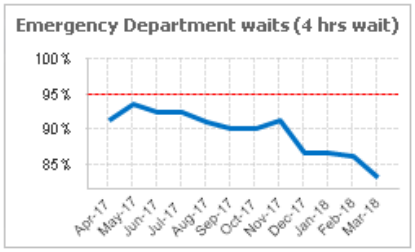
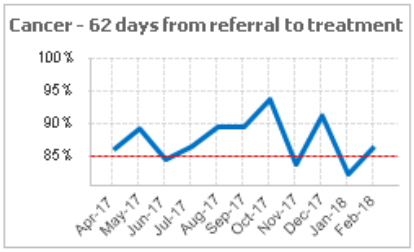
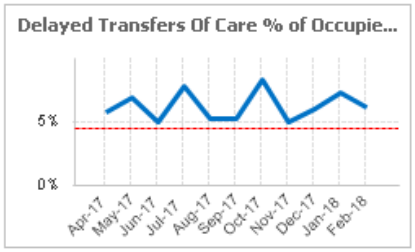
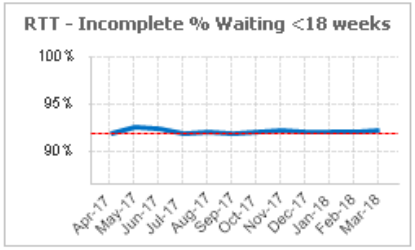
Summary Page - Indicators

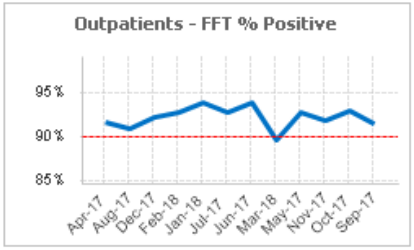
Category	Indicator	17_18 Target	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	2017-2018
ED	Emergency Department waits (4 hrs wait)	>95%	91.1%	93.5%	92.4%	92.3%	90.9%	89.9%	90.1%	91.3%	86.5%	86.5%	86.1%	83.1%	89.4%
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	72	68	63	59	64	72	82	82	81	75	77	95	74
Cancer	Cancer - 14 days to first seen	>93%	93.2%	93.2%	95.3%	95.7%	94.7%	94.3%	93.7%	96.1%	96.0%	94.9%	94.2%		94.7%
Cancer	Cancer - 62 days from referral to treatment	>85%	86.0%	89.1%	84.4%	86.4%	89.4%	89.5%	93.8%	83.6%	91.2%	82.2%	86.5%		87.4%
Admitted	Non Elective Re-admissions within 30 days	<5.5%	6.2%	6.0%	5.8%	6.8%	7.1%	6.5%	7.0%	5.7%	7.3%	5.5%	6.0%	6.4%	6.4%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	5.8%	6.9%	5.0%	7.8%	5.2%	5.2%	8.3%	5.0%	6.0%	7.3%	6.2%		6.3%
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.0%	92.6%	92.4%	92.0%	92.1%	92.0%	92.1%	92.2%	92.1%	92.1%	92.1%	92.3%	92.2%
Outpatients	Outpatients - FFT % Positive	>90%	91.6%	92.8%	93.9%	92.8%	90.8%	91.5%	93.0%	91.9%	92.3%	93.8%	92.8%	89.6%	92.4%
Community	Community - FFT % Positive	>90%	98.5%	94.9%	93.9%	94.8%	96.7%	96.5%	95.3%	94.8%	96.0%	95.4%	94.6%	96.5%	95.5%
Staff	Staff - FFT % Recommend Care	>70%			69.0%			69.4%							69.2%

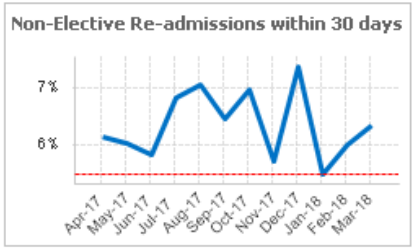












Safe Services - Indicators and Performance

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Category	Indicator	17_18 Target	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	2017-2018	Performance
Admitted	Admissions to Adult Facilities of pts under 16 yrs of age	0	0	0	0	0	0	0	1	0	0	0	0	0	1	
Admitted	HCAI C Difficile	<17	2	3	0	1	0	1	3	0	0	0	1	0	11	
All Areas	CAS Alerts Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
All Areas	Actual Falls	400	31	44	45	34	31	27	34	28	35	38	27	43	417	
All Areas	Avoidable Grade 3 or 4 Pressure Ulcers	0	2	2	3	2	2	3	3	3	3	9	3	3	38	
All Areas	Harm Free Care %	>95%	93.2%	93.9%	96.6%	93.5%	93.8%	95.1%	94.1%	93.5%	94.1%	93.4%	92.2%	93.9%	93.9%	
Maternity	Non Elective C-Section % Rate	<15%	19.2%	18.9%	19.7%	22.5%	18.8%	19.8%	20.8%	23.4%	21.7%	18.8%	22.0%	14.5%	20.0%	
All Areas	Medication Errors causing serious harm	0	0	0	0	0	0	0	1	0	0	0	0	0	1	
Admitted	MRSA Bacteraemia Incidences	0	0	0	1	0	0	0	0	1	0	1	0	0	3	
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	18.1%	16.6%	18.3%	17.3%	21.7%	17.1%	16.5%	20.1%	17.2%	19.4%	18.6%	21.5%	18.5%	
All Areas	Serious Incidents	0	2	4	4	3	6	2	5	2	0	7	1	2	38	
Admitted	VTE Risk Assessment %	>95%	95.2%	95.4%	95.6%	95.3%	96.7%	96.0%	95.3%	96.0%	95.2%	95.1%	95.2%		95.6%	

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Safe Services - Commentary

Falls
There were 43 falls reported in March 2018. Eight low harm incidents and 2 moderate falls, which were investigated using the 72 hour report process. All found not to meet the criteria of serious incidents. There were 33 no harm falls reported in March 2018.

Pressure Ulcers
In March 18 there were 3 avoidable category 3 pressure ulcers across Whittington Health.
Cavell ward x 1 category 3 to the sacrum. There was no clear evidence that the patient's position was changed regularly or that the patient was reminded to change position.

District nursing x 2 category 3 pressure ulcers; in West Haringey DN team and one in the Central Haringey DN team.
One was a pressure ulcer to the heel and the other to the sacrum. Assessments and care planning were incomplete for both therefore an upgrade of equipment or introduction of additional equipment was not identified.

The action plan, including focus on assessments, retraining Health Care Assistants to complete SKINN bundles, record keeping audit and monitoring Patients of Concern in both areas, continues to be monitored by the Head of Nursing and within the ISCU's quality and risk board meetings.

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

Non Elective C-section rate
Achieved target

Serious Incidents
There were 2 SIs declared in March 2018.
1.2018.7161 Unexpected Death – Influenza (IM)
2.2018.6532 Patient fall (IM)]

Caring Services - Indicators and Performance

Category	Indicator	17_18 Target	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	2017-2018	Performance
ED	ED - FFT % Positive	>90%	84.0%	87.4%	84.0%	85.5%	83.0%	80.4%	81.6%	83.3%	83.1%	81.9%	82.6%	76.9%	82.9%	
ED	ED - FFT Response Rate	>15%	16.9%	15.6%	13.8%	13.1%	13.7%	12.6%	13.2%	12.3%	11.5%	12.8%	15.3%	14.1%	13.8%	
Admitted	Inpatients - FFT % Positive	>90%	98.0%	94.2%	97.0%	95.8%	95.2%	97.7%	98.3%	98.3%	97.2%	96.5%	96.4%	95.9%	96.7%	
Admitted	Inpatients - FFT Response Rate	>25%	21.6%	22.7%	19.8%	20.9%	14.9%	16.0%	18.0%	18.2%	16.1%	17.4%	17.9%	16.2%	18.3%	
Maternity	Maternity - FFT % Positive	>90%	93.6%	90.2%	88.1%	92.7%	89.4%	92.4%	94.9%	96.0%	95.9%	95.9%	99.3%	97.0%	94.6%	
Maternity	Maternity - FFT Response Rate	>15%	24.7%	22.2%	20.1%	23.5%	30.1%	18.5%	37.4%	36.2%	49.8%	56.3%	61.0%	18.7%	32.8%	
Outpatients	Outpatients - FFT % Positive	>90%	91.6%	92.8%	93.9%	92.8%	90.8%	91.5%	93.0%	91.9%	92.3%	93.8%	92.8%	89.6%	92.4%	
Outpatients	Outpatients - FFT Responses	400	357	623	537	485	338	433	569	593	336	420	461	249	5401	
Community	Community - FFT % Positive	>90%	98.5%	94.9%	93.9%	94.8%	96.7%	96.5%	95.3%	94.8%	96.0%	95.4%	94.6%	96.5%	95.5%	
Community	Community - FFT Responses	1500	725	1192	970	1224	858	940	731	638	605	875	1157	779	10694	
Staff	Staff - FFT % Recommend Care	>70%			69.0%			69.4%							69.2%	
All Areas	Complaints responded to within 25 working day	>80%	100.0%	83.3%	93.9%	76.0%	81.0%	72.2%	72.7%	68.8%	88.2%	76.9%	87.5%	92.0%	82.7%	
All Areas	Complaints (including complaints against Corporate division)	N/A	22	24	38	32	24	25	26	24	18	30	21	33	317	

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Caring Services - Commentary

FFT

For March 2018 there was a drop in the overall number of responses for both Community and Outpatient FFT.

- Community FFT declined from 1,157 responses in February to 779 in March. The Head of Nursing is working on a recovery plan. Community recommend rates remain very high at 97%.
- In Outpatients there was a decline from 461 in February to 249 in March. The decline in Outpatients is an outlier, as responses here have consistently been above the 400 target for the past 18 months. Outpatients saw a slight decline in their recommend rate from 93% in February to 89.6% in March.
- The inpatient FFT results remained consistent with what has been collected in Q4, with a response rate of 16% and recommend rate of 96%. The patient experience team are working with volunteers to have FFT collection a staple aspect of ward befriending support.
- ED saw a slight decline from 15.3% response rate in February to 14.1% in March.
- Maternity again received a high response rate of 18.7% and recommend rate of 97%.

'You said, we did'

Nightingale Ward – You said: *"the room temperature to some of the rooms was unpleasantly cold; we have worked in collaboration with the facilities department to install portable heaters during the cold months of the year."*

Montuschi Ward – You said*: "the toilets are frequently messy; we have fed this back to our domestic team and conduct close monitoring of the cleanliness across the ward with particular focus to the toilets."*

Caring Services - Commentary

Complaints

During March 2018 the Trust closed 33 complaints; 25 complaints required a response with 25 working days and 8 were allocated 40 working days for investigation due to their complexity.

In regard to the 25 working day target, the Trust achieved a performance of 92%, exceeding its 80% target for the second consecutive month.

- One complaint allocated 25 working days remains outstanding and overdue, i.e. S&C (1).
- In addition, two 40 working day complaints also remain outstanding, i.e. S&C (2).
- 62% of complaints (5) allocated 40 working days hit their target.

The majority of complaints were allocated to S&C 21% (7), CYPS 21% (7) and IM 18% (6).

Severity of complaints: 51% (17) were designated 'moderate', 42% (14) were designated 'low' risk and 6% (2) were designated 'high'.

- Of the two complaints designated high risk, one related to 'medical care' (i.e. incorrect treatment provided), and one related to 'admission, discharge transfer arrangements' (i.e. patient discharged with wrong/incorrect medication).

A review of the complaints for March shows that 'medical care' 36% (12) continues to be the main issue for patients. In March this was followed by 'attitude' 15% (5) and 'communication' 15% (5).

- In regard to 'medical care,' 42% of patients (5) felt that 'inadequate treatment' had been provided, whilst 17% (2) complaints related to 'incorrect treatment being provided' and 17% (2) related to 'poor treatment' being provided.
- In regard to 'attitude', 60% of patients (3) stated that staff had been 'inconsiderate/uncaring or dismissive'.
- In regard to 'communication', patient concerns were evenly distributed with patients highlighting that communication lacked 'clarity' or was 'confusing', that there was a 'lack of information to patient', 'no reply to telephone contact', 'communication was poor', or that there was 'nor response to the original condition/complaint/query'.

Of the 31 complaints that have closed, (including those allocated 40 working days), 29% (9) were 'upheld', and 35% 11() were 'partially upheld' meaning that, currently, 64% have been upheld in one form or another.

Effective Services - Indicators and Performance

Category	Indicator	17_18 Target	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	2017-2018	Performance
Maternity	Breastfeeding Initiated	>90%	90.2%	91.6%	93.3%	94.5%	92.3%	93.2%	91.7%	92.5%	90.7%	92.7%	92.0%	94.2%	92.4%	
Maternity	Smoking at Delivery	<6%	5.4%	3.4%	5.7%	7.5%	4.8%	7.1%	6.2%	6.3%	4.3%	3.8%	5.2%	4.5%	5.4%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	6.2%	6.0%	5.8%	6.8%	7.1%	6.5%	7.0%	5.7%	7.3%	5.5%	6.0%	6.4%	6.4%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	70.0	83.7	75.5	69.6	77.0	44.6	86.3	89.6	75.2				75.7	
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	75.4	76.7	104.5	71.8	91.6	38.2	98.9	96.9	44.6				80.5	
Trust	Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 mont...	1.14			0.73			0.73							0.73	
Admitted	Mortality rate per 1000 admissions in-months	14.4	7.2	7.6	6.5	6.4	7.2	2.6	8.6	8.5	12.0	9.4	9.9	10.1	8.0	
Community	IAPT Moving to Recovery	>50%	50.3%	53.0%	56.4%	52.3%	56.5%	55.1%	50.8%	53.0%	50.9%	47.5%	51.4%		52.5%	
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%						85.0%	94.1%	84.4%	71.7%	93.0%	80.0%	87.5%	84.6%	

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Effective Services - Commentary

Non Elective re-admission within 30 days

March's performance has seen a marginal increase and is the same as the average for the year.
Update report for Whittington Health piloting of discharge to assess pathway 1:
As more data is available the initial trend suggests the first week of discharge is resulting in low re-admission rates (5%), and an 18% 30 day readmission rate. The 30 day readmission rate in this cohort of patients who require additional support on discharge compares favourably with the 21% 30 day readmission rate for all Islington adult (> 55yrs) with admissions Oct 2017 - March 2018.

During the winter period where Speech and Language Therapy had a pilot rapid response service there was a marked drop in hospital re-admissions. Prior to commencing pilot re-admission rate was 7.2% for specific Speech and Language Therapy issues. In the months that the pilot ran re-admission rates were: December: 5%, January: 4.1%, February: 1.8% and March: 2.9% The ICSU is monitoring this trend over the next months including looking at capacity and demand within the Speech and Language Therapy Service.

Responsive Services - Indicators and Performance

Category	Indicator	17_18 Target	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	2017-2018	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	91.1%	93.5%	92.4%	92.3%	90.9%	89.9%	90.1%	91.3%	86.5%	86.5%	86.1%	83.1%	89.4%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	72	68	63	59	64	72	82	82	81	75	77	95	74	
ED	Ambulance handovers waiting more than 30 mins	0	28	14	40	27	23	35	38	15	34	34	37		325	
ED	Ambulance handovers waiting more than 60 mins	0	1	0	7	4	2	1	0	3	11	12	3		44	
ED	12 hour trolley waits in A&E	0	5	4	3	2	4	3	0	0	0	0	0	0	21	
Cancer	Cancer - 14 days to first seen	>93%	93.2%	93.2%	95.3%	95.7%	94.7%	94.3%	93.7%	96.1%	96.0%	94.9%	94.2%		94.7%	
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	96.0%	94.1%	100.0%	100.0%	95.9%	98.1%	98.9%	100.0%	100.0%	97.9%	95.0%		97.8%	
Cancer	Cancer - 62 days from referral to treatment	>85%	86.0%	89.1%	84.4%	86.4%	89.4%	89.5%	93.8%	83.6%	91.2%	82.2%	86.5%		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	>94%	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 - drugs	>98%	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 - 62 Day Screening	>90%	100.0%		100.0%		100.0%								100.0%	
Cancer	Cancer - 62 Day Upgrade															
Access	DM01 - Diagnostic Waits (<6 weeks)	>99%	99.0%	99.1%	99.1%	99.0%	99.0%	99.1%	99.1%	99.2%	99.1%	99.1%	99.1%	99.2%	99.1%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.0%	92.6%	92.4%	92.0%	92.1%	92.0%	92.1%	92.2%	92.1%	92.1%	92.1%	92.3%	92.2%	
Access	Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	3	1	1	0	0	0	0	0	0	5	

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Cancer Performance - 62D and 2WW by Tumour Group

Cancer - 62D Performance by Tumour Group

Indicator	17_18 Target	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	2017-2018	Performance
Breast	>85%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%		97.7%	
Gynaecological	>85%	100.0%	100.0%	0.0%	50.0%	66.7%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%		75.9%	
Haematological (Excluding Acute Leukaemia)	>85%	100.0%	50.0%	100.0%				100.0%						90.0%	
Lower Gastrointestinal	>85%	100.0%	100.0%		87.5%	50.0%	100.0%	71.4%	76.9%	85.7%	75.0%	66.7%		83.5%	
Lung	>85%	83.3%		100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	0.0%	50.0%		87.8%	
Other	>85%														
Skin	>85%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.7%	100.0%		100.0%	100.0%		99.2%	
Testicular	>85%	100.0%	100.0%	100.0%		100.0%								100.0%	
Upper Gastrointestinal	>85%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	66.7%	0.0%	50.0%		61.5%	
Urological (Excluding Testicular)	>85%	54.5%	80.0%	61.5%	57.1%	50.0%	57.1%	94.1%	100.0%	83.3%	100.0%	100.0%		78.4%	

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Cancer Performance - 62D and 2WW by Tumour Group

Cancer – 2WW Performance by Tumour Group

Indicator	17_18 Target	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	2017-2018	Performance
Breast	>93%	98.1%	94.8%	98.6%	99.2%	93.9%	98.3%	98.7%	97.3%	99.0%	98.8%	95.1%		97.4%	
Childrens	>93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Gynaecological	>93%	92.6%	97.8%	96.5%	96.2%	100.0%	100.0%	96.5%	100.0%	100.0%	96.3%	98.5%		97.5%	
Haematological	>93%	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%	88.9%	100.0%	100.0%	50.0%		94.4%	
Lower Gastrointestinal	>93%	89.2%	87.3%	93.9%	89.3%	88.0%	89.7%	79.7%	93.9%	90.6%	87.2%	90.7%		89.1%	
Lung	>93%	94.4%	100.0%	92.9%	100.0%	100.0%	90.5%	100.0%	84.2%	100.0%	96.2%	95.2%		95.4%	
Other	>93%	80.0%	100.0%											83.3%	
Skin	>93%	100.0%	99.4%	98.6%	99.4%	99.4%	98.7%	97.1%	100.0%	100.0%	98.0%	98.6%		99.0%	
Upper Gastrointestinal	>93%	39.1%	43.3%	77.6%	83.8%	79.5%	57.7%	77.8%	78.8%	60.0%	73.5%	80.8%		71.1%	
Urological	>93%	96.8%	100.0%	95.7%	98.2%	100.0%	95.9%	100.0%	98.5%	100.0%	98.9%	97.3%		98.3%	

Community Average Waits

Community Average Waits from Referral Received Date to Date First Seen – March 2018

Local Specialty Code	Routine Avg Adjusted Wait (in weeks)	Routine Target	Total Routine Patients 1st Seen	Urgent Avg Adjusted Wait (in weeks)	Urgent Target	Total Urgent Patients 1st Seen
Adult Wheelchair Service	3.7	12	26	13.00	2	1
Adults Speech and Language The...	3.3	12	148	0.86	2	1
Bladder And Bowel Management	13.6	12	90	17.07	2	2
CAMHS	6.0	8	162	1 Days	5 Days	1
Cardiology Service	2.4	6	27	3.14	2	1
Child Development Services	6.2	18	85			0
Community Children's Nursing	1.5	18	95	0.14	6	7
Community Paediatrics Services	7.0	16	30	3.46	6	51
Community Rehabilitation (CRT)	3.8	12	143	3.04	2	29
Community Rehabilitation (ICTT)	5.0	12	235	4.12	2	77
Diabetes Service	5.4	6	106	0.00	2	1
Family Nurse Partnership	2.1	12	14			0
Health Visiting	2.0	8	1114			0
Intermediate Care (REACH)	3.6	6	104	1.03	2	58
Looked After Children	3.7	52	18			0
Lymphodema Care	4.6	6	12			0
Musculoskeletal Service - CATS	3.2	18	268	2.38	6	3
Musculoskeletal Service - Routine	3.8	8	1520	2.31	2	59
Nutrition and Dietetics	5.0	8	175	0.00	2	1
Occupational Therapy	12.9	18	28			0
Paediatric Wheelchair Service	5.0	12	6			0
Physiotherapy	8.3	18	94			0
PIPS	2.2	12	8			0
Podiatry (Foot Health)	5.7	8	531	3.23	2	13
Respiratory Service	3.3	6	71	6.12	2	31
School Nursing	5.4	12	58			0
Speech and Language Therapy	9.9	18	196	16.61	6	8
Tissue Viability Service		-	0	1.37	2	64

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Responsive Services - Commentary

Emergency Department (ED) four hours' wait and Ambulance handover time
Performance against the 95% target for March was 83.15%. This was unfortunately lower than March 2017 which was at 88.39%. Q4 performance (17/18) was 85.19% which was slightly lower than the same quarter the year previous (85.96%). Overall performance against the 95% target for 17/18 improved in comparison to 16/17, where we reported 89.43%, an increase of 3% on 16/17.

Activity was up on last year by 7.5%, 9217 attendances (March 18) against 8527 (March 17). The situation this year was exacerbated by flu, an increase in complex DTOCS and high acuity on the wards.

Ambulance activity was up by 15% compared to the same time last year; 1929 (March 18) compared to 1639 (March 17).
Actions: The trust has implemented weekly MADE (Multiple Discharge Events), attended by senior representatives from both Haringey and Islington which aim to increase to bi-weekly (Tues and Thurs) from May 2018.
There is also continued focus on medically optimised < 2 %, over 21 day 'stranded patients' < 18% and over 7 days 'stranded patients' <40%.

The following are the main areas of focus specific to ED:

- RAT (Rapid Assessment and Treatment) refocus and achieve target time to treat.
- Fit to Sit: In place from end of February 2018 and overseen by Lead Matron. To create cubicle/assessment capacity to optimise flow within ED department.
- Percentage of ED Activity Diverted to AEC: Achieved target of 5% in February 2018.
- A review of Consultant, Registrar and Junior Doctor shift times (in line with demand) is taking place to ensure the department has the right capacity at the right time to manage demand.

Cancer
Issue 2WW: The cancer standard for 2 week waits has been achieved by the Trust overall. The areas which are under the standard as individual tumour groups are:
Upper GI: 80.39% 10 breaches out of a total of 51
Lower GI: 90.57% 10 breaches out of a total of 106
Haematology: 50% 3 breaches out of a total of 6
Action: Endoscopy has provided 9 additional target lists to accommodate the 2ww referrals since February 2018. March performance showing an

Responsive Services - Commentary

Cancer cont.

Issue 62 days: The cancer standard for 62 day waits has been achieved by the Trust overall. The areas which are under the standard are:

Lower GI: 66.7% 1 breach out of a total of 3, 4 weeks delay for colonoscopy

Lung: 50% 0.5 breaches out of a total of 1, patient delayed the diagnostic tests

Upper GI: 61.5% 1 breach out of a total of 2, complex case sent to UCLH for diagnostic test & then discussed at the SMDT for consideration of staging at UCLH but patient came back to WH for chemotherapy.

Action: Endoscopy capacity has been increased as per plan. March figures have shown an improvement.

Community waits

All Community services, except Bladder and Bowel, are meeting the routine time agreed. With Urgent patients there needs to be a review of the booking process and the way that patients are contacted to book and agree an appointment. Currently patients are given 5 working days to respond.

Adult Wheelchair Services: This is an anomaly, only one patient recorded, and this will be removed from this report ongoing.
Community Rehab (CRT and ICTT): Coding errors continue to be found after screening assessments, whereby referrals are marked urgent, but should have been coded as routine. Lack of staff capacity to see patients in the 2 weeks also contributed.
Bladder and Bowel service continues to be a challenge with routine waits 13+ weeks.
Nutrition and Dietetics has shown a marked improvement in waiting time through the introduction of Education Groups, a reduction in the number of service delivery sites and consistency across grade with the number of patients seen.
SLT urgent waits: Service leads working with practitioners to re-visit criteria urgent.
Podiatry: Showing improvement.

Bladder and Bowel, Podiatry, Nutrition and Dietetics and Children and Young People services are all priority services within the Community Improvement Programme.
As part of the Community Improvement Programme a revised community dashboard is expected to be ready for the May Trust Board.

Category	Indicator	17_18 Target	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	2017-2018	Performance
Theatres	Hospital Cancelled Operations	0	6	9	9	2	6	8	15	9	10	8	2		84	
Theatres	Cancelled ops not rebooked < 28 days	0	2	0	0	0	0	0	0	5	1	1	0		9	
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	245	300	210	334	250	247	398	211	282	334	269		3080	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	5.8%	6.9%	5.0%	7.8%	5.2%	5.2%	8.3%	5.0%	6.0%	7.3%	6.2%		6.3%	
Maternity	Women seen by HCP / midwife within 10 weeks	>50%	45.8%	52.8%	48.7%	58.0%	61.4%	59.0%	56.8%	65.2%	64.0%	52.6%	47.5%	61.7%	56.0%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%	97.5%	96.5%	94.7%	94.7%	97.3%	98.8%	95.0%	97.5%	94.5%	95.0%	93.6%		96.0%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	88.6%	93.8%	91.9%	88.7%	89.3%	89.4%	91.6%	88.6%	86.0%	91.5%	93.3%		90.1%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	90.3%	94.1%	96.1%	91.7%	94.6%	94.8%	92.1%	96.7%	95.4%	96.4%	93.8%		94.3%	
Community	Haringey - HR1 % carried out before child aged 15 months		42.6%	37.6%	46.4%	45.0%	40.2%	33.1%	68.5%	67.6%	60.8%	67.0%	68.0%		52.1%	
Community	Haringey - HR2 % carried out before child aged 30 months		38.1%	35.0%	34.3%	52.2%	33.4%	42.5%	45.3%	49.6%	39.2%	56.9%	74.7%		45.3%	
Community	Islington - HR1 % carried out before child aged 15 mths		70.2%	66.3%	70.8%	60.5%	68.2%	73.0%	66.8%	68.3%	67.9%	73.4%	79.0%		69.4%	
Community	Islington - HR2 % carried out before child aged 30 mths		77.9%	75.9%	72.3%	80.2%	72.6%	72.5%	65.0%	75.3%	71.9%	70.1%	69.8%		73.1%	
Community	Haringey - 8wk Review % carried out before child aged 8 weeks			32.4%	33.9%	41.7%	31.0%	35.1%	31.0%	33.0%	33.0%	20.3%	25.8%		31.5%	
Community	Islington - 8wk Review % carried out before child aged 8 weeks			44.1%	44.9%	47.6%	48.5%	41.8%	55.5%	60.3%	60.5%	55.2%	70.4%		53.6%	

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Responsive Services - Commentary

Hospital Cancelled operations

Issue 2 operations cancelled due to non-clinical reasons in February 2018

Gynaecology	1	previous case overran
General Surgery	1	flood in theatres

Action taken: Both patients rebooked within 28 days

All consultants are asked to check their theatre lists two weeks in advance to ensure that they are booked properly

Timescale: already in place

Cancelled operations not booked within 28 days

There were no cancelled operations not booked within 28 days.

Delayed transfers of care

This key performance indicator improved slightly however continues to be challenging. The main area remains Islington Social Services, showing capacity and demand issues. Individual cases continue to be escalated through to directors to reduce number of delays caused. Weekly MADE events are held, managing escalated issues. Senior staff from key organisations have committed to attend the weekly meeting to facilitate timely discharges. MADE events on DTOCs will move to twice a week from May 2018. MADE outcomes are shared with all clinical teams.

Responsive Services - Commentary

New Birth Visit
Islington: 93.8% Very slight fall in performance but remain on track to achieve 95% target for quarter
Haringey: 93.3% Continued upward trajectory and improvement
Improvement plan to achieve 95% target

Mandated HCP: Health Reviews at 8 weeks, 1 and 2-2 1/2 years

1 year review at 15 months: good progress continues from both boroughs. Both Haringey & Islington continue to make steady upward trajectories; Both boroughs have agreed targets with commissioners for 2018/19

2 - 2 1/2 review at 30 months: Islington stable at 70%; Haringey continues to make significant, continuous improvements from 38% April 2017 to 74.7% March 2018. Coverage has also been reported as 100% since February.

6-8 week review: Islington have reversed potential downward trend and shown a significant increase in performance to 70.4%. Haringey have improved but remain well below expected target of 60% - improvement plan and agreed trajectory in place, first agreed targets to be achieved by quarter two 2018/19 and full target in one year.

Haringey is working to improve all aspects of the mandated HCP with a robust service improvement action plan.

Well Led Services - Indicators and Performance

Category	Indicator	17_18 Target	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	2017-2018	Performance
HR	Appraisals % Rate	>90%	80%	79%	79%	78%	78%	75%	71%	69%	71%	71%	72%	69%		
HR	Mandatory Training % Rate	>90%	82%	82%	82%	82%	82%	79%	80%	80%	81%	81%	81%	83%		
HR	Permanent Staffing WTEs Utilised	>90%	88.7%	88.9%	87.4%	86.1%	87.4%	87.3%	87.9%	87.6%	86.3%	87.3%	87.3%	87.3%	87.5%	
HR	Staff FFT % recommended work	>50%			54.5%			53.3%							53.8%	
HR	Staff FFT response rate	>20%			18.2%			21.6%							19.9%	
HR	Staff sickness absence %	<3.5%	3.4%	3.3%	3.6%	3.3%	3.5%	3.4%	3.7%	3.6%	3.7%				3.6%	
HR	Staff turnover %	<10%	14.8%	14.4%	14.0%	14.7%	15.0%	14.4%	14.1%	14.3%	14.5%	14.4%	14.7%	14.6%	14.5%	
HR	Vacancy % Rate against Establishment	<10%	11.3%	11.1%	12.6%	13.9%	12.6%	12.7%	12.1%	12.4%	13.7%	12.7%	12.7%	12.7%	12.5%	
HR	Nursing Staff Average % Day Fill Rate - Nurses		86.3%	87.1%	85.7%	87.3%	85.9%	79.6%	85.2%	81.0%	80.7%	78.9%	78.8%	86.4%	83.5%	
HR	Nursing Staff Average % Day Fill Rate - HCAs		116.8%	121.2%	111.4%	114.3%	110.7%	122.8%	133.3%	129.9%	136.1%	131.5%	137.9%	159.4%	126.9%	
HR	Nursing Staff Average % Night Fill Rate - Nurses		92.3%	93.7%	92.4%	92.3%	92.8%	102.8%	96.0%	91.3%	92.0%	89.1%	89.3%	97.7%	93.3%	
HR	Nursing Staff Average % Night Fill Rate - HCAs		121.7%	124.1%	118.1%	128.2%	113.8%	136.7%	146.2%	143.9%	141.7%	148.2%	143.9%	161.8%	135.4%	
HR	Safe Staffing Alerts - Number of Red Shifts		0	0	0	0	121	55	32	16	33	31	12	19	319	

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Average Staff Cost Per Patient

Category	Staff Type	17_18 Target	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Trend
Medical	Average staff cost per patient		107	91	95	96	97	97	95	94	93	98	104	
Nursing	Average staff cost per patient		190	169	169	171	171	164	165	167	198	167	182	
Other	Average staff cost per patient		217	198	194	209	205	209	196	193	214	191	195	

Well Led Services - Commentary

Human Resources

Vacancy factor overall from the trust has remained static. However it can be reported that nursing and midwifery vacancy rate has dropped between December 2017 and Feb 2018 from 21% to 19%, with Band 5 vacancy rate reducing by 6%. HCA vacancy rate has reduced from 23% to 19%.

There has been a spike in sickness absence in January 2018. This was expected given the level of flu and respiratory problems reported during the winter months. The highest rates are within the following ICSUs: EUC, Women's health, Surgery and PPP. These are being discussed at the ongoing performance reviews.

The FFT results for Q3 is 59% and response rate 43%

Safer Staffing

For approval of the board: Nursing staff average percentage for day and night staff, split by nurses and HCA has now been added to the Performance report. The number of staffing Alerts per month has also been added.

Activity - Indicators and Performance

Category	Indicator	17_18 Target	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Activity
ED	ED Attendances	8285	8285	8699	8239	8537	7853	8051	8816	8549	8579	8897	8082	9218	
ED	ED Admission Rate %		15.8%	16.1%	16.0%	15.1%	15.8%	16.5%	17.0%	16.9%	15.4%	15.3%	14.7%	14.8%	
Community	Community DNA Rate %	<10%	7.1%	7.0%	7.6%	7.3%	7.8%	7.7%	8.1%	7.9%	6.8%	7.6%	7.6%	7.6%	
Community	Community Face to Face Contacts		52668	62915	61537	59804	51859	57467	57599	60640	50448	59890	53947	59628	
Admissions	Elective and Daycase		1618	1790	1931	1904	1830	1828	1907	2004	1587	1944	1733	1871	
Admissions	Emergency Inpatients		2117	2211	2131	2163	2136	2242	2456	2368	2180	2216	1910	2244	
Referrals	GP Referrals to an Acute Service		6297	7600	7045	6829	7145	6766	7435	7454	5751	7615	7146	7586	
Referrals	% of GP Referrals that were completed via ERS		20.5%	19.7%	21.5%	23.3%	29.1%	31.3%	33.9%	35.9%	39.0%	48.3%	46.2%	49.3%	
Referrals	% e-Referral Service (e-RS) Slot Issues	<4%	35.1%	32.7%	39.1%	35.7%	25.0%	22.4%	17.3%	14.7%	10.3%	13.3%	16.8%	17.4%	
Maternity	Maternity Births	333	301	329	322	314	319	344	347	337	332	321	253	315	
Maternity	Maternity Bookings	377	345	483	364	380	378	338	420	385	302	405	375	370	
Outpatients	Outpatient DNA Rate % - New	<10%	12.4%	11.9%	11.2%	11.8%	12.6%	11.4%	11.0%	10.2%	11.0%	10.9%	10.9%	10.8%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	11.6%	11.7%	10.2%	11.6%	12.0%	11.1%	10.2%	10.1%	10.7%	12.1%	9.9%	11.2%	
Outpatients	Outpatient New Attendances		7567	9404	9114	8633	8751	8880	9776	10087	7986	10459	9129	9440	
Outpatients	Outpatient FUp Attendances		15644	18621	18991	17821	17406	17441	19482	19269	15870	18840	16427	16997	
Outpatients	Outpatient Procedures		4980	6097	6354	5748	5787	6471	7097	7451	5836	7392	6786	6976	
Theatres	Theatre Utilisation	>85%	84.9%	85.9%	82.7%	83.4%	80.8%	81.2%	86.1%	85.6%	85.7%	85.6%	87.2%	88.8%	

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Average Tariff by Point of Delivery (POD)

Category	Point of Delivery (POD)	17_18 Target	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Trend
Average Tariff	Daycases		739	727	709	699	704	693	687	717	710	697	684	
Average Tariff	Elective		3772	2701	3726	4014	3535	4042	3959	3525	3526	3403	3550	
Average Tariff	Non-Elective		1790	1883	2356	2199	2335	1693	2188	2180	2561	2670	2362	

Activity - Commentary

eRS

From 16th April Whittington Health are accepting all GP referrals to and Consultant Led Outpatients Services via the NHS e-Referral System. This is in line with the National 'Paper Switch Off' Project and it is also a requirement of the NHS England 208/19 Contract for all GP referrals to Consultant Led First Outpatients Appointments to be made via the NHS e-Referral System (eRS) by Monday 1st October 2018.
Whittington Health is a "Wave 1 – Early Adopter" site and so has been designated an earlier Paper Switch Off date.
Any referrals made, via paper or email, are now returned to the referrer and will need to be re-referred via eRS.
Whittington Health have weekly implementation group represented by all services in place. With support from:

- Local and regional NHS Digital
- eRS leads in Haringey and Islington CCG

DNA

A technical issue with the data extracts sent across to DrDoctor from the Trust was identified which meant patients were only reminded of their appointments and could not reply to request reschedule. This has now been corrected and successful testing was completed on 11/04/18. Go live dates for Respiratory, COOP and Haematology was scheduled for 13/04/18 and was completed successfully with DrDoctor representative present on site. Further clinic code and booking team mapping will be carried out to identify more clinics that do not use the access centre to reschedule patients, with an aim to go live with these areas first before we commence with the access centre team.

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Whittington Health Trust Board

25th April 2018

Title:	**Risk Register Summary Report, April 2018**		
Agenda item:	**18/061**	**Paper**	**9**
Action requested:	For agreement		
Executive Summary:	This paper provides a brief overview of the risk management structure and a summary of the high level risks (NPSA risk score ≥16) currently on the Risk Register in April 2018. The Trust has set a lower threshold for risks reviewed at Board sub-committees (≥15) to ensure Executive and Non-Executive Director oversight. The Non executive directors and the executive lead for the committee have responsibility to escalate any risks scored 15 to the Trust Board as required. All risks <15 are managed at an ICSU and corporate level and escalated to the relevant Board sub-committee as required.		
Summary of recommendations:	• The Trust Board are asked to review all >16 risks and agree there is adequate mitigating actions and assurance to manage these risks • The Trust Board are asked to consider if any > 16 risks not currently on the Board Assurance Framework (BAF) should be added to the BAF.		
Fit with WH strategy:	Clinical Strategy, Estates Strategy, Recruitment and Retention strategy		
Reference to related / other documents:	As above		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Risk Resister works in conjunction with the BAF to provide the Board with assurance that appropriate actions are taken to remove, reduce or transfer any risk to the corporate objectives.		
Date paper completed:	16/4/18		

Author name and title:		**Gillian Lewis, Head of Governance and Risk**		**Director name and title:**		**Michelle Johnson, Chief Nurse and Director of Patient Experience**	
Date paper seen by EC	**23/4/18**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

1 INTRODUCTION

Whittington Health is committed to ensuring that there is a robust organisational governance structure, with clear lines of reporting and accountability for risks. This paper provides a brief overview of the risk management structure and a summary of the high level risks currently on the Risk Register. Risk management overview

1.1 The Trust maintains a central database for all risks on DATIX, an electronic incident and risk management system. In order to maintain consistency across the trust all risks are collated by Integrated Clinical Service Unit (ICSU), Corporate Department (IM&T; Facilities and Estates; Finance, Human Resources and Workforce) or as Organisation wide risk. All risks are then categorised under key headings and given a risk grading. This process ensures that risks can be automatically collated and filtered through DATIX to ensure they are reviewed by the appropriate leads. All ICSUs/Directorates/Board Committees are responsible for ensuring there are clear risk management structures and processes in their areas.

2 >15 RISK REGISTER UPDATE APRIL 18

2.1 Risk Register **Update, April 2018**
As at 1/4/18, the Trust currently has four risks scored as >20 and eighteen risks graded as 16. There are 17 risks scored as 15 which are monitored at Board sub-committee level.

2.2. There are three key themes from the current high level risks on the risk register;

- Workforce and recruitment
- Facilities and estates
- Financial

2.3 These risks have all been escalated for inclusion on the BAF due to the strategic implications and are monitored by the Trust Board through this assurance mechanism. However a brief summary of the risks and key mitigating actions is outlined below.

2.4 Workforce and Recruitment

DATIX	ICSU	Category	Title	Current risk scoring
693	Integrated Medicine ICSU	Human Resources and Workforce	Nurse Staffing Levels in Integrated Medicine ICSU	16
859	Emergency and Urgent Care ICSU	HR and Workforce	High vacancy rate in District Nursing Service	16

2.5 Each ICSU has a specific action plan to mitigate the risk, including short-term provision such as the use of bank and agency as well as recruitment initiatives to fill substantive posts. Across the Trust, this has been identified as a risk to our strategic objective to 'Develop and support our people and teams' and captured on the BAF **(Ref: BAF 4 *Inability to increase substantive workforce capacity).*** Trust wide actions to address this concern are reflected in the Recruitment and Retention strategy and include regular recruitment days, overseas recruitment drive, and bank and agency rates review.

2.6 Facilities and Estates

DATIX	ICSU	Category	Title	Current risk scoring
91	Women's Health ICSU	Estates or Infrastructure	Labour ward has 1 obstetric theatre.	20
697	Women's Health ICSU	Patient Safety and Quality	Maternity and neonatal redevelopment	20
817	Facilities and Estates	Estates or Infrastructure	Building environmental planned preventative regime for heating, ventilation and air conditioning systems	16
680	Facilities and Estates	Estates or Infrastructure	Hospital roof maintenance to K and F block	16
820	Facilities and Estates	Estates or Infrastructure	Whittington Hospital Escalators in A Block	16
807	Facilities and Estates	Estates or Infrastructure	Works arising from fixed electrical installation testing	16
750	Facilities and Estates	Patient Safety and Quality	Mental Health Patient Security Van does not meet current CQC standards	16
746	Facilities and Estates	Patient Safety and Quality	Northern Health Centre- Lift Reliability Issues	16

2.7 There are specific action plans in place to mitigate each risk, and this has been identified as a strategic risk to our corporate objective to 'deliver quality, patient safety and experience' (**BAF 15: Failure to modernise the Trust's estate**). The Trust Board monitor actions against this risk through the BAF process, including implementation of the Estates Strategy.

2.8 Financial

DATIX	ICSU	Category	Title	Current risk scoring
784	Finance	Financial	Failure to deliver CIPs and savings to £16.5m 2018/19	20
780	Finance	Financial	Budget Control	16

880	Finance	Financial	Failure to achieve planned activity levels	16
723	Emergency and Urgent Care (EUC) ICSU	Financial	Finance deficit in EUC ICSU	16
772	Surgery and Cancer ICSU	Financial	Not meeting CIP target and financial balance for 2018/19	16

2.9 Each ICSU and Corporate Department has a specific plan in place to manage their budget and meet the required Cost Improvement Plan savings required for 2018/19. This has been identified as a strategic risk to our corporate objective to 'Develop our business to ensure we are financially sustainable.' (**BAF 5: Failure to deliver CIPS and transformation savings**) which is monitored through this assurance process.

2.10 Other >16 risks which are reflected on the BAF and monitored by Trust Board through this mechanism

Risk Title	Score	Reflected on BAF	Key actions
768: Failure to maintain the breast service	16	BAF10 Failure to sustain the breast service due to workforce changes	• Agreed as a priority clinical area to collaborate with UCLH. • Joint post for surgery with UCLH recruitment complete. • Advert for substantive Breast radiologist agreed and candidates interested in applying. • Consultant mammographer in place. • Still one gap in surgical consultant team. In discussion with FL and UCLH to help support WH.
796: Imaging & Pathology IT Cybersecurity Risk	16	BAF16: Failure to establish cyber security across the Trust	• Digital strategy in place • Internal cyber security audit completed • Capital funding for firewalls has been confirmed and orders now being placed. • Departments developed schedules of all impacted devices, including upgrade and patching of medical devices where possible.
683: Overcrowding ED	16	BAF 3: Failure to meet performance targets in ED BAF 14: Failure to deliver safe and high quality urgent and emergency pathway	• MH Emergency Care Improvement Plan recommendations to be implemented system wide • CD oversight on clinical rotas • Consultant recruitment continues • Advanced Nurse Practitioner appointed • Head of Nursing attending daily bed meets to review capacity

			• Introduction of ED checklist • Introduction of Fit to Sit • Introduction of Nurse Led Rapid assessment of patients coming via Ambulance • Twilight shifts sustained • Increased nursing numbers on both day and night

2.11 >16 risks not currently on BAF

Risk	Department	Category	Title	Score	Comments and Key actions
855	Clinical Support Services ICSU	Patient Safety and Quality	Radiology reporting Backlog	16	Following an information request from the CQC (national review) the Trust identified a large backlog of potentially unreported radiology reports, dating back to 2014 (4000records). • The risk was escalated to Executive Team, CQC and commissioners, and an action plan put in place to review the backlog. • As at 16/4/18 the backlog was reduced to 208 reports. To date, no patient harm has been identified as a result of the backlog with the reports primarily relating to erroneous filing. • Internal RCA Investigation in progress to identify the root cause of the backlog and understand why the backlog was

					not identified sooner.
876	Patient Access, Prevention and Planned Care ICSU	Information Technology	Failure to transition effectively to and implement Electronic Referral System	16	Risk that the trust may lose income if not ready for the switch off of paper referrals on 16/4/18. • NHS Digital supporting the trust to set up all clinics on ERS ready for switch off on 16/4/18 • Clinical maintenance team to build capacity into clinics, linked with ERS and DoctorDoctor • Operational Directors for each specialty implementing action plans to create capacity to manage existing waiting lists for slots, against making others available for GPs to book.
	Organisation wide	Information Governance	Medical records not located in medical files	16	There are currently some patient records that have not been filed within the patient case notes and are held loosely in Health Records or other areas of the trust. • Project in progress to file all loose notes in the appropriate record. • On going filing of high risk documentation while project work is completed to introduce more robust process
688	Surgery and Cancer	Patient Safety and Quality	688: ITU bed occupancy and flow	16	• Review of occupancy of ITU and strategy for optimal usage of ITU bed base discussed at TMG in March 2018,

					in line with COCA recommendations. • Admission and discharge criteria for IT reviewed

3.0 RECOMMENDATIONS AND CONCLUSION

3.1 The format of this report is new and comments on design and information content would be welcomed.

3.2 The majority of the >16 risks are reported on the BAF and this provides assurance that the mechanism for raising concerns from front line to board are in place.

Whittington Health
NHS Trust

Trust Board
25th April 2018

Title:	Annual Operational Plan		
Agenda item:	**18/062**	**Paper**	**10**
Recommendations:	For approval		
	The operational plan provides the overall operational objectives for the Trust. It provides the narrative and context for the activity panning, quality planning, workforce planning and financial planning for 18/19. The annual operating plan, attached, details the plan for year two of our original 2017 – 19 operational plan. This update for year two will be submitted to NHSI. The plan details the integration of the Trusts Operating Plan with the NCL Partners STP plan.		
Reference to related / other documents:	Operational Plan 17-19 Clinical Strategy 2015 -2020		
Reference to areas of risk and corporate risks on the Board Assurance Framework:			
Date paper completed:	30/10/18		
Paper previously presented at:			

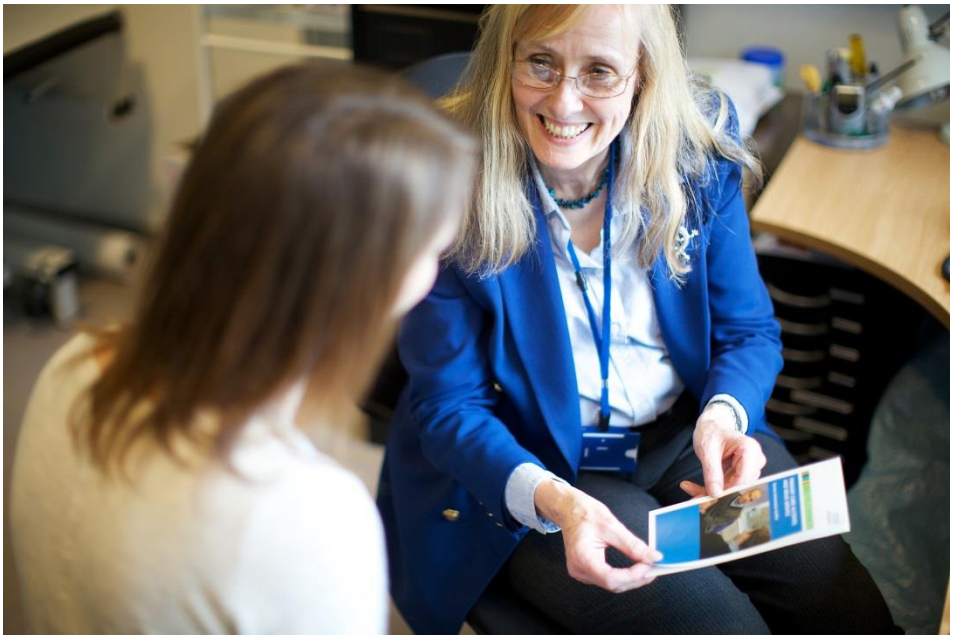
Author name and title:	**Helen Taylor**	**Director name and title**		**Dr Helen Taylor** **Acting Director of Strategy**	
Equality Impact Assessment complete?		**Quality Impact Assessment complete**		**Financial Impact Assessment complete?**	

Whittington Health

Trust Operational Plan

2017/18 – 2018/2019

Updated April 2018 for 2018/19



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1 Introduction

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

Over the last 2 years the organisation has been working closely with the Haringey and Islington GP Federations and Clinical Commissioning Groups (CCGs), Local Health Authorities (LHAs) and local providers (including Mental Health) in developing the Haringey & Islington Health and Wellbeing Partnership. The objective of this partnership is to work in an integrated and collaborative way to provide high quality health and social care for our local population. This work has been recognised and supported by, and integrated into the North Central London (NCL) Sustainability and Transformation Plan (STP).

As an Integrated Care Organisation (ICO) with community and hospital services across Islington and Haringey, Whittington Health is in a unique and important position to deliver the strategic objectives of the STP. The Trust's mission, documented in our clinical strategy, is to 'help local people live longer, healthier lives'. A key strategic goal is to secure the best possible health and wellbeing for all our community, of which prevention and health promotion is a key objective. An example of this is our CQC rated 'outstanding' community dental services. A key priority next year is embedding our work in co-creating health and shared decision making across our geography and taking a population-based approach to prevention. To further develop this we have developed a community engagement strategy which we will implement in 18/19 and have worked closely with Healthwatch and other partners in the development of our quality account this year. Our Children and young People Services have very active community engagement and we are suing their experiences and success to support our wider engagement in the organisation.

In addition to prevention, the Trust has led on the development of important service transformation such as our 'outstanding' ambulatory care model, rapid response and frailty units, and integrated care networks, which align directly with intentions to deliver care closer to home.

Having recently reviewed the Clinical Strategy and Trust Strategic Priorities (see appendix 1) the structure will be evolving from seven integrated clinical service units to five. This will further support the delivery of the clinical and operational priorities by the clinical service units in both community and hospital.

The Trust has bettered its control total requirement for 3 consecutive years, in an increasingly challenging financial environment. For 2017/18 the Trust's final control total requirement, taking into account A&E performance and additional funding for seasonal pressures, was a surplus of £0.6m. Actual performance for the year was a surplus of c. £0.7m, which entitled the Trust to a STF (Sustainability & Transformation Funding) incentive payment of c. £0.2m, giving a final surplus for the year of c. £0.9m.

A central goal for Whittington Health is to reduce costs whilst continuing to deliver high quality care. This has been demonstrated by recent CQC rating, in which the Trust as a whole continues to be rated 'Good' overall and the Whittington Hospital site has improved from 'requires Improvement' to 'Good'.

Last year (2017/18) was the second year of a 2-year programme cost improvement plan, which targeted a total improvement of c. £25m. In drafting the current financial plan, the Trust has taken into account the actual CIP performance in 2017/18, the need to address the underlying deficit and the requirements to achieve the 2018/19 control total. To support the 2018/19 plans transformational cross cutting projects will be supported by the Programme Management Office and Executive Sponsorship together with the new ICSU structure formed to enable delivery at clinical service level.

This operational plan reflects both the opportunities and risks faced by the organisation.

2 Activity planning

The 18/19 activity plans have been based on a forecast outturn position agreed with our lead commissioners plus agreed growth levels applied by point of delivery. The plan is reflective of the Trust view of the likely commissioner QIPP delivery in 18/19

Demand and capacity have been assessed via the use of IST models for endoscopy, imaging, trauma and orthopaedics and the emergency department which is in line with national practice and an approach supported by commissioners. Further, capacity takes into account the activity that can be provided within the funded establishment and will be adjusted for, where appropriate:

- Full year effect of new appointments
- Part year business cases taking into account an increased full year effect
- Any planned and agreed service changes for 2018/19
- Lessons learned from winter resilience planning. Particular examples of how this has been incorporated include the most appropriate location for the winter pressures ward, forming a better link for stepping down patients (intermediate and re-ablement care) and a focus on the management of frailty within the emergency pathway.

The validation process for demand and capacity includes:

- Checking outpatient capacity against clinic slots
- Clinic templates to improve 'Did Not Attend' (DNA) rates
- 'New' to 'Follow up' ratios
- Weekly director led PTL meetings

The clinically led structure of the ICSUs within WH has meant that each ICSU has developed a business plan led by its Clinical Director. Key elements to these plans have been identifying areas of changing demand and the consequent impacts on capacity. This work was developed in collaboration with the finance and information teams and has informed the development of this plan.

A consequence of this work the pressure areas for demand and capacity identified are most likely to include Endoscopy and Diagnostic Imaging and the Emergency Department (ED).

2.1 Cancer

The Trust Cancer Strategy work is moving forward and is linked to the National Cancer Strategy, the London Cancer agenda, the Cancer Vanguard work and is aligned to the Trusts Clinical Strategy. We continue to participate in the Quality Service Team review process (formerly Cancer Peer Review).
The Trust is compliant with the two week standard. Since April 2017 we have met the 62 day standard apart from two months, June and November; however we have met this standard for both quarters one and two for 2017. Whittington Health still continues to engage with the North Central and North East London commissioners to improve performance, in particularly in light of inter-trust-transfers. In 2017/18 transfer times have been monitored to ensure prompt referral. Work also continues with formal sign off of tumour group specific pathways with ideal timings of actions across the pathway. In addition Multidisciplinary Teams are well established with representatives of the professional groups involved in the diagnosis and treatment of patients.

2.2 Referral to Treatment

Whittington Health continues to deliver the incomplete standard sustainably, however there are a number of individual specialities that are not compliant. These specific areas are being addressed through individual action plans over this next year with a target completion date of October 2018.

The table below outlines the specialities that are non-compliant for the incomplete standard as of April 2018.

Speciality	Incomplete %	No. patients + 18 weeks	No. patients over tolerance
General Surgery	83.1%	391	206
Ophthalmology	79.09%	161	100
Rheumatology	78.52%	93	59
Trauma & Orthopaedic	85.60%	242	108

Our trajectory for 2018/19 is to achieve 93% and for our RTT waiting lists will be no greater in March 2019 than in March 2018, maintaining our good performance.

2.3 Emergency Department

Performance has remained challenging for the organisation during 2017/18, compounded by an increase in activity compared to the same period last year. This is consistent with neighbouring Trusts in North Central London; however, our performance has been in the top quartile of Trusts. One of the key plans of the Trust for 2017/18, to address this has been to develop a new model for the medical workforce utilising a skills mix of consultants and nurse practitioners rather than middle grade posts. Implementation of this plan has begun; a number of these posts have been filled and recruitment is currently underway for the remaining posts.

One challenge has been outflow from the Emergency Department (ED) to in-patient wards. The Trust has a robust improvement plan in place which is outlined in the quality improvement section and is designed to optimise patient flow, allow the organisation to respond to the increase in demand for its services and to support achievement of the ED target. This work has been supported by ECIP over the summer months and includes the embedding of the SAFER bundle across all the inpatient wards.

The Chief Executive Officer (CEO) chairs our local A&E Delivery Board and the organisation is working closely with commissioners and other providers to explore system-wide quality improvement and further resilience measures.

Performance relating to the care of patients with mental health issues has improved in 17/18 with no 12 hour breaches since September 2017. We have also refurbished our Section 136 suite and will be opening a new mental health recovery suite which will further improve care in 18/19.

Our performance plan in ED for 2018/19:

2018/19 Plan		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	%	**91.1%**	**93.5%**	**92.4%**	**92.2%**	**91.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**90.0%**	**95.0%**

This plan has been developed and agreed with NHSI. The performance plan for first quarter is higher than the remainder of the year, however we will endeavour to exceed the plan by continuing to focus on quality, optimising the flow, work closely with our partners to reduce Delayed Transfers of Care and implement the departmental improvement initiatives.

2.4 Endoscopy Services

Over 2017/18 there have been improvements in delivering our planned activity. Using the NHS recognised Demand and Capacity modelling we have a clear understanding of our capacity within the service. This has informed the consequent activity plans that have full clinical sign off. This, also, has informed a workforce review of the skill mix within the clinical team, leading to the development of nurse endoscopist roles which are being put into place in the service.

2.5 Imaging

There has been increased activity in CT and MRI due increased Out Patient (OP) demand as part of the drive for earlier diagnosis in cancer. To develop the imaging services to meet the demands of the future we have undertaken a radiographer workforce redesign which includes the development of radiographic assistants and reporting radiographers. In addition we have upgraded our gamma camera to a SPECT CT ensuring we can provide a high quality Nuclear Medicine services and in 18/19 we will be renewing a CT scanner and our mobile x-ray equipment.

2.6 Pathology

The Trust has identified a partner to work with through 2018/19 to support the networking of the Whittington Pathology services and we are working closely with NHSI pathology network teams to support this service transformation.

2.7 Community Services

The Trust continues to value the importance of delivering high quality community services. These services are key in delivering WH mission of 'Helping local people live longer, healthier lives'. The new ICSU structure has been developed to further support this and the Trust will be focusing on delivering modern community services in collaboration with its partners in Haringey and Islington and other boroughs. This will be further enabled through our estates and digital 'Fast Follower' work.

We will continue to celebrate our successes and best practice working such as: the Life Force Team, the Outstanding Community Dental Services, Speech and Language Services, our MSK transformation work and our Virtual Ward.

By working closely with our partners we will strengthen our District Nursing Services, Community Children's Services and our smaller community services such as Bladder and Bowel.

2.8 Outpatients

An outpatient transformation plan will be implemented in 18/19. This work includes a review of demand, capacity and activity to improve efficiency and productivity over the next 12 months.

The remodelling will be to support a better patient experience through more efficient patient pathways, patient engagement and explore other enablers using technology

3 Quality Planning

3.1 Quality governance framework

Whittington Health (WH) maintains a robust quality governance framework (reviewed annually) in place to promote and monitor quality at all levels throughout the Trust. Quality governance builds on the National Quality Board (NQB 2018) definition of quality i.e. focused on the areas, which matter most to people who use services. These are:

- **Safety:** people are protected from avoidable harm and abuse. When mistakes occur lessons will be learned
- **Effectiveness:** people's care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.

- **Positive experience**: - Caring i.e. staff involve and treat people with compassion, dignity and respect, and responsive and person-centred i.e. services respond to people's needs and choices and enable them to be equal partners in their care.

This framework allows for effective management of quality from ward and community services to Trust Board and provides assurance of progress and delivery against quality governance, quality priorities and quality improvement plans, whilst also enabling clear and appropriate escalation of issues. The objective of the governance framework is to provide assurance to the Board that the Trust is focused on learning lessons.

The responsibility for quality is jointly held by the Medical Director and Chief Nurse & Director of Patient Experience**.**

The Quality Committee, a sub-committee of the Trust Board, provides assurance on behalf of the Board on the quality priorities and ensures the maintenance of effective risk management and quality governance systems. This includes reviewing key areas identified in the Trust Patient Safety Committee and Patient Experience Committee, and undertaking two deep-dives per annum into each of the Integrated Clinical Service Units (ICSUs).

The Trust Management Group (TMG) holds responsibility for the delivery of the quality planning and maintaining the quality governance framework.

The Trust Board's annual cycle of business includes quarterly Quality and Patient Safety Reports and monthly quality performance dashboards. To maintain in contact with the personal impact of care each Trust Board meeting is opened by a patient experience story led by the patient and/or family, followed by clinicians reporting on what lessons have been learnt and how they have been disseminated.

The responsibility for the delivery of quality within the ICSUs is held jointly by the triumvirate i.e. Clinical Director, Head of Nursing and Director of Operations. The quality agenda is monitored at the monthly ICSU Boards with a focus on quality monitoring systems, patient safety and safety huddles, patient experience walkabouts, NICE guidelines, auditing programmes, serious incident reporting and patient feedback.

3.2 Quality improvement methodology model

The Trust agreed a Service and Quality Improvement (QI) Strategy March 2017 to embed QI across the Trust in 18/19. In addition the Trust commissioned, through UCL Partners, GE Partners to undertake a Quality Improvement review using the iQUASER tool. The findings from this survey will be used to support the implementation of the QI strategy.

In partnership with UCLP, the Trust will be developing staff capability through a three tiered training approach and increase front line staff awareness through the identification of QI leads in each department to champion QI methodology.

An additional focus over the next 12 months will be experience led improvement approaches such as 'The Start, Stop' model to collect ideas from staff and widen patient and public participation in the Patient Safety Forum.

As a consequence of the review undertaken we will include an Improvement Story as well as a Patient Story at each Board and develop the performance report using SPC charts to monitor improvement.

3.3 Quality Priorities 2018/19

The Trust's quality priorities are defined through learning from incidents and/or complaints and claims; NHS contracts standards and National/NCL and local objectives. The Trust focus is as follows:

Sign up to safety (SU2S) – 2018/19 is the final delivery year of three-year programme. Year three focuses on sustainability of the impact on rates of **sepsis, Acute Kidney Injury (AKI), falls, pressure ulcers and improvements to the care of people with learning disabilities**.

Quality Account – Quality priorities for 2018/19 have been developed following extensive engagement and consultation with staff and stakeholders and are based on both national and local priority areas.

Each priority and target is considered and refined by clinicians, managers and external bodies and agreed at the patient safety committee, patient experience committee and education and research committee.

Work in 2018/19 will focus on strengthening the work on prevention of pressure ulcers, and falls reduction as well as continuing the focus on improving the care and positive experience of people with learning disability/autism. Medicine management and learning from medication errors will also be considered as a priority.

The targets have been reviewed and approved at TMG and Quality Committee. Priorities have been shared with our commissioners, local Healthwatch members and presented to local councillors.

3.4 Quality Assurance

The Trust Board receives assurance on the delivery of quality through the Trust governance framework and reports externally to CCG, NHSI and CQC. Internal assurance from the ICSUs is provided through the quarterly performance meetings with the executive team, ICSU senior management team and chaired by the Chief Executive. In these meetings quality and patient safety performance is triangulated alongside activity, workforce, and financial performance.

The assurance focus on 2018/19 is as follows:

- **CQC** – In February 2018, Whittington Health was awarded a rating of 'good' by the CQC, with a rating of 'outstanding' for caring. This followed a well led inspection as well as targeted inspections of the Critical Care Unit, Hospital Outpatients Department, CAMHS inpatient unit and Children and Young People's Community Health Services.

  The summary report highlighted many areas of good practice across the organisation; however, the inspection team also identified areas for improvement. The Trust has developed an action plan based on these improvement recommendations. This action plan will be shared with the CQC and commissioners and is monitored through the ICSU governance structure and reported by exception to the TMG.

  Internally the Trust will maintain the **Peer review programme -** The framework for these reviews is based on the CQC five key lines of enquiry with services given an overall rating in line with CQC criteria. This is a targeted approach to enable focused peer reviews using intelligence monitoring through CQC Insight report, performance and nursing indicators dashboards as well as the workforce dashboard.

- **Clinical Quality Reference Group** – Working with the CCG Director of Quality to improve the assurance to the CCG on quality priorities and areas of concern

- **Learning Lessons** outcomes from the Trust **Serious Incident Executive Advisory Group** – An executive led review of all serious incidents from the initial identification through to final sign off of internal and Strategic Executive Information System (StEIS) Root Cause Analysis (RCA) reports. The group considers whether serious incident or never event criteria have been met and ensures the Trust's duties in relation to Duty of Candour are discharged appropriately. The group also ensures that key learning is shared with staff through a dedicated page on the Trust intranet and through a monthly report to Trust Board.

- **Patient Stories** – extending the value and strength of listening to the patient voice at Trust sub committees and ICSU quality monitoring

3.5 Summary of the improved quality impact assessment (QIA) process 2018/19

The QIA process has been refreshed in preparation for identification and delivery of 2018/19 Cost improvement plans (CIP). There is a focus on local ICSU responsibility and ownership from the ICSU Clinical Directors and Heads of Nursing for CIPs, with the Medical Director and Chief Nurse overseeing the higher risk plans.

ICSUs apply a QIA tool to assess the risk of any cost improvement programme project; these fall into two categories i.e. Level 1 - low risk or Level 2 - high risk. Low risk schemes are signed off through a local governance process. High Risk schemes are presented to the Medical Director and Chief Nurse by the respective operational and clinical directors. These focus on the specific indicators of quality and where any adjustments are required before approval for the scheme can move to implementation. CIPs are reviewed by an appropriate committee quarterly or more frequently if necessary, to identify any changes to risk and quality throughout the implementation process or until the panel are satisfied that there is no ongoing risk.

3.6 Summary of triangulation of quality with workforce and finance

Quarterly ICSU performance reviews will focus on providing assurance to the executive team through a triangulation of quality, workforce, performance and finance information. This triangulation will drive priorities and monitoring for the ICSU of quality concerns. In detail performance reviews examine the following:

Safety, Quality Patient Experience and Risk	Performance	People Issues	Finance
• Quality indicators and data e.g. infection prevention, safety thermometer, nursing indicators • Clinical incidents /Serious Incidents • Complaints (numbers trends and response rates) and compliments • Clinical and national audit results • Risk register/service issues • Patient feedback and engagement e.g. FFT, national surveys • CQC improvement action plan	• Activity • Performance national standards and community waiting times	• Staff survey action plans • Temporary staffing levels/spend • Recruitment issues/vacancy rates • Sickness rates and sickness management plans • Appraisal Rates • Mandatory training compliance • Organisational development interventions	• ICSU and service line position and cost pressures • Financial plans and milestones for next year • Year-end projections • PbR and Coding issues • CIP progress

For 2018/19 the quality improvement activity of each ICSU will also be monitored the quarterly reviews.

4 Workforce planning

Workforce planning is an integral part of our performance and management culture and strategic planning and is integrated into a number of the Trust's systems and processes. The Trust's two areas of focus are recruitment and retention plans and the undertaking of an organisation wide approach to tackling bullying. This includes an external assessment of the culture of the organisation and recommendations for change.

This section outlines our workforce planning strategy, methodology, and processes including productivity and transformation plans.

4.2 Workforce strategy

In 2017/18 we will continue implementation of our Workforce Strategy 2016-2021, focussing on: leadership; a flexible and responsive workforce; recruitment and retention; and education and training. This strategy was developed with wide engagement and consultation aligned with the Clinical Strategy.

4.3 Workforce planning methodology

The workforce planning process is aligned and integrated with the Trust's business planning process, led by individual ICSUs. Throughout the process ICSUs Clinical and Operational Directors are supported by HR Business Partners who advise and challenge ICSUs on the workforce impact of their plans and ensure alignment with workforce and clinical strategy. This involves:

- Working with ICSUs to discuss workforce issues such as recruitment and retention, activity planning, education requirements and the delivery of key performance indicators;
- Analysing and monitoring workforce changes at a local level (which is aggregated to a Trust wide position);
- Ensuring current and future workforce needs are represented in business plans, consider growth, as well as options to develop new roles, new ways of working, and associated training implications.

Final ICSU plans are presented individually to the Trust's Board, Executives and all other Clinical, Operational and Corporate Directors in a peer-review and challenge session. Following this, amended plans are used to inform the Trust's Operational Plan.

In addition to the annual business planning process, the Director of Workforce is represented at the Investment Group which is responsible for approving business cases in-year and reviewing business plans during the planning process prior to proceeding to the Trust Management Group and the CIP Delivery Steering Group. Here the group triangulates between the workforce, finance, activity, IT and estates implications of all business cases and service changes.

4.4 Workforce planning governance and risk management

Workforce planning is an integral part of the ICSU Boards. These committees oversee local workforce strategies, including transformation and risk management and ensure the impact of proposed developments on existing and future workforce requirements are properly considered.

In addition:

- All workforce risks are reviewed quarterly.
- Action plans for reducing amber and red rated risks are monitored on a quarterly basis by the Trust Management Group.
- High level risks are reported to Workforce Assurance Committee, which is chaired by a Non-Executive Director and subsequently added to the Board Assurance Framework.
- Workforce intelligence is used regularly to help the Trust make decisions. We are developing integrated workforce dashboards which triangulate workforce information, clinical quality and safety metrics:
- Safe nurse staffing levels are monitored continuously, supported by ongoing assessment of patient acuity. As part of 'Showing we care about speaking up' we encourage and support all staff to nursing scorecards triangulate workforce information with other quality metrics.
- Workforce intelligence and Key Performance Indicators (KPIs) are reported at the Trust Board and are standing items on Performance Review Group meetings (PRGs). The Workforce Assurance Committee receives comprehensive corporate workforce information and analysis. Metrics include vacancy and sickness rates, turnover and appraisal compliance and temporary staffing.

4.5 Workforce efficiency, transformation and new initiatives

Service improvement is a key element of all our ICSU plans, which look at how existing workforce can support delivery and also how the roles and workforce will transition to deliver programmes including seven day services and elimination of agency usage.

A number of workforce initiatives have been agreed locally and are integrated into our Trust plans and will deliver transformation and efficiency.

These include:

- Developing new service delivery models, such as the use of pioneer pharmacists on wards and development of urology nurses' roles, to reducing reliance on agency staff and improve quality and safety.
- Prioritising clinical collaboration with NCL providers to ensure service productivity is maximised, services are lean and sustainable, and reducing costs and reliance on agency staff. In time, aligning this with broader NCL STP ambitions to pool resources.
- To further reduce agency spend develop initiatives to improve vacancy, attrition and agency rates such as reviewing bank pay rates, continue with director level scrutiny of agency and bank shifts, widen the roll out of e rostering and continue to monitor and challenge spend through the weekly agency tracker.
- Enhancing the health and wellbeing of staff through our health and Wellbeing Strategy, and linking this to the NCL STP ambition to implement a healthy workplace charter to improve employee wellbeing and reduce avoidable sickness absence.
- Recruitment delivering recruitment campaigns (internal and external), through open days, job fairs, develop sideways transfer schemes, continue with EU and overseas recruitment, develop rotational posts with other trust e.g. UCLH, increase local community campaign's, continue to be active partners in The Widening Participation initiative through the apprenticeship schemes and further education colleges.

In the following years, our workforce and operations will develop to focus on care closer to home, aligning with the NCL STP. Our aim is to identify the education and training needs of our current and future workforce, equipping them with the skills and flexibilities that are required in the changing health and social care environment. Our education and development plans are developed and updated through:

- Trust level analysis of organisation-wide educational and training needs analysis which is being developed through the re-structure of the Learning, Development and OD department/s.
- Analysis and discussion about training needs at ICSU Quarterly Performance Review Meetings.

In line with the STP, we will roll out recommended training programmes where they are relevant and applicable, such Making Every Contact Count (MECC), Mental Health First Aid (MHFA), and dementia awareness.

4.6 Local workforce advisory boards and engagement with commissioners

The Director of Workforce is attends the Health Education North Central London (HENCL) forum, and the Trust's workforce planning submission to HENCL is dovetailed with our internal business planning cycle. This assesses workforce plans over five years supporting sector and national education commissioning and planning intentions. The HENCL plan is signed off by Trust professional leads and shared with commissioners.

5 Financial planning

The Trust's final control total requirement for 2017/18, taking into account A&E performance and additional funding for seasonal pressures, was a surplus of £0.6m. Actual performance for the year was a surplus of c. £0.7m, which entitled the Trust to a STF (Sustainability & Transformation Funding) incentive payment of c. £0.2m, giving a final surplus for the year of c. £0.9m. This means the Trust has now bettered its control total requirement for 3 consecutive years, in an increasingly challenging financial environment.

As a result of bettering its control total for 2017/18 the Trust will be eligible for a bonus STF payment, in addition to the incentive payment, the value of which will be confirmed by the end of April.

The Whittington Health 2018/19 draft financial plan is a fully integrated component of the Trust's Operational Plan and builds on the planned outturn forecast for 2017/18, overlaid with key planning assumptions for the forthcoming financial year, as set out in the section 5.1 below.

The financial model is inclusive of a 5-year capital plan, for which the schemes are consistent with the Trust's clinical strategy, and clearly provide for the delivery of safe, productive services. Further detail in respect of capital planning is provided below.

Having completed the detailed planning the Trust has accepted its control total for 2018/19 of a £4.7m surplus (inclusive of an additional STF allocation) and is planning to achieve the full STF available.

5.1 Financial forecasts and modelling

Using the 2017/18 forecast outturn (per the Month 9 TFMS submission) as a starting point, the Trust has reviewed the position, making iterative adjustments to take account of the outlined planning assumptions. This has informed the initial 2018/19 plan position, before subsequent adjustments were made to account for local and specific national planning factors.

With respect to income & activity modelling, the Trust has utilised the Month 8 (flex) technical forecast outturn as the starting point for 2018/19 planning. To this, technical changes have been made to reflect IR (Identification Rules) movements, the 2018/19 National Tariff, agreed coding changes and STF funding. The start point, together with these technical changes, is materially agreed with our host commissioner.

The Trust has agreed differential demographic and non-demographic growth to the main elective and emergency points of delivery. The Trust has been through a process of clinically agreeing the effectiveness of commissioner QIPP and the outcome of these clinical agreements is reflected in the contract and plans.

Expenditure plans are based on the recurrent outturn for the current financial year with the following planning adjustments:

- Application of standard national planning assumptions
- Identification of material non-recurrent income and expenditure
- Specific pay planning assumptions, including the effect of the apprenticeship levy
- Pay award (1%) & Incremental drift (0.7%)
- Non-pay inflation (generally 2%, with additional for drug inflation)
- Financial efficiency (CIP plans for 2018/19)
- Internal transformation incentive scheme
- Contingency (1% of turnover) and reserve requirements

Capital and cash plans reflect the key linkages between operational finance plan, strategic capital developments and high priority capital expenditure to support clinical service strategy

5.2 Efficiency savings 2018/19

A central goal for Whittington Health is to reduce costs whilst continuing to deliver high quality care. 2017/18 was the second year of a 2-year programme, which targeted a total improvement of c. £25m.

In drafting the current financial plan the Trust has carefully considered the efficiency requirements, taking into account actual CIP performance in 2017/18, against the 2-year programme, the need to address the underlying deficit and requirements to achieve the 2018/19 control total.

The total CIP programme for 2018/19 is c. £16.5m, of which £2.7m is delivered by flow through CIPs (full year effect) from 2017/18 and £13.8m from new schemes. Following the experiences in 2017/18 the Trust has agreed a revised delivery model for cost improvement in 2018/19, the key changes being:

- a differential approach with local areas to deliver a business as usual improvement of 2%;
- larger, cross organisation, schemes being delivered by cross ICSU teams and an Executive sponsor. The larger schemes may have third party support where necessary;
- use of Carter Metrics and Model Hospital data to support transformational schemes which include outpatients, community and networking; and
- the PMO will refocus and have a smaller central resource, which will monitor progress and track benefits, whilst each ICSU will receive direct support. That support will be focused on delivering savings only initially. The change managers will also support one of the cross cutting schemes.

The Trust has established a comprehensive programme to deliver its efficiency goal, with clear linkage to the Lord Carter provider productivity programme, and taking into account issues to date. The objectives of the programme are to:

- **Reduce costs whilst protecting quality:** Work with management and frontline staff to identify safe, sustainable savings

- **Establish integrated programme capabilities:** Put strong programme governance in place, supported by active programme management to drive delivery

- **Build a sustainable approach to continuous improvement:** Empower the clinical and operational leads to develop and execute continuous improvement, and hold them accountable for it

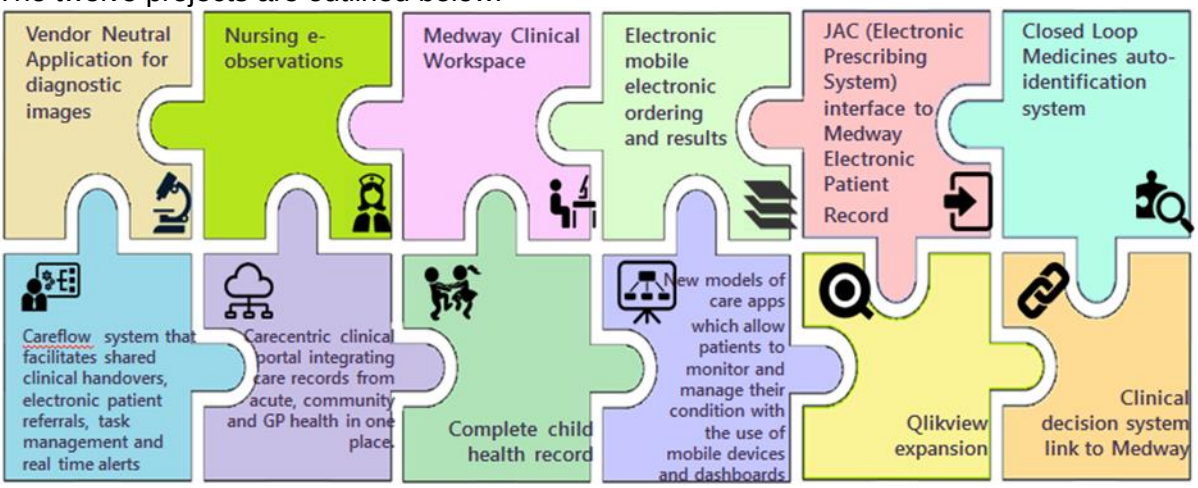
A robust governance process supports the programme to ensure effective oversight.

5.3 Capital Planning

The Trust's capital plan continues to have a focus on the strategic priority to improve and develop the current maternity care facilities. On completion the plan will also ensure that there are no red rated, capital related, risks.

Following our successful application, the Fast Follower Project is a key component of the 2018/19 capital plan. The Fast Follower programme includes working with University Hospital Bristol to generate a 'blue print' of how to become a 'paperlite' organisation using System C. The programme involves twelve projects to support Whittington Health becoming a leading digitally integrated organisation.

The twelve projects are outlined below:



The planned capital programme for 2018/19 (excluding MES & PFI Lifecycle commitments) is set at an affordable level of c. £11.7m investment. The investment is supported by internally generated sources of capital funding, together with matched funding for the Fast Follower Project and a charitable donation towards the costs of the maternity care facilities development.

Capital Scheme	£m
Maternity: Obstetrics Theatre & NICU	3.4
Fast Follower	4.3
Existing Commitments (Imaging replacement & Community Dental)	1.3
Estates	1.1
Medical Equipment	0.9
General & Contingency	0.7
Total Capital Plan – 2018/19	**11.7**

Schemes contained within the capital programme therefore, reflect the high priority investments required by the Trust during 2018/19 to sustain safe and productive services, and are anchored to the Trust risk register to ensure that prior to investment commitments being finalised, there is a collaborative assessment and agreement for schemes to proceed. Schemes can be broadly assigned to estates, IT and medical equipment areas.

5.4 Risks & Challenges

The Trust has confirmed that it would like to accept its notified control total for 2018/19 as outlined in the letter from NHS Improvement dated 6TH February 2018. Accordingly, the draft planning submission for 8th March is structured to deliver a £4.7m surplus on the receipt of £9.4m Sustainability & Transformation Funding.

As would be expected, there a number of challenges & risks the Trust will need to manage both in the lead up to and during 2018/19 in order to deliver its control total, the most significant of which being the delivery of its efficiency (CIP) programme, together with the agreement of a contract for clinical service provision with local lead CCGs. The key risks and challenges currently identified through the planning process include:

- Delivery of the CIP programme together with a cost response to agreed QIPP
- Achievement of the agency expenditure ceiling balanced against safe care provision and the know challenges/barriers e.g. supply shortages for clinical staff across London
- Cash flow management through quarters 3 and 4

6 Links to the local STP (North London Partners in Health and Care)

Whittington Health has played an important role in the development of the North Central London (NCL) Sustainability and Transformation Plan (STP). The Trust's Chief Executive is represented at the NCL STP Transformation Board and is the Senior Responsible Officer for the STP Workforce workstream whilst the Medical Director is clinical lead and co-chairs the NCL Partners in Health and Care clinical cabinet. Furthermore, clinical and corporate leads are closely involved in the process.

The STP has four strategic aspects – prevention, service transformation, productivity and enablers – which will be delivered through eleven (draft) work streams – prevention, health and care closer to home, mental health, urgent and emergency care, optimising elective care, consolidation of services, cancer, productivity, workforce, digital and estates.

As an Integrated Care Organisation (ICO) with community and hospital services across Islington and Haringey, Whittington Health is in a unique and important position to deliver the strategic objectives of the STP. The following sections highlight just some of the work Whittington Health is doing in relation to the STP.

6.1 Service transformation

Whittington Health is on the forefront of delivering services that are crucially aligned with the objectives of the STP. The Trust has in place an 'outstanding' ambulatory care model, rapid response and frailty units, IAPT, CAMHS and integrated care networks, which align directly with intentions to deliver care closer to home and re-define urgent and emergency care in NCL. The Trust plays a key role in delivering community mental health services for adults, children and young people, as well as providing wider women's health and paediatrics services across NCL. In 2018/19, the Trust will continue to focus on networking services through clinical collaboration which will optimise achievement of cancer priorities and elective pathways.

Throughout 2018/19 the work to deliver system and population based care through the Islington and Haringey Wellbeing Partnership within the North Central London Health and Care (STP) will continue. This work enables us to maintain progress in the in delivery of integrated care with partners in primary care, social care and mental health providers.

6.2 Prevention

As an ICO, the community reach of the Trust also enables us to deliver on the STPs increased emphasis on prevention. Our work in supporting patients with a number of prevention and behavioural change focused services, including 'making every contact count', will continue to be embedded in services across the organisation. The Trust delivers community services in smoking cessation, dietetics, community nutrition, dentistry and we will seek to build and develop these services further. Our offer, coupled with our specialism in Paediatrics, Women's Health and CAMHS, will provide a crucial vehicle for delivering the STP's prevention strategy and 'achieving the best start in life'.

6.3 Enablers

Whittington Health has been actively engaged in the NCL estates work and considers estates to be a priority enabler. The Trust, during 2018/19 will develop its master plan to deliver its estates strategy. The plan will act as a catalyst for new models of care, such as 'out of hospital' work streams including the 'Care Closer to Home Integrated Networks' (CHINs). This is a key enabler for the transformation outlined in the STP and the work across the Islington and Haringey Wellbeing partnership, which is closely aligned with the local devolution agenda.

The Trust will also be building its digital capacity further, building on the successes of existing schemes that have improved patient access through technology and its status as a 'Digital Fast Follower'. Already these initiatives have had positive impact, such as through the use of iPads in our District Nursing Virtual Wards

which have had significantly increased patient facing time. Specifically, we have commenced the use of the e-community tool which has increased our ability to effectively schedule work as well as providing continuity thus increasing productivity further. This work has been shortlisted for a Health Service Journal (HSJ) Value award. The use of store and forward RIO is now being rolled out and will mean the ability to have accurate and timely patient records in the home. We are a Wave 1 Organisation in and from the 16th April 2018 we will also implement an e-referral service which will improve patient pathways, reduce DNAs and improve productivity as part of the national ERS programme. The renewed focus on digital as an enabler in the STP aligns fundamentally with the priorities of Whittington Health.

6.4 Productivity

Whittington Health will continue to prioritise productivity throughout 2018/19 using the model hospital to identify areas of focus for quality and cost improvement. Through this, we will complete work to consolidate our histopathology, cytology and pathology services and expand the scope of our Pharmacy Community Interest Company which opened in July 2017. The Pharmacy work has also been shortlisted for an HSJ Value award,

We will continue to work with others on improving back office functions in line with the Carter report and Model Hospital work. In 2018/19 our services will place emphasis on cross-NCL clinical collaboration to maximise services productively whilst also delivering improved patient outcomes and pathways and tackling agency spend. Tackling agency spend as a primary objective will remain a key priority of the Trust.

6.5 Summary

In summary, in year one of this plan the Trust improved its overall CQC rating from Requires Improvement in the hospital to an overall ‘Good’ rating, with ‘Outstanding’ for caring, delivered a surplus and reduced its underlying deficit. This Operational Plan is an update of the two year plan 2017-2019 and reflects the risks and opportunities presented to the Trust in the remaining year 2018/19.

Although facing a number of challenges Whittington Health is a strong integrated care organisation, focused on population health in North Central London. It is a good organisation with ‘outstanding’ for caring, with a plan to achieve its Control Total and a strong focus on delivery in18/19.

Appendix 1: Strategic Priorities

Strategic priorities

Strategic workstream	Work streams		Clinical strategy goals
Whittington Health	Quality	Deliver the quality account Maintain CQC rating as "Outstanding" for Caring Move overall CQC rating from "Good" to "Outstanding" Network vulnerable services.	
	Enablers	Workforce: Develop sustainable roles and new roles Estates strategy to provide capital funding and support modernised delivery e.g. new maternity services, community services Digital: Use fast follower position to support productivity improvements	
	Productivity	Transform pathology service; further develop pharmacy transformation; use CIPFT and model hospital to identify improvement priorities;	
NHS Networking	Breast cancer	Develop a joint breast cancer service with collaboration with UCLH	
	Maternity	Work in collaboration with UCLH	
	Clinical collaboration with Homerton	Provide nuclear medicine and explore other potential networked services	
	Community dental work	Provide dental care at community sites in Camden, Islington, Haringey and Enfield and NWL	
	Increasing health prevention with Hackney	Maintain and expand Hackney IAPT, and smoking cessation; build relationship with GP federation	
	Growing our services	Explore partnership opportunities for wider community services, and further develop community education programmes.	
Increasing Integration in Care	Health and care closer to home	Develop community teams, provide GP federation support e.g. IT and B&T. Develop our estates plan with CHINs and local authorities. Explore shared opportunities for savings and increased productivity with social care & workforce projects; Work with the care closer to home to provided consistent high quality CHIN model; work on frailty, CYP, & MH	
	Mental and physical health	Explore new mixed roles, integrate mental and physical health, provide MH as part of CYP community offer	
	Collaboration with local authorities & social care	Develop links with partnership to improve productivity; use estates strategy to develop integrated hubs; WH support the care home agenda as an B&T provider	
System Working	Urgent and emergency care reduction	Reduce ED demand working in partnership with the CHINs, innovative models such as the virtual ward, and ambulatory care, developing community workforce, and developing social care and mental health links	
	Planned care	Estates strategy to support wider NCL initiatives around planned care; increase community team funding to reduce planned care need ; partner with UCLH to support networked services	

Whittington Health
NHS Trust

Trust Board
25th April 2018

Title:	Trust Operational Objectives Update		
Agenda item:	18/063	Paper	11
Recommendations:	For approval		
	This includes the 2017/18 Trust corporate objectives and the final 17/18 outcomes. It also includes the proposed 2018/19 operational plan and a high-level dashboard of the Trust operational objectives for 2018/19. The dashboard reflects the objectives in the operational plan and will be used to report progress on the Trust's objectives to the Board.		
Reference to related / other documents:	Trust Operational Plan Clinical Strategy		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Links to the overall BAF		
Date paper completed:	18/04/18		
Paper previously presented at:			

Author name and title:	**Helen Taylor**	**Director name and title**		**Dr Helen Taylor Acting Director of Strategy**	
Equality Impact Assessment complete?		**Quality Impact Assessment complete**		**Financial Impact Assessment complete?**	

Whittington Health Corporate Objectives 17/18-January 2018 Update

Our Mission
'Helping Local People Live Longer Healthier Lives.'

The Trust vision is to be a national leader in delivering safe, personal, coordinated care to the local community. It is geographically placed in the centre of North Central London (NCL) with a portfolio of services covering the populations of Haringey and Islington but also with some community services in Camden, Enfield, Barnet and Hackney. Externally the developments such as the North Central London (NCL) Sustainability Programme and the Islington and Haringey Wellbeing Programme have a number of strategic priorities which will impact on Whittington Health (WH). This condensed plan summarises the operational objectives that will support WH achieve its clinical strategy and feed into the external developments across Islington, Haringey and NCL.

Deliver high quality, safe care and improved patient experience

Quality of care and patient safety are at the forefront of Whittington Health. The Trust's quality priorities are framed within the context of the 'Sign-up to Safety' initiative, supplemented by a desire to improve patient experience and enhance clinical leadership and engagement.

	in progress and on track
	not met
	completed

Objective	Baseline	Success	Governance/monitoring	Executive lead	End of year outcome
Safety Incidents					
Increase reporting of safety incidents as this is a good indicator of a strong safety culture	**Middle of the pack**	**Top 20% in the NRLS**	**Patient Safety Committee (PSC) Quality**	**Chief Nurse Medical Director**	

			Committee (QC)		
Achieve the WH Quality targets set out in the quality account.	**Identified in each target plan**	**As identified in each target plan**	**PSC and QC**	**Medical Director**	
Avoidable Mortality					
Establish a trust-wide process for the review of all inpatient deaths	**N/A**	**100%**	**QC**	**Medical Director**	
Quality Improvement					
Address the quality improvement identified in the CQC report	**CQC action plan in place**	**Monitor delivery of actions. Ongoing process including mock inspections completed**	**ICSU Board, ICSU Quarterly review, TMG, QC**	**Chief Nurse**	
Reduce the number of avoidable Falls that result in severe harm	**5**	**<5**	**QC Trust Board**	**Chief Nurse**	
Improve care of people with grade 4 pressure ulcers	**4 in community 0 in hospital**	**<4 in community 0 in hospital**	**QC Trust Board**	**Chief Nurse**	
Ensure there are no 'never events'	**2**	**Zero**	**QC Trust Board**	**Chief Nurse**	
Improve our performance regarding infection control	**2**	**Zero MRSA**	**QC Trust Board**	**Chief Nurse**	
Achieve the 4 hour target for the	**87.36%**	**Implement**	**TMG**	**Chief Operating Officer**	

Emergency Department		**quality improvement plan and trajectory including achievement of 95% by March 2018**	**Trust Board**		
Achieve the cancer access targets Cancer: Urgent referral to first visit Cancer: Diagnosis to first treatment Cancer: Urgent referral to first treatment	 **96.4%** **99.7%** **86.7%**	**Trust compliant with cancer targets.** **93% within 14 days** **96% within 31 days** **85% within 62 days**	**TMG** **Trust Board**	**Chief Operating Officer**	
Achieve the national access standard for : Referral to Treatment (RTT) RTT patients waiting 52 weeks Diagnostic waits Improved Access to Psychological Therapies (IAPT)	 **Incomplete** **93.1%** **0** **99.5%** **50%**	**Trust complaint with the 18 week standard** **Incomplete Threshold 92%** **0** **99%** **50%**	**TMG** **Trust Board**	**Chief Operating Officer**	

recovery target					
Lead the Haringey and Islington Wellbeing Partnership in developing a population based model for Children and Young People in Islington and Haringey	**Plan agreed**	**Service improvement and outcome measures in place**	**ICSU Board TMG Haringey and Islington Wellbeing Partnership Delivery Board**	**Chief operating Officer**	
Work as part of the Haringey and Islington Wellbeing Partnership develop a population based model for Diabetes and CVD in Islington and Haringey	**Plan agreed**	**Service improvement and outcome measures in place**	**ICSU Board TMG Haringey and Islington Wellbeing Partnership Delivery Board**	**Chief Operating Officer**	
Lead the Haringey and Islington Wellbeing Partnership in developing a population based model for Frailty in Islington and Haringey	**Plan agreed**	**Service improvement and outcome measures in place**	**ICSU Board TMG Haringey and Islington Wellbeing Partnership Delivery Board**	**Chief Operating Officer**	
Patient Experience					
We will reduce the amount of time patients wait for booked transport from home to hospital	**Potential 2 hour wait**	**Reduce 15-20 minute wait time**	**QC**	**Chief Nurse**	
We will reduce outpatient clinic appointment cancellations	**14%**	**<10%**	**QC**	**Chief Nurse**	

We will reduce noise at night for patients	**In patient survey result**	**Improve in patient survey result and additional real time patient feedback**	**QC**	**Chief Nurse**	
We will improve continuity of care when receiving visits from the district nursing team	**TBC**	**TBC**	**QC**	**Chief Nurse**	

Develop and support our people and teams

Our workforce is at the heart of our vision to provide excellent care delivered by expert and caring staff. We are dependent on the creativity and expertise of our staff

Objective	**Baseline**	**Success**	**Governance/ Monitoring**	Executive Lead	**End of year outcome**
Workforce development					
Recruit to, and maintain a substantive workforce to within 10% of establishment levels	**16%**	**<13.5%**	**ICSU board, ICSU Quarterly Review, WAC**	Director of Workforce	
Reduce and maintain overall turnover to 10.5% or lower	**c14%**	**10.5%**	**ICSU board, ICSU Quarterly Review, WAC**	Director of Workforce	
Staff Survey 2017 • Increase response rate • Improvement in key areas	**35.9%**	**40%**	**ICSU board, ICSU Quarterly Review,**	Director of Workforce Chief Operating Officer	

through workforce strategy and promotion at ICSU level			**TMG, WAC**		
Improve the quality of appraisal and achieve the 90% target	**Staff survey results suggest appraisal not seen as helpful. 80% baseline**	**Improved results in staff survey.** **90% staff undergo annual appraisal**	**ICSU board, ICSU Quarterly Review, TMG, WAC**	Director of Workforce Chief Operating Officer	
Tackling bullying and harassment	**30% staff replying reported**	**Improved result in staff survey**	**TMG Trust Board**	Director of Workforce	
Deliver the expanding apprenticeship programs throughout the organisation	**33 Apprentices in post**	**HCA appointments are made as apprenticeships**	**WAC**	Director of Workforce	
Develop and implement staff survey action plans in each ICSU	**Survey results**	**Action plans in place and implementation measured at each quarterly review**	**ICSU board, ICSU Quarterly Review, WAC**	Chief Operating Officer	
Maintain the Mayor of London Charter standard and roll out staff health and wellbeing initiatives	**Charter standard in place**	**Charter standard in place**	**WAC**	Director of Workforce	
Annual staff achievement awards in place and established	**N/A**	**Annual awards ceremony**	**Trust Board**	Chief Nurse	
Deliver the Quality Improvement strategy through 2017/18	**N/A**	**25% of staff trained**	**TMG**	Director of Workforce Chief Operating Officer	

Develop our business to ensure we are clinically and financially sustainable.

A central goal for Whittington Health is to reduce costs whilst continuing to deliver high quality care. This is the second year of the £25m cost reduction plan that is required in order for it to achieve a sustainable position.

Objective	Success	Governance/Monitoring	Executive Lead	End of year outcome
Financial objectives				
Ensure the Trust achieves the agreed Control Total for 2017/18 and collects all the STF monies	**Each ICSU and corporate area delivers plans**	**ICSU board, ICSU Quarterly Review, TMG, F&B**	**All**	
Ensure operational excellence in our Community business	**Improved data quality Complete benchmarking Metrics developed SLR data in place and being used**	**ICSU board, ICSU Quarterly Review, TMG, F&B**	**Chief Operating Officer**	
Efficiency Savings				
Deliver the cost reduction of £17.8m	**Each ICSU deliver its CIP programme and a reduces run-rate**	**ICSU board, ICSU Quarterly Review, TOM, Project Management Office (PMO)**	**Chief Operating Officer**	
Reduction in agency spend	**Reduction from £13.197m to NHSI targets**	**ICSU board, ICSU Quarterly Review, F&B**	**All**	
Carter Review				
Review Carter measures and data on model hospital	**Measures agreed for all areas**	**TMG Trust Board**	**All**	
Deliver the Hospital Pharmacy Transformation Programme	**Plan submitted to NHSI**	**ICSU Board, ICSU quarterly review, TMG**	**Chief Operating Officer**	
To improve medical productivity	**100% job plans on Allocate**	**TMG**	**Medical**	

	New policy implemented on job planning		**Director**	
Workforce productivity	**e roster used fully on wards to ensure rosters built on acuity rather than bed numbers**	**TMG**	**Chief Nurse**	
Estates and Capital Plan				
Deliver the Strategic Estates Plan	**Select vehicle and procure for delivery** **Development plan in place and agreed** **Business case approved for development** **Endoscopy improvement project completed**	**Capital Planning Group, F&B** **TMG** **Trust Board**	**Chief Financial Officer** **Director of Strategy**	
New Contracts				
Increase WH market share and identify tenders and contracts to support this objective.	**Business development plan in place** **Contracts awarded**	**TMG, F&B**	**Chief Financial Officer** **Director of Strategy**	
Develop new funding models for integration and new models through the Wellbeing Partnership	**Design and evaluate new funding models**	**F&BD** **Trust Board**	**Chief Financial Officer**	

Further develop and expand our partnerships and engagement

In order for us to achieve our mission and clinical strategy the most successful model will be local partnership working with a range of agencies. Our locality has a long and strong history of joint working, which we will continue to develop.

Objective	Success	Governance and Monitoring		End of year outcome
Develop our partnerships and engagement				
Active membership of the Health and Wellbeing Partnership	**WH is represented at all forums of the Wellbeing Partnership and leads one of the clinical programmes**	**TMG**	**Director of Strategy**	
Actively participate in the North Central London Sustainability and Transformation Plan	**STP supports the principles of population health outlined in the WH Clinical Strategy**	**TMG**	**Director of Strategy**	
Progress work as Digital Exemplar Fast Follower programme	**Plan by end of June Relationship developed with Bristol Hospital Trust**	**TMG**	**Chief Financial Officer**	
Working with Haringey and Islington CHIN developments as part the Health and Wellbeing Partnership and the STP.	**Plans in development WH integral to CHINs developed and alignment of services**	**ICSU Board TMG Haringey and Islington Wellbeing Partnership Delivery Board**	**Medical Director (Integrated Care) Chief Operating Officer Director of Strategy**	
Develop clinical collaborations with UCLH	**Clinical pathways and collaborative working to deliver sustainable services**	**ICSU Board, ICSU Quarterly review, TMG**	**Director of Strategy**	

Further enhance our reputation for excellent multidisciplinary and integrated education and training.	**Implement the Education Strategy and develop operational plan** **Successfully lead the Nursing Training Superhub for North Central London** **Extend e training model in ED department that uses the 'Moodle' platform to deliver short courses and learning support courses for targeted sectors of the workforce**	**Education Strategy Group** **WAC**	**Medical Director**	
Increase the culture of research development within WH	**Open 20% more studies by March 2018** **Open two additional commercial trials** **Increase income from research by 20%**	**ICSU Board Research and Development Office**	**Associate Medical Director and Research Lead**	

Community Engagement				**End of year outcome**
Ensure community of Islington and Haringey are able to engage with WH	**Revise the Communication and Engagement Strategy Develop a community engagement model and implement a programme of engagement e.g. social media, 'listening events' and a digital community forum for local residents to engage with.**	**TMG Trust Board**	**Director of Communication Director of Strategy**	
Community activation and engagement including embedding co-production into clinical pathway development	**TBC**	**TMG Trust Board**	**Chief Operating Officer Director of Strategy**	

Operational objectives 2018-19

Safety	Quality	People	Finance	Partnership
Quality improvement				
Digital strategy				
Safety incident reporting ⟷ • Increase reporting of safety incidents *Chief Nurse, Medical Director* *Clinical SG 3*	**Cancer and RTT** ⟷ • Achieve cancer and referral to treatment national standards *Chief Operating Officer* *Clinical SG 1, 2, 4, 6*	**Recruitment goal** ⟷ • Recruit and maintain sustainable workforce *Director of Workforce* *Clinical SG 6*	**Efficiency savings** ⟷ • Deliver £16.5m savings through CIPs *Chief Operating Officer* *Clinical SG 6*	**STP** ⟷ • Actively participate in NCL STP *Director of Strategy* *Clinical SG 1, 6*
Falls, ulcers & infection ⟷ • Cut by 25% inpatient falls leading to severe/moderate harm • Zero tolerance for avoidable pressure ulcers • Reduce hospital acquired infections *Chief Nurse* *Clinical SG 2, 3*	**Emergency department** ⟷ • Deliver quality improvement plans to support achievement of four-hour target *Chief Operating Officer* *Clinical SG 1, 2, 3, 6*	**Turnover goal** ⟷ • Reduce turnover and maintain at lower levels • Reduce sickness and absence rates *Director of Workforce* *Clinical SG 6*	**Control total** ⟷ • Deliver 2018/19 control total and collect all STP monies *All* *Clinical SG 6*	**Wellbeing Partnership** ⟷ • Develop Haringey and Islington Wellbeing Partnership • Develop Care Closer to Home Integrated Networks (CHINs) *Director of Strategy* *Clinical SG 1, 2, 6*
Improve mortality investigations • Review all inpatient deaths *Medical Director* ⟷ *Clinical SG 3*	**Mental health** ⟷ • Maintain treatment and waiting time standards *Chief Operating Officer* *Clinical SG 1, 2, 3, 4*	**Safe staffing levels** ⟷ • Continuously monitor safe staffing levels *Chief Nurse (?)* *Clinical SG 3, 6*	**Estates** ⟷ • Deliver strategic estates plan and link to NCL STP *Chief Financial Officer, Director of Strategy* *Clinical SG 6*	**UCLH cooperation** ⟷ • Develop collaborative pathways with UCLH *Director of Strategy* *Clinical SG 1, 6*
Better Births Review ⟷ • Deliver BBR action plan *Chief Nurse* *Clinical SG 1, 2, 3*	**Patient experience** ⟷ • Improve FFT response and use to improve patient experience *Chief Nurse* *Clinical SG 1, 4, 6*	**Training** ⟷ • Deliver Quality Improvement training *Associate Medical Director* *Clinical SG 5, 6*	**Cut agency spend** ⟷ • Improve vacancy, attrition, agency rates *All* *Clinical SG 6*	**Research** ⟷ • Increase culture of research development *Associate Medical Director* *Clinical SG 5*
7 day service ⟷ • Meet four priority standards for seven day service *Chief Operating Officer* *Clinical SG 1, 2, 3*	**CQC action plan** ⟷ • Deliver actions to meet CQC areas for improvement *Chief Nurse* *Clinical SG 1, 3, 6*	**Appraisals** ⟷ • Improve quality of appraisals *Director of Workforce, Chief Operating Officer* *Clinical SG 6*	**Carter Review** ⟷ • Use Carter measures to improve productivity, including e-rostering and back office improvements *All* *Clinical SG 3, 6*	**Digital fast follower** ⟷ • Progress digital fast follower projects *Chief Financial Officer* *Clinical SG 6*

Whittington Health NHS Trust

Trust Board

25th April 2018

Title:	**Risk Management Strategy 2018-2021**		
Agenda item:	**18/064**	**Paper**	**12**
Action requested:	Approval of the Risk Management Strategy		
Executive Summary:	1. The Risk Management Strategy provides a framework for the identification, management and escalation of risk within the organisation. 2. The Trust vision is to 'help local people live longer healthier lives' and ensuring sound governance and risk management is fundamental to this ambition. 3. The Trust recognises that quality and risk management must be embedded in order for the organisation to function safely and effectively. 4. This Strategy will be reviewed by the Trust Board annually and updated in line with current best practice and/or any change in legislation. 5. The risks that are scored ≥**16** will be reviewed at Trust Board on a six monthly basis. 6. A robust organisational governance structure, with clear lines of accountability and roles responsible for risk is in place. 7. To strengthen the Trust's ability to deliver effective risk management, the organisational structure includes a number of Board Committees with responsibility for risk. 8. The Risk Management Strategy was previously reviewed at Trust Management Group, the sub committees of the Board and at a Board Seminar		
Summary of Recommendations:	The risk register is driven from ICSU/Corporate department level to Trust Board. The development of the strategy has incorporated best practice and guidance from the NPSA and Good Governance Institute. The responsibility of the Board is to approve the strategy and to agree the reporting mechanism for >16 risks to be reported to the Board six monthly. The relationship with the Board Assurance Framework is clear and that risks to achievement of the Trust objectives are articulated clearly.		
Fit with WH strategy:	Efficient and effective care		
Reference to related / other documents:	Board Assurance Framework		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Relates directly to the BAF and its relation to the Risk Register		
Date paper completed:	12 February 2018 revised after Board Seminar March 18		

Author name and title:		**Gillian Lewis Head of Governance and Risk**		**Director name and title:**		**Michelle Johnson Chief Nurse and Director of Patient**	
Date paper seen by TMG	23/4/18	**Equality Impact Assessment completes?**	n/a	**Quality Impact Assessment complete?**	n/a	**Financial Impact Assessment ?**	n/a

1. INTRODUCTION

Risk is an inherent within the delivery of healthcare. The Risk Management Strategy provides a framework for the identification, management and escalation of risk within the organisation.

The Trust vision is to 'help local people live longer healthier lives' and ensuring sound governance and risk management is fundamental to this ambition. The Trust recognises that quality and risk management must be embedded in order for the organisation to function safely and effectively. The Trust Board is committed to ensuring that risk management forms an integral part of the organisation's philosophy, practices, activity and planning and not viewed as a separate programme of work.

The Trust Board seeks assurance that systems, policies and people are operating in a way that is effective, focused on key risks, and is driving the delivery of the Trust's goals and objectives. It is aware of the risks within the organisation, and that it has made effective decisions on the management of risk based on the available evidence. The risk management strategy functions within a governance framework described in a number of Trust policies (**Appendix 1**).

The Trust Board seeks assurance from the Board Assurance Framework and Trust Risk Register.

This Strategy will be reviewed by the Trust Board annually and updated in line with current best practice and/or any change in legislation.

1. DEFINITIONS

Risk management - is a systematic process of risk identification, analysis and evaluation and correction of potential and actual risks to a patient, visitor or member of staff.

Clinical Risks - which relate to the provision of high quality patient-centred care e.g. medication errors, patient falls, and patient safety risks.

Non-clinical Risks – relate to the environment in which patient care takes place including the use of facilities by staff, patients, contractors and other visitors e.g. health and safety risks, financial risks, reputational risks, information governance risks etc.

Risk Register - database used to collate and monitor all risks in an organisation

2. Purpose

Strategic aims for the Risk Management Strategy are

- Compliance with relevant statutory mandatory and professional requirements and maintenance of the Trust's registration with the Care Quality Commission (CQC)

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- Consistent and effective risk management processes at all levels of the organisation
- Open culture where people feel encouraged to take responsibility for reporting and managing risks
- Integration of risk management into business processes, such as ensuring service developments do not adversely impact on safety

3. Organisational Structure for Risk Management

A robust organisational governance structure, with clear lines of accountability and roles responsible for risk is key to the delivery of the Trust's risk management strategy (**see Appendix 1 and 2**).

To strengthen the Trust's ability to deliver effective risk management, the organisational structure includes a number of Board Committees with responsibility for risk. The Audit & Risk Committee, Quality Committee, Finance & Business Committee and Workforce Assurance Committee all have a responsibility in monitoring risk and providing assurance to the Trust Board that there are systems in place to effectively identify, manage and escalate risks across the trust.

Each Committee has responsibility for specific risks to ensure there is clear accountability and oversight, and that information flows quickly to the Board and its committees. Each committee has a responsibility to commission 'deep dives' into areas that warrant closer scrutiny in order to manage risk.

Audit and Risk Committee is responsible for providing an objective review of the Trust's system of internal control including financial systems, financial information, assurance arrangements e.g. governance and risk management, and compliance with legislation. The Committee has responsibility for overseeing its sub-committees functions in relation to risk, as well as reviewing and monitoring the trust's risk appetite and providing assurance to the Trust Board.

Quality Committee provides assurance to the Board on quality and safety. The Committee reviews all risks rated >15 on the ICSU risk registers and the corporate estates risk register. It reviews all organisation wide risks under the scope of the Committee including clinical and corporate risks from the areas of patient and public safety, patient experience, clinical effectiveness and audit, regulatory compliance (i.e. CQC), research, health & safety, and workforce issues (including statutory and mandatory training) where it relates to quality and safety.

Finance and Business Development Committee is to support further development of financial and business development strategies of the Trust and monitor progress against to ensure achievement of financial targets and business objectives and the financial sustainability and stability of the Trust. The Committee reviews risks rated >15 relating to finance, information governance and IT.

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Workforce Assurance Committee is to monitor all staffing and workforce risks. The Quality Committee will also monitor workforce risks that present a potential or actual risk to quality and safety.

4. Key principles of Risk Management

Through a process of risk identification, risk assessment, mitigation and control, the organisation will maintain a Trust wide Risk Register, using DATIX, the Trust's risk management software programme.

- **Identification**: Early identification promoted through a culture of openness and transparency, encouraging staff to report incidents and near misses
- **Assessment**: The trust has a standard approach to risk assessment, using the nationally recognised risk matrix (http://www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/risk-assessment-guides/risk-matrix-for-risk-managers/) and online risk assessment form on DATIX to assess all risks under the key headings of controls, assurance, and gaps.
- **Management**: Individual risk managers are responsible for reviewing the risk assessment and identifying the appropriate action to take to reduce or eliminate the risk. Some risks that cannot be reduced or represent a risk to the strategic objectives of the trust must be escalated appropriately to the relevant Trust Board sub-committee.

To promote a consistent approach the Trust will ensure that risk management is supported by the development of formal mechanisms to assess risk and to measure the effectiveness of risk management, plans and processes. In particular:

- Providing training and support to managers and identified risk leads to enable them to manage risk as part of role and/or line management responsibilities
- Providing a Risk Register guide for staff outlining the approval, monitoring and reporting process for all risks on DATIX
- All risks are collated by ICSU or Corporate Department (IM&T; Facilities and Estates; Finance, Human Resources and Workforce) or as organisation wide
- All risks are categorized under 8 key headings;
    - Patient Safety and Quality
    - Financial
    - HR and Workforce
    - Health and Safety
    - Estates or Infrastructure
    - Information Technology
    - Information Governance
    - Security
- There will be a process of challenge at Performance Review meetings by the Executive in relation to assumptions underpinning risk ratings and mitigation plans

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- Risk management will be supported by accurate, timely and effective incident reporting, including categorising the consequences of risk and investigating system failures
- Evidence will be maintained to demonstrate that recommendations and action plans have been developed and changes implemented accordingly to mitigate risk
- Risk assessments will be undertaken for strategic policy decisions and documents relating to new projects
- Risk assessments will be undertaken for all cost improvement programmes which includes a quality impact assessment

5. Reporting and monitoring risk

The Chief Nurse is responsible for ensuring the risk register is maintained according to the risk management strategy.

6.1 Local management of risk

- ICSU directors and corporate department directors are responsible for developing and maintaining their respective risk registers
- While individual risk handlers are responsible for reviewing and monitoring the risks only ICSU directors and corporate directors can approve new risks or agree significant changes to the risk register
- Risk registers are reviewed at the relevant ICSU Boards and/or department meetings using the reporting or dashboard function from DATIX to ensure a dynamic, live database
- Each ICSU's risk register will be formally reviewed as part of the ICSU quarterly Performance Review process. At these meetings the ICSUs will be expected to report on their top risks rated ≥15, and present action plans for minimising and managing these risks.
- All risks ≥15 will be escalated to the relevant Board Sub-Committee and Trust Management Group for review and agreement.

6.2 ≥15 Risk Register

- The Trust has set a threshold of ≥15 risk grading for review at Board sub-committees. This is to ensure that there is Non-Executive Director and Executive Director Lead oversight of these risks and a clear escalation process to Board.
- All ICSUs/Directorates are responsible for ensuring there are clear risk management structures and processes in their areas, including the regular review of all their ≥15 risks from a specialty to ICSU/Directorate level
- All risks ≥15 and are automatically escalated to the relevant sub-committees and collated from the central database on DATIX
- The Head of Governance and Risk is responsible for managing and reporting on the ≥15 Risk Register
- Monthly review of the ≥15 Risk Register by Trust Management Group and Executive Team monthly
- Trust Board Sub-Committees have delegated responsibility for risk from the Trust Board and provide assurance to the Trust Board that the ≥15 Risk Register is being

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actively reviewed. Any concerns are escalated for Board consideration as required. This process ensures that the ≥15 Risk Register has regular Non-Executive and Executive oversight.

6.3 Reporting process for ≥15 Risk Register

- The Trust Board delegates responsibility for the ≥15 risk register to the relevant board sub-committees via the executive directors lead for the committee
- Sub-committee chairs and Executive director lead to escalate any concerns with the risk register to Board as required
- Each committee produces a bi-monthly report on the ≥15 risk register
- The Quality Committee reviews all risks ICSU and Estates and Facilities risks ≥15, as well as any organisation wide risks. In addition, the Quality Committee considers finance, information governance and IT risks for information and escalates any concerns around quality and safety to the responsible Board sub-committee.
- The Finance and Business Development Committee reviews all Finance, IM&T and Information Governance risks ≥15, and also reviews all risks categorised as financial, information governance or information technology from the ICSU risk registers.
- The Workforce Assurance Committee reviews all workforce risks ≥15 and also reviews all risks categorised as 'HR and workforce' from the ICSU risk registers.
- The Audit and Risk Committee will review the full ≥15 Risk Register and provide assurance to Trust Board that there is an effective governance structure in place to manage risks.
- In addition, all risks ≥16 to be presented to public Board in a six monthly report and will include the connection to the Board Assurance Framework (BAF)
- The Trust Board will review the BAF six monthly

7. Board Assurance Framework

The Board Assurance Framework (BAF) provides a structure and process that enables the Trust to focus on the risks to achieving its annual objectives and be assured that adequate controls are operating to reduce these risks to tolerable levels (Good Governance Institute 2009).

The Board and its Committees review the progress in controlling risks to these important objectives, the levels of assurance, and plans to mitigate the impact of the actual or potential risk on the Trust. It importantly deterimines the accountablity structure for the risk.

All risks to achieving the Trust's objectives will be recorded on the BAF and reported to the Board.

The relationship between the risk register and BAF is set out in the table below (**note this is an example, not based on actual DATIX references).** The fundamental difference between the Risk Register and the BAF, is that the Risk Register is a tool focused on the day to day management of risk for the organisation. The BAF focuses on risk assurance of the corporate objectives and that there are clear mitigation and accountability of any risks that threaten the success of the Trust objectives. At times

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the risks affecting the day to day management of the Trust will have implications for the delivery of the Trust's strategic objectives, these risks are escalated for inclusion on the BAF via the Board sub-committees and the Executive Team and Trust Management Group.

Strategic objective	Risks against achieving this objective (BAF)	Links with >15 Risk Register
SO1.To deliver a consistent high quality safe service	BAF1: Failure to recruit and retain staff	DATIX ref 63: Inadequate consultant cover in Emergency Department (scored 16) DATIX ref 73: High nursing vacancy rate in District Nursing Service (scored 15) DATIX ref 102: High nursing vacancy rate on care of older people's wards (scored 15)

7.1 Reporting on the BAF

- The Director of Strategy, Development and Corporate Affairs, with the Head of Governance and Risk, will ensure the link between the ≥15 risk register and BAF is maintained
- The Head of Governance and Risk will present the key changes to the >15 Risk Register to the Trust Management Group (TMG), highlighting any correlating implications for the BAF. The TMG is responsible for recommending changes to the BAF that must be approved by the Trust Board.
- The Director of Strategy Development and Corporate Affairs is responsible for maintaining and reporting on the BAF, including updating the framework with assurance and mitigating actions as required, ensuring the BAF is kept up to date with changes to the ≥15 risk register and providing reports to Trust Board as required to highlight significant changes to the BAF.
- Director of Strategy Development and Corporate Affairs presents BAF to Trust Board six monthly

8. Risk Tolerance and Risk Management Options

The aim of the Risk Management Strategy is not to remove all risk but to recognise that some level of risk will always exist. It is recognised that taking risks in a controlled manner is fundamental to innovation and developing a positive culture.

Risk tolerance is the amount of risk that an organisation is prepared to accept, or be exposed to at any point in time and every risk needs to be assessed for the tolerable level of risk. This strategy outlines the approach the Trust will take in assessing its risk tolerance.

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8.1 Risk Management Options

To provide safe and effective care to patients the organisation identifying risks and takes appropriate action to address them. This will typically be to either eliminate the risk entirely, or to reduce it to an acceptable level. Risk management options are categorised as follows:

Risk Avoidance

Risk avoidance is action that avoids any exposure to the risk. Where the level of risk is unacceptably high and the Trust cannot, for whatever reason, put adequate control measures in place the Trust will consider whether to stop the relevant services at the Trust. The decision on Risk Avoidance may only be made by the Executive Team, Trust Management Group and agreed by the Chief Executive, in consultation with the Trust Board and relevant stakeholders as appropriate.

Risk Transfer

Risk transfer is the action of handing over a risk to a willing third party. An example of such a risk transfer measure would be the decision that patients requiring certain high-risk surgical procedures for which the required level of surgical expertise or equipment is not available in the Trust will be referred to a tertiary centre for their treatment. In this case a balance of risk must be considered – the risk from transferring the patient must be less than the risk of operating in the Trust environment.

Risk Mitigation

Risk mitigation is defined as taking steps to reduce or eliminate risks. This is the most commonly used approach in risk management. Some risks, when identified can be readily reduced or removed through the introduction of suitable control measures, (e.g. new policies, electronic safeguards, and environmental changes).

Risk Acceptance

Risk acceptance does not reduce any effects of the risk; it is the process of actively deciding that the trust will accept the consequences (impact) of a risk if it occurs. When all reasonable control mechanisms have been put in place, some residual risk will inevitably remain in many Trust processes and can be accepted. Risk acceptance by the Trust will be systematic, explicit and transparent.

8.2 Assessing Trust Risk Tolerance Level

Risk tolerance is the amount of risk that any organisation is prepared to accept, or tolerate, or be exposed to at any point in time.

The Trust follows the Good Governance Institute Guidance on setting risk tolerance levels (**https://www.good-governance.org.uk/services/risk-appetite-for-nhs-organisations-a-matrix-to-support-better-risk-sensitivity-in-decision-taking/**). The risk tolerance of the trust may vary across different elements (e.g. financial, regulatory, quality and safety or reputation).

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This will be monitored through the Audit and Risk Committee who review the >15 Risk Register and BAF to provide assurance to Trust Board that the trust is operating within its agreed risk tolerance.

9. Training

At the heart of this Strategy is the desire to learn from events and situations in order to continuously improve management processes. All members of staff have an important role to play in identifying, assessing, reviewing and managing risk. The Trust will develop all staff to ensure they have the knowledge and skills in risk management appropriate to their role and provide information, training and support to achieve this.

The Trust will:

- Ensure all staff have access to a copy of this Risk Management Strategy via the Trust's Intranet
- Communicate with staff actions to be taken with respect to assurance, quality and risk issues e.g. via the Trust weekly e-noticeboard
- Develop policies, procedures and guidelines based on the results of assessments, investigations and all identified risks
- Ensure that training programmes raise and sustain awareness of the importance of identifying and managing risk
- Ensure that staff have the knowledge, skills, support and access to expert advice necessary to implement the policies, procedures and guidelines associated with this Strategy
- Facilitate specific risk management training for Board Members, Executives and Senior Managers, as specified

10. Monitoring the Effectiveness of the Strategy

The Trust Board will review this strategy annually.

The Trust will seek assurance that risk management activities and systems are being appropriately identified and managed through the following:

- The Annual Governance Statement and the Board Assurance Framework
- Achievement of the Trust's strategic goals and annual corporate objectives
- Achievement of the ICSU business plans
- Compliance with National Standards, e.g. Care Quality Commission
- Monitoring of key performance indicators via the Trust and ICSU performance dashboards
- Receiving assurance from internal and external audit reports that the Trusts risk management and governance processes are being implemented
- External reporting is undertaken in accordance with reporting requirements and timescales
- Risk register reports to TMG and Board sub-committees and minutes from meetings
- Audit and Risk Committee review of trust compliance with agreed risk tolerance

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The Head of Governance and Risk will be responsible for ensuring systems and processes are in place to monitor the effectiveness of the Risk Management Strategy.

11. Equality Impact Assessment

This Strategy and its impact on equality have been reviewed in line with the Trust's Equality Scheme and no detriment was identified.

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Appendix 1 – Key Trust Policies

Strategy / Policy	Hyperlink
Risk Register Guidance	Located on DATIX
Health & Safety Policies	http://whittnet.whittington.nhs.uk/default.asp?c=7078&
Serious Incident Investigation Policy	http://whittnet.whittington.nhs.uk/document.ashx?id=8436
Adverse Incident Reporting and Investigation Policy	http://whittnet.whittington.nhs.uk/document.ashx?id=2518
Major Incident Plan	http://whittnet.whittington.nhs.uk/document.ashx?id=8
Business Continuity Plan	http://whittnet.whittington.nhs.uk/document.ashx?id=6
Safeguarding Children Policy	http://whittnet.whittington.nhs.uk/document.ashx?id=7
Safeguarding Adult Policy	http://whittnet.whittington.nhs.uk/document.ashx?id=5
Being Open Policy	http://whittnet.whittington.nhs.uk/document.ashx?id=7
Raising Concerns (Whistleblowing) Policy	http://whittnet.whittington.nhs.uk/document.ashx?id=5

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Appendix 2 – Duties and Accountabilities

The Chief Executive is the Accountable Officer and has overall accountability and responsibility for governance and risk management within the Trust. Following the implementation of a system of Director line-accountability, responsibility for providing assurance on all areas of governance and risk has been delegated to individual Executive Directors and NEDs.
The Trust Board holds The Executive Directors to account for progress with mitigating identified risks. The key areas that each Executive Director has accountability for are defined on the Board level and Director Accountability Structure **Appendix 5**. Each Director has clear assurance systems and structures in place to support the delivery of their areas of responsibility that includes line management structures and supporting working groups, forums and/or committees. The Executive Team and each Director is accountable to the Board through the Board Committee structure.
Chief Nurse and Director of Patient Experience is the accountable Director for the Trust Risk Management Strategy, policies and procedures and the >15 Risk Register.
Director of Strategy is the accountable Director for the Trust Board Assurance Framework. They are responsible for the day to day management of the Board Assurance Framework, for ensuring that the BAF is kept up to date in line with the >15 Risk Register and for providing reports to Trust Board and other relevant committees on the BAF as required. In addition the Director of Strategy and Corporate Affairs is responsible for the Senior Information Risk Owner role (SIRO)
Chief Finance Officer is the accountable Director of management of the Local Counter Fraud services and reporting mechanisms and for the management of the Trust internal and external audit plans and reporting
Head of Governance and Risk is accountable to the Deputy Chief Nurse for ensuring systems and processes are in place to monitor the effectiveness of the Risk Management Strategy and further development of the Trust's integrated governance and risk management processes. The Head of Governance and Risk is also responsible for overseeing the day to day management/coordination of risks across the organisation. The role is an expert resource for all clinical and non-clinical risk related issues, professional advice and support to senior managers and leads risk triangulation and reporting through the interrogation and trend analysis of incident data held on DATIX
Integrated Clinical Service Unit Leadership Teams and Corporate Department Leads are responsible for ensuring that effective governance and risk management processes, as described within this strategy, are in place and implemented within their ICSUs and/or Departments and are responsible for leading and monitoring clinical governance issues with relevant staff. Each Integrated Clinical Service Unit (ICSU) will be accountable through the ICSU performance structures, including the quarterly quality and performance challenge days, and to the Executive Directors
All Managers (medical, clinical and non-clinical) All managers are accountable for the day-to-day identification and management of all risks within their area of responsibility. They must ensure that risk registers are maintained on DATIX; that risk assessments are undertaken and preventive action is carried out where necessary or escalation of the risk where required
Health and Safety Advisor The Safety and Security Advisor is responsible for overseeing the day-to-day management/coordination of non-clinical risks throughout the organisation in conjunction with other non-clinical risk management specialist who are responsible for their respective areas.
All Staff (Inc. contract staff and agency staff) Management of risk is a fundamental duty of all staff. All staff must follow Trust policies and procedures; ensure that identified risks and incidents are dealt with swiftly and effectively; report all incidents and near misses on DATIX; and undertake mandatory training. All staff, including locums, agency and honorary contracted staff have a personal and professional responsibility to be familiar with the Risk Management Strategy, follow policies and guidelines and take the necessary actions required to reduce risk (see the Trust's Incident Reporting and Investigation Policy

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Whittington Health
NHS Trust

Executive Offices
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Trust Board
25 April 2018

Title:	Register of Deed of Execution and Seal		
Agenda item:	**18/065**	**Paper**	**13**
Action requested:	Approval for the latest Register of Deed of Execution and Seal		
Executive Summary:	A report to the Board of the use of the Trust Deed of Execution / Seal which is recorded on the Whittington Health NHS Trust formal Register for the period 1 April 2017 to 31 March 2018		
Summary of recommendations:	To take assurance that the use of the Trust's Deed of Execution / Seal has been administered in accordance with Trust Standing Orders		
Fit with WH strategy:	Compliance with the Trust SOs, SFOs and governance framework		
Reference to related / other documents:	Aligns to the Trust public body statutory requirements and duties		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured on risk registers and/or Board Assurance Framework.		
Date paper completed:	27 March 2018		

Author name and title:		**Director of Corporate Affairs**		**Director name and title:**		**Chief Executive**	
Date paper seen by ETM	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

Register of Deed of Execution 1 April 2017 to 31 March 2018

Reference	Details	Date
18/01	CHP – Community Health Partnerships Limited and Whittington Health. Counterpart BEH LIFT underlease for part of Vale Drive Primary Care Centre, Vale Drive EN5 2ED	04/04/2017
18/02	Community Health Partnerships Limited and Whittington Health. Counterpart Ealing Hammersmith & Fulham and Hounslow NHS LIFT underlease for part of Thelma Golding Health Centre (also known as Heart of Hounslow Centre for Health) 92 Bath Road, Hounslow TW3 3EL	20/04/2017
18/03	Whittington Health & Compass Contract Services (UK) Limited. Lease of Unit 1, The Whittington Court (revision of previous)	21/04/2017
18/04	Whittington Health & XLNT (Health) Limited. Lease of Unit 3, The Whittington Court (revision of previous)	21/04/2017
18/05	Whittington Health & Foodco UK LLP t/a Muffin Break. Lease of Unit 2, The Whittington Court	21/04/2017
18/06	Haringey Sexual Health Contract	16/05/2017
18/07	Haringey School Nursing Contract	09/06/2017
18/08	Contract variation – Haringey School Nursing Service	10/07/2017
18/09	Contract variation – Haringey Health Visiting & Family Nursing Partnership	10/07/2017
18/10	Whittington Hospital NHS Trust & Whittington Pharmacy CIC lease of Whittington Pharmacy Highgate Hill London	12/07/2017
18/11	Whittington Hospital NHS Trust & Whittington Pharmacy CIC Business transfer agreement in relation to the business assets of the Whittington Hospital Pharmacy	12/07/2017
18/12	Whittington Pharmacy Community Interest Company & Whittington Health NHS Trust operating level agreement	12/07/2017
18/13	Whittington Pharmacy Community Interest BHH LIFT company limited underlease for part of Alexandra Avenue Health & Social Care Centre	13/07/2017
18/14	Community Health Partnerships Limited & WH Ealing Hammersmith & Fulham and Hounslow NHS LIFT – underlease for part of Grand Union Village Health Centre, Taywood Road Northolt UB5 6WL	09/08/2017
18/15	Forest Vale Fundco Limited & Community Health Partnerships Limited Deed of Covenant	10/10/2017
18/16	Community Health Partnerships Limited & WH Counterpart underlease of Evergreen Primary Care Centre	10/10/2017
18/17	BHH LIFT Accommodation Services Limited Community Health Partnerships Limited Licence to underlet part of Alexandra Avenue Health & Social Care Centre	10/10/2017
18/18	Mayor & Burgesses of London Borough of Haringey & Whittington Health NHS Trust contract for provision of Occupational Health Services	04/12/17
18/19	Com Health Partnerships Ltd Lease for Holloway Community Health Centre, 11, 15B, 15C and 17 Hornsey Road	15/01/18

Whittington Health NHS Trust

Trust Board 25 April 2018
ITEM 18/066
Doc 14.1

Minutes
Quality Committee, Whittington Health

Date & time:	14th March 2018 at 14:00 – 16:00
Venue:	Room 6 Whittington Education Centre, Whittington Hospital
Chair:	Anu Singh (AS), Non-Executive Director
Members Present:	Michelle Johnson (MJ), Chief Nurse & Director of Patient Experience Carol Gillen (CG), Chief Operating Officer Deborah Harris-Ugbomah (DHU), Non-Executive Director Richard Jennings (RJ), Medical Director Yua Haw Yoe (YHY), Non-Executive Director
In attendance	Dorian Cole (DCo), Head of Nursing, **CYP** Stuart Richardson (SR), Operations Director, **CSS** James Connell (JC), Patient Experience Manager Gillian Lewis (GL), Head of Governance and Risk Fiona Isacsson (FI), Operations Director, **S&C** Leanne Rivers (LR) Patient Representative Alison Kett (AK), Head of Nursing **IM** Wayne Blowers (WB), Quality Improvement and Compliance Manager Theresa Renwick (TR), Adult Safeguarding Lead Karen Miller (KM), Children's Safeguarding Lead Kelly Collins (KC), Lead Nurse, **PPP** Nicole Callender (NC), Matron, **WH**

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Agenda items

1.1	**Welcome & Apologies**	**Chair**
	AS welcomed the committee. Apologies from Deborah Clatworthy (DC), Head of Nursing, Surgery and Cancer	

Actions	**Deadline**	**Owner**
/		

1.2	Declarations of Conflicts of Interests	Chair
	No conflicts of interest were noted.	

Actions	Deadline	Owner
/		

1.3	Minutes of the previous meeting	Chair
	AS referred the committee to the minutes from the previous meeting in January 2018. MJ asked for a minor amendment to section 4.5 from past tense to present. AS queried whether the Trust has investigated other trust's mental health capacity policies and guidelines. Sarah Hayes not present to feedback to committee on action status.	

Actions	Deadline	Owner
Sarah Hayes to feedback discussions w/Theresa Renwick re: investigating other trust's mental health capacity policies	9th May	Sarah Hayes

1.4	Matters Arising	Chair
	No matters were raised.	

Actions	Deadline	Owner
None		

2.1	CQC inspection update	
	The paper was taken as read. MJ reported on the findings from the CQC inspection report including the excellent improvement achieved by the outpatient department. MJ emphasised that whilst the CCU had made improvements around safety, more work was still needed in the areas of responsiveness and well-led due to delayed discharges and ITU capacity. MJ highlighted the ongoing challenges with delayed discharges from the CCU as noted in the CQC report. RJ identified that we are not yet getting this right and that it needs a different level of attention than we have given it over the last two years. CG suggested that the same level of focus needs to be given to this as has been seen with mental health 12 hour breaches, which since last summer has been zero. AS asked how ligature risks at Simmons house were picked up again by the CQC inspection given the actions taken to improve this issue after the 2016 CQC report. GL noted that some areas had been missed off the risk assessment checklist. DC confirmed that the CQC found evidence of one room that was not on the ligature risk assessment checklist for Simmons House.	

Actions	Deadline	Owner
Send out messages thanking all services that did well in the CQC report	28/3/18	MJ

2.2	Draft Risk Management strategy
	GL took the paper as read. GL reported that the health and safety committee will now report to the quality committee and that Information Governance will report to the Audit and risk committee. GL clarified that operational risks are to be reported on the greater than 15 risk register and that risks with strategic implications will also be reported within the Board Assurance Framework. FI asked for a committee structure diagram for further clarification. GL explained that this will be produced once the strategy has been to the Audit and Risk committee and subsequently to the board for approval. YHY and FI noted that the new risk register format provides better and clearer identification of risks.

Actions	Deadline	Owner
Committee structure diagram to be included in the Risk Management Strategy, once updated version provided by Director of Corporate Affairs.	June 2018	GL

3.1	Clinical Support Services ICSU	
	SR presented the paper which was taken as read. SR reported that medicines incident reporting has increased but requires continued improvement. SR highlighted the recognition from the CQC for the outstanding practice in the hospital one-stop breast and skin cancer outpatient clinics and the good medicines management systems in place SR presented the top risks for the ICSU as storage and handling of medicines, temperature monitoring of fridges used for medicines storage, IT cybersecurity and radiology reporting backlogs. SR identified that the radiology reporting backlog was declared at 4000 images between 2014-2017, at time of meeting 1300 remained that needed review. Commissioners are aware of this risk. To date there have been no incidents of patient harm identified. There is a robust process in place to monitor any potential clinical harm and also around the management of the backlog. DH asked whether the DTC 6 month report goes into the public domain and that due to the sensitive nature of the pharmacy wholly subsidiary an additional sentence could be	

	added to explain this. AS noted the low FFT numbers from the CSS ICSU. SR reported on the ongoing actions for improving these figures. DH highlighted that the current data showing 100% satisfaction is not meaningful due to the very low numbers reported on.

Actions	Deadline	Owner
SR to add additional sentence to DTC report around wholly subsidiary status of pharmacy	21/3/18	SR
SR to further investigate ways of increasing FFT feedback for CSS with JC	9/5/18	SR

3.2	Patient Access, Prevention and Planned Care ICSU	
	KC presented the paper which was taken as read. KC reported that there has been one serious incident of a patient having a long wait to be seen by podiatry. Actions implemented include introducing locum cover for the service and employing two new members of staff. KC informed the committee that 10 staff members from the ICSU will be attending the upcoming Quality Improvement training day run by UCL Partners. FI noted the great QI work taking place within the ICSU.	

Actions	Deadline	Owner
/		

4.1	Quality and Safety Risk Register	
	GL presented the risk register update which focuses on risks scored greater than 15. GL highlighted that the estates risks have been reviewed and there is no change to their high risk status. 830 has had a reduction in risk grading, 836 records storage risk reduced to likely, 859 is a new risk. MJ questioned whether Risk 830 (Haringey Community Paediatric Consultant gaps in Child Protection Rota) should have been reduced yet as the substantive posts had not been filled. GL noted that Neeta Patel had advised the risk had reduced as the posts were currently filled with temporary staff. DC to review the risk grading.	

Actions	Deadline	Owner
DC to review the risk grading on 830	9/5/18	DC

4.2	Aggregated Incidents, Complaints and Claims Q3	
	GL reported on the high level of incident reporting that takes place within the trust and that we have seen a reduction in harm levels due to better validation and understanding. GL signposted the committee to 'Greatix' as a way of recognising good staff feedback and practice. LR suggested also nominating staff for staff awards on the basis of	

	Greatix feedback. GL noted that violence and aggression reporting on Datix is now recorded separately from security transfers. GL highlighted a learning lesson theme around communication with patients and families and the work taking place with falls prevention, preventing PJ paralysis, John's Campaign and Freedom to Speak Up Huddles. RJ questioned the accuracy of the one of the clinical claims within the report as to whether quantum has already been determined prior to one of the trials taking place.

Actions	**Deadline**	**Owner**
GL to clarify the current status of the clinical claim and amend the report depending on findings.	28/3/18	GL

4.3	**Patient Safety Q3 report**	
	RJ noted that this paper has already been to public board. RJ highlighted the number of mortality reviews is lower than the expected average. The Trust is within our tolerances of MRSA cases. Influenza will be reported within the Q4 report (end of winter reporting period). There needs to be more work/learning done on minimising unrecognised tuberculosis at work. The Learning Disability work of Hellen Odiembo (LD Nurse) who has now left the trust should be recognised.	

Actions	**Deadline**	**Owner**
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4.4	**Quality Impact Assessment of CIPs**	
	RJ gave a verbal update. There is a robust process in place to review the quality impact of cost improvement plans (CIP). The committee was given assurance that financial reductions are not being made that would compromise patient safety. RJ explained that there needs to be some refinement around realistic and achievable CIPs in 2018-19. AS asked what was the method to rate risk and whether themes from CIPs could be presented to the quality committee in a report. RJ reported that the risk threshold determines what comes to the panel and that he would triangulate the information for the next quality committee.	

Actions	**Deadline**	**Owner**
RJ to provide a QIA of CIPs themed report for Q4 reporting.	9/5/18	RJ

4.5	**Verita independent review of suicides and deaths of mental health patients who attended the Whittington ED department**	

	GL reported that only the summary report will go to public board as the full report has information that could be considered patient identifiable. The review was triggered by a cluster of seven patient tragic deaths and actions have already been taken prior to the publication of this report. These include: looking at an alternative facility for the 136 suite, the safe supervision of mental health patients through the trust, and co-location of the psychiatric liaison service. MJ highlighted the recommendation for improved joint working and information sharing across Whittington Health and partner mental health Trusts. RJ suggested an additional paragraph be added to the report on the wider national picture on mental health and the strategy for managing mental health patients in conjunction with MHT neighbours.

Actions	**Deadline**	**Owner**
RJ to provide info on national picture of increasing mental health patients need in urgent care in hospitals and local strategy to GL for inclusion in Verita report	April 2018	RJ/GL

4.6	**Patient Experience Report Q3**	
	JC presented the Q3 report. JC noted the ongoing work to improve response rates, particularly in the community and emergency department where new volunteers have increased paper response rates. Going forward, 'You said, We did' templates for public noticeboards will be on a quarterly rather than monthly basis. JC noted the recruitment of 18 volunteers, 39 ward befrienders and a new volunteer lead between April and Dec 2017.	

Actions	**Deadline**	**Owner**
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4.7	**Safeguarding Q3 report**	
	TR presented the Adult safeguarding report: Mandatory training compliance has been declining and consequently training sessions are being offered once per week. TR highlighted the good understanding and awareness of adult safeguarding by CCU and Outpatients picked up in the CQC report. TR noted that staff are not recording on Anglia ICE when they have completed a MCA due to time barriers. KM presented the Children's safeguarding report: Mandatory training compliance is currently below the Trust target. Non-compliance is highest amongst trainee doctors. KM reported that she updated the training needs analysis in November 2017 of which level of safeguarding training staff are required to undertake and has updated this for	

	all staff employees.

Actions	Deadline	Owner
KM to ensure ESR is updated for safeguarding children's training and to review the training needs analysis in six months	May 2018	KM

4.8	Self Assessment and review of TOR	
	WB presented the suggestions from the annual self assessment survey sent to all regular attendees of the quality committee. The points for discussion were for: • The frequency of reporting of assurance reports from the research committee, national audits and H&S committee • The frequency of reporting of assurance reports from the current quarterly reporting groups • Is there adequate representation at the committee to effectively challenge reports? The committee felt that the quarterly reports were appropriate, however suggested that safeguarding may be better reported six-monthly and should tie in with the reporting requirements for Trust Board and CQRG. The committee felt more assurance was required on clinical effectiveness.	

Actions	Deadline	Owner
AS and MJ to meet to discuss the above points for revising the 2018/19 TOR and 2018/19 annual work cycle	9/5/18	MJ/AS

4.9	Nursing Quality Indicators	
	MJ presented the January NQIs MJ highlighted that there needs to be more work done around the narrative for maternity and the addition of other indicators. The January indicators highlight 99% hand hygiene compliance and good nutritional screening levels. MJ noted, in her experience, that these indicators are well developed compared to what other Trusts have in place.	

Actions	Deadline	Owner
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4.10	Trust Policy update	
	WB presented the current status of trust policies. • 9 policies and SOPs have been reviewed and approved by the Policy	

	Assurance Group since the last quality committee • 3 new policies have been approved and ratified • 67 policies in total, and 36 policies overseen by the Quality Committee remain outstanding WB highlighted the lack of a lead author for the visiting times policy and the Pre-operative fascia iliac block procedure. FI agreed to help establish a suitable lead for pre-operative fascia iliac block procedure and DC noted the visiting times policy might tie in with the existing work on a Carer's Policy.

Actions	**Deadline**	**Owner**
Lead for pre-operative fascia iliac block procedure to be assigned	May 2018	FI/ WB

7. Any other business

The next Quality Committee is scheduled for **Wednesday 9th May 2018**, from 2pm-4pm in WEC Room 6.

Future dates:

- 11th July 2018
- 12th September 2018
- 14th November 2018

Whittington Health NHS

Draft minutes of

The Whittington Health Charitable Funds Committee

Held on 21 March 2018

Present:	Tony Rice	TR	Non-Executive Director (Chair)
	Steve Hitchins	SH	Chairman
	Stephen Bloomer	SB	Chief Finance Officer
	Graham Brogden	GB	Head of Fundraising
	Juliette Marshall	JM	Interim Director of Comms & Engagement
	Jon Ware	JW	Head of Financial Services
	Fiona Smith	FS	Interim Director or Communications
	Vivien Bucke	VB	Business Support Manager, Finance

Item	Discussion

18/001 **Welcome, Apologies for Absence & Declarations of Interest**

1.1 Apologies were received from Siobhan Harrington & Michelle Johnson. No Declarations of Interest were received.

18/002 **Approval of Minutes of the meeting held on 1st November 2018**

2.1 The minutes were agreed as an accurate record.

18/003 **Financial Report Month 11 2017/18**

3.1 JW stated the paper set out income and expenditure and balance sheet for the Charity, as at the end of month 11 (February 2018). Previously it had been noted that expenditure had been £140,000 larger than income during the year, this paper provided more detail as to the movements behind that. I&E headlines as follows:

- Income in the YTD is £138,000, so a little higher than 2016-17. If it continues at the same pace in m12, it is likely to beat 2016-17 by 5-10%. The main drivers are legacies and investment income slightly higher than previous year.
- Expenditure in the YTD is £411,000, which is almost exactly 11/12ths of the 2016-17 figure. The main increase has been in the purchase of equipment, the total being approximately £220,000, most of this is Kanitz and Women's Services.

3.2 JW stated investments had performed strongly in 2017-18 as in 16-17 with a gain of £133,000. TR asked if the gain from investments could be classified as unrestricted and was told by SB that there would need to be a policy change and we should consult the fund holders. However, currently income and costs are spread across funds, which is a standard charitable funds process.

3.3 TR asked about the Kanitz fund monies remaining and was told that the Kanitz Fund Committee had plans to spend the funds and are currently evaluating software and meeting suppliers before putting final bids together. **Action: Finance staff to liaise via Sam Barclay and update the committee.**

3.4 Balance sheet headlines:
Following an update to likely timelines on the maternity project (£1m earmarked), £1.25m has been invested into bank deposits for six months. The Trust had reported in its financial plans to NHSI and in the draft capital programme for 2018-19, that we expect maternity phase 1 to be largely complete by the end of 2018-19 and that the £1m will part fund it.

3.5 The Committee noted the report.

18/004 Fund Balances

4.1 JW presented the paper setting out the breakdown of funds by various categories and taking into account significant movements in those balances. Overall movement in funds balances in the year is a decrease of £140,000, reflecting the fact that expenditure had been higher than the sum of income and gains on investment in the year to date.

4.2 The table in para 2.4 showed the movements in categories since the audited accounts for March 2017. Main movements and points to note are as follows:

- General use has remained steady. This is the result of:
    - CFC decision in November to reallocate the costs of the fundraising team across all funds rather than just GF;
    - Fewer bids going through GF; and
    - Reasonable amount of fundraising (e.g. through marathon) is for the Charitable Fund as a whole; which lands in here.
- Unrestricted funds up by £140,000, largely reflecting the outcome of the fund plans exercise to reclassify some legacies as unrestricted. Some funds moved the other way, notably Lifeforce and Ifor Ward play terrace which became restricted. Some expenditure items also, notably in women's services.
- Restricted funds down by £325,000, reflecting the above. In addition the largest expenditure items in year have come from restricted (e.g. Kanitz equipment).
- Revaluation up £133,000 from gains on investments.

18/005 Applications for Funding

5.1 JW stated the paper set out bids for funding and since the last Committee the Trust had processed 27 bids for funding and three of these required formal Committee approval:

- Women's Services to replace recliner armchairs on Cellier used by both new mothers as part of breastfeeding, as well as fathers staying over while partners are in labour. Current chairs are failing infection control standards. As the chairs are not standard, they are eligible for charitable funding rather than addressing a red risk and being eligible for capital funding. **Approved**
- Coyle Ward two digital reminiscence systems for the application of digital

reminiscence therapy (DRT). Have been used in other Trusts to support the wellbeing of dementia patients and help them to familiarise themselves and feel more comfortable in an unfamiliar environment. **Approved**

- Stammering Children Research for the publication of the 2nd edition of Practical Intervention for Early Childhood Stammering. The text has allowed for advances in research on stammering children. The Trust aims to generate some royalties for the Fund as a result of sales. **Approved**

5.2 TR supported the Noise at night working group request for the purchase of earplugs and suppressed lighting for nurse stations and asked for an update. JW responded the question is how to fund this and he suggested the funding be split across the ward funds. FS suggested a specific fundraising campaign for this and for Communications to work with the Chief Nurse to set as one of the nursing priorities for the year ahead. Without this earplugs could be purchased but not distributed and this would be a waste of money; therefore there is a need to focus on cascading the message. **Action: Communications to bring back a proposal to the next Committee to include first 1/2 years be funded within existing funds and further fundraising plans**.

5.3 The Committee discussed the funding of screens in patient waiting areas. **Action: Communications to report back on the viability of this.**

5.4 It was noted that all capital bids must have a RAP attached before they can be approved. However, for some Charitable Funds purchased items a RAP had not been included and consequently some items had been purchased without consumables included. **Action: Medical equipment over £5,000 must now include a RAP- JW.**

18/006 Fundraising Update Report & General Fundraising report

6.1 GB outlined the fundraising activities since the last committee and he emphasised both Arsenal and Tottenham football clubs had re-affirmed an interest in doing more throughout the year. In response to the funds raised against the target for the Ifor play terrace project, TR asked that emails be sent to donors to ensure the target is reached. However, FS reported that there was now a need to replace the floor and there is an assumption that the original cost will raise. Plans from Bright Horizons had been sent to the Architect who is obtaining costings from the Quantity Surveyor.

6.2 SH questioned why a similar sized trust such as Kingston, and not in such an affluent area, had raised so much more for charitable funds than the Trust and he felt £400,000 rather than £200,000 should be the target to raise. FS suggested that with the £200,000 target plus £150,000 for the Ifor play terrace, funds should be raised for Cellier ward to give a total of £400,000.

6.3 SB presented evidence that other similar Trusts were raising greater amounts of money and suggested that it was not unreasonable that we look for a higher return for the investment made in fundraising. It was agreed that we look at what fundraising activities other trusts undertake and hence ways that we can increase the amounts of funds raised as a matter of urgency. There followed a discussion on

specifics with areas such as the difficulty on contributing via the website raised by SH and FS (with funding for the website already allocated by NHS Elect) but also the scope of fundraising activities and the need for more initiatives and if possible a greater number of our own (Whittington Trust) events. The Committee agreed we needed to be more ambitious in our activities and fundraising targets aside from the primary focus of a major fundraise for the large project. The draft plan for fundraising strategy was deferred for a re write (as a matter of urgency that included detailed actions and targets for the next three years.

6.4 SH felt the detail on planned activities is needed as the Committee could not agree and commit to, spend without such detail. He also raised the point that Charitable Funds events are very hospital based and community events were a necessity and opportunity that we should explore and launch asap. SH also raised the scope to access local Trust and Family funds in North London and the City Guilds both of which groups had substantial funds for deployment in good causes with the Whittington Trust well placed to qualify for donations.

6.5 **Actions:**

1. The target for income to be increased to £400,000
    a. £150,000 Ifor play terrace,
    b. £200,000 general fund plus additional
    c. £50,000 with possibly enhancements for a ward area
2. Proposal for a website development to support charitable giving to come to a future committee FI/SB to discuss
3. FS/JM to investigate the introduction of Text donations information to be added to the friends and family cards.
4. GB to look at district general hospital legacy packs in addition to those that had been looked at and bring the updated Legacy campaign pack to the next Committee.

18/008 ICSU Priorities 2018/19

8.1 FS reported progress made with ICSUs on discussing priorities for charitable investment and fund raising. The committee discussed the feedback and the relationship with the capital programme and what is above normal treasury expenditure.

18/009 Large Fund Raising Campaign

9.1 The paper described an option for a large campaign to raise funds for set out the requirements for launching a campaign and SB stressed any option put forward must have Trust Management Group support before being presented to the charitable committee for agreement.

9.2 The paper was discussed and the Committee agreed that the final document should include:

- Resourcing cost and time for each phase
- Detail and list local organisations
- Target phase 1 donors
- IT dimensions