T R U S T   B O A R D

14.00 – 17.00
Wednesday 7 October 2015

Whittington Education Centre Room 7

Meeting	Trust Board – Public
Date & time	7 October 2015 at 1400hrs – 1630hrs
Venue	WEC 7

AGENDA

Steve Hitchins, Chairman Anita Charlesworth, Non-Executive Director Paul Lowenberg, Non-Executive Director Tony Rice, Non-Executive Director Anu Singh, Non-Executive Director Prof Graham Hart, Non-Executive Director David Holt, Non-Executive Director	Simon Pleydell, Chief Executive Siobhan Harrington, Director of Strategy & Deputy Chief Executive Stephen Bloomer, CFO Dr Richard Jennings, Medical Director Dr Greg Battle, Medical Director (Integrated Care) Philippa Davies, Director of Nursing and Patient Experience Lee Martin, Chief Operating Officer Norma French, Director of Workforce

Attendees
Lynne Spencer, Director of Communications & Corporate Affairs
Kate Green, Minute Taker

Contact for this meeting: Kate Green (kate.green4@nhs.net) or 020 7288 3554

Agenda Item		Paper	Action and Timing
Patient Story			
	Patient Story *Philippa Davies, Director of Nursing & Patient Experience*	*Oral*	*Note* 1400hrs
15/115	**Declaration of Conflicts of Interests** *Steve Hitchins, Chairman*	*Oral*	*Declare* 1420hrs
15/116	**Apologies & Welcome** *Steve Hitchins, Chairman*	*Oral*	*Note* 1425hrs
15/117	**Minutes, Action Log and Matters Arising 2 September** *Steve Hitchins, Chairman*	**1**	*Approve* 1430hrs
15/118	**Chairman's Report** *Steve Hitchins, Chairman*	*Oral*	*Note* 1435hrs
15/119	**Chief Executive's Report** *Simon Pleydell, Chief Executive*	**2**	*Note* 1445hrs
Patient Safety & Quality			
15/120	**Safe Staffing Report** *Philippa Davies, Director of Nursing & Patient Experience*	**3**	*Note* 1455hrs
15/121	**Serious Incident Report** *Philippa Davies, Director of Nursing & Patient Experience*	**4**	*Note* 1505hrs

15/122	**Trust response to Morecombe Bay (Kirkup) Report** *Philippa Davies, Director of Nursing & Patient Experience*	**5**	*Approve* 1515hrs
Strategy			
15/123	**Trust Draft Research Strategy** *Professor Graham Hart, Non Executive Director*	**6**	*Approve* *1525hrs*
Performance and Delivery			
15/124	**Financial Performance Month 5** *Stephen Bloomer, Chief Finance Officer*	**7**	*Note* 1535hrs
15/125	**Performance Dashboard Month 5** *Lee Martin, Chief Operating Officer*	**08**	*Note* 1545hrs
15/126	**Workforce KPIs Month 5** *Norma French, Director of Workforce*	**09**	*Note* 1555hrs
15/127	**Annual Report partnership working with the London Borough of Islington** *Lee Martin, Chief Operating Officer*	**10**	*Note* *1605hrs*
Governance/Regulatory			
15/128	**TDA Oversight Statements** *Siobhan Harrington, Director Strategy & Deputy Chief Executive*	**11**	*Approve* 1615hrs
15/129	**Working Capital Facility – updated signatories** *Stephen Bloomer, Chief Finance Officer*	**12**	*Approve* 1625hrs
15/130	**Trust Board Assurance Framework (BAF)** *Siobhan Harrington, Director Strategy & Deputy Chief Executive*	**13**	*Approve* 1635hrs
15/131	**Tackling Bullying and Harassment** *Norma French, Director of Workforce*	**14**	*Note* 1645hrs
Any other urgent business and questions from the public			
	No items notified to the Chairman		
Date of next Trust Board Meeting			
	04 November 2015 Whittington Education Centre, Room 7		
Register of Conflicts of Interests: The Register of Members' Conflicts of Interests is available for viewing during working hours from Lynne Spencer, Director of Communications & Corporate Affairs, at Trust Headquarters, Ground Floor, Jenner Building, Whittington Health, Magdala Avenue, London N19 5NF - communications.whitthealth@nhs.net.			

ITEM: 01
Doc: 15/117

The minutes of the meeting of the Trust Board of Whittington Health held in public at 1400hrs on Wednesday 2nd September 2015 in the Whittington Education Centre

Present:	Stephen Bloomer	Chief Finance Officer
	Anita Charlesworth	Non-Executive Director
	Philippa Davies	Director of Nursing and Patient Experience
	Norma French	Director of Workforce
	Siobhan Harrington	Director of Strategy/Deputy Chief Executive
	Steve Hitchins	Chairman
	David Holt	Non-Executive Director
	Richard Jennings	Medical Director
	Paul Lowenberg	Non-Executive Director
	Lee Martin	Chief Operating Officer
	Simon Pleydell	Chief Executive
	Tony Rice	Non-Executive Director
	Anu Singh	Non-Executive Director
	Graham Hart	Non-Executive Director
In attendance:	Kate Green	Minute Taker
	Lynne Spencer	Director of Communications & Corporate Affairs

Patient Story

Philippa Davies introduced Mr & Mrs Lewison. Mrs Lewison had undergone emergency surgery last February having suffered from Crohns' disease for some 40 years.

The surgeon had been unable to complete the operation which had resulted in her being left with an open wound. Following three weeks on ITU she had been transferred to Victoria Ward, and she described in detail her experiences on that ward, which had been largely negative due to staff lacking the knowledge or experience to manage her very specialist wound care needs. Mrs Lewison paid tribute to the skills and commitment of stoma nurse Elaine Cronin, but explained that despite Elaine's detailed care plans and instructions for her colleagues for times when she was not on duty other staff were unable to adequately care for her needs, particularly during the night.

Sharon Pilditch, Ward Manager for Victoria Ward, acknowledged there had been failings in Mrs Lewison's treatment, outlined the factors which had led to the shortcomings in her care, and informed Board members of the steps which had been taken to rectify matters, including bespoke training programmes, employment of additional staff to the stoma care team, the physical movement of Victoria ward to a more appropriate environment and ensuring there was sufficient specialist cover at nights and weekends.

Board members thanked Mrs Lewison for the courage she had displayed in recounting her story, and requested assurance around the escalation process, recruitment and retention and testing to ensure appropriately skilled staff were in place when very specialist care was required.

Sincere apologies were extended to Mrs Lewison for her experiences on Victoria Ward, and it was agreed that:

- Tests would be carried out in order to ascertain staff on duty were adequately qualified to care for all patients on the ward at any given time

- Philippa Davies and Norma French would review which staff have received specialist training in complex stoma care
- Board members in conjunction with staff leading on patient safety 'huddles' would review processes to ensure any items of concern identified as part of these visits were appropriately escalated in a timely fashion.

Steve Hitchins extended his thanks to Mrs Lewison for recounting her story, and also asked for the Board's thanks to be extended to the Victoria Ward staff, in recognition of the fact that they had been working incredibly hard under less than ideal circumstances, which he was pleased to hear had now been improved.

15/101 Declaration of Conflicts of Interest

101.01 Newly-appointed Non-Executive Director David Holt declared his position as a Non-Executive Director at the Tavistock & Portman NHS Foundation Trust and also that his wife was a Whittington Health Consultant.

101.02 Steve Hitchins declared his position as Vice-Chair of the Newlon Housing Trust, landlord of the Holloway Community Health Centre.

15/102 Apologies and welcome

102.01 Apologies for absence were received from Dr Greg Battle and Councillor Paul Convery. David Holt was welcomed to his first Board meeting as a newly appointed Non-Executive Director of Whittington Health. He introduced himself as living locally with his family, having a background in finance and working with Ebbsfleet Development Corporation and Land Securities.

15/103 Minutes of the previous meeting, action log and matters arising

103.01 A minor typing error was identified in the minute covering last month's patient story – in the second line, the year should read 2013 rather than 2031. Other than this, the minutes of the meeting held on 1st July were approved, and there were no matters arising other than those already scheduled for discussion.

Action log

103.02 (94.04) The cancer services strategy was due for presentation at the Board in November. The items on End of Life Care had been included on the cycle of business and could therefore be removed from the action log.

15/104 Chairman's Report

104.01 Steve Hitchins began his report by welcoming David Holt to his first meeting of the Board, and also James Neidle, seconded from the Home Office to work in business planning.

104.02 Anita Charlesworth was to move to a full-time position at the Health Foundation and would therefore be resigning from the Whittington Health Board at the end of the year. She had been a member of the Board for five years and on the CCG Board prior to this.

104.03 Steve informed Board colleagues that he had recently attended the funeral of former Whittington Health chaplain Emile Jones. This had, he said, been an 'amazing event' at which more than 700 people had been present.

104.04 Whittington Health had recently hosted a visit from Andy Burnham MP, and was due to welcome Lord Prior, Parliamentary Under Secretary of State for NHS Productivity.

104.05 The annual Whittington Health Oration was scheduled to take place at 6.00pm on Monday 21st September and Professor Sir Mike Richards from the Care Quality Commission will be the guest speaker.

104.06 There had been a change to the Trust's whistleblowing policy, which required the Board to name a Non-Executive Director staff could go to with concerns. It had been agreed that Anita Charlesworth would act in this role. David Holt would be the Non-Executive Director responsible for MHPS (maintaining high professional standards).

104.07 Steve was pleased to report that all serious incident reports would now be reported to the public board meeting to increase transparency.

15/105 Chief Executive's Report

105.01 Simon Pleydell began his report by reminding board colleagues that the Trust was now in the run-up to the Care Quality Commission (CQC) inspection visit which was to begin on 8th December. There was a great deal to be done in preparation for the visit, and a clear need to communicate to staff in order that they felt confident in the process. Roadshows and meetings had already been held, and a new project manager Julie King had been appointed. This was a developmental process and an opportunity to demonstrate the quality of the services provided by the Trust.

105.02 A year ago the Trust Development Authority (TDA) had approved the Outline Business Case for the development of the Trust's maternity and neonatal care services, and discussions continue. It was clear that London TDA supported the Trust's ambition, however the application had now become subject to further analysis which reflected the current financial operating environment for public bodies. Simon felt that the Trust should remain optimistic and confident as the case for change was compelling.

105.03 No cases of MRSA bacteraemia had been declared so far this year, and four cases of C. Difficile, making an average of one per month and therefore below target, although it was acknowledged just one new case was too many. There was a new patient feedback system for the Friends and Family test, and of the 1067 responses received during August 96% had stated they would recommend Whittington Health as a place to receive treatment. Simon was pleased to report that the Trust had met the 31 and 62 day cancer wait targets.

105.04The new Integrated Clinical Support Units (ICSUs) continued to transition to their new structures, and Rachel Landau had been appointed as Clinical Director for Emergency & Urgent Care. The new structure had helped to enable the successful transfer of Victoria ward services to Mercer's Ward.

105.05 The Trust's financial position would be covered by Stephen Bloomer's report, however Simon informed the Board that the Trust had received a letter from the TDA requesting its planned end of year deficit be reduced from £19.5m to £15m. The executive team was considering the revised plan and there would be opportunity to discuss this in more detail at the Annual General Meeting of the Trust which would take place at 1700hrs that evening.

105.06 The Trust had commissioned Sweett's to work on an estate review, and this would involve a two-stage process; with input and engagement from staff and services comprising the first stage of the work then local community engagement forming the second. Everyone would need to be clear about what they wanted to emerge from the exercise, and the product would need to be one which was fit for purpose, i.e. one which enabled delivery of the Trust's clinical strategy.

105.07 The CCGs had confirmed Whittington Health as Lead Provider for frail elderly and diabetes services for the boroughs of Islington and Haringey. This offered an opportunity to encourage development and integration within these services in line with the Trust's ethos. The first meeting of chief officers involved was scheduled to take place the following day.

105.08 There had been a major power systems outage at the end of July, and Simon offered his apologies to any patients who had suffered any inconvenience as a result of this. Simon thanked all staff and was aware they had made a major effort to maintain safe systems within both hospital and acute services. He reported that pharmacy staff had gone to tremendous lengths to ensure services were maintained despite the temporary loss of the electronic prescribing system. There would now be an external review of the resilience of the Trust's IT structures, as well as a look at what opportunities might be offered by the latest development in technology. The findings of this external review would be reported back to the Board.

15/106 Safer Staffing Report

106.01 Philippa Davies introduced the safer staffing report covering the Trust's position in July. This had, she said, been another month when it had been necessary to provide specials to care for several particularly vulnerable patients. Philippa had circulated the Nursing & Midwifery Council (NMC) guidelines to registrants setting out their responsibilities in relation to staffing and patient safety.

106.02 David Holt referred back to the patient story which had been presented earlier and enquired whether the information gathered for this report would have highlighted this situation. Philippa replied that it would not, but in any case what the patient story had demonstrated was not a shortage of numbers but a lack of specialist skills. The new health rostering system would however provide additional data which would make the report more meaningful. Information would also be generated from other sources, e.g. the patient safety huddles.

106.03 Richard Jennings added that one possible area for improvement in quality was handover. Anita Charlesworth suggested further scrutiny of how services were delivered to vulnerable patients with specific needs, in particular patients suffering from mental health problems. The report was accepted by the Board.

15/107 Serious Incident Report

107.01 Prior to that day's meeting serious incident reports had been received by the Trust Board meeting held in private, and the presentation of this report to the public Board represented a welcome increase in openness and transparency. It was noted that the report presented showed not only the number and type of incidents reported but also the lessons learned from these incidents.

107.02 Philippa Davies informed the Board that 6 new serious incidents had been declared during July, making a total of 21 since 1st April, therefore there had been no marked increase in numbers. In answer to a request from Steve Hitchins to elaborate on the process for SI declarations, Philippa explained that following an incident, discussions would initially be held within the relevant team prior to contacting her, Lee Martin or Richard Jennings. A 72 hour report would then be produced, which was largely a fact-finding exercise. The SI panel would then meet to discuss whether this particular incident met the specific SI criteria and if so then an investigation would be initiated; this would generally be concluded within 45 days. The findings would then be brought back firstly to the panel, then to the family of the patient concerned, then to the Commissioning Support Unit (CSU).

107.03 The previous summer there had been 60 uncompleted incident reports, there were now none outstanding. Richard Jennings stressed that considerable progress had been made on sharing the learning from incidents, saying that stronger processes had been developed for doing so. He added that there was clear evidence to show that organisations which were open and transparent about their incident reporting gradually experienced a decline in the number of incidents occurring.

107.04 In answer to a question from Paul Lowenberg about diagnostics, Richard replied that all cases had been reviewed, and no evidence had been found to suggest that any patients had suffered any adverse effects. Richard reported that regarding the care of the deteriorating patient, two important initiatives were being progressed: the timely recognition of sepsis and acute kidney disease. Both had been put forward as part of the submission to the national 'Sign up to Safety' programme.

15/108 Financial Report

108.01 Stephen Bloomer began his report by informing the Board that the Trust had declared a £5.1m deficit at the end of July, a position marginally better than had been planned. Month 4 had been a difficult one, largely because of a failure to hit the CIP target. A number of actions had since been taken to rectify this, with a particular emphasis on flexible staffing.

108.02 Tony Rice spoke of the changing culture within the Trust and the imperative to adapt to a culture of cost discipline. Siobhan Harrington agreed, adding that with the advent of the new ICSUs clinical engagement and ownership were critical. She had met with five of the seven ICSU leaders to discuss how they wished to conduct their business planning processes over the coming months, including their plans for savings. At the end of November there would be a Board challenge session.

108.03 Stephen spoke of the need for a clear focus on CIP plans, assuring the Board that a regular cycle of meetings had been established to progress and monitor CIPs, with a particular emphasis on several key deliverables. Moving to income, there were some issues around resilience funding, however discussions with the Trust's commissioners were already taking place on this.

108.04 Returning to the issue of flexible staffing, Norma French informed the Board that she and Philippa Davies had spent some considerable time seeking to clarify the exact position and underlying reasons for it. The vacancy rate for nursing was below 7% which was extremely positive, and there was a cohort of overseas nurses awaiting their PIN numbers. There were also 144 nurses in the recruitment 'pipeline', however delays were occurring which had prevented their starting work, and the reasons for this were currently the subject of investigation. A weekly nursing temporary staffing meeting had now been established, and in addition to looking at the position on temporary staffing the meeting would also be looking at staff who had been absent on ill health grounds for some considerable length of time and seeing what enablers might be used to assist them in returning to work.

15/109 Performance Dashboard

109.01 Introducing this item, Lee Martin apologised for not having circulated the revised front sheet to the report, although a draft version had now been produced. He proceeded to highlight areas of focus set out on page 3, where detailed work had been completed and improvement plans were now in place. On out-patient services, Lee said that one of the key issues was staffing and the team had carried out a major recruitment event and expected there to be a full complement of staff in place by the end of September. The other positive news to report was that several IT solutions had been identified which could be put in place and a training programme had started.

109.02 Within ED a workshop had been carried out with the new clinical team from which two plans had emerged; the short-term one had been implemented and the results could already be seen.

109.03 Overall the Trust had a good reputation for non-cancellation of elective procedures – there had however been a small number during this period so a review was being carried out to ascertain the reasons for this and whether any action might have been taken to prevent these. The team had also looked at readmission rates, and it had been noted that a system had been introduced whereby patients had been provided with a special number to call should they be suffering from difficulties post-discharge.

109.04 Moving to MSK services, Lee informed the Board that the Trust was in discussion with the commissioners over the sharp rise in referrals. In answer to a question from Anita Charlesworth about IAPT waiting times, Lee replied that IAPT indicators were to be included in the dashboard as from next month. Referring to the District Nursing rates, he explained that on this occasion there had been some difficulty with validation of the data.

109.05 The meeting discussed the Trust's SHMI position, and Richard Jennings reiterated that mortality rates were lower than would usually be expected from a hospital of the Whittington's size. Moving on to complaints, Paul Lowenberg enquired about the apparent drop in response times within Women & Family services, and it was agreed that Amanda Hallums would look into this and provide the Board with a response. Anita Charlesworth also reminded colleagues that it had been agreed to review quality metrics for children and young people, and this could be discussed at Quality Committee the following week.

109.06 In answer to a question about new birth visits, Lee replied that there were some issues around staffing, however the team had put in place some safety checks to ensure people were able to get help when required and had details of the appropriate people to contact for assistance. Finally, he informed the Board that there would be a detailed look at theatre utilisation in November.

15/110 Workforce KPIs

110.01 Norma French began her report by informing members that the supporting narrative had been increased and she hoped this would prove helpful to the Board. There was at present an overall vacancy factor of 12.4%, and within nursing, of 6.7%. The position on staff sickness appeared to have worsened, however this was possibly attributable to application of the new policy or improvements in reporting.

110.02 Mandatory training rates continued to improve, however staff appraisal remained a cause for concern. New paperwork for the appraisal process had been approved by the Trust Management Group in August, and Charlotte Johnson had been spending time with each ICSU Director of Operations to go through this and ensure it was fully understood and could be easily implemented. Norma was confident the Board would see an improvement in corporate areas by the end of the month.

110.03 Steve Hitchins thanked Norma and all staff involved in the recruitment day due to take place the following Saturday. He was particularly pleased to note that it was possible for people to arrive with a CV and leave with an offer letter.

15/111 Staff Survey Action Plan 2014/15

111.01 Scrutinising the staff survey action plan for 2014/15, Norma informed the Board that she believed that we should make specific reference to bullying and harassment. The 2015 survey was due to begin the following month. Steve Hitchins was pleased she had raised the issue, which Simon Pleydell stressed was a collective issue and one which was

anything but straightforward to deal with. It was agreed that Norma would bring a paper to the following Board, and Simon stressed that a range of options should be presented to address the problem.

15/112 TDA Oversight Statements

112.01 Siobhan Harrington introduced the new templates designed for the monthly submission to the Trust Development Authority. It was noted that the Trust was not compliant with Level 2 performance against the requirements of the Information Governance toolkit, and an action plan had been put into place to rectify this. The statements were formally agreed by the Board.

15/113 July Quality Committee Minutes

113.01 Anu Singh as Chair of the Quality Committee drew out several themes from its most recent meeting, as follows:

- mandatory training and appraisal, about which it was planned to review progress at the Quality Committee due to take place the following week
- the difficulty of maintaining a grip on actions agreed within ICSUs, which again would be discussed at the following week's committee
- the need for the committee to review the provision of services provided to all vulnerable adults within both acute and community settings.

Nursing & Midwifery Revalidation

113.02 Philippa Davies informed the Board that the Nursing & Midwifery Council (NMC) had pilot sites for revalidation, and these would be reporting in October. The earliest that revalidation for nurses and midwives would come into force nationally was April 2016. Graham Hart spoke of the importance of supporting Trust staff through the process, and it was agreed that the responsibility was down to the Trust as a corporate body rather than its individual staff. The TDA would be requesting updates from all Trusts.

15/114 Finance & Business Development Committee

114.01 Tony Rice reported on the most recent meeting of the Finance & Business Development Committee. In summary, the key focus was on delivery of the CIP, which remained an important priority for the committee to oversee.

Action Notes Summary

103.02	Cancer services strategy due for presentation at the Board	November	LM
105.08	External review of the resilience of the Trust's IT structures - look at what opportunities might be offered by the latest development in technology. The findings of this external review would be brought back to the Board .	tbc	GW
108.02	Board challenge session with executives and the 7 ICSU's	November	ALL
109.05	Complaints responses performance had dropped within Women & Family services - it was agreed that Amanda Hallums would look into this and provide the Board with a response	7 October	LM
109.06	LM informed the Board that there would be a detailed look at theatre utilisation in November – feedback to Board	December	LM
111.01	It was agreed that Norma would bring a bullying and harassment paper to the following Board	7 October	NF

Whittington Health Trust Board

7 October 2015

<table>
<tr><td>Title:</td><td colspan="7">Chief Executive Officer's Report to the Board</td></tr>
<tr><td>Agenda item:</td><td colspan="3">15/119</td><td colspan="2">Paper</td><td colspan="2">02</td></tr>
<tr><td>Action requested:</td><td colspan="7">For discussion and information.</td></tr>
<tr><td>Executive Summary:</td><td colspan="7">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.</td></tr>
<tr><td>Summary of recommendations:</td><td colspan="7">To note the report.</td></tr>
<tr><td>Fit with WH strategy:</td><td colspan="7">This report provides an update on key issues for Whittington Health's strategic intent.</td></tr>
<tr><td>Reference to related / other documents:</td><td colspan="7">Whittington Health's regulatory framework, strategies and policies.</td></tr>
<tr><td>Reference to areas of risk and corporate risks on the Board Assurance Framework:</td><td colspan="7">Risks captured in risk registers and/or Board Assurance Framework.</td></tr>
<tr><td>Date paper completed:</td><td colspan="7">27 September 2015</td></tr>
<tr><td colspan="2">Author name and title:</td><td colspan="2">Simon Pleydell, Chief Executive</td><td colspan="2">Director name and title:</td><td colspan="2">Simon Pleydell, Chief Executive</td></tr>
<tr><td>Date paper seen by EC n/a</td><td>n/a</td><td>Equality Impact Assessment complete?</td><td>n/a</td><td>Quality Impact Assessment complete?</td><td>n/a</td><td>Financial Impact Assessment complete?</td><td>n/a</td></tr>
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Chief Executive Officer Report

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

1. QUALITY AND PATIENT SAFETY

The way forward

To build a sustainable future, we need to find significant savings over this and next year. In 2015/16 we have a cost improvement target to deliver a savings target of £16.5 million and there will be a further similar savings target for 2016/17. We know from our experience that top down target setting and cost cutting will not work. We have started an initial piece of work with Boston consulting Group (BCG) who have an established track record of working alongside clinical leaders and teams to help us pull together our service plans for next year.

BCG will work with our Integrated Clinical Service Units (ICSUs) and the new clinical leaders who have been appointed. This presents a real opportunity for our Trust to approach our change programme differently to ensure we identify new and potential areas of opportunity. This approach will enable us to move forward successfully and to become a sustainable organisation.

Never Event

I regret that the Trust has reported a never event for a nasogastric tube incident. A full and thorough investigation is underway in line with our policies and procedures and the outcome will be reported to the board as part of the monthly serious incident report. This will highlight the lessons learned and actions taken to prevent further events occurring. I would like to sincerely apologise to the patient and their family and I am pleased that the patient is now recovering.

Ward refurbishments and changes

We have successfully completed planned hospital ward refurbishments within the month. This was carefully managed to prevent disruption for our patients and staff. The changes that have taken place include Bridges Ward closing and medical patients moved to the recently refurbished Victoria Ward. The former surgical patients on Victoria Ward are now on Mercer Ward. The Clinical Decision Unit (CDU) has also been successfully refurbished. Thank you to staff who worked incredibly hard to support these improvements.

Murray ward official opening

During the month, the official opening of Murray ward took place and I would like to thank award winning actress Tameka Empson from the well-known soap opera Eastenders who opened the ward and spoke fondly of our hospital and staff. Murray ward cares for women during their pregnancy or in their early stages of labour. The £650,000 improvements will benefit both staff and patients and forms part of our ongoing plans for refurbishment of the wards in the hospital.

Care Quality Commission (CQC)

The Trust continues to make good progress to prepare for a full CQC inspection which has been confirmed will take place from week commencing 7 December over a 3 week period. The inspection will identify best practice, as well as highlighting areas which may need improvement.

This is an excellent opportunity for the Trust to showcase its services and for staff to explain how we are implementing our clinical strategy to help local people live longer healthier lives.

Maternity and Neonatal

The Trust continues to work positively with the TDA to secure a decision on the full business case which will help modernise maternity and neonatal facilities. This will be a significant milestone and will help to achieve the Trust's vision to provide safe, personal, coordinated care. I will update the Board on the current discussions at this meeting.

Recruitment Open Day for Nurses and Midwives

On Saturday 5 September Whittington Education Centre hosted another successful nurse and midwife recruitment day with a dozen applicants signed up to join the Trust in the forthcoming months. Teams of clinicians greeted the potential candidates and gave them a tour of the hospital site and its extensive training facilities. These days are part of an ongoing initiative to showcase the benefits of working for Whittington Health and the excellent training and clinical facilities to potential employees in a relaxed and informal environment.

MRSA Bacteremia

The Trust is pleased to report that it has had no cases of MRSA for this financial year. The Trust has a robust zero tolerance approach to MRSA bacteremia breaches and will continue to keep this as a top patient safety and quality priority.

Clostridium Difficile

The Trust reported that it has had no new cases of Clostridium Difficile reported during August. This brings the Trust total to 4 cases for the year to date. The target is for no more than 17 cases in each year. The Trust has reminded colleagues to be extra vigilant with regular awareness raising initiatives on the importance of adhering to infection control procedures to maintain a strong focus on patient safety as the top priority.

Cancer Waiting Time Targets

The Trust continues to perform extremely well for its national cancer targets. The Trust achieved all 8 national cancer waiting time targets for the latest reporting period up to August 2015. The cancer targets include important patient safety areas such as two weeks from referral to first appointment, 31 days from decision to treatment and 62 days from referral to treatment waits.

Staff survey 2015/16

The annual NHS Staff Survey was launched at the end of September. This will gather important views to enable the Trust Management Group to inform their business plans with work priorities that tackle the issues staff raise as areas for improvement. There is a report on today's agenda by the Director of Workforce that considers the work that has been completed during 2015 by management from the 2014/15 survey to support our continuing efforts to address concerns which staff have raised.

Whistleblowing and raising concerns

The Trust is committed to encouraging openness and honesty in the workplace, and creating a supportive culture where members of staff feel able to raise concerns without any fear of repercussions. We have a whistleblowing policy so staff can raise concerns safely so that issues are raised early and in the right way. This is displayed on our intranet and regularly communicated to staff to ensure it remains high profile and visible for easy access. The Trust has promoted the following people assigned to support staff to safely raise concerns in confidence:

- Philippa Davies, director of nursing and patient experience
- Anita Charlesworth, non-executive director

John's Campaign - dementia

The Trust was pleased to be named in the Observer as one of the first 100 hospitals in the UK to welcome carers to stay with people with dementia at all times. We have pledged to support carers of patients with dementia whenever the patient needs them, including overnight if necessary. This shows our determination to promote compassionate and caring services for one of the most vulnerable group of our patients. The campaign was founded after the death of Dr John Gerrard in November 2014.

2. FINANCE MONTH 5

At the end of August, the Trust is reporting a year to date deficit of £6.48m which is £768k behind its planned position. The Trust continues to face a very challenging financial position and is reporting an overspend against the budgeted expenditure by £861k during the first five months of the year.

This is largely due to under-performance against the saving targets against the Operating Plan that was planned to significantly increase from July onwards. At the end August, the Trust had achieved £1.4m (82%) of the planned savings and the year to date delivery is £3m which is 65% of planned savings.

The Trust ended the month with a cash balance of £6.7m, which was £3.5m more than it had planned. This was due to the successful collection of large outstanding debts as well as ongoing negotiations with some creditors which are not yet concluded.

The Trust is £748k underspent against its year to date capital plan following a review of planned spend to support the financial position.

The Trust is actively working towards improving the financial position and a number of activities are already showing results. These include reduction in agency spend in August, reduction in capital spend and focus on collecting outstanding debts.

The Operational Plan submitted to the TDA will help the Trust to deliver its planned deficit for 2015/16 and the required savings programme of £16.5m. The Trust believes this is a realistic Plan that can be delivered and will improve the run rate to help achieve future financial balance.

Strengthening controls on maximising income, not overspending on agreed budgets, maintaining a focus on quality and delivering the savings programme at greater pace will be a major focus in the forthcoming months.

3. Staff Awards

A new staff awards process has just been launched. The awards aim to recognise and celebrate staff and their achievements and contributions. A new framework has been agreed which supports and better reflects the promotion of our values: innovative, compassionate, accountable, respect and excellence. The categories of awards which staff can be nominated for are:

- **Monthly excellence awards:** to recognise individuals, teams and groups who exceed normal expectations for the benefit of patients, users, carers or staff.

- **Virtual 'Wall of Fame':** Staff, patients, carers and members of the public are asked to submit areas of work, ideas or projects to appear on a 'virtual wall of fame' on our facebook page.

Annual excellence awards will take place each year to celebrate long service, retirement, employee of the year, team of the year, amongst other categories.

4. Estate strategy

The Trust is currently developing an Estates Strategy that will enable the Clinical Strategy 2015-2020 to be delivered. The work is well underway with engagement of staff and stakeholders in considering the environment required to deliver care for our local population over the next five years. We are engaging with our local community in a number of ways; attending local meetings, meeting with local groups and having informal events across the Trust. We will also be holding an open day in November. The Estates Strategy will come to December Trust Board.

Simon Pleydell
Chief Executive Office

Whittington Health Trust Board

07 October 2015

Title:	Safe Staffing (Nursing and Midwifery)		
Agenda item:	**15/120**	**Paper**	**03**
Action requested:	For information		
Executive Summary:	This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in August 2015. Key issues to note include: • The majority of areas reported greater than 95 per cent 'actual' versus 'planned' staffing levels. • A number of areas reported 'actual hours worked' over and above those 'planned' which was attributed in the main to the provision of extra support required due to extra beds on wards with more highly dependent patients. • The decrease in 1:1 specials requested this month compared to last.		
Summary of recommendations:	Trust Board members are asked to note the August UNIFY return position and processes in place to ensure safe staffing levels in the organisation. Unify is the online collection system used for collating, sharing and reporting NHS and social care data.		
Fit with WH strategy:	Efficient and effective care, Francis Report recommendations, Cummings recommendations and NICE recommendations.		
Reference to related / other documents:	Clinical Strategy		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	3.4 Staffing ratios versus good practice standards		
Date paper completed:	September 2015		

Author name and title:		**Dr Doug Charlton Deputy Director of Nursing**		**Director name and title:**		**Philippa Davies – Director of Nursing and Patient Experience**	
Date paper seen by EC	**22/09**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

v.1.

Safe Nurse Staffing Levels

1.0 Purpose

To provide the Board with an overview of nursing and midwifery staffing levels in terms of 'actual' versus 'planned' hours on our wards in August 2015 and an assurance that these levels are monitored and managed daily.

2.0 Background

Whittington Health is committed to ensuring that levels of nursing staff, which include Registered Nurses (RNs), Registered Midwives (RMs) and Health Care Assistants (HCAs), match the acuity and dependency needs of patients within clinical ward areas in the hospital. This includes an appropriate level of skill mix of nursing staff to provide safe and effective care. These staffing levels are viewed along with reported outcome measures, 'registered nurse to patient ratios', percentage skill mix ratio of registered nurses to HCAs and the number of staff per shift required to provide safe and effective patient care.

Staff fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st – 31th August 2015 for The Whittington Hospital has been uploaded and submitted on UNIFY, the online collection system used for collating, sharing and reporting NHS and social care data. Patients and the public are now able to see how hospitals are performing on this indicator on the NHS Choices website. This data sits alongside a range of other safety indicators.

3.0 Fill rate indicator return

As described above, the 'Fill rate indicator return' was completed and submitted. A copy of the UNIFY submission is available on request and is available to view on the trust website. The 'actual' number of staffing hours planned is taken directly from our nurse roster system, following which a look back exercise is undertaken. There were occasions when planned hours were revised either up or down taking into account an increase or reduction in patient bed numbers. On occasions when there was a deficit in 'planned' hours versus 'actual' hours, staff were moved from other areas to ensure safe staffing levels across our hospital. Staff were also moved to ensure wards/areas were staffed to a safe ratio of permanent versus temporary staff.

Appendix 1 details a summary of fill rates 'actual' versus 'planned' in August 2015. The average fill rate was 102.3% for registered staff and109.6 % for care staff during the day and102.0 % for registered staff and100.2 % for care staff during the night.

Three wards fell below 95% fill rates for qualified nurses but were managed safely by moving staff from other green RAG rated areas and with the assistance of matrons and practice development nurses. Above 100% fill rate occurred in eight areas where nurses were required to care for patients who needed 1:1 care due to mental health and or high dependency and or acuity issues. Above average fill rates in excess of 100% for HCA's continues on wards where vulnerable patients require 1:1 care and where nurses are awaiting their NMC registration.

3.1 Additional Staff (Specials 1:1)

When comparing August's requirement for 1:1 'specials' with previous months, the figures continue to demonstrate a low level of need. There was a considerable reduction in 1:1

requests in August (70) compared to the previous month (165). The requests made for this level of care are to ensure the safe management of particularly vulnerable groups of patients including elderly patients at risk of falls due to severe confusion, agitation and those patients detoxifying from drugs or alcohol. The number of RMN 'specials' required to care for patients under a mental health section or for patients with dementia continue to fluctuate.

4.0 'Real Time' management of staffing levels to mitigate risk

Safe staffing levels are reviewed and managed on a daily basis. At the daily 08.30am bed meeting, the Director of Nursing/Deputy Director of Nursing in conjunction with matrons, site managers and other senior staff review all registered and unregistered workforce numbers by ward. Consideration is given to bed capacity and operational activity within the hospital which may impact on safe staffing. Actions are agreed to ensure that all areas are made safe.
Ward shifts are rated 'red' 'amber' or 'green' according to numbers of staff on duty, taking into account patient numbers, acuity and dependency.

- Green shifts are determined to be safe levels and would not require escalation as these constitute the levels expected through the agreed ward establishment.

- Amber shifts are determined to be at a minimum safe level. The matron will be alerted, but no further escalation will be required. Staff will prioritise their work and adjust their workload through the shift accordingly, with a continual review of any changes to the acuity and dependency of patients.

- Red shifts are determined to be at an unsafe level. Mitigating actions will be taken, and documented, which may include the movement of staff from another ward and utilisation of supernumerary staff within the numbers or reducing the number of patients on the ward to match the staff availability. In exceptional circumstances, activity would be reduced through reduction in the number of beds. This addresses the risk and reduces the shift to an amber rating.

In summary, in August a total of 14/1395 (1.0%) shifts triggered 'red' which was lower than previous months. Of these, 4/372 (1.1%) occurred in the Surgical Integrated Care Service Unit, 9/93 (9.6%) in the Women's ISCU and 1/651 (0.1%) shifts were reported to have triggered 'red' in the Medicine and Frailty & Networked Service ISCU).

5.0 Conclusion

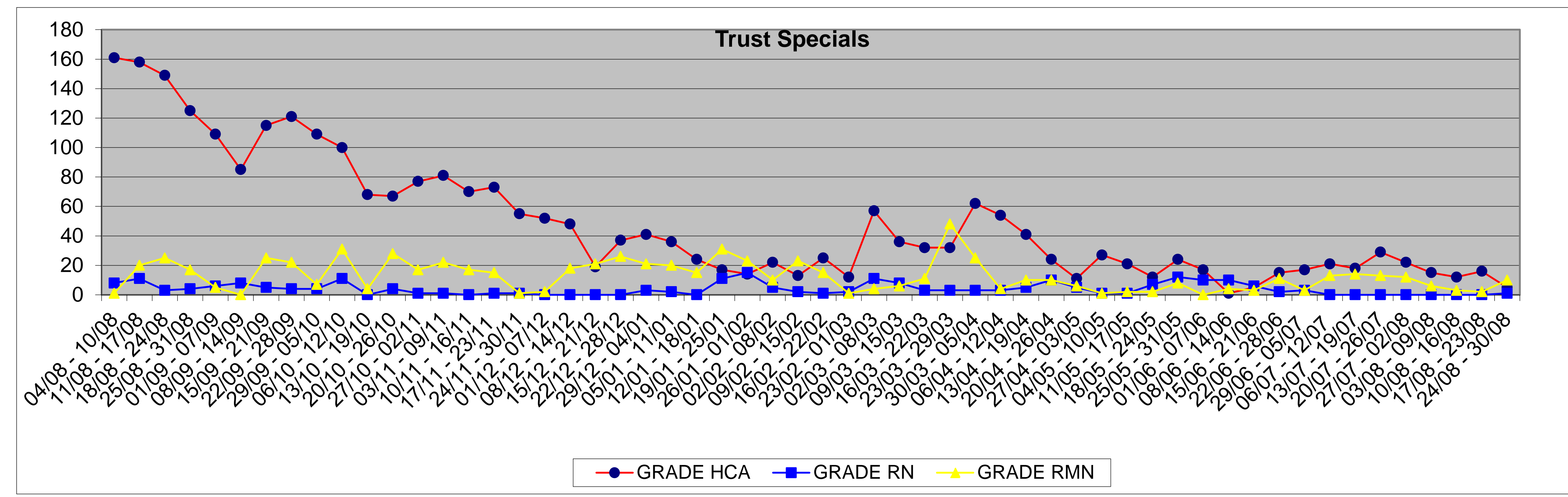
Trust Board members are asked to note the August UNIFY return position and processes in place to ensure safe staffing levels in the organisation.

Appendix 1

Fill rate data - summary
August 2015

Day				**Night**				**Average fill rate data- Day**		**Average fill rate data- Night**	
Registered nurses/ midwives		Care staff		Registered nurses/ midwives		Care staff		Registered nurses/ midwives	Care staff	Registered nurses/ midwives	Care staff
Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual				
27922 hours	28554 hours	10579 hours	11596 hours	24171 hours	24656 hours	6543 hours	6557 hours	102.3%	109.6%	102.0%	100.2%

August 2015



Nursing and Patient Experience
Direct Line: 020 7288 3589
www.whittington.nhs.uk

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

07 October 2015

<table>
<tr><td>Title:</td><td colspan="7">Serious Incidents - Monthly Update Report</td></tr>
<tr><td>Agenda item:</td><td colspan="3">15/121</td><td colspan="2">Paper</td><td colspan="2">04</td></tr>
<tr><td>Action requested:</td><td colspan="7">For Information</td></tr>
<tr><td>Executive Summary:</td><td colspan="7">The purpose of this report is to provide an overview of the reporting and management of Serious Incidents (SI) via StEIS (Strategic Executive Information System) as of the end of August 2015.
This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.</td></tr>
<tr><td>Summary of recommendations:</td><td colspan="7">None</td></tr>
<tr><td>Fit with WH strategy:</td><td colspan="7">1. Integrated care
2. Efficient and Effective care
3. Culture of Innovation and Improvement</td></tr>
<tr><td>Reference to related / other documents:</td><td colspan="7">Supporting evidence towards CQC fundamental standards (12) (13) (17) (20). Ensuring that health service bodies are open and transparent with the relevant person/s. NELCSU. SI Reporting. National Framework for Reporting and Learning from Serious Incidents Requiring Investigation, Whittington Health Serious Incident policy.</td></tr>
<tr><td>Reference to areas of risk and corporate risks on the Board Assurance Framework:</td><td colspan="7">Corporate Risk 179- Risk has been mitigated and closed on Datix. Currently, there are no gaps in assurance with regard to Serious Incidents performance.</td></tr>
<tr><td>Date paper completed:</td><td colspan="7">21/09/2015</td></tr>
<tr><td colspan="2">Author name and title:</td><td colspan="2">Jayne Osborne, Quality Assurance Officer and SI Co-ordinator</td><td colspan="2">Director name and title:</td><td colspan="2">Philippa Davies, Director of Nursing and Patient Experience</td></tr>
<tr><td>Date paper seen by EC</td><td>22/09</td><td>Equality Impact Assessment complete?</td><td>n/a</td><td>Risk assessment undertaken?</td><td>n/a</td><td>Legal advice received?</td><td>n/a</td></tr>
</table>

Serious Incident Monthly Report

1. Introduction

The purpose of this report is to provide an update to the Board on the reporting and management of serious incidents as reported via StEIS (Strategic Executive Information System) as at the end of August 2015.

The management of Serious Incident's (SIs) includes not only identification, reporting and investigation of each incident but also implementation of any recommendations following investigation and dissemination of learning to prevent recurrence.

2. Background

The Serious Incident Executive Approval Group (SIEAG) — comprising the Executive Medical Director, Director of Nursing and Patient Experience, Chief Operating Officer and the Head of Integrated Risk Management meets weekly to review Serious Incident investigation reports in addition to investigations into high severity incidents to ascertain whether these meet the reporting threshold of a serious incident (as described within the NHSE Serious Incident Framework (March 2015).

3. Serious Incidents

3.1 The Trust declared 2 serious incidents during August 2015 bringing the total to 23 since 1st April 2015. These include incidents that were later downgraded (de-escalated).

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 incidents are also uploaded to the NRLS (National Reporting and Learning Service) in line with national guidance and CQC registration requirements.

All serious incidents to the NHS Commissioning Board (via the National Reporting and Learning System; NRLS) which then shares the information with the CQC.

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

Category	Month Declared	Summary
Maternity/Obstetric incident	July 15	Unexpected stillbirth of an infant at 35 weeks.
Sub-optimal care of the deteriorating patient	July 15	Patient deteriorated and was transferred to a tertiary referral unit.
Child protection	July 15	Alleged abuse.
Sub-optimal care of the deteriorating patient	July 15	Following a period of care in ITU patient transferred to ward and condition deteriorated
Diagnostic incident including delay	July 15	Delay in a number of referred patients being seen in a timely manner
Wrong route administration	Aug 2015	Epidural procedure – near miss
Loss of usage of major outages relating to hospital services.	Aug 2015	Loss of ability to access the electronic patient record and PACS.

3.3. The table below details serious incidents by category reported to the NEL CSU. The Trust reported 2 serious incidents in August 2015

STEIS 2015-16 Category	April	May	June	July	Aug
Child protection	0	0	0	1	0
Communication issue	1	0	0	0	0
Confidential information leak/Information governance breach	1	2	0	0	1
Diagnostic Incident including delay	0	2	0	1	0
Drug incident	0	0	0	0	1
Maternity/Obstetric incident mother and baby (includes foetus, neonate and infant)	0	1	0	1	0
Pressure ulcer grade 3	5	1	0	0	0
Screening Issues	0	0	0	1	0
Slips/Trips/Falls	1	0	0	0	0
Suboptimal care of deteriorating patient	0	1	0	2	0
Total	8	7	0	6	2

4. Submission of SI reports

All final investigation reports are reviewed at a meeting of the SIEAG chaired by an Executive Director (Trust Medical Director or Director of Nursing and Patient Experience) and has membership from the Executive Operational Team and Integrated Governance Department. The Integrated Clinical Support Unit's (ICSU) Operational Directors or their deputies are expected 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 cause identified and the actions are aligned with the recommendations, so that lessons are learnt and appropriate action is taken to prevent future harm.

On completion of the report the patient and/or relevant family member are given the opportunity to receive a copy of the report and a 'being open' meeting is offered in line with duty of candour recommendations.

Lessons learned following the investigation are shared with all staff and departments involved in the patient's care through various means including the 'Big 4' in theatres, 'message of the week' in Maternity and Obstetrics and other departments. Learning from identified incidents is also published on the Trust Intranet making them available to all staff.

4.1 The Trust submitted 3 reports to NELCSU in August 2015. Currently there are no overdue incident reports awaiting submission.

4.2. The table below gives a brief summary of the incident and a selection of actions taken as a result of the lessons learnt from the investigation.

Summary	Actions taken as result of lessons learnt
Confidential Information Leak Loss of paediatric handover sheet was found by a member of the paediatric team off the hospital grounds.	• The hospital ward handover template has been modified to include the words ‘name’ and ‘role’ prompt at the top of the sheet so that the owner of each sheet can be identified. • The Handover process has been reviewed to include a reminder regarding handover sheet use and disposal. This is now a standing item on the Junior Doctors Induction programme. • An audit of compliance is being undertaken on the second week of each month to monitor compliance with guidance. • A bench marking exercise is being carried out to assess how other organisations minimize the risk of lost handover sheets.
Confidential Information Leak Confidential Information was emailed to an external government email address. Progress report of notes awaiting validation.	• A review of the current report content has been undertaken and all information not essential has been removed. • All staff were reminded that they must check that email addresses on distribution lists are current, correct and for the intended recipient NHS mail addresses (nhs.net) and to check when ‘replying to all’ that recipients are all on a secure email system.
Unexpected intrapartum death of a term infant.	• Staff have undertaken structured reflective learning. • The report is used for wider learning within the department in relation to patient experience and the management of women in the early stages of labour.

Summary	Actions taken as result of lessons learnt
Delayed referral to antenatal specialist services. Sickle Cell and Thalassemia Centre Screening	• All healthcare professionals who see women for antenatal related check-ups will ensure appropriate specialist referrals have been made. • A review is being undertaken to discuss and agree a pathway with the Sickle Cell and Thalassemia Centre, laboratory and midwifery services. • The Trust is reviewing and updating its antenatal Screening policy. • A review of the process for screening and referral of all positive antenatal screening blood tests to move to referrals being made via Anglia ICE.
Delayed diagnosis of cancer A delay in the follow up of outstanding diagnostic test results.	• Standing Operation Procedure has been developed for patients with cancer attending out-patients clinics.

5. 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

7th October 2015

Title:	Whittington Health NHS Trust Response to Report of the Morecambe Bay Investigation – Kirkup Report 2015		
Agenda item:	**15/122**	**Paper**	**05**
Action requested:	The Trust Board is asked to note the gap analysis and agreed action plan		
Executive Summary:	• The Report of the Morecambe Bay Investigation (Kirkup Report 2015) was published in March 2015 • Whittington Health Women`s Health Services has undertaken a gap analysis with respect to the recommendations cited in the report • Where gaps have been identified action points have been agreed and RAG rated • The action plan has been approved by the Women`s Health Services Board and presented to the Trust Management Group • Main themes to be addressed are: staffing and skill mix; dissemination of themes and learning; compliance with appraisal and mandatory training • There is a designated lead appointed by the Women`s Health Services Board • Action plan is to be monitored monthly, first update is due October 2015		
Summary of recommendations:	To note the report for assurance		
Fit with WH strategy:	Complies with Trust strategic intent		
Reference to related / other documents:	www.gov.uk/government/publications		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured on risk registers and/or BAF		
Date paper completed:	August 2015		

Author name and title:	**Amanda Hallums Director of Operations –Women`s Health Services**	**Director name and title:**	**Philippa Davies Director of Nursing**

Date paper seen by EC	**22/09**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Trust Response to the Kirkup Report – The Report of the Morecambe Bay Investigation (2015)

Gap Analysis and Action Plan – Whittington Health Maternity Services

Introduction

The Kirkup report (the Report of the Morecambe Bay Investigation, March 2015) was written following an independent investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBFT) from January 2014 to June 2013.

Serious failings were identified as part of the review. This highly critical report articulates damning criticism of the maternity unit at Furness General Hospital (FGH) and those responsible for regulating and maintaining the Trust.

It highlights serious mistakes, repeated over a long period of time and cites 20 instances of significant major failures of care at FGH associated with three maternal deaths and the deaths of 16 babies at or shortly after birth. Different clinical care in these cases would have been expected to prevent the outcome in one maternal death the deaths of 11 babies. This was almost four times the frequency of such occurrences at the Trust's other main maternity unit at the Royal Lancaster Infirmary.

The report states the maternity department was dysfunctional with serious problems in 5 main areas:

- **Clinical competence** of a proportion of clinical staff (midwifery, paediatric and obstetric) fell significantly below the standard for a safe, effective service. Essential knowledge was lacking ; guidelines not followed ; warning signs in pregnancy were sometimes not recognised or acted upon appropriately
- **Working relationships** were poor between midwives, obstetricians and paediatricians. A "them and us" culture with repeated instances of poor or failure to communicate impacting significantly on clinical care
- **An overzealous pursuit** of natural childbirth influenced by a small number of dominant individuals leading at times to unsafe care
- **Failure to risk assesses** the appropriate place for birth and advising mothers of their suitability to deliver at FGH. The hospital did not have the appropriate level of neonatal intensive care support to manage preterm babies. Paediatricians often adopted a "watch and wait" approach.
- **There was a grossly deficient response from clinicians** to serious incidents. Investigations were mostly uni-disciplinary and conducted by the same individual. Reports failed to identify key failures of care; there was little evidence of dissemination / sharing of lessons learned; and a protective approach to midwives.

The 44 recommendations detailed within the report are far reaching with 18 specific to UHMBFT and the remaining 26 aimed at other organisations eg NHS Trusts; CQC; RCM; RCOG; Department of Health. Many contain target dates for completion.

A national review of Maternity Services has been established under the leadership of Baroness Cumberledge. The timescale for reporting is the end of 2015.

Gap Analysis

A gap analysis has been carried out in relation to the maternity services provided by Whittington Health (WHMS) . The analysis has been conducted using the recommendations cited in the Kirkup Report (2015)

Whittington Health Trust and its maternity services generally comply with the majority of the recommendations. The Trust has robust mechanisms in place for incident reporting and investigation ; the management of complaints; duty of candour is strongly embraced; there is a culture of openness ; MDT working across the maternity services is strong; risk assessment procedures ensure the pursuit of normal childbirth at all costs is avoided. Midwifery Supervision is robust.

Where there are gaps and additional action required this is set out in the attached action plan (Appendix 1) and the supporting Gap Analysis Template (Appendix 2).The main areas for action include:

- The development of a maternity strategy
- Embedding of the new ICSU structures
- Through the ICSU governance structure ensure findings and themes from complaints, incidents, audit reviews and serious incidents are shared widely
- Development and implementation of an action plan in response to the staff survey findings
- Agree a new structure and process in readiness for the anticipated replacement of framework for midwifery supervision, which is highly effective within the Trust.
- Clinical Leadership training for newly appointed Clinical Directors and Clinical Leads
- Staffing and skill mix review
- To further improve training and appraisal compliance
- To contribute to the development of Trust Protocol setting out Duty of Trust and staff in relation to inquests

Monitoring

The action plan, once approved will be monitored monthly.

A Kirkup Lead Consultant has been appointed by the Women`s Health Services Board to oversee the implementation of the action plan: the recommendations from the Cumberledge Review once published; and other actions emanating from the CQC; NHSE; DoH and Royal Colleges .
Progress will also be reported to the Trust Board and relevant sub-committees

Amanda Hallums
Director of Operations Women`s Health Services
August 2015

ACTION PLAN – Appendix1

KEY ISSUE:	GAP ANALYSIS	KEY ACTIONS:	PROGRESS: [to be updated every 2 months]	LEAD	TIMESCALE	RAG rating Red Amber Green
1. Skills, Knowledge and competencies of staff caring for critically ill patients [Recommendation 2]						
TRUST-WIDE Trust should review the skills, knowledge, competencies and professional duties of care of all staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies.	All maternity staff, midwives, Doctors, anaesthetist, nurses, health care assistants, GPs and staff from other departments, eg A&E Attend PROMPT skills and drills training. Nurses and midwives attend courses on care of the critically ill patient. Consultant lead for women with complex medical needs. Midwife lead for women with complex medical needs. Evidence based guidelines accessible on the intranet for all staff. Staff are informed of new guidelines/policies via monthly risk management report and message of the week and email communication Guidelines include Care	Undertake review of staff training and competencies. Ensure full compliance with initial training and refresher programme Ensure adequate availability of training programmes Agree audit programme With Head of Midwifery		Head of Midwifery / Leads for Obstetric Anaesthetics / Anaesthetics and Critical Care Head of Midwifery / Specialist Midwife	Review end October 2015	

KEY ISSUE:	GAP ANALYSIS	KEY ACTIONS:	PROGRESS: [to be updated every 2 months]	LEAD	TIMESCALE	RAG rating Red Amber Green
	of the severely ill patient , Management of anaesthetic complications MEOWs well established	Undertake quarterly documentation audit of Meows chart		Policy / Guidelines Midwife		
2: Identify and develop measures that will promote effective multidisciplinary team-working (Recommendation 5)						
MATERNITY Identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities.	Well established and well attended multidisciplinary weekly perinatal meeting Weekly multidisciplinary labour ward business meeting Multidisciplinary skills and drills training Monthly multidisciplinary Clinical governance meeting Weekly RCA meeting of high risk incidents Ad hoc multidisciplinary ward based emergency scenarios Weekly CTG meetings Midwives participate in new Doctors induction	Ensure continued attendance of staff at all levels Ensure decisions / key points communicated Ensure outcomes disseminated widely Continue with ward / department based scenarios		Head of Midwifery Clinical Governance Lead Midwife Clinical Governance Lead Midwife	Ongoing	

KEY ISSUE:	GAP ANALYSIS	KEY ACTIONS:	PROGRESS: [to be updated every 2 months]	LEAD	TIMESCALE	RAG rating Red Amber Green
	programme, example bereavement and FGM training, datix and clinical governance Updating and writing of new policy and guidelines is multidisciplinary Training data base is held Skills and drills training is multidisciplinary Doctors are invited to attend, midwifery three day annual update, if there are topics that they feel are of benefit.	Continue to maintain ongoing review Continue to ensure full compliance		Practice Development Midwife -		Green
3: Protocol for risk assessment in maternity services (Recommendation 6)						
MATERNITY Draw up a protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of delivery in the Midwife Lead Unit and who should not; who will carry out this assessment against which criteria; and	Antenatal guidelines are based on NICE and RCOG guidance and include guidance on referral of high risk women to the obstetric team The maternity yellow notes have detailed risk assessment for antenatal intrapartum and postnatal	Ensure published guidance disseminated / policies / practice reviewed			Ongoing	Green

KEY ISSUE:	GAP ANALYSIS	KEY ACTIONS:	PROGRESS: [to be updated every 2 months]	LEAD	TIMESCALE	RAG rating Red Amber Green
how this will be discussed with pregnant women and families.	care. There is birth centre criteria which has been agreed between the 5 local trusts in the North Central London network Women who choose to use the birth centre all have a risk assessment at 36 weeks to confirm they are still meet the criteria the birth centre.	Ensure audit of transfers to Labour Ward		Head of Midwifery		
The protocol should involve all relevant staff groups, including midwives, paediatricians and obstetricians.	Women who fall in to the amber category have an agreed detailed plan of care written by the obstetrician and lead midwife for the birth centre. Where women request care outside of criteria a meeting is held which also includes a midwife and obstetrician and a plan of care discussed and written in the case notes.					
Individual decisions on delivery must be clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all staff are aware that they should not vary	Women are given leaflet on choice of place of birth and discussions are based on NICE inclusion criteria Monthly Vaginal Birth		Due for completion end of September 2015	Senior Midwives – Labour Ward and Birth Centre	End of September 2015	

KEY ISSUE:	GAP ANALYSIS	KEY ACTIONS:	PROGRESS: [to be updated every 2 months]	LEAD	TIMESCALE	RAG rating Red Amber Green
decisions without a documented risk assessment	After Caesarean (VBAC) clinic Pathway for vaginal birth after caesarean section The SOM team are involved with the women helping to plan care Guideline for transfer of care of mother to the labour ward Guideline for transfer of care for bay to NICU Guideline for care of women in all care setting currently being updated	Audit individual cases			Ongoing	
4: Audit risk assessment protocols on place of delivery, transfers and management of care, and effective multidisciplinary care. (Recommendation 7)						
MATERNITY Audit the operation of maternity and paediatric services,	Obstetrician clinical governance lead appointed.	Progress with Kirkup action plan to be reported to Trust Board	Initial , preliminary feedback provided at WHS Board 10 August 2015	Kirkup Lead Consultant	Monthly	

KEY ISSUE:	GAP ANALYSIS	KEY ACTIONS:	PROGRESS: [to be updated every 2 months]	LEAD	TIMESCALE	RAG rating Red Amber Green
to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups.	Obstetric Kirkup lead appointed Obstetric Audit lead appointed Audits presented at monthly perinatal meetings and monthly trust audit afternoons. Multidisciplinary attendance Maternity dashboard used to identify themes and trends for audits Lead for NICU attends labour ward business meeting Weekly perinatal meeting and labour ward business meeting, and monthly maternity governance meeting attended by neonatal lead, paediatrician and obstetrician	through ISCU Clinical Governance Committee and Trust Quality Committee Establish a plan to improve rollout of findings from audits and action plans. Audit action plans have been fully implemented		Head of Midwifery Clinical director Obstetric audit lead Clinical governance lead midwife	October 2015	

KEY ISSUE:	GAP ANALYSIS	KEY ACTIONS:	PROGRESS: [to be updated every 2 months]	LEAD	TIMESCALE	RAG rating Red Amber Green
5: Recruitment & retention strategy. (Recommendation 8)						
Identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with one or more other centre(s) to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust. Development of the strategy should be completed by January 2016	Low vacancy rate. Ongoing recruitment to fill any vacancies promptly. Birth rate plus work force analysis tool has been undertaken Band 5 preceptor midwives limited to 12 to ensure skill mixed 12 months preceptor programme for newly qualified midwives Strong links with Middlesex university. Consultant midwives and Supervisor of midwives teach at the university Midwives and SOM attend university board of study programme Annual training needs analysis carried out based on appraisals,	Staffing and skill mix review to be undertaken based on the recommendations of birth rate plus Monitor staffing monthly and record on maternity dashboard : MW :Birth Ratio ; 1:1 care in labour Ensure full compliance with Trust standard of		Head of Midwifery Head of HR and Head of Resourcing	December 2015	Amber

KEY ISSUE:	GAP ANALYSIS	KEY ACTIONS:	PROGRESS: [to be updated every 2 months]	LEAD	TIMESCALE	RAG rating Red Amber Green
	SOM annual reviews and thematic reviews from incidents where an individual or group of staff may require training Dr have training every Friday afternoon 2 local training sessions and two regional training sessions Dr have 1 hours training sessions three times a week this includes CTg training and case discussions Annual staff survey undertaken and has highlighted the need to address perceived behaviours in some areas	90% by November 2015 Develop action plan to address survey findings form women health Re audit staff after plan has been implemented using survey monkey Clinical director, Director of Operations and HOM to hold open staff meeting		Matrons Head of Midwifery / Senior Midwives Clinical Director Director of Operations and Head of Midwifery	November 2015 October 2015 November 2015	

KEY ISSUE:	GAP ANALYSIS	KEY ACTIONS:	PROGRESS: [to be updated every 2 months]	LEAD	TIMESCALE	RAG rating Red Amber Green
6. Raise awareness of incident reporting [Recommendation 11]						
TRUST-WIDE Trust should identify and implement a programme to raise awareness of incident reporting, including requirements, benefits and processes. The Trust should also review its policy of openness and honesty in line with the duty of candour of professional staff, and incorporate into the programme compliance with the refreshed policy.	Datix system in place. All levels of staff in maternity report on datix Incidents reviewed at local maternity clinical governance meeting Multidisciplinary RCA carried out and reported SIs reviewed at the trust quality and patient safety committee Trust has a well published being open policy Duty of candour embedded in the culture of maternity services	Monthly review of incidents and risk register to ensure gaps closed and lessons learned Record in minutes Ensure learning disseminated		Head of Quality and Integrated Risk Management		Green

KEY ISSUE:	GAP ANALYSIS	KEY ACTIONS:	PROGRESS: [to be updated every 2 months]	LEAD	TIMESCALE	RAG rating Red Amber Green
7. Incident Investigation process (Recommendation 12)						
TRUST-WIDE Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate	RCA training and training records List of investigators Learning shared via rolling half day, Patient Safety Committee, ISCU quality meetings, dedicated page on intranet Maternity investigations are carried out by a muliti disciplinary team Action plans with RCA reports Standardised Serious Incident Templates Serious Incident Panel Chaired By Medical	Maternity need to ensure that there is wider dissemination from lessons learned. To be included in quarterly risk management report to all staff To be included on midwifery mandatory three day study day To be included in Dr training sessions Quarterly Formal clinical governance report to the board		Head of Quality and Integrated Risk Management HOM and maternity clinical governance lead College tutor	November 2015 November 2015	

KEY ISSUE:	GAP ANALYSIS	KEY ACTIONS:	PROGRESS: [to be updated every 2 months]	LEAD	TIMESCALE	RAG rating Red Amber Green
arrangements for staff debriefing and support following a serious incident.	Director and Director of Nursing Serious Incident Report discuss at Trust Board Newly formed Women's Health Services Board					
8: Review the complaints system (Recommendations 13 & 31)						
TRUST Review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants. Review the complaints system, with particular reference to strengthening local resolution and	Robust Trust policy in place . Quality Committee reports Key Performance Indicators and Board Reports Oversight by CCGs at Clinical Quality Review Group Lessons learned shared on dedicated intranet page	Share across ICSU Disseminate across ICSU		Head of Patient Experience Clinical Governance Lead Midwife Head of Midwifery Director of Operations	In place from September	

KEY ISSUE:	GAP ANALYSIS	KEY ACTIONS:	PROGRESS: [to be updated every 2 months]	LEAD	TIMESCALE	RAG rating Red Amber Green
improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints.						
TRUST_WIDE & MATERNITY The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee.	Local resolution meetings Encouraged and held within maternity services for serious incidents and complaints Women involved in terms of reference for investigations • Where appropriate external reviews invited	Ensure offered and documented			Ongoing	
	Local Maternity services Liaison committee to be re established	Director of Operations to work up plan with appointed MSLC Chair	To agree funding for chair of MSLC	Director of Operations and CCG lead	October 2105	

KEY ISSUE:	GAP ANALYSIS	KEY ACTIONS:	PROGRESS: [to be updated every 2 months]	LEAD	TIMESCALE	RAG rating Red Amber Green
	Birth reflections clinic established July 2015 for women to discuss concerns re their care and experience of childbirth	Evaluate after 4 months		Matron – Labour Ward	November 2015	
9. Clinical leadership (Recommendation 14)						
MATERNITY Review leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events.	• New ICSU structure agreed • New CD and clinical leads appointed • Governance Framework agreed • Inaugural Board meeting held 10 August 2015 Senior midwives have attended clinical leadership training Portfolio evidence of training available New ICSU 1 July 2015	New arrangements to be disseminated across the WHS ICSU Training needs analysis to undertaken for clinical leads		Clinical Director / Director of Operations / Head of Midwifery	Sept 2015	

KEY ISSUE:	GAP ANALYSIS	KEY ACTIONS:	PROGRESS: [to be updated every 2 months]	LEAD	TIMESCALE	RAG rating Red Amber Green
10: Standards for responsibilities for clinical quality of managers. (Recommendations 16 & 29)						
MATERNITY Ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and provide appropriate guidance and where necessary training. TRUST Standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and non-executives.	To be evidenced in job plans Appraisals and PDPs Job descriptions Set within services and individual objectives Defined through Trust Values	Complete Job planning and appraisals of SMT		Clinical Director /Director of Operations / Head of Midwifery Director of Human Resources	October 2015	
11. Clear standards should be drawn up for incident reporting and investigation in maternity services (Recommendation 23)						
MATERNITY These should include the mandatory reporting and	Maternal deaths, unexpected neonatal and intrapartum deaths, and stillbirth are reviewed.	Disseminate findings		Clinical Governance Lead Midwife		Green

KEY ISSUE:	GAP ANALYSIS	KEY ACTIONS:	PROGRESS: [to be updated every 2 months]	LEAD	TIMESCALE	RAG rating Red Amber Green
investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths.	External reviews are requested for maternal death The is mandatory reporting of all SIs					Green
TRUST-WIDE & MATERNITY Include a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and independent, multidisciplinary peer review, and should certainly be framed to exclude conflicts of interest between staff.	Families included in the feedback from the investigation reports but could be better included in the investigation process. Adverse Incident Policy outlines standard process for IRI / SI investigations & reports – investigators often from a different team but with the input of specialists • Duty of Candour at point of incident • Letter to families re investigation with invitation to ask specific questions • Ongoing liaison with families via RM team • Circulation of report with invitation to a meeting	Families to be invited to contribute their view of the incident. •Families to be included in defining the Terms of Reference as per latest Guidance Revise Adverse Incident Policy in line with changes to national guidance, ensuring that all points within this key issue are addressed		Head of Quality and Integrated Risk Management Clinical Governance Lead Midwife	October 2015	Amber

KEY ISSUE:	GAP ANALYSIS	KEY ACTIONS: (include views of the patient / families in the investigation and have a formal section in the SI report for this information)	PROGRESS: [to be updated every 2 months]	LEAD	TIMESCALE	RAG rating Red Amber Green
12. Duty of Candour (Recommendation 24)						
TRUST-WIDE & MATERNITY The duty of candour should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive personal feedback on the results.	Maternity: Families are included in the feedback from the investigation reports but could be better included in the investigation process. Trust-wide: As per number 11(recommendation 23)	Families to be invited to contribute their view of the incident. As per number 11(recommendation 23)		Head of Quality and Integrated Risk Management		
13. NHS Boards to report openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust (Recommendation 25)						
TRUST-WIDE A duty should be placed on all NHS Boards to report	Trust Board meetings held in public (note confidentiality arrangements)	Review if any additional learning / reporting can be shared externally		Director of Communications and Corporate Affairs	October 2015	

KEY ISSUE:	GAP ANALYSIS	KEY ACTIONS:	PROGRESS: [to be updated every 2 months]	LEAD	TIMESCALE	RAG rating Red Amber Green
openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, including prompt notification of relevant external bodies such as the Care Quality Commission and Monitor.	Commitment to being open as per Trust values Robust corporate governance arrangements with established links with CQC and Monitor (CQC receive all Si reports & NRLS alerts Scrutiny by CCG and TDA –summary of discussions at Board Local liaison with the CCG and existing evidence of report sharing Annual Quality Account Trust Annual Report & annual governance statement (published on Trust website)	Trust to publish by September 2015				
14. The introduction of a clear national policy on whistleblowing (Recommendation 26)						
As well as protecting the interests of whistleblowers, this should be implemented in a way that ensures that a systematic and proportionate response is made by Trusts to concerns identified.	Trust Raising Concerns Policy Trust values • Staff survey Examples of action taken following whistleblowing concerns reported confidentially to Trust Board sub- committee	Staff survey action plan		Director of Human Resources	October 2015	

KEY ISSUE:	GAP ANALYSIS	KEY ACTIONS:	PROGRESS: [to be updated every 2 months]	LEAD	TIMESCALE	RAG rating Red Amber Green
15: Standards for professional duties and expectations of clinical leads at all levels. (Recommendation 28)						
TRUST Standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors.	Standard job descriptions for staff involved with 'quality' eg Clinical Director Revalidation processes (in place for medical staff & being developed for nursing staff) Appraisal and objectives	All ICSU`s to ensure 90% compliance		Director of HR Medical Director Director of Nursing Directors of Operations	November 2015	
TRUST Provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met.	• Established links in place with CQC	ICSU to review compliance against standards Agree key actions				
16: A protocol should be drawn up setting out the duties of the Trust and their staff in relation to inquests. (Recommendation 30)						

KEY ISSUE:	GAP ANALYSIS	KEY ACTIONS:	PROGRESS: [to be updated every 2 months]	LEAD	TIMESCALE	RAG rating Red Amber Green
A protocol should be drawn up setting out the duties of the Trust and their staff in relation to inquests. This should include, but not be limited to, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation.	Policy for Incidents and Standard Operating Procedure Clear roles and responsibilities included in the above. Legal services manager facilitates process Incident SoP in place, updated June 2015. All statements and Investigations recorded on Datix Weekly status report	Due for review Dec 15		Legal services manager		

Appendix 1 – Gap analysis against all recommendations

Key:
NHSE – NHS England
PHSO – Parliamentary Health Service Ombudsman
CQC – Care Quality Commission
DH – Department of Health
RMN / N – Royal College of Midwifery / Nursing
NMC – Nursing & Midwifery Council
GMC – General Medical Council
RCP / OG – Royal College of Physicians / Obstetrics & Gynaecology
NICE – National Institute for Health & Care Excellence
WHMS – Whittington Health Maternity Services

No.	Recommendation	Applicability	Relevant (Y / N)	On A/P (Y/N/NA)	Comment
1	The University Hospitals of Morecambe Bay NHS Foundation Trust should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but also for the length of time it has taken to bring them to light and the previous failures to act. This should begin immediately with the response to this Report.	Trust	N	N/A	Applicable to Morecambe Bay only
2	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. This review should be completed by June 2015, and identify requirements for additional training, development and, where necessary, a period of experience elsewhere.	Trust	Y	Y	• Multidisciplinary skills and drills • MEOWS embedded • SBAR • Consultant Labour Ward cover • Guidelines in place for care of seriously ill patient **Action 1 (Trust-wide & maternity)**
3	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify	Trust	N	N/A	Applicable to Morecambe Bay only

No.	Recommendation	Applicability	Relevant (Y / N)	On A/P (Y/N/NA)	Comment
	opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. These should be in place in time for June 2015.				
4	Following completion of additional training or experience where necessary, the University Hospitals of Morecambe Bay NHS Foundation Trust should identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation. This should be completed by September 2015.	Trust	N	N/A	Applicable to Morecambe Bay only
5	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms of employment. These measures should be identified by April 2015 and begun by June 2015.	Trust	Y	Y	• Well established MDT Perinatal meetings – weekly • Weekly multidisciplinary Labour Ward Business meeting • Monthly MDT / Policy Guidelines meeting • Clinical Leadership Group for Obstetrics • WHMS Management Board established **Action 2 (Maternity)**
6	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up a protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which criteria; and how this will be discussed with pregnant women and families. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust staff are aware that they should not vary decisions without a documented risk	Trust	Y	Y	• Risk assessment at booking and again at 36/40 to determine birth option • Any woman choosing to give birth outside of criteria seen jointly by obstetrician and

No.	Recommendation	Applicability	Relevant (Y / N)	On A/P (Y/N/NA)	Comment
	assessment. This should be completed by June 2015.				midwife . Plan of care agreed **Action 3 (Maternity)**
7	The University Hospitals of Morecambe Bay NHS Foundation Trust should audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups. This should be in place by September 2015.	Trust	Y	Y	Action 4 (Maternity)
8	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with one or more other centre(s) to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust; in addition, opportunities for flexible working to maximise the advantages of close proximity to South Lakeland should be sought. Development of the strategy should be completed by January 2016.	Trust	Y	Y	Action 5 (Maternity)
9	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify an approach to developing better joint working between its main hospital sites, including the development and operation of common policies, systems and standards. Whilst we do not believe that the introduction of extensive split-site responsibilities for clinical staff will do much other than lead to time wasted in travelling, we do consider that, as part of this approach, flexibility should be built into working responsibilities to provide temporary solutions to short-term staffing problems. This approach should be begun by September 2015.	Trust	N	N/A	Maternity services are on one site.
10	The University Hospitals of Morecambe Bay NHS Foundation Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as ‘buddying’ and we endorse the approach under these circumstances. This could involve the same centre identified as part of the recruitment and retention strategy. If a suitable partner is forthcoming, this arrangement should be begun by September 2015.	Trust	N	N/A	N/A

No.	Recommendation	Applicability	Relevant (Y / N)	On A/P (Y/N/NA)	Comment
11	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and implement a programme to raise awareness of incident reporting, including requirements, benefits and processes. The Trust should also review its policy of openness and honesty in line with the duty of candour of professional staff, and incorporate into the programme compliance with the refreshed policy. This should be begun with maternity staff by April 2015 and rolled out to other staff by April 2016.	Trust	Y	Y	• Trust policy in place • All incidents reviewed and themes identified. • WHMS need to strenghthen dissemination of themes and learnings **Action 6 (Trust-wide)**
12	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident. This should be begun with maternity units by April 2015 and rolled out across the Trust by April 2016.	Trust	Y	Y	• Team and individual debriefing Given . SoMs debrief individually through supervision framework Doctors in training debriefed via Training Lead and Consultant **Action 7 (Trust-wide)**
13	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants. The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee. This should be completed, and the improvements demonstrated at an open Board meeting, by December 2015.	Trust	Y	Y	• WHMS advocate offer of meeting • MSLC to be established – Oct 2015 complaint review to be a standing agenda item **Action 8 (Trust-wide)**

No.	Recommendation	Applicability	Relevant (Y / N)	On A/P (Y/N/NA)	Comment
					Cross reference recommendation 31
14	The University Hospitals of Morecambe Bay NHS Foundation Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. The Trust has implemented change at executive level, but this needs to be carried through to the levels below. All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events. This review should be commenced by April 2015.	Trust	Y	Y	• New Trust ICSU Structure • CDs appointed and Clinical Leads **Action 9 (Maternity)**
15	The University Hospitals of Morecambe Bay NHS Foundation Trust should continue to prioritise the work commenced in response to the review of governance systems already carried out, including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust's services. This work is already underway with the facilitation of Monitor, and we would not seek to vary or add to it, which would serve only to detract from implementation. We do, however, recommend that a full audit of implementation be undertaken before this is signed off as completed.	Trust	N	N	Applicable to Morecambe Bay only
16	As part of the governance systems work, we consider that the University Hospitals of Morecambe Bay NHS Foundation Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and it should provide appropriate guidance and where necessary training. This should be completed by December 2015.	Trust	Y	Y	Action 10 (Maternity & Trust-wide) Cross reference recommendation 29
17	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify options, with a view to implementation as soon as practicable, to improve the physical environment of the delivery suite at Furness General Hospital, including particularly access to operating theatres, an improved ability to observe and respond to all women in labour and en suite facilities; arrangements for post-operative care of women also need to be reviewed. Plans should be in place by December 2015 and completed by December 2017.	Trust	N	N	Applicable to Morecambe Bay only (NB> Site already reconfigured)
18	All of the previous recommendations should be implemented with the involvement of Clinical Commissioning Groups, and where necessary, the Care	Trust	N	N	Applicable to Morecambe Bay only

No.	Recommendation	Applicability	Relevant (Y / N)	On A/P (Y/N/NA)	Comment
	Quality Commission and Monitor. In the particular circumstances surrounding the University Hospitals of Morecambe Bay NHS Foundation Trust, NHS England should oversee the process, provide the necessary support, and ensure that all parties remain committed to the outcome, through an agreed plan with the Care Quality Commission, Monitor and the Clinical Commissioning Groups.				
19	In light of the evidence we have heard during the Investigation, we consider that the professional regulatory bodies should review the findings of this Report in detail with a view to investigating further the conduct of registrants involved in the care of patients during the time period of this Investigation.	NMC GMC	N	N	National action
20	There should be a national review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the requirements to sustain safe services under these conditions. In conjunction, a national protocol should be drawn up that defines the types of unit required in different settings and the levels of care that it is appropriate to offer in them.	NHSE CQC RCM / N RCP / OG NICE	N	N	National action
21	The challenge of providing healthcare in areas that are rural, difficult to recruit to or isolated is not restricted to maternity care and paediatrics. We recommend that NHS England consider the wisdom of extending the review of requirements to sustain safe provision to other services. This is an area lacking in good-quality research yet it affects many regions of England, Wales and Scotland. This should be seen as providing an opportunity to develop and promote a positive way of working in remote and rural environments.	NHSE	N	N	National action
22	We believe that the educational opportunities afforded by smaller units, particularly in delivering a broad range of care with a high personal level of responsibility, have been insufficiently recognised and exploited. We recommend that a review be carried out of the opportunities and challenges to assist such units in promoting services and the benefits to larger units of linking with them.	RCM / N RCP / OG	N	N	National action Also relevant to Health Education England
23	Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. We believe that there is a strong case to include a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and independent, multidisciplinary peer review, and should certainly be framed to exclude conflicts of interest between staff. We recommend that this build on national work already begun on how such a process would work.	NHSE CQC DH	Y	Y	• Incident reporting in WHMS IS embedded • Reporting is through WHS Clinical Governance Committee and

No.	Recommendation	Applicability	Relevant (Y / N)	On A/P (Y/N/NA)	Comment
					Trust Quality and Patient Safety Committee **Action 11 (Maternity & Trust-wide)**
24	We commend the introduction of the duty of candour for all NHS professionals. This should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive personal feedback on the results.	NHSE CQC	Y	Y	• WHMS fully supports the duty of Candour • Following any SI the family is offered an opportunity to meet with a SoM or Midwifery manager and consultant to ensure they have an opportunity to contribute **Action 12 (Maternity & Trust-wide)**
25	We recommend that a duty should be placed on all NHS Boards to report openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, including prompt notification of relevant external bodies such as the Care Quality Commission and Monitor. The Care Quality Commission should develop a system to disseminate learning from investigations to other Trusts.	CQC DH	Y	Y	Action 13 (Trust-wide)
26	We commend the introduction of a clear national policy on whistleblowing. As well as protecting the interests of whistleblowers, we recommend that this is implemented in a way that ensures that a systematic and proportionate response is made by Trusts to concerns identified.	DH	Y	Y	• Trust has Whistleblowing policy • Policy on intranet • SoMs discuss whistleblowing with supervisee during annual review

No.	Recommendation	Applicability	Relevant (Y / N)	On A/P (Y/N/NA)	Comment
					Action 14 (Trust-wide)
27	Professional regulatory bodies should clarify and reinforce the duty of professional staff to report concerns about clinical services, particularly where these relate to patient safety, and the mechanism to do so. Failure to report concerns should be regarded as a lapse from professional standards.	NMC GMC	N	N	Also relevant to Professional Standards Authority for Health & Social Care
28	Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors. Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met.	Trust NHSE CQC NMC GMC	Y	Y	**Action 15 (Trust-wide)**
29	Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and non-executives. All Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met.	Trust NHSE CQC	Y	Y	• Set in job descriptions • Discussed through appraisal • Set in service and individual objectives • Set in WH Values **Action 10 (Maternity & Trust-wide) Cross reference recommendation 16**
30	A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. This should include, but not be limited to, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation.	NHSE CQC	Y	Y	**Action 16 (Trust-wide)**
31	The NHS complaints system in the University Hospitals of Morecambe Bay NHS Foundation Trust failed relatives at almost every turn. Although it was not within our remit to examine the operation of the NHS complaints system nationally, both the nature of the failures and persistent comment from elsewhere lead us to	NHSE PHSO CQC DH	Y	Y	**Action 8 (Trust-wide) Cross reference recommendation 13**

No.	Recommendation	Applicability	Relevant (Y / N)	On A/P (Y/N/NA)	Comment
	suppose that this is not unique to this Trust. We believe that a fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints.				
32	The Local Supervising Authority system for midwives was ineffectual at detecting manifest problems at the University Hospitals of Morecambe Bay NHS Foundation Trust, not only in individual failures of care but also with the systems to investigate them. As with complaints, our remit was not to examine the operation of the system nationally; however, the nature of the failures and the recent King's Fund review (*Midwifery regulation in the United Kingdom*) lead us to suppose that this is not unique to this Trust, although there were specific problems there that exacerbated the more systematic concern. We believe that an urgent response is required to the King's Fund findings, with effective reform of the system.	NHSE DH NMC	N	N	• Strong supervision framework in place • 2013 SoM team of year award • 2014 SoM of Year Award • All women have access to a SoM, this is widely publicised National action
33	We considered carefully the effectiveness of separating organisationally the regulation of quality by the Care Quality Commission from the regulation of finance and performance by Monitor, given the close inter-relationship between Trust decisions in each area. However, we were persuaded that there is more to be gained than lost by keeping regulation separated in this way, not least that decisions on safety are not perceived to be biased by their financial implications. The close links, however, require a carefully coordinated approach, and we recommend that the organisations draw up a memorandum of understanding specifying roles, relationships and communication.	CQC DH Monitor / CCG	N	N	National action
34	The relationship between the investigation of individual complaints and the investigation of the systemic problems that they exemplify gave us cause for concern, in particular the breakdown in communication between the Care Quality Commission and the Parliamentary and Health Service Ombudsman over necessary action and follow-up. We recommend that a memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and follow-up, including explicitly agreed actions where issues overlap.	PHSO CQC	N	N	National action

No.	Recommendation	Applicability	Relevant (Y / N)	On A/P (Y/N/NA)	Comment
35	The division of responsibilities between the Care Quality Commission and other parts of the NHS for oversight of service quality and the implementation of measures to correct patient safety failures was not clear, and we are concerned that potential ambiguity persists. We recommend that NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility.	NHSE PHSO CQC Monitor / CCG	N	N	National action
36	The cumulative impact of new policies and processes, particularly the perceived pressure to achieve Foundation Trust status, together with organisational reconfiguration, placed significant pressure on the management capacity of the University Hospitals of Morecambe Bay NHS Foundation Trust to deliver against changing requirements whilst maintaining day-to-day needs, including safeguarding patient safety. Whilst we do not absolve Trusts from responsibility for prioritising limited capability safely and effectively, we recommend that the Department of Health should review how it carries out impact assessments of new policies to identify the risks as well as the resources and time required.	DH	N	N	National action
37	Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. We recommend that an explicit protocol be drawn up setting out how such processes will be managed in future. This must include systems to secure retention of both electronic and paper documents against future need, as well as ensuring a clearly defined transition of responsibilities and accountability.	DH	N	N	National action
38	Mortality recording of perinatal deaths is not sufficiently systematic, with failures to record properly at individual unit level and to account routinely for neonatal deaths of transferred babies by place of birth. This is of added significance when maternity units rely inappropriately on headline mortality figures to reassure others that all is well. We recommend that recording systems are reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts.	NHSE	N	N	National action
39	There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have	DH	N	N	National action

No.	Recommendation	Applicability	Relevant (Y / N)	On A/P (Y/N/NA)	Comment
	raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot CHAPTER EIGHT: Conclusions and recommendations **191** understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay.				
40	Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer.	DH	N	N	National action
41	We were concerned by the ad hoc nature and variable quality of the numerous external reviews of services that were carried out at the University Hospitals of Morecambe Bay NHS Foundation Trust. We recommend that systematic guidance be drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them.	RCM / N	N	N	National action Also relevant to the Academy of Medical Royal Colleges
42	We further recommend that all external reviews of suspected service failures be registered with the Care Quality Commission and Monitor, and that the Care Quality Commission develops a system to collate learning from reviews and disseminate it to other Trusts.	CQC Monitor / CCG	N	N	National action
43	We strongly endorse the emphasis placed on the quality of NHS services that began with the Darzi review, *High Quality Care for All*, and gathered importance with the response to the events at the Mid Staffordshire NHS Foundation Trust. Our findings confirm that this was necessary and must not be lost. We are concerned that the scale of recent NHS reconfiguration could result in new organisations and post-holders losing the focus on this priority. We recommend that the importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations.	NHSE DH	N	N	National action
44	This Investigation was hampered at the outset by the lack of an established framework covering such matters as access to documents, the duty of staff and former staff to cooperate, and the legal basis for handling evidence. These obstacles were overcome, but the need to do this from scratch each time an investigation of this format is set up is unnecessarily time-consuming. We	DH	N	N	National action

No.	Recommendation	Applicability	Relevant (Y / N)	On A/P (Y/N/NA)	Comment
	believe that this is an effective investigation format that is capable of getting to the bottom of significant service and organisational problems without the need for a much more expensive, time-consuming and disruptive public inquiry. This being so, we believe that there is considerable merit in establishing a proper framework, if necessary statutory, on which future investigations could be promptly established. This would include setting out the arrangements necessary to maintain independence and work effectively and efficiently, as well as clarifying responsibilities of current and former health service staff to cooperate.				

Direct Line: 020 7288
www.whittington.nhs.uk

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board

07 October 2015

<table>
<tr><td colspan="3">Title:</td><td colspan="5">Trust Research Strategy</td></tr>
<tr><td colspan="3">Agenda item:</td><td colspan="5">06</td></tr>
<tr><td colspan="3">Action requested:</td><td colspan="5">For approval</td></tr>
<tr><td colspan="3">Executive Summary:</td><td colspan="5">Whittington Health is committed to excellence in clinical and community based health research. We aim to offer our patients the opportunity to participate in research which may benefit their own health and can also contribute to improved population health, locally, nationally and internationally. We wish to build on and develop our existing research capabilities and research potential of our organisation.</td></tr>
<tr><td colspan="3">Fit with WH strategy:</td><td colspan="5">Fits with clinical strategy and strategic goal 6 to be a leader of medical, multi professional education and population based clinical research</td></tr>
<tr><td colspan="3">Reference to related / other documents:</td><td colspan="5">Fits with national strategy for the NHS</td></tr>
<tr><td colspan="3">Reference to areas of risk and corporate risks on the Board Assurance Framework:</td><td colspan="5">Captured on risk register/BAF</td></tr>
<tr><td colspan="3">Date paper completed:</td><td colspan="5">17 September 2015</td></tr>
<tr><td colspan="2">Author name and title:</td><td colspan="2">Rob Sherwin, Consultant</td><td colspan="2">Director name and title:</td><td colspan="2">Rob Sherwin, Consultant</td></tr>
<tr><td>Date paper seen by EC</td><td>22/09</td><td>Equality Impact Assessment complete?</td><td>n/a</td><td>Quality Impact Assessment complete?</td><td>n/a</td><td>Financial Impact Assessment complete?</td><td>n/a</td></tr>
</table>

Whittington Health Research Strategy 2015-2020

1) Foreword

Whittington Health is committed to excellence in clinical and community based health research. We aim to offer our patients the opportunity to participate in research which may benefit their own health and can also contribute to improved population health, locally, nationally and internationally. We wish to build on and develop our existing research capabilities and research potential of our organisation.

We will focus our efforts on:

- critically engaging with the concept of 'integrated clinical care', rigorously evaluating its delivery and outcome.
- identifying areas of clinical excellence that would benefit from increased academic engagement, securing the investment to create research hubs and centres.
- cultural change to create a research environment in which patients, clinical and professional staff can work together to identify tractable research questions that will result in improved health and wellbeing in the population we serve.

Many hospitals and community trusts participate in research projects, but to be a Research Trust requires a step change in ambition, partnership working and investment. Whittington Health is committed to making that change and to becoming a recognised centre for innovative, applied health research.

1.1 Why do we do research?

1. High quality research offers patients and their families the opportunity to participate in research studies which may develop or improve treatments and so improve the health of patients.

2. A strong reputation for research excellence will make Whittington Health a more attractive place to work, leading to improved staff recruitment and retention.

3. There is the potential to generate revenue for the Trust, which can be invested in and further enhance the Trust's research capabilities.

4. We have a duty of care to ensure that clinical services are informed by the most recent research findings and where appropriate, to contribute to this evidence base. In addition to contributing to the evidence base of knowledge, research fosters a culture of questioning and reflection which supports the development of future clinician scientists.

5. Research active institutions deliver better quality care for their patients

This research strategy uses the framework of the Whittington Health Clinical Strategy 2015-2020 (http://www.whittington.nhs.uk/default.asp?c=20804) whose overarching aim is to help local people live longer, healthier lives. The purpose of

this research strategy is to focus the trust's research efforts and map our research aims to the clinical strategy. This research strategy defines our research objectives and provides a narrative as to how to achieve them.

2. Strategy

We aim to be a national leader in the study of integrated care. We wish to support our clinicians in the evaluation of integrated care services thus providing an evidence base for service development. We envisage that the strengthening of partnerships with mental health, social care, clinical education and primary care services will offer the opportunity to assess the optimal integration of care. We wish to be at the forefront of studies of the provision of integrated care.

In addition we wish to build on our existing research strengths and further focus our research portfolio on to the clinical areas that affect our population of patients. This includes expanding the research that we perform into the promotion of health and wellbeing for our patients and the staff that work with us.

Nurses and Midwives within the Trust are committed to providing excellent nursing and midwifery care and are ideally placed to contribute to and conduct high quality research. However, nationally and locally, it is recognised that the total number of nurses and midwives involved in research needs to be increased and that a greater proportion of nurses and midwives capable of working at the highest level of research practice needs to be developed. Therefore the Nursing and Midwifery Research Strategy Group will aim to:

Build capacity and capability through developing skills and confidence in leading, participating, evaluating and disseminating high quality nursing and midwifery research for the benefit of patient care and service provision.

Identify areas which the Trust can be known for its quality nursing and midwifery research.

Build effective links and collaborations with external partners.

Develop infrastructures to enhance and sustain nursing and midwifery research capacity and capability.

Advise and influence Trust policy and practice in its goal to establish an appropriate environment for fostering and sustaining research programmes of the highest quality.

3. Our Mission

To create a research environment in which patients and clinical staff work together to identify research questions that will result in improved health and wellbeing for the population that we serve. To achieve this we will develop a research portfolio that investigates integrated care, promotion of health and wellbeing and illnesses that affect our local population. We wish to provide the scientific evidence that supports the delivery of our clinical services, whose aim is to help local people live longer, healthier lives.

4. Our Vision (How we deliver our mission)

Central to the delivery of our research goals is the participation of our patient population in research studies. We will work with the communities that we serve within the Boroughs of Islington, Haringey and further afield and also with our public, private and voluntary sector partners to promote our research goals. These communities represent a vibrant complex and multi-ethnic population whose health needs will be reflected in our research studies.

In addition, we will develop a research culture within Whittington Health where research is high on the agenda. The research community within Whittington Health includes nurses, midwives, pharmacists, allied health professionals and doctors who are committed and trained in research methodology. The Trust has demonstrated its commitment to research through the support of the executive and non-executive directors, which has been reflected in financial support. Whittington Health must also build on and expand the research community within which it works. This includes partnerships with UCL partners academic health sciences network, National Institute for Health Research (NIHR) Biomedical Research Centre at University College London Hospitals NHS Foundation Trust, University College London (UCL), Middlesex University, the North Thames Clinical Research Network and the Collaboration for Leadership in Applied Health Research and Care (CLAHRC).

5. Strategic Goals

5.1 We aim to open 20% more studies per year over the next two years and to recruit up to 20% more patients into NIHR adopted portfolio studies. In addition to this we aim to open two commercial studies per annum.

Year	Patients recruited into NIHR Portfolio Studies	Number of NIHR Portfolio studies
2010/11	1087	
2011/12	815	
2012/13	564	
2013/14	289	
2014/15*	588	20

* One NIHR commercial study was opened in this year.

5.2 We shall increase public involvement in R&D, by working with our expert clinical groups and voluntary sector partners.

5.3 The R&D office will aim to increase income from research by 20% per annum.

5.4 We aim to improve communication of research successes within Whittington Health. To achieve this a number of separate initiatives will be instigated and monitored:

- Grand rounds: We aim to have one R&D grand round (weekly, lunchtime, educational meeting) per year, where multidisciplinary discussion and review of research that is relevant to patient care can occur.

- Trust matters: The R&D Department will provide monthly updates for circulation in the Trust newsletter.

- Integrated Clinical Service Unit (ICSU) meetings: The R&D director will attend at least one meeting per year of each of the Trust ICSU boards to promote research and development.

- Inter and Intranet pages: The Research and Development intranet and publicly visible web pages will be updated on a six monthly basis.

5.5 We wish to develop excellence in Research Governance. At present the R&D team comprises a research facilitator (Band 6 1.0 WTE) and the Director for Research and Innovation (0.2 WTE), supported by Noclor who provide additional research governance support (http://www.noclor.nhs.uk/).

- Achieve national performance metrics for granting research permissions (for studies that have not been through the North Thames Clinical Research Network (CRN) harmonisation process)
- The R&D office will arrange regular ‘good clinical practice’ (GCP) training to ensure that all research active members of the Trust have up-to-date training.
- Auditing of research studies will be performed as per the Trust’s standard operating procedure.

5.6 We aim to strengthen our links with local and national academic partners. Whittington Health plays an important role within UCLPartners (UCLP). We will strengthen our links and improve the visibility of Whittington Health through research collaborations and participation in the North Thames Clinical Research Network (CRN).

6. Principles:

- The research goals of the Trust will mirror and reflect the clinical goals as outlined in the clinical strategy
- Patients, their carers and staff must be involved in the on-going development of our research strategy and the overseeing of research governance within the Trust.
- The Trust is committed to highest standards of research governance.
- Whittington Health is committed to working with key stakeholders to develop the research portfolio within the Trust.
- The research strategy will use SMART goals to assess progress

7. Focusing Research:

Our research portfolio will help us to provide the scientific underpinning for the Trust's clinical strategy. Research questions that could support the clinical strategy (http://www.whittington.nhs.uk/default.asp?c=20804) include

- What is the best way to deliver health promotion to our patient population?
- Does multidisciplinary team working improve the health and wellbeing of our population and is it cost effective?
- How can technology support patient care?
- Does the embedding of quality metrics across patient pathways improve health outcomes?
- Which self-management programmes improve health outcomes for patients with long term conditions?
- What is the range and combination of methodologies appropriate for research in an integrated care organisation?
- Which educational interventions work for improving integrated care teaching?
- What is the efficacy of evidence based interventions when applied to the Whittington Health population?

If we consider the populations that our clinical strategy is focused on, there are specific research questions that could help to inform the new models of clinical care:

7.1 Older people: Research within this area of clinical need will study self-management strategies and the benefits of ambulatory care. In addition we will study the treatment modalities which provide a rapid response and the intermediate care for our older population. This research will also focus on the delivery of integrated care by general practitioners, geriatricians, locality based services, medicines management review and rehabilitation services.

7.2 Long Term Conditions: Within our existing research portfolio we have thriving and successful research groups investigating heart failure, COPD, diabetes and haematological disorders. We will expand this research portfolio and investigate the delivery of health promotion and the assessment of care metrics throughout the care pathway for patients with long term conditions.

7.3 Planned Medical Care: Our research portfolio will focus on the assessment of enhanced recovery and the delivery of care through One Stop and Virtual Clinics. We will investigate the management of patients along the 'obesity pathway' including prevention and optimal surgical interventions for patients with obesity. In addition we will further develop our studies into joint replacement and the care of patients with cancer.

7.4 Unplanned Care: Our research efforts will focus on the study of health promotion and innovative models of care for both pre-hospital and emergency patients.

7.5 Women, children and families: We will focus our studies on interventions that promote the public health agendas of enabling children to speak at age two and to be ready to learn at age five when they attend school. This includes studies of how to deliver the optimal pre-conception care including psychological support, antenatal,

intrapartum and postnatal care. In addition we wish to study the role of the family nurse practitioner, health visiting, perinatal mental health and speech and language therapy interventions. The study of the delivery of hospital at home for children and the delivery of integrated paediatric mental health strategies is important, to underpin our clinical strategy; as is the treatment of children with complex long term conditions. Our research will map onto the national agenda to improve outcomes for children ie long term conditions, actually sick child and early years development.

8. Conclusion:

We are committed to deliver a premier, research active Research Trust which studies the clinical needs of our patients and focuses our research on the understanding of the benefits and challenges of an integrated care organisation. We wish to become the leader in the field of the study of integrated care and also to focus our research efforts on studies that benefit our unique patient population and build on our existing research strengths. We are mindful that recruitment into the National Institute for Health Research (NIHR) research portfolio studies is a measure of a research active organisation. We will therefore monitor in real time and recruit patients into these studies. The R&D department will assist the integrated Clinical Service Units within the trust by collating the on-going research within each unit and so encouraging the embedding of research within the daily business of the trust's operational structure. A measure of the success of this strategy will be our ability to attract and retain clinicians of high quality who are research active and maintain a research portfolio during their employment with Whittington Health.

Whittington Health Trust Public Board

7 October 2015

Title:	Finance Update		
Agenda item:	**15/124**	**Paper**	**7**
Summary of recommendations:	The Board are requested to discuss the implications of the revised financial target in the attached papers.		
Fit with WH strategy:	Delivering efficient, affordable and effective services. Meeting statutory duties.		
Reference to related / other documents:	Previous monthly finance reports to the Trust Board. Operational Plan papers (Trust Board: March, April and May 2014). Board Assurance Framework (Section 3).		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	All risks captured on the BAF and/or Corporate Risk Register		
Date paper completed:	7th October 2015		

Author name and title:	**Steve Bloomer, Chief Finance Officer**	**Director name and title:**	**Steve Bloomer, chief Finance Officer**

Date paper seen by EC	**6 Oct**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Finance Update for Month 5

1.0 Introduction

1.1 This paper sets out the current financial position as at the end of month 5 and summarises the revised plan submitted to the NTDA on 11th September 2015.

2.0 Month 5 Financial Position

2.1 At the end of August, the Trust posted a year to date deficit of £6.48m which is £768k behind its planned position.

2.2 For the year to date the Trust is on target with income target and overspent against its expenditure budgets by £861k. In August however, the Trust was £895k behind its income plan, and met its budgeted expenditure.

2.3 The detail is included in Appendix A

3.0 The 15/16 Stretch Target Plan

3.1 The Trust was asked to revise its initial plan for a £19.5m deficit by £4.5m to a stretch target of a deficit of £15m on July 3rd.

3.2 We responded on 20th August to set-out how this could be achieved and what support may be required centrally to help us achieve the position. This was discussed by the Board on September 2nd.

3.3 A formal submission was made on 11th September with a revised plan. This plan will be used to monitor our financial position going forward. The changes were made to the Income and Expenditure however the capital and funding elements of the revised plan document were locked to change which will create differences to our position particularly in cash flow and the NTDA are aware of this.

3.4 The key changes to the plan are:

- Non-recurring improvements to facilities and estate costs following commercial negotiation £1.4m;
- Re-phase the restructuring enabling costs reducing the in-year spend by £2m;
- Review capital investment decisions to reduce revenue consequences; and
- Maximise income and contribution through additional clinical income and other income including the estate.

3.5 The risks to delivery of the stretch target are:

- Failure to deliver our current ambitious 5.5% CIP, income stretch target and improved budgetary control;
- The Trust and commissioners are unable to approve a winter resilience funding that delivers the capacity required;
- Failure to approve the maternity business case which if stopped there will be a £1m revenue consequence which cannot be absorbed in to the revised stretch target. This is as a result of currently capitalised project work e.g.

fees and planning which would have no on-going value once the schemes ceases; and

- Failure to attract additional activity outside of the block contract.

3.6 In order to achieve the target the Trust may require support from the NTDA in the following areas:

- Approval of the Maternity Business Case.
- Support at mediation with local CCGs on the contractual issues particularly winter resilience funding. The Trust cannot absorb the cost of £1.7m which is unfunded in the stretch target. Capacity would need to close and local access targets missed. An alternative would be to reduce or remove access targets for this period.
- To help avoid the potential double charge on financing if PDC is used at January's ITFF as this could be in excess of £0.5m

3.7 The revised plan financial statements are shown in Appendix B

Appendix B: Revised Plan Financial Statements

Statement of Comprehensive Income

2015/16

	Full Year (£000s)
Total Income	**290,162**
Non-Pay	73,625
Pay	211,823
Contingency	5,187
Total Operating Expenditure	**290,635**
EBITDA	**-473**
Depreciation	8,162
Dividends Payable	4,750
Interest Payable	3,232
Interest Receivable	-11
Net Surplus / (Deficit) - before IFRIC 12 adjustments	**-16,606**
Add back impairments and adjust for IFRS & dona	1,586
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**-15,020**

Statement of Financial Position

	Plan 31 March 201 £000
Property, plant and equipment	206,620
Intangible assets	2,891
Trade and other receivables	5,675
Total Non Current Assets	**215,186**
Inventories	1,356
Trade and other receivables	21,844
Cash and cash equivalents	1,619
Total Current Assets	**24,819**
Total Assets	**240,005**
Trade and other payables	39,169
Borrowings	255
Provisions	723
Total Current Liabilities	**40,147**
Net Current Assets (Liabilities)	**(15,328)**
Total Assets less Current Liabilities	**199,858**
Borrowings	43,993
Provisions	1,697
Total Non Current Liabilities	**45,690**
Total Assets Employed	**154,168**
Public dividend capital	86,277
Retained earnings	(10,118)
Revaluation reserve	78,009
Total Taxpayers' Equity	**154,168**
Capital cost absorption rate	**3.5%**

Statement of Cash Flows

	Full Year 2015/16 £000
Operating Surplus / (Deficit)	(8,635)
Depreciation and Amortisation	8,162
Impairments and Reversals	1,500
Interest Paid	(3,565)
Dividend (Paid)/Refunded	(4,750)
(Increase)/Decrease in Inventories	71
(Increase)/Decrease in Trade and Other Receivables	(2,403)
Increase/(Decrease) in Trade and Other Payables	(10,538)
Provisions Utilised	(1,012)
Increase/(Decrease) in Movement in non Cash Provisions	100
Net Cash Inflow /(Outflow) from Operating Activities	**(21,070)**
Interest Received	11
(Payments) for Property, Plant and Equipment	(9,626)
(Payments) for Intangible Assets	(432)
Cash Flows from Investing Activities	**(10,047)**
New Public Dividend Capital received in year: PDC Revenue	23,900
Loans received from DH - New Capital Investment Loans	9,295
Loans repaid to DH - Capital Investment Loans Repayment of Principal (Existing)	(164)
Capital element of payments relating to PFI, LIFT Schemes and finance leases	(1,642)
Cash Flows from Financing Activities	**31,389**
Beginning of the Period	1,347
Ending Cash	**1,619**

Finance overview | Position Summary

Indicator	Measure	In-Month Plan	In-Month Actual	YTD Plan	YTD Actual
Monitor COSR	score	-	-	1	1
EBITDA margin	%	3.44%	-0.12%	0.86%	0.13%
EBITDA achieved	£000s	822	-27	1,033	157
Adjusted net deficit margin	%	-2.20%	-5.90%	-4.77%	-5.41%
Adjusted net deficit achieved	£000s	-525	-1,357	-5,704	-6,474
Liquidity ratio	days	-	-	-20	-20
Capital Servicing Capacity	times	-	-	0.00	-0.30
Income	£000s	23,884	22,989	119,602	119,587
Pay	£000s	17,672	17,577	88,982	88,513
Non-Pay	£000s	6,182	5,439	31,222	30,917
CIPs	£000s	1,680	1,374	4,761	3,090

The Trust remains within Monitor's COSR high risk category and this is not expected to change in 2015/16.

Year to date EBITDA performance declined in August due to lower than expected clinical activity.

Finance overview | Statement of comprehensive income

At the end of August, the Trust posted a year to date deficit of £6.48m which is £768k behind its planned position.

For the year to date the Trust is on target with income target and overspent against its expenditure budgets by £861k. In August however, the Trust was £895k behind its income plan, and met its budgeted expenditure.

The decline in income in August is a result of lower clinical activity, largely due to the holiday period, in areas such as elective and outpatient activity across all ICSUs as the plan is phased in equal twelfths.

The pay overspend in August was £618k in August (£1.0m ytd). This is mainly driven by non-delivery of staffing CIPs, overspends in the medical ICSUs and an in-month reporting classification change which moved interim contractor spend from the non-pay pay line.

Non pay was underspent in August due to reporting classification described above, the capitalisation of IT project spend which had been previously recognised as revenue and a reduction of direct spend due to lower activity.

CIP delivery in August increased to £1.4m (82% of target), of which £675k was non recurrent. The year to date delivery is £3m which represents 65% of planned savings.

The Trust ended the month with a cash balance of £6.7m, which was £3.5m more than it had planned. This was due to the successful collection of large outstanding debts as well as ongoing negotiations with some creditors which are not yet concluded.

The Trust is £748k underspent against its YTD capital plan following a review of planned spend to support the financial position.

The trust is actively working towards improving the financial position and a number of activities are already showing results. These include reduction in agency spend in August, reduction in capital spend and focus on collecting outstanding debts.

The Trust is forecasting to meet its planned 15/16 stretch target of £15.0m deficit, but there are a several risks to this outcome, including:

- underachievement of CIP delivery (£4m)
- poor management of expenditure budgets (£3m)
- failure to achieve the income targets set within its major CCG contract (£8m)
- write-off of capital setup costs should the maternity business case not materialise (£1m)
- overspend against resilience funding as the Trust does not have an agreed plan for winter with the CCGs (£1m)
- poor record keeping of temporary staff bookings on Health Roster and subsequent control (£1m)

Finance overview | Statement of comprehensive income

in £000	In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	YTD Budget (£000s)	Ytd Actuals (£000s)	Variance (£000s)	Full Year (£000s)
Total Income	**23,884**	**22,989**	**-895**	**119,602**	**119,587**	**-15**	**290,162**
Non-Pay	6,103	5,439	664	31,059	30,917	142	73,625
Pay	16,959	17,577	-618	87,511	88,513	-1,003	211,823
Contingency	0	0	0	0	0	0	5,187
Total Operating Expenditure	**23,062**	**23,016**	**46**	**118,569**	**119,430**	**-861**	**290,635**
EBITDA	**822**	**-27**	**-849**	**1,033**	**157**	**-876**	**-473**
Depreciation	690	672	19	3,452	3,364	89	8,162
Dividends Payable	410	410	0	2,051	2,051	0	4,750
Interest Payable	255	256	-1	1,275	1,259	16	3,232
Interest Receivable	1	3	2	4	12	8	-11
Net Surplus / (Deficit) - before IFRIC 12 adjustment	**-533**	**-1,362**	**-830**	**-5,741**	**-6,505**	**-764**	**-16,606**
Add back impairments and adjust for IFRS & Donate	7	6	-1	35	31	-4	1,586
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**-525**	**-1,357**	**-831**	**-5,706**	**-6,481**	**-768**	**-15,020**

Finance overview | Statement of financial position

The statement of financial position shows the assets, liabilities and equity held by the Trust and is used to assess the financial soundness of an entity in terms of liquidity risk, financial risk, credit risk and business risk.

Trade Receivables: The Trust has made significant progress in collecting a number of long outstanding debts and more efforts are being put in place to collect more. These include £1m estates invoices from Haringey CCG and £400k from NHS England. In total, about £4m was collected from various NHS organisations.

Cash: The cash position was better than planned due to the collection of large outstanding debts, and because the Trust has yet to settle outstanding supplier queries. These are presently being negotiated.

Payables: Significant progress has also been made in this area and the number of outstanding invoices being negotiated is reducing as a result.

Borrowings: Borrowings are greater than planned as the working capital support is yet to be paid off by PDC funding which would be assessed on application. Equally, PDC is lower than planned for the same reason. The Trust is engaging with the TDA on the application process.

				Year to Date	Year to Date
	As at 1 April 2015 £000	Plan 31 March 2016 £000	Plan YTD 30 June 2015 £000	As at 30 June 2015 £000	Variance YTD 30 June 2015 £000
Property, plant and equipment	194,918	213,298	193,401	192,856	(545)
Intangible assets	4,481	4,903	4,446	5,072	626
Trade and other receivables	757	533	755	778	23
Total Non Current Assets	**200,156**	**218,734**	**198,602**	**198,706**	**104**
Inventories	1,427	1,356	1,456	1,504	48
Trade and other receivables	19,223	16,942	15,298	18,422	3,124
Cash and cash equivalents	1,347	1,619	5,245	7,131	1,886
Total Current Assets	**21,997**	**19,917**	**21,999**	**27,057**	**5,058**
Total Assets	**222,153**	**238,651**	**220,601**	**225,763**	**5,162**
Trade and other payables	38,847	33,913	34,909	37,800	2,891
Borrowings	1,809	255	1,259	1,136	(123)
Provisions	1,380	557	1,020	1,319	299
Total Current Liabilities	**42,036**	**34,725**	**37,188**	**40,255**	**3,067**
Net Current Assets (Liabilities)	**(20,039)**	**(14,808)**	**(15,189)**	**(13,198)**	**1,991**
Total Assets less Current Liabilities	**220,195**	**233,542**	**183,413**	**185,508**	**(1,887)**
Borrowings	34,950	43,993	34,952	45,483	10,531
Provisions	1,952	1,697	1,952	1,946	(6)
Total Non Current Liabilities	**36,902**	**45,690**	**36,904**	**47,429**	**10,525**
Total Assets Employed	**143,215**	**158,236**	**146,509**	**138,079**	**(8,430)**
Public dividend capital	62,377	87,287	70,877	62,377	(8,500)
Retained earnings	6,187	(14,901)	980	1,152	172
Revaluation reserve	74,651	85,850	74,652	74,550	(102)
Total Taxpayers' Equity	**143,215**	**158,236**	**146,509**	**138,079**	**(8,430)**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**	**3.5%**	

Finance overview | Cost improvement programmes

In month 5 savings amounting to 1,374k (82%) were delivered against the TDA operating plan of £1.68m. Year to date, £3,090k (65%) has been achieved.

£675k of the savings delivered in August are classified non-recurrent and therefore may not reduce underlying expenditure in 2016/17. The YTD non recurrent savings amount to £1,171k.

Against savings schemes allocated to ICSUs, August's performance was 90% and YTD it was 81%. Trust wide schemes delivered 74% in August and 37% YTD.

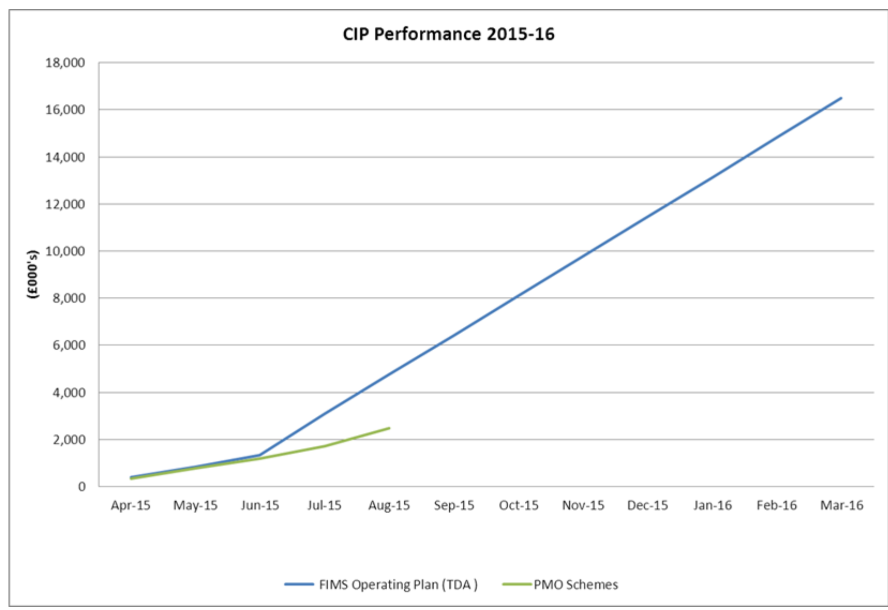
August's improved performance was due to the delivery of mitigating schemes within ICSUs, reduced clinical agency expenditure and the postponement of £338k of restructuring costs to 2016/17.

These mitigations included:

- the generation of income from overseas patients
- holding vacancies in Surgery, Women's and Outpatients ICSUs
- temporary staffing reductions
- student midwives reductions
- reduced expenditure on orthopaedic prosthetics (due to lower activity volume)

Trust-wide schemes of £4.8m must be delivered in the last 6 months to ensure the Trust meets its planned deficit. These schemes include procurement efficiencies, reductions in temporary staffing and postponing expenditure on a non-recurrent basis.

	Annual	August				YTD			
Integrated Clinical Service Units	Plan £'000	Plan £'000	Act £'000	% achieved	Var £'000	Plan £'000	Act £'000	% achieved	Var £'000
Medicine Frailty and Network Services	1,730	177	141	80%	(36)	476	354	74%	(122)
Surgical Services	1,610	133	134	101%	2	545	474	87%	(71)
Emergency and Urgent Care	489	43	27	62%	(16)	189	157	83%	(32)
Womens Services	1,050	68	89	132%	21	313	217	69%	(96)
Childrens Services	1,399	118	110	93%	(8)	499	448	90%	(51)
Clinical Support Services	635	56	38	68%	(18)	262	148	57%	(113)
OP and Long Term Conditions Services	672	33	39	119%	6	115	80	70%	(34)
Corporate	2,401	208	171	82%	(36)	663	587	89%	(76)
Peformance against PMO schemes	**9,985**	**835**	**750**	**90%**	**(85)**	**3,061**	**2,466**	**81%**	**(595)**
Trust-wide Schemes	6,515	845	624	74%	(221)	1,700	624	37%	(1,076)
Performance against Operating Plan	**16,500**	**1,680**	**1,374**	**82%**	**(306)**	**4,761**	**3,090**	**65%**	**(1,671)**



Operations Directorate
Direct Line: 020 7288 5440
www.whittington.nhs.uk

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

Whittington Health Trust Board
7th October 2015

Title:	Trust Board Report October 2015 (August 15 data)		
Agenda item:	**15/125**	**Paper**	**08**
Action requested:	For discussion on progress		
Executive Summary:	The following is the Performance and Quality report for October 2015; a number of highlights and areas for focus are identified. <u>Summary of report:</u> **QUALITY** • **Inpatient deaths** remain as expected. • **Completion of valid NHS number**: Remain just below the standard of 95% for SUS submission. The A&E data set has fallen below target this month. • **SHMI:** Whittington Hospital mortality rate remains lower than expected for the Trust. • **HSMR:** Continuing to perform better than expected for the national standard. **PATIENT SAFETY** • **Harm Free Care:** Below target due to pressure ulcers, action plan in place with community teams. • **Falls (audit):** Remain at 0.30% • **VTE assessment:** Achieved standard. • **Medication errors causing severe/moderate/low harm:** No severe or moderate medication errors. • **Never events:** None. • **CAS alerts:** None outstanding. • **Serious incidents**: No new incidents reported in August 2015. **PATIENT EXPERIENCE** • **Family and Friend Test:** Achieves standard. • **Mixed sex Accommodation:** No breaches. • **Patient admission to adult facilities for under 16 years of age:** No breaches. • **Complaints:** Below target for 2 of the 5 ICSU's. Focus on internal processes. • **Patient admission to adult ward for under 16 years of age:** None.		

	INFECTION PREVENTION • **MRSA:** No new cases • **E.coli:** No new cases • **MSSA:** No new cases • **C Difficile:** No new cases • **Ward Cleanliness:** Overall cleanliness rate at 97.8%. **ACCESS** **Acute** • **First to follow-up:** Whittington Health performance better than the National Standard. • **Theatre Utilisation:** Focus is now on smaller services provided by other organisations. • **Hospital cancellations:** Achieved for first appointment and just below target for follow up appointment. • **Patient DNA:** Remain underachieving around 12% for first appointment and 14% for follow up appointment. • **Hospital cancelled operations:** 5 patients cancelled in August due to theatre unexpectedly needed for emergency operations, no escort available and a list which overrun. • **Cancelled ops not rebooked within 28 days:** none • **RTT 52 week wait:** No patients waited over 52 weeks for first appointment. • **RTT 18 weeks Admitted Target 90%:** Overall achieved • **RTT 18 weeks non-Admitted Target 95%:** Overall achieved • **RTT 18 weeks incomplete Target 92%:** Overall Achieved. • **Diagnostic waits Target 99%:** Under performance standard due to endoscopy back log and a small number of patient choice within Audiology • **Cancer:** Overall achieved **Community** • **Service cancellations:** Slightly up in August 2015. Due to recording issues within RiO of cancellations of clinics. • **Patient DNA:** Achieved standard. • **Face to Face contacts:** Monitoring in place and reviewed for contract performance. • **Appointments with no outcome:** Above target and monitored within services. • **MSK wait 6 week (non-consultant led):** Below target due to reduced capacity, action plan in place • **MSK 18 weeks:** Achieved. • **IAPT:** Achieved. • **GUM:** below target due to reduced capacity, action plan in place.

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EMERGENCY AND URGENT CARE

- **Emergency Department standard:** Achieved

MATERNITY

- **Woman seen by HCP or midwife within 12 weeks and 6 days:** below target action plan in place
- **New birth visits within 14 days:** Improved performance, action being monitored.
- **Elective C-section rate:** elective above standard. Emergency achieved standard,
- **Breastfeeding initiated:** Under achieving this month. From September 2015 volunteers from the NCT are supporting the department to encourage breastfeeding. An area of relaxation has been created on Celliers wards including sofas and chairs for woman to breast feed as a cohort.
- **Smoking at delivery:** Achieved.

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<tr><td colspan="2">Summary of recommendations:</td><td colspan="6">That the board notes the performance.</td></tr>
<tr><td colspan="2">Fit with WH strategy:</td><td colspan="6">All five strategic aims</td></tr>
<tr><td colspan="2">Reference to related / other documents:</td><td colspan="6">N/A</td></tr>
<tr><td colspan="2">Reference to areas of risk and corporate risks on the Board Assurance Framework:</td><td colspan="6">N/A</td></tr>
<tr><td colspan="2">Date paper completed:</td><td colspan="6">21st September 2015</td></tr>
<tr><td colspan="2">Author name and title:</td><td colspan="2">Hester de Graag, Performance Lead</td><td colspan="2">Director name and title:</td><td colspan="2">Lee Martin, Chief Operating Officer</td></tr>
<tr><td>Date paper seen by EC</td><td>22/09</td><td>Equality Impact Assessment complete?</td><td>n/a</td><td>Quality Impact Assessment complete?</td><td>n/a</td><td>Financial Impact Assessment complete?</td><td>n/a</td></tr>
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Oct 2015 Trust Board Report (August data)

Whittington Health NHS

Quality	Threshold	Jun-15	Jul-15	Aug-15
Number of Inpatient Deaths	-	25	25	29
NHS number completion in SUS (OP & IP)	99%	98.60%	98.59%	arrears
NHS number completion in A&E data set	95%	95.33%	94.80%	arrears

Quality (Mortality index)	Threshold	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14
SHMI	-	0.54	0.60	0.66

Quality (Mortality index)	Threshold	Mar-15	Apr-15	May-15
Hospital Standardised Mortality Ratio (HSMR)	<100	87.9	73.2	67.2
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	144.3	62.2	116.9
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	69.3	77.3	44.4

Patient Safety	Threshold	Jun-15	Jul-15	Aug-15
Harm Free Care	95%	93.6%	94.7%	94.0%
VTE Risk assessment	95%	95.1%	95.3%	arrears
Medication Errors actually causing Serious/Severe Harm	0	0	0	0
Never Events	0	0	0	0
CAS Alerts (Central Alerting System)	-	0	0	-
Proportion of reported patient safety incidents that are harmful	-	36.1%	40.7%	37.0%
Serious Incident reports	-	0	6	0

Access Standards

Referral to Treatment (in arrears)	Threshold	May-15	Jun-15	Jul-15
Diagnostic Waits	99%	95.8%	93.5%	94.1%
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0

Efficiency and productivity - Community	Threshold	Jun-15	Jul-15	Aug-15
Service Cancellations - Community	8%	7.5%	8.0%	8.8%
DNA Rates - Community	10%	6.9%	7.5%	7.3%
Community Face to Face Contacts	-	63,131	62,279	48,937
Community Appts with no outcome	1.0%	3.5%	2.0%	4.8%

Community Access Standards	Threshold	Jun-15	Jul-15	Aug-15
MSK Waiting Times - Non-Consultant led patients seen in month (% < 6 weeks)	95%	81.4%	80.9%	70.5%
MSK Waits - Consultant led patients seen in month (% < 18 weeks)	95%	100.0%	100.0%	arrears
IAPT - patients moving to recovery	50%	51.9%	50.9%	arrears
IAPT Waiting Times - patients waiting for treatment (% < 6 weeks)	-	93.6%	94.5%	arrears
GUM - Appointment within 2 days	100%	96.0%	96.0%	95.6%

Efficiency and Productivity

Efficiency and productivity - acute	Threshold	Jun-15	Jul-15	Aug-15
First:Follow-up ratio - acute	2.31	1.35	1.42	1.37
Theatre Utilisation	92%	81.6%	81.8%	81.5%
Hospital Cancellations - acute - First Appointments	8%	5.6%	5.6%	5.0%
Hospital Cancellations - acute - Follow-up Appointments	8%	7.6%	8.2%	7.0%
DNA rates - acute - First appointments	10%	12.8%	12.4%	13.0%
DNA rates - acute - Follow-up appts	10%	12.7%	14.5%	14.5%
Hospital Cancelled Operations	0	6	3	5
Cancelled ops not rebooked < 28 days	0	0	0	0
Urgent procedures cancelled	0	1	0	0

Meeting threshold / Failed threshold

Patient Experience	Threshold	Jun-15	Jul-15	Aug-15
Patient Satisfaction - Inpatient FFT (% recommendation)	-	93%	95%	95%
Patient Satisfaction - ED FFT (% recommendation)	-	89%	91%	94%
Patient Satisfaction - Maternity FFT (% recommendation)	-	81%	93%	93%
Mixed Sex Accommodation breaches	0	0	0	0
Complaints	-	25	33	23
Complaints responded to within 25 working day	80%	70%	69%	arrears
Patient admission to adult facilities for under 16 years of age	-	0	0	0

Emergency and Urgent Care	Threshold	Jun-15	Jul-15	Aug-15
Emergency Department waits (4 hrs wait)	95%	94.4%	95.1%	95.8%
ED Indicator - median wait for treatment (minutes)	<60	95	81	61
30 day Emergency readmissions	-	235	246	arrears
12 hour trolley waits in A&E	0	0	0	0
Ambulatory Care (% diverted)	>5%	3.4%	3.0%	3.2%
Ambulance Handover (within 30 minutes)	0	3	2	arrears
Ambulance Handover (within 60 minutes)	0	0	0	arrears

Infection Prevention	Threshold	Jun-15	Jul-15	Aug-15
Hospital acquired MRSA infection	0	0	0	0
Hospital acquired *C difficile* Infections	17 (15/16)	1	1	0
Hospital acquired *E. coli* Infections	-	0	0	0
Hospital acquired MSSA Infections	-	1	1	0
Ward Cleanliness	-	98%	98%	arrears

Cancer Access Standards (in arrears)	Threshold	May-15	Jun-15	Jul-15
Cancer - 14 days to first seen	93%	92.4%	93.9%	93.2%
Cancer - 14 days to first seen - breast symptomatic	93%	94.7%	93.3%	93.6%
Cancer - 31 days to first treatment	96%	100.0%	100.0%	100.0%
Cancer - 31 days to subsequent treatment - surgery	94%	100.0%	100.0%	-
Cancer - 31 days to subsequent treatment - drugs	98%	100.0%	100.0%	100.0%
Cancer - 62 days from referral to treatment	85%	93.8%	90.0%	89.3%

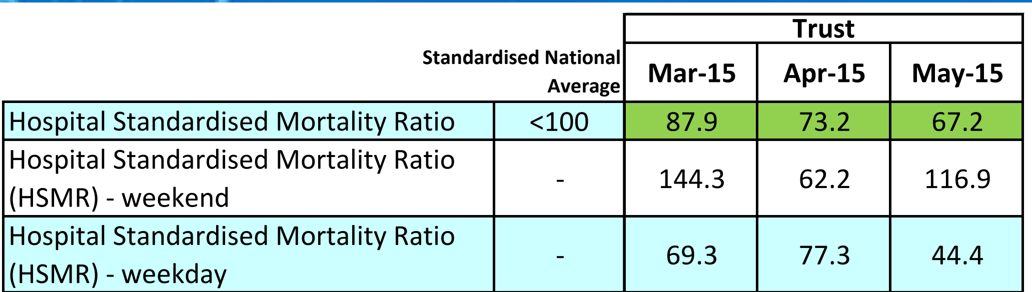
Access Standards (RTT)

Referral to Treatment (in arrears)	Threshold	Jun-15	Jul-15	Aug-15
Referral to Treatment 18 weeks - Admitted	90%	90.9%	90.8%	90.6%
Referral to Treatment 18 weeks - Non-admitted	95%	95.0%	95.0%	95.1%
Referral to Treatment 18 weeks - Incomplete	92%	92.6%	92.2%	92.2%

Maternity	Threshold	Jun-15	Jul-15	Aug-15
Women seen by HCP or midwife within 12 weeks and 6 days	90%	80.7%	82.8%	82.7%
New Birth Visits - Haringey	95%	87.8%	93.3%	arrears
New Birth Visits - Islington	95%	89.7%	92.7%	arrears
Elective Caesarean Section rate	14.8%	10.2%	17.8%	9.1%
Breastfeeding initiated	90%	87.6%	91.0%	88.7%
Smoking at Delivery	<6%	3.8%	3.7%	4.7%

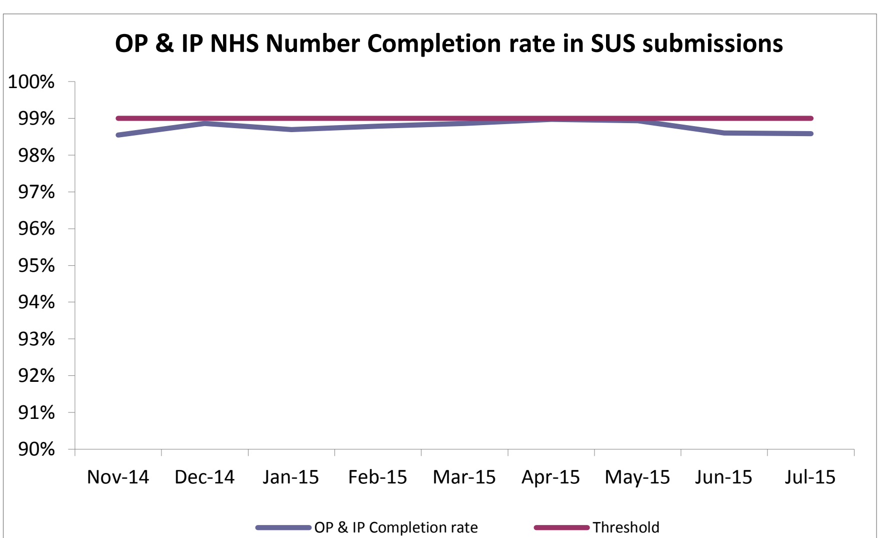
Meeting threshold
Failed threshold

	Threshold	Trust Actual		
		Jun-15	Jul-15	Aug-15
Number of Inpatient Deaths	-	25	25	29
Completion of a valid NHS number in SUS (OP & IP)	99%	98.60%	98.59%	arrears
Completion of a valid NHS number in A&E data sets	95%	95.33%	94.80%	arrears



	Standardised National Average	Trust		
		Mar-15	Apr-15	May-15
Hospital Standardised Mortality Ratio	<100	87.9	73.2	67.2
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	144.3	62.2	116.9
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	69.3	77.3	44.4

		Lower Limit	Upper Limit	RKE SHMI Indicator
SHMI	Jan 2014 - Dec 2014	0.89	1.12	0.66
	Oct 2013 - Sep 2014	0.88	1.13	0.60
	Jul 2013 - Jun 2014	0.88	1.14	0.54
	Apr 2013 - Mar 2014	0.87	1.15	0.54
	Jan 2013 - Dec 2013	0.88	1.14	0.62
	Oct 2012 - Sep 2013	0.89	1.13	0.63
	Jul 2012 - Jun 2013	0.88	1.13	0.63



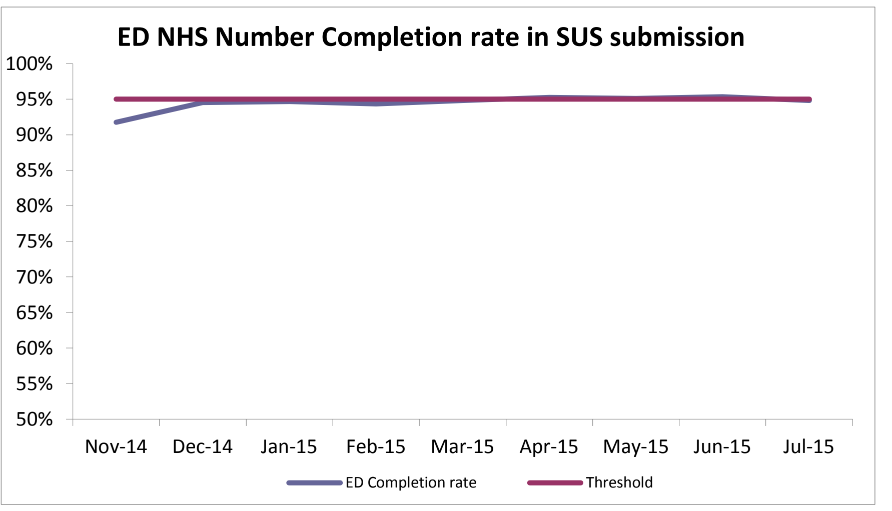
Commentary

Inpatient Deaths
Issue: The number of in-patient death remain at expected level.
Action: A cross check to ensure that the new ICSU quality meetings include audits
Timescale: end of September 2015, reporting back in October 2015

Completion of valid NHS number
Issue: NHS number completion in SUS dataset remains just under target. The A&E dataset has fallen under target after 2 months of compliance.
Action: Reports to support the process are in place.
Timescale: Expected to be compliant in October 2015 due to training schedule and new staff commencing.

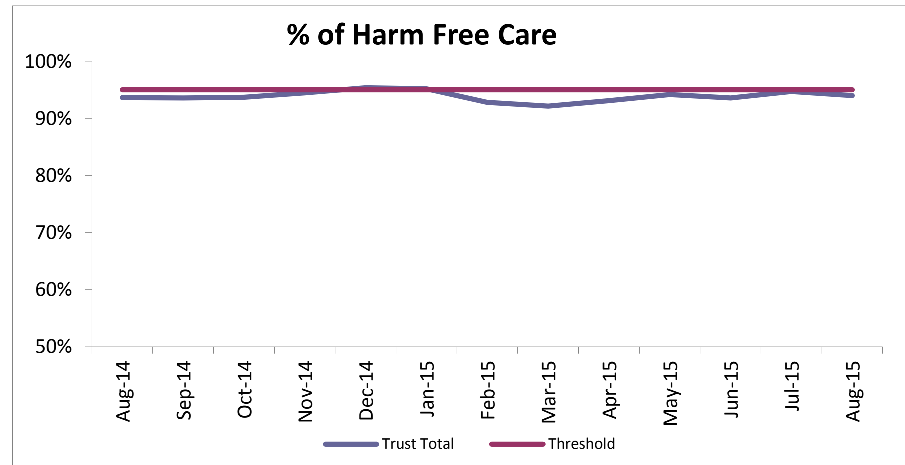
SHMI
WH score remains below the lower limit which therefore, indicates that the mortality rate remains lower than expected at our Trust.

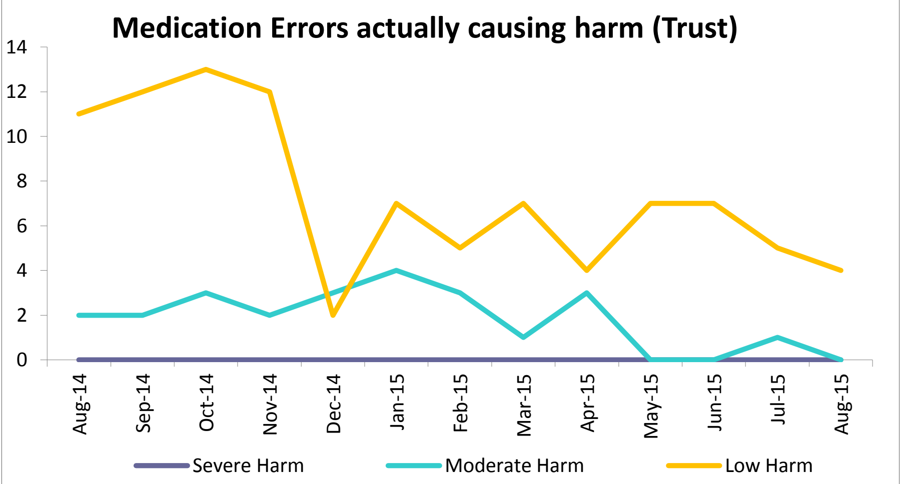
HSMR
In May 2014 Whittington Health reported 22 in-patient deaths. The overall standardised mortality rate has remained expected level for Whittington Hospital, which means the balance between elective admissions and non-elective admissions are back at expected levels. While for the weekend figure the relative risk figure (as reported) is above 100, more information is needed to determine whether this is significant. Looking at the upper and lower controls for Sat & Sun (not shown in the actual dashboard), we can see that the number of deaths during May is not significantly different to expectations to point to it being either higher or lower. Keep in mind that there were 9 observed deaths for patients admitted on the weekend, and the 'Dr Foster expected number' was 9.39

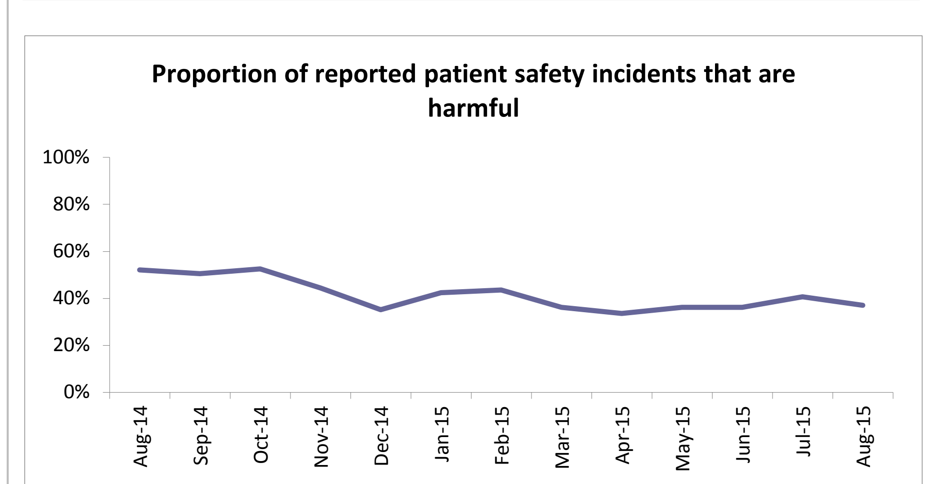


Data extracted on 09/09/2015

	Threshold	Trust Actual May-15	Jun-15	Jul-15	Aug-15	Trend
Harm Free Care	95%	94.2%	93.6%	94.7%	94.0%	
Pressure Ulcers (prevalence)	-	5.12%	5.72%	4.21%	5.68%	
Falls (audit)	-	0.30%	0.29%	0.40%	0.00%	
VTE Risk assessment	95%	95.0%	95.1%	95.3%	arrears	
Medication Errors actually causing **Serious** or **Severe** Harm	0	0	0	0	0	
Medication Errors actually causing **Moderate** Harm	-	0	0	1	0	
Medication Errors actually causing **Low** Harm	-	7	7	5	4	
Never Events	0	0	0	0	0	
Open CAS Alerts (Central Alerting System)	-	2	0	0	0	
Proportion of reported patient safety incidents that are harmful	-	36.1%	36.1%	40.7%	37.0%	
Serious Incidents (Trust Total)	-	7	0	6	0	







Commentary

Harm Free Care
Issue: Scoring below target.
Action: Continued HFC monitoring and learning from reviews is in place. Thematic action plan in community in place to monitor the number of pressure ulcers acquired by patients under the care of Whittington Health. This plan is monitored by an overarching pressure ulcer prevention group spanning Haringey and Islington and include partner organisations.
Timescale: On-going

Pressure Ulcer prevalence
Issue: Prevalence remains around 5%.
Action: The improvements put in place in the community have identifying the need for education to families around pressure ulcers. This is ongoing work.
Timescale: On-going

Medication Errors actually causing harm
Issue: No Serious medication error have been reported in 2015 . The 4 low medication errors include , 2 patients in the community who missed their dose of medication in the Learning Disabilities Respite Unit and one patient in the hospital, due to weekend prescribing handover. One dose of medication was given to a baby to quickly due to confusion over timing on the paper drug chart, which was used when the electronic system was down.
Action: All errors are investigated and appropriate action taken.
Timescale: completed

CAS Alerts
Issue: No CAS alerts open
Action: None
Timescale: completed

	Threshold	Trust Actual May-15	Jun-15	Jul-15	Aug-15	Trend
Patient Satisfaction - Inpatient FFT (% recommendation) **	-	92%	93%	95%	95%	
Patient Satisfaction - Emergency Department FFT (% recommendation) **	-	91%	89%	91%	94%	
Patient Satisfaction - Maternity FFT (% recommendation) **	-	89%	81%	93%	93%	
Mixed Sex Accommodation (not Clinically justified)	0	0	0	0	0	
Complaints (**incl Corporate**)	-	34	25	33	23	
Complaints responded to within 25 working day	80%	67.74%	70.00%	68.97%	Arrears	
Patient admission to adult facilities for under 16 years of age	-	0	0	0	0	

Number of complaints received

Trust Total

* Complaints responded to within 25 working days are previous months figures (reported in arrears)
** FFT calculation has now changed nationally from Nov 2014

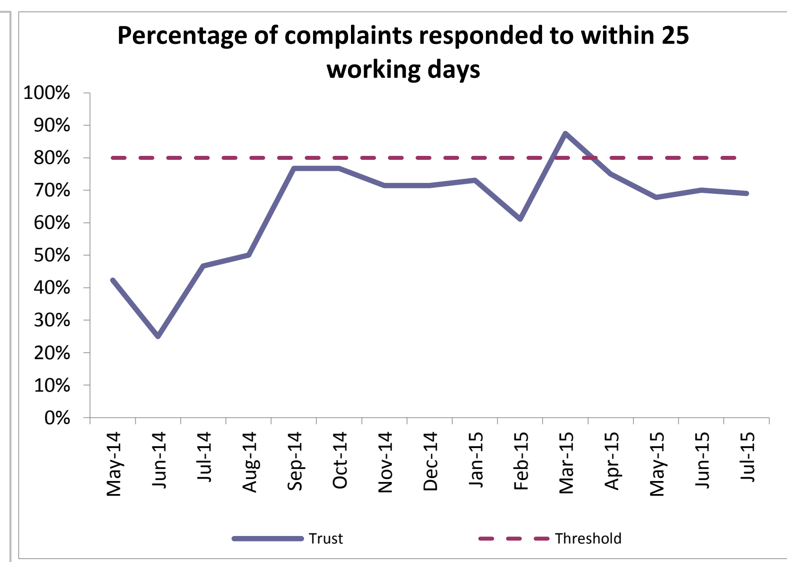
Commentary

Patient Satisfaction - a local standard of 90% has been agreed, all areas meet this standard
Action: continue to raise awareness and role out into community and OPD
Timescale: On-going

Mixed Sex Accommodation
A policy and processes embedded in the services and no breaches for 11 consecutive months.

Complaints
The complaints compliance figure includes all services within the Trust. The operational services score as follows:
Action: All complaints are monitored weekly within the ICSU's.
New training being developed by corporate team for Complaints handling and ongoing recruitment for the vacant post supporting the ICSU's.
Timescale: Stepped improvement expected over the next months.

ICSU	Number of complainst	Compliance score
SCD/OP	6	75%
CS	3	67%
EUC	10	90%
MFNS	2	100%
WFS	1	0%



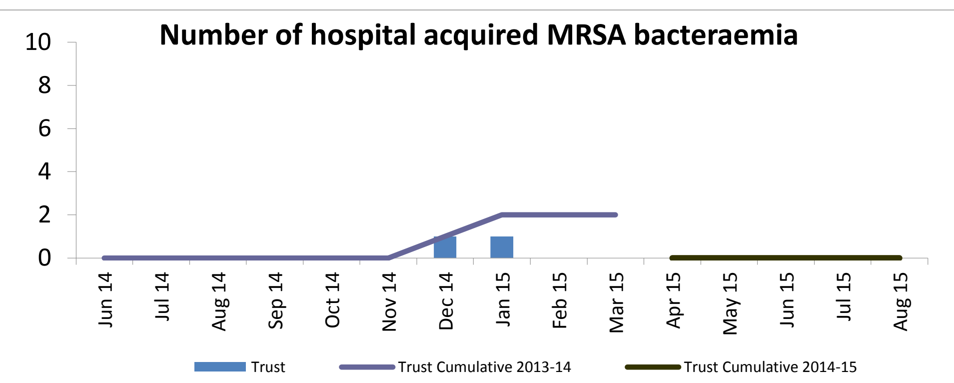
	Threshold	Trust Actual May-15	Jun-15	Jul-15	Aug-15	Trend
MRSA	0	0	0	0	0	
E. coli Infections*	-	0	0	0	0	
MSSA Infections	-	0	1	1	0	

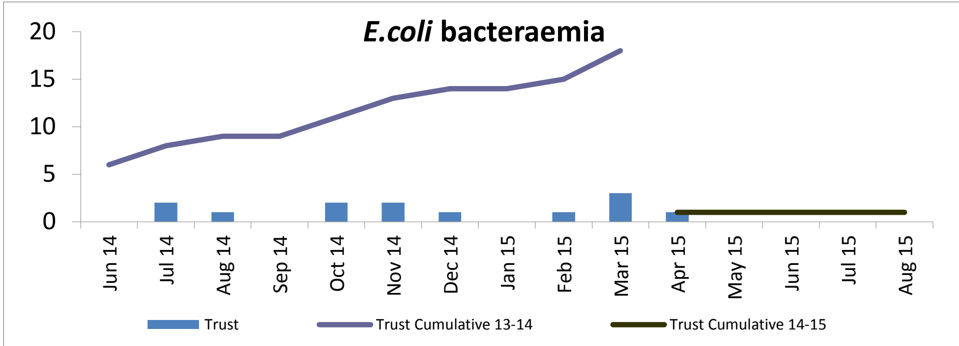
	Threshold	May 15	Jun 15	Jul 15	Aug 15	2015/16 Trust YTD
C difficile Infections	17 (Year)	1	1	1	0	4

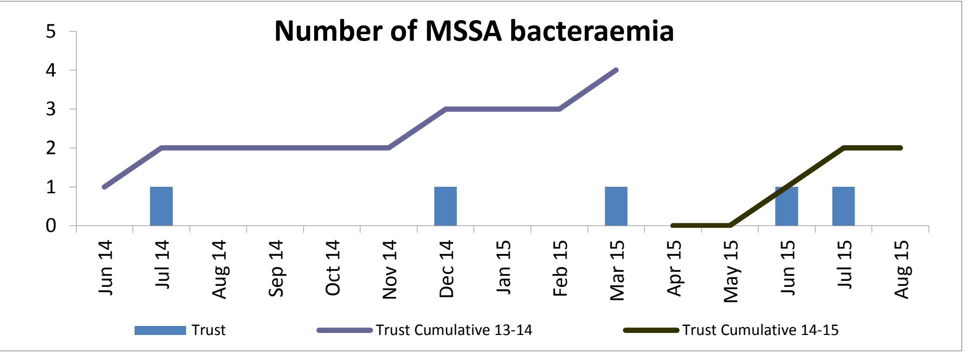
* E. coli infections are not specified by ward or division

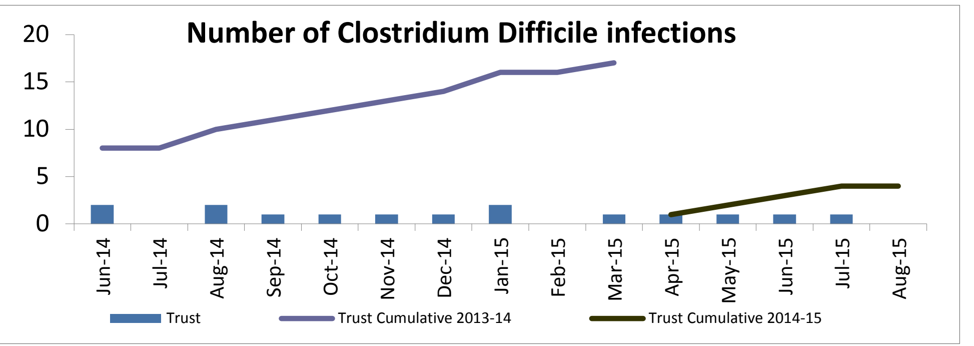
Ward Cleanliness

Audit period	Trust 01/09/14 to 02/10/14	06/11/14 to 16/12/14	19/01/15 to 17/02/15	14/04/15 to 01/05/15	15/06/15 to 10/07/15	Trend
Trust %	98.2%	98.1%	98.3%	98.4%	97.9%	









Commentary

MRSA / MSSA
No new infections

E.coli Infection
No new infections

C Difficile
No new infections

Ward Cleanliness
Issue: Ward Cleanliness figures for Aug/Sept to be released in next board report.
Action: A detailed action plan is in place for infection prevention, cleaning standards and audits are being carried out by Estates and matrons to ensure standards are maintained.
Timescale: In place.

	Trust						Trend
	Threshold	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Trend
First:Follow-up ratio - acute	2.31	1.43	1.35	1.35	1.42	1.37	
Theatre Utilisation	92%	80.4%	83.9%	81.6%	81.8%	81.5%	
Hospital Cancellations - acute - First Appointments	<8%	5.2%	5.9%	5.6%	5.6%	5.0%	
Hospital Cancellations - acute - Follow-up Appointments	<8%	7.7%	8.3%	7.6%	8.2%	7.0%	
DNA rates - acute - First appointments	10%	12.0%	11.8%	12.8%	12.4%	13.0%	
DNA rates - acute - Follow-up appointments	10%	14.0%	14.1%	12.7%	14.5%	14.5%	
Hospital Cancelled Operations	0	6	4	6	3	5	
Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	
Urgent Procedures cancelled	0	0	1	1	0	0	
Urgent Procedures cancelled (of these how many cancelled 2nd time)	0	0	0	0	0	0	

Commentary

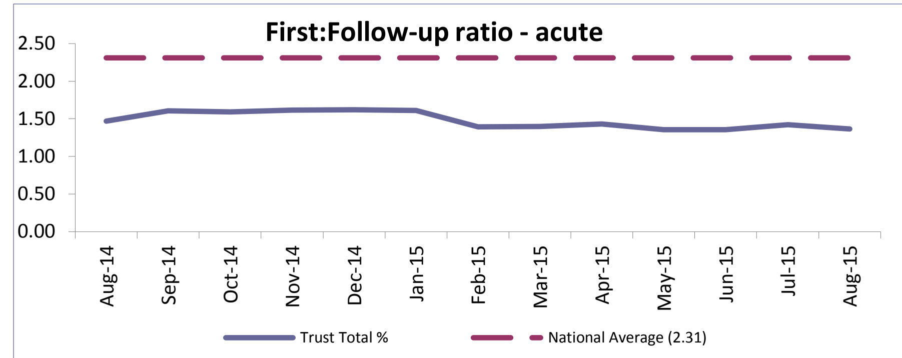
First: Follow-up ratio - acute
The new to follow up rate is continuing to be is under the national benchmark of 2.31.

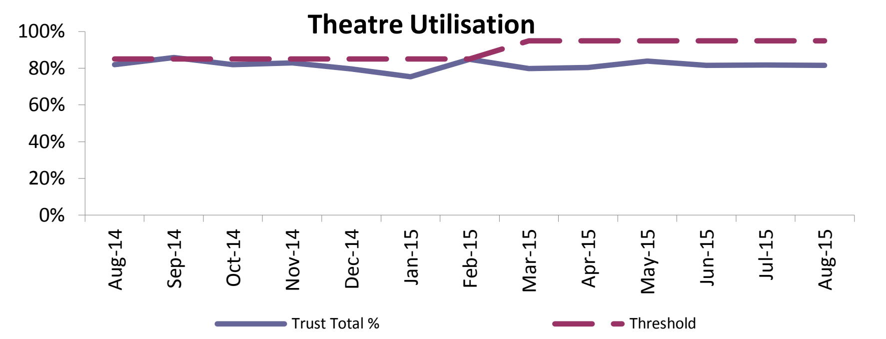
Theatre Utilisation
Issue : Under target, remaining at around 80%. Specialities with low utilisation tend to be the low volume specialities.
Action : Clinical staff are provided with a report showing activity and usage each week. This is being monitored at the surgical board. The services with low utilisation are meeting with the clinical director and director of operations to agree schedules and patient booking.
Timescale : Immediate

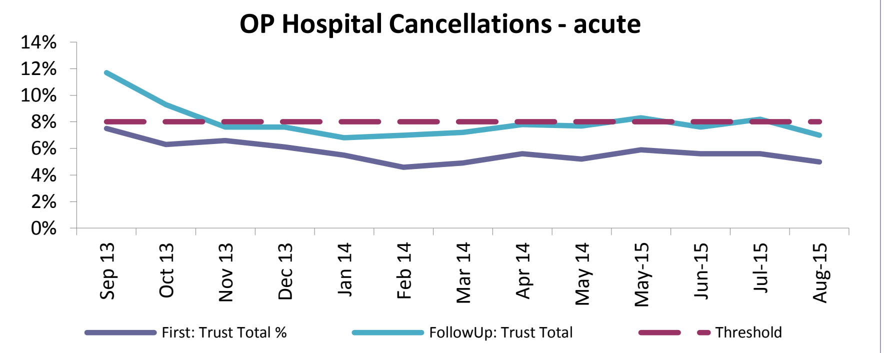
Hospital Cancellations - acute
Achieved.

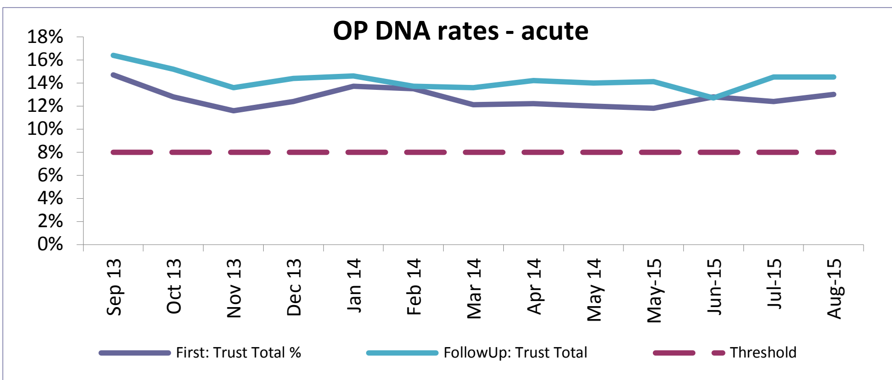
Did not attend
Issue: Overall 'Did not attend ' remained around the same.
Action: All services are now using protocols including given choice at point of booking, reminder call 7 days and 1 days before appointment. EPR is in the process of being re-aligned with the service Netcall, with text reminding being rolled out to all out pateint clinics.
Timescale: Improvement to be seen in November dashboard.

Hospital Cancelled Operations
Issue: There were 5 operation cancelled by the hospital in August due to non-clinical reasons, all patients were clinically categorised as routine. All have been rebooked within the 28 day period. Orthopaedics cancelled 3 operations as the theatre was needed for emergency cases, Urology cancelled one operations as there was no escort and Gynaecology cancelled one operation as the list overran.
Action: The Surgical board monitor cancellations.





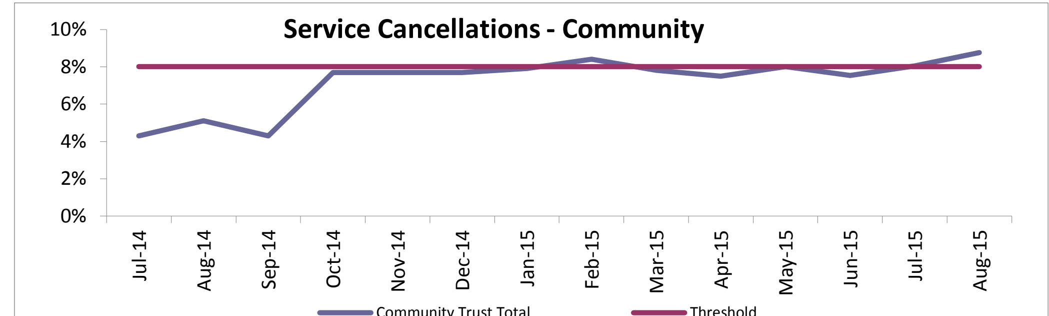




Whittington Health NHS

	Threshold	May-15	Jun-15	Jul-15	Aug-15	Trend
	Trust					
Service Cancellations - Community	8%	8.0%	7.5%	8.0%	8.8%	
DNA Rates - Community	10%	7.9%	6.9%	7.5%	7.3%	
Community Face to Face Contacts	-	57,504	63,131	62,279	48,937	
Community Appointment with no outcome	1.0%	3.5%	3.5%	2.0%	4.8%	

N.B. From October 2014, figures include Community Dental activity (SCD)



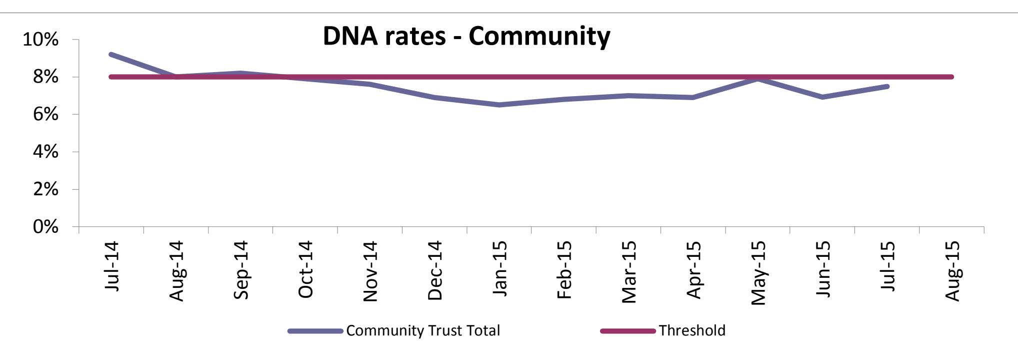
Commentary

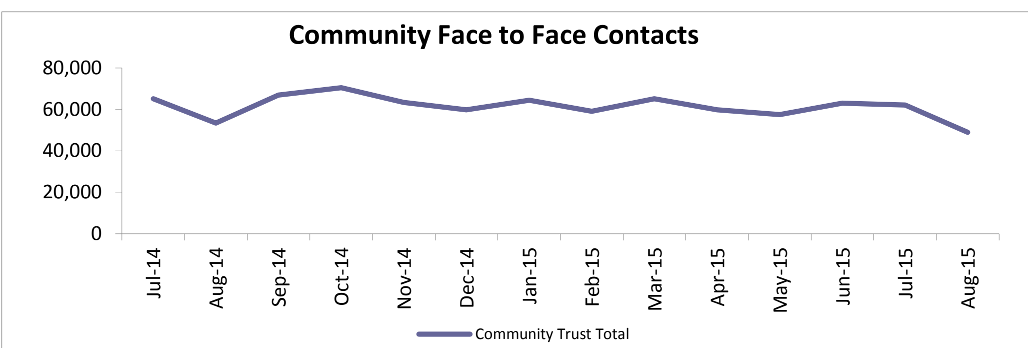
Service Cancellations - Community
Issue: Some regular clinics are cancelled during the holiday period and this shows as service cancellations in the system, however no patients are booked in these clinics sessions, therefore this does not affect patient appointments.
Action: The new version Open Rio will be able to reflect service cancellation more accurately.
Timescale: Role out in October 2015.

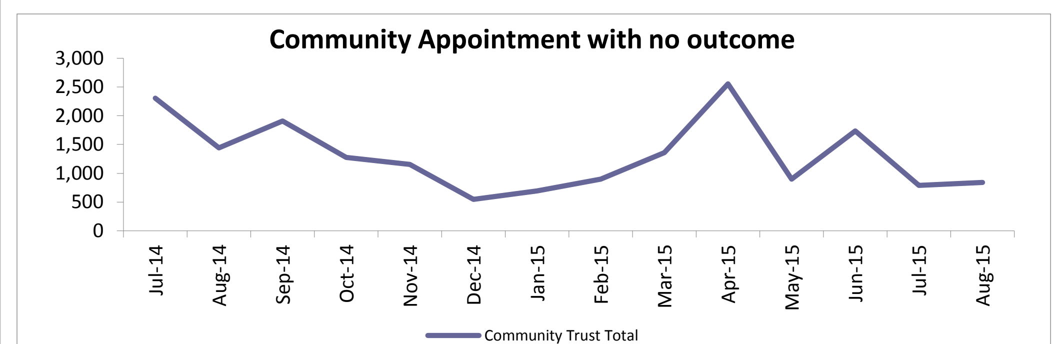
DNA Rates - Community
Community clinics - Achieved.

Community Face to Face Contacts
All services are monitored against activity targets.

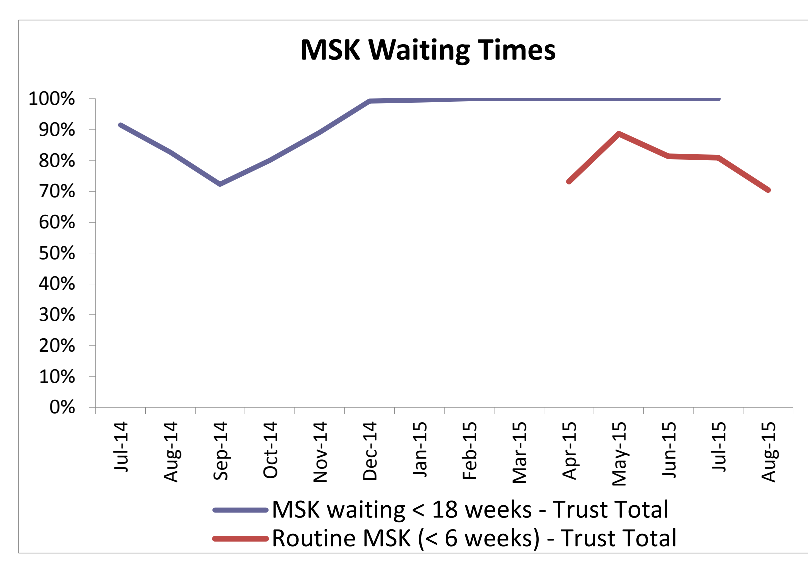
Community Appointment with no outcome
A process is in place to complete all outcomes of appointment within the same timelines as the acute services. This process has been standardised and training provided. The high volume service District Nursing have most un-outcomed appointments, a improvement plan is lead by the Operational director of Emergency and Urgent Care ICSU.
Action: Monitor to ensure the new processes are embedded.
Timescale: Immediately.







	Threshold	Trust Actual Jun-15	Jul-15	Aug-15	Trust YTD
District Nursing Wait Time - 2hrs assess (Islington)	-	35.0%	71.4%	66.7%	61.2%
District Nursing Wait Time - 2hrs assess (Haringey)	-	66.7%	91.9%	88.9%	84.4%
District Nursing Wait Time - 48hrs for visit (Islington)	-	97.7%	97.1%	96.3%	92.9%
District Nursing Wait Time - 48hrs for visit (Haringey)	-	97.4%	98.4%	91.5%	97.8%
MSK Waiting Times - Routine MSK (<6 weeks)	95%	81.4%	80.9%	70.5%	76.1%
MSK Waiting Times - Consultant led (<18 weeks)	95%	100.0%	100.0%	arrears	100.0%
IAPT - patients moving to recovery	50%	51.9%	50.9%	arrears	51.1%
GUM - Appointment within 2 days	100%	97.4%	96.0%	95.6%	97.8%
Haringey Adults Community Rehabilitation (<6 weeks)	-	68.0%	76.0%	78.0%	76.0%
Haringey Adults Podiatry (Foot Health) (<6 weeks)	-	87.0%	69.0%	73.0%	72.2%
Islington Community Rehabilitation (<6 weeks)	-	78.0%	89.0%	86.0%	83.0%
Islington Intermediate Care (<6 weeks)	-	61.0%	63.0%	70.0%	60.1%
Islington Podiatry (Foot Health) (<6 weeks)	-	88.0%	70.0%	69.0%	69.0%



Commentary

District Nursing
The two response times for District Nursing are now reported electronically.
Issue: Referrals for DN are processed in the Central Referral Team and Urgency is taken from the referral form, filled in by the referrer. The referral is then triaged by the Specialist Nurse and the Urgency might be changed, hence the lower scores than previously reported. The true Urgent referrals are mostly phoned through to the Service and are always seen within 2 hours. Examples of urgent referrals are 'End of Life Care change' and 'Blocked catheter'.
Action: Process from Central Referral Team to triaging to be reviewed.
Timescale: End of September 2015, to report back in October dashboard.

MSK
MSK Waiting Times - Routine MSK (<6 weeks):
Issue: Increased demand and also a reduction in capacity due to AL. The main issue is the capacity for specialist community clinics.
Action: A action plan has been completed following review of the total waiting list and realignment of capacity.
Timescale: immediate
MSK Waiting Times - Consultant led (<18 weeks): Standard is being met.

IAPT
Achieved. IAPT waiting times have been added to the front sheet and are preforming above the threshold of seeing 75% of all patients within 6 weeks. The threshold of 18 weeks is 95%. Next month this target will be added to this part of the dashboard.

GUM
Issue: Staffing reduction due to vacancies .
Action: Alignment of demand and clinic capacity has taken place .

	Threshold	Trust (arrears) Jun-15	Jul-15	Aug-15	Trend
Referral to Treatment 18 weeks - Admitted	90%	91.2%	90.9%	90.8%	
Referral to Treatment 18 weeks - Non-admitted	95%	95.5%	95.0%	95.0%	
Referral to Treatment 18 weeks - Incomplete	92%	92.8%	92.6%	92.2%	
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	
Diagnostic Waits	99%	95.8%	93.5%	94.1%	

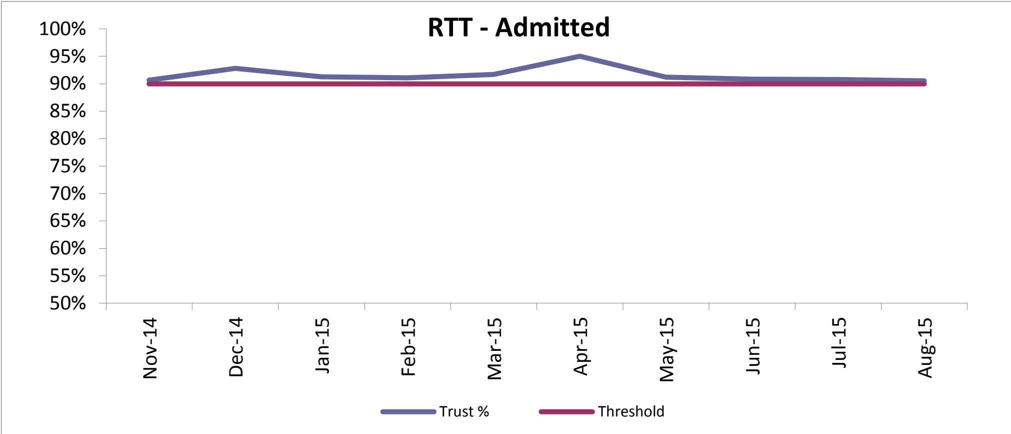
Commentary
RTT
Achieve standard

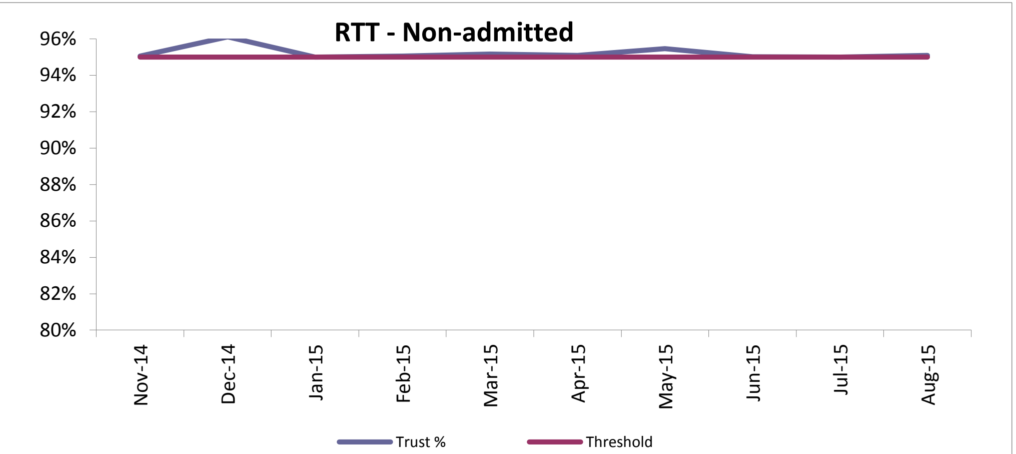
Diagnostic Waits
Issues: Endoscopy demand has exceeded capacity and a backlog has built. Audiology have a small number patients who wish to be treated outside the 6 weeks standard.
Action: Endoscopy action plan in place to increase the capacity for patient bookings, audiology have reviewed capacity and all patients booked.
Timescale: Compliance with the standard by September 2015 (October 2015 dashboard)

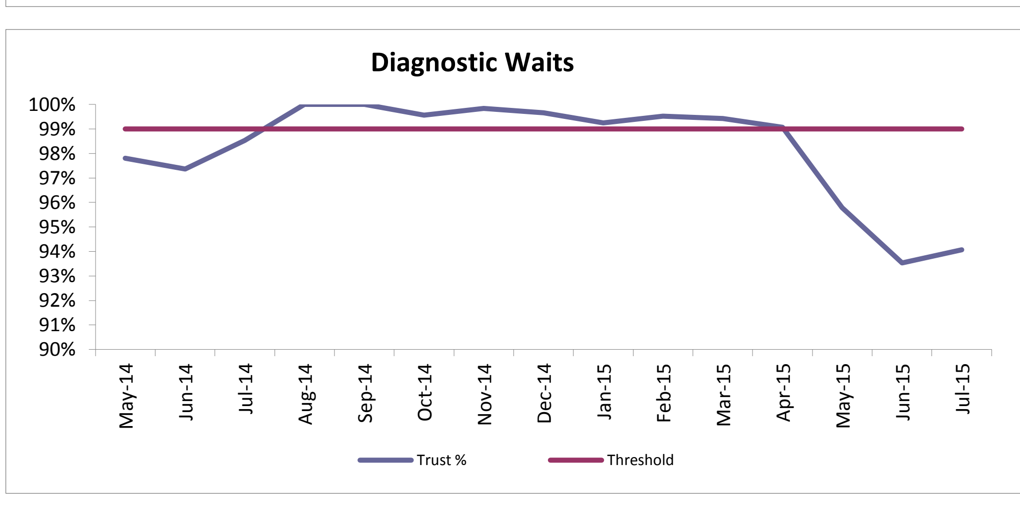
Waiting times - OPD appointment
Cardiology 7 Weeks, Dermatology 11 Weeks , Endocrine 7 Weeks, ENT 9 Weeks, Gastroenterology 8 Weeks, General Surgery 5 Weeks , Gynaecology 6 Weeks, Neurology 9 Weeks, Pain 11 Weeks , Rheumatology 4 Weeks, Thoracic Medicine 6 Weeks, Urology 3 Weeks, Vascular 11 Weeks, Ophthalmology 5 Weeks, Trauma and Orthopaedic 6 weeks.

Diagnostic waiting times (radiology) all under 6 weeks (42 days) waiting time standard

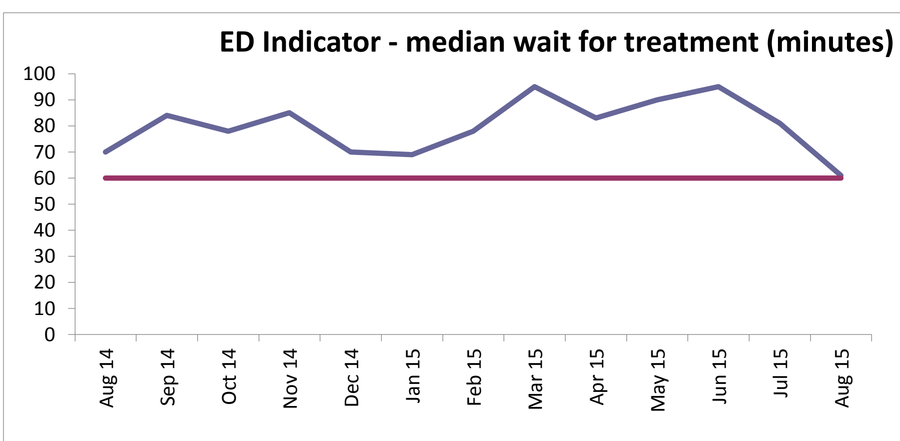
Imaging Modality wait in days: CT 28 days, MRI 29 days, Nuclear Medicine 14 days, DEXA 37 days, Fluoroscopy 22 days, Mammography 26, Ultrasound (Gynae) 7 days, Ultrasound General (Radiologist Lead) 32 days, Ultrasound Paediatrics 50 days, Ultrasound MSKs 38 days, Ultrasound Hernias 44 days, Ultrasound Obstetrics Anomaly 46 days, Ultrasound Obstetrics Growth 22 days, Ultrasound Abdomen & Gynae at Hornsey General 7 days.

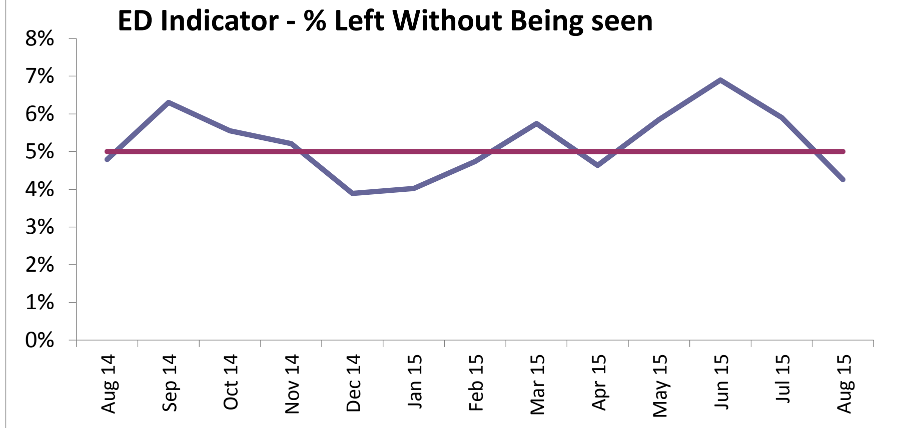






	Threshold	Trust Actual		2015/16
		Jul-15	Aug-15	Trust YTD
Emergency Department waits (4 hrs wait)	95%	95.1%	95.8%	94.7%
Emergency Department waits (4 hrs wait) Paeds only	95%	97.9%	98.4%	97.3%
Wait for assessment (minutes - 95th percentile)	<=15	13	12	14
ED Indicator - median wait for treatment (minutes)	60	81	61	82
Total Time in ED (minutes - 95th percentile)	<=240	240	240	279
ED Indicator - % Left Without Being seen	<=5%	5.9%	4.3%	5.5%
12 hour trolley waits in A&E	0	0	0	0
Ambulance handovers 30 minutes	0	2	arrears	13
Ambulance handovers exceeding 60 minutes	0	0	arrears	0



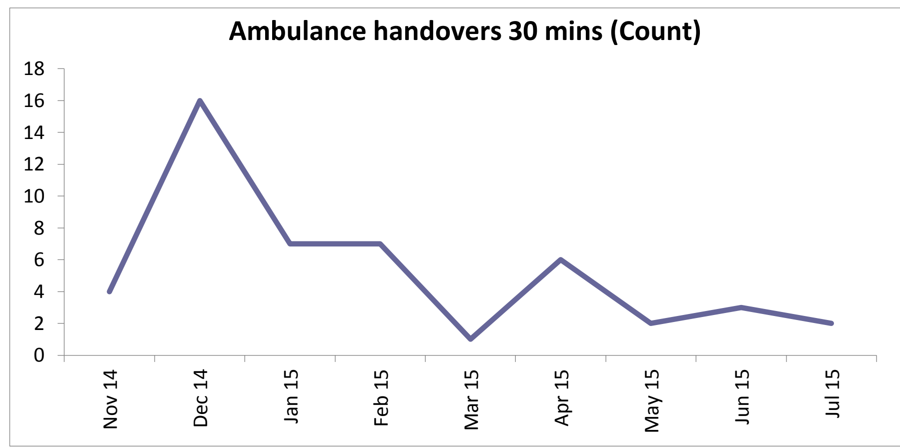


Commentary

Implementation of the action plan to improve performance against the national standard underway. August was again compliant. The medium wait for treatment has improved and is now just below the standard. The percentage of patients who left without being seen is also within target this month.

The themes for improvement are - aligning staffing to demand patterns, training for new senior staff in floor coordination and access management, demand and surge escalation plans, and alignment of ENP (European Neighbourhood Policy).

ED waits for Paediatrics remain above standard.



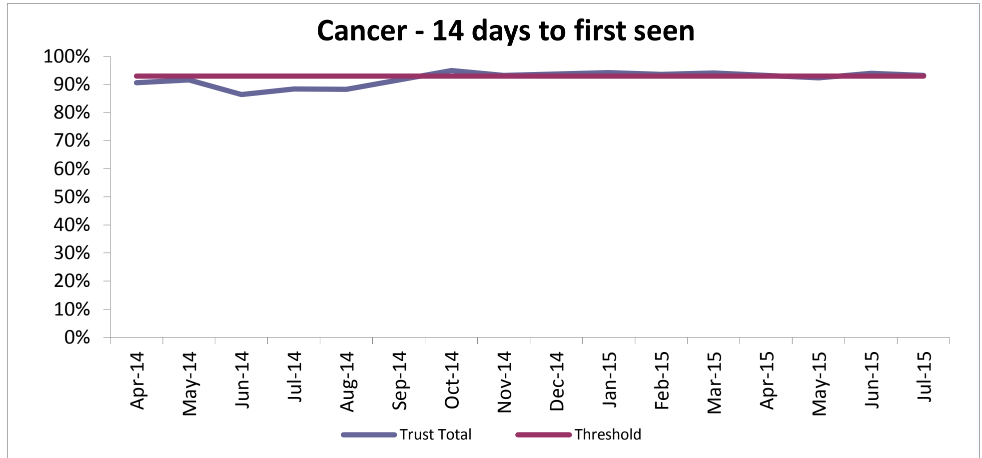
	Threshold	Jul-15 May-15	Jun-15	Jul-15	Trend	2015/16 Trust Q1	Q2	Q3	Q4	YTD
Cancer - 14 days to first seen	93%	92.4%	93.9%	93.2%		93.2%	93.2%	-	-	93.2%
Cancer - 14 days to first seen - breast symptomatic	93%	94.7%	93.3%	93.6%		93.6%	93.6%	-	-	93.6%
Cancer - 31 days to first treatment	96%	100.0%	100.0%	100.0%		100.0%	100.0%	-	-	100.0%
Cancer - 31 days to subsequent treatment - surgery	94%	100.0%	100.0%	-		100.0%	-	-	-	100.0%
Cancer - 31 days to subsequent treatment - drugs	98%	100.0%	100.0%	100.0%		100.0%	100.0%	-	-	100.0%
Cancer - 62 days from referral to treatment	85%	93.8%	90.0%	89.3%		93.2%	89.3%	-	-	92.5%
Cancer - 62 days from consultant upgrade	-	93%	83%	67%		92.9%	66.7%	-	-	90.3%

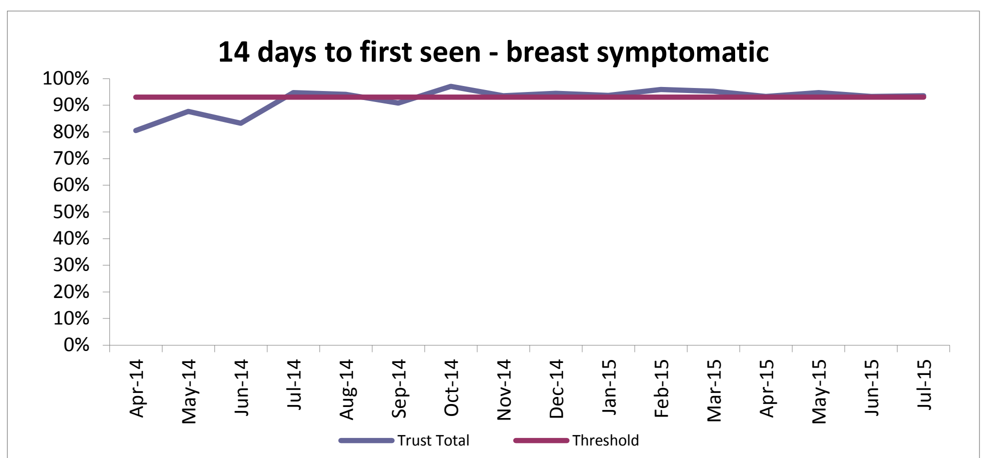
Commentary

All cancer targets were achieved this month and met for QRT 2.

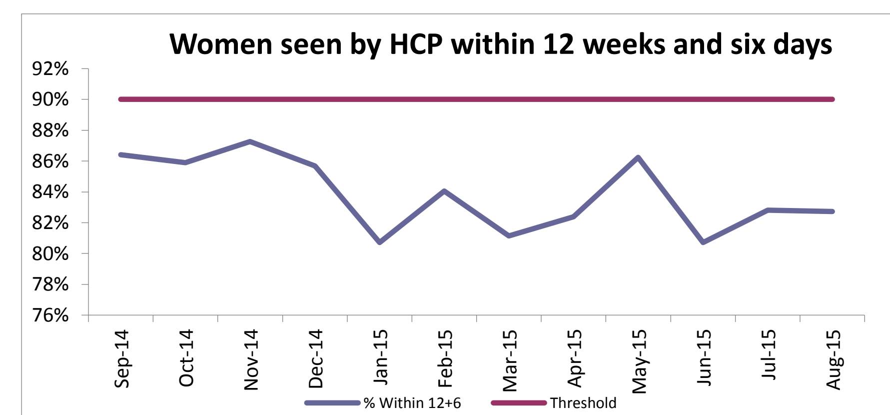
The Cancer Patients tracking list is monitored daily and discussed in the weekly PTL meeting.

The 'dash' in July 15 for 31 days to subsequent treatment - surgery indicates that there were no patients for this month.





	Threshold	Trust Actual Jun-15	Jul-15	Aug-15	2015/16 Trust YTD
Women seen by HCP or midwife within 12 weeks and 6 days	90%	80.7%	82.8%	82.7%	82.9%
New Birth Visits - Haringey	95%	87.8%	93.3%	Arrears	83.0%
New Birth Visits - Islington	95%	89.7%	92.7%	Arrears	89.4%
Elective Caesarean Section rate	14.8%	10.2%	17.8%	9.1%	12.2%
Emergency Caesarean Section rate	-	22.4%	17.8%	18.9%	18.2%
Breastfeeding initiated	90%	87.6%	91.0%	88.7%	89.90%
Smoking at Delivery	<6%	3.8%	3.7%	4.7%	4.0%



Commentary

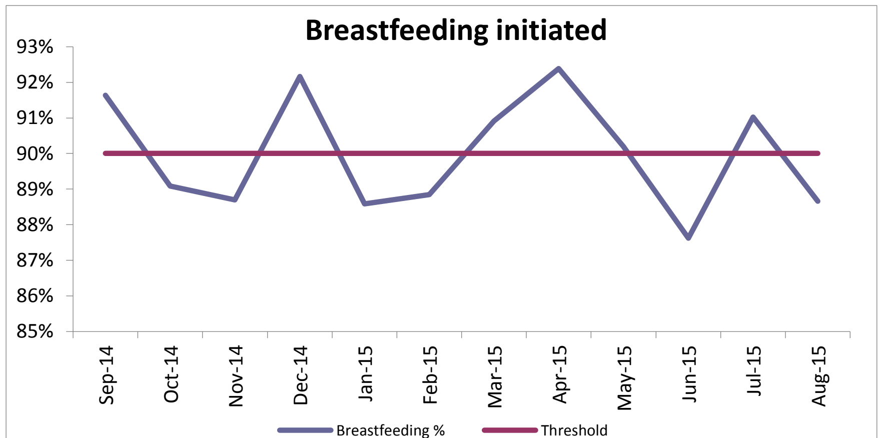
Women seen by HCP or midwife within 12 weeks and 6 days
Issue: The 12+6 target remains challenging across the sector and London.
Action: Women are now being contacted in order to confirm they are attending the scheduled appointment . The bookings team frequently experience problems with accuracy of contact details. Data transfer is no longer an issue . The majority of women within this category do receive an appointment within 12 + 6 deadline, however indicate a wish for an alternative appointment, which accounts for 10 % of our total monthly bookings .
Timescale: From September 2015 the Maternity Dashboard will record as an exception report the percentage of women offered an appointment with the time frame and compliance if all had been seen . Every effort will be made to continue to contact women and explain the rationale to be seen within that timeframe .

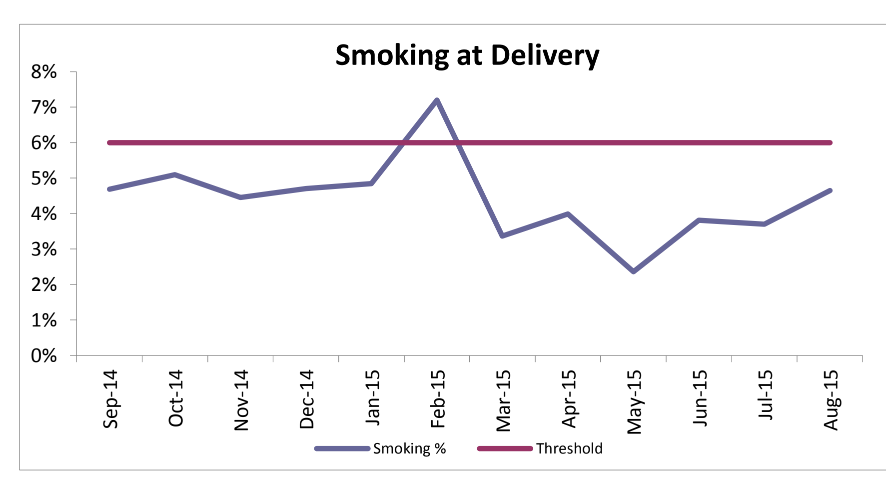
New Birth Visits
Issue: Both boroughs improved.
Action: Action plan continue to be monitored. Targeted recruitment to vulnerable teams.
Timescale: Ongoing

Caesarean Section rate
Target met

Breastfeeding
Issue: Fluctuating target, overall year to date below expected target of 90%.
Action: From September volunteers from the NCT will be visiting the Post Natal ward to offer further support and complement the work of the midwives and our Breast Feeding Midwife Specialists . A relaxation area has been created on Cellier ward away from the main traffic with sofas and chairs for women to sit and breast feed as a cohort . They will be supported by staff whilst doing so .
Timescale: Ongoing

Smoking





Whittington Health Trust Board

07 October 2015

Title:	Corporate Workforce Information – August 2015		
Agenda item:	**15/127**	**Paper**	**09**
Action requested:	For information		
Executive Summary:	This report gives details of the Trust workforce key performance indicators (KPIs) as at 31st August 2015. This report has been prepared within the limited time and resources available and will evolve over the coming months. The report covers the following workforce KPIs: 1. Vacancy rate; 2. Sickness absence rate; 3. Turnover rate: 4. Appraisal rate: 5. Statutory and mandatory training rate		
Summary of recommendations:	The Trust Board is are asked to note the content of this report and support the Workforce Directorate as we improve the quality of workforce information that can be provided. In addition staff with management responsibilities are request to give attention to the workforce key performance indicators they are responsible for within their area		
Fit with WH strategy:	Aligns fully to strategic intent.		
Reference to related / other documents:	Aligns to HR policies and procedures.		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured in risk registers and board assurance framework as relevant.		
Date paper completed:	21st September 2015		

Author name and title:	**Norma French Director of Workforce**	**Director name and title:**	**Norma French Director of Workforce**

Date paper seen by EC	**22/09**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

WHITTINGTON HEALTH NHS TRUST

Paper to:	Trust Management Group Trust Board
Paper from:	Director of Workforce
Date:	17th September 2015
Subject:	Corporate Workforce KPIs – August 2015

1.0 Introduction

This report gives details of the Trust workforce key performance indicators (KPIs) as at 31st August 2015. This report has been prepared within the limited time and resources available and will evolve over the coming months.

Workforce information is a priority objective for the directorate over the coming months. It is hoped that the analysis and granularity of the information will improve as resources and skills come into place. Over time it is anticipated that more qualitative information will be available and provided.

2.0 ICSU and Directorate Workforce Information

Since July 2015 workforce information by ICSU has been provided to the Heads of Human Resources on a monthly basis. This includes information on staff in post, sickness absence and turnover. Statutory and Mandatory and appraisal rates are also provided to the ICSUs on a monthly basis. This is important management information which managers within the ICSUs require to assist in their day-to-day management responsibilities.

3.0 Vacancy Rate

Table 1 below and Graph 1.1 of Appendix 1 give details of the vacancy rate as at 31st August 2015. The vacancy rate for the Trust rose slightly in August to 14.8% and above the Trust target of 13%. Focussed analysis has been undertaken to understand the current nurse vacancy factor, as this group of staff attribute the majority of temporary staff spend. The Directors of Nursing and Workforce have begun chairing a Nurse Recruitment and Retention Committee with the aim of ensuring a comprehensive control of staffing programme to address the vacancy rate and level of temporary staff spend. In addition, reducing the number of vacant posts and time to fill, the most effective utilisation of staff through effective rota management and control of

absence and annual leave, etc., and the reduction of the recruitment costs of agency staff per head are all high priority. The remit of the Vacancy Control Panel (VSP) has been revised and expanded with effect from 28th September to include the review of all temporary staff requests of more than one week.

TABLE 1 – Workforce KPIs

Management of the workforce	Threshold	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Trust Turnover Rate	<13%	14.1%	14.4%	14.2%	14.8%	14.4%
Total trust vacancy rate	<13%	12.5%	14.2%	13.5%	13.7%	14.4%
Sickness rates	<3%	2.8%	2.5%	2.9%	3.0%	2.9%

Table 2 shows the analysis by ICSU/Department of vacancy rates. Ideally we would wish to review the information by ICSU and staff group, however the resources to manipulate to this level were not available in the time to prepare this report. However Table 3 indicates the vacancy rate across all medical and nursing and midwifery staff (AfC band 5 and above). Over time it is anticipated that the manipulation of this information will become easier and more accessible.

TABLE 2 – Vacancy Rate by ICSU/Directorate

Directorate	Vacancy WTE	Vacancy WTE %
Children’s Services	78.49	8.60
Clinical Support Services	31.75	11.51
Corporate Services	167.36	22.79
Emergency & Urgent Care	120.97	23.36
Med, Frailty & Networked Services	15.01	2.47
Op, Prevention & Lt Conditions	72.93	22.55
Surgery	95.28	14.40
Women & Family Services	61.94	15.74
Grand Total	**643.73**	**14.4**

TABLE 3 – Vacancy Rate by Professional Group

Staff Group	WTE Vacant	Vacancy Rate
Medical and Dental	39.42	8.11%
Nursing and Midwifery	205	14.6%

4.0 Sickness Absence Rate

Table 1 above and Graph 1.2 of Appendix 1 give details of the sickness absence rate at 31st August 2015. The level for sickness rates in August remain below the Trust target at 2.9% and below the national target of 3.5%. Each ICSU receives a monthly report on long term absence, along with short term sickness trigger reports to enable appropriate case management by line managers.

When looking at the sickness absence rate at directorate level, Finance and Facilities had the highest rate in August (both at 5.4%). Within the ICSUs the highest rates were: Out Patients, Prevention and LTC (4.6%); Women's and Family Services (4.5%) and Emergency and Urgent care (4%).

The average sickness absence rate for the NHS in England was 4.4% in July 2015. North East and Central London has the lowest average at 3.61%.

5.0 Turnover

Table 1 above and Graph 1.3 of Appendix 1 give details of the turnover rate as at 31st August 2015. Turnover is the percentage of employees that leave the trust over the past year. Turnover rate in August has decreased slightly. A revised exit interview scheme was approved in September and will be launched in October and publicised with the help of colleagues in the communications team. It is intended that details of exit interviews are reported to TMG on a regular basis.

Turnover by staff group indicates that nursing and midwifery have the highest rate at 18% with AHPs at 17%. At a directorate level: Corporate, Finance and Facilities are 21% and 17% respectively. Emergency and Urgent Care had a turnover of 18% (with nursing and midwifery being the highest).

Medicine. Frailty and Network Service and Out Patients, Prevention and LTC services both had a turnover of 16%. In Medicine, AHPs had the highest turnover, in particular occupational therapists, dieticians and speech and language therapists. In Out-Patients it was nursing who had the highest turnover.

6.0 Appraisals

The overall rate decreased by 2% in July. This is disappointing given the increased focus on this indicator in recent months. Table 4 below details the monthly rate since April 2015. The implementation of action plans for the ICSUs remains a priority. Compliance rates for appraisals continue to be reviewed on a regular basis within management teams. The revised appraisal scheme, which is expected to support improvement in the rates of appraisal, was launched in early September. As with Statutory and Mandatory training, appraisal rates are a priority for the Executive Team with regular feedback to directors and ICSUs of performance in their area of responsibility.

The Head of Education and Leadership Coach are happy to be invited to attend relevant ICSU / Department meetings to support managers. A series of nine workshops have been arranged over the next two months for line managers. These workshops accommodate twenty participants and are advertised through the bulletin and on the intranet. Intranet pages have been revised and refreshed to accommodate changes. The graph in Appendix 2 shows the decline in the rate since April 2015. Appendix 3 gives a breakdown of appraisal rates by ICSU.

The range across ICSUs/departments is 16% - 79%. Worryingly the following areas fall below 50%: women's and children's; facilities; procurement; Chief operating Officer and IM&T.

TABLE 4 – Appraisal and Stat/Man Training Rates

		Trust				
Development of the workforce KPIs	**Target**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**
Appraisal	90%	58%	56%	56%	54%	52%
Mandatory Training	90%	73%	76%	77%	78%	78%

7.0 Statutory and Mandatory Training

Table 2 above along with the graph in Appendix 4 give details of the rates since April 2015. The Trust compliance rates are below average for other Trusts across London. A review of action plans continues to be part of performance review meetings in ICSUs and corporate areas. As a result each Director has been tasked with forecasting when significant improvements will be made in compliance rates for their staff. A mandatory training workbook has been launched with the purpose of increasing compliance rates and is making a significant difference in the completion of mandatory training.

Appendix 5 gives benchmarking data from other Trusts who participate in the London Streamlining initiative. Thirty-three Trusts participate in this initiative and the range of compliance is 69%-97%, with just four Trusts above the 90% target.

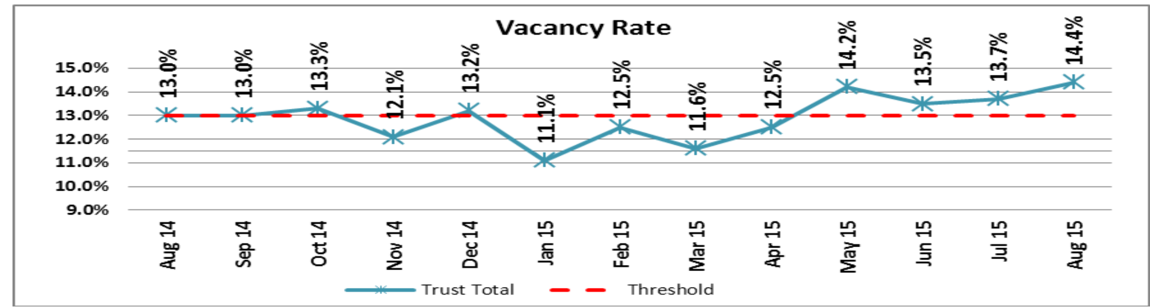
Appendix 6 gives a breakdown of compliance rates by subject matter. This shoes that none of the subject matter are above the target of 90%. Managers have been asked to urgently review staff who are not compliant and arrange for them to complete training. There are some technical issues with accessing e-learning on ESR and this has been escalated to IT for urgent attention.

8.0 Recommendations

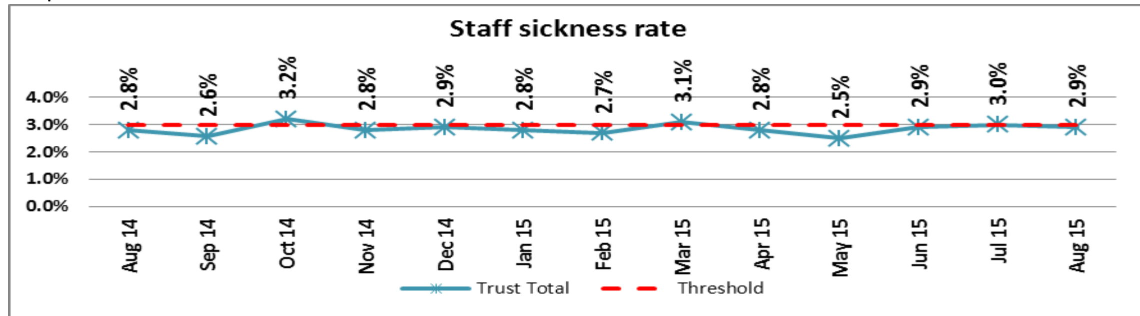
The Board are asked to note the content of this report and support the Workforce Directorate as we improve the quality of workforce information that can be provided. In addition staff with management responsibilities are requested to give attention to the workforce key performance indicators they are responsible for within their area.

APPENDIX 1

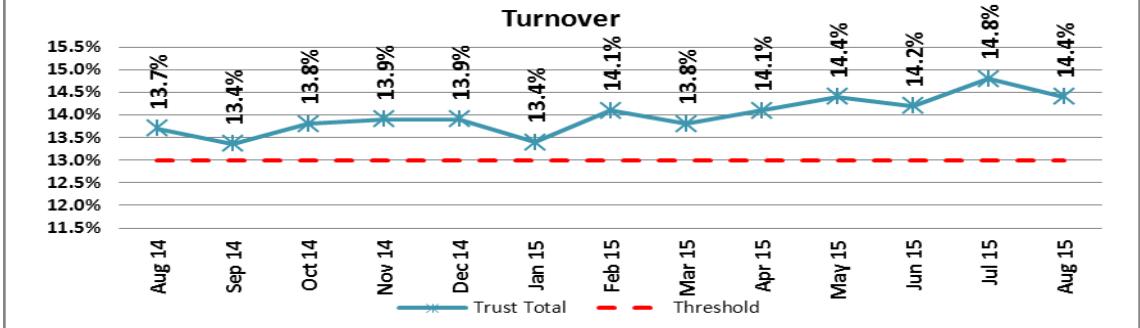
Graph 1.1



Graph 1.2

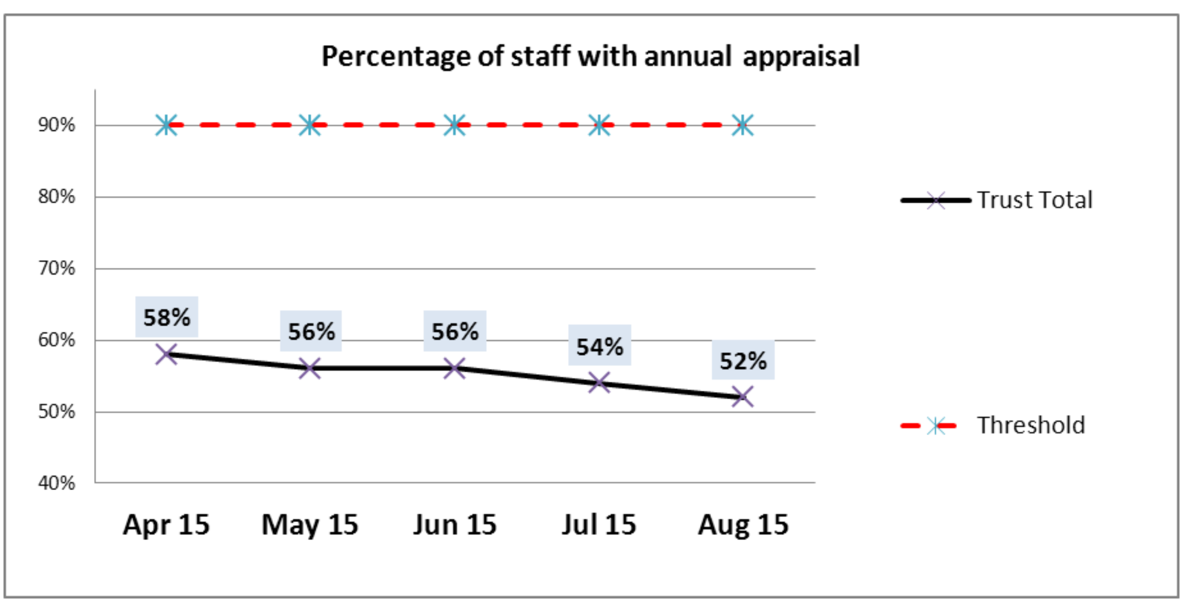


Graph 1.3



APPENDIX 2

Graph 2.1



APPENDIX 3

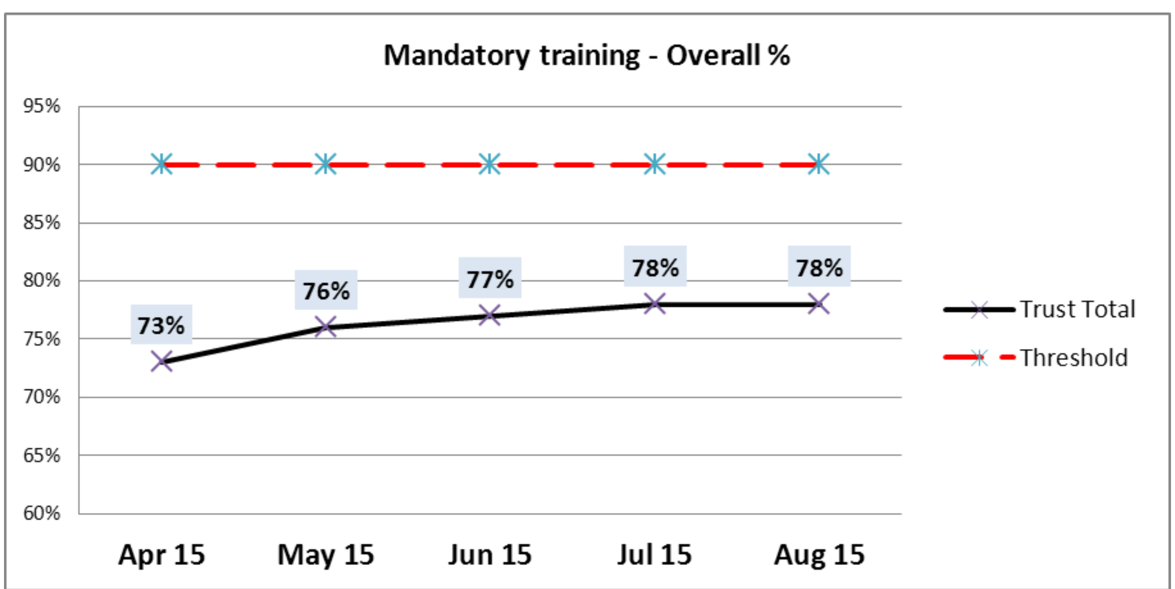
APPRAISAL RATE BY ICSU/DIRECTORATE AT AUGUST 2015

Divisions	Staff Nos:	Quarter 1	July-15 %	August %	%	Comment
Integrated Care & Acute Medicine	1,339					
Surgery Cancer & Diagnostics	792					
Women Children & Families	1,283					
Medicine, Frailty & Networked Service	674	70	72	68	-4	
Emergency & Urgent Care	348	65	64	66	+2	
Clinical Support Services	263	60	58	52	+4	
Outpatient, Prevention & Long Term	249	56	60	64	+4	
Children's Services	893	49	51	50	-1	
Women & Family Services	370	35	35	36	+1	
Surgery	567	51	49	51	+2	
Workforce	46	84	85	79	-6	Appraisal dates all agreed and diaried and will be completed by September 2015
Nursing &Patient Experience	58	60	60	73	+13	
Facilities	258	59	43	26	-17	Urgent action required
Medical Director	17	44	38	54	+16	
Finance	53	42	51	50	-1	

Procurement	98	36	20	16	-4	Urgent action required
Chief Operating Officer	6	30	17	20	+3	Urgent action required
Trust Secretariat	20	28	60	75	+15	
Information Technology	61	96	53	48	-5	Urgent action required
Total	**3891**	**57**	**54**	**52**	**-2**	

NB: Data included in above table excludes staff who have joined Whittington Health within the past 12 months; on maternity and adoption leave; career break; external secondment and bank staff.

APPENDIX 4



APPENDIX 5

BENCHMARKING DATA FROM LONDON STREAMLINING PROJECT – AUGUST 2015

Streamlining London	No of employees	OLM Data Upload	Non-OLM Data Upload	Current Overall Compliance Rate	Last Updated
BARKING, HAVERING & REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	5,693	not completed	n/a	81%	27-Feb-15
BARNET ENFIELD AND HARINGEY MENTAL HEALTH TRUST	2,815	not completed	n/a	77%	31-Aug-15
BARTS HEALTH NHS TRUST	15,054	completed	n/a	81%	31-Aug-15
CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	1,500	not completed	n/a	89%	31-Jul-15
CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	7,000	n/a	not completed	88%	31-Jul-15
CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST	6,560	completed	n/a	90%	30-Jun-15
CHELSEA & WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	3,500	not completed	n/a	80%	31-Jul-15
CROYDON HEALTH SERVICES NHS TRUST	3,646	completed	not completed	79%	31-Aug-15
DARTFORD AND GRAVESHAM NHS TRUST	3,000	completed	n/a	80%	31-Jul-15
EAST LONDON NHS FOUNDATION TRUST	3,416	completed	n/a	81%	31-Jul-15
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	4,320	completed	n/a	85%	31-Aug-15
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS TRUST	4,075	n/a	not completed	80%	31-Aug-15
GUY'S & ST THOMAS' NHS FOUNDATION TRUST	12,817	completed	n/a	88%	31-Aug-15
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	3,490	completed	n/a	82%	31-Aug-15
HOUNSLOW & RICHMOND COMMUNITY HEALTHCARE NHS TRUST	942	not completed	n/a	83%	02-Dec-14

IMPERIAL COLLEGE HEALTHCARE NHS TRUST	8,662	not completed	not completed	83%	31-Aug-15
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	11,672	completed	n/a	74%	31-Aug-15
KINGSTON HOSPITAL NHS TRUST	2,504	not completed	n/a	82%	31-Aug-15
LEWISHAM & GREENWICH NHS TRUST	5,858	completed	n/a	80%	31-Aug-15
LONDON NORTH WEST LONDON HOSPITALS NHS TRUST)	8,480	completed	not completed	69%	2013 Figures
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	1,880	n/a	n/a	82%	31-Aug-15
NORTH EAST LONDON NHS FOUNDATION NHS TRUST	5,404	n/a	not completed	89%	31-Aug-15
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	2,994	completed	n/a	80%	31-Aug-15
ROYAL BROMPTON AND HAREFIELD NHS FOUNDATION TRUST	3,236	n/a	not completed	97%	31-Jul-15
ROYAL FREE LONDON NHS FOUNDATION TRUST	10,647	completed	n/a	76%	31-Jul-15
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	1,389	not completed	n/a	83%	31-Aug-15
ST GEORGES HEALTHCARE NHS TRUST	8,070	completed	completed	72%	30-Jun-15
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	3,462	completed	not completed	90%	31-Aug-15
THE ROYAL MARSDEN NHS FOUNDATION TRUST	3,899	completed	n/a	85%	31-Aug-15
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	7,000	n/a	not completed	89%	31-Jul-15
WEST LONDON MENTAL HEALTH NHS TRUST	2,973	completed	n/a	90%	31-Aug-15
WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST (merged with Chelwest)	1,889	completed	not completed	85%	27-Feb-15
WHITTINGTON HEALTH NHS TRUST	4,080	completed	n/a	78%	31-Aug-15

APPENDIX 6

TABLE: Mandatory Training Activity from April to August 2015

Subject	Frequency	Total Staff (as of August '15)	Trained (August)	April	May	June	Quarter 1	July	Aug	Difference since last month	Gap % to Achieve Compliance	Outstanding (based on staff multiplied by subjects)
Child Protection Level 1	3 years	1003	830	76%	78%	79%	**77%**	81%	83%	+2%	7%	173
Child Protection Level 2	3 years	1861	1336	73%	75%	77%	**75%**	73%	72%	-1%	18%	525
Child Protection Level 3	3 years	1117	812	67%	69%	71%	**69%**	71%	73%	+2%	17%	305
Equality & Diversity	3 years	3981	3387	85%	86%	86%	**86%**	86%	85%	-1%	5%	594
Fire Safety	2 years	3981	3020	73%	78%	76%	**76%**	76%	76%	-	14%	961
Health & Safety	2 years	3981	2962	70%	73%	75%	**73%**	74%	74%	-	16%	1019
Infection Prevention & Control	2 years	3981	3304	80%	82%	83%	**82%**	83%	83%	-	7%	677
Information Governance	Annual	3981	2990	72%	75%	75%	**74%**	76%	75%	-1%	18%	991
Moving & Handling	2 years	3981	3081	73%	74%	75%	**74%**	78%	77%	-1%	13%	900
Resuscitation	2 years	2892	2303	76%	79%	79%	**78%**	79%	80%	+1%	10%	589
Safeguarding Adults Level 1	3 years	1003	842	65%	69%	73%	**69%**	83%	84%	+1%	6%	161
Safeguarding Adults level 2	3 years	2978	2350	60%	69%	75%	**68%**	77%	79%	+2%	11%	628
Conflict	3 years	2865	1997	71%	70%	70%	**70%**	71%	70%	+2%	20%	868
Overall %				**73%**	**76%**	**77%**	75%	**78%**	**78%**			**8,391***

*8,391 represent the number of outstanding training subjects to be completed by staff. Staff may have more than one training subject outstanding.

Whittington Health Trust Board

07 October 2015

Title:	The 2015/16 Annual Report on Partnership working with the London Borough of Islington		
Agenda item:	**15/127**	**Paper**	**10**
Action requested:	To note the Annual Report and endorse the achievements		
Executive Summary:	Whittington Health and the London Borough of Islington have an existing Section 75 Partnership Agreement which, together with the Intermediate Care Integrated Provider Agreement, supports effective partnership working to provide a better coordinated service to vulnerable people; ensure that opportunities to share expertise and specialist knowledge are maximised; and to minimise the duplication of work. The report details some of the key achievements and over the last year and outlines planned future developments. It is important to preserve the benefits of integrated working and to use the opportunities to develop further integration of frontline teams over the coming year.		
Fit with WH strategy:	In line with the clinical strategy		
Reference to related / other documents:	Complies with the ICO engagement and partnership working strategy		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured on risk registers and/or BAF		
Date paper completed:	18th September 2015		

Author name and title: Carole Macgregor		**Service lead, Islington rehab& intermediate care , LBI/WH**		**Director name and title: Carol Gillen**		**Director of Operations MFNS/Deputy COO**	
Date paper seen by EC	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

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

London Borough of Islington and Whittington Health NHS Trust

1. INTRODUCTION

This report covers the main achievements of the last year in the provision of integrated services for adults and older people, and identifies the key priorities for 2015/16.

2. KEY AREAS OF ACHIEVEMENT 2014-15

2.1 Developing Integrated Locality Team Working

The 'Moving Forward' programme plan for 2014/15 included developing a new integrated model between community rehabilitation, intermediate care and social care which sought to ensure that the services that were delivered in partnership were sustainable and able to respond to the increasing number of people being supported to remain in their own homes and independent for as long as possible.

The new model required significant changes to social care structures in order to ensure that duplication was minimised, outcomes improved and statutory obligations related to changes in legislation met. The Care Act 2014 has significant operational implications for adult social care with an anticipated increase in demand from those requesting assessments, new duties to provide additional support (e.g. to self-funders) and an increased focus on providing information, advice and guidance to all.

It also required changes to the Whittington Health Community Rehabilitation Team (CRT) and REACH team in order to deliver a model of care that supported the delivery of community intermediate care and rehabilitation as part of an integrated service with social services, with co-located teams, a single point of access for referrals and advice and shared screening of new referrals.

Using the learning from the N19 pilot that ran from June 2013 – March 2014, a project group was set up to develop and agree the operational aspects of the model which included work streams for:

- A single point of referral and advice for social care and REACH/CRT teams (Access and Advice Team)
- Streamlining assessments and reviews including a review of forms
- Review of discharge services
- Agreeing the locality team bases and team staffing structures
- Review of reablement service and home care
- Review and update the Links for Living website
- Review of urgent response provision in social care and links to development of rapid response team with Islington CCG (ICCG).
- Training and development programme for staff

The Access and Advice service will support Islington to fulfil its duties in Care Act 2014, this requires health and social services to provide advice and information, guarantee preventative services which could help reduce or delay the development of care and support needs, and inter-professional working. Staff working in this service have been trained to quickly identify how best to meet people's needs, offer advice or suggestions as to where they can find services or solutions for their needs, or quickly route them to screening and services that they require.

The 'Links for Living' pages have been redesigned to offer an effective and attractive way to support people to find information about a range of health and social care services, and to enable them to consider what they need, with advice how to access this.

Consultations were held with staff on the proposed reorganisation during October &

November 2014 with a go live date proposed for April 2015. The purpose of the reorganisation was to:

- Ensure that the service delivers more personalised, integrated support
- Ensure that all service users have the best opportunity to achieve their maximum level of independence with the required level of support tailored towards their needs
- Ensure that the service is configured to provide a high quality and cost effective service by removing multiple handoffs and duplication of work between Health and Social Care teams
- Respond to the additional duties introduced by the Care Act which necessitate operational changes to the service Contribute to the health and social care efficiency targets.

2.2 Keeping Independent at Home

The past year has seen continued improvement and innovation in the Reablement service.

The 'In reach' services continue to work with the Whittington and UCLH, linking strongly to the hospital teams with a focus on delivering faster discharges, over 7 days.

A successful pilot to base a physiotherapist within the Reablement service, with the dual aims of providing timely physiotherapy intervention, and providing training and advice for the enablers to gain competencies in helping people mobilise and prescribing simple mobility aids, continued in 2014-15 and a bid submitted to commissioning to continue the funding in 2015/16.

- 188 people were referred for physiotherapy as part of their Reablement during April – December 2014.
- 66% of service users either achieved or partly achieved their goals during their 6 week involvement with reablement, with the option of continued physiotherapy via the REACH community team.

The Enhanced Reablement service has continued to provide intensive support packages to people who would otherwise be at high risk of admission to residential or nursing home (typically due to dementia). During 2014/15 Enhanced Reablement had a total of 57 referrals of which 43 were accepted for a service.

Outcomes for these people were: -

- 7 transferred to a period of standard reablement at home
- 16 transferred to ongoing support and remained at home
- 12 needed further medical or therapy services
- 7 required no further services

Mainstream reablement has provided free care and rehabilitation at home for 543 Islington residents in 2014/15. Reablement continues to deliver good results in terms of independence for service users; outcomes following reablement intervention show that 67.4% of service users have no ongoing care needs and the proportion of older people who were at home 91 days after their discharge from reablement services was 83.9%

The **Intermediate Care Team** coordinate and provide the therapy and social work support to people using the 12 intermediate care beds that were provided at Mildmay (within extra supported housing) and to ensure that services are coordinated to support people to return home if possible.

55 people were admitted to the Mildmay intermediate care beds in 2014-15.

The discharge destinations from these services are: -

Discharge Destination from Intermediate Care Beds (Mildmay)	% Service Users
Home	58.1%
Extra Care Sheltered / Supported Housing	7%
Hospital	14.5%
Residential / Nursing Home	7%
Other	12.7%

The contract for the intermediate care beds at Cheverton Lodge (Barchester Healthcare) ended at the end of March 2014. The review of Intermediate Care continued during 2014/15 which included finding a new provider for intermediate care beds in Islington. 40 Spot placements were required in 2014/15, funded by the intermediate care pooled budget, due to the lack of available intermediate care beds during this time.

ICCG approached Whittington Health with regards to creating additional inpatient intermediate care and rehabilitation capacity given the lack of capacity. Two rehabilitation beds and four intermediate care beds opened temporarily on the Cavell Rehabilitation Unit at Whittington Hospital from 17th November 2014 – 1st May 2015. This was a very positive pilot with 17 patients admitted during this period with an average length for stay of 40 days and a positive change in Barthel scores i.e. they were more independent on discharge. 60% of the patients were able to return home at discharge. The location of these beds within an acute facility appeared to have resulted in an earlier move from an acute bed than would otherwise have been possible and/or facilitated on-going investigations in a less acute setting.

Ten intermediate care beds opened at St Anne's Nursing Home in February 2015 which has improved the availability of bed based care in the community and facilitated discharges from acute Trusts. No further Spots placements have been required for intermediate care since these beds opened. The Intermediate Care Team (WH/LBI) provide the therapy and social work support to people in these beds, as with Mildmay intermediate care unit & this additional capacity will relieve some of the pressure on demand for intermediate care rehabilitation over the winter months.

The Intermediate Care teams (REACH and Reablement) again participated in the National Audit of Intermediate Care.
The national average for people over 65 years of age admitted into Reablement is 2.1% (2010). Islington has consistently admitted over 3.5% since 2010, and also scored highly for numbers of people leaving Reablement with no ongoing homecare need.

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

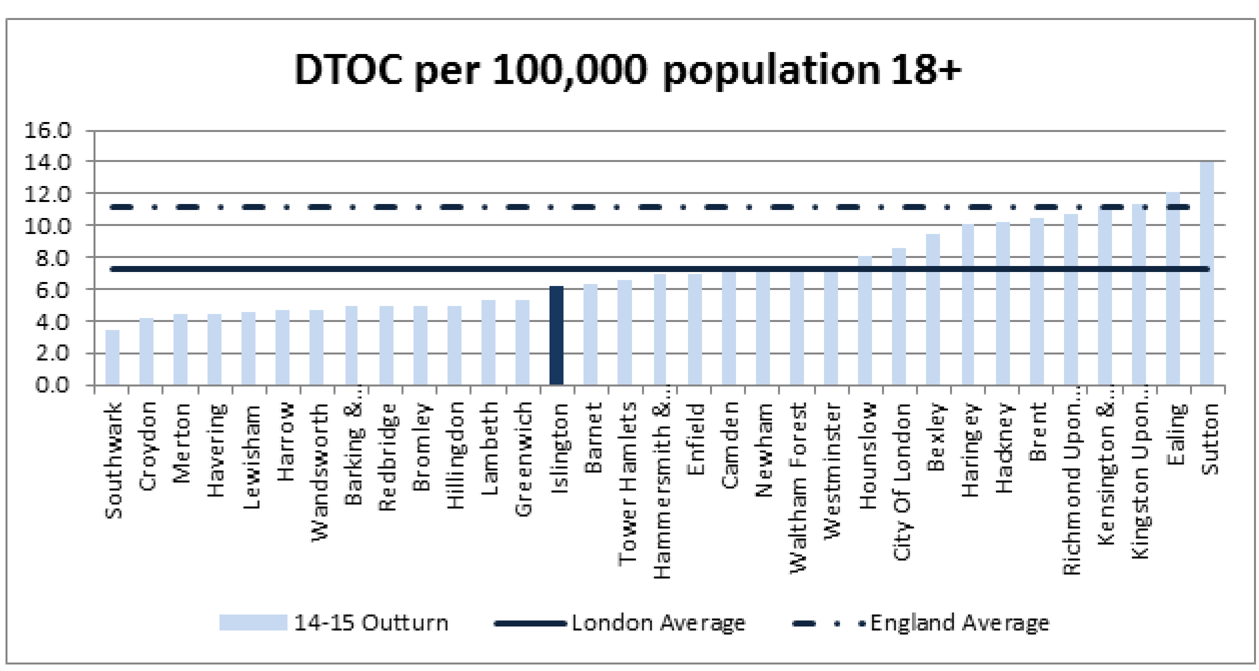
2.3.1 Delayed Transfers of Care

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

- In-reach to both local acute Trusts by the Reablement Service
- Daily teleconferencing to discuss people with complex needs, and to agree actions across hospital and community teams towards discharge
- Social workers attending daily 'board rounds' on the wards, and 7 day social work over the winter period.
- Access to Reablement at weekends
- Prompt access to necessary equipment via TCES (community equipment)
- Use of the Integrated Pooled budget to fund 'spot placements' so that people can move out of hospital for further assessment of their needs

- A new support worker (employed by Age UK) to carry out practical tasks necessary for hospital discharge, in a timely way e.g. getting keys cut, enabling essential work to prepare people's home for them to return to being carried out whilst they are still in hospital
- Links to the voluntary sector, particularly Age UK, to support people on return home e.g. following an attendance at accident and emergency.

Islington perform well in terms of our benchmarking position and have consistently been a highly performing authority in London for the past 4 years. Performance has declined slightly in 2014-15 to 6.2 delayed transfers of care per 100,000 of the population compared to 4.8 per 100,000 in 2013 -14. It is worth noting however that Islington rates of delay are still significantly lower than the London average of 7.0 delays per 100,000 of the population, and the England average of 11.2 delays per 100,000 of the population.



2.3.2 Avoiding Hospital Admission

Evidence shows that older people often 'decompensate' and lose their ability to keep independent in hospital, due to being in an unfamiliar environment, not keeping active to maintain muscle strength, and losing confidence. In the past year there has been an increased emphasis on supporting and caring for people at home if they do not need an admission for acute medical care.

The **Facilitating Early Discharge Service** (FEDS) is made up of therapists working 8.30am-8.30pm, 7 days a week in the 'front of hospital' assessment team, and provides a rapid assessment of people's ability to go straight home safely, with any essential equipment, and with a seamless link to community services from both health and social care. FEDS aim to screen all patients who require a therapy assessment as part of a full MDT assessment within 12 hours as per the Emergency Care standards.

The team also includes a technician who can provide a bridge between hospital at home and can for example, complete home safety checks, practice with new equipment in the home setting immediately post discharge, assess for non-essential equipment and arrange provision, e.g. bathing, practice exercises etc.

A linked social worker is involved in assessing the more complex patients, and the team also refer direct to Age UK for follow up contact and social support. The week-end social worker funded by winter resilience money also worked closely with this team.

An additional service provided by Camden Carelink was commissioned with winter resilience funds, and this provides a very fast response to provide short-term enabling care to support earlier hospital discharge over extended hours.

These initiatives are successfully minimising the time people spend in hospital, and supporting them to remain independent where possible.
As Ambulatory Care has developed the FEDS team also link with the team there to provide a rapid assessment and access to services for people who are receiving medical intervention in the new centre, and thereby avoiding a hospital admission.

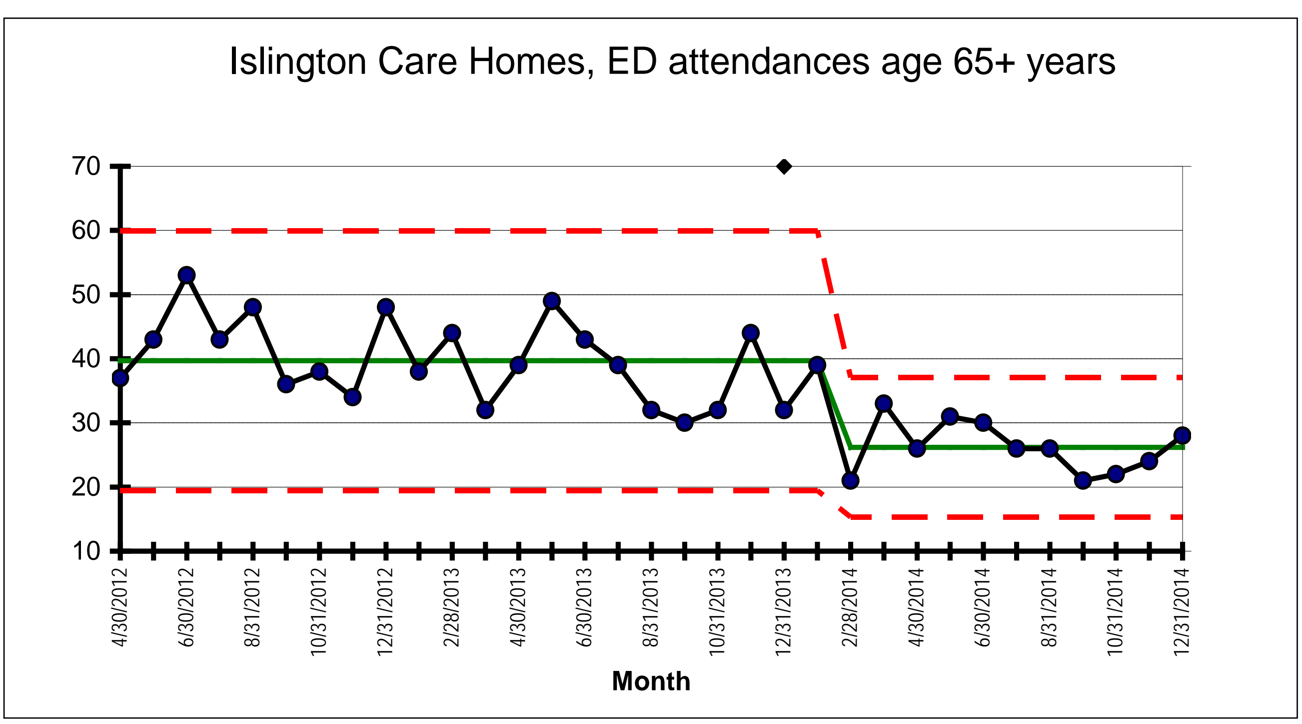
The Integrated Community Ageing Team (ICAT -previously known as the Community Geriatrician service) started in April 2014, with recurrent funding of £200k p/a from the Strategic Investment Fund.

The service provides clinical support to care homes and, through the locality MDT's, to the wider population of older adults in Islington. ICAT has been proactive in developing additional pathways as set out below

- Telephone line at Whittington Health or UCLH for clinical advice, 9-5, Monday to Friday
- In-reach assessment, flagging all patients from care homes admitted to UCLH and Whittington to ensure continuity of senior medical care
- Regular visits to care homes providing consultant level medical assessment
- Education and training
- Co-ordinating wider input to care homes
- 'Hot' clinics in Ambulatory care unit (Geriatrician input to ambulatory care)

The service is provided by consultant geriatrician at the Whittington (Dr Ruth Law) providing 7 sessions, a GPwSI (Dr Philly O'Riordan) providing 2 sessions and the UCLH consultant geriatrician (Dr Nadia Raja) providing 3 sessions.

To date, the ICAT service has focussed on Care Homes. The care home population represents some of the most vulnerable people with the highest health needs outside of acute hospitals. In 2013-14, prior to the start of ICAT, there were 607 London Ambulance Service call-outs from the Islington care homes, 85% of which were conveyed to hospital, with an average length of stay in the hospital of 15 days for these residents. As a result of various initiatives into the Care Home sector, this trend of ED attendances is decreasing.



A report from Healthwatch Islington has been commissioned to examine the qualitative impact of ICAT. We were keen to demonstrate qualitative impact for a population that would otherwise be difficult to reach. The report is attached below but feedback included

"The ICAT service has made an obvious difference to his overall health and wellbeing. The doctor has reduced the number of hospital admissions by reviewing medication and carrying out procedures that a GP may have previously referred to hospital. He used to be admitted regularly so this has made a positive difference to his physical and psychological wellbeing" (Interview with staff about service user)

"With (ICAT doctor) I felt extremely well handled and very engaged and she knows all about geriatrics and strokes. She has a wonderful attitude and so well organised. The service is more than good, it's excellent"

To maintain impact in care homes and move the team beyond this setting to work in the community, ICAT were successful in bidding to expand the team further in 2015/16 which will include recruiting a multidisciplinary skills-mix of specialist Nurses and 2 physiotherapists/ occupational therapists to work within ICAT. The key initiative would be the delivery of Comprehensive Geriatric Assessments into the community. This is a process of care involving a holistic, multidimensional, interdisciplinary assessment of an individual by a number of specialists. The British Geriatric Society have demonstrated it to be associated with improved outcomes in a variety of settings, and a University of Oxford Cochrane review identified

- High quality evidence that CGA improves care of frail older patients admitted to hospital, including a 30% higher chance that patients would be in their own home 6 months later
- High quality evidence that CGA decreases the number of patients admitted to residential care.

An update on progress of the team will be included in the 2015-16 report.

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

During 2014-15 the action plan included the following work streams:

- Development of the nursing audit tool
- Quality performance reporting
- Support for residents with PEG
- Medicine management
- Hospital avoidance SOP for deteriorating patients
- Training and workforce development

2.4 Integrated Community Equipment Service

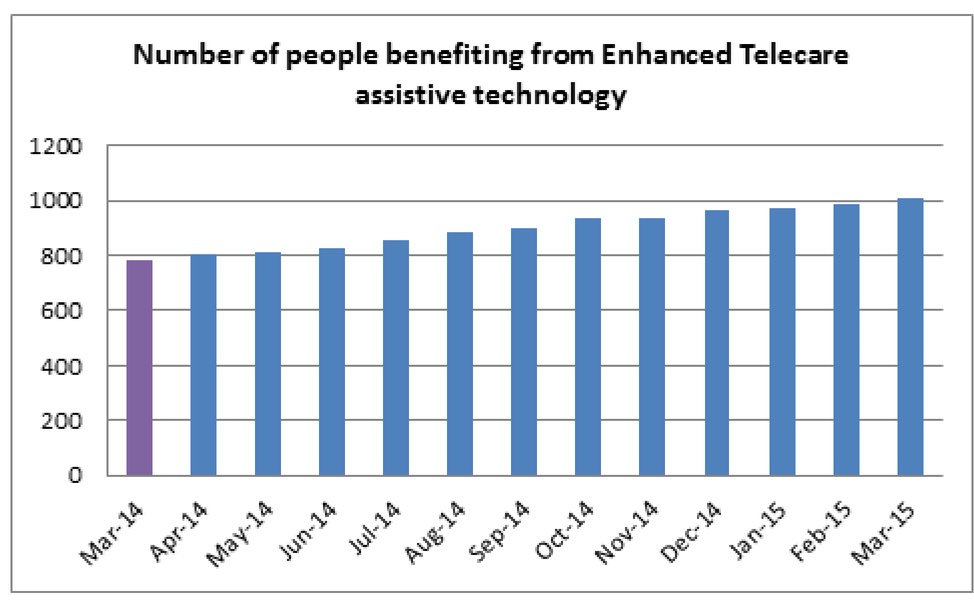
The Transforming Community Equipment Services project (TCES) has now been 'live' since February 2011, when the retail model for simple aids to daily living, and joining the London Consortium for Complex Aids to Daily Living, were introduced in Islington.

In 2014-15 between 186-273 service users a month were issued with prescriptions and the redemption rates have averaged 84%, which is above the national average.
Trends in prescriptions are monitored jointly, and processes in place to ensure appropriate and consistent prescribing of equipment.

2.5 Expansion of the use of Telecare

The number of people issued with Telecare equipment has been steadily growing, with a range of health and social care services making referrals to Telecare for residents. The project to assess for and provide complex Telecare equipment is still continuing with the new locality teams, and aims to increase knowledge of the range of equipment available across health and social care teams, and how it can be used to keep people safe and independent at home.

In the last year, Telecare has also been successfully installed as part of the development of new independent living units for people with learning disabilities, and used in sheltered and supported accommodation schemes.



3. PLANNED DEVELOPMENTS

3.1 Embedding the Integrated Locality Teams

The new integrated social care and rehabilitation teams, based at Vorley Road in the North of the borough and at Calshot Street in the south, went live on 30th March 2015. Teams comprise both health staff (physiotherapists, occupational therapists and rehab assistants) and social care staff (social workers, OTs and case managers). Referrals are now managed by the new Access and Advice Team based at 222 Upper Street.
Since go live date, support has been given by the service leads and team managers to embed the new ways of working with frontline staff, addressing operational issues as they arise.
The new model is being formally evaluated in September 2015, with the final report due at the end of October 2015. The purpose of this review is to examine how well the model is bedding down and recommend actions to address any deficient areas in order to realise the primary anticipated benefit of improved customer experience through integrated working.

3.2 Developing the locality-based model with GPs

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

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

3.3 Pooled Budget for Intermediate Care

There is a Commissioning intention to further extend the existing pooled budget for Intermediate Care, in order to strengthen the opportunities to provide Islington residents with high quality rehabilitation and recovery services by providing a unified pathway, incorporating Readmission Prevention projects at UCLH and Whittington Hospital. The partnership is responding to this by engaging strongly with work to further improve the services offered, and to make them as timely and seamless as possible.

In the immediate future the following projects are continuing: -

- Weekend access to the Reablement Service
- Supporting weekend working linked to admission avoidance or earlier discharge at the acute hospitals (UCLH and Whittington)
- A pharmacist that Reablement can access to check that people understand and are taking their medication correctly, as this can prevent readmissions
- Outreach by the REACH team to Islington residents temporarily placed out of borough
- A support worker to support earlier discharge from both acute hospitals (Age UK post, funded by the pooled budget)

4. CONCLUSION

The strong history of partnership working between Islington Social Services and the health services that are now within Whittington Health NHS Trust provides a solid platform to further develop local and locality services that are truly 'joined up' and delivered in a way that offers integrated care and support, to the benefit of Islington residents.

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

Carole MacGregor, Service Lead Islington Community Rehabilitation Service

Carol Gillen
Director of MFNS/Deputy COO

Whittington Health Trust Board

7 October 2015

Title:	TDA oversight report		
Agenda item:	**15/128**	**Paper**	**11**
Action requested:	Approve the self-certification for board governance to report to the TDA for submission of the monthly oversight report. This is a new format and replaces the former template issued by the TDA.		
Executive Summary:	The Trust is required to produce monthly self-certification statements for board governance. The report provides the details for September 2015. The Trust will declare compliance with its board governance statements except the IG Toolkit level 2. The Trust has a plan in place to achieve IG Toolkit level 2 in 2015/16.		
Summary of recommendations:	The Board are asked to approve the compliance statements and identify any gaps or concerns.		
Fit with WH strategy:	Aligns with financial and clinical strategies		
Reference to related / other documents:	Complies with SFI's, SOs and NHS reporting requirements		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	All risks are documented and captured on the Trust Datix risk management software system and/or the corporate risk register and BAF		
Date paper completed:	29 September 2015		
Author name and title:	**Hannah Finney, Strategic Planning Manager**	**Director name and title:**	**Siobhan Harrington, Deputy Chief Executive and Director of Strategy**

Date paper seen by EC	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

NHS Trust Development Authority oversight report for September 2015

1. Introduction

This report is used as the basis for the Trust's response to the TDA monthly oversight reporting requirements. This template replaces the former statements reported to the Board. The Trust is required to confirm compliance with a set of Board self-certificated statements.
These compliance statements should be discussed and approved by the Trust Board with the discussion minuted. The Board should have or request access to assurance in relation to the accuracy of the reports and any associated actions.

2. Monitor compliance statements

		Compliant (Yes/risk/no)	Issue	Action plan
1.	**Condition G4:** Fit and proper persons as Governors and Directors	Yes	n/a	n/a
2.	**Condition G5:** Having regard to Monitor Guidance	Yes	n/a	n/a
3.	**Condition G7:** Registration with the Care Quality Commission	Yes	n/a	n/a
4.	**Condition G8:** Patient eligibility and selection criteria	Yes	n/a	n/a
5.	**Condition P1:** Recording of information	Yes	n/a	n/a
6.	**Condition P2:** Provision of information	Yes	n/a	n/a
7.	**Condition P3:** Assurance report on submissions to Monitor	Yes	n/a	n/a
8.	**Condition P4:** Compliance with the National Tariff	Yes	n/a	n/a
9.	**Condition P5:** Constructive engagement concerning local tariff modifications	Yes	n/a	n/a
10.	**Condition C1:** The right of patients to make choices	Yes	n/a	n/a

11.	**Condition C2:** Competition oversight	Yes	n/a	n/a
12.	**Condition IC1:** Provision of integrated care	Yes	n/a	n/a

3. Board assurance statements

		Executive Lead	Compliant (Yes/risk/no)	Issue	Action plan	Timetable
For CLINICAL QUALITY, that:						
1.	The Board is satisfied that, to the best of its knowledge, and using its own processes and having had regard the TDA's oversight, (supported by the Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	Director of Nursing & Patient Experience	Yes	n/a	n/a	n/a
2.	The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	Director of Nursing & Patient Experience	Yes	CQC Inspection announced December 2015	n/a	n/a

3.	The Board is satisfied that process and procedures are in place to ensure all medical practitioners providing care on behalf of the Trust have met the relevant registration and revalidation requirements.	Executive Medical Director	Yes	n/a	n/a	n/a
For FINANCE, that:						
4.	The Board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.	Chief Financial Officer	Yes	For 2014/15 the Trust reported a deficit of £7.3m. The Trust financial position has been affected by historic underachievement of CIP, income, activity, coding and budgetary controls.	In June external auditors judged the Trust as a going concern. The Trust is working with commissioners to ensure contracts and payments recognise the actual work done. The Trust has developed a more comprehensive CIP governance structure with detailed tracking including accountability and exception reporting. A CIP PMO has been established which reports to a Steering Group. A Quality Impact Group is in place to ensure a robust process for identifying quality impact scores and validating schemes to protect patient safety and quality am is chaired by the Medical Director or Director of Nursing and Patient Experience. The Trust has begun Phase 1 of a programme of work with external support to identify further schemes and ensure there are detailed plans for 2016/17 so that the Trust achieves financial balance in the future.	31/03/16

For GOVERNANCE, that:						
5.	The Board will ensure that the Trust remains at all times compliant with the NTDA Accountability Framework and shows regard to the NHS Constitution at all times.	Director of Comms & Corporate Affairs	Yes	n/a	The Trust Board will receive a briefing paper on the NHS constitution. This national initiative has recently been amended and republished.	Nov 15
6.	All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.	Director of Nursing & Patient Experience	Yes	n/a	n/a	n/a
7.	The Board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.	Director of Nursing & Patient Experience	Yes	n/a	n/a	n/a
8.	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the Board are implemented satisfactorily.	Director of Strategy / Deputy Chief Executive	Yes	n/a	n/a	n/a
9.	An Annual Governance Statement is in place, and the Trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury.	Director of Strategy / Deputy Chief Executive	Yes	The Trust has delayed revision and sign off for the risk management strategy in order to realign with the new ICSUs.	The Board will receive a revised risk management strategy in November which aligns with the new ICSUs	Nov 15

10.	The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.	Chief Operating Officer	Yes	ED improvement plan in place Detailed winter planning has commenced	The Trust is committed to achievement against targets. Work continues supported by our CCG colleagues to drive improvements and compliance with the standards which are off target. These are documented within the Board monthly performance reports and reported to the TDA each month. Plans are in place to mitigate areas which are off trajectory.	n/a
11.	The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Director of Strategy / Deputy Chief Executive	No	Non-compliant	An action plan has been agreed with the IG team to achieve Level 2 and is being monitored by the IG Committee. The ICO audit recently reported a 'yellow' result in July 2015.	31/03/16
12.	The Board will ensure that the Trust will at all times operate effectively. This includes maintaining its Register of Interests, ensuring that there are no material conflicts of interest in the Board of Directors; and that all board positions are filled, or plans are in place to fill any vacancies.	Chief Executive	Yes	n/a	n/a	n/a
13.	The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Chief Executive	Yes	n/a	n/a	n/a

14.	The Board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.	Chief Executive	Yes	n/a	n/a	n/a

Whittington Health Trust Board

7 October 2015

Title:	Board resolution to update signatories for the DH revolving loan facility		
Agenda item:	**15/129**	**Paper**	**12**
Action requested:	For approval		
Executive Summary:	The current revolving facility was put in place prior to the appointment of the permanent CFO With the new CFO now in post, it is important to update the signatories and this paper sets out the Board Resolution to implement this change.		
Summary of recommendations:	For approval		
Fit with WH strategy:	Working capital performance		
Reference to related / other documents:	Complies with SOs and SFIs		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured on risk registers and/or BAF		
Date paper completed:	23.9.15		

Author name and title:	**Bola Agboola Head of financial services**	**Director name and title:**	**Stephen Bloomer Chief Finance 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

The Whittington Hospital NHS Trust Board

Resolution re Revolving Loan facility

The existing revolving loan facility with the below terms refers:

- Revolving loan facility: **£23,900,000**
- Purpose: **Working capital support**
- Final Repayment date: **13 April 2020**
- Interest rate: **3.5%**

The Board of Executive Directors of the Whittington Hospital Trust hereby make a resolution to authorise the following personnel to execute and manage the transactions relating to this facility (including the Utilisation Requests) on its behalf:

- Chief Executive Officer
- Chief Finance Officer
- Deputy Director of Finance

The Board makes an undertaking to comply with the terms and conditions (and additional terms and conditions) of the loan agreement.

The Board certifies that any of the above-mentioned personnel can sign on its behalf certifying that copy documents relating to items specified in Schedule 1 of the loan agreement (attached) and provided to the Lender is correct, complete and in full force and effect as at a date no earlier than the date of the Agreement.

Schedule 1 of the Loan Agreement

SCHEDULE 1: CONDITIONS PRECEDENT

1. Authorisations

1.1 A copy of a resolution of the Board of Executive Directors of the Borrower:

(A) approving the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;

(B) authorising a specified person or persons to execute the Finance Documents to which it is a party on its behalf; and

(C) authorising a specified person or persons, on its behalf, to sign and/or despatch all documents and notices (including, if relevant, any Utilisation Request and) to be signed and/or despatched by it under or in connection with the Finance Documents to which it is a party.

(D) Confirming the Borrower's undertaking to comply with the Additional Terms and Conditions

1.2 A certificate of an authorised signatory of the Borrower certifying that each copy document relating to it specified in this Schedule 1 and provided to the Lender is correct, complete and in full force and effect as at a date no earlier than the date of this Agreement.

2. Financial Information

Updated financial statements of the Borrower unless otherwise available.

3. Finance Documents

3.1 This Agreement (original).

3.2 The original or certified copy (as the Lender shall require) of any Finance Document not listed above.

4. General

4.1 A copy of any other Authorisation or other document, opinion or assurance which the Lender considers to be necessary or desirable in connection with the entry into and performance of the transactions contemplated by any Finance Document or for the validity and enforceability of any Finance Document.

4.2 Evidence that the fees, costs and expenses then due from the Borrower pursuant to Clause 13 (*Costs and expenses*) have been paid or will be paid by the first Utilisation Date.

ENDs

Whittington Health Trust Board

7 October 2015

Title:	Board Assurance Framework		
Agenda item:	**15/130**	**Paper**	**13**
Action requested:	For approval		
Executive Summary:	All NHS Trusts are required to provide a Board Assurance Framework as a mechanism for the Board to ensure the effective and focused management of principal risks to the achievement of its strategic goals and corporate objectives. This framework has been developed for 2015/16 following the approval of the Clinical Strategy at Trust Board in March 2015. The current framework incorporates feedback from the Board Seminar in May 2015 and July 2015 which highlighted the risks to the strategic goals and corporate objectives of the Trust that are set out in the Trust's operational plan for 2015/16. Of the 19 risks identified in the BAF - 13 risks remain as scored in July 2015. - 2 risks have been given a higher rating. Risk 7 regarding meeting our corporate objective of delivering quality, patient safety and patient experience; and Risk 14 regarding our Maternity & Neonatal development. - 4 additional risks have been added; Risk 16 regarding the Trust becoming paperless by 2020; Risk 17 regarding changes in the commissioning and providing landscape; Risk 18 regarding the CQC inspection and Risk 19 regarding the culture of the organisation at a time of continued change. The top risks at that time identified by Executives through this process are:- ➢ CO3 Develop our business to ensure we are financially sustainable ➢ Delivery of CIP as part of our duty to breakeven and meet control totals ➢ Risk that we will not achieve our planned income ➢ The risk to our maternity and neonatal redevelopment The BAF will be further discussed at the Audit and Risk Committee and we will continue to refine the format to ensure it		

	fully meets the requirements of the Board.
Summary of recommendations:	The Board are asked agree the Board Assurance Framework and highlight areas/gaps the Board would like included.
Fit with WH strategy:	Aligns with the Trust Clinical Strategy 2015/20.
Reference to related / other documents:	In line with risk policies and procedures.
Date paper completed:	28 September 2015

<table>
<tr><td colspan="2">Author name and title:</td><td colspan="2">Siobhan Harrington, Deputy Chief Executive and Director of Strategy</td><td colspan="2">Director name and title:</td><td colspan="2">Siobhan Harrington, Deputy Chief Executive and Director of Strategy</td></tr>
<tr><td>Date paper seen by TMG</td><td>22 Sept 2015</td><td>Equality Impact Assessment complete?</td><td>n/a</td><td>Risk assessment undertaken?</td><td>n/a</td><td>Legal advice received?</td><td>n/a</td></tr>
</table>

Whittington Health Trust Board Assurance Framework 2015/16 - September 2015

BAF Ref	Type	Strategic Goal (SG) / Corporate Objective (CO) / Priority	Impact	Likelihood	Current rating (IxL)	High Level Risks	Positive Controls / Mitigations	Gaps in Controls	Rating post mitigations	Reporting & Monitoring	Actions/ Action Plans	Deadline	Executive Lead	Accountable Lead	External Assurance (eg audits/ inspections)
1	National and Local Priorities	SG1 Deliver consistent high quality, safe services	4	4	16	There is a risk that the Trust does not deliver consistently high quality safe services. Safety and quality may not be placed centrally at the heart of all that the Trust delivers. We may not achieve operational excellence; fail to meet operational performance targets; fail to match demand and capacity; we may not have the right workforce in place to deliver the services; we may not implement effectively our clinical leadership model and integrated clinical service units; and there is a risk that the CIP programme impacts on quality and safety.	• Quality and safety as key objective of the organisation led by medical and nursing Director • Clinical Directors and integrated service units in place from 1 July with governance and TMG in place. Clear accountability for delivery of quality, safety, operational and financial performance • Recruitment of Director of workforce & improvements in workforce data and planning being delivered. • Risk management strategy review. • Clinical Strategy to inform ICSU business planning • CIP governance in place including QIA process • Quality Account in place. • Sign up to Safety programme. •Improvement plans in place where needed	ICSU business plans not yet in place. Trust performance report to be reviewed. Workforce strategy & plan being developed.	12	TB performance reports Reports to Quality Committee CIP governance &TMG	Business plans by end of November. Review of performance report underway. Workforce strategy & plan February 2016.	Monthly targets	Medical Director & Nursing Director	LM/NFPD/RJ/SMH	CQC reports, internal audit, external reports
2	National and Local Priorities	SG2 Secure best possible health & wellbeing for our community	3	4	12	There is a risk that the Trust does not secure the best possible health & wellbeing for our community as there is a risk that we do not maintain positive relationships with partners in including primary care, local authorities, mental health trusts, voluntary sector and our local communities. There are risks in contracts and the reduction in partners' budgets that may lead to unintended consequences. There is a risk that we do not have the staff engagement and ownership in delivering the clinical strategy. There is a risk that the Estates are not appropriate to deliver new ways of working.	• Integrated Care Medical Director leadership • Briefing process in place across ICSUs • Transformation Leadership Group in place across Haringey & Islington and member of Islington Health & Wellbeing Board • Integrated care programme arrangements in both Boroughs • Reviewed clinical leadership model in place with clear briefing structure • Development of Trust Estates Strategy underway	Engagement strategy, Estates Strategy & I&MTStrategy to be reviewed. Quarterly reports to Board. Contracts register being completed	9	Board cycle of business 15/16 to include quarterly reports from Estates & IT	TB Reports scheduled. Estates Strategy to TB December 2015	From Sept 2015	Director of Strategy	PI / GW	External reports such as Kings Fund and Public Health reports
3	National and Local Priorities	SG3 Innovate & continuously improve quality of our services	4	3	12	That the Trust does not innovate and continously improve the quality of our services as there is a risk that the quality of our data will not support this agenda; there is a risk that we are contrained in terms of financial investment; there is a risk that we will not be able to recruit and retain our staff to deliver the improvement in quality. These factors may add risk to our delivery of the London Quality Standards and our delivery of 7 day working. There is the risk that our clinical leadership model takes time to bed in to deliver the transformation and change required. There is a risk that we do not have the improvement capability in place to deliver the change.	• Kings Fund recognition of innovation • Annual Operating Plan 15/16 • Data Quality Group refresh underway • CIP to include invest to save schemes • CIP governance • Quality Committee • ICSU structure and CDs & DOs • External support to work with clinicians to identify quality initiatives for 2016/17 • Quality Account & Sign Up to Safety Plan 15/16 Recruitment plan in place • Work to embed Trust values underway and staff survey action plan in place • External review of data quality completed	Data quality improvement plan. Business plans for ICSUs. Well Led Framework governance review. Workforce Plan.	8	Performance report to TB. Quality committee report to TB. IG toolkit. CQRG reporting.	Business plans by end of November. TB performance report refresh. Data quality group to develop improvement plan.	Dec-15	Medical Director	LM/PD/RJ/SMH	CQC inspection December 2015 Internal audit ICO audit

BAF Ref	Type	Strategic Goal (SG) / Corporate Objective (CO) / Priority	Impact	Likelihood	Current rating (IxL)	High Level Risks	Positive Controls / Mitigations	Gaps in Controls	Rating post mitigations	Reporting & Monitoring	Actions/ Action Plans	Deadline	Executive Lead	Accountable Lead	External Assurance (eg audits/ inspections)
4	National and Local Priorities	SG4 Integrate care in patient centred teams	4	3	12	There is a risk that the Trust does not integrate care in patient centred teams at the scale or pace required due to risks as a result of staff changes leading to reduced focus on patient centred care; there is also a risk that or relationships with partners across health & social care system may become more challenging which could impact on models of care; there is the potential for different models of integrated care in different boroughs and unintended impacts of changes in budgets in social care and public health impacting on commissioning. There are also risks in the economics of the integrated care models and application of the Better Care Fund. In delivering integrated care there is the risk that staff do not fully engage in delivering the clinical strategy and that we do not have the IT infrastructure to support integrated care and interoperability	• Integrated care programme arrangements in Boroughs • Health & Wellbeing Boards • Transformation Leadership group across Haringey & Islington • Clinical leaders and operational structure in place and business planning underway in each ICSU • IT developments underway including Integrated Care Informatics Steering Group in Islington • Innovative pathways and care models in place	Community Engagement & Communication Strategy; Discussions underway regarding Accountable Care models.	8	To report to TMG & Board	Establish KPIs and regular reporting on integrated care metrics	Oct-15	Director of Strategy/ Chief Operating officer	LS/LM	CQC reports Internal audit
5	National and Local Priorities	SG5 Support patients to be active partners in their care	4	4	16	That the Trust does not support patients to be active partners in their care as there is a risk that we do not have the clinical leadership and engagement in the model and delivery of the clinical strategy; that we have not mainstreamed self management and patient activation models across all clinical services; that contracts are likely to see a reduction in price to deliver these models which may make it difficult to embed across the system. There is a risk that our website is not of sufficient quality and up to date to support this agenda.	• Supportive self management models of care supported by clinicians •Training programmes in place for clinicians & patients • Expert patient programme • Being built into integrated practice unit clinical model for Diabetes and electronic initiative within strategy • Engagement with commissioners regarding intentions. • Website redevelopment underway.	Business plans for each integrated service unit. Renewed website not yet in place.	12	TMG, Trust Board	Establish KPIs and regular reporting	From Oct 2015	Medical Director Integrated care	LM/GB/RJ/SB	CQC reports
6	National and Local Priorities	SG6 Leader of medical, multi-professional education & population based clinical research	4	4	16	There is a risk that we do not become a leader of medical, multi professional education and clinical research as the Trust may focus on business as usual and not deliver the Education strategy or fail to develop a clinically owned research strategy. The Trust may fail to enable the ICSUs to have the capacity to deliver on this agenda as well as operational and quality priorities.	• Excellent training programmes / facilities at WH • Engagement with UCLP & Health Education England • Education & Research team with budget • International leading clinical experts at WH • Integrated care education strategy in place; • Education Steering Group in place chaired by Medical Director Integrated Care	Research strategy	12	To report to Quality Committee; updates to TB on education & research	Establish KPIs and regular reporting Research Strategy to TB	From Sept 2015	Medical Directors	IB/RS/GB	HEE/ UCLP

BAF Ref	Type	Strategic Goal (SG) / Corporate Objective (CO) / Priority	Impact	Likelihood	Current rating (IxL)	High Level Risks	Positive Controls / Mitigations	Gaps in Controls	Rating post mitigations	Reporting & Monitoring	Actions/ Action Plans	Deadline	Executive Lead	Accountable Lead	External Assurance (eg audits/ inspections)
7	National and Local Priorities	CO1 Deliver quality, patient safety & patient experience	4	4	16	That the Trust does not deliver quality, patient safety and great patient experience as there is a risk that patients have a poor patient experience; experience a serious incident or that the Trust breaches local or national targets or does not deliver to local London or national standards. There is a risk that we do not meet the requirements of our regulator, the CQC, with regard to quality and the inspection regime There is a risk that quality and safety are impacted by the delivery of a significant CIP programme.	• Friends and Family test reports to Board • New electronic real time patient experience trackers in place • Quality Committee & governance including risk management strategy • Integrated reporting of complaints, PALs • Director of Nursing and Patient Experience reports • Infection control annual work programme • Quality Account • CQC preparation programme in place • QIA process for CIPs	Quality strategy refresh; Nursing & AHP strategy	12	Reports to Quality Committee and TB	CQC preparation plan	Oct-15	Director of Nursing & Patient Experience and Medical Director	DC/PF	CQC inspection December 15/16
8	National and Local Priorities	CO2 Develop & support our people & teams	4	4	16	That the Trust does not develop or support our people and teams which will impact on the quality of care delivered and the implementation of our clinical strategy. The Trust may fail to have an OD strategy that delivers the changes required and the leadership development required. The Trust may fail to have adequate Equality/ Diversity awareness and workplans in place. The Trust may fail to achieve appraisal compliance and mandatory training compliance. There is a risk to recruitment and retention of staff.	• New leadership substantive team including permanent Director of Workforce • New appraisal system in place • Equality and Diversity Lead officer in place and applying principles of Equality Delivery scheme and Workforce Race Equality Standard • Training functions integration work underway • Trust leadership programme developed • Renewed focus on appraisal & statutory mandatory training through TMG and ICSU performance reviews	All staff to have a PDP. Workforce planning immature; KPIs and regular reports by ICSU	12	Reports to Quality Committee & Audit & Risk Committee & TB	Establish KPIs and regular reporting	From Sept 2015	Director of Workforce	CJ/RG	CQC reports
9	National and Local Priorities	CO3 Develop our business to ensure we are financially sustainable	5	4	20	That the Trust does not develop the business to ensure it is financially sustainable as there are risks that we will fail to achieve CIP delivery; income achievement & there is a risk of overspending against budgets. There is a risk that our cash position deteriorates. The risk will be greater if we fail to deliver our Clinical Strategy, business planning process and identify our change programme for 2016/17. There is a risk that we fail to develop a credible five year long term financial model. There is a risk that we do not deliver our business development strategy. There is a risk that in rephrasing our capital plan to support the cash position we could increase backlog.	• Finance & Business Development Committee • Trust Management Group • Business Pipeline & contracting reports • Working towards lead provider model • Clinical Strategy to inform ICSU business plans • COO leading CIP team with improved governance • Business planning process & resource • TDA meetings with Trust • External support for identification of clinical change programme for 2016/17 • LTFM in place and with TDA • ICSU performance reviews in place with CEO	Data Quality Robust activity Data reporting Business processes being improved	15	TB reporting F&BD TMG Income Steering Group Performance reviews with CEO	Strengthen accountability and reporting	Month on Month	Chief Finance Officer	LM/SMH/VC	Audit reports

BAF Ref	Type	Strategic Goal (SG) / Corporate Objective (CO) / Priority	Impact	Likelihood	Current rating (IxL)	High Level Risks	Positive Controls / Mitigations	Gaps in Controls	Rating post mitigations	Reporting & Monitoring	Actions/ Action Plans	Deadline	Executive Lead	Accountable Lead	External Assurance (eg audits/ inspections)
10	National and Local Priorities	CO4 Further develop & expand our partnerships & engagement	5	3	15	There is a risk that we do not further develop and expand our partnerships and engagement as maintaining relationships whilst developing locality working with GP providers and Local Authority colleagues and others within a financially challenged health economy will be challenging. There is a risk that we will lack engagement and momentum if developing and delivering new models of care. There is a risk that we do not engage actively with our community, our local GPs and the voluntary sector in delivering our clinical strategy and business as a Trust.	• Finance & Business Development Committee • Trust Management Group • Integrated care programme arrangements • Business Pipeline & contracting reports • Working towards lead provider arrangements • Clinical Strategy to inform ICSU annual plans • Medical Director - GP • Estates communication strategy in place	Refresh engagement strategy and Primary care strategy	10	TB & CCG reporting	Meetings with Shadow Governors and Board Integrated care programme plans	Quarterly	CEO and Medical Director I and Director of Strategy	All Executive	HOSC reporting
11	CIP	Delivery of CIP impacting on duty to breakeven and meet control totals	5	4	20	There is a risk that the Trust does not deliver the CIP which will impact on the duty to break even and meet our control totals. There is a risk that people will overspend their budgets and therefore negate the delivery of their CIP plans. There is a risk that the CIP programme does not deliver as planned.	• Finance & Business Development Committee • Trust Management Group • Permanent Chief Finance Officer in place • COO leading CIP team & governance arrangements in place • CEO performance reviews of Clinical service units • Zero tolerance off trajectory performance for CIP targets • CIP & monthly trajectory set and agreed by Board • Annual Operational Plan 2015/16 signed off by Board & TDA	Substantive Finance Team. Detailed activity profiles by CSU.	15	Finance & Business development Committee; TB & TDA reporting	Independent audit Action Plan	Weekly CIP meetings; monthly Board reports	Chief Operating Officer	All Executive	Audit reports
12	IG toolkit level 2	Level 2 compliance	4	3	12	There is a risk that the Trust will not achieve Level 2 compliance on the IG toolkit as a result of staff having competing workloads to complete in time; that we fail to develop ownership of IG agenda across the whole organisation and that we incurr potential financial fines and reputational damage.	• IG Committee in place • SIRO and Caldicott Guardian in place • ICO national audit completed • Permanent team • Statutory Mandatory training monitoring and improvements being made to health records and data quality in the Trust.	Data quality group governance & terms of reference to be refreshed. Health records management review	8	TMG, Audit & Risk Committee & Quality Committee	mandatory training health records data quality	Ongoing	Director of Strategy (SIRO)	AP/CJ	Internal audit ICO audit CQC
13	Income	Risk that we will not achieve our planned income	5	4	20	There is a risk that we will not achieve our planned income which will mean there is a risk to financial plan delivery this year with a potential further impact on next year and the Trust LTFM. There are specific risks in relation to maternity activity and income; and orthopaedic spinal activity and income	• Income group in place chaired by CFO • Strengthened Finance & Business Development Committee • Maternity marketing campaign in place • Activity plan in place re orthopaedic activity	Activity plans detail being finalised by clinical service unit	15	TMG; FBD; TB	Maternity activity plan Spinal activity plan	Bi weekly Income group	Clinical Directors and Chief Operating Officer	LM/VC/FI/CB/FE	Audit reports; TDA; CSU
14	Service developmet	Maternity	5	4	20	There is a risk that we do not grow our maternity work and that the TDA do not support our Full Business Case, which would lead to a risk to the future maternity and neonatal services on site	• FBC with TDA within timescale and with strong case for change approved by TB January 2015 • Regular TDA meetings • TMG & CEO review of maternity activity • Marketing plan under review • Clinical Director & Ops Director in place for Women & Families services • Close working with partners and GPs and women regarding maternity services	KPIs to Trust Board & TMG	15	TOM; TMG and CEO	Marketing plan review	Oct-15	Clinical Director Womens Health and Director of Strategy	FE/CB/SH/UG	TDA

BAF Ref	Type	Strategic Goal (SG) / Corporate Objective (CO) / Priority	Impact	Likelihood	Current rating (IxL)	High Level Risks	Positive Controls / Mitigations	Gaps in Controls	Rating post mitigations	Reporting & Monitoring	Actions/ Action Plans	Deadline	Executive Lead	Accountable Lead	External Assurance (eg audits/ inspections)
15	National and Local Priorities	Business continuity & emergency Planning	4	2	8	There is a risk that during an incident staff are not aware of incident planning or business continuity which will impact on patient safety and quality - and delivery of the operational and financial plans of the Trust	• Monthly steering committee • EPLO emergency planning officer weekly meetings with manager • Urgent & emergency care; policies and procedures in place; training in place including scenario training	Evacuation policy under review	8	Emergency planning committee; Borough Resilience Group; NHS E monthly meeting	Action plan in place based on national guidance & review of incidence	Ongoing	Chief Operating Officer	LS	National team annually National audit autumn contract
16	Local priority	Achieve Digital Maturity Index to be compliant with CQC requirements from 2016 and 5YFV and PHAC2020 requirements to become paperless by 2020	4	4	16	There is a risk that we do not invest in the core IT infrastructure, including fit for purpose data centres, to develop and maintain fast, secure, mobile and resilient access to IT services and becoming paperless to support improved patient care Risk that we do not invest in new IT solutions that enhance theTrust's Digital Maturity Index e.g. ITU, non-radiological images in the Vendor Neutral Archive, Vital Signs monitoring for Early Warning Scores, Blood Transfusion Tracking, Electronic Document Management System, Tele-health and Telemedicine solutions for patients with Long Term Conditions	• IM&T Strategy 2013-15 • Annual IM&T Development Workplan linked to annual IT capital investment programme • Develop revised IM&T Strategy 2016-2020 to align with the new Clinical and Estates strategies	IM&T Strategy 2016-2020 to be developed No CCIO in post Need a broader cohort of clinical leads for IT developments	12	TMG	Develop revised IM&T Strategy 2016-2020 to align with the new Clinical and Estates strategies	On-going	Chief Finance Officer	GW	CQC inspections HSCIC Digital Maturity Index assessments UCLP assessments TIAA audits
17	Local priority	changes in local commissioning and provider landscape	4	4	16	There is a risk that changes in the local commissioning and provider landscape impact on the future sustainability of Whittington Health	• Commissioners supportive of the ICO model • Contract in place • Transformation leadership group in place across Haringey and Islington • CEO and CFO fully engaged in work of Carnall Farrar in NCL strategic review	NCL strategic plan to be developed.	12	TMG Trust Board	Considering new models of care and potential for an ACO locally	Nov-15	CEO and Director of Strategy	SMH/VC/SB/CDs/MDs	NHSE/TDA
18	National and Local Priorities	Care Quality Commission Inspection	4	4	16	There is a risk that the Trust will not achieve the outcome of the CQC inspection that it is aspiring to achieve. There is a risk that the outcome will negatively impact on the future reputation of the Trust which would have a further impact potentially on staff morale; recruitment and retention and the confidence of our local population and stakeholders.	CQC Programme Board in place chaired by CEO Expert advisor in place in preparation Continued focus on quality and safety as strategic goal and corporate objective Preparation plan in place and mock inspections	Capacity to deliver	12	Quality Committee TMG TB	Programme Preparation plan in place	Dec-15	Director of Nursing & Patient Experience and Medical Director	All Executive	CQC

BAF Ref	Type	Strategic Goal (SG) / Corporate Objective (CO) / Priority	Impact	Likelihood	Current rating (IxL)	High Level Risks	Positive Controls / Mitigations	Gaps in Controls	Rating post mitigations	Reporting & Monitoring	Actions/ Action Plans	Deadline	Executive Lead	Accountable Lead	External Assurance (eg audits/ inspections)
19	Local priority	Culture across the organisation	5	3	15	There is a risk that the culture of the organisation does not enable change to take place at the pace required for clinical and financial sustainability	• Development programme in place for leadership • Policies updated • Values of the organisation being embedded • Organisational development programme being refreshed • External support in place to help change programme • Staff survey action plan in place	Capacity to deliver	12	TMG Trust Board	staff survey action plan	Dec-15	Director of Workforce	All Executive	Staff survey CQC

Whittington Health Trust Board

07 October 2015

Title:	Tackling Bullying and Harassment		
Agenda item:	**15/131**	**Paper**	**14**
Action requested:	For information		
Executive Summary:	This paper outlines work undertaken to promote anti-bullying and harassment across the Trust and sets out options for consideration for future interventions. The Whittington Health's 2014 national staff survey results were published in February 2015. A total of 1,563 out of 3,988 permanent staff took part in the survey, a response rate of 39%. The national average for 2014 was 42%. There were twenty-eight key findings based on the questions and measurements in the survey. The Trust was in the top 20% for three indicators and in the bottom 20% for six. When comparing with the previous year the Trust was in the top 20% for five and in the bottom for 20% for seven. 28% of all staff that responded reported that they experienced bullying, harassment and abuse from patients, their relatives or other members of the public in the previous 12 months, a decrease of 1% since 2013. 28% of all staff reported that they experienced bullying, harassment and abuse from staff in the previous 12 months, an increase of 4% since 2013, dropping us into the bottom 20% of Trusts across England. The Trust must develop a culture whereby barriers are recognised and addressed, policies are seen as effective, and each report of bullying is treated seriously. This papers sets out actions to achieve positive cultural change which will help to eradicate bullying and harassment.		
Summary of recommendations:	The Board is asked to • accept the report as assurance of the progress to date on tackling bullying and harassment; • consider and make recommendations regarding plans that are under development (table, section 2.0) which require further resourcing; • discuss and consider proposals as set out in section 3.0		
Fit with WH strategy:	Aligns fully to strategic intent.		
Reference to related / other documents:	Aligns to HR policies and procedures.		
Reference to areas of risk and corporate risks on the BAF	Captured in risk registers and board assurance framework as relevant.		
Date paper completed:	21st September 2015		

Author name and title:		**Norma French Director of Workforce**		**Director name and title:**		**Norma French Director of Workforce**	
Date paper seen by EC	**22/09**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

WHITTINGTON HEALTH NHS TRUST

Paper to:	Trust Board
Paper from:	Director of Workforce
Date:	7 October 2015
Subject:	Tackling Bullying and Harassment

1.0 Background

The Whittington Health's 2014 national staff survey results were published in February 2015. A total of 1,563 out of 3,988 permanent staff took part in the survey, a response rate of 39%. The national average for 2014 was 42%.

There were twenty-eight key findings based on the questions and measurements in the survey. The Trust was in the top 20% for three indicators and in the bottom 20% for six. When comparing with the previous year the Trust was in the top 20% for five and in the bottom for 20% for seven.

28% of all staff that responded reported that they experienced bullying, harassment and abuse from patients, their relatives or other members of the public in the previous 12 months, a decrease of 1% since 2013.

28% of all staff reported that they experienced bullying, harassment and abuse from staff in the previous 12 months, an increase of 4% since 2013, dropping us into the bottom 20% of Trusts across England.

It is important to consider the other areas that fell into the bottom 20% as they could be seen as being interrelated to bullying and harassment of staff. They are:

1.1 staff being appraised;
1.2 staff working extra hours;
1.3 staff suffering work related stress;
1.4 staff believing that the Trust provides equal opportunities to career progression;
1.5 staff experiencing discrimination at work;
1.6 staff experiencing bullying and harassment from staff.

The Trust must develop a culture whereby barriers are recognised and addressed, policies are seen as effective, and each report of bullying is treated seriously.

In September 2015 a report was published following the NHS TDA commissioning of the Good Governance Institute (GGI) to investigate allegations of bullying at Worcester Acute NHS Trust. That report said that the Trust's "dignity at work" policy for addressing bullying and harassment was not fit for purpose, either as a document or the way it is being administered. The GGI found divergent views amongst different teams at the Trust as to what constituted bullying and harassment, which exacerbated inconsistent approaches to policy and investigations. The report said that interviewees at board and senior management level felt the Trust's culture was positive and did not include bullying and harassment. There was a feeling that the terms had been used "by staff that did not want to be managed". It is important that Whittington Health reviews the experience at Worcester and ensures its own practices are fit for purpose.

This paper sets out action that the Trust has taken in the last 12 months to tackle bullying and harassment, along with proposals for consideration for future action.

2.0 Actions Taken to Date

The Medical Director for Integrated Care is the Trust's executive diversity champion and has been working closely with the Trust's Equality Lead/Head of Education, Learning and Development. The table below sets out the actions taken by the Trust over the past 12 months, along with plans that are still in development.

	Theme	Action(s)	Responsibility	Outcome(s)
1	Update Equality Policy	Conducted local staff survey and focussed groups for staff and patients to consult on revised policy	Head of Education	Equality Policy updated and due to be launched during September 2015. The title of the policy "Promoting Equality, Diversity and Human Rights".
2	Organisational Values	Chief Executive's presentation at corporate induction sets out the Trust's commitment to ICARE as the Trust's values, in particular treating all individuals with 'kindness and respect'. The Chief Executive personally invites new starters to address inappropriate behaviour or to speak to him personally.	Chief Executive	To set the standard for expected behaviour throughout the Trust. To give confidence that anti-bullying and harassment campaign is being led from the top of the organisation. To embed the Trust's organisational values that inform individual and organisational (or cultural) behaviour.
3	Celebrate Equality and Diversity Week	Human Rights Conference hosted by Medical Director Integrated Care and closed by the Chairman. 11th May 2015	Head of Education and team	Total of 52 attendees. Evaluation of event varied from good to excellent. Feedback – would welcome another conference to enable other staff to attend.
4	Develop action plan to achieve Whittington Health's baseline date for 2015 to be compliant with NHS Workforce Race Standard (WRES)	1. Produce equality data on current workforce, based on WRES guidelines 2. Update equality data on personal files via ESR to inform publication of reports 3. Recruitment forms capture relevant equality data monitoring data 4. Availability of equality workforce data by ISCU/department and staff make use data to make informed decisions.	Head of Education and team Revised date – September 2015 to March 2016	Outstanding – due lack of capacity and skills within the Workforce Directorate
5	Raising awareness –	Developing	Head of Education	Increase health

	LGBT	workshop/sessions to start in September 2015	and team	professionals and front-line staff knowledge and understanding
6	Domestic Violence Week	Conference scheduled for November 2015	Head of Education in conjunction with Adult Safeguarding team and Learning & Development Services	To promote awareness and increase understanding of the issues faced by victims, families and wider community
7	Trust Board development	BRAP (a charity with a focus on equality, human rights and inclusion) The Director of BRAP gave a presentation of equalities and inclusion in July 2015 Follow-up presentation in November 2015	Director of Workforce/ Head of Education	To explore executive responsibility and provide corporate leadership
8	Leadership and management development	Development of equality/unconscious bias/anti-bullying training for line managers	Head of Education To commence October 2015 to March 2016	To increase understanding, give confidence and skills to performance manage potential situations
		Development of a masterclass workshop for ISCU leads and TMG (to be confirmed)	Head of Education and Leadership Coach Deadline: February 2016	To understand legal responsibilities and good practice
		Development of a workshop for HR professionals and team	Head of Education Deadline: September 2015	1) To offer support and advice to colleagues/managers on issues of inclusion 2) To understand how to support the Trust deliver against the WRES obligations
9	BME focus group	Focus group with cross-section of staff 27th July 2015; 8th September 2015	Head of Education/ Director of Nursing Chairman	To gain some insight and explore staff experiences and observations

3.0 Proposals for the Future

Having a Trust policy on an issue is a common answer to a problem, but a policy is only part of the solution. Any policy is worthless without a culture that believes in and supports it. A policy must be effectively implemented and form part of a drive to shift culture in a positive direction. The policy needs to be owned at every level of the organisation and managers should lead by example. This requires buy-in from the Trust Board down.

Staff should also be encouraged and supported to challenge bullying behaviour. Previous surveys among NHS staff have shown that a significant proportion of victims say they are unlikely to report incidents out of fear of repercussions or the belief that nothing would be done about it, and claim that poor communication and management are the reason. Those who have been bullied will only come forward if they are able to report their concerns in a "safe" way that means they will not be victimised or cast aside.

Training for managers is also imperative. They should be given the confidence to tackle a situation if it arises and not feel that they should immediately pass it to HR to deal with. It is far better for managers to feel they can tackle a bullying issue at an early stage than to leave the issue to fester and end up in court. There are key steps the Trust needs to consider:

- Look at the culture of the Trust - where and how might the risk of harassment arise?
- Foster an environment where staff feel able readily to raise any concerns, before they become problems;
- To support this, have a clear and well publicised policy to tackle harassment issues;
- Back this up with training (including how to handle grievances) and set good examples through role models;
- Deal with harassment wherever and however it arises, to demonstrate that it is unacceptable and will not be tolerated;
- Provide independent employee assistance, including confidential counselling and other support for employees to enable them to challenge unreasonable behaviour which, left unchecked, could lead to harassment

There are a number of initiatives that the Trust may wish to consider to compliment the work to date and work in progress as set out in section 2.0. These are as follows:

3.1 Creation of Harassment Adviser Roles

Harassment Advisors can be trained to support staff who feel that they may be the target of bullying or harassment. Their role is to listen and talk through the problem with the person, explain the Trust's procedure, discuss the options, and provide ongoing support. The Advisors are also there to offer help and support to those accused of bullying or harassment. For a Trust the size of Whittington Health it is recommended that a group of around 10 – 15 individuals receive specialist training for the role.

The role must be supported by both unions and management and Advisers should be allowed up to four hours per month to undertake their role if called upon. A supporting protocol of ethic would be developed and regular supervision and updates will need to be provided to keep the Harassment Advisers up to date with issues such as new legislation. They should be representative of all levels in the Trust and their appointment should follow a rigorous selection process designed to ensure a thorough understanding of the role and the boundaries within which it operates and that management and union roles were not undermined.

Developing the Harassment Adviser role at Whittington Health will require funding and securing external expert support to develop an appropriate training package.

3.2 *Counselling and Support Interventions*

The Trust Employee Assistance Programme (EAP) run by *People@Work* provides a range of counselling and support interventions. The team provide a supportive and confidential environment where they can work with individuals to develop strategies to take back to the

workplace to resolve these issues. Staff can access on-line advice 24 hours a day. However the current contract with *People@Work* is such that referral to counsellors can only be made via occupational health. Therefore this service may not be consistently accessed as an intervention in bullying and harassment cases. It is recommended that on receipt of a formal complaint and as part of the initial review process, individuals be actively encouraged to seek resolution of the issue through a mediation process which an EAP service can provide.

As part of this approach, the various counselling and support interventions need to be further strengthened with the provision of coaching, particularly aimed at managers, which will assist individuals with confidence building and adopting a solution focused approach to workplace issues.

Increasing the remit of the contract with *People@Work* and developing a tailored coaching programme for managers cannot currently be resourced within existing budgets.

3.3 *Communications*

It is proposed that there is a concerted effort via the existing Trust communication systems to publicise bullying and harassment related articles from the autumn onwards. Staff should be reminded of the bullying and harassment procedure; referred to further information and support and advised of our plans for the future. In addition our Bullying and Harassment Policy should be re-launched with a new one-page easy to follow guide for staff to use to decide what action to take if they are experiencing or witnessing inappropriate behaviour.

3.4 *Training*

A range of training interventions continue to take place, however we are in the process of reviewing the Trust's offering for leadership development and it is proposed that this offering covers aspects including: conflict resolution; coaching skills; giving and receiving feedback, and dealing with and recognising bullying and harassment in the workplace, and perhaps consider in-depth or advanced 'handling grievance' training for first and second tier line managers. In addition consideration of mandatory e-learning in this area for all staff should be given.

3.5 *External Assistance – Task and Finish Group/Facilitated Sessions*

The Trust may wish to consider approaching an external organisation (for example ACAS) for assistance in identifying what bullying looks like within the Trust. This would involve the creation of a Task and Finish Group involving ACAS who would facilitate a series of information gathering sessions (for example through focus groups) that can be genuinely representative of the remainder of the Trust. ACAS would produce a report of its findings for presentation to the Task and Finish Group.

This initiative, along with financial resources, will require buy-in from the Trust Board, managers and staff side representatives.

3.6 *360 Degree Appraisals*

It is recommended that consideration be given to introducing 360 degree appraisals for all senior managers and directors as part of the annual appraisal process. What this will mean is that an individual is assessed not only by their line manager, but by their peers and juniors. There is also an element of self assessment. The Leadership Academy 360 Appraisal Tool is a well-regarded system which can be purchased at a cost of around £45 per individual.

4.0 Recommendations

This paper outlines work undertaken to promote anti-bullying and harassment across the Trust and sets out options for consideration for future interventions.

Capacity to focus more resources on tackling significant aspects, such as the workforce data, to provide data and make improvements are limited due to organisational constraints.

The Board is asked to:

a) note the progress to date on tackling bullying and harassment;
b) consider and make recommendations regarding plans that are under development (table, section 2.0) which require further resourcing;
c) discuss and consider proposals as set out in section 3.0 and agree proposals that should be further worked up further, fully costed and presented to TMG with a timeline for implementation.