NHS
Whittington Health
NHS Trust

Trust Board meeting in Public Agenda

There will be a meeting of the Trust Board in Public on **Thursday, 25 November 2021** from **9.30am to 11.05am** via video conference.

Item	Time	Title	Presenter	Action
		Standing agenda items		
1	*9.30*	Welcome, apologies, declarations of interest	Trust Chair	Note
2		Patient experience story	Deputy Chief Nurse	Discuss
3	*9.55*	30 September 2021 public Board meeting minutes, action log, matters arising	Trust Chair	Approve
4		Chair's report	Trust Chair	Note
5		Chief Executive's report	Chief Executive	Note
		Quality and safety		
6	*10.15*	Quality Assurance Committee report	Committee Chair	Note
		People		
7	*10.25*	Staff wellbeing and support	Director of Workforce	Discuss
		Performance		
8	*10.35*	Financial performance and capital update	Chief Finance Officer	Review
9		Integrated performance report	Chief Operating Officer	Review
		Governance		
10	*10.55*	Digital Strategy	Director of Strategy & Corporate Affairs	Approve
11		Audit and Risk Committee report	Committee Chair	Note
12		Charitable Funds Committee report	Committee Chair	Note
13		Questions to the Board on agenda items	Trust Chair	Note
14	*11.05*	Any other urgent business	Trust Chair	Note

Minutes of the meeting held in public by the Board of Whittington Health NHS Trust on 30 September 2021

Present:	
Baroness Julia Neuberger	Chair
Siobhan Harrington	Chief Executive
Kevin Curnow	Chief Finance Officer
Dr Clare Dollery	Medical Director
Professor Naomi Fulop	Non-Executive Director
Amanda Gibbon	Non-Executive Director
Carol Gillen	Chief Operating Officer
Michelle Johnson MBE	Chief Nurse & Director of Allied Health Professionals
Tony Rice	Non-Executive Director
Anu Singh	Non-Executive Director
Baroness Glenys Thornton	Non-Executive Director
Rob Vincent CBE	Non-Executive Director
In attendance:	
Dr Junaid Bajwa	Associate Non-Executive Director
Ruben Ferreira	Freedom to Speak Up Guardian (item 6)
Norma French	Director of Workforce
Jonathan Gardner	Director of Strategy & Corporate Affairs
Gordon Houliston	Director of Operations, Children and Young People Integrated Clinical Service Unit (jtem 10)
Dr Sarah Humphery	Medical Director, Integrated Care
Tina Jegede	Joint Director, Race, Equality, Diversity & Inclusion and Nurse Lead, Islington Care Homes
Andrew Sharratt	Acting Director of Communication & Engagement
Swarnjit Singh	Joint Director, Race, Equality, Diversity & Inclusion and Trust Secretary

No.	**Item**
1.	**Welcome, apologies and declarations of interest**
1.1	The Chair gave a warm welcome to everyone present at the meeting. She explained that the normal patient experience item which started board meetings held in public would instead be included in Whittington Health's Annual General Meeting, taking place later today.
1.2	There were no apologies. Junaid Bajwa reported he had been appointed as a Non-Executive Director on the Board of the Medicines and Healthcare products Regulatory Authority.
1.3	**The Board noted the declaration for inclusion in the register of Board members' interests.**

2.	**Minutes of the meeting held on 30 June 2021**
2.1	The draft minutes were agreed as a correct record. The action log was noted, including the Board seminar to be held on 8 October to discuss work taking place on population health and anchor institution initiatives to help tackle local health inequalities.
3.	**Chair's report**
3.1	The Chair acknowledged that it remained a very busy time in community and hospital services and thanked staff for their amazing work in continuing to deliver high quality care during the pandemic, while also planning for and administering the Covid-19 booster and winter flu vaccinations. She congratulated Norma French on her appointment as Director of Workforce for the North Central London Integrated Care System and Tina Jegede and Swarnjit Singh on their appointments as Joint Directors of Race, Equality, Diversity & Inclusion.
3.2	The Chair reported on the meeting of the University College London Health Alliance's Board held on 27 September 2021. She welcomed decisions taken to work collaboratively on elective recovery pathways and work taking place on staff development programmes. In addition, she thanked Tony Rice and Amanda Gibbon for participating in recruitment panels for Consultant positions. During discussion, it was noted that, while it was sometimes difficult to recruit to certain clinical specialities, the selection panel for a consultant paediatrician had welcomed the very strong field of candidates attracted by this opportunity.
3.3	**The Board noted the Chair's report**.
4.	**Chief Executive's report**
4.1	Siobhan Harrington thanked staff who were working incredibly hard in the face of pressures normally experienced during the winter. She highlighted the following: • This morning, there were 11 hospital inpatients with Covid-19 • Amanda Pritchard, Chief Executive of NHS England and Improvement, and other senior colleagues held a call with London's NHS Chief Executives, Medical Directors and Chief Nurses. There was a real respect for and acknowledgment of how hard people were working during a challenging time and a clear recognition that the health and wellbeing of staff was a high priority • All staff were being encouraged to complete the annual NHS staff survey. Their survey feedback was incredibly important and was used to improve the experience of working in the NHS which was itself linked to improved patient care • While there were significant challenges across health and social care systems, Whittington Health was making good progress in its work on the recovery of elective and community services • Partners in the North Central London Integrated Care System were developing the sector's winter plan. Whittington Health was integrally involved in this process, and the plan would be considered at the Board's meeting in October

	• Maintaining a real grip on recurrent expenditure would remain important in the two final quarters of the year • Tina Jegede and Swarnjit Singh had joined the Board as non-voting directors and would lead work to help improve outcomes for staff equality and inclusion • During October, there were several excellent events held to celebrate Black History Month, including the unveiling of a statue from the Nubian Jak Community Trust recognising the service provided by Commonwealth and Windrush nurses and midwives in the NHS • Lorna Wells, Senior Midwife, Lukasz Kulesza, Information Technology Project Manager, and Theresa Renwick, Safeguarding lead were three excellent and worthy winners of the staff excellence awards this month
4.2	Michelle Johnson reported that the Covid-19 booster and winter flu vaccination campaigns had started this week. In reply to a query from Rob Vincent, she explained that, based on intelligence, the NHS was offering patients and staff a quadrivalent influenza vaccination which was designed to protect people against four different flu strains.
4.3	Anu Singh asked whether there was any support which the Board might provide to help improve equality and inclusion for staff. Tina Jegede welcomed the support and commitment of Board members to this work and explained that a report would be considered by the Workforce Assurance Committee in December before coming to the Board.
4.4	**The Board noted the Chief Executive's report.**
5.	**Quality Assurance Committee**
5.1	Naomi Fulop thanked Swarnjit Singh for an excellent report which helpfully set out the key areas where the Committee took significant assurance from the items discussed at the meeting. Highlights included • The bi-annual safeguarding report, discussed at the Committee's previous meeting • A review of the Board Assurance Framework entries related to the Trust's Quality strategic objective • Performance against recovery targets, particularly in day case and outpatient activity • A presentation from the Emergency & Integrated Medicine Integrated Clinical Service Unit (ICSU) which included work to improve the patient experience for people with sickle cell disease through the creation of an ambulatory care model which allowed patients to alert the emergency department that they were on their way to hospital • Progress with delivery of the nursing and midwifery strategic priorities, such as the identification of Patient Experience Ambassadors for each ICSU
5.2	In reply to a question from Rob Vincent about complaints concerning appointments, Carol Gillen provided assurance that work was taking

	place with the Patient Advice and Liaison Service team regarding appointment queries. In addition, she highlighted work taking place with local General Practitioners through the Clinical Interface Group which included primary care colleagues and with partners in North Central London on improving the information provided to patients.
5.3	**The Board noted the Chair's assurance report for the Committee meeting held on 8 September.**
6.	**Freedom to Speak Up Guardian**
6.1	Ruben Ferreira presented the report and drew attention to the initiatives taking place to promote a freedom to speak up culture. These included the development of the Freedom to Speak Up Advocates' Network (which now had 41 members), continued visibility and promotion through close working with the Communications team, and greater collaboration with the Directors of Inclusion and each of the four staff equality networks.
6.2	Amanda Gibbon welcomed the report, especially the fact that none of the 43 concerns raised during the period of the report were made anonymously - testament to the positive culture developed. Siobhan Harrington and the Chair thanked Ruben Ferreira for his work as the Trust's Freedom to Speak up Guardian and offered him the Board's continued support.
6.3	**The Board noted the report and the work taking place by the Freedom to Speak Up Guardian from March to August 2021.**
7.	**Workforce Assurance Committee**
7.1	Anu Singh reported that the Committee was served with a very high calibre of reports. She highlighted the discussion on international nurse recruitment where Committee members heard directly from staff recruited from overseas about the positive welcome they had received, and the support provided to them, as part of acclimatisation and adaptation to the NHS and the UK.
7.2	**The Board noted the Chair's report for the Committee meeting held on 1 September and the areas of significant assurance highlighted.**
8.	**2020/21 Annual doctors' medical appraisal and revalidation**
8.1	Clare Dollery reported that medical appraisals for doctors were suspended in March 2020 in response to the Covid-19 pandemic and restarted in October 2020 using a new format developed by the Academy of Medical Royal Colleges. She was pleased to see the positive feedback received about medical appraisals and sought approval to submit the report. Clare Dollery also highlighted work identified for next year, which included increasing the pool of appraisers, completing a peer review exercise, reviewing the Revalidation policy and the procurement of a new appraisal software system.

8.2	**The Board approved the annual doctors' medical appraisal and revalidation report for submission to the higher-level responsible Officer for the NHS England, London region.**
9.	**Financial performance and capital update**
9.1	Kevin Curnow took the report as read. He emphasised the following points to Board members: • The Trust's performance was broadly on plan, with its deficit of £923k at the end of August £30k better than planned. The receipt of c. £2.8m of elective recovery funding had helped to mitigate increased expenditure in some areas and the delayed delivery of some of cost improvement programmes due to the pandemic. Assurance was provided that all corporate departments and ICSUs were working to reduce respective run rates during the latter six months of the year • At the end of August, the Trust had spent £4.6m of its capital allocation, £1.4m behind plan. This was largely due to the phasing of the plan and the forecast was that all the 2021/22 capital allocation would be spent • The Trust was signed up to the NHS's commitment to improve its Better Payment Practice Performance (BPPC) by paying 95% of all invoices within the standard credit terms. Overall, the Trust's BPPC was 90% by volume and value • National guidance was due to be issued for operational and financial arrangements covering the second half of the financial year.
9.2	During discussion, the following points arose: • In reply to a question from Junaid Bajwa, Siobhan Harrington explained that staff were thinking and working innovatively in community services and cited the work being undertaken by the Rapid Response and Virtual Ward teams • Rob Vincent and Tony Rice highlighted the capital expenditure plan and noted that the Finance and Business Development Committee would be carrying out a deep dive into estates work, the emergency department, and one community service
9.3	**The Board noted the financial performance and capital expenditure report for the end of August 2021.**
10.	**Integrated performance report**
10.1	The report was taken as read. Carol Gillen pointed out these key headlines: • August was a very challenged month with service and workforce challenges experienced across the local health and social care system and the whole of London • Performance against the four-hour access standard was 80.1%. The national average in August was 77.01%, the London average was 80.27% and the NCL average was 80.98%. There were three mental health 12-hour trolley breaches related to the availability of beds in

	that service. NHS England and Improvement's Emergency Care Improvement Service team would be providing feedback to support Whittington Health • The level of patient DNAs had increased as a result of some patients refusing to have Covid-19 swabs prior to treatment and other patients who did not wish to come to a hospital environment. Work was also taking place to optimise theatre utilisation and included benchmarking against Getting It Right First-Time measures • Good progress was being achieved on reducing the number of patients who had waited over 52 weeks since their referral to treatment: Whittington Health was the only provider in North Central London sector which has no patients who had waited more than 104 weeks for treatment since referral • The detailed appendices provided updates and trajectories for how the Community Audiology and Therapies Services aimed to reduce sizeable backlogs which had grown during the pandemic to less than a 12 week wait to first assessment, to increase activity above benchmark levels in therapies and to achieve the six weeks waits target for audiology diagnostics
10.2	During discussion, the following points were made: • Amanda Gibbon asked for an update on staffing across the boroughs served by audiology services. In response, Gordon Houliston referred to the benefits of scale which would be felt in audiology services and advised that staff from currently served boroughs where such waiting times were lower would help the service now being provided in the London Borough of Barnet. He provided assurance that the recovery trajectory was positive and saw the inherited backlog in Barnet being cleared by Summer 2022 • Gordon Houliston also provided assurance on plans to help reduce waiting times for speech and language therapy assessments in Barnet. He explained that Whittington Health was now the major provider of children's therapies services in North London and had a key aim to reduce waiting times across the whole area it served • Siobhan Harrington thanked Gordon Houliston and his team who had worked very hard and highlighted the opportunity to bring a patient or staff story item to a future Board meeting in six months' time which demonstrated the progress achieved on speech and language services across North London
10.3	**The Board noted the integrated performance report and that an update would come back on speech and language services in North London to its April 2022 meeting.**
11.	**Audit and Risk Committee**
11.1	Rob Vincent reported that a good meeting had been held with quality reports presented and drew attention a very good review by the internal audit team on patient experience work during the pandemic. He also highlighted to Board members that the Committee had sought assurance on the implementation of recommendations for consultant job planning

	which had been impacted by the pandemic by its next meeting in October.
11.2	**Board members noted the Chair's assurance report for the Audit and Risk Committee meeting held on 22 July.**
12.	**Charitable Funds Committee report**
12.1	Tony Rice reported that there was a significant amount of activity under way in the charity, such as the development of a new website and on the consolidation of funds. He explained that the Committee would hold an additional meeting in December. Tony Rice outlined the bids approved by the Committee at its last meeting. These covered the installation of a sensory room at Simmons House Adolescent inpatient unit, for artworks at the hospital site and at Simmons House to help improve patient health and wellbeing, and for musical therapy interventions.
12.2	**The Board noted the Chair's assurance report for the meeting held on 29 June.**
13.	**Questions to the Board on agenda items**
13.1	There were none received.
14.	**Any other business**
14.1	Jonathan Gardner highlighted updates on the development of maternity services. He explained that the Strategic Outline Case was being developed with a phased plan for the development of the neo-natal intensive care unit and the maternity unit and provided assurance that there was continued engagement with clinicians and the local authority who were both very supportive of the plans.

Action log, 30 September 2021 Public Board meeting

Agenda item	Action	Lead(s)	Progress
Integrated performance scorecard	Bring an update on performance in speech and language therapy services to the April 2022 meeting.	Carol Gillen	In hand for April 2022

Meeting title	**Trust Board – public meeting**	**Date: 25 November 2021**
Report title	**Chair's report**	**Agenda item: 4**
Director lead	Julia Neuberger, Chair	
Report author	Swarnjit Singh, Trust Secretary	
Executive summary	This report provides a summary of activity since the last Board meeting held in public.	
Purpose:	Noting	
Recommendation(s)	Board members are asked to note the report	
Risk Register or Board Assurance Framework	Quality 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective, or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.	
Report history	None	
Appendices	None	

Chair's report

This report provides an update to Board members on recent activities:

Covid-19 – As always, and particularly during this COVID 19 epidemic, I want to thank all our staff for all their care and attention in proving care to our patients at our healthcare sites. I have been incredibly impressed by their continued resilience and professionalism in responding to the pressures placed upon the NHS by the Covid-19 pandemic, the recovery of elective and other services, and the onset of winter pressures.

External meetings – I attended meetings with colleagues in North Central London Integrated Care System, the University College London Health Alliance Board and with partners at the London Borough of Islington.

Service visit – on 6 October, I had the pleasure of visiting the Holloway District Nursing Service with Siobhan Harrington to learn of the excellent service they provide in the community.

Awarding of the freedom of the Borough to Whittington Health by the London Borough of Islington – I was thrilled to join a small group of staff and Siobhan Harrington at the Town hall for Siobhan to receive the Freedom of the Borough on our behalf.

Trust Board seminar – on 8 October, Board members held an engaging and interesting seminar. The topics discussed included the 2021/22 priorities and operational guidance issued by NHS England and Improvement, the lease for the Community Diagnostic Hub in Wood Green and Whittington Health's work on population health and being an anchor institution.

Corporate induction – I was pleased to meet new recruits to Whittington Health on 11 October and 8 November.

Consultant recruitment – I am very grateful to the following non-executive directors who participated in recruitment and selection panels for these Consultant posts:

Date of panel	Post title	Non-Executive Director panel member
30/09/2021	Interventional Radiology Consultant	Tony Rice
12/10/2021	Consultant in Gastroenterology	Amanda Gibbon
09/11/2021	Consultant in Cardiology	Julia Neuberger
11/11/2021	Consultant in Anaesthetics	Glenys Thornton

London Workforce Race Equality Standard for Non-Executive Directors – I am delighted to report that Glenys Thornton will attend this development programme commissioned by NHS

England and Improvement. This initiative is designed to enable NHS Boards and Integrated Care Systems improve their individual and collective capability on race and inequality in order to hold to account the executive as well as support them in their decision-making processes on matters such as allocation of resources and equal opportunities for black, Asian, and ethnic minority staff in their organisations. I look forward to the learning being shared with other Board members in due course.

Meeting title	**Trust Board – public meeting**	**Date: 25 November 2021**
Report title	**Chief Executive's report**	**Agenda item: 5**
Executive director lead	Siobhan Harrington, Chief Executive	
Report author	Swarnjit Singh, Trust Secretary, and Siobhan Harrington	
Executive summary	This report provides Board members with updates on developments nationally and locally since September's Board meeting held in public.	
Purpose	Noting	
Recommendation	Board members are invited to note the report and to approve the Digital strategy	
Risk Register or Board Assurance Framework	All Board Assurance Framework entries	
Report history	Report to each Board meeting held in public	
Appendices	None	

Chief Executive's report

Since our last Board meeting, the Trust continues to operate against a backdrop of increased demand for services across the health and social care system. Our teams are working through the challenges of caring for people with Covid-19, alongside treating more patients and the recovery of services. Our focus is on maintaining patient safety whilst also caring for our amazing staff. I would like to thank each and everyone of our staff in the community and hospital who continue to care for our patients. As we enter the next few months, we anticipate it will be a challenging winter and we will continue to support our teams and listen to what we can do more of to maintain our focus on 'caring' and support the team spirit that is Whittington Health. A separate report on today's agenda provides an update on the support which has been provided to our staff.

Covid-19 vaccination consultations

The Secretary of State for Health and Social Care[1] announced the outcome of two consultations. The first consultation considered whether people working in care homes should be vaccinated against Covid-19 as a condition of employment from 11 November 2021. The second consultation looked at extending this requirement to health and other social care settings, including in NHS hospitals and independent healthcare providers. The outcome of this consultation is a requirement for all healthcare workers to be vaccinated against Covid-19 from 1 April 2022.

Whittington Health's latest Trust Covid-19 vaccination statistics are shown below. In addition, as of 17 November, 56% of our substantive staff had received their winter flu vaccination.

Staff group	%
Substantive staff vaccinated with first jab	88%
Substantive staff vaccinated with second jab	81.3%
Substantive staff vaccinated with booster jab	25.8%
BAME staff vaccinated with first jab	85.4%
BAME staff vaccinated with second jab	78.5%
BAME staff vaccinated with booster jab	19.7%

Inquiry into mortuary offences

Following the trial of David Fuller for sexual offences committed while working at Maidstone and Tunbridge Wells NHS Trust, the Secretary of State for Health and Social Care announced that a public inquiry would be led by Sir Jonathan Michael. The inquiry will report next year and will identify areas for action by all NHS trusts.

UK security level

Following the shocking terrorist incident at Liverpool Women's Hospital, the national security level has changed from Substantial to Severe. On Monday, 22 November, the Trust will conduct an exercise to test its Major Incident Response arrangements as part of its preparedness for emergency situations.

[1] https://www.gov.uk/government/speeches/health-secretary-statement-on-vaccines-as-a-condition-of-deployment

Sickle cell care
On 16 November, the All-Party Parliamentary Group on Sickle Cell and Thalassaemia[2] published the findings from its inquiry into care for patients with sickle cell disease. Key findings from the inquiry include evidence of sub-standard care for sickle cell patients admitted to general wards or attending Accident and Emergency departments, a low awareness of sickle cell among healthcare professionals, insufficient investment in sickle cell care, and negative attitude towards sickle cell patients. The Trust's Management Group will review the inquiry's recommendations for improved practice and care for sickle cell patients within our strategy for this service findings.

North Central London Integrated Care System
I would like to congratulate Frances O'Callaghan on her appointment as Chief Executive of the NHS Integrated Care Board (ICB) for North Central London. The North Central London ICB will come into existence in 2022 when the Health and Care Bill is passed, as a new NHS body with responsibility for:

- improving outcomes in population health and healthcare
- tackling inequalities in outcomes, experience, and access
- enhancing productivity and value for money
- helping the NHS to support broader social and economic development

NHS System Oversight Framework
The North Central London Integrated Care System was categorised by NHS England and Improvement within segment two of its System Oversight Framework. The segmentation decision indicates the scale and nature of the support provided by NHS England and Improvement.

Whittington Health received notification of its allocation under segment two of the System Oversight Framework (see appendix 1). This segmentation reflects NHS trusts that receive flexible support delivered through peer support, clinical networks, and from NHS England and NHS Improvement to address areas of challenge. There are four segments within the framework, with segment 1 allocated to NHS trusts and systems described as consistently high performing.

Digital strategy
At its seminar on 28 October, the Trust Board discussed and fed back ideas for our Digital strategy which is included on today's agenda for final ratification.

Sustainability
As the UN's COP26 summit has been taking place in Glasgow this month, Whittington Health has continued to reflect on what more we can do as part of our contribution. The Trust is proud of its achievements over the last five years as we have:

- reduced our carbon emissions by 32% since 2016/17
- implemented a gold-standard recycling scheme to eliminate waste to landfill
- Grown our electric vehicle fleet to 13 cars & six chargers to significantly reduce carbon dioxide emissions from business travel and improve local air quality
- invested in LED lighting upgrades making significant electricity savings

[2] https://www.sicklecellsociety.org/no-ones-listening/

- implemented an Anti-Idling policy so that our drivers do not leave engines running while stationary to reduce an unnecessary source of air pollution
- introduced the Clean Air Walk in Archway which encourages visitors, staff, and patients of Whittington Hospital to travel between the hospital and Archway station using side streets to avoid any harmful pollution on Highgate Hill. The route goes through the Girdlestone Estate which contains a park and children's playground
- implemented a cycle to work scheme for staff to purchase a cheaper bicycle making their commute cheaper and more environmentally friendly
- planning routes for patients who are particularly vulnerable to air pollution through an air quality app as evidence suggests that air pollution is linked to poor recovery and higher infection rates of COVID-19 due to damage caused to the lungs

Going forward there is more that Whittington Health wants to do. Our future plans include:

- publishing our Green Plan which provides detail on our wider approach to environmental sustainability
- quantifying and developing plans to reduce our “NHS Carbon Footprint Plus” which includes emissions from our supply chain
- procuring 100% certified green electricity
- developing a Heat Decarbonisation Plan to define how the organisation will reach the NHS target of Net Zero Carbon by 2040
- becoming a “Clean Air Hospital” with the support of Global Action Plan & the local council to ensure patients and staff have access to clean air when visiting the hospital

Fire safety

The Trust has previously reported to the Board the issue of a small fire in the basement of the hospital at the Archway site back in 2018. The resulting investigation revealed that smoke detection and compartmentation was either faulty or had not been installed correctly at the time of build. It was also discovered that the lifecycle maintenance regime of equipment may not have been carried out by the supplier to the required standards. The Trust has since implemented a 24-hour ‘waking watch’ as well as trained over 550 staff as fire wardens and strengthened its fire safety team, in conjunction with ongoing advice and support from the London Fire Brigade and NHS England and Improvement, to mitigate any operational risks.

Since the ownership and responsibility of the building returned to the Trust, it has engaged with independent surveyors to determine whether fire safety provision, building fabric condition and the lifecycle maintenance works conform to the historic standards when they were built and current standards if they have since been replaced or repaired. It is anticipated that these surveying and reporting works will be completed by Q1 2022/3. The surveyors will advise on the work required to return the building to a compliant standard.

Whittington Health Staff Made Freepersons of Islington

I am proud to announce that all of Whittington Health's staff were made honorary freepersons of the London Borough of Islington at a special ceremony held on 18 October at Islington Town Hall. The title of Honorary Freeperson is the highest

honour the council can bestow and is reserved for people and organisations who are exceptional in their service to the public. The Freedom of the Borough award is a real tribute to our colleague's dedication, strength and professionalism, at all times, but especially over the past months of the pandemic as they have cared for Londoners in need. Leader of the Council, Councillor Kaya Comer-Schwartz said: "It is a great privilege to award the Freedom of the Borough to Islington's heroes who have done so much to improve the lives of local people. Our brilliant health workers are so richly deserving of this recognition. The last two years have shown just how massive their contribution is to life in the borough. They have worked so hard to keep us safe during the health crisis, which must have been exhausting and overwhelming at times. On behalf of Islington Council, I want to say that we are so grateful for their selfless service."

Board Maternity Safety Champions
I am pleased to report that Clare Dollery, Medical Director, will formally be returning to be the joint maternity safety champion alongside Michelle Johnson, our Chief Nurse and Director of Allied Health Professionals. They will be assisted in this by Baroness Glenys Thornton, our Non-Executive Director lead for maternity services.

Deputy Chief Nurse
I would like to congratulate Breeda McManus, our Deputy Chief Nurse, who will be leaving Whittington Health for a six-month secondment with Homerton University Hospital Foundation Trust as their new Chief Nurse after nearly three years with us. Deborah Clatworthy will remain as Deputy Chief Nurse during this period.

Quality and safety operational performance
Headlines include the following:

- Covid-19 - as of 17 November, Whittington Health had 21 Covid-19 positive inpatients, including one inpatient in our intensive care unit.
- Emergency Department – in October, there was continued pressure on the emergency care pathway across the UK. At Whittington Health, performance against the four-hour access standard was 73.9%. In London, the average during this period was 76.4% and the North Central London average was 72.55%. There was one non-mental health and two mental health 12-hour trolley waits
- Cancer – performance against the two week wait standard was 79.3% in September 2021; performance against the 62 day standard was at 64.9%. An appendix to the integrated performance report later on this agenda provides further detail on performance against cancer targets
- Referral to Treatment – at the end of October, there were 558 patients waiting more than 52 weeks for treatment
- Workforce – staff appraisal rates in October were at 66% and compliance against mandatory training requirements was at 78.8%
- Ambulance handover times – there is a detailed appendix provided with the integrated performance report which details work taking place to reduce or eliminate ambulance handover times

Financial performance
At the end of October, Whittington Health reported a deficit of £1.4m, a favourable variance of £0.2m against a planned deficit of £1.6m. The deficit position was due to

delays in implementing cost improvements schemes and other expenditure not covered by funding arrangements bin place for the first six months of this financial year. The Trust has spent £6.1m of its capital allocation so far this year. While this is £3.0m behind plan, the Trust is still forecasting to spend its capital allocation for 2021/22.

Tynemouth Road update

At the end of October, building work started at Tynemouth Road Health Centre. The significant investment into the Centre will make it the new Children and Young People's health hub for Haringey. Several of our services will be moving to the site from St Ann's Hospital and Bounds Green Health Centre, including Haringey children's therapies and community paediatrics. The renovated site will include clinic spaces designed for children and young people, improved facilities for local families and refurbished office spaces that will support agile working. We will share further updates with you over the coming months as the project progresses.

Diagnostic services in Haringey

I am delighted to announce that a new Community Diagnostic Centre, hosted by Whittington Health, will be opening in the Wood Green Shopping Centre early next Summer. The Centre will offer x-ray, ultrasound, ophthalmology, and phlebotomy services to local people in the heart of our community. By bringing care closer to people's home, the centre aims to make accessing care easier and to reduce waiting lists, which have increased due to the pandemic. We also hope that by locating these services in the heart of the high street we can stimulate footfall which will help to support and bolster the local economy. As approved at the private Board meeting held in October, Whittington Health has now signed the lease for the Centre.

Remembrance Day

As part of Remembrance Day activities on 11 November, Whittington Health's staff marked their respect for contribution made by members of the armed forces. In addition, staff were also able to see a speech from Brigadier Paul Baker OBE who talked about the importance of Armistice Day. Tina Jegede also attended the Islington Remembrance service on behalf of the Trust.

Staff excellence award

I am pleased to congratulate Robyn Day, Staff Nurse, who was awarded this month's staff award for demonstrating our Excellence value. Robyn was nominated for keeping the ward safe and patients well cared for despite the difficult circumstances over many months.

Meeting title	**Trust Board – public meeting**	**Date: 25 November 2021**
Report title	**Quality Assurance Committee Chair's report**	**Agenda item: 6**
Committee Chair	Naomi Fulop, Non-Executive Director	
Executive director leads	Michelle Johnson, Chief Nurse & Director of Allied Health Professionals and Clare Dollery, Medical Director	
Report author	Marcia Marrast-Lewis, Assistant Trust Secretary	
Executive summary	The Quality Assurance Committee met on 10 November 2021 and was able to take significant or reasonable assurance from the following items considered: • Chair's report, Quality Governance Committee • Board Assurance Framework – Quality entries • Annual review of the Risk Management Strategy • Trust Risk Register • Performance on elective recovery • Bi-Annual Nursing Establishment Review • Surgery and Cancer Integrated Clinical Service Unit (ICSU) quality improvement and assurance presentation • Serious Incidents report for August and September • Quarter two, Quality report • 2020/21 Medicines Optimisation Annual Report • 2020/21 Research and Development Annual Report • 2020/21 Infection Prevention and Control Annual Report There are no items for which the Committee is reporting limited assurance to the Board.	
Purpose	Note	
Recommendations	Board members are asked to note the Chair's assurance report for the meeting held on 10 November 2021	
Risk Register or Board Assurance Framework	Quality strategic objective entries	
Appendices	1. Nursing and midwifery establishment review 2. 2020/21 Medicines Optimisation Annual Report 3. 2020/21 Research and Development Annual Report 4. 2020/21 Infection Prevention and Control Annual Report – summary presentation. 5. Q1 learning from deaths report	

Committee Chair's Assurance report

Committee name	Quality Assurance Committee
Date of meeting	10 November 2021

Summary of assurance:

1. The Committee confirms to the Trust Board that it took significant assurance in the following areas:

Chair's report, Quality Governance Committee

The Committee took good assurance from the Chair's report provided for the Quality Governance Committee meeting held on 26 October 2021. It was noted that good progress made within the Emergency & Integrated Medicine Integrated Clinical Service Unit (ICSU) in relation to patient safety, clinical teaching in diabetes for nutrition and dietetics students and the implementation of the SWAN palliative care project. The assurance report highlighted challenges around the national shortage of first line tuberculosis drugs, and it was agreed that an update would be provided to assure Committee members that patient care was not been adversely affected. Members noted specific areas of patient safety challenge around incident reporting of a higher number of falls and pressure ulcers in Surgery & Cancer ICSU which had been adversely affected by COVID-19. Members were assured that work was ongoing to recover elective activity and to manage increased numbers of patients on the two-week cancer referral pathway.

Board Assurance Framework

The Committee considered the latest iteration of Q3 2021/22 Board Assurance Framework (BAF) which detailed risks to the delivery of the Trust's Quality strategic objectives. Members agreed the recommendation by the Trust's Management Group to increase the risk score from 12 to 16 (increase in likelihood) for BAF entry People 1 which related to staff recruitment and retention to reflect current workforce pressures, especially increased staff turnover.

Risk Management Strategy

The Committee considered the annual review of the Trust Risk Management Strategy this was influenced by a successful positive outcome to the internal audit review of risk management arrangements. The review gave an overall rating of significant assurance with minor improvement recommendations. The Committee was assured that risk management arrangements at the Trust were robust and effective. The Committee noted slight changes to the strategy were recommended to help embed risk management at divisional and directorate level. They covered agenda setting, stronger evidential assurance that key risks were regularly reviewed, and increased awareness of risks which would enable staff were familiar with the top three risks to their strategic objectives.

Trust Risk Register

The Committee noted key changes to the quality risk register since it was last considered by the Committee in September 2021. The Committee noted the closure of the risk related to interventional radiology; the downgrading of the risk related to inadequate establishment of anaesthetic staff because of

successful recruitment of two new members of staff and the downgrading of the risk related to premises for dental services as new premises had been identified, still work required for contractual arrangements to be agreed and completed.

One new risk was added to the risk register regarding non-provision of patient transport services to Ealing, Hounslow and Hillingdon Dental Services.

The Committee noted increased risk scores related to an increasing number of medicines that were in short supply and for non-compliance with face to face resuscitation training. Committee members also agreed to recommend that non-compliance with annual statutory and mandatory training requirements be considered for inclusion on the BAF.

The Committee took reasonable assurances that appropriate mitigating actions were in placed apart from the patient transport risk and an action was agreed to report back to the next committee meeting for assurance.

Elective recovery update
The Committee reviewed an update on elective recovery performance for the week ending 24 October 2021 and noted the following.

- A decrease in the numbers of patients waiting longer than 52 weeks for treatment
- Elective/day case surgery was at 97.1% of 2019/20 activity
- Outpatient attendances were at 91.3% of 2019/20 activity
- Community activity stood at 59.5% of 2019/20 activity. However, once all cases were outcome, this performance level should rise to 72.6%
- Clock stops of patient activity would now be monitored as part of planning arrangements for the second half of the financial year

The Committee received information on progress that clinical harm reviews were being completed for patients currently on 52 week waiting lists. And were updated on a NCL group considering the best way to take these forward.

Bi-Annual Nursing Establishment Review
The Committee was able to take good assurance from the Bi-annual Safer Staffing Establishment Review which covered data from January to July 2021. The Committee noted the following issues:

- The Trust continued to be impacted by COVID-19 and an increase in the acuity of patients seen
- Staffing establishments remained at appropriate levels within recommended guidelines in several settings except for Simmons House CAMHS inpatient unit, Critical Care Unit, Ifor children's ward, the Emergency Department (ED), Nightingale respiratory Ward and the Acute Assessment Unit (AAU)
- A significant COVID-19 impact remained and was expected to continue for the remainder of the financial year and therefore several measures would need to remain in place to manage the continued implications of the pandemic on safer staffing

The Committee discussed the following measures:

- A fixed-term increase of the establishment for critical care nurses to be reviewed in one year, should be implemented and financed from COVID-19 funding. The alternative was to continue with temporary staff when the ratio of level 3 patients breached the current establishment of level 2 and level 3 patients (total 10 beds) which was set at 60:40 nurse patient ratio.
- Secure fixed-term funding for the proposed changes of Simmons House or alternatively continue with temporary staff on a day-to-day basis.
- Secure permanent funding to staff Ifor Ward, an increase in the establishment in the ED, AAU and Nightingale ward.
- Continue to increase staff deployment for ED with the use of temporary staff financed from COVID-19 funding

Committee members received reasonable assurance that nurse recruitment levels could be achieved and that the nurse recruitment team had successfully recruited 9-10 international nurses over the last few months, new graduates were coming through despite a national shortage of nurses, and that work was ongoing with the clinical education team and preceptorship lead to encourage new graduates to come to Whittington Health. It was acknowledged that, while new graduates did not have the necessary skills to work in ED, additional training would be developed to ensure that newly graduated staff could be deployed to the ED, in the quickest time possible. It was noted that intensive care support was available to international nurses who were skilled working in the ED, so that they were being allocated to ED on their first job within the trust. The Committee approved the report which would be appended to the Committee Chair's assurance report for the November Board meeting to be held in public.

Surgery and Cancer ICSU

The Committee considered a briefing paper which provided an overview of safety, quality, and clinical effectiveness across the ICSU from 1 January 2021 to 30 September 2021. The period was particularly challenging because of the second and third waves of the pandemic. The ICSU saw increases in patient acuity and patients requiring critical care unit support. Increases in cancer referrals had been marked with more complex and advanced stages of disease. Focussed work was carried out to maintain good levels of elective activity, specifically high-volume, low complexity work.

The Committee received good assurance that initiatives were in place to improve quality governance generally and were further supported by the following:

- Positive verbal feedback received from the Care Quality Commission (CQC) following a virtual direct monitoring activity of the Dental Service in August 2021
- The Implementation of online pre-operative education sessions for patients undergoing bariatric surgery
- The implementation of several support groups for cancer patients covering, new diagnosis, menopausal symptoms and a group for patients who had prostate cancer

The Committee gave its thanks for a comprehensive update of the work being undertaken and looked forward to receiving a further progress update in due course.

Serious Incidents

Committee members discussed the Serious Incidents (SIs) report for August and September 2021. Four SIs were declared during the period which covered:

- Two falls both resulting in a fractured neck of femur
- The death of a full-term baby
- One Never Event related to a retained gauze swab following a vaginal delivery

The Committee noted the report and took good assurance that the serious incident process was managed effectively at the Trust and that lessons learned because of these SIs were being shared effectively.

Q2 Quality report

The Committee was able to take good assurance from the quarterly Quality report and noted the following issues:

- The pressure ulcer improvement programme was ongoing, skin care ambassadors had been appointed and a reduction in pressure ulcers was reported for the fourth consecutive month
- The Perfect Ward app had been launched. It was designed to support regular ward-led audits to allow for real time monitoring and targeted improvements
- Seven national clinical audit reports were published during the reported period, and no outliers were identified for Whittington Health
- Complaint investigation and response targets were not met for a second consecutive quarter, work underway to recover the performance
- The findings of two new national patient surveys (Maternity 2021 and Children and Young People Services 2020) would be shared externally in January 2022

The Committee noted key areas of good practice and approved the report for inclusion as an appendix to the Committee Chair's report to the November Board meeting being held in public.

Medicines Optimisation Annual Report

The Committee received the 2020/21 annual report covering the work of the Pharmacy and multidisciplinary teams across the Trust. Committee members welcomed the report which detailed:

- Several initiatives and changes within the pharmacy department to support ongoing COVID-19 pressures
- The work of the Drugs and Therapeutics Committee
- Digital transformation and the roll out of an electronic prescribing and medicines administration system
- Financial performance
- Workforce and development matters within the function

	• The impact of CQC inspections and the Trust's response to the Grant Thornton internal audit review findings **Research and Development Annual Report** The Committee received the annual report highlighting the Trust's research and development activities during 2020/21. They noted the following: • Active participation in COVID-19 related studies such as RECOVERY and SIREN which had significant positive impact on treatments for patients with COVID-19 as well an understanding of vaccination and antibody responses • 1,197 patients took part in research across 20 studies, with 1,019 of those patients entered into five National Institute for Health Research priority studies • Although there was a decrease in funding to the North Thames Clinical Research Network, Whittington Health continued to achieve good value for money The Director of Research and innovation refreshed the Trust's research strategy and initiated a Research Oversight Group (ROG) with internal stakeholders and external partners providing 'critical friend' feedback **Infection Prevention & Control Annual Report** The Committee reviewed the 2020/21 annual report It noted work undertaken to investigate the cause of nosocomial infections with a focus on learning at ward and team level to maintain safe standards of infection prevention and risks. The report detailed the Trust's response to COVID-19 infections and the rollout of a staff vaccination programme. The report also covered learning from healthcare associated infections and the mandatory reporting of clostridium difficile and MSRA infections. A summary of the report will be included as an appendix to the Chair's assurance report at the November Trust Board in public.
2.	**Present:** Professor Naomi Fulop, Non-Executive Director (Committee Chair) Amanda Gibbon, Non-Executive Director (Vice Chair) Baroness Glenys Thornton, Non-Executive Director Dr Clare Dollery, Medical Director Carol Gillen, Chief Operating Officer Michelle Johnson, Chief Nurse and Director of Allied Health Professionals **In attendance:** Breeda McManus, Deputy Chief Nurse Gillian Lewis, Associate Director, Quality Governance Dale-Charlotte Moore, Deputy Chief Operating Officer Kat Nolan-Cullen, Compliance and Quality Improvement Manager Chetan Bhan, Clinical Director, Surgery & Cancer ICSU Sharon Pilditch Associate Director of Nursing, Surgery & Cancer ICSU Stuart Richardson, Chief Pharmacist

	Kathryn Simpson, Research Portfolio Manager Julie Singleton, Infection Prevention & Control Lead Nurse Swarnjit Singh, Trust Secretary Marcia Marrast-Lewis, Assistant Trust Secretary Carolyn Stewart, Executive Assistant to the Chief Nurse **Apologies:** Monika Dulnikiewicz, Director of Environment

Meeting title	Quality Governance Committee	**Date:** 10/11/2021
Report title	**Bi-annual Safer Staffing Establishment Review**	**Agenda item:** 2.6
Executive director lead	Michelle Johnson, Chief Nurse & Director of Allied Health Professionals	
Report author	Maria Lygoura, Lead Nurse for Safer Staffing	
Executive summary	• In line with National Quality Board (NQB) guidance this report provides an update for the latest safe nursing and midwifery staffing establishments across the Trust. • The review was undertaken in September 2021 using data from January to July 2021. • This paper presents the safe staffing establishment assessment, comparisons with national data and recommendations for the establishment of the following areas: ▪ Inpatient adult and child wards ▪ Emergency Department (ED) ▪ Critical Care Unit (CCU) ▪ Simmons House child and adolescent mental health inpatient ward ▪ Theatres department • The impact of pandemic linked to the continuing high levels of Covid-19 and related activity across the Trust and to the increase of the acuity level of the patients is well known. • While the staffing establishments remain at appropriate level and within recommended guidelines in several settings, key exceptions include the staffing levels for Simmons House, Critical Care Unit, Ifor ward, the Emergency Department, Nightingale ward, and the AAU. • The duration of the post Covid-19 effect remains undetermined but likely to continue for the rest of 2021/22. It is therefore recommended to consider the following options to manage the implications of the pandemic on safer staffing effectively and sustainably: ▪ **Fixed term increase of the establishment for Critical Care and review activity in 1 year.** This should be financed through the Covid-19 funding. Alternatively, continue with temporary staff when the ratio of level 3 patients goes over the current establishment which is set at 60:40. ▪ **Fixed term funding for the proposed changes of Simmons House.** Funding to be sought from Mental Health Transformation and/or NCEL collaborative. Alternatively, continue with temporary staff on a day-to-day basis to manage additional acuity.	

	▪ **Substantive funding for the proposed CYP mental health staffing (Ifor ward)**. Funding to be sought from Mental Health Transformation and/or NCEL collaborative. Alternatively, continue with temporary staff on a day-to-day basis for to manage additional acuity. ▪ **Substantive funding for the proposals for AAU and Nightingale ward.** These settings are designated to use their bed base flexibly for Covid and host the patients with highest acuity among the wards. ▪ Continue **increased staff deployment for the Emergency Department (ED) with use of temporary staffing** which is financed through Covid-19 funding. Use flexibly the 2nd site for paediatrics ED.
Purpose:	1. The Quality Governance Committee is asked to review and agree that the appropriate level of detail and assessment has been undertaken to assure itself that the clinical areas reviewed continue to be safely staffed 2. To discuss the potential future workforce challenges
Recommendation	The Quality Governance Committee is asked to: 1. Review and agree that the appropriate level of detail and assessment has been undertaken to assure itself that the clinical areas reviewed continue to be safely staffed; and 2. Agree with the recommendations on adjustments to skill mix and establishments
Risk Register or Board Assurance Framework	BAF risk Quality 1 - Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation. BAF risk People 1 - Failure to recruit and retain high quality substantive staff could lead to reduced quality of care, and higher costs
Report history	1. Nursing and Midwifery debate and challenge sessions, various dates in September 2021 2. Nursing and Midwifery Leadership Group, 27 September 2021 3. Executive Team Meeting, October 2021 4. Trust Management Group 12 October 2021 5. Quality Governance Committee, 26 October 2021
Consultation process	1. Debate and challenge session with the Associate Directors of Nursing & Midwifery (ADON/Ms), Finance Manager, and an external reviewer 2. Nursing and Midwifery Leadership Group 3. Chief Finance Officer and Executive Team
Appendices	1. Workforce data 2. Benchmarking 3. Summary Table

Six Monthly Safer Staffing Review of Nursing and Midwifery Establishments

1. Introduction and context

1.1 The impact of nursing staffing levels on the quality of care and patients' outcomes is well documented. Several studies link staffing levels and skill-mix to patients' outcomes and mortality rates (Ball et al 2019, NIHR 2019).

1.2 The purpose of this paper is to report on the outcomes of the review of nursing staff establishments undertaken in September 2021 using activity data from January to July 2021. This 6-monthly review forms part of the Trust approach to the systematic review of staffing resources to ensure safe staffing levels effectively meet patient care needs. The paper should be considered alongside the information provided each month at the performance indicators dashboard.

1.3 The National Quality Board (NQB) and NHS Improvement (NHSI) published guidance and recommendations for providers to ensure that establishments are based on patient safety, acuity, and financial sustainability in line with Care Quality Commission (CQC) fundamental standards (NQB 2016, NHSI 2018). NQB guidance states that providers:

- must deploy sufficient suitable qualified, competent, skilled, and experienced staff to meet treatment needs of patients safely and effectively
- should have a systematic approach to determining the number of staff and range of skills required and keep them safe at all times
- must use an approach the reflects current legislation

1.4 This report fulfils expectation of the NQB for Trusts in relation to safe nurse staffing and fulfils a number of the requirements outlined in the NHSI 'Developing Workforce Safeguards' which sets out guidance to support providers to deliver high quality care through safe and effective staffing.

1.5 In December 2020, NHS England and NHS Improvement (NHSE/I) together with Health Education England (HEE), produced advice on acute sector workforce models during Covid-19. The document provides a framework to support trusts to organise their workforce in a way best suited to deliver plans while responding to Covid-19 surges.

1.6 Whittington Health established a Covid-19 incident management team to coordinate the response and various emergency business continuity arrangements were put in place. Among others, a key priority was to manage and deploy our staffing resources most effectively and support staff wellbeing. The day-to-day management of safe staffing has now reverted to the pre pandemic model with local leads involvement and overview from the Chief Nurses (CN) and the Director of Operations.

1.7 As an integrated care organisation, Whittington Health aims to ensure that community and hospital nursing, midwifery and health visiting staffing levels are reviewed periodically. The last Safe Staffing review was presented to the Trust Board in September 2020. Due to Covid-19 response the scheduled review in March 2021 was a modified version that presented the impact on nurse staffing levels and actions taken to assure safe staffing during the period of the first two waves.

1.1 Safer staffing and skill mix reviews were undertaken in September 2021 for the following clinical areas:

- Adult inpatient wards
- Critical Care Unit (CCU)
- Emergency Department (ED)
- Theatres
- Simmons House - child and adolescent mental health inpatient ward
- Children and Young People (CYP) areas

Future reviews will include increasingly comprehensive assessments of community nursing, health visiting, school nursing and community children's nursing.

2. Methodology

2.1 Nursing & midwifery staff establishments are formally reviewed biannually or annually for several areas, to ensure that the nursing & midwifery workforce meets the demands of clinical care provision, deliver safe care with a positive patient experience, and fits within the financial strategic objectives of the organisation.

2.2 The assessment process for safer staffing is formed using a triangulated approach that is recommended by the National Quality Board (NQB) and involves the use of evidence-based tools, professional judgments and comparison with peer organisations. The NQB also advocates taking account of the wider multidisciplinary staffing arrangements as well as the financial plans of the organisation. Safer Nursing Care Tool (SNCT) and Mental Health Optimal Staffing Tool (MHOST) are among the evidence-based tools that are endorsed by the National Institute of Health and Care Excellence (NICE) and NQB. Both tools take into consideration the activity in a service alongside with the acuity and dependency level of the patients.

2.3 The SNCT was used to estimate the optimal establishment for the inpatient adult and children ward and the MHOST for Simmons House and the mental health beds of Ifor ward. Safe staffing assessment in CCU was informed by recommendations issued from the Faculty of Intensive Care Medicine and NICE. Activity and acuity of the patients in ED were evaluated along with benchmarking information of peer services.

2.4 Recommendations from the British Association of Perinatal Medicine (BAPM) and the Royal College of Nursing (RCN) guided the establishment review in NNU.

2.5 A systematic workforce assessment with BirthRate Plus® has recently commenced for the maternity services; the report and its recommendations will be available in January 2022.

2.6 The Association for Perioperative Practice (AfPP) sets out minimum staffing requirement and its guidance was utilised to review the establishment in theatres department.

2.7 The nurse-to-patient ratios as recommended by NICE was utilised where appropriate. Professional judgement was applied having considered the layout of each setting and performance on quality indicators.

2.8 Debate and challenge sessions on the staffing review and proposals took place with the participation of the CN, the Associate Directors of Nursing (ADoN) for Integrated

Clinical Service Units (ICSUs) finance managers, service managers, and matrons. An external lead nurse for workforce participated in the debate and challenge for the Children and Young People (CYP) to validate methodology and findings.

2.9 Data was collected from Electronic Staff Record (ESR), QlikView®, HealthRoster® and SafeCare® for the period of January to July 2021. Information for national data and benchmarking was obtained from Model Hospital database and NHSE/I website. The Quality Indicators (QI) sensitive to nursing and midwifery staffing were evaluated aiming to identify potential association of performance to staffing levels.

3. Vacancy levels & retention

3.1 There is a trend of reduction of the vacancy level for all nursing staff. The overall vacancy level across the trust is reduced by 4.4% since July 20 with significant decrease seen in the group of unregistered nursing staff (Table 1 & Appendix 1). Vacancy rate for registered N&M staff remans at same level with minor fluctuations. The theatres department and Ifor children's ward are the areas with the greatest challenges while Emergency and Integrated Medicine (EIM) has improved its position (Appendix 1).

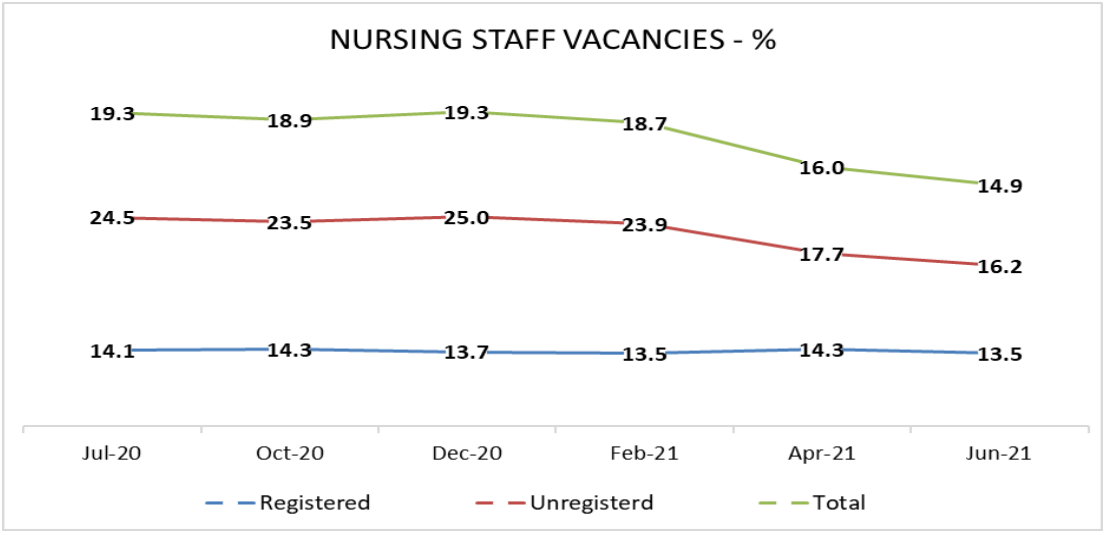


Table 1: Nursing and midwifery vacancies July 20 – June 21 (source ESR)

3.2 Annual turnover in June 2021 for all N&M staff was 13.08% across all ICSUs. This represents a 3% increase since July 2020 (Table 2).

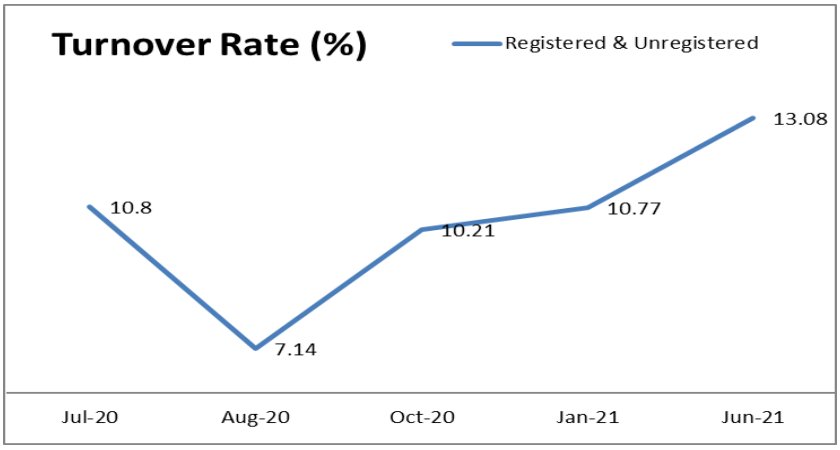


Table 2: Turnover rates July 20 – June 21 (source ESR)

The staff retention strategy incorporates a collection of programmes to improve staff wellbeing, to enable and support compassionate leadership, and enhance staff job satisfaction. It is recognised that career development is a dominant factor for staff retention. Training and development opportunities extend from the Band 2 development programme to post graduate degrees. The preceptorship programme continues to provide focused support for newly qualified nurses, midwives, nursing associates and international nurses with new cohorts 6 times a year. The Whittington preceptorship programme in association with Capital Nurse successfully piloted an Early Year Intervention Programme (EQIPT) which has been accredited from Middlesex university.

3.3 The Nurse Recruitment Team (NRT) have been undertaking a number of recruitment activities. These include recruitment events for graduate, band 5 national and international nurses and midwives, health care support workers, nursing associates and return to practice nurses. Currently, 89 nurses are in the pipeline to join the organisation by January 2022 and 7 Nursing Associates (NA) were placed in post by the end of September 2021. Routes in to nursing projects are in progress aiming to increase the uptake into the Trainee Nurse Associates (TNA), Return to Practice, nursing apprenticeship and nursing graduates' schemes.

4 Findings and Analysis

Summary

During the review period there were high occupancy levels on the adult wards with escalation beds been utilised primarily on Cavell, Cloudesley, Meyrick and Victoria wards. The overall acuity and dependency level of the patients on Nightingale ward, the Acute Assessment Units, Critical Care, Emergency Department and Simmons House has been higher in comparison to the last safer staffing review. The Mental Health paediatric patients on Ifor ward and Simmons House presented with higher acuity level resulting in increased requirement for Enhanced Care or 1:1 observations. The activity and safer staffing data during the reference period indicate that staffing deployment and establishments are deemed sufficient in most settings. Nightingale ward, the Acute Assessment Units, Critical Care, the Emergency Department, Simmons House and Ifor ward require additional support.

4.1 Emergency Department (ED)

The Emergency Department (ED) contains an adult and a paediatric area. Both areas continue to maintain adequate social distancing and segregate the patients with high suspicion of Covid-19 infection in line with government guidance. Paediatric ED remains divided into covid-risk and covid-protect areas with some distance apart. There has been a raise in daily attendances during March to July 2021 with evidence of higher acuity level of the patients. Attendances of patients with Mental Health diagnosis has been in an increasing trend. **Daily staffing deployment since the onset of Covid-19 pandemic was adjusted to meet the increase in Care Hours demand. Activity data from the reference period and prediction for winter activity indicate maintaining a similar daily staffing deployment.**

4.2 Acute Assessment Units (AAU)

AAU is located in Mary Seacole North and South (MSN & MSS) with capacity of 34 beds that include 10 side-rooms. The unit flexibly uses its beds to accommodate

suspected and/or confirmed covid cases who require Level 2 care and/or undergoing Aerosol Generating Procedures (AGP). Average bed occupancy from January to July 2021 was 27.5 ranging from 15 to 34 patients. The number of Level 2 patients per shift fluctuated from 0 to 10 (average 3 pt/shift). The requirement to provide 1:1 and Enhanced Care (EC) ranged from 0 – 5 pt/shift. CHPPD of the AAU was 10.9 (specialty national average CHPPD: 10.1). **Analysis of safer staffing requirement showed that MSS would benefit from augmenting the skill-mix and number of nurses deployed.**

4.3 **Care Of Older People Unit (COOP)**

COOP unit is located in Cavel, Cloudesley and Meyrick wards with capacity of 60 beds that include 10 side-rooms. The unit can expand to 74 beds with 14 escalation beds. Average bed occupancy from January to July 2021 was 66 ranging from 54 to 74 patients. The largest proportion of patients are dependent on carers and on average 7 patients per shift require 1:1 or EC. Staffing deployment was adjusted when escalation beds were in use to meet additional demand for Care Hours. **Current staffing deployment and the adjustments during periods of expansion of bed capacity are in line with safer staffing requirements.**

4.4 **Nightingale ward**

A 21 beds ward including 9 side-rooms and 4 monitored Level 2 beds. The ward accommodates patients with chronic and acute respiratory conditions, ITU stepdown and tracheostomy care. Nightingale is a ward that flexibility uses its beds to accommodate suspected and/or confirmed covid cases who require Level 2 care and/or undergoing AGP. Average daily bed occupancy during January to July 2021 was 20 of which 3.6 were for Level 2 patients and 1.7 patients required 1:1 or EC. **The activity during the reference period suggests that the ward requires additional Health Care Assistant (HCA) support at night.**

4.5 **Montuschi and Victoria wards**

Montuschi is a 16 beds acute cardiology ward with 1 escalation bed which includes 2 side-rooms and capacity for 4 Level 2 coronary care patients. Average daily bed occupancy during January to July 2021 was 14 with range of 12 – 17 beds.
Victoria is a 16 beds ward for medical patients, primarily with gastroenterology & haematology conditions. The ward includes 3 side-rooms and capacity to expand to 20 beds. Average daily bed occupancy during January to July 2021 was 19 and 3 patients requiring EC. Staffing deployment was adjusted when escalation beds were in use to meet additional demand for Care Hours. **Current staffing deployment on both wards and the adjustments during periods of expansion of bed capacity are in line with safer staffing requirements.**

4.6 **Coyle and Mercers wards**

Coyle is a 24 beds surgical ward with 1 escalation bed and includes 4 side-rooms. Bed capacity can expand to 31 in periods of high bed pressures. The ward accommodates non-elective orthopaedic/trauma, elective and non-elective urology and gynaecology patients. Average bed occupancy during January to July 2021 was 18 with most frequent usage of 20-26 beds. Staffing deployment was adjusted when escalation beds were in use to meet additional demand for Care Hours.
Mercers is a 16 beds surgical ward with 2 escalation beds and includes 8 side-rooms. The ward accommodates elective spinal and bariatric cases and emergency laparotomies. Average daily bed occupancy during January to July 2021 was 14.

Both wards combined had a requirement for 1 EC per shift. **Current staffing deployment on both wards and the adjustments during periods of expansion of bed capacity are in line with safer staffing requirements.**

4.7 **Critical Care Unit (CCU)**

Critical Care is unit of 10 beds capacity that accommodates critically ill ventilated and high dependency patients in single or multiple organ failure. CCU can utilise up to 4 side-rooms and expand to 13 or 15 beds. Average daily bed occupancy during January to July 2021 was 9 with most frequent occupancy of 6 – 12. The establishment is set for 60/40 split between the Level 3 and Level 2 patients and since the onset of Covid-19 pandemic the unit has been accommodating higher number of Level 3 patients (75/25). **The activity and safer staffing data during the reference period suggest that CCU requires an increase to the RN numbers to meet the additional Care Hours demand.**

4.8 **Theatres**

Theatre department has 6 major operating rooms plus 1 for emergency obstetrics and 5 day-surgery rooms. The department performs 100 sessions per week predominantly elective operations, emergency, and trauma cases. It also supports elective C-section, Flexi-cystoscopy, and ECT/cardioversion lists. Theatre staff are divided into 3 groups: Theatres General for scrubs practitioner, anaesthetic assistants, and recovery practitioners. **A review of the staffing model concluded that the scrub team are over-established vs guidelines, while the recovery team is about right, and the anaesthetics team is under-established vs guidelines.**

4.9 **Ifor ward**

A 15 beds paediatric ward consisted of 12 acute paediatric and 3 Child and Adolescent Mental Health Service (CAMHS) beds. The ward utilises side-rooms (10 available) only for Infection Prevention and Control (IPC) precautions and/or aggressive CAMHS patients. Ifor ward underwent readjustments of its activity following the end of NCL paediatric Hub and fluctuation in the number of acute CAMHS admissions. Recent workforce challenges caused by the increase of vacancies are receiving targeted focus in the Trust recruitment efforts. **The activity and safer staffing data during the reference period suggests that Ifor requires Mental Health Nurses and HCA added to the current establishment.**

4.10 **Paediatric Short Stay Unit (PSSU), Paediatric Day Care Unit (PDCU), Paediatric Outpatients**

PSSU is an ambulatory care setting that can host up to 6 children and operates 7 days per week. Average activity from May to July 2021 was 5 patients per day. PDCU operates Monday to Friday with capacity for 10 children who undergo day care minor procedures, day surgery (patients recover in theatres recovery), blood transfusions, feed challenges etc. Average activity from May to July 2021 was 6 patients per day. Paediatric Outpatients is consisted of Consulting rooms and phlebotomy rooms and take approximately 1200 appointments per month. **Adjustments of the staffing deployment and skill mix across the three units is recommended and can be achieved with internal transfers of staff and funds.**

4.11 **Neonatal Unit (NNU)**

NNU is consisted of 23 cots and 4 isolation rooms. There are 6 cots allocated for intensive care, 6 for high dependency, and 11 for special care. The special care baby

unit is located on the floor directly above NNU and accommodates less acutely unwell babies. Average daily occupancy from February to July 2021 was 15 ranging from 8 to 23; most frequent cot usage was 13 to 18. The average acuity of the babies during the reference period was below the capacity of the unit. Most babies required special care (Level 1) and Level 2 support. **Current staffing deployment is deemed sufficient to meet the Care Hours demand.**

4.12 **Simmons House Adolescent Unit**

Simmons House (SH) is an in-patient and day-patient psychiatric unit, located in a separate site, with maximum capacity for 12 patients for young people between 13 and 18 years of age. In recent months, SH has seen a consistent increase of the bed occupancy and acuity of the patients. There has been an increase in incidents of self-harm and aggression which led to an increase in EC and 1:1 requirement. **Crisis management out of hours and the increased activity at SH suggests that daily staffing deployment requires an uplift.**

5. Benchmarking – Model Hospital

NB It should be noted that the recommended peer trusts are not all ICOs or of the same size with comparable number of sites. There are also inconsistencies in how trusts are reporting the CHPPD which affects the figures produced.

5.1 The trust average CHPPD in July 2021 was 10. This figure is higher from the median of peer trusts and nationally. The variance is reduced when compared to previous years (Table 3).

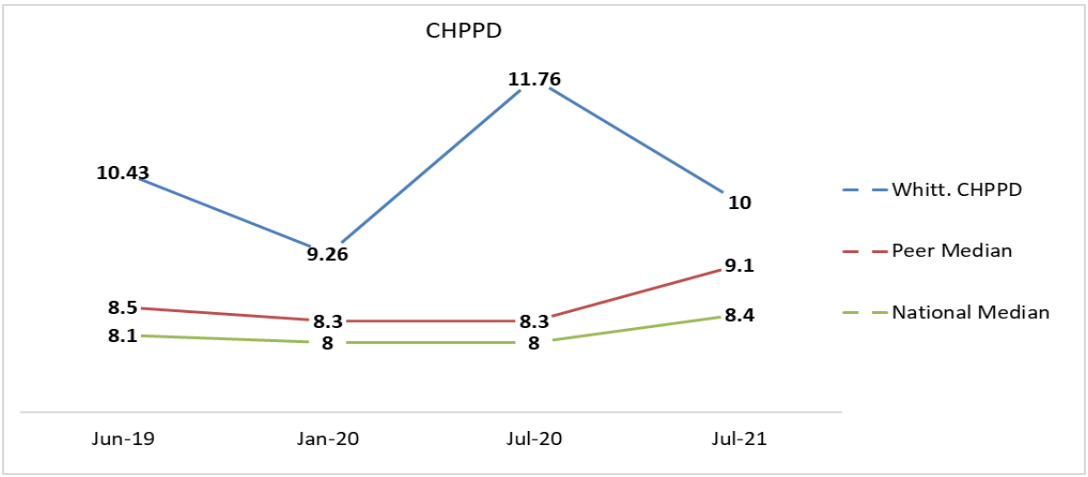


Table 3: CHPPD Activity June 19 – July 21 (source: Model Hospital, NHSE/I)

The CHPPD on most wards is close to the national and peer average. The CHPPD of Critical Care and Ifor ward which cause the inflated Trust overall figure could be attributed partly to reporting inconsistencies across the system and the mix of patients Ifor ward accommodates (CAMHS) (Table 2 in Appendix 1)

5.2 The Trust vacancy rate of registered nurses in June 2021 was higher in comparison to peer and national median. Spending on temporary staffing suggests that bank staff filled the largest number of vacant duties as opposed to agency and the spending on temporary staffing is proportionate to the vacancy rate in comparison to other trusts. These figures also indicate that the potential risk to quality of care from

hight vacancy rate is partially reduced with the usage of internal bank staff (Tables 4, 5 and 6 in Appendix 2).

6. Conclusion and recommendations

A robust ward staffing establishment review was undertaken using a mixed methodology of approaches and in line with recommendations from the National Quality Board and NICE guidance. Overall, the staffing establishments remain appropriate and within recommended guidelines in several settings. There are some key exceptions where acuity and dependency levels and growing demand have outstripped the previously agreed daily staff deployment. Recommendations for uplifts in these areas will be put forward are summarised in Appendix 3.

Key points raised:

6.1 The adult emergency department to retain the current covid model of daily deployment while social distancing and segregation of Covid risk patients affects the flow of the patients. This will result in an increase of the establishment by 14.1 WTE of Band 3 HCA and 0.15 WTE of Band 5 Nurses.

6.2 Current establishment of the paediatric emergency department is sufficient for hosting all its patients in one site. The department requires temporary uplift of its establishment of 8.6 WTE Band 5 RNs and 2.6 WTE Band 3 HCAs for the duration it operates in two separate areas.

6.3 AAU will benefit from improving the skill-mix on the night shifts on MSN with the conversion of 1 Band 4 Nursing Associate (NA) to 1 Band 5 nurse. MSS daily staff deployment should be enhanced with 1 nurse on every shift. This will result in an increase of the establishment by 2.31 WTE of Band 5 nurses and reduction of the Band 4 NA by 0.21 WTE.

6.4 The Care of Older People wards (COOP) have sufficient establishment for 60 beds. This establishment does not include the high demand of enhanced care.

6.5 Nightingale ward will benefit from adding 1 HCA on every night shift. This addition will result in an increase of the establishment by 2.6 WTE Band 2 HCAs.

6.6 Montuschi and Victoria wards have sufficient establishment for their funded beds. This establishment does not include the high demand of enhanced care or usage of escalation beds.

6.7 Mercers and Coyle wards have sufficient establishment for their funded beds. This establishment does not include the high demand of enhanced care or usage of escalation beds.

6.8 In view of the increase of the Level 3 patients and the expectation from NCL to use minimum of 3 escalation beds in critical care, it is proposed that CCU increase its establishment to accommodate 10 Level 3 patients. This entails 3 additional nurses on every shift. This proposal results in an increase of the establishment by 13.53 WTE Band 5 nurses.

6.9 Application of the AfPP guidance created opportunities to make adjustment to the

skill-mix and reduction of RNs in general theatres. It is proposed that the RN establishment in general theatres is reduce by 5 WTE (2.5 Band 5, 2.5 Band 6) and convert 1 Band 5 RN to 1 Band 4 NA per year for the total of 3 RNs. Under the same guidance, staffing gap was identified for the Theatres anaesthetics team and an increase of 4 Band 5 nurses is recommended.

6.10 Ifor children's ward requires an addition of 5.4 WTE of Mental Health nurses (RMN) and 7 WTE of HCAs to support the team with the high acuity and frequent 1:1 observations of CAMHS patients. Small adjustments are also proposed for the paediatric short stay unit, day care unit and outpatients to enable safe staffing daily deployment. The establishment of NNU is sufficient for its funded cots and activity.

6.11 To support Simmons House with their increased activity, the higher acuity level of its patients and manage the risks of being remote from other acute care settings, an increase is required to the establishment of 5 WTE Band 5 RMN, and 2.26 WTE Band 3 HCA. This staffing level will also enable 50% cover of the enhanced care requirement.

7. Financial Implications

7.1 It is anticipated that the proposed increase in the establishment of Simmons House, CCU and Ifor ward will have significant cost implications for the organisation. It is therefore recommended to prioritise the investment/expenditure to the areas with the highest risk. Funding for these three areas should be sought through COVID-19 funding, MH Transformation and then the NECL CAMHS tier 4 units collaborative.

7.2 The impact of pandemic linked to the continuing high levels of Covid-19 and related activity across the Trust and to the increase of the acuity level of the patients is well known. However, the duration of the post Covid effect remains undetermined but likely to continue for the rest of 2021/22. It is therefore recommended to consider the following options to manage the implications of the pandemic on safer staffing effectively and sustainably:

- Fixed term increase of the establishment for Critical Care and review activity in 1 year. This should be financed through the Covid-19 funding. Alternatively, continue with temporary staff when the ratio of level 3 patients goes over the current establishment which is set at 60:40.
- Fixed term funding for the proposed changes of Simmons House. Funding to be sought from Mental Health Transformation and/or NCEL collaborative. Alternatively, continue with temporary staff on a day-to-day basis to manage additional acuity.
- Substantive funding for the proposed CYP mental health staffing (Ifor ward). Funding to be sought from Mental Health Transformation and/or NCEL collaborative. Alternatively, continue with temporary staff on a day-to-day basis for to manage additional acuity.
- Substantive funding for the proposals for AAU and Nightingale ward. These settings are designated to use their bed base flexibly for Covid and host the patients with highest acuity among the wards.
- Continue increased staff deployment for the Emergency Department (ED) with use of temporary staffing which is financed through Covid-19 funding. Use flexibly the 2nd site for paediatrics ED.

8. Next Steps

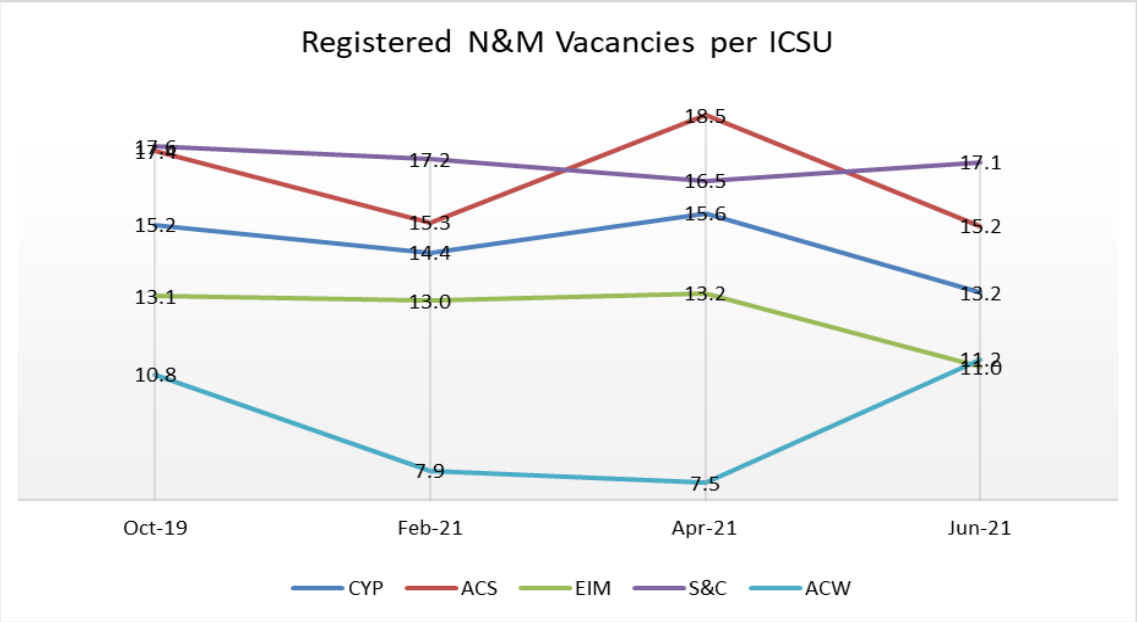
8.1 External review of this report will be sought by NHSE/I to validate methodology and findings.

8.2 An evaluation to be undertaken of the benefits realisation for the current management of enhanced care

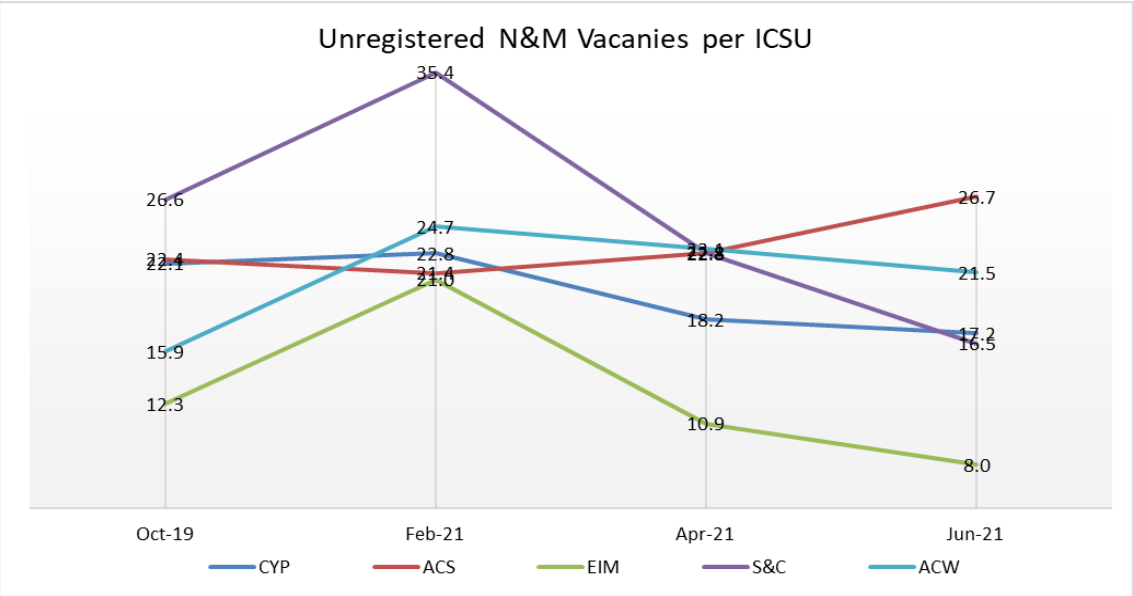
8.3 The next establishment review will take place in March 2022 (reporting to Trust Board April 2022). Other areas of the Trust that will be reviewed at this time include:

- Midwifery
- Endoscopy Unit
- Ambulatory Care
- Health Visiting
- School Nursing
- Community Children's nursing
- District Nursing

Appendix 1 – Vacancies per ICSU (source: ESR)



N&M Vacancies per ICSU	CYP	ACS	EIM	S&C	ACW	Total
Oct-19	15.2	17.4	13.1	17.6	10.8	14.8
Feb-21	14.4	15.3	13.0	17.2	7.9	13.5
Apr-21	15.6	18.5	13.2	16.5	7.5	14.3
Jun-21	13.2	15.2	11.0	17.1	11.2	13.5



Unregistered N&M Vacanies per ICSU	CYP	ACS	EIM	S&C	ACW	Total
Oct-19	22.1	22.4	12.3	26.6	15.9	19.9
Feb-21	22.8	21.4	21.0	35.4	24.7	25.1
Apr-21	18.2	22.8	10.9	22.8	23.1	19.6
Jun-21	17.2	26.7	8.0	16.5	21.5	18.0

Appendix 2 – Model Hospital

Table 1

CHPPD	Data period	Trust value	Peer median	National med
Care Hours per Patient Day - Total Nursing and Midwifery staff	Jul 2021	10.0	9.1	8.4
Care Hours per Patient Day - Registered Nurses and Midwives	Jul 2021	5.9	5.3	5.0
Care Hours per Patient Day - Healthcare Support Workers	Jul 2021	4.1	3.3	3.3

Table 2 (source NHSE/I, July 2021)

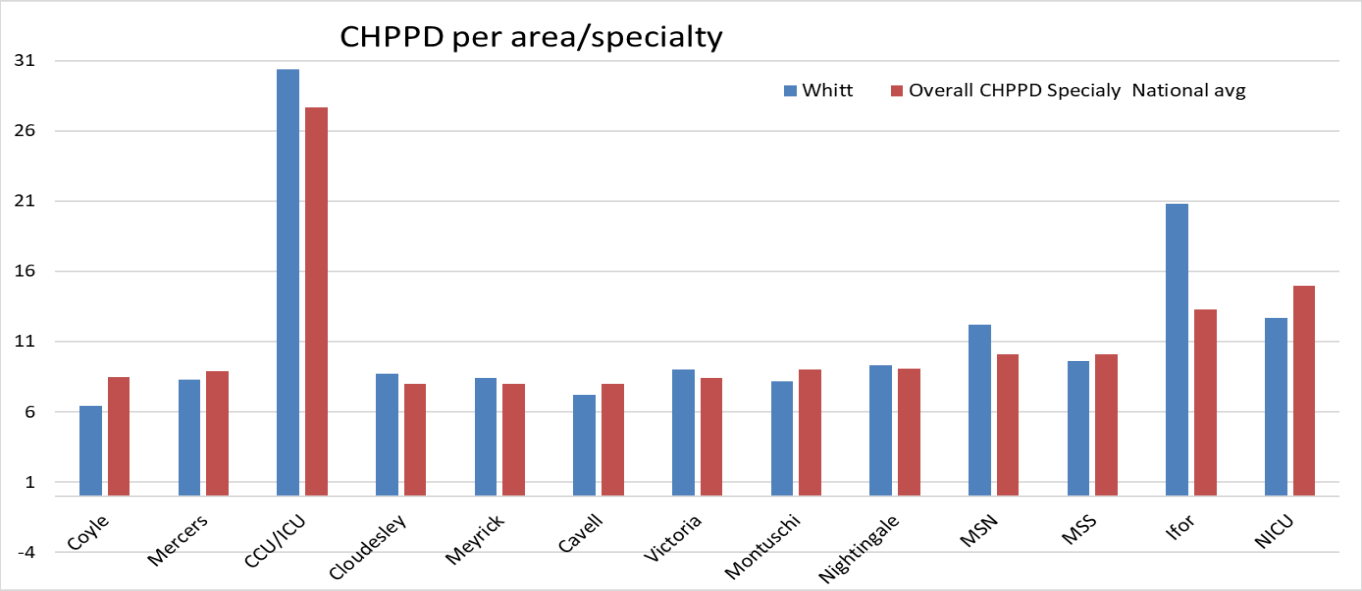


Table 3

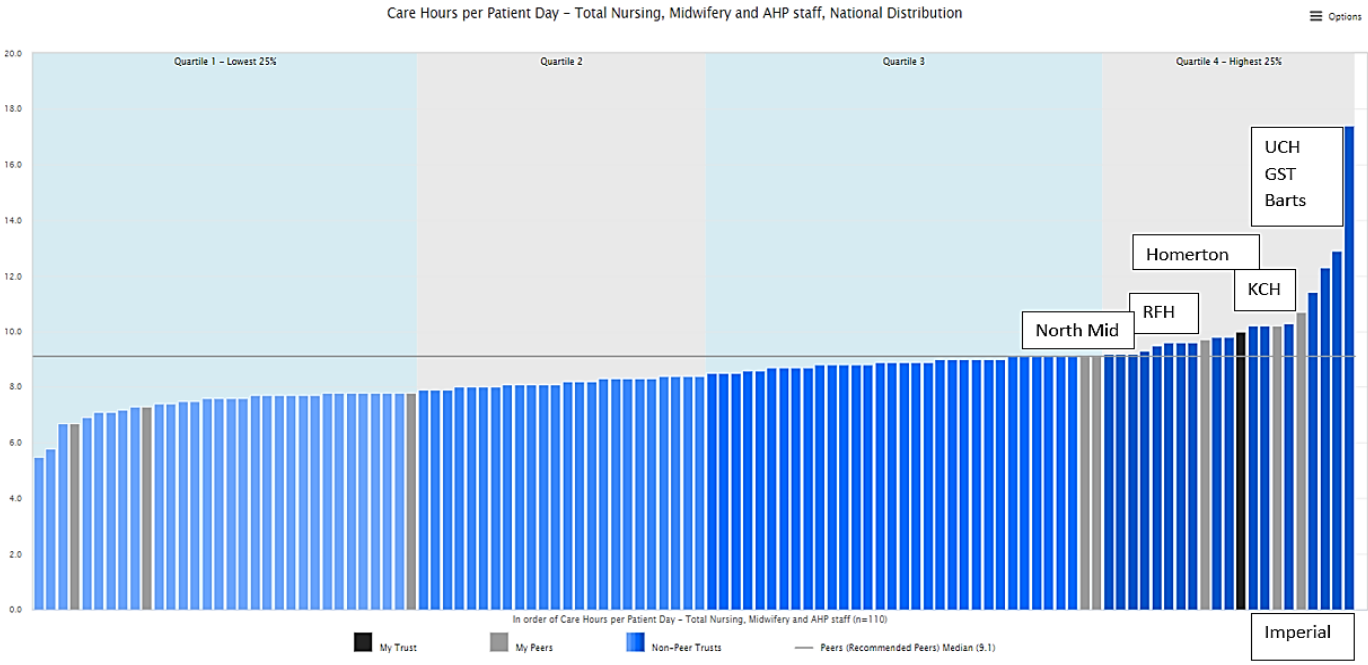


Table 4

New Domain	Data period	Trust value	Peer median	National median	Chart
Overall Agency Staff Spend	Jun 2021	£2.40m	£2.31m	£3.05m	
Overall Agency Spend as a % of Total Spend	Jun 2021	3.7%	4.4%	3.8%	
Overall Bank Staff Spend	Jun 2021	£7.86m	£5.20m	£6.41m	
Overall Bank Spend as a % of Total Spend	Jun 2021	12.0%	8.7%	7.8%	

Table 5

Management and Culture	Data period	Trust value	Peer median	National median	Chart
Registered Nurses: Vacancy rate	Jun 2021	13.5%	8.9%	9.6%	
Registered Nurses: Agency Spend as a % of Total Spend	Jun 2021	5.5%	3.1%	4.2%	
Registered Nurses: Sickness absence rate	Apr 2021	4.8%	5.3%	4.4%	

Table 6

Nursing and Midwifery	Data period	Trust value	Peer median	National median	Chart
Sickness Absence Rate - All Nursing and Midwifery Staff	Jul 2021	6.7%	7.1%	6.7%	

Appendix 3 – Summary table

		Summary	Bed occupancy/ Activity	WTE June 21 Budget	CHPP D WTE	SNCT WTE	**Profes. Judg. WTE**	**Comments & Recommendations**	**Proposed WTE & daily deployment**	RN to Pt Ratio	Reg. to Pt Ratio	Staff to Pt ratio	Reg. staff %
EIM	Emergency Department - (ED) Adult	**Majors Large:** 13cubicles + 2MH rooms – takes suspected & confirmed covid cases, includes 2 covid risk resus spaces **Majors Small**: 8 spaces. Located in previous CDU/EMU area **Resus**: 2 covid protect spaces **UTC Minors:** 9 cubicles, plus 2 side-rooms for EMU pts requiring isolation. Very high flow of patients. **EMU**: in ambulatory Care **RAT, Triage**: 5 cubicles (3trolleys + 2 Chairs), **Streaming** : 1 space	Average daily attendances 220 pts (Jan/Feb 21). 300 pts Mar/July 21. Lower number of arrivals from 11pm to 10am. 6-10 daily attend. of MH pts.	87.54 wte 75.55 RN 11.99 HCA	NA	NA	101.7 WTE 75.7 registered 26 unregistered	**Increase establishment as seen in Prof J** Consider twilight shifts during hours of high attendance	See Prof J WTE **Day**: 14RN+5HCA **Nt**: 14RN+5HCA	NA	NA	NA	75%
EIM	Emergency Department - (ED) Paediatric	12 cubicles across 2 areas: **Covid-secure area** contains 7 cubicles, including 2 resus beds with separate waiting room & triage room. **Covid-risk area** contains 4 cubicles, triage area with 1 cubicle, drug preparation room and separate waiting area.	Avg daily attend. 61 pts (Mar20-Feb21). 8 more from 2019/20. Lower No of arrivals from 10pm to 10am. Significant increase of acuity of pts.	17.00 wte 16.00 RNs 1 play spec	N/A	N/A	**Option 1** 27.2 WTE 24.60 registered 2.60 unregistered	**Option 1 (winter planning): Increase establishment on fixed term basis as seen in Prof J or utilise temporary staffing.** Consider twilight shifts during hours of high attendance from. Review establishment at the end of the winter activity.	**Option 1** See Prof J WTE **Day**: 5RN +1HCA **Nt**: 4RN	NA	NA	NA	90%
							Option 2 17.00 WTE 16.00 RNs 1 play spec	**Option 2:** **No change;** review activity and staffing at the end of the winter. This proposal is for 1 Paediatric ED area. Operating in 2 separate areas is a temporary arrangement.	**Option 2** See Prof J WTE Day: 3 RN Nt: 3 RN				

		Summary	Bed occupancy/ Activity	WTE June 21 Budget	CHPPD WTE	SNCT WTE	**Profes. Judg. WTE**	**Comments & Recommendations**	**Proposed WTE & daily deployment**	RN to Pt Ratio	Reg. to Pt Ratio	Staff to Pt ratio	Reg. staff %
EIM	Acute Assessment Unit (AAU)	**AAU:** 34 beds (inc. 10 side-rooms) located in Mary Seacole North & Mary Seacole South. Patients admitted from the ED requiring assessment & treatment prior to discharge or transfer to a ward. **Current challenges:** High pts Flow, fluctuating number of Level 2 patient (inc. ITU stepdown and tracheostomy care), flexibility to accommodate suspected and/or confirmed covid cases and patients undergoing AGP, high requirement for enhanced care (EC). **Current planned deployment:** **Day: 6RN+2B4+4HCA** **Nt: 4RN+ 2B4+4HCA**	Avg daily bed occ. 27.5 (range 15 - 34). No of Level 2 pts per shift fluctuated from 0 -10. Jan, Feb, June & July had higher No of L2 pts. The No of pts requiring EC ranged 0-5	62.24 WTE 41.46 regis (33.46 RN + 8 NA) 20.78 HCA	73.1 wte 43.4 RNs 29.7 HCA	65.0 wte 45.5 RNs 19.5 HCA	64.34 wte 43.56 regist (35.77 RN + 7.79 NA) 20.78 unreg	**Increase the No of RNs by 1 on every shift for 6 months** (with temp staff initially). This addition is for MSS. **Convert 1 NA from Nt shifts to RN** (for MSN).	**See Prof J WTE** **Day**: 7RN + 2 NA +4HCA **Nt**: 6RN + 1 NA + 4HCA	1:5	1:4	1:3	70%
EIM	Mary Seacole North	see AAU - 16 beds (inc 6 side-rooms)	see AAU	see AAU	32.0 wte 19.0 RNs 13.0 HCAs	30.4 wte 21.3 RNs 9.1 HCAs	see AAU	**See AAU.** Coordinate deployment between the units to align with national specialty CHPPD.	**Day**: 3RN + 1 NA +2HCA **Nt**: 3RN + 2HCA	see AAU	see AAU	see AAU	see AAU
EIM	Mary Seacole South	see EIM - 18 beds (inc 4 side-rooms)	see AAU	see AAU	41.1 wte 24.4 RNs 16.7 HCAs	34.6 wte 24.2 RNs 10.4 HCAs	see AAU	**See AAU.** Coordinate deployment between the units to align with national specialty CHPPD.	**Day**: 4RN + 1 NA +2HCA **Nt**: 3RN + 1 NA + 2HCA	see AAU	see AAU	see AAU	see AAU

		Summary	Bed occupancy/ Activity	WTE June 21 Budget	CHPP D WTE	SNCT WTE	**Profes. Judg. WTE**	**Comments & Recommendations**	**Proposed WTE & daily deployment**	RN to Pt Ratio	Reg. to Pt Ratio	Staff to Pt ratio	Reg. staff %
	Care of Older People Unit (COOP)	**COOP:** 60 funded beds (plus 14 escalation beds) for the care of older people. Located in Cavell, Cloudesley & Meyrick wards. **Current challenges**: most of the patients are highly dependent with high proportion requiring enhanced care. Capacity to flex up to 74 beds.	Avg daily bed occ. Jan-Jul21: 66.2 (range 54 - 74). 70-75% of pts scored as dependent on staff to meet their needs. On avg 7 pts daily require EC.	92.19 WTE 51.57 Regis 40.63 Unreg	108.6 WTE 54.3 RNs 54.3 HCAs	100.1 wte 60.1 RNs 40.0 HCAs	94.8 wte 54.0 regist 40.8 unreg	no changes are recommended to the establishment	No change **Early: 3** NIC **Day**: 6 RN + 3NA + 9 HCA **Nt**: 6 RN + 3 NA + 6 HCA	1:10	1:6.6	1:3.6	56%
EIM	Cavell Ward	see COOP - 20 beds + 4 escalation beds (inc 3 side-rooms)	as above	see COOP	36.2 WTE 18.1 RNs 18.1 HCAs	34.0 wte 20.4 RNs 13.6 HCAs	31.6 wte 18.0 regist 13.6 unreg	see COOP	No Change **Early: 1** NIC **Day**:2RN+ 1NA+3 HCA **Nt**:2RN+1NA+ 2 HCA	1:10	1:6.6	1:3.6	56%
EIM	Cloudesley Ward	see COOP - 20 beds + 5 escalation beds (inc 3 side-rooms)	as above	see COOP	36.2 WTE 18.1 RNs 18.1 HCAs	33.5 wte 20.1 RNs 13.4 HCAs	31.6 wte 18.0 regist 13.6 unreg	see COOP	No Change **Early: 1** NIC **Day**: 2RN + 1NA + 3HCA **Nt**:2RN+1NA+ 2HCA	1:10	1:6.6	1:3.6	56%
EIM	Meyrick Ward	see COOP - 20 beds + 5 escalation beds (inc 4 side-rooms)	as above	see COOP	36.2 WTE 18.1 RNs 18.1 HCAs	32.6 wte 19.6 RNs 13.0 HCAs	31.6 wte 18.0 regist 13.6 unreg	see COOP	See Prof J. **Early: 1** NIC **Day**: 2RN+1 NA+3HCA **Nt**:2RN+1NA+ 2HCA	1:10	1:6.6	1:3.6	56%

		Summary	Bed occupancy/ Activity	WTE June 21 Budget	CHPP D WTE	SNCT WTE	**Profes. Judg. WTE**	**Comments & Recommendations**	**Proposed WTE & daily deployment**	RN to Pt Ratio	Reg. to Pt Ratio	Staff to Pt ratio	Reg. staff %
EIM	Nightingale Ward	A 21 beds ward consisted of 9 side-rooms and 3 bays of 4 beds each; that include 4 monitored HDU beds . The ward accommodates patients with chronic and acute respiratory conditions, ITU stepdown and tracheostomy care **Current challenges:** fluctuating number of Level 2 patient (inc. ITU stepdown and tracheostomy care), flexibility to accommodate suspected and/or confirmed covid cases and patients undergoing AGP.	Avg daily bed occ. Jan-July21: 20. Avg daily No of Level 2 pts 3.6. On avg 1.7 pts daily require 1:1 and/or enhanced care.	31.6 WTE 23.8 regist (18.6 RN + 5.2 NA) 7.80 unreg	43.2 WTE 25.2 RNs 18.0 HCAs	31.0 wte 21.7 RNs 9.3 HCAs	34.2 WTE 23.8 regist (18.6 RN + 5.2 NA) 10.4 unreg	**Increase the number of HCA at night shifts by 1**	See Prof J WTE **Day**: 4 RN + 1NA + 2 HCA **Nt**: 3 RN + 1 NA + 2 HCA	1:6	1:4.6	1:3.2	70%
EIM	Montuschi Ward	16 +1 escalation bed acute cardiology ward providing 4 x L2 coronary care, designated area for tracheostomy care	Avg daily bed occ. Jan-July21: 13.8 (range 12-17, 14-16 the most frequent activity). Avg daily No of Level 2 pts 1. On avg 1.2 pts daily require enhanced care.	20.98 WTE 15.79 Regist 5.19 Unreg	32.5 WTE 22.4 RN 10.1 HCA	25.7 WTE 18.0 RN 7.7 HCA	20.98 WTE 15.79 regist 5.19 unreg	no changes are recommended to the establishment	No Change **Day**: 3 RN + 2 HCA **Nt**: 3 RN	1:5.3	1:5.3	1:4	75%
EIM	Victoria Ward	16 Beds for medical (Gastroenterology & Haematology) patients. **Current challenge**s: 4 escalation beds, high acuity & dependency, mental health and enhanced care	Avg daily bed occ. Jan-July21: 19.3 (range 15-31). On avg 3 pts daily require enhanced care.	24.8 WTE 17.0 Regist 7.80 Unreg	30.4 WTE 15.2 RNs 15.2 HCAs	25.5 wte 17.8 RNs 7.6 HCAs	24.8 WTE 17.0 Regist (12 RN + 5 NA) 7.80 Unreg	no changes are recommended to the establishment	**No change** **Early:** **1** NIC **Day**: 2 RN + 1 NA + 1.5 HCA **Nt**: 2 RN + 1 NA + 1 HCA	1:7	1:5	1:4	76%

		Summary	Bed occupancy/ Activity	WTE June 21 Budget	CHPPD WTE	SNCT WTE	**Profes. Judg. WTE**	**Comments & Recommendations**	**Proposed WTE & daily deploymen**	RN to Pt Ratio	Reg. to Pt Ratio	Staff to Pt ratio	Reg. staff %
S&C	Coyle Ward	Surgical ward of 24 (+1) beds distributed in 4 side-rooms & 5 bays. The ward accommodates non-elective orthopaedic/trauma pts, elective and non-elective urology and gynaecology pts. **Current challenges**: fast turnover of pts.	Avg daily bed occ. Jan-July21: 18.2 (range 10-32) On avg 0.8 pts daily require EC	37.03 WTE 25.03 reg 12.0 unreg	46.1 WTE 25.0 RNs 21.1 HCAs	38.0 wte 26.6 RN 11.4 HCA	33.06 WTE 25.27 regist (20.27 RNs + 5 NAs) 7.79 unreg	no changes are recommended to the establishment	No change **Early: 1**NIC **Day**:4RN+1 NA+2HCA **Nt**:3RN+1 NA+1HCA	1:6	1:5	1:4	76%
S&C	Mercers Ward	Surgical ward of 16 (+2) beds distributed in 8 side-rooms & 2 bays. accommodates 6 elective spinal pts, elective bariatric and emergency laparotomies. **Current challenges** include high acuity of pts, ICU stepdown, ward layout	Avg daily bed occ. Jan-July21: 13.6 (range 7-16) avg 0.3 pts daily require EC	28.2 WTE 20.2 regist 8.0 Unreg	32.2 WTE 19.7 RNs 12.5 HCAs	27.7 wte 17.3 RN 7.4 HCA	28.77 WTE 21.00 regist 7.77 unreg	no changes are recommended to the establishment	No change **Day**: 4RN+1NA+ 2HCA **Nt**: 3RN+1HCA	1:4.5	1:4	1:3	73%
S&C	Critical Care Unit (CCU)	A unit of 10 beds (+ 3 escalation beds) capacity that accommodates critically ill ventilated and high dependency patients in single or multiple organ failure. The current establishment is set to accommodate 60% Level 3 and 40% Level 2 patients. **Current challenges**: Seasonal fluctuation of activity and peaks during covid surges. Increase in % of Level 3 patients.	Avg daily bed occ. Jan-July21: 8.6 (range 3-15, most frequent occupancy 6-12). 75% of the pts were L3.	58.7 WTE 57.7 RN 1.0 Unreg	60.5 WTE 54.5 RNs 6.0 HCAs	N/A	72.23 WTE 71.23 RN 1 H.Keeper	Proposal for 10 Level 3 beds to accommodate safe use of the 4 s/rms and covid segregation: increase the WTE of Band 5 RN as seen on Prof J for 6 months. Consider redeployment if over established at the end of the 6 months	See Prof J. WTE **Day**: 13RN+ 1HK **Nt**: 13 RN	1:1 for L3 1:2 for L2	N/A	N/A	100 %
S&C	Theatres	6 major theatre operating rooms plus 1 emergency Obstetric room , 5 day surgery rooms plus support of C-section, Flexi and ECT/cardioversion lists. Predominantly deals with elective operation, emergency and trauma lists. Theatre staff are divided into 3 groups: Scrubs practitioners for theatres general, Anaesthetic assistant & recovery practitioners. **ACTIVITY**: Avg of 100 sessions per week excluding the Elective Orthopaedic Centre (session = half day list)	**Theatres GENERAL**	61.10 wte 42.86 Regist 18.25 Unreg	0	N/A	56.1 WTE 37.9 Regist 18.25 Unreg	**Reduce RN WTE by 5 (2.5 wte Band 5 RN, 2.5 wte Band 6 RN). Conversion of 1 Band 5 RN to 1 Band 4 NA per year for the total of 3 RNs** (3 years). Develop own NA staff from Band 3 HCAs. Band 3 posts to be reviewed, To move to band 2 HCA model. No changes to porters	N/A	N/A	N/A	N/A	N/A
			Theatres ANAESTHETICS	19.98 wte 10.18 RN 9.80 ODP	N/A	N/A	23.98 WTE 14.18 RN 9.80 ODP	Add 4 WTE of RN at Band 5	N/A	N/A	N/A	N/A	N/A
			Theatres RECOVERY	16.79 wte RNs	N/A	N/A	16.79 WTE RNs	**No Change. Additional staffing requirements for Red & Amber recovery to be managed as cost pressure**		N/A	N/A	N/A	N/A

		Summary	Bed occupancy/ Activity	WTE June 21 Budget	CHPP D WTE	SNCT WTE	**Profes. Judg. WTE**	**Comments & Recommendations**	**Proposed WTE & daily deployment**	RN to Pt Ratio	Reg. to Pt Ratio	Staff to Pt ratio	Reg. staff %
CYP	Ifor Ward	15 bedded paediatric ward consisted of 13 acute paediatric and 3 CAMHS Tier 1&2 beds. The ward hosts L2 patients. **Current challenges:** Workforce (vacancies & skill mix). Readjustment of activity following the end of NCL paediatric Hub. Fluctuation in number of acute CAMHS pts, high acuity of the CAMHS pts and requirement for 1:1 care. Forecast for high prevalence of RSV that will entail expansion of bed capacity & increased demand for L2 beds. Surge plan in place.	Avg daily bed occ. May-July21: 10 (range 4-16, most frequent occupancy 8-12). The No of L2 pts per shift fluctuated from 0-4, On avg 1.2 pts daily require 1:1 MH.	29.78 WTE 25.95 Regist 3.83 Unreg	**RCN Guide** 40.80 WTE 34.0 RN 6.80 HCAs	37.6 wte 26.7 RN 10.9 HCA	43.07 WTE 26.8 RNs 5.4 RMNS 10.87 HCAs	To ensure the minimum recommended staff to patient ratio and safe staffing for the MH pts an **increase of the total establishment is required of 13.29 WTE: 0.85 wte Band 5 RN, 5.4 wte RMNs, 7.04 Band 2 HCA.**	See Prof J. WTE **Day**: 5RN+1RMN +2HCA **Nt**: 4 RN + 1RMN +2 HCA	1:2.7	1:2.7	1:2	75%
CYP	Paediatric Short Stay Unit (PSSU)	operates 7 days/week - 4 beds plus 2 cubicles – can host up to 6 patients – patients' type: discharges from Ifor waiting medical review, referrals from ED	Average activity from May to July 2021 was approx. 5 patients per day	4.92 WTE Nurse	N/A	N/A	4.5 WTE Nurse	**reduce RN WTE by 0.42**	See Prof J. WTE 2 RNs	1:3	N/A	N/A	N/A
CYP	Paediatric Day Care Unit (PDCU)	operates Monday to Friday, 8 beds in 2 bays plus 2 s/rms – patients' type: day care for minor procedures, day surgery (patients recover in theatres recovery), blood transfusions, feed challenges, etc	Average activity from May to July 2021 was approx. 6 patients per day	13.62 WTE 8.36 regist 2.0 unreg 3.26 OT	N/A	N/A	13.66 WTE 5.4 RN 5.0 HCA 3.26 OT	**convert 2.9 RN WTE to 3 HCA WTE**	See Prof J. WTE 2RN + 1 HCA	1:3	N/A	N/A	N/A
CYP	Paediatric Outpatients	Consulting rooms and phlebotomy rooms. Procedures:blood withdrawal, assessments, diagnostic tests, administration of treatment	Approx. 1200 appointments per month (July 21) 406 procedures		N/A	N/A			See Prof J. WTE 1 RN + 2 HCA	N/A	N/A	N/A	N/A

		Summary	Bed occupancy/ Activity	WTE June 21 Budget	CHPPD WTE	SNCT WTE	**Profes. Judg. WTE**	**Comments & Recommendations**	**Proposed WTE & daily deployment**	RN to Pt Ratio	Reg. to Pt Ratio	Staff to Pt ratio	Reg. staff %
CYP	NNU	23 cots: 6 intensive care cots, 6 high dependency cots, 11 special care cots and four isolation cots (not included in the 23). The special care baby unit is housed on the floor directly above NNU and accommodates less dependent babies who do not require ventilation	Avg daily bed occ. Feb-July21: 15.2 (range 8-23), most frequent 13-18 cots). The No of **L3** pts per shift was 0- 3. The No of **L2** pts was 3 - 9. The No of **L1** pts was 7 - 15	58.68 WTE 50.14 RN 5.53 NN 3.01 HCA	**RCN Guide** 43.80 WTE RNs	N/A	58.94 WTE 53.75 RNs 5.19 NN	No Change Maintain establishment for 23 cots with up-to-date Acuity & Dependency distribution. Adjust daily staffing deployment to align with activity	10 RN + 1 NN	1:1 for L3 1:2 for L2 1:4 for L1	N/A	N/A	90%
CYP	Simmons House	Simmons House (SH) Adolescent Unit is an in-patient and day-patient psychiatric unit with maximum capacity for 12 patients for young people between 13 and 18 years of age. SH is part of Whittington Health located in a separate site. **Challenges:** increase of acuity and dependency of patients, high demand for enhanced care (**EC**) and at arms length observations.	100% occupancy Faster throughput of patients leading to reduced length of stay and higher acuity of the patients	29.04 WTE 14.0 RN 15.04 HCA	N/A	MHOST 48.6 wte 24.3 RMN 24.3 HCA	35.0 WTE 18 RMN 17 HCA	**Increase establishment (see Prof J) to enable 50% cover of EC and additional support as a standalone unit by 7.26 wte: 5 x Band 5 RMN, 2.26 x Band 3 HCA).**	3 RMN + 3 HCA	1:4	1:4	1:2	52%

NHS
Whittington Health
NHS Trust

Medicines Optimisation Annual Report 2020/21

STUART RICHARDSON

Chief Pharmacist

Table of Contents

EXECUTIVE SUMMARY

The Medicines Optimisation standards specified by the Care Commission (CQC) and NHS Improvement require Trust Boards to receive an annual report to provide assurance on the use of medicines within the Trust. The Trust Drugs & Therapeutics Committee oversees medicines governance across the Organisation.

This report summarises the activities of groups and committees responsible for the management of medicines at Whittington Health NHS Trust and describes developments throughout the 2020-2021 year.

As a result of the COVID-19 pandemic, the NHS has been exposed to unprecedented pressures and has rapidly evolved to provide care in new and innovative ways. Consequently, additional focus has been placed on the safe and effective use of medications during this period. The Whittington Health NHS Trust Pharmacy team has risen to the challenge and have successfully worked locally and also across the North Central London (NCL) health system to ensure high standards of medicines management continues to be met, whilst also taking on new and expanded roles linked to the provision of COVID-19 therapies and associated programmes. This has meant that a risk-based approach has been taken to prioritise workload and balance business as usual with COVID related priorities.

The Drugs & Therapeutics Committee (D&TC) has overseen the Trusts formulary throughout the year and has ensured the timely addition of all relevant NICE Technology Appraised medicines to the formulary. The group continues to work closely with the Joint Formulary Committee for to ensure that prescribing is aligned across primary and secondary care in NCL. To support the governance around medicines usage, the group also met in an amended format to approve any urgent COVID-19 recommendations in a rapid and effective manner linking in closely with the Clinical Pathways Group. A significant increase in clinical trial activity was facilitated during the year in support of research into COVID therapies and treatment pathways.

Core medicines related policies and guidelines ratified by D&TC were reviewed and updated as required throughout the year.

The Medicines Safety Group (MSG) continues to review medication related incidents across the Organisation, identifying trends and supporting risk reduction. All NHS England Patient Safety Alerts are reviewed, and their action overseen by the group. All COVID vaccine related incidents noted across the Trust including the Local Mass

Vaccination Centre were fed into the NCL Vaccine Progamme to support sector wide learning. A thematic approach to medication safety has been agreed and will continue in 2021/22.

Incident reporting has fluctuated throughout the year subsequent to competing COVID related priorities. The total number of medicine incidents reported was marginally reduced compared with last year (3%). The number of incidents drates as moderate upwards remained at 1% as per previous years. The proportion of medicines incidents as a total of all incidents is slightly below the National rate for reporting medication incidents based on National Reporting and Learning System (NRLS) data compared with other similarly sized Trusts. Ongoing efforts to increase reporting locally will continue in 2021/22. The majority of incidents were classed as 'Near miss', 'No harm' or 'Low Harm' indicating that staff are more open to reporting medicines related incidents, which subsequently encourages learning from incidents and the proactive implementation of safeguards. Key learning from incidents is disseminated through the publications Medicines Matters and Spotlight on Safety throughout the year.

We have procured an enhanced digital auditing tool in line with Internal Audit and CQC recommendations to undertake Safe and Secure Handling of Medicines audits and Controlled Drug audits within the organisation. This will enable robust ownership and oversight of audit outcomes and targeted action planning. Utilisation of the tool within the organisation already ensures a consistent approach to governance related activity.

Risks relating to medicines are managed through the MSG and Pharmacy Risk Register. The top risks are reviewed regularly at the Divisional Board meeting. All risks are under constant review and are being actively managed. Updates on mitigations in place are noted within the risk register. Significant capital investment in 2020/21 has supported the procurement of temperature-controlled cabinets, enhanced security and storage arrangements for medicines across the trust.

Optimising the safe and effective use of medicines is a key component of the Digital Pharmacy and Trust Fast Follower programmes. Whilst initial work with System C was paused in year, significant progress has been made in support of readiness for upgrade of the existing Electronic Prescribing and Medicines Administration (EPMA) Solution (JAC) which will be realised in 2021/22. In response to COVID, the team facilitated the increase in digital outpatient prescribing from 35% to 95% with work ongoing. Successful procurement of an enhanced anticoagulation prescribing system supportive of integration with other trust systems occurred in year and wi be implemented in 2021/22. Whittington Health are the first Trust in North Central London to go-live with the NHS Discharge Medicines Service (DMS) which involves suitable patients that meet pre-set criteria being referred to their nominated community pharmacy digitally utilising our EPMA solution. This is a National Medication Safety priority and will facilitate safer transfer of care across boundaries.

Medicine's expenditure overall saw a 1% decrease year on year, a 2.9% increase in PbR excluded medicines spend, largely driven by the increasing use of biosimilar medicines, and a 4.2% decrease in in-tariff spend driven by COVID and reduced activity. A significant reduction in expenditure on drugs commissioned by the Cancer Drugs Fund (CDF) was seen due to a number of therapies being approved by NICE.

In support of local partnership working and developing a cross sector workforce, we hosted 4 Preregistration Trainee Pharmacy Technicians (PTPTs) on a cross sector programme of training with a local Mental Health Trust and GP Federations. This concept will then extend to the pre-registration Pharmacist cohort for 2021/22 where one trainee will work in a local GP practice for 13 weeks of the year.

Whittington Pharmacy CIC (WPCIC), a Wholly Owned Subsidiary of Whittington Health NHS Trust, completed its four year of trading and demonstrated agility in the provision of medicines to patients during COVID and financial sustainability. A postal service, local delivery service utilising trust volunteers in addition to a drive thru process were implemented and ensured patients received the medicines they required in a timely way. Patient experience data obtained during this period demonstrated very positive patient satisfaction levels.

The optimisation of medicines use throughout COVID19 at Whittington Health NHS Trust has been a great success this year and has seen significant enhancement in partnership working both internally and externally across the Integrated Care System. The learning from this year will feature significantly in our priorities and modus operandi going forward and we look forward to progressing and building on out successes.

1.0 INTRODUCTION

Medicines management encompasses a range of activities intended to improve the way that medicines are selected, procured, prescribed, dispensed and administered.

This report summarises the activities of groups and committees responsible for the management of medicines at Whittington Health, and describes developments throughout the 2020/2021 year and plans for 2021/22

Additional sections have been added to this report for 2020 – 2021 to recognise the exceptional work undertaken by the Pharmacy department to support the response to the COVID-19 pandemic

2.0 DRUGS & THERAPEUTICS COMMITTEE

The Whittington Health Drug and Therapeutics Committee (DTC) provides multi-disciplinary leadership to ensure appropriate management of medicines and the continuous improvement in the safe use of therapies within the organisation. This includes both acute and community settings.

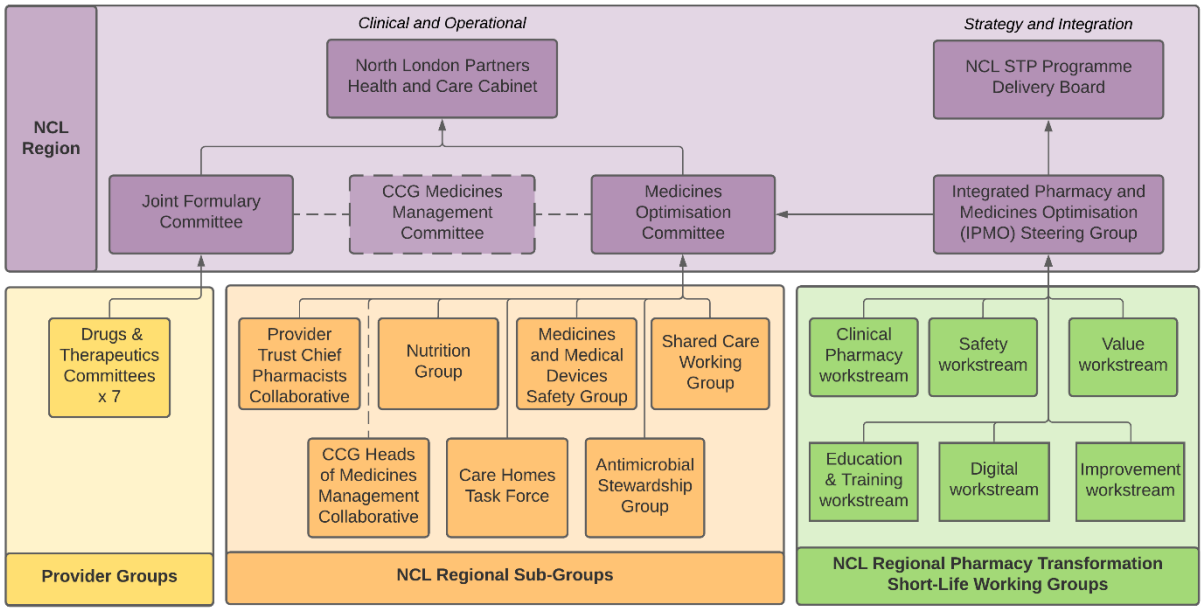
The DTC meet every 2 months to consider new drugs applications, Patient Group Directions (PGD), guidelines and any other issues concerning medicines management in the Trust. Medicine Safety is addressed through a sub-committee (Medicines Safety Group) which reports to the DTC.

The DTC also work collaboratively with the North Central London Medicines Optimisation Network (NCL MON).

During the COVID-19 pandemic, the DTC set up an interim process, with agreed terms of reference, to oversee rapid guideline, protocol and pathway development and approval. This included extraordinary meetings and new prioritisation criteria for review of documents to ensure urgent and relevant items were discussed in a timely manner.

3.0 NORTH CENTRAL LONDON MEDICINES OPTIMISATION NETWORK

The Whittington Health is part of the NCL MON, which consists of committees and groups of healthcare professionals working across different sectors of the NHS with the aim to ensure safe, effective and cost-effective use of medicines in North Central London. A schematic of the Committees and Working Groups across NCL forming the MON is shown below.



Note: solid lines indicate a line of reporting. Dotted lines indicate a line of communication.

3.1 JOINT FORMULARY COMMITTEE

The Joint Formulary Committee (JFC) includes representatives from the Clinical Commissioning Groups, Primary Care Networks and the Provider organisations for the North Central London Sector.

The NCL JFC advise relevant stakeholders in NCL on appropriate, equitable, evidence-based and cost-effective medicines use. The JFC meets every month and it scientifically assesses medicines in terms of comparative efficacy, safety, convenience and cost-effectiveness. The current remit of JFC is thus scientific and advisory in nature and hence makes recommendations to accountable budget holders. The JFC is driven by an evidence-based approach and new medicines will be recommended if they offer a significant advantage over existing products.

The local DTCs still consider new drugs as advised by JFC when the drug is likely to affect only the local hospital and no other hospitals within the sector.

The DTC and the Pharmacy team work collaboratively with the NCL JFC in different ways, including attendance at JFC meetings; local implementation of JFC decisions; sharing of information about local use of drugs or previous DTC decisions which may support JFC evaluations; review of draft JFC documents and gathering of local experts' opinion and maintenance of NetFormulary.

A summary of new medicines considered by the JFC and implemented at the Whittington is found in appendix 1 of this report.

3.2 MEDICINES OPTIMISATION COMMITTEE (MOC)

The NCL MOC is a subgroup of the JFC which aims to provide strategic medicines optimisation leadership across NCL by sharing work and decision making between primary care, secondary care, tertiary care, community care, and social care.

The NCL MOC aims to identify opportunities to improve safety, patient care and experience through medicines optimisation in all sectors that medicines are used in NCL.

Meetings are held on a quarterly basis and consequently there is a large element of work that takes place outside the meetings.

WH have also worked closely with the Medicines Efficiency Programme Team, a subgroup of the MOC developed and focussed on sector wide implementation of cost efficiencies, specifically implementation of biosimilars and use of Blueteq.

3.3 NETFORMULARY

Since June 2019 the Whittington Health Drug Formulary has been available on NetFormulary, the NCL single web-based formulary platform. NetFormulary brings together formulary-related information from different NCL Trusts aiming to improve efficiency and transparency in the formulary management and reduce unwarranted variation in drug treatment across NCL.

NetFormulary is available on the internet (click here) to internal and external healthcare professionals and also to members of the public. It is regularly updated by JFC and local Trusts, who work in collaboration to ensure its contents are up-to-date and accurate.

3.4 IMPROVING PHARMACY AND MEDICINES OPTIMISATION (IPMO)

NHS England and NHS Improvement have established an Integrating Pharmacy and Medicines Optimisation (IPMO) programme with the vision of creating a collaborative and integrated approach to the provision of patient care with medicines across a local system - a single system focused on delivering the best outcomes for patients and best value for the taxpayer. This involves many healthcare professionals including pharmacists, pharmacy technicians, assistant technicians and support staff, who should provide leadership in the optimal use of medicines.

As part of the North Central London Medicines Optimisation Network, a group of Pharmacy Leaders have developed a vision as well as a common set of principles and enablers to guide the integration, development and transformation of pharmacy and medicines-related services and to drive the delivery of better outcomes from medicines in North Central London. The pharmacy community will continue to liaise with various Programme Leads across the emerging Integrated Care System (ICS)

to support and enhance the system response to the Long-Term Plan, Medium Term Financial Strategy and local priorities.

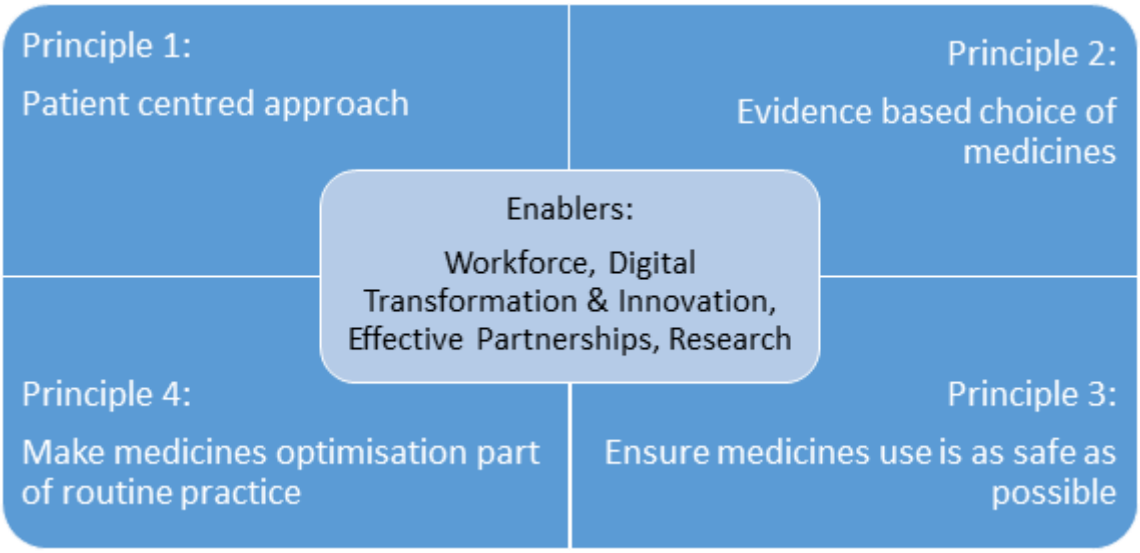


Figure 1: Vision – To improve the health and wellbeing of our population through the best use of medicines and pharmacy

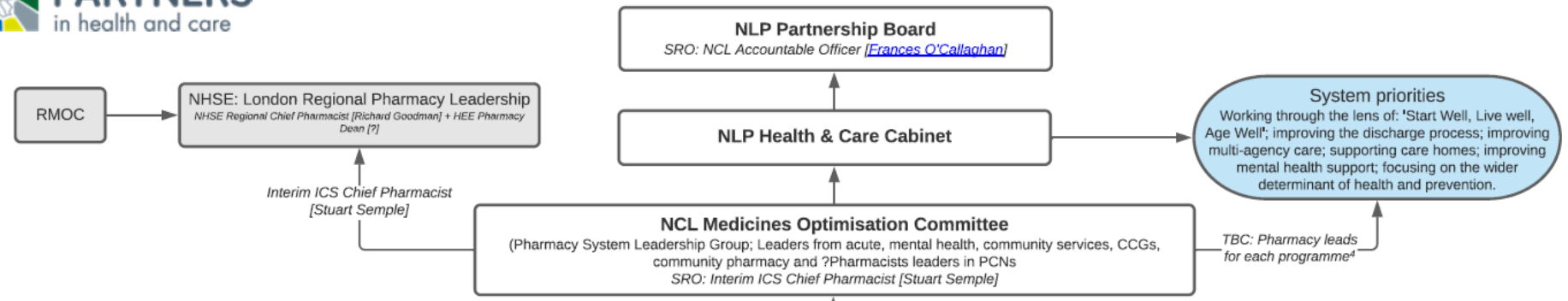
The Integrating NHS Pharmacy and Medicines Optimisation (IPMO) programme published in September 2020 aims to develop a framework, which will set out how to systematically tackle the medicines optimisation priorities for the local population in an STP/ICS footprint and use the expertise of pharmacy professionals in the strategic transformation of systems in order to deliver the best patient outcomes from medicines and value to the taxpayer.

In order to deliver IPMO in NCL, we have appointed an 'interim' ICS chief pharmacist and formed the IPMO steering group to provide leadership, strategy and oversight the delivery of the IPMO programme. The IPMO programme in NCL will operate under three key Domains (workstreams):

- Workforce
- Safety
- Value

NORTH LONDON PARTNERS in health and care

North Central London: Pharmacy transformation domains and governance structure



Outcome domain	Pharmacy workforce[1]	Medicines safety[1]	Value[1]
Workstreams	**Clinical Pharmacy and Education & Training[2]** *Leads: Rachael Clark (NCL CCG) & Robin Offord (UCLH)*	**Safety & Digital[2]** *Leads: Amalin Dutt (NCL CCG) & Stuart Richardson (WH)*	**Value & Improvement** *Leads: Paul Gouldstone (NCL CCG) & Sarah Stern (NMUH)*
Strategic aim	*Maximising the clinical contribution of the pharmacy workforce and developing an integrated pharmacy workforce across all sectors and at all levels*	*Ensuring the safe use of medicines across all NHS service and deploying new technology enabled service delivery options*	*Ensure the best value for money from medicines with a resilient medicines supply chain and improving health outcomes for people who use medicines and pharmacy services*
Areas of focus *** See overleaf for additional information regarding areas of focus**	**Clinical Pharmacy*** • Workforce development and integration of clinical pharmacy: - Mental health - PCN - Care Home - Community health services - Community pharmacy - Trusts - Public health pharmacist • Consultant Pharmacists • Genomics	**Education & Training*** • Place-based pharmacist and technician training • Consolidate E&T functions • Mental health clinical framework • Deploying NHS People Plan • Ensure workforce digital ready	**Safety*** • Antimicrobial stewardship • Support national medicines safety agenda: - PINCER - Valproate • EPMA systems • Automated dispensing and administration systems • Medicines reconciliation	**Digital*** • HEI to support population health management • HIE access to clinical records • TCAM	**Value*** • Efficiency of medicines supply chain • Consolidate and rationalise pharmacy services • Aseptics services review • System Efficiency Plan (SEP)	**Improvement*** • Proactive care for LTC • STOMP/STAMP • QI methodology • Evidence-based practice

4.0 COVID 19 RESPONSE & MEDICINES OPTIMISATION

Pharmacy services and the use of medicines played and continue to play a very significant part in Whittington Health NHS Trust's response to COVID 19. This includes both the treatment of patients admitted as a result of the virus in addition to the ongoing vaccination programme.

Trust Support

- Prepacks / over labelling
- Prefilling syringes (Trust and Nightingale)
- Supported ITU syringe production
- Supporting medicines handling at ward level (ITU/ED/others)
- Amended DTC approach to support priority COVID items
- Electronic Outpatient prescriptions implemented
- Provided dedicated pharmacy discharge support
- Increased ordering and procurement support
- Trust assurance over oxygen infrastructure
- Development of oxygen decision model for CPAP and Optiflow
- Development of oxygen usage electronic dashboard
- Regional and National returns and alerts
- Trust assurance regarding oxygen provision (VIE and Cylinders)
- Managed multiple local stock shortages
- Supported NCL (and wider) ICUs with stock shortages
- Supported relocation of services to the Northern Health Centre and adjustment of medicines provision in support of Whittington Health assuming the South Hub for Paeds during COVID
- Supported relocation of some pharmacy stock to other areas of the Trust
- Flexibility with staffing
- Changes to chemotherapy production times

Clinical Pharmacy Practice

- Skilling up staff on ITU
- Broad ward rota management; much more flexible approach
- Developed guidance around handling patients own medicines
- Adjusted Antimicrobial guidance with emerging evidence
- Managed local approach to significant medicines shortages
- Trialled remote working capabilities for clinical staff
- Amended weekend and bank holiday working
- Expanded development opportunities for staff
- Highlighted critical level of staff needed to operate pharmacy services
- Strengthened working relationships with Acute and Community pharmacy teams
- Given opportunity for staff to shine

Anti-coagulation

- Managed uncertainty and provided reassurance to concerned patients
- Use of answer phone messages / automated email responses / letters sent to patients to keep patients up to date on service provision and changes
- Supported an NCL wide approach to managing anticoagulation
- Developed a clear and easy to follow protocol for the management of patients who were shielded or low risk
- Pharmacy managed service

Electronic Prescribing and Medicines Administration

- Structured training times for EPMA
- Remote working and remote training enabled
- Great support from “EPMA champions” to take on some training. This has also helped strengthened process and procedures within EPMA.
- Switch of outpatient prescribing from paper to electronic – 37% to 97%
- Used EPMA to support safe prescribing in new clinical areas (COVID admission and Recovery prescribing bundles)
- Single Point of Access for EPMA enquiries

COVID-19 treatment and vaccination

- Managing the staff COVID-19 vaccination Pfizer clinic and some AstraZeneca roving clinic.
- Managing the Hornsey COVID-19 mass vaccination centre
- Managing inpatient roving COVID-19 vaccination session
- Implementation of Remdesivir for patients requiring supplemental oxygen and within 10 days of symptoms onset.
- Implementation of Dexamethasone for patients who are severely or critically ill with COVID-19
- Implementation of tocilizumab for COVID positive patients

COVID 19 and Oxygen provision

- COVID 19 highlighted the critical importance of oxygen provision within the organisation with significant requirements for high flow oxygen provision to patients as a fundamental aspect of their care.
- The Chief Pharmacist assumed the Trust Clinical Lead position for Oxygen and supported the organisation navigate the challenges associated with its use during both surges within year.
- The Chief Pharmacist also assumed Chairmanship of the Medical Gas Group which was stood up to weekly throughout the surges to monitor and manage demand.
- The Trust response to oxygen management was truly a multidisciplinary approach with colleagues from multiple clinical and non-clinical disciplines.
- An electronic automated dashboard was created using vitals data to monitor real time oxygen use and oxygen and high flow device use was monitored

through the Trust Gold COVID meetings that stepped up and down in line with surge activity.

- The Medical Gas Group were successful winners of the 2020-21 Quality Improvement ‘People’s Choice’ Award for all work done with oxygen throughout the year.

Embedding COVID-19 changes to practice

- After the first wave of COVID-19, the significant amount of learning and changes to practice were captured through a department wide “Phoenix” project.
- The aim of this project was to reflect on the changes to practice throughout the COVID-19 pandemic and ensure that all learning was captured and any positive changes to practice remained once COVID-19 pressures had reduced.
- Through facilitated reflective sessions with the Pharmacy department, the Phoenix Project working group identified the following key themes. Each theme was then further developed through a task and finish approach with the support of volunteers from the department.
- Progress within each project were tracked through the Trust wide Transformation Board.

1. Roles and Responsibilities within the department
2. Working From Home
3. Communication and staff engagement
4. Staff support and wellbeing
5. Staff induction
6. Supporting Trust wide discharge processes
7. Using technology to develop practice

- Work continued on these projects for approximately 6 months, at which point, the learning was summarised and gathered to inform changes to the department Vision and Objectives. This ensured that the learning had been captured at a strategic level.
- The wellbeing, working from home, staff induction and discharge support has remained post COVID-19 and continues to provide benefits to the team and ensures that the department is still able to work in an agile and responsive manner.

5.0 POLICY, GUIDELINE AND DOCUMENT APPROVAL

The DTC are responsible for reviewing and approving policies, guidelines, and other documents related to medicines management. A summary of these documents approved by DTC in 2020/21 is listed in the table below.

Title	Type	D&TC date
Carbetocin for prevention of post-partum haemorrhage	Drug application	April 2020 (COVID-19 interim sub-committee)
Varenicline (Champix®) supply in community pharmacies	Patient Group Direction	July 2020
Covert administration guideline (new)	Guideline	July 2020
Rapid tranquilisation guideline (new)	Guideline	July 2020
TB service guideline (update)	Guideline	July 2020
Terizidone for TB	Drug Application	30 July 2020
Naloxone guideline (new)	Guideline	July 2020
Temporary alternative insulin guide (new)	Guideline	July 2020
NBM guideline (update)	Guideline	July 2020
Refeeding Syndrome guideline (update)	Guideline	July 2020
Arranging delivery of To Take Away (TTA) pre-pack medication in Radiology and Endoscopy departments	SOP	July 2020
Intravenous Immunoglobulin Use Guideline (update)	Guideline	September 2020
Medicines Management in Community Clinics (new)	SOP	September 2020
Medicines Policy MP10 - Non-Medical Prescribing (update)	Policy	September 2020
Anaesthetic Paediatric Emergencies – Drugs and Equipment box	SOP	September 2020
Medicines Policy MP15 - FP10 prescriptions (new)	Policy	November 2020

Rapid Tranquilisation for Paediatrics guideline (new)	Guideline	January 2021
Phospho Soda bowel cleansing preparation for capsule endoscopy	Drug application	March 2021
Bowel prep guideline (update)	Guideline	March 2021
Administration of Sodium Fluoride 50mg/ml dental suspension (new)	Patient Group Direction	March 2021
Administration of dental local anaesthetics with adrenaline	Patient Group Direction	March 2021
Administration of dental local anaesthetics without adrenaline	Patient Group Direction	March 2021

COVID-related documents approved

Title	Type	D&TC date
Povidone-Iodine 0.5% solution for dental services	Drug application	April 2020 (COVID-19 extraordinary meeting)
VTE treatment and prophylaxis in COVID-19 guideline (new)	Guideline	April 2020 (COVID-19 extraordinary meeting)
VTE prophylaxis in pregnancy	Guideline	April 2020 (COVID-19 extraordinary meeting)
Dexmedetomidine use in ITU	Proposal for extended use during COVID-19	April 2020 (COVID-19 extraordinary meeting)
Gastro infusion service at Highgate Private Hospital	Flowchart	April 2020 (COVID-19 extraordinary meeting)
Antibiotic use in suspected and confirmed COVID-19 patients	Guideline	April 2020 (COVID-19 extraordinary meeting)
Guidance on managing patient own drugs during COVID-19	Guideline	April 2020 (COVID-19 extraordinary meeting)
Systemic anti-cancer treatment	Proposal for temporary changes during COVID-19	May 2020 (COVID-19 extraordinary meeting)
Vitamin D deficiency guideline (update)	Guideline	May 2020 (COVID-19 extraordinary meeting)
Methylprednisolone injection administration by MSK services (COVID-19 update)	Patient Group Direction	September 2020
Triamcinolone injection administration by MSK services (COVID-19 update)	Patient Group Direction	September 2020

Lidocaine injection administration by MSK services (COVID-19 update)	Patient Group Direction	September 2020
VTE treatment and prophylaxis in COVID-19 guideline (update)	Guideline	January 2021
Administration of COVID vaccine to patients on anticoagulation	Guideline	January 2021
Delaying Rituximab for Rheumatoid Arthritis	Proposal for temporary changes during COVID-19	January 2021
COVID-19 Vaccine Handling and Management Policy	Policy	January 2021
COVID-19 vaccine - Pfizer-BioNTech and AstraZeneca	National Protocol	January 2021
COVID-19 vaccine - Pfizer-BioNTech and AstraZeneca	Patient Specific Direction and Consent Form	January 2021
COVID-19 vaccine - Pfizer-BioNTech and AstraZeneca	Guidance for Clinical Assessors and Vaccinators	January 2021
COVID-19 vaccine - Pfizer-BioNTech and AstraZeneca	FAQ - vaccine excipients and general information	January 2021
COVID-19 vaccine - Pfizer-BioNTech and AstraZeneca	Competency assessment for safe dilution, preparation and drawing-up	January 2021

6.0 NON-FORMULARY AND UNLICENSED DRUGS

6.1 NON-FORMULARY DRUGS

The usage of non-formulary (NF) drugs is closely monitored by Pharmacy and DTC, which are responsible for approving their use for individual patients. Initiation of treatment with non-formulary drugs requires review and approval by DTC chair/deputy. In 2020/21 there were 103 requests for initiation of non-formulary drugs, of which 83 requests were approved.

An annual report of usage of non-formulary (NF) drugs is compiled and reviewed at DTC once a year. This helps ensure appropriate medications have been used, cost containment measures are being implemented and patient safety is maintained. In addition, the formulary pharmacy team also monitors NF drug usage through monthly reports.

Any issues related to inappropriate use of NF drugs are reported to pharmacy team leads e.g. if there is a formulary option which could have been used or if an item which is considered less suitable for prescribing has been selected. This has been useful to ensure that NF items are only used when clinically appropriate. Monthly review will continue for 2021/22.

The formulary and high-cost drug teams are currently reviewing the process to request the use of high-cost drugs outside the formulary and outside existing commissioning pathways, which represents local financial pressure. The project aims to identify potential funding routes for locally funded treatments and strengthen the governance process for the use of these treatments in our trust.

6.2 UNLICENSED MEDICINES

The use of unlicensed medicines is sometimes necessary when there is no licensed alternative available. Once again, in 20/21 the usage of new unlicensed medicines has been linked to shortages of the licensed version of the medicine.

Most of the time, this is guided by advice from the Department of Health and Social Care (DHSC) or Specialist Pharmacy Service (SPS). The pharmacy team monitors this and ensures compliance with unlicensed medicines regulations.

In February 2019, the Human Medicines Regulations 2012 were changed to introduce Serious Shortage Protocols (SSP). Further changes came into force in July 2019, in the NHS (amendments relating to serious shortage protocols) Regulations 2019. If the Department of Health and Social Care (DHSC) decide there is a serious shortage of a specific medicine or appliance, then an SSP may be issued.

The contractor must use their professional skill and judgement to decide, alongside medical experts, whether it's reasonable and appropriate to substitute the patient's

prescribed order for the active SSP. The patient would also have to agree to the alternative supply for that dispensing month.

Examples of where unlicensed medicines were supplied due to shortages include:

Phytomendione injection, Calcium Chloride 10% injection, and Tuberculin injection

Unlicensed medicines are also regularly supplied to paediatric patients who are prescribed drugs that are not available in a liquid form. Due to the short shelf life and low demand, manufacturers have not sought a license to manufacture on a large scale.

In 2020/21 159 different unlicensed products were supplied, a slight increase from 147 in 2019/20. With increasing shortages being seen as a consequence of both Brexit and COVID 19, it is anticipated that there will be a further rise in the use of unlicensed medicines.

7.0 NICE DRUG TECHNOLOGY APPRAISAL (TA) AND IMPLEMENTATION

Technology appraisals (TA) are recommendations on the use of new and existing medicines and treatments within the NHS. The Department of Health has stated that all medicines that have a positive NICE TA, and are relevant to the Trust clinical practice, must be available on the Trust Formulary. In addition, it is required that all Trusts publish their formularies on their public website, so it is transparent to all patients and the general public which drugs are available. A statement of compliance to the NICE TA guidance must also be published on the site. The Trust is compliant with this directive.

A NICE TA report is submitted to each DTC meeting and medicines or treatments relevant to Whittington Health are added to the formulary and made available to our patients.

Included in the appendix 2 is a list of relevant drugs that have received a positive NICE TA and were ratified by DTC in 20/21.

7.1 IMPLEMENTATION OF NICE TECHMNOLOGY APPRAISALS (TA)

The DTC also monitor the local implementation of NICE TA. A report is presented to every DTC meeting to highlight the use of new drugs and implementation of new treatments one year after being initially ratified by DTC. This allows the committee to identify potential barriers to the implementation or inappropriate use of drugs, which can be addressed. A summary of these drugs can be found on appendix 3.

8.0 PATIENT GROUP DIRECTIVES (PGDS)

Patient group directions (PGD) allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription.

The DTC ratify and approve Whittington Health PGDs.

There are 43 PGDs from several clinical areas in use across the Trust, in both acute and community settings. All these PGDs are reviewed and approved by the DTC. To support the management of the PGDs these have been all collated in one location on the intranet. The Pharmacy team keep a PGD database which helps to identify any reviews and updates needed.

The DTC also ratify NHS England PGDs to ensure governance. NHS England London Region in collaboration with Public Health England (PHE) develops and publishes a suite of vaccine PGDs to provide system-wide leadership and consistency for delivery of immunization and vaccination programmes across London.

In 20/21 the DTC approved the use of national PGDs and protocols developed as part of the COVID-19 immunisation programme, which allowed the vaccination of thousands of members of staff throughout the pandemic.

A summary of PGDs approved by DTC in 2020/21 is listed in appendix 4.

9.0 MEDICINE FUNDING STREAMS - CANCER DRUGS FUND (CDF)

The Cancer Drugs Fund (CDF) is a source of funding for anti-cancer treatment in England..

The CDF enables:

- Early access for patients to the most promising new treatments
- A fast-track NICE process for companies to apply for appraisals
- Financial certainty with a fixed budget and a mechanism to control expenditure.
- Greater flexibility from NHS England in the deals agreed with the pharmaceutical industry to encourage the responsible pricing of cancer drugs.

All new systemic anti-cancer therapy drug indications expected to receive a marketing authorisation will be appraised by NICE following Ministerial referral. NICE can make one of three recommendations:

- Recommended for routine commissioning- ‘yes’
- Not recommended for routine commissioning- ‘no’
- Recommended for use within the CDF
- More of these drugs are now NICE approved

All CDF related updates and actions are managed formally through the DTC.

In response to the COVID-19 pandemic, NHS England and NHS Improvement endorsed various interim treatment change options to allow for greater flexibility in the management of cancer. These options were based on the clinical opinion from members of the Chemotherapy Clinical Reference Group and specialised services cancer pharmacists. Each treatment option was clinically assessed against particular criteria, such as the treatment being less immunosuppressive and thereby mitigates a patient's likelihood of contracting COVID-19 or becoming seriously ill with COVID-19.

These treatment options were formally approved by DTC and made available for clinicians to choose as appropriate.

10.0 CHEMOTHERAPY

Nationally Standardised Dose Banding and Standardised Product Specifications for Adult Intravenous Anticancer Therapy (SACT)

Dose banding in chemotherapy is not a new concept and has been done locally at the Trust for some time. Standardisation of chemotherapy doses offers one avenue for achieving improved value in this area – with clear system wide benefits. The approach is in line with the Efficiency and Productivity review undertaken by Lord Carter, which recommends the elimination of waste through a consistent approach to patient care.

In 2019/20, the Trust met all requirements relating to a Medicines Optimisation CQUIN that included a medicines optimisation and stewardship indicator on improving efficiency in the cancer treatment pathway. The scheme aimed to support a standardised approach to monitoring chemotherapy waste and to promote schemes to minimise waste.

Given the agreement in 2020/21 to suspend CQUINS, no further audits were completed or data submitted, however, the principles associated with the CQUIJN were maintained.

11.0 ANTIMICROBIAL PHARMACIST STEWARDSHIP ACTIVITIES

In Whittington Health, the antimicrobial stewardship programme is well established.

The Trust has a dedicated Consultant Antimicrobial Pharmacist who works with the Microbiologists to lead on the trust's Antimicrobial Stewardship programme and is part of the North Central London (NCL) Antimicrobial Pharmacist Group, London Antimicrobial Stewardship (AMS) group and the UKCPA Pharmacy Infection Network.

During the COVID-19 pandemic, resources were re-directed towards managing this new infectious disease.

The trust's guideline for the treatment of lower respiratory antimicrobial was revised to accommodate the supply shortages of antimicrobials, the increased numbers of

patients admitted with infections related to the SARS-CoV-2, and the need to rationalise antimicrobial dosing regimen to limit staff exposure and use of personal protective equipment (PPE).

The new drug, Remdesivir was implemented at Whittington in June 2020 for the treatment of hospitalised COVID-19 patients requiring supplemental oxygen. All patients given Remdesivir were registered on Blueteq and reported on the ISARIC 4C system.

In July 2020, Dexamethasone was used off-license for the treatment of patients with severe or critical COVID-19 disease in-line with recommendation from the MHRA COVID-19 Therapeutic Alert.

In December 2020, Whittington Health began the COVID-19 vaccination programme for health and social care staff at the hospital site. The Hornsey mass vaccination centre was open to members of public in January 2021, which ran a 0.5 pod model 7-days a week.

As more patients were admitted with more severe non-COVID related infections due in delays in seeking medical advice, OPAT service provided support in preventing admissions and reduce length of stay.

11.1 QUARTERLY ANTIMICROBIAL POINT PREVALENCE

The Quarterly Antimicrobial Point Prevalence Audit was suspended following the COVID-19 pandemic.

11.2 CQUIN TARGETS

The Q4 CQUIN audits were suspended following the COVID-19 pandemic

11.7 INTERNAL AND EXTERNAL COMMITTEES

Contribution as an active member in the:

- Trust Antimicrobial Steering Group (ASG)
- Trust Infection Prevention and Control Committee (IPCC)
- Trust Drug & Therapeutics Committee (D&TC)
- Trust Clinical Guideline Committee (CGC)
- Trust CQUIN Delivery Board
- Trust Pelvic Floor MDT
- Trust Sepsis Group
- Trust Influenza Planning Committee
- NCL Antimicrobial Pharmacist Group (NCLAPG)
- London AMS Group

12.0 HORIZON SCANNING

In previous years, a horizon scanning document identifying future cost pressures was presented to the January DTC meeting. This year staffing pressures due to COVID meant that a full horizon scanning exercise was not completed. Some cost pressure estimates were based on historic drug usage data.

The total maximum predicted drug cost-pressure for 2020-21 was approximately £5.8 million. Local (in-tariff) drug cost pressures for 2020-21 were estimated to be £50k. The cost pressure associated with the uptake of CCG-commissioned drugs was estimated at £170k. The cost pressure associated with the uptake of NHSE-commissioned drugs was estimated at £5.6 million

The main cost pressures for 2020/21 were associated with the expansion of the clinical haematology service and cancer drugs, both commissioned by NHSE / CDF, which were estimated at £4.6million.

The actual cost pressures for 2020/21 were not as high as anticipated. This is due to the negative impact the COVID-19 pandemic had on the delivery of planned services.

13.0 IMMUNOGLOBULIN - IVIG

Therapeutic intravenous immunoglobulin (IVIg) is a blood product used in a number of clinical situations. However, there have been concerns over the availability of IVIg to the NHS due to global shortages.

The Updated Commissioning Criteria for the use of therapeutic IVIg in immunology, haematology, neurology and infectious diseases in England was published in November 2019. It provides greater detail around the role, dose and place of IVIg in the treatment pathway for individual indications alongside possible alternative treatment options. The colour coding scheme, which was previously devised for demand management but often utilised as a commissioning tool, has been replaced by categorisation of IVIg use into routinely commissioned or not commissioned categories based on the strength of evidence.

A clinical guideline is available at the Whittington related to IVIg management. The use of IVIg at the Whittington must be approved prior to being prescribed by two of the consultants present on the IVIG local panel.

Our North Central London Sub-Regional Assessment Panel oversee the IVIg usage at Whittington and provide a local London list of indications where the first dose of immunoglobulin can be given prior to panel approval.

The regional panel meet every month to discuss any updates around IVIg and the local panel meet twice a year. Dose reviews are being carried out twice a year for

long term patients to ensure the current dose is correct. This is then communicated to the patient's GP.

During 2020/21 Whittington Health has between 5 and 7 patients on long-term IVIg treatment and an average of 3 patients treated acutely each month.

14.0 MEDICINES SAFETY GROUP

The Medicines Safety Group (MSG) meets every two months and reports into the Drugs and Therapeutics Committee (D&TC) and Patient Safety Group (PSG). The MSG consists of representatives of different staff groups and services.

Standing items on the agenda are, review of medication incidents reported on Datix, report on medication incidents referred to the Serious Incident Executive Advisory Group (SIEAG), MHRA and company drug alerts and NHS England Patient Safety Alerts.

Themed meetings have been planned for 2020/21 – planned themes include, controlled drugs, high risk drugs – including anticoagulants, insulin and gentamicin, omitted drugs and the new steroid emergency card.

The Chair of the Group has changed as of March 2021 and is now the Deputy Chief Nurse. The terms of reference and membership of the Group have been reviewed.

14.1 MEDICATION INCIDENTS REPORTED ON DATIX

The Medicines Safety Officer (MSO) sends monthly reports to the Clinical Directors and Safety Leads for the Integrated Clinical Service Units (ICSUs) and presents a bi-monthly combined summary to the MSG for discussion: these report themes and trends.

Medication incidents received - April 2020- March 2021

Month	Number of medication incidents reported (*)	Number of incidents causing moderate or greater harm (**)
April	37	0
May	41	0
June	52	1
July	43	1
August	46	0
September	50	0
October	56	0
November	60	0
December	42	0
January	56	2

February	69	1
March	52	2

(*) Figures as reported at the month end
(**) Figures as of 22.7.21

There were 604 medication incidents reported on Datix from April 2020-March 2021: seven of these incidents (1% of the total) caused moderate or greater harm.

This compares with 627 medication incidents reported on Datix from April 2019 to March 2020: eight of these incidents (1% of the total) caused moderate or greater harm

And with 623 medication incidents from April 2018 to March 2019 where seven incidents (1% of the total) caused moderate or greater harm and 615 incidents reported from April 2017 to March 2018 where six incidents (1% of the total) caused moderate or greater harm.

The discrepancies seen between months during 2020/21 may be explained by COVID activity: where normal activity within the hospital was reduced.

All medication safety incidents are reviewed by the Trust Medication Safety Officer and trend identification and subsequent learning shared throughout the organisation via the Trust Medicines Safety Group

With regards to the staff group, the highest reporters of medication related incidents are hospital nurses followed by pharmacy staff and district nurses.

Incidents involving the administration of drugs continue to be the most frequently reported type of incident, followed by incidents concerning controlled drugs, prescribing incidents and dispensing by pharmacy incidents.

The Emergency and Integrated Medicine ICSU reports the greatest number of medication incidents – in line with other incident reporting on Datix.

14.2 LEARNING FROM INCIDENTS

Learning from incidents occurs in the following ways:

1. Articles in ‘Medicines Matter’. This is a quarterly Pharmacy publication that is sent to all staff and available on the intranet. Each edition has a medicines safety section.

   Areas covered in 2020/21 included:

   - Omitted doses of antiretroviral medication
   - Prescribing paracetamol containing products safely
   - Prescribing alternative insulins out of hours

2. Articles in Spotlight on Safety. This is a bi-monthly publication produced by the Risk Department and available on the intranet.

3. Presentations to the monthly Patient Safety Forum (PSF). These are usually undertaken by junior medical staff that present and reflect on an incident they have been involved in. This is coordinated by the Medical Director for Patient Safety. Topics covered have included:

    - Gentamicin prescribing following an incident where a patient received the incorrect dose. The available resources were discussed by the Antimicrobials Pharmacist.
    - Review and management of patients taking dual anticoagulation.
    - Review of the Acute Coronary Syndrome (ACS) protocol

4. Individual feedback is also carried out via Datix by the MSO during investigation of incidents. This can often lead to more background information on particular incidents – for example with JAC or other operational issues. These are followed up with the relevant section within pharmacy.

Learning also occurs via the clinical pharmacy meetings and pharmacy team meetings where incidents and their causes can be discussed in more detail.

- Team leads within pharmacy also report on medication incidents to their Quality Boards.
- Feedback to individuals via Datix.
- Feedback to ward staff via the ward pharmacy network.
- Feedback to the local MSO & MDSO network – this includes community colleagues as well as other local hospitals.

14.3 NHS ENGLAND PATIENT SAFETY ALERTS (PSA)

The MSG and MSO work with the Trust Compliance Officer to develop action plans and ensure completion dates are adhered to. Details of all PSAs can be found on Datix.

14.4 PHARMACY RISK REGISTER

The Pharmacy Risk Register (PRR) is a subsection of the ACW ICSU risk register. Whilst the risk register predominantly incorporates risks associated with the delivery of pharmacy services, it also contains a number of risks associated with medicines management that are not necessarily specific to pharmacy.

The content of the pharmacy risk register is the responsibility of the Chief Pharmacist. The Chief Pharmacist delegates responsibility for the daily ongoing review of the PRR to the Clinical Governance Pharmacist.

The risk register is formally reviewed once a month with the top 3 risks formally noted at the ACW ICSU Board. The top 3 risks are further noted at the Quarterly Performance Review.

At the end of 2020/21, there were 11 risks on the PRR graded as per the table below.

Risk grading	Number of risks
Extreme	3
High	4
Moderate	3
Low	1
Total	**11**

The three extreme risks high relate to:

1. Staffing challenges associated with Pharmacy Technical Services in that the Accountable Pharmacist and Authorised pharmacist are both pregnant and will complete similar periods of maternity leave. Further, a COVID risk assessment will require them to work from home from week 28 therefore reducing on site oversight of technical services activity. Failure to recruit into the two maternity leave positions would be a major risk and could result in a negative impact on patient care and any Regional Quality Assurance Inspection (due June 2021) [*Addendum – both positions have now been recruited into and a recent inspection has demonstrated the service to be 'low-risk' with a small number of minor actions required*]

2. Areas of electrical and heating non-compliance. In addition, the environment is no longer fit for purpose for the staff numbers in the department and enhanced space utilisation is required. A failure to correct the no compliance and resolve the space issues leads to risks of non-compliance and an environment that is not supportive of staff health and wellbeing especially given the requirements for social distancing due to COVID. [*Addendum – a series of works have been conducted and have minimised this risk significantly]*

3. The strategic direction for Whittington Health was to go-live with System C EPMA/CLMA in 2021. This would replace the JAC EPMA v2014 solution currently used in the Trust (supplied by WellSky) as this system is no longer being supported by Wellsky. Due to the delay in development of System C EPMA an upgrade of JAC EPMA from v2014 to v2020 is now required. This will require significant Capital investment and resourcing to support parallel workstreams and deployment of what is effectively a completely new version of JAC EPMA. [*Addendum – Capital investment secured to support upgrade of the current system – implementation planned for end Sept 2021]*

Of the 4 high risks, include:

1. Patient safety and Quality risk relating to the electronic system utilised for anticoagulation services and its lack of interoperability and auditing capability. Tendering new IT solution. *[Addendum: a new system has been procured and is the process of being implemented]*

2. Financial risk associated with funding arrangements for Whittington Pharmacy CIC given current gain share arrangements. Ongoing discussion with commissioners. *[Addendum: This has since been resolved and removed from the register*]

3. Security of Pharmacy stores – given the increasing security requirements associated with medicines resulting from shortages, Brexit and anticipation of COVID vaccines, the security arrangements for Pharmacy stores requires upgrading. *[Addendum: Store's doors replaced with steel doors, new camera and lighting installed]*

4. Patient Safety and Quality risk associated with non-compliance with the requirements of EL (97)52 Aseptic Dispensing in NHS Hospitals. Action plan in place and updates provided regularly *[Addendum: Significant progress made with actions and subsequent inspection confirmed service as 'low risk']*

The remaining low rated risks are a combination of patient safety, and IT related risks. In addition to the risks on the PRR, there are also 4 organisational wide risks of note relevant to medicines:

1. High ambient temperature of ward/unit treatment rooms

2. Medicine's storage and handling – security of medicines at ward level

3. Temperature monitoring of Fridges used for medicines storage.

4. Trust wide compliance with the revised Royal Pharmaceutical Society Guidelines for the Safe and Secure Handling of medicines.

These risks are being managed through a series of actions being taken in conjunction with Estates and the Senior Nursing teams.

Significant Capital investment was agreed in 2020/21 in support of these risks resulting in the purchase of:

- Temperature Controlled Cabinets
- New RFID controlled Patient's Own Drug Lockers throughout the organisation
- Automated medicines cabinets (Omnicell) for Emergency medicines out of hours
- Swipe Card Access to all treatment rooms.

Work continues in support of strengthening arrangements around effective oversight of electronic temperature monitoring of medicines fridges across the organisation.

All risks are under constant review and are being actively managed. Updates on mitigations in place are noted within the risk register. To an extent, these risks and a number of others on the risk register are inherent risks and clarification in terms of

During the year, seven risks were closed and removed from the risk register as a result of action plans being completed, or risks being sufficiently mitigated following intervention.

15.0 CONTROLLED DRUG REPORT FOR WHITTINGTON HEALTH

The Pharmacy Department has responsibility for the governance surrounding the safe and secure handling of controlled drug drugs within the Trust in order to fulfil current UK legislation such as the Misuse of Drugs Act 1971 and Controlled Drugs (Supervision of Management and Use) Regulations 2013 DOH.

The governance arrangements in place currently include:

- Three monthly audits on all wards and departments in Whittington Hospital
- LIN (Local Intelligence Report) reports every 4 months to NHS England CD Officer
- CD incidents are reported on Datix and classed as high risk
- CD Datix incidents are escalated to the Chief Pharmacist and reviewed by the Clinical Governance Pharmacist and Medication Safety Officer
- Incidents of concern are investigated and if considered appropriate our allocated Police CD Liaison Officer is contacted for further advice and the incident is reported directly to NHS England Controlled Drug Division, Chief Pharmacist and Trust CDA
- Regular reviews are undertaken of our ordering and prescribing of CD's using ADIOS (Abusable Drugs Investigational Software) to identify any areas of above normal activity relating to CD's
- Controlled Drug Policy (MP9) as part of Trust Medicine Policy in place and up to date
- Trust Controlled Drug Accountable Officer (CDAO) in place supported by the Chief Pharmacist, Clinical Governance Pharmacist and Medication Safety Officer

In 2020/21 there were 113 CD related incidents reported (compared with 120 in 2019/20). The majority of incidents are minor/low risk. There were 10 moderate to high-risk incidents in 2020/21 compared to the prior year, with three cases of unaccounted for loss of a Controlled Drug. Each of these is reviewed through the Serious Incidents Advisory Executive Group (SIEAG), thoroughly investigated and reported to the Local Intelligence Network.

CD related incidents are more commonly reported due to the associated significance of these medicines and any associated concerns. All incidents are reviewed by the Medicines Safety Officer and Clinical Governance Lead Pharmacist and communicated externally to NHS England via the Local Intelligence Networks for shared learning across the sector and country.

16.0 NON-MEDICAL PRESCRIBERS (NMPS)

The Non-Medical Prescribing Group is a sub-group of the DTC and provides assurance of the arrangements in place for non-medical prescribers (NMPs) across all areas of Whittington Health, including the hospital and community settings in both Haringey and Islington.

Chaired by the Chief Pharmacist, this group incorporates nursing, AHP and pharmacist representation from both acute and community settings with agreed terms of reference.

The Non-Medical Prescribing policy is a subsection of the Medicines Policy (MP10) and was developed to support the safe and effective use of medicines throughout Whittington Health. It sets out the policy guidance for NMP staff in Whittington Health.

Further to the Internal Audit report relating to Medicines Management in 2019/20, a new section of the Medicines Policy was created outlining in detail the governance arrangements associated with the use of FP10 prescriptions for both medical and non-medical prescribers. This was reviewed by the group and circulated across the organisation.

It is important to establish that the skills of non-medical prescribers are being used within the Trust, and to ensure that NMPs are prescribing within their clinical competence. The 2019 non-medical prescribing audit reported that 76% of respondents to an on-line survey were actively prescribing. JAC and ePACT data confirmed that all NMPs were prescribing within their agreed scope of practice.

In 20/21, work started on the development of an electronic Annual Declaration for all non-medical prescribers intended to support annual review of active prescribers within the organisation. This will operate alongside the 2-yearly audit of prescribing data for non-medical prescribers, next due in 2021/22.

Whilst limited in capacity this year in light of COVID, the members commenced conversations around the development of a Non-Medical Prescribing Strategy and this work will continue in 2021/22.

17.0 INFORMATION TECHNOLOGY

17.1 EPRESCRIBING AND PHARMACY STOCK CONTROL

The Electronic Prescribing and Medicines Administration (EPMA) team continue to update and modify JAC EPMA in line with good medicine management practice and in response to incidents and recommendations from various forums and staff groups. Changes are ratified by the JAC Project Group which provides a multidisciplinary forum to discuss issues and potential mitigations. Changes are then reported into DTC.

The EPMA team have completed the rollout to all outpatient clinics with ~95% of all outpatient prescriptions generated on JAC. Work is ongoing to identify those clinicians that are still using paper prescriptions and provide extra support to them if needed to be able to prescribe safely on JAC. The Emergency Department (outpatient only), Children's Ambulatory Care and Roses Day Centre are all now live on JAC with future plans to allow ED to perform inpatient prescribing on JAC too.

The EPMA team are currently working on upgrading the JAC EPMA and pharmacy stock control (PSC) systems in the Trust to the most up-to-date version. This will ensure we are on a fully supported system with an array of benefits that are not realised in the current v2014 system. Once a like for like implementation is done in the Trust, phase 2 will look to optimise the system and increase the use of functionality such as infusions, oxygen and warfarin prescribing which are all still prescribed on paper drug charts. Regular updates are provided to the Trust's Transformation Board on progress.

17.2 EPMA TEAM

The EPMA team secured significant investment for the JAC EPMA/PSC upgrade to ensure robust testing of the upgrade was performed and recognising the extensive level of support that will be required to train all end users in the Trust. The expanded team will allow for the safe maintenance of EPMA/PSC systems currently in place whilst testing, configuring, and optimising the future JAC upgrade. Extensive stakeholder management is also required for several workstreams, from ratifying new workflows and builds in the upgrade, through to ensuring robust end user testing and training is carried out. The team will also aim to develop how we best use data from these systems to inform our operational and clinical practice.

Significant progress has been made to date with developing e-learning packages to allow staff to complete mandatory JAC EPMA training. This has had very positive feedback allowing the flexibility to complete the training from any location and for bank staff to be able to complete it prior to starting at the Trust.

17.3 POWERGATE

Powergate, the system used by pharmacy purchasing to electronically transmit orders to suppliers and wholesalers, has been successfully upgraded to the latest

available version. This ensures we are fully supported and provides us with the opportunity to implement additional functionality such as electronic invoicing. The Purchasing team in Pharmacy are able to use the upgraded systems with little support required.

17.4 FAST FOLLOWER

Whittington Health has been working on a number of projects within the NHS Fast Follower programme. This includes Barcoding for Safety which incorporates Closed Loop Medicine Supply and Administration.

It has now been agreed that the objectives of this can be best achieved working with our systems provider System C (who have supported Care Vitals etc.) and the work required to achieve this is now set within their programme and roadmap.

This will require that we switch our current Electronic Prescribing and Medicines Administration (EPMA) system to an integrated one as part of System C.

The project team were working up an action plan to support the implementation of the Closed Loop Medicine Administration (CLMA) and an integrated EPMA. Extensive work was done on scoping out the requirements of the system in order to develop a product that was fit for purpose and had the potential to streamline processes, improve staff satisfaction and most importantly patient safety. There has been very positive engagement from clinicians who have attended workshops to define requirements. These workshops were held monthly where different components of the system are discussed.

The team started testing the initial drops of the system and reported a number of issues which System C are now looking at as well as revisiting timelines to complete the development phase before planning for the deployment phase.

17.5 DAWN

The Trust's anticoagulation prescribing system HeliconHeart is being replaced by DAWN with an anticipated go-live date of 31st August 2021. The project team is working on ensuring data migration from HeliconHeart to DAWN is accurate and where possible ensuring interfaces with other clinical systems are developed in order to streamline the process, reduce risks associated with this area (namely manual transcription of bloods and blood request forms) and use resources more efficiently. Good progress has been made to date with Phase 2 of the project looking to develop and optimise some of the interfaces and make the pathway less manual, more automated and ultimately safer for patients.

17.6 DISCHARGE MEDICINES SERVICE

The Whittington are the first Trust in North Central London to go-live with the NHS Discharge Medicines Service (DMS) which involves suitable patients that meet pre-set criteria being referred to their nominated community pharmacy. The aim is to improve communication across the care interface and ensure discharge, which is

associated with an increased risk of avoidable medication related harm, is as safe as possible.

Referrals are sent to the community pharmacy via a secure electronic system, PharmOutcomes. Basic integration work has been done with JAC EPMA and the ICE discharge system to ensure the process is as automated and streamlined as possible. The Whittington are still in the pilot stages of the rollout but will expand to cover any patient in the Trust should they meet the criteria. Assistance is also being provided to other Trusts across NCL who are interested in starting the DMS service.

18.0 CLINICAL TRIALS

The Clinical Trials (CT) Pharmacy team supports the Trust to carry out robust research, contributing to new clinical knowledge and evaluating new treatments. The Pharmacy team is responsible for the overall management of Investigational Medicinal Products (IMPs).

A CT policy (a subsection of the Medicines Policy) sets out the standards required for the management of investigational medicinal products (IMPs) for clinical trials at the Whittington Health to ensure that trials involving IMPs are conducted in compliance with the principles of Good Clinical Practice (GCP), regulations, and legislations. Compliance with the standards provides public assurance that the rights, safety and well-being of trial subjects are protected, and the clinical trial data are credible.

By the end of 20/21 there were 12 IMP CT open which were supported by pharmacy, including ‘RECOVERY’, one of the national urgent public health COVID-19 studies. This trial involved not only Research and Pharmacy Clinical Trials teams but also a wide range of doctors, pharmacists and nurses in a huge effort to enrol as many patients as possible and offer them potential treatment options. Evidence from this study supported the introduction of new COVID-19 treatments such as dexamethasone and tocilizumab. Over the first semester of 2021/22 there are 6 new studies being opened and supported by pharmacy.

Until 20/21 Whittington Health was part of the UCL Partners Harmonisation project for clinical trials. We closely collaborated with the National Institute for Health Research - Clinical Research Network North Thames (NIHR – CRN North Thames) and performed technical assessments of clinical trials protocols on behalf of the participating sites. The project had been running for many years and aimed to maximise the involvement of patients in clinical trials and to reduce the NHS approval times. Although successful, due to growing number of national reviews performed by the Health Research Authority, the UCLP project for protocol reviews came to an end in 20/21. Our CT Pharmacy team performed 11 technical assessments of CT protocols as part of the UCLP Harmonisation project in 20/21.

19.0 WHITTINGTON PHARMACY COMMERCIAL INTEREST COMPANY

COVID-19 has resulted in decreased prescription activity, retail sales and Travel Health.

Whittington Pharmacy CIC (WPCIC) provided 51552 items to outpatients and Emergency Department (ED) attenders in 2020/21, a 32% reduction on 2019/20. Retail sales for the CIC decreased by 29%.

Waiting times for prescriptions have decreased year on year averaging 16mins in 2020/21 compared to 18mins in 2019/20 minutes which has helped provide a better experience for our patients.

The third set of annual accounts for 2019/2020 was filed at Companies house along with the first Community Interest Company Report (CIC34) describing a small profit. The accounts for 2020/21 are currently in progress and equally demonstrate a small profit in 2020/21 despite the challenges associated with COVID and increased costs associated with postal and couriering of medicines. All profits associated with the CIC are reinvested back into the organisation.

The COVID-19 Pandemic changed the way WPCIC has operated to help ensure that patients received their medications. Lockdowns and remote working had resulted in a far greater use of electronic prescriptions (90% plus) towards the end of 2020/21 compared with around 30% pre COVID-19. Patients had been receiving their medication by courier, volunteers, post, and by 'drive-thru' via the layby immediately outside the hospital on Magdala Avenue.

There were Zero Datix recorded complaints for WPCIC in 2020/21 in keeping with the prior year.

Whittington Pharmacy CIC aims to provide the very best, efficient, safe and friendly service, tailored to the needs of our patients and customers and patient satisfaction surveys have helped to measure patient experience, which has provided some very positive feedback. A survey was conducted over the telephone and over 90% of the patients were satisfied or very satisfied with the service. Routine paper forms collecting patient experience data were suspended for safety. The WPCIC website was updated with instruction relating to COVID and accommodates direct input of patient experience feedback. This will be further promoted in 2021/22.

20.0 FINANCIAL PERFORMANCE

Medicines expenditure for 2020/21 is summarised in the table below:

	2020/21	2019/20	variance (£)	variance (%)
Total	£13,381,679	£13,519,262	-£137,583	-1.0%
PbRex	£8,854,380	£8,594,657	£259,723	2.9%
CDF	£267,479	£319,900	-£52,421	-19.6%
In tariff	£4,725,299	£4,924,605	-£199,306	-4.2%

2020/21 saw a decrease in total medicines expenditure of £137k from 2019/20 (-1%). 66 % of drug expenditure was PbR Excluded (PbRex). This is a small increase from 18/19 (61%).

Expenditure on in-tariff drugs decreased by £199k (-4.2%) from 2019/20. Generally, in-tariff expenditure increases with inflation ~4%. The decrease in in-tariff expenditure is attributed to the COVID-19 pandemic

In 2019/2020, Whittington Health negotiated a new model of payment with NHSE for aseptically produced chemotherapy drugs. This moves from the historic flat on-cost model to one which invoices a fee per item, which has been modelled on technical services activity. This model remains in place.

The trust continues to gain drugs income from the use of biosimilar adalimumab, due to the difference between the national reference price of adalimumab, which is the agreed cost to the commissioners, and its acquisition cost.

In response to the COVID-19 crisis, with the stated aim of reducing the administrative burden, both the local commissioners and NHSE issued a block payment from Q1 2020-21. At the time of writing this report block payment still remains in place and it is anticipated that block payment will remain in place until Q2 of 2021-22.

The block payment was negotiated based on activity from month 8-10 in 2019/20 and was later uplifted for other factors. Block payment is not broken down by services. An overarching sum is received by the trust. This is monitored by the income team.

To ensure strong financial governance high-cost drug income has continued to be reported and monitored as if the payment-by-results contract was still in place.

21.0 RESEARCH & AUDIT RESEARCH

The Pharmacy Department continues to develop and support a culture of research and publication.

Any audit, quality improvement or research project undertaken by pharmacy is registered with the Whittington Clinical Governance Department.

The table below summarises projects that were completed in the 2020/21 financial year.

Project Title	Type
Antibiotic Point Prevalent audit (Weekly)	Audit
LUTS clinic prescribing (Monthly)	Audit
Controlled drugs audits (annually)	Audit
An audit of monitoring and prescribing standards of adult patients initiated by Whittington Health NHS Trust on prophylaxis Azithromycin to reduce frequency of infective exacerbation COPD and Bronchiectasis	Audit
Assessing the appropriateness of dosing, indication and monitoring vancomycin in patients over March to June 2020 during the COVID peak	Audit
To assess the quality of the smoking cessation service provided by the acute med team at Whittington Hospital	Audit
The administration of Parkinson's disease medication times in in-patient hospital settings	Audit
Audit to assess the quality of prescribing Ferinject® in Maternity wards during the COVID-19 pandemic	Audit
Electronic Outpatient prescribing	QI
Pharmacist attendance at discharge meetings	QI
The value of domiciliary medication reviews	Research
Determining the attributes and characteristics of pharmacy on-call enquiries	Research
Research into perceptions of Leadership in different HCPs (nurses, doctors & pharmacists)	Research

22.0 INNOVATION IN SERVICE DELIVERY - INNOVATIVE PHARMACY ROLES

Whittington Health Pharmacy department has a number of innovative roles and has made significant progress in developing and roles to support the integrated care agenda.

22.1 CROSS SECTOR ROLES

In order to support the NHS Long Term plan and the work force initiatives that follow it, we are hosting 4 Preregistration Trainee Pharmacy Technicians (PTPTs) on a

cross sector programme of training. The sectors involved in this programme include two GP federations in Haringey and Islington, High gate Mental Health Trust along with Whittington Health NHS Trust. The four organisations are working together to produce four PTPTs who in 2 years' time will be competent to work in GP practice and the acute setting. This concept will extend to the pre-registration Pharmacist cohort for 2020/21 where one trainee will work in a GP practice for 13 weeks of the year.

We have also started to explore how our junior pharmacists in the care of the elderly rotation can work with the ICAT pharmacists in the community, to develop higher level consultation skills.

22.2 VTE PHARMACIST

A case for a new post was successfully developed in year to be overseen by the anticoagulation pharmacy team with the intention of:

- Increasing the VTE risk assessment from ~85% currently to 95% as per NICE guidance - increased ward presence and clinical profile with the senior clinicians.
- Education and training of junior Drs (August induction), nurses and other relevant HCP (Trust induction), senior Drs (induction) and HCAs.
- Ward visits daily to assess the uptake of risk assessments and raise VTE profile
- Root cause analysis of hospital acquired VTE and reporting to Trust board / patient safety committee
- Working with the IMT team to create a mandatory VTE risk assessment so that all patient admissions are counted.
- Working with information IT team to improve the data generated and shared with Drs.

This post will be recruited into May 2021.

22.3 ADULT COMMUNITY SERVICES TEAM LEAD

This post was created to provide clinical pharmacy strategic leadership across the various domains of our Adult Community Services (ACS) Integrated Clinical Service Unit (ICSU) and ensure robust governance arrangements exist within pathways including the safe and secure handling of medication.

The post will coordinate the work of the pharmacy team currently working across the ACS ICSU and provide expert clinical and professional leadership for these team members.

The post will develop the role of pharmacy within ACS and demonstrate how pharmacy can support the provision of excellent care to our patients in the community through the development of new care pathways.

The role will support development of our already integrated pharmacy workforce within this clinical domain and work with partners across the North Central London (NCL) system, to support clinical development of the pharmacy workforce as a whole

in line with the NCL Improving Pharmacy and Medicines [IPMO] Transformation Plan.

22.4 DIGITAL & INFORMATICS LEAD PHARMACIST

In recognition of the advancing digital agenda within the trust in addition to several digital advances specifically related to medicines, a new position was created and recruited into in June 2020. This post is instrumental in the development and advancement of our electronic prescribing and administration system and all other digital systems in pharmacy with a focus on patient Safety. In addition, this role is key to us ensuring that we utilise all data that is being generated through our digital systems to support the delivery of service provision and the targeting of high-risk patients within our care. This role has both an internal focus, but also one that considers digital medicines activities across the sector as we move to move system wide working over the coming years.

23.0 EDUCATION & TRAINING

23.1 UNDERGRADUATE STUDENTS

We have a strong commitment in providing clinical work placed training for 3rd and 4th year undergraduates from UCL. However after careful consideration and negotiation with UCL and partner Secondary care organisations in London, it was felt that this initiative would be suspended for this academic year. We hope to re-invigorate experiential learning in the next academic year after evaluating implications from Covid.

23.2 TRAINEE PHARMACISTS

The department takes in 5 trainee pharmacists each year. Each year the department has enjoyed positive feedback from the pre-registration trainees. They are given an opportunity to provide constructive feedback, and this is used to improve the training program year on year. For the coming year we have collaborated with Fed4Health to produce a unique training programme which incorporates a thirteen-week placement in a GP surgery. We eagerly anticipate celebrating its success.

23.3 CLINICAL PHARMACY DIPLOMAS

All junior rotational pharmacists are encouraged to begin the post-graduate clinical diploma to further their education. Upon evaluation of the different programmes available, we have decided that the UCL diploma has the structure and vision to best develop our junior pharmacist workforce. The department has no barrier to entry and endeavour to support all junior pharmacists financially, and with the allocation of an informed educational supervisor. During 2020/21 we enrolled a total of six new

pharmacists onto the UCL programme and continued to support a further eight pharmacists studying for a variety of diploma courses ranging from UCL, Keele and Queens University Belfast.

23.4 APPRENTICESHIPS AND PRE-REGISTRATION TRAINEE PHARMACY TECHNICIANS (PTPTS)

Much of the 2020/21 has been spent setting up an education governance structure for level 2 and level 3 learners; from ensuring all legacy pharmacy support staff are enrolled onto an appropriate competency-based programme, to regular review meetings with practice supervisor to monitor learner progress. We are aiming to enrol four legacy learners onto a GPhC recognised competency programme with Buttercup's training.

In the future all pharmacy support staff will be expected to undertake the BTEC level 2 certificate in the principles and practice for pharmacy support staff (Apprenticeship).

In 2020/21 we have also supported three staff members with functional skills training in preparation for them undertaking a level 2 qualification later in 2021

Two PTPTs continue to progress well with the BTEC Level 3 Diploma in the Principles and Practice for Pharmacy Technicians. This new qualification will enable the development of pharmacy technicians who can support Medicines Optimisation on wards and be an accredited final checker at the point of completing the programme. A further four PTPTs have been supported on this programme through the HEE cross sector pilot, where learners rotate through Whittington Health, Camden and Islington Mental Health trust and two GP surgeries in Islington and Haringey. Although this pilot has been challenging to organise with partners, we are still keen to continue engaging with the cross-sector nature of the programme, but as the employer organisation.

23.5 LOCAL FACULTY GROUP (LFG)

As part of a move to develop Education Governance in pharmacy, all Trusts are now required to have a Pharmacy Local Faculty Group (LFG). The purpose of Local Faculty Groups is to:

- ensure there are systems and processes in place to develop learning programmes, teaching and assessment for pre-registration pharmacy trainees
- ensure there is leadership, management and administrative support to underpin high quality learning environments
- ensure teaching, learning and assessment is clearly linked to national syllabus and curriculum
- review the pharmacy LFG report and Education Strategy

During 2020/21 a total of four LFG meetings took place jointly with Camden & Islington Mental Health Trust. The meetings continue to gather momentum and ensure that we have a dynamic mechanism to review our education and training governance structure with good input from our learners. This year we have made significant efforts to improve attendance from practice supervisors, which has led to representation from most training sections within the department

Although not mandated by HEE for this year, the department has completed the annual LFG report outlining the current governance and quality arrangements in place within Whittington Health. The report also details the Education and Training (E&T) priorities for the department for the coming year, many of which focus on:

- embedding the GPHc new Interim learning outcomes derived from the new Initial Education and Training Standards for pharmacists.
- finalising the PTPT training document for both the 2-year PTPT programme and also the cross-sector pilot programme.

23.6 INTERNAL TRAINING PROGRAMMES

There has been a real focus to promote the uptake of both internal and external training programmes during 2020/21. Examples of training that have been arranged include:

- Internal: Bespoke Line management training - to upskill new and current line managers
- External: CPPE – leading for change

23.7 INDEPENDENT PRESCRIBING (IP) QUALIFICATION FOR PHARMACISTS

As of April 2021, there are 12 pharmacist independent prescribers, 7 of whom are active and a further three undertaking the IP course:

Column1	Number	Scope (or intended) of practice
Pharmacist IPs	12	Anticoagulation (x4), Bone protection (frailty), Cancer (x2), Chronic pain, Acute medicine, General Practice, Critical care, Rheumatology, Oncology, Paediatrics
Active Pharmacist IPs	7	Anticoagulation (x3), Acute medicine, General Practice, Oncology
Pharmacist IPs in training	3	

Increasing prescribing capacity and identifying opportunities for pharmacist IPs forms part of the department's strategy.

24.0 EXTERNAL ASSESSMENTS

24.1 EXTERNAL REGIONAL QUALITY ASSURANCE AUDIT REPORT OF ASEPTIC PREPARATION

The aseptic preparation of medicines at WH Pharmacy was assessed on 30th May 2019 by the Regional Specialist Pharmacy Services, Pharmaceutical Quality Assurance Service. The service was assessed to be Low Risk. The team were commended for the improvements made since the previous audit and for maintaining a high-quality service.

Formal reassessment of the unit is due in June 2021, delayed as a result of COVID. *[Addendum: The unit was reinspected and awarded 'low risk status' subsequent to the good progress made with prior actions and formalisation and strengthening of the Quality Assurance arrangements over the prior 18 months*].

24.2 MEDICINES MANAGEMENT INITIATIVES – CQC & INTERNAL AUDIT

Over the past year, there has been considerable focus placed upon the management of medications across our ward areas. These activities have been linked to our most recent CQC inspection and internal Grant Thornton audit.

Results from both reports identified discreet areas of work that would improve how medicines are managed across the Trust. These areas were:

- Implementation of temperature-controlled medication cabinets to mitigate the impact of high ambient temperatures in treatment rooms where medications are stored
- Improving security of stored medications through the installation of swipe card-controlled access pads to treatment rooms and areas where medications are stored.

Both projects have been scoped and implementation has begun with significant progress being made in a short space of time. Both projects are due to complete by the end of the 21/22 financial year.

In addition to the above work, further investment was secured from the Trust to implement two additional medicines management solutions that will improve patients' access to medications. The projects will see the installation of bedside patient's own medication lockers and an improved process for accessing critical medications out of hours through the installation of an automated dispensing cabinet (Omnicell). The latter project will also increase the security and governance of how medications are managed during times where pharmacy services are unavailable.

The Trust's approach to regular medicines management audits has been reviewed and adjusted to provide timelier and support outputs. The Pharmacy team have worked with senior nursing colleagues to populate a weekly rota to inspect medicines management procedures in clinical areas. The results from the audit are fed back to the ward teams instantly and followed up with the ward managers and matrons for the clinical teams to ensure appropriate action plans are completed and improvements implemented. It is anticipated that all areas will be inspected at least twice a year and the ICSUs senior

nurse meetings and Quality and Safety meetings will review the progress made in terms of medicines management topics and provide support to the ward-based teams, if needed. Every 6 months, a summary report of completed audits and associated action plans will be shared with the Drugs and Therapeutics Committee to comply with Trust governance processes and to provide assurance to associated groups. Future work in this area will focus on implementing a software package (Perfect Ward) to support this process and will support a more flexible approach to medicines management audits, within our community setting.

Action plans linked to results from the CQC and Grant Thornton audit are reviewed through the Drug and Therapeutics Committee. The overwhelming majority of tasks contained with the plan are now complete and actions plans will be closed down in the very near future. Outstanding actions are linked to the projects described earlier on in this section.

25.0 INTEGRATED CARE

A number of services are provided by the pharmacy team under the umbrella heading of Integrated Care.

During covid every team has rapidly adapted to the changing landscape, providing new services through redeployment or driving the adoption of virtual working while still providing excellent care.

25.1 INTEGRATED COMMUNITY AGEING TEAM (ICAT), ISLINGTON

The ICAT is a consultant-led multidisciplinary team (MDT) specialising in Comprehensive Geriatric Assessments (CGA) for patients who are registered with an Islington GP. This is usually carried out in the patient's own home, but 'Hot Clinics' are also offered at Whittington Hospital and at University College Hospital which may be more appropriate where further investigations such as x-rays are required. The ICAT geriatricians and specialist pharmacists also provide visits and support to patients in Care Homes in Islington.

During Covid the domiciliary arm of the ICAT team were redeployed to various locations, covering gaps in the hospital, running of vaccines centres and home administration of vaccines to the most vulnerable in the community.

Within care homes the team moved at pace to deliver the ICAT service virtually, leveraging over 5 years of experience and relations to ensure clinical support was always available to those who needed it. A support network was put together for any care home staff who raised questions around patient care.

25.2 INTEGRATED COMMUNITY AGEING TEAM (ICAT), HARINGEY

ICAT is the process of building an MDT for Haringey care homes, based on the successful model in Islington. Pharmacy is playing a key role in the organisation of the service and will support with at least a 0.5 WTE 8a position, this will be in addition to a consultant and matrons.

Strong links will be forged between the two boroughs to ensure standardised care.

25.3 PROACTIVE AGING WELL SERVICE ISLINGTON

The Proactive Ageing Well Service (PAWS), previously known as the North Islington Frailty Team, has been successfully delivering a preventative health care offer to moderately frail older people in Islington since January 2018. The service initially piloted in the North CHIN the service expanded borough-wide in April 2019 with the continued support of Islington CCG and the Better Care Fund. The team comprises of a nurse, physio, pharmacist, community navigator and is overseen by a consultant geriatrician and GPwSI in geriatrics.

The Proactive Ageing Well Service represents an innovative and unique service that was home-grown in Islington and recently termed 'World Leading' in its approach to older person's care by NHS England. At its core, the service encapsulates the ambitions of the NHS Long Term Plan - presenting a truly multi-disciplinary, integrated, place-based service working around the patient in the community setting to uncover and address unmet need – supporting them to age well for longer.

The pharmacist carries out compressive geriatric assessments including basic observations such as lying and standing blood pressure measurements. They also carry out holistic medication reviews which significantly reduce polypharmacy by deprescribing and optimising patient therapies. Other interventions include ordering bloods tests, scans as well referring to other services. From February 2019 – April 2020 the projected savings due to medication changes were £47,531.

The PWAS team was completely redeployed throughout the initial waves of covid, the pharmacist was put into vaccine centres at short notice but made invaluable contributions to the safe and effective running of the vaccine centres.

25.4 REABLEMENT & INTERMEDIATE CARE

The Islington Reablement service is supported by a specialist pharmacist and a pharmacy technician. During 20/21 the service was suspended due to covid but the pharmacy resource was used to support with vaccine uptake in carers, PPE provision and training, eMAR development and implementation, medication training for Islington residential staff, policies around covid and clinical support to the SPOA.

Key priorities going forward;

- Improved error reporting and management borough wide through centralised systems

- Ensuring safe implementation of eMAR and harnessing data led interventions and training
- Support with wider developments of best practice of medication support in a domically care setting
- Continue to leverage integrated network to improve transfer of care and make timely interventions.
- Development of new senior pharmacy technician to facilitate and lead on the running and development of medication support
- Standardise systems and care provided to all Islington in-house services

Pre covid both the pharmacist and the technician carried out medication focused reviews, these are expected to continue at the same levels. Extrapolated figures in 19/20 from a monthly snapshot audit suggest the pharmacist made 228 interventions and the pharmacy technician made 720 interventions. Predicted monthly savings (using RiO score) due to pharmacy interventions is £6,264. 252 medications have been stopped, started or dose changed. 180 patient medication reconciliation and charts have been produced.

25.6 HARINGEY MULTI-AGENCY CARE AND COORDINATION TEAM (MACC)

A 1.0WTE pharmacist supports this service receiving referrals for medication reviews as well as being responsible for a caseload of patients for which they coordinate their care. This involves carrying out initial assessments for mental health, social services, financial planning and falls prevention, in-line with the service's holistic approach to patient care. The pharmacist monitors the patient's progress throughout their care to ensure the action plan has been completed and the patient can be discharged safely.

The pharmacist works closely with an array of community teams, making referrals where necessary, these may include SLT, Stroke Team and Intermediate Diabetes Team.

The pharmacist provides training to the MDT to up-skill the team to be able to manage minor medication related problems, as they arise.

Data for financial year 2020-21:

Patients on caseload	99
Patients where pharmacist was Care Coordinator	28
Patients seen for initial assessment	33
Patient visits	77
Medication reviews	91

Telephone assessments	5
Queries sent to GP	375

25.7 GP PHARMACIST

- WH has a GP practice pharmacist who is fully integrated within primary care. As a prescriber, they are involved in running Long Term Conditions clinics and are a crucial part in the functioning of the practices.
- Increasing use of online medication ordering.
- Improved working with repeat prescriptions, nursing home prescribing and evidence-based prescribing in an aim to promote safe and effective prescribing while reducing cost.
- A strong link with WH pharmacy ensures ongoing Continuing Professional Development and assists with issues identified across the interface.
- Proactively helped assure supplies or alternatives to medications affected by covid-19 to prevent treatment delays.
- Facilitated change in repeat prescribing during covid-19.
- Engaged in PCN activates including high-cost drug monitoring, AF, PQSS, care home prescribing, QI projects on medication safety, electronic prescribing and process changes.

25.8 DN LIAISON PHARMACIST

Pharmacy plays an active role in supporting the district nursing service, sitting strategically with the district nurse professional development team pharmacy supports with;

- Regular training of district nursing staff:
    - Medicines management workshop to all new starters in district nursing service, which includes transcribing, CD recording, high risk medicines, as well as ordering, storage, disposal.
    - Supporting Diabetes training day, for HCA, PTs, NA, APs (support HCP) by delivering sessions on oral diabetic medication, insulins, and other injectable drugs.
- Monitoring of medication incidents in DN service and provision of ad-hoc training to teams or individuals where needed or where training is requested by team leads.
- Induction, professional supervision, and CPD support for PTs in DN service.
- Answering medication queries.

- Pharmacy memos - following medication incidents or alerts.
- Writing or reviewing SOPs, policies, and protocols regarding medication.
- Recruitment, and promotion of innovative PT role

25.9 COMMUNITY PAEDIATRIC SERVICES

WH specialist paediatric pharmacy team supports the clinicians and nurses working in the paediatric community services

- Providing clinical advice and medicines information.
- Supporting medicines management with a particular focus on supply, storage and recording of medicines and controlled stationary, with regular stock checks and attending regular business meetings to resolve and advise on supply, storage and records issues
- Training all community staff with regular sessions on medicines management.
- Creating guidelines and SOP around medicines management

The paediatric services covered are:

- Northern Health Centre (NHC) – community children's nurse
- Islington hospital @ Home paediatric service
- Islington children with complex care service
- Haringey Immunisation services at St. Ann's Hospital.
- Islington Immunisation at NHC
- Islington and Haringey allergy clinics at Highbury Grange and Hornsey Central health centre respectively

Islington and Haringey paediatric community consultant clinics –at NHC and St. Ann's Hospital respectively

- Haringey Audiology- at St. Ann's Hospital
- Islington Neonatal community outreach team at NHC
- Palivizumab clinic- supply and ensure NHSE High-cost drug funding criteria

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- Haringey Audiology- at St. Ann's Hospital
- Islington Neonatal community outreach team at NHC
- Palivizumab clinic- supply and ensure NHSE High-cost drug funding criteria

Paediatric clinics were paused during the period of COVID to allow for a focus on management of COVID patients within the acute setting.

During the second surge, Whittington Health NHS Trust became the South Hub for paediatrics. The pharmacy team supported the expansion and adjustment in treatment areas for paediatrics and associated medicines management requirements. The team supported the training of staff from neighbouring trusts brought into support the South Hub.

25.11 CAMHS SERVICE AND SIMMONS HOUSE (SH)

Simmons House Adolescent Unit is a 12 bed Tier 4 inpatient CYP mental health unit in Muswell Hill.

- The paediatric pharmacists provide a full clinical service to inpatients. Participate in the weekly MDT consultant led ward round as a member of the core team. Provide advice and support on safe medicines management by regular MDT medicine management meetings.
- CAMHs service based at the NHC- paediatric pharmacists provide medicines information, screening of outpatient prescriptions and clozapine monitoring for paediatric clozapine patients.

- Liaising with the CAMHs MDT to ensure repeat prescriptions are ready in a timely manner, providing seamless care for outpatients
- Collaborating on mental health guidelines and GP shared protocols.
- Supporting patients and their families with advice and information

26.0 FINANCIAL SAVINGS AND MODEL HOSPITAL

26.1 TOP TEN MEDICINES 2020/21

From the Carter Report, the Model Hospital was developed to help reduce unwarranted variation across English NHS acute hospitals. This includes a Top Ten medicines dashboard with real-time metrics to benchmark and track performance.

From April 2018, these metrics have been opportunity targets for each medicine, calculated to capture any additional savings opportunities against baseline usage/spend in 2017/18.

This additional savings target takes into account the drop in originator and biosimilar / generic prices, biosimilar uptake, and also any changes to volume.

In 2020-21, optimising use of the 'top ten' medicines delivered **additional savings of £1.15 million** against target benchmark value of £537.29k.

26.2 TOP TEN MEDICINES

Metric	WH annual target	Additional savings achieved at WH YTD	Comments

Adalimumab additional annual savings target **(from Nov 20)**	**£11k**	**£77k** **1370% achievement against additional savings target**	This is the productivity opportunity that would be released by purchasing 100% of adalimumab at the new reduced contract price.
Adalimumab best value biologic annual saving **(to Oct 20)**	**£440k**	**£794k** **176% achievement against additional savings target** **Peer median 150%**	Adalimumab best value biologic annual saving (from November 2019). We have performed well against the savings target and compared with our peers. Further opportunities were realised in 2020-21 by tighter controls on switchbacks to originator product and the introduction of the best-value product, Idacio.
Biosimilar IV trastuzumab additional annual savings target **(To July 2020)**	**£2k**	**£11k** **2715% achievement against additional annual savings target** **Peer median 532%**	The potential additional annual savings that could be delivered by achieving, or surpassing, an 80% uptake of biosimilar trastuzumab IV Uptake was 91% and additional savings target exceeded.
Biosimilar trastuzumab additional annual savings target **(From August 2020**	**£11k**	**From Dec 2020 update: £5k** **49% achievement against additional annual savings target** **Peer median 100%**	Calculated additional annual savings that could be delivered by achieving, or surpassing, a 90% uptake of IV biosimilar trastuzumab. There are issues with data recording for trastuzumab biosimilar data. Model hospital reports £0 additional savings in all months except Sept. Only one patient remains on originator IV prep. The data in model hospital does not reflect actual usage for this drug product.
Biosimilar infliximab additional savings target	**£19k**	**£118k** **624% achievement against additional annual savings target** **Peer median 94%**	This metric shows the potential additional annual savings that could be delivered by achieving, or surpassing, 90% uptake of biosimilar Infliximab. Infliximab biosimilar (Zessly) uptake is currently 100% Infliximab almost exclusively used in gastro.

			Historically, new patients started on biosimilar but reluctance to switch existing patients. However, uptake of infliximab biosimilar improved through 19-20 with greater buy-in from gastro, and a gainshare arrangement for switching to the best value Zessly brand of infliximab in 20-21.
Biosimilar etanercept additional savings target	**£7k**	**£84k** **1277% achievement against additional savings target** **Peer median 126%**	This metric shows the potential additional annual savings that could be delivered by achieving, or surpassing, 90% uptake of biosimilar etanercept. Etanercept biosimilar uptake in 20/21 has fluctuated widely between 52% and 96% (average 86%).
Biosimilar Rituximab additional savings target	**£0K**	**£40k** **Peer median N/A**	This metric shows the potential additional annual savings that could be delivered by achieving, or surpassing, 80% uptake of Rituximab A target value of £0 indicates that we have already achieved (or surpassed) the 80% baseline of biosimilar Rituximab. Our current uptake of biosimilar rituximab is 100%
Posaconazole price drop annual savings	**N/A**	**N/A**	The potential additional annual savings that could be achieved by uptake of posaconazole following the reduction in price. Posaconazole is a non-formulary drug at The Whittington
Bortezomib additional annual savings target (from October 2020)	**£1.2k**	**£2.1k** **183% achievement against additional annual savings target** **Peer median 97%**	The potential additional annual savings that could be achieved by uptake of bortezomib following the reduction in price Bortezomib is not a high value line for WH. Issues with the production unit isolator meant unlicensed syringes were purchased. This reduced the savings that could be realised.
Bortezomib price drop annual savings	**£39k**	**£37k**	The potential additional annual savings that could be achieved by uptake of bortezomib

(to Sept 20)		**90% achievement against additional savings target** **Peer median 45%**	following the reduction in price.
Metric	**WH annual target**	**Additional savings achieved at WH YTD**	**Comments**
Adalimumab additional annual savings target **(From Nov 20)**	**£11k**	**£77k** **1370% achievement against additional savings target**	This is the productivity opportunity that would be released by purchasing 100% of adalimumab at the new reduced contract price.

27.0 HOMECARE SERVICES

WH provides a number of therapies via Homecare providers as set out in the table below with figures as at the end of 2020/21. These are high-cost medicines utilised in the management of long-term conditions within predominantly Gastroenterology, Rheumatology and Dermatology and Haematology.

This area is continuously increasing in patient volume and this activity presents a significant workload to the Pharmacy team.

Whilst Covid 19 has impacted on the provision of outpatient services including patients on homecare therapies, the companies have seen a significant rise in numbers given the preference for patients receiving their medicines directly to their homes and this has led to a number of providers becoming overwhelmed.

We have expanded the numbers of Healthcare at Home providers that we utilise as a trust in view of the capacity available in the market and to spread therapy provision. The team continue to support the provision of Homecare therapies and are working with NCL and commissioners to determine cost effective ways of supporting this service provision going forward.

Homecare provider	No. of Patients 2021
HC1	400
HC2	23
HC3	77

HC4	47
Grand Total	**547**

27.0 PHARMACY & MEDICINES OPTIMISATION VISON & OBJECTIVES

The department continued to work towards its vison and objectives identified in 2019/20.

"To deliver and support outstanding medicines management and ensure the optimal use of medicines for all patients"

28.0 FUTURE WORK

Future work for pharmacy services is largely driven by the Trust's and department's Objectives, Professional Standards, the Medicines Value Programme, the NHS Long Term Plan and the emerging Integrated Pharmacy and Medicines Optimisation programme. It includes:

- Significant upgrade of the Trustwide Electronic Prescribing and Medicines Administration system with increased functionality
- Implementation of a new, enhanced Patient Management System for Anticoagulation Services
- Development of electronic medicines optimisation dashboards in support of priotising patient care and safe medicines use.
- Expansion of the electronic transfer of discharge summaries to community pharmacy and other providers
- Ongoing COVID related priorities including supporting the ongoing vaccine programme, clinical trials and implementation to therapies used to treat and prevent COVID 19 including monoclonal antibodies
- Supporting an increase in the number of clinical trials being conducted within the organisation
- Continuing to increase the number of active prescribing pharmacists
- Increasing the use of Quality Improvement as a tool to develop and enhance pharmacy service provision
- Supporting organisation wide compliance with Guidance on Safe and Secure Handling of Medicines, including deployment of temperature-controlled cabinets, swipe card access and RFID patients own drug lockers.
- Developing the pharmacist, technician and assistant technical officer roles to support increased patient facing medicines optimisation.
- Delivering ongoing medicines related efficiencies in line with the NHSI Model Hospital Top 10 medicines
- Scoping and developing pharmacy roles and relationships within the developing and local ICS Workforce agenda locally.
- Working with NCL partners to develop and support the Improving Pharmacy and Medicines Optimisation (IPMO) agenda.
- Develop and support the provision of high-quality medicines optimisation to care homes across the ICS
- Setting up a pharmacist led Biologics Initiation Clinic
- Setting up a pharmacist supported osteoporosis Clinic (Denosumab)
- Refresh department objectives and our Medicines Optimisation Strategy utilising learning from COVID and reflective of ICS priorities.

APPENDIX 1: SUMMARY OF JOINT FORMULARY COMMITTEE (JFC) DECISIONS RATIFIED AT D&TC BETWEEN MAY 2020-MARCH 2021

Considered at JFC in February 2020		
Drug	**Indication**	**Decision**
Anagrelide	Treatment of essential thrombocythemia when first line agent hydroxycarbamide is not considered suitable according to the London Cancer essential thrombocythemia guidelines	**Decision:** Added to the NCL Joint Formulary **Prescribing:** Secondary care **Tariff status:** In tariff **Funding:** Trust **Fact sheet or shared care required**: No
Ruxolitinib	STAT1 GOF mutations in PID	**Decision:** Added to the NCL Joint Formulary **Prescribing:** Secondary care **Tariff status:** Not routinely commissioned **Funding:** Trust **Fact sheet or shared care required:** No
Leuprorelin (Prostap®)	In combination with tamoxifen or aromatase inhibitor to manipulate oestrogen levels in women with breast cancer, as an alternative to goserelin	**Decision:** Added to the NCL Joint Formulary **Prescribing:** Secondary care **Tariff status:** In tariff **Funding:** Trust **Fact sheet or shared care required:** No
Considered at JFC in May 2020		
Sildenafil	Persistent pulmonary hypertension of the new-born	**Decision:** Added to the NCL Joint formulary **Prescribing:** Secondary care **Tariff status**: In tariff **Funding:** Trust **Fact sheet or shared care required:** No
Amitriptyline	Second-line pharmacological management of irritable bowel syndrome in patients who remain symptomatic despite use of an antispasmodic	**Decision:** Added to the NCL Joint formulary **Prescribing:** Primary and secondary care **Tariff status:** In tariff **Funding:** CCG/Trust **Fact sheet or shared care required:** No
Pancrex V powder	To unblock enteral feeding tubes	**Decision:** Added to the NCL Joint Formulary **Prescribing:** Secondary care **Tariff status:** In tariff **Funding:** Trust **Fact sheet or shared care required:** No **Patients expected:**

		Already in use at WH
Pancrex V powder	For pancreatic enzymes deficiency in patients with NG or PEG tubes	**Decision:** Added to the NCL Joint Formulary **Prescribing:** Secondary care initiation, primary care continuation **Tariff status:** In tariff **Funding:** Trust **Fact sheet or shared care required:** No **Patients expected:** Already in use at WH
Pancrex V powder	For pancreatic enzymes deficiency in patients with swallowing difficulties who are unable to take Creon due to administration difficulties or oral irritation	**Decision:** Added to the NCL Joint Formulary **Prescribing:** Secondary care initiation, primary care continuation **Tariff status:** In tariff **Funding:** Trust **Fact sheet or shared care required:** No **Patients expected:** Already in use at WH
Varenicline	In combination with nicotine replacement therapy for smoking cessation	**Decision:** Added to the NCL Joint Formulary **Prescribing:** Initiation in Secondary care; NRT continued until the Target Quit Date and Varenicline continued until the course is complete (by Primary, Secondary or Community health service) **Tariff status:** In tariff **Funding:** Hospital/CCG **Fact sheet or shared care required:** No **Additional information:** Approved in combination with smoking until target quit date (NICE TA 123) and in combination with weaning dose of NRT for patients that cannot smoke during the smoking cessation period **Patients expected:** Already in use at WH
Nebulised iloprost or epoprostenol	For refractory COVID-19 associated Acute Respiratory Distress Syndrome	**Reviewed by:** JFC **Decision:** Added to the NCL Joint Formulary **Prescribing:** Secondary care **Tariff status:** In tariff **Funding:** Hospital **Fact sheet or shared care required:** No **Additional information**: Approved in line with NHSE clinical guide for the management of critical care for adults with COVID-19 during the coronavirus pandemic

Considered at JFC in June 2020		
EAMS: Remdesivir	For the treatment of hospitalised adults or adolescents with suspected or laboratory-confirmed SARS-CoV-2 infection and severe disease	**Decision**: Added to the NCL joint formulary **Prescribing**: Secondary Care **Tariff status**: N/A **Funding**: FoC via EAMS **Fact sheet or shared care required**: No Superseded by NHS policy
Subcutaneous Vedolizumab	For patients with ulcerative colitis or Crohn's disease, who are asked to shield due to COVID-19 (as defined by the British Society of Gastroenterology), as an alternative to intravenous Vedolizumab	**Reviewed by**: JFC **Decision:** Short-term approval only **Prescribing:** Secondary care only **Tariff status:** Excluded from tariff **Funding:** CCG **Fact sheet or shared care required:** No **Patients expected:** Currently 2 patients due to allocation quota. Future use will depend on JFC review of the NCL IBD pathways in September.
Considered at JFC in July 2020 (02/07/21)		
Triptorelin (3.75mg preparation)	Treatment for precocious puberty	**Decision:** Added to the NCL Joint Formulary **Prescribing:** Secondary care **Tariff status:** In tariff **Funding:** Trust **Fact sheet or shared care required**: Referred to SCG **Additional points:** Does not include modified release preparation **Patients expected:** Already in use at WH
Prilocaine 1%	Local anaesthesia for short-acting nerve block	**Decision:** Added to the NCL Joint Formulary **Prescribing:** Secondary care only **Tariff status:** In tariff **Funding:** Trust **Fact sheet or shared care required:** No **Patients expected:** Already in use at WH
Moxifloxacin eye drops	Treatment for corneal ulcer associated with bacterial	**Decision:** Added to the NCL Joint Formulary

	keratitis	**Prescribing:** Secondary care only **Tariff status:** In tariff **Funding:** Trust **Fact sheet or shared care required:** No
Oral Voriconazole	Treatment for fungal infection	**Decision:** Added to the NCL Joint Formulary **Prescribing:** Secondary care only (micro approval) **Tariff status:** Excluded from tariff **Funding:** NHSE **Fact sheet or shared care required:** No **Patients expected:** Already in use at WH
Gadoxetate (Primovist®)	Liver-specific contrast agent	**Decision:** Added to the NCL Joint Formulary **Prescribing:** Secondary care only **Tariff status:** In tariff **Funding:** Trust **Fact sheet or shared care required:** No **Patients expected:** Already in use at WH
Encorafenib and Cetuximab	Pre-NICE Free of charge scheme: for treatment of metastatic BRAF V600E mutated colorectal cancer	**Decision:** Added to the NCL joint formulary **Prescribing:** Secondary care only **Tariff status:** N/A **Funding:** FoC **Fact sheet or shared care required:** No **Patients expected:** 2-3/year
Nivolumab	EAMS: Treatment for unresectable advanced, recurrent or metastatic oesophageal squamous cell carcinoma	**Decision:** Added to the NCL joint formulary **Prescribing:** Secondary care only **Tariff status:** N/A **Funding:** FoC **Fact sheet or shared care required:** No **Patients expected:** 4-5/year
Esmya (ulipristal acetate)	For uterine fibroids Suspension of the licence and medicines recall	**Decision:** Removed from the NCL joint formulary
Idacio® (biosimilar adalimumab)	for new patients	**Decision:** Added to the NCL joint formulary **Prescribing:** Secondary care only **Tariff status:** Excluded from tariff **Funding:** CCG **Fact sheet or shared care required:** No **Patients expected:** already used at Whitt
Milrinone	Short term treatment of acute heart failure in patients with acute decompensated right sided heart failure or severe	**Decision:** Added to the NCL joint formulary **Prescribing:** Secondary care only **Tariff status:** In tariff **Funding:** Trust

	congestive heart failure unresponsive to/unable to tolerate conventional therapy	**Fact sheet or shared care required:** No

Considered at JFC in August 2020

Drug	Indication	Decision
Memantine	Management of Parkinson's disease dementia when cholinesterase inhibitors are not suitable	**Reviewed by**: UCLH **Decision**: Added to the NCL joint formulary **Prescribing:** Primary and secondary care **Tariff status:** In tariff **Funding:** Trust/CCG **Fact sheet or shared care required:** No
Levosimenden	Patients not responding to (or intolerant of) conventional inotropes if they have a reasonable expectation of survival and one of the below: • Acute decompensation of severe chronic heart failure (NYHA III/IV) • Low cardiac output syndrome • Takotsubo cardiomyopathy	**Reviewed by**: UCLH **Decision**: Added to the NCL joint formulary **Prescribing:** Secondary care **Tariff status:** In tariff **Funding:** Trust **Fact sheet or shared care required:** No **Patients expected:** very low numbers (1 patient/year)
Terizidone	Treatment of TB, an alternative to cycloserine when there are supply issues and shortages	**Reviewed by**: WH **Decision**: Added to the NCL joint formulary **Prescribing:** Secondary care **Tariff status:** In tariff **Funding:** Trust **Fact sheet or shared care required:** No **Patients expected:** recently used for 6 patients during shortage of cycloserine
Levofloxacin	Treatment of TB, an alternative to moxifloxacin when there are supply issues and shortages, or in patients with liver impairment	**Reviewed by**: WH **Decision**: Added to the NCL joint formulary **Prescribing:** Secondary care **Tariff status:** In tariff **Funding:** Trust **Fact sheet or shared care required:** No Already current practice at WH
Isavuconazole	Treatment of proven or probable invasive aspergilosis or mucomycosis when other agents are not appropriate due to inefficacy, contraindications, adverse effects, resistance or drug-drug interactions that	**Reviewed by**: JFC **Decision:** Added to the NCL joint formulary, conditional on individual Trusts updating their antifungal guidelines **Prescribing:** Secondary care **Tariff status:** Excluded from tariff **Funding:** NHSE

	cannot otherwise be managed	**Fact sheet or shared care required:** No **Patients expected:** 1-2 patients/year
Considered at JFC in September 2020		
Drug	**Indication**	**Decision**
Hydrogen peroxide cream	Non-bullous impetigo	**Reviewed by:** JFC **Decision**: Added to NCL joint formulary **Prescribing**: Primary and secondary Care **Tariff status**: In tariff **Funding**: Trust/CCG **Fact sheet or shared care required**: No **Patients expected:** TBC, but support from Dermatologists
Tolvaptan	Hyponatraemia associated with the syndrome of inappropriate antidiuretic hormone secretion in adult patients	**Reviewed by:** JFC **Decision**: Added to the NCL joint formulary (see additional information) **Prescribing**: Secondary care **Tariff status**: Not routinely commissioned **Funding**: Trust **Fact sheet or shared care required**: No **Additional information**: Approved conditional on Trusts incorporating into hyponatraemia guidance (to be reviewed and approved at Trust MMC/DTCs) **Patients expected:** 1-5 patients/year. Endocrinology team to update Hyponatraemia guideline.

Considered at JFC in October 2020		
Drug	**Indication**	**Decision**
Levetiracetam IV	Second line agent for the management of status epilepticus not responsive to benzodiazepines	**Reviewed by:** UCLH **Decision**: Added to the NCL joint formulary **Prescribing**: Secondary care **Tariff status**: In tariff **Funding**: Trust **Fact sheet or shared care required**: No
Sodium valproate IV	Second line agent for the management of status epilepticus not responsive to benzodiazepines	**Reviewed by**: UCLH **Decision**: Added to the NCL joint formulary **Prescribing: Secondary care** **Tariff status: In tariff** **Funding: Hospital** **Fact sheet or shared care required:** No
Methotrexate Injection	Ectopic pregnancy	**Reviewed by**: UCLH **Decision**: Added to the NCL joint formulary **Prescribing:** Secondary care **Tariff status:** In tariff **Funding: Hospital** **Fact sheet or shared care required:** No
Rufinamide	Lennox-Gastaut syndrome epilepsy	**Reviewed by**: UCLH **Decision:** Added to the NCL joint formulary **Prescribing:** Primary and secondary care **Tariff status:** In tariff **Funding: Hospital/CCG** **Fact sheet or shared care required:** Yes, existing NCL shared care guideline in place
Fixapost® (Timolol + Latanoprost) preservative free eye drop	Glaucoma combination therapy - to be used when compliance/cost issues arise; restricted to patients with true preservative allergy and/or people with clinically significant and symptomatic ocular surface disease (evidence of epithelial toxicity and/or severe dry eyes). See NCL guideline for place in therapy	**Reviewed by:** MEH **Decision:** Added to the NCL joint formulary **Prescribing:** Primary and secondary care **Tariff status: In tariff** **Funding:** Hospital/CCG **Fact sheet or shared care required:** No
Omeprazole suspension	For paediatrics <1 year with a gastric tube	**Reviewed by:** JFC **Decision**: Added to the NCL joint Formulary

		Prescribing: Primary and secondary care **Tariff status**: In tariff **Funding**: Trust/CCG **Fact sheet or shared care required**: No **Additional information:** Not approved for all other indications
Lamotrigine	For prophylaxis of shortlasting unilateral neuralgiform headache attacks (inc SUNCT and SUNA)	**Reviewed by:** JFC **Decision**: Added to the NCL joint Formulary subject to inclusion of the teratogenic risk on the secondary care headache protocol **Prescribing**: Primary and secondary care **Tariff status**: In tariff **Funding**: Trust/CCG **Fact sheet or shared care required**: No **Additional information**: Dose is 50mg daily, titrated up to a maximum of 700mg daily according to response.

Considered at JFC in November 2020

Drug	Indication	Decision
Paracetamol	Patent ductus arteriosus	**Reviewed by:** UCLH **Decision:** Added to the NCL joint formulary **Prescribing:** Secondary care **Tariff status:** In tariff **Funding:** Trust **Fact sheet or shared care required:** No
Aspirin	VTE thromboprophylaxis following elective knee replacement in patients at low risk of VTE	**Reviewed by:** UCLH **Decision:** Added to the NCL joint formulary **Prescribing:** Secondary care **Tariff status:** In tariff **Funding:** Trust **Fact sheet or shared care required:** No
Aspirin	VTE Thromboprophylaxis following periacetabular osteotomy	**Reviewed by**: UCLH **Decision:** Added to the NCL joint formulary **Prescribing:** Secondary care **Tariff status:** In tariff **Funding:** Trust **Fact sheet or shared care required:** No
Liraglutide (Saxenda®)	Free of Charge Scheme: For maintaining suitability for bariatric surgery whilst on	**Reviewed by:** JFC **Decision:** Added to the NCL joint formulary

	the bariatric surgery waiting list	**Prescribing:** Secondary care **Tariff status:** N/A **Funding:** FoC **Fact sheet or shared care required:** No **Additional information:** Approval is time limited for 1 year
Cefiderocol	Treatment of Ambler class B beta-lactamase producing pathogens with proven susceptibility to cefiderocol with no other suitable treatment options	**Reviewed by:** JFC **Decision:** Approved in line with the NCL summary of options available for treatment of resistant gram-negative infections **Prescribing:** Secondary care, microbiologist approval only **Tariff status:** In tariff **Funding:** Trust **Fact sheet or shared care required:** No
Meropenem/vaborbactam	Treatment of infections due to proven or suspected multi-drug resistant aerobic, gram negative pathogens with proven susceptibility to meropenem vaborbactam and no other treatment options	**Reviewed by**: JFC **Decision**: Approved in line with the NCL summary of options available for treatment of resistant gram-negative infections **Prescribing:** Secondary care, microbiologist approval only **Tariff status:** In tariff **Funding:** Trust **Fact sheet or shared care required:** No

Considered at JFC in December 2020

Drug	**Indication**	**Decision**
Aripiprazole IM	Rapid tranquilisation in children and young people (>12 years)	**Reviewed by:** UCLH **Decision**: Added to the NCL joint formulary **Prescribing**: Secondary Care **Tariff status**: In tariff **Funding**: Trust **Fact sheet or shared care required**: No
Olanzapine IM	Rapid tranquilisation in children and young people (>12 years)	**Reviewed by:** UCLH **Decision:** Added to the NCL joint formulary **Prescribing:** Secondary Care **Tariff status:** In tariff **Funding:** Trust **Fact sheet or shared care required:** No
Ferric maltol (Feraccru®)	Mild-moderate iron deficiency anaemia in Inflammatory Bowel Disease patients	**Reviewed by:** JFC **Decision**: Approved for 6 months only **Prescribing**: Secondary care **Tariff status**: In tariff

	who are actively following PHE advice to shield and failed 2 oral iron ferrous products during COVID-19 pandemic	**Funding**: Trust **Fact sheet or shared care required**: No **Additional information:** Decision will be reviewed in July 2021
Biosimilar rituximab	Delayed use for rheumatoid arthritis during COVID-19 pandemic	**Reviewed by**: JFC **Decision**: Approved for 6 months only **Prescribing:** Secondary care **Tariff status:** Excluded from tariff **Funding:** Trusts are receiving block payment from CCGs therefore the short-term cost-pressure will be borne by the Trust and will require individual Trust funding approval **Fact sheet or shared care required:** No
Etoricoxib	Osteoarthritis, rheumatoid arthritis, ankylosing spondylitis and acute gout	**Reviewed by**: JFC **Decision**: Added to the NCL joint formulary **Prescribing:** Secondary care initiation and primary care continuation **Tariff status:** In tariff **Funding:** Hospital and CCG **Fact sheet or shared care required:** No **Additional information:** Approved in line with the NCL Etoricoxib For Rheumatology Indications Position Statement
Pfizer/BioNTech Covid-19 vaccine	Prevention of symptomatic COVID-19	**Reviewed by**: JFC **Decision**: Added to the NCL joint formulary **Prescribing:** Primary and Secondary care **Tariff status:** N/A **Funding:** N/A **Fact sheet or shared care required:** No

APPENDIX 2: SUMMARY OF NICE TA APPROVED DRUGS RATIFIED AT D&TC BETWEEN APRIL 2020 -MARCH 2021 (APPLICABLE OR POTENTIALLY APPLICABLE TO THE TRUST)

Date	Product	Indication
JUNE 2020 (TA 631)	Fremanezumab (Ajovy)	Prophylaxis of migraine in adults who have at least 4 migraine days per month
JUNE 2020 (TA 632)	Trastuzumab emtansine (Kadcyla)	Adjuvant treatment of adult patients with HER2-positive early breast cancer who have residual invasive disease, in the breast and/or lymph nodes, after neoadjuvant taxane-based and HER2-targeted therapy
JUNE 2020 (TA 633)	Ustekinumab	Treatment of moderately to severely active ulcerative colitis
JULY 2020 (TA 638)	Atezolizumab with Carboplatin and Etoposide	Untreated extensive-stage small-cell lung cancer
JULY 2020 (TA 639)	Atezolizumab with nab-paclitaxel	Untreated PD-L1-positive, locally advanced or metastatic, triple-negative breast cancer
AUG 2020 (TA 641)	Brentuximab vedotin with cyclophosphamide, doxorubicin and prednisone (CHP)	Untreated systemic anaplastic large cell lymphoma
AUG 2020 (TA 643)	Entrectinib	Treating ROS1-positive advanced non-small cell lung cancer

AUG 2020 (TA 644)	Entrectinib	Treating NTRK fusion-positive solid tumours
SEPTEMBER 2020 (TA 649)	Polatuzumab vedotin (with rituximab and bendamustine)	Treatment of relapsed or refractory diffuse large B-cell lymphoma in adults who cannot have a haematopoietic stem cell transplant
SEPTEMBER 2020 (TA 651)	Naldemedine	Treatment of opioid-induced constipation in adults who have had laxative treatment
OCTOBER 2020 (TA 653)	Osimertinib	Treatment of epidermal growth factor receptor (EGFR) T790M mutation-positive locally advanced or metastatic non-small-cell lung cancer (NSCLC) in adults, only if: Their disease has progressed after first-line treatment with an EGFR tyrosine kinase inhibitor
OCTOBER 2020 (TA 654)	Osimertinib	Untreated locally advanced or metastatic epidermal growth factor receptor (EGFR) mutation-positive non-small-cell lung cancer (NSCLC) in adults.
OCTOBER 2020 (TA 655)	Nivolumab	Treatment of locally advanced or metastatic squamous non-small-cell lung cancer (NSCLC) in adults after chemotherapy, only if: It is stopped at 2 years of uninterrupted treatment, or earlier if their disease progresses and They have not had a PD-1 or PD-L1 inhibitor before.
NOVEMBER 2020 (TA 657)	Carfilzomib	Carfilzomib for previously treated multiple myeloma

NOVEMBER 2020 (TA 658)	Isatuximab	Treatment of adult patients with relapsed and refractory multiple myeloma in combination with pomalidomide and dexamethasone
NOVEMBER 2020 (TA 659)	Galcanezumab	Galcanezumab for the prophylaxis of migraine in adults
NOVEMBER 2020 (TA 661)	Pembrolizumab	Treatment for untreated metastatic or unresectable recurrent head and neck squamous cell carcinoma.
DECEMBER 2020 (TA 663)	Venetoclax	Treatment of untreated chronic lymphocytic leukaemia in combination with obinutuzamab
DECEMBER 2020 (TA 664)	Liraglutide	For management of overweight and obesity
DECEMBER 2020 (TA 665)	Upadacitinib	Treatment of severe rheumatoid arthritis
DECEMBER 2020 (TA 666)	Atezolizumab	In combination with bevacizumab for treating advanced or unresectable hepatocellular carcinoma
DECEMBER 2020 (TA 667)	Caplacizumab	Treatment of acute acquired thrombotic with plasma exchange and immunosuppression
JANUARY 2021 (TA 668)	Encorafenib	In combination with cetuximab for previously treated BRAF V600E mutation-positive metastatic colorectal cancer
JANUARY 2021(TA 669)	Trifluridine–tipiracil	Treatment of metastatic gastric cancer or gastro-oesophageal junction adenocarcinoma after 2 or more therapies

JANUARY 2021 (TA 670)	Brigatinib	ALK-positive advanced non-small-cell lung cancer that has not been previously treated with an ALK inhibitor
FEBRUARY 2021 (TA 671)	Mepolizumab	Treating severe eosinophilic asthma

For details about NICE TA recommendations please see https://www.nice.org.uk/guidance/published?

APPENDIX 3. IMPLEMENTATION OF NICE TA DRUGS RATIFIED IN 2019/20 BY D&TC AT WHITTINGTON HEALTH*

*Usage 1 year after ratification by D&TC

NICE TA	Drug	Indication	Comments
March 2019 (TA 565)	Benralizumab (Fasenra)	Add on therapy for treating severe eosinophilic asthma in adults.	**Patients initially expected:** 0 **Usage:** 0
March 2019 (TA 566)	Cochlear Implant	For children and adults with severe to profound deafness	**Patients initially expected:** 0 **Usage:** 0 – patients normally sent to GOSH or UCLH
March 2019 (TA 567)	Tisagenlecleucel Immunocellular CAR T-cell therapy. Contains the patient's own T cells (a type of white blood cell) that have been modified genetically in the laboratory so that they make a protein called chimeric antigen receptor (CAR)	Treatment of relapsed or refractory diffuse large B-cell lymphoma after 2 or more systemic therapies (adults)	**Patients initially expected: 0**

March 2019 (TA 569)	Pertuzumab (with trastuzumab)	Adjuvant treatment of HER2-positive early-stage breast cancer	**Patients initially expected:** Likely to be used (numbers not specified) **Usage: 17**
March 2019 (TA 571)	Brigatinib	Anaplastic lymphoma kinase (ALK)-positive advanced non-small-cell lung cancer previously treated with crizotinib (Adults)	**Patients initially expected:** Likely to be used (numbers not specified) **Usage**: 0
March 2019 (TA572)	Ertugliflozin	Monotherapy or with metformin for treating type 2 diabetes in adults	**Patients initially expected:** 0 **Usage:** 0 - Likely as other SGLT-2 receptor inhibitors already on Trust formulary
April (TA 573)	Daratumumab with (bortezomib and dexamethasone)	Previously treated multiple myeloma in adults.	**Patients initially expected:** 5-6 per year **Usage: 0**
April (TA 574)	Certolizumab pegol (Cimzia)	For treating moderate to severe plaque psoriasis in adults.	**Patients initially expected:** unlikely to use **Usage: 12**
April (TA 575)	Tildrakizumab (Ilumetri)	moderate to severe plaque psoriasis in adults	**Patients initially expected:** 0 **Usage:** 0

April (TA 577)	Brentuximab vedotin (Adcetris)	CD30-positive cutaneous T-cell lymphoma in adults	**Patients initially expected:** 0 **Usage:** 0
May 2019 (TA 578)	Durvalumab (Imfinz)	Monotherapy for the treatment of locally advanced, unresectable non-small-cell lung cancer in adults whose tumours express PD-L1 on ≥1% of tumour cells and whose disease has not progressed following platinum-based chemoradiation	**Patients initially expected:** Nil (patients referred to UCLH) **Usage:** 0
May 2019 (TA 579)	Abemaciclib (Verzenios)	Treatment of hormone receptor-positive, human epidermal growth factor 2 (HER2)-negative locally advanced or metastatic breast cancer in adults who have had endocrine therapy.	**Patients initially expected:** 3 / year **Usage: 4**
May 2019 (TA 581)	Nivolumab (with Ipilimub)	For untreated advanced renal carcinoma	**Patients initially expected:** Not treated at the Whittington **Usage: 0**
June 2019 (TA 583)	Ertugliflozin (Steglatro) As monotherapy or with metformin and a dipeptidyl peptidase-4 inhibitor	Treatment of type 2 diabetes in adults	**Patients initially expected:** 0 **Usage:** 0 - Likely as other SGLT-2 receptor inhibitors already on Trust formulary
June 2019 (TA 584)	Atezolizumab (Tecentriq, Roche) plus bevacizumab (Avastin, Roche), paclitaxel and carboplatin	Treatment of metastatic non-squamous non-small-cell lung cancer (NSCLC) in adults: who have not had treatment for their metastatic NSCLC before and whose PD-L1 tumour proportion score is between 0% and 49%	**Patient initially expected:** 1st patient due to start end of July **Usage:**

		Or when targeted therapy for epidermal growth factor receptor (EGFR)-positive or anaplastic lymphoma kinase (ALK)-positive NSCLC has failed	
June 2019 (TA 585)	Ocrelizumab	Treatment of early primary progressive multiple sclerosis with imaging features characteristic of inflammatory activity in adults	**Patients initially expected:** 0 **Usage:** 0
June 2019 (TA 586)	Lenalidomide With dexamethasone	Treatment of multiple myeloma after 1 treatment with bortezomib	**Patient initially expected:** 1 / year **Usage: 5**
June 2019 (TA587)	Lenalidomide plus dexamethasone	For previously untreated multiple myeloma in adults who are not eligible for a stem cell transplant	**Patient initially expected**: 4-5 / year **Usage: 8**
JULY 2019 (TA 588)	Nusinersen (Spinraza)	Treatment of spinal muscular atrophy (SMA) in children and adults.	**Patients initially expected:** 0 **Usage: 0**
JULY 2019 (TA 589)	Blinatumomab (Blincyto)	Treatment of Philadelphia-chromosome-negative CD19-positive B-precursor acute lymphoblastic leukaemia in remission with minimal residual disease activity in adults.	**Patients initially expected:** 0 **Usage:** 0
JULY 2019 (TA 590)	Fluocinolone acetonide intravitreal implant (Iluvien)	Treatment of recurrent non-infectious uveitis in adults	**Patients initially expected: 0** **Usage: 0**

JULY 2019 (TA 591)	Letermovir (Prevymis)	Treatment for preventing cytomegalovirus disease after a stem cell transplant.	**Patients initially expected:** 0 **Usage: 0**
AUGUST 2019 (TA 592)	Cemiplimab (Libtayo)	For treating locally advanced or metastatic cutaneous squamous cell carcinoma in adults.	**Patients initially expected:** 0 **Usage**: 0
AUGUST 2019 (TA 593)	Ribociclib (Kisqali)	Treatment for hormone receptor-positive, human epidermal growth factor receptor 2 (HER2)-negative, locally advanced or metastatic breast cancer in adults who have had previous endocrine therapy. Recommended for use within the Cancer Drugs Fund	**Patients initially expected:** 1-2 per year **Usage:** 0 Lack of patient need, Ribociclib is alternative to first line Palbociclib if not tolerated
AUGUST 2019 (TA 595)	Dacomitinib (Vizimpro)	For untreated locally advanced or metastatic epidermal growth factor receptor (EGFR) mutation-positive non-small-cell lung cancer in adults. (1st line treatment)	**Patients initially expected:** May be used as an alternative to erlotinib **Usage: 0**
AUGUST 2019 (TA 596)	Risankizumab (Skyrizi)	For treating moderate to severe plaque psoriasis in adults.	**Patients initially expected:** 1-2 patients per year **Usage: 2**

APPENDIX 4. PATIENT GROUP DIRECTIONS (PGD) APPROVED BY D&TC BETWEEN APRIL 2020 -MARCH 2021

Title	D&TC date
Omnipaque PGD	June 2020
Varenicline (Champix®) PGD	July 2020
Methylprednisolone Acetate	Sep 2020
Triamcinolone Acetonide	Sep 2020
Lidocaine Hydrochloride	Sep 2020
Live attenuated influenza vaccine nasal spray suspension (LAIV) Patient Group Direction (NHSE PGD)	Nov 2020
Inactivated influenza vaccine Patient Group Direction (NHSE PGD)	Nov 2020
BCG Vaccine AJV (PGD)	Jan 2021
Haemophilus influenzae type b and meningococcal C conjugate vaccine (Hib/MenC) (PGD)	Jan 2021
Administration of human papillomavirus vaccine [Types 6, 11, 16, 18] (Recombinant, adsorbed) (HPV) to individuals from 12 years of age or from school year 8 in accordance with the national immunisation programme (PGD)	Jan 2021
Measles, mumps and rubella vaccine (PGD)	Jan 2021

Pneumococcal polysaccharide vaccine (PPV23) (PGD)	Jan 2021
HepA/B Vaccine (PGD)	Jan 2021
Low dose Diphtheria, Tetanus, Polio (Td/IPV) (PGD)	Jan 2021
Flublok (QIVr) quadrivalent recombinant vaccine	Jan 2021
PGD for the supply of bowel preparations MOVIPREP® (polyethylene glycol) and PICOLAX® /CITRAFLEET® (sodium picosulphate) by registered nurses prior to lower gastrointestinal endoscopy	Mar 2021
PGD for Chlorphenamine Maleate administration in Paediatrics ED	Mar 2021
PGD for Ibuprofen administration in Paediatrics ED	Mar 2021
PGD for Paracetamol administration in Paediatrics ED	Mar 2021
Salbutamol administration in Paediatrics ED	Mar 2021
Administration of Sodium Fluoride 50mg/ml dental suspension (new)	Mar 2021
Administration of dental local anaesthetics with adrenaline	Mar 2021
Administration of dental local anaesthetics without adrenaline	Mar 2021

APPENDIX 5: USE OF RESOURCES (FROM MODEL HOSPITAL)

Money & Resources	Data period	Trust value	Peer median	Benchmark value	Chart	Actions
Top 10 Medicines – Additional Savings Delivered to Current Month (2019-20)	To Mar 2020	£1.21m	£1.74m	£830.23k		
Top 10 Medicines – Additional Savings Delivered to Current Month (2018-19)	To Mar 2019	£598.09k	£1.30m	£486.43k		

Money & Resources	Data period	Trust value	Peer median	National median	Chart	Actions
Use of Generic Immunosuppressants [% Generic vs Total Spend (Selected Drugs)]	2018	90%	77%	76%		
Choice of Paracetamol Formulations [% IV Paracetamol vs Total Spend]	2019/20	44%	68%	61%		
Use of Inhalation Anaesthetics - % Sevoflurane`	Mar 2020	100%	88%	87%		

Safe	Data period	Trust value	Peer median	National median	Chart	Actions
Total Antibiotic Consumption in DDD*/1,000 Admissions	2018/19	5,221	6,199	4,756		
Percentage of antibiotics prescriptions with evidence of review within 72 hours	Q4 2018/19	93%	91%	96%		
% Diclofenac vs Ibuprofen & Naproxen (Monthly)	Mar 2020	4.81%	5.25%	4.07%		

Effective	Data period	Trust value	Peer median	National median	Chart	Actions
Clinical Pharmacy Activity [Pharmacist Time Spent on Clinical Pharmacy Activities]	2018/19	76%	80%	77%		
Clinical Pharmacy Activity [Technician Time Spent on Clinical Pharmacy Activities]	2018/19	57%	35%	42%		
Clinical Pharmacy Activity [Pharmacy Assistant Time Spent on Ward Activities]	2018/19	17%	0%	20%		
% of qualified pharmacist prescribers routinely prescribing	2018/19	31%	42%	78%		
% of pharmacists registered for over three years who are also qualified as prescribers	2018/19	49%	23%	44%		
% Medicines Reconciliation Within 24 Hours of Admission	2018/19	85%	78%	71%		
Dose-Banded Chemotherapy [Doses Delivered as Standardised Bands]	2018/19	100%	96%	99%		
Medication Incidents Rate per 1,000 bed days	Mar 2019	4.1	4.1	4.3		
% Medication Incidents Reported as Causing Harm or Death/All Medication Errors	Mar 2019	14.6%	9.2%	10.7%		
Number of Days Stockholding	2018/19	27	21	20		
Pharmacy Deliveries per Day [Average Number of Deliveries]	2018/19	15	14	15		
e-Commerce - Ordering (Alliance)	2016/17	98.8%	98.0%	96.6%		
e-Commerce - Ordering (AAH)	2016/17	99.4%	91.7%	94.0%		

Caring	Data period	Trust value	Peer median	National median	Chart	Actions
National Inpatients Survey - Medicines Related Questions	2017/18	78.4%	71.7%	72.8%		

Responsive	Data period	Trust value	Peer median	National median	Chart	Actions
Sunday ON WARD Clinical Pharmacy Hours of Service (MAU/Equivalent)	2017/18	8	0	4		

Meeting title	**Quality Assurance Committee**	**Date:** 10.11.2021
Report title	Research & Development Annual Report 2020/21	**Agenda item:** 4.4
Executive director lead	*Dr Clare Dollery, Medical Director*	
Report author	*Kathryn Simpson, Research Portfolio Manager*	
Executive summary	The Trust has remained research active through 2020-21 with some significant changes to the study portfolio and ways of working. The active participation in COVID-19 related studies such as RECOVERY and SIREN that have had significant impacts on treatments for covid as well an understanding of vaccination and antibody responses 1,197 patients took part in research across 20 studies, 1,019 of those patients were entered into just 5 NIHR badged 'priority' studies. Specific recruitment targets for COVID-19 studies were not imposed on sites, rather targets were based on % of admissions; an example being that the target for the RECOVERY trial recruitment was 10% of all admissions, we were able to recruit 13% of admissions, exceeding the target. The number of studies open and recruiting was reduced by a third as for most of the year other specialties remained on hold but is expected to increase in time. There was a decrease in funding to the North Thames Clinical Research Network (CRN) that was passed onto Trusts. Whittington Health has a good value for money (VFM) track record and received less reduction as a result and were successful in applying for contingency funding in response to the pandemic. The usual VFM calculations have not been applied this year in response to the pandemic so comparison to other sites in this way is not possible. Existing commercial studies continued for patients already recruited with visits moving to remote where possible. 1 commercial trial (COVID-19 related) opened at the end of the year but did not recruit as eligible patient numbers were very low. Sponsors remain keen to open commercial trials with us once capacity to deliver the studies returns. Section 10 describes important clinical benefits for patients and the NHS which have arisen from studies which recruited at Whittington Health. The Director of Research and innovation refreshed the research strategy and initiated a Research Oversight Group (ROG) with internal stakeholders and external partners providing 'critical friend' feedback. The department underwent an external audit as requested by the Audit and Risk Committee and an action plan has been created.	
Purpose:	*Review*	
Recommendation(s)	*The Committee is asked to review the annual report*	

Risk Register or Board Assurance Framework	
Report history	*Not applicable*
Appendices	*Appendix 1; 20 studies that recruited in year*

Research & Development Annual Report 2020/21

1 Introduction

Whittington Health is a research active organisation committed to research as part of innovation in the care of our patients benefitting outcomes for all patients[i]. Our research strategy aims, broadly defined are:

1.1 Support and encourage all grades and disciplines of staff to engage in the Trust's Research and Innovation agenda

1.2 Work with expert clinical groups and voluntary sector partners to increase public and patient involvement in our research.

1.3 Develop and expand research relationships with academia

1.4 Increase engagement with industry

1.5 Focus on our areas of unique strength

2 Review of Recruitment into NIHR Studies 2020/21

2.1 1,197 Patients were successfully recruited into National Institute of Health Research (NIHR) portfolio studies. These are studies recognised as nationally/internationally important by the NIHR, where the funding for the studies has been awarded in open competition e.g. from the Medical Research Council (MRC).

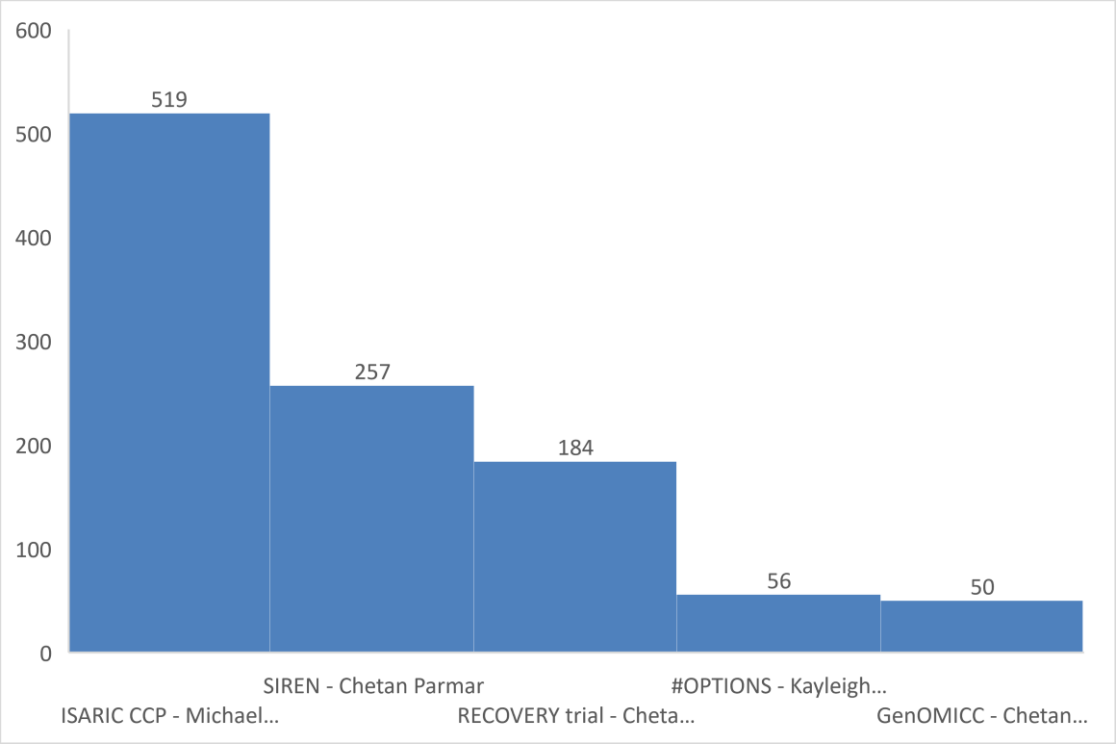
2.2 In 2019/20 the Trust exceeded the recruitment target, set by the North Thames Clinical Research Network (CRN), recruiting 803 into 29 studies. The national pause of most research as the pandemic began in March 2020 had a seismic effect on research activity in the UK. In 20/21 there was no recruitment target agreed between the Trust and the North Thames CRN and study targets for covid studies were largely based on % of admissions, an example being that the target for the RECOVERY trial recruitment was 10% of all admissions, we were able to recruit 13% of admissions, exceeding the target.

Graph 1. Whittington Health recruitment into NIHR portfolio studies 19/20 & 2020/21

2.3 Recruitment numbers alone do not reflect the complexity of studies e.g. simple observational studies compared to complex interventional drug trials. Whittington Health has a track record of recruiting

patients into complex interventional studies, which was again the case this year. RECOVERY was the most successful complex study recruiting in year with 183 patients randomised, by far the largest number of patients recruited into an interventional drug study in a 12-month period for the trust.

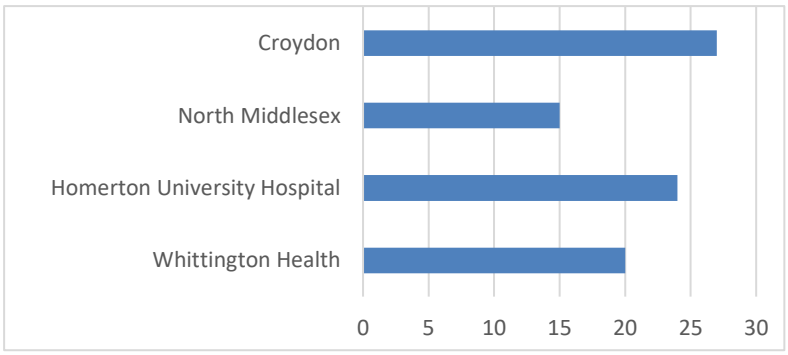
2.4 The clinical areas that continued to be able to recruit or re-open to recruiting to studies were: reproductive health, surgery, ED, TB, critical care and CAMHS. Our aim going forward will be to re-open and re-engage with clinical areas to increase activity across the Trust.



Graph 2. Whittington Health top 5 recruiting studies 2020/21

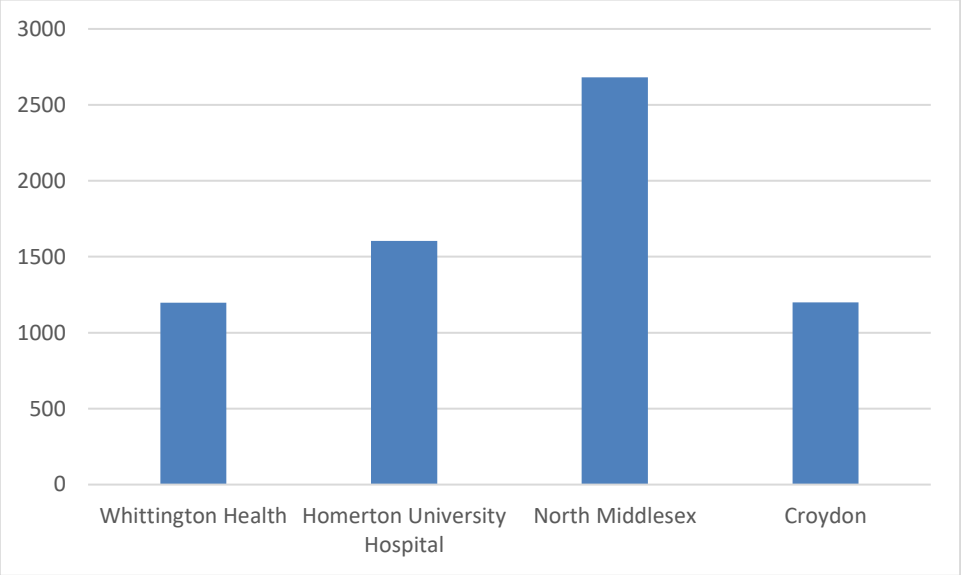
3 Benchmarking of recruitment into NIHR portfolio studies

3.1 When compared to other similar size acute trusts, the number of studies open and recruiting at Whittington Health last year was within a similar range to other trusts



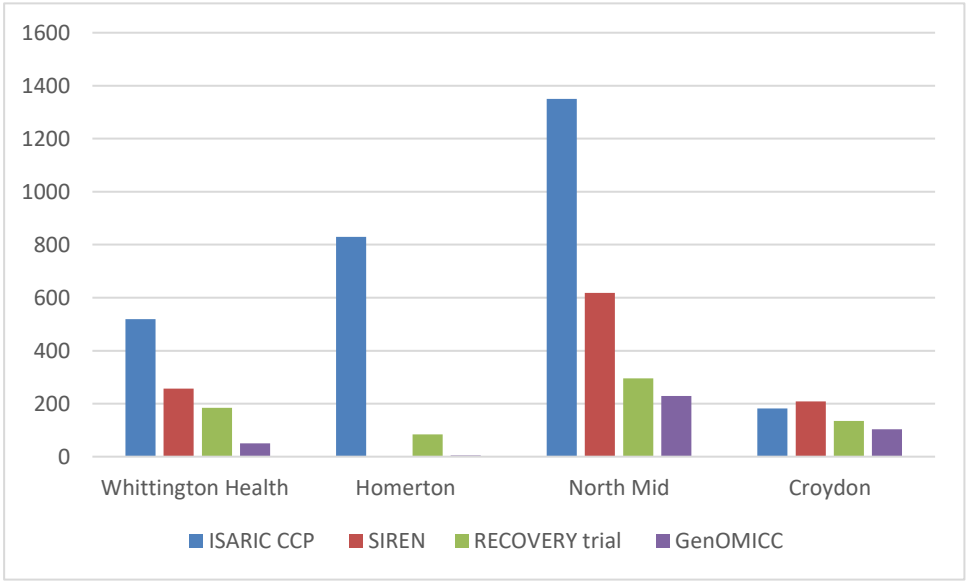
Graph 3. Benchmarking similar size trusts open studies 2020/21

3.2 Overall recruitment compared to other similar size acute trusts was reasonable, though substantially lower than North Middlesex, mainly due to their higher number of COVID-19 admissions.



Graph 4. Benchmarking similar size trusts overall recruitment 2020/21

3.3 As evidenced below in graph 5, there was variable performance compared to other sites over our top recruiting covid studies with some sites not opening key priority studies or failing to recruit numbers of note. The performance of International Severe Acute Respiratory Infection Consortium Clinical Characteristics Protocol (ISARIC CCP) is directly linked to the number of COVID-19 admissions.

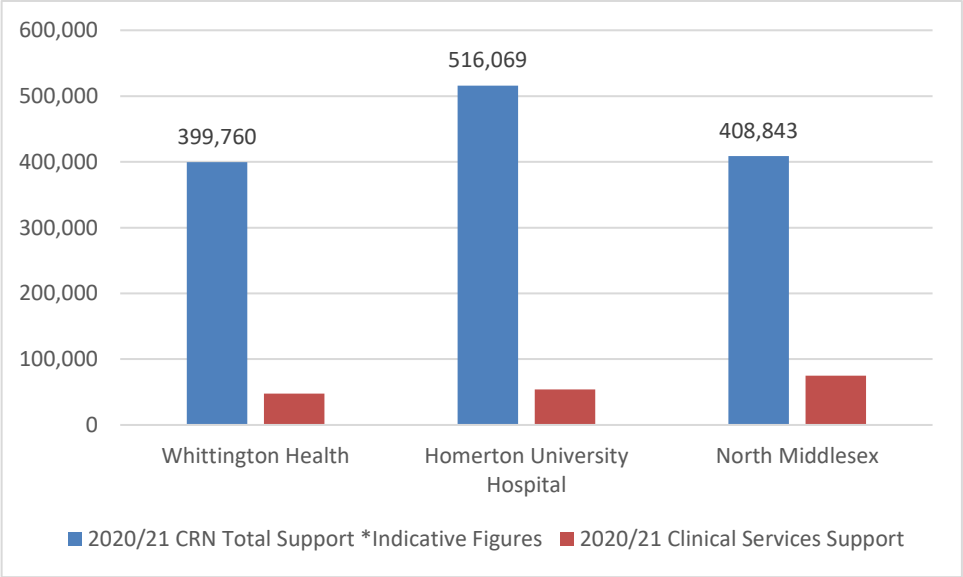


Graph 5. Benchmarking similar size trusts to top-recruiting covid studies 2020/21

***Appendix 1 – List of 20 studies that recruited participants in 2020/21**

4 Financial Support to R&D from the North Thames CRN 2019/20

4.1 When compared to other similar size trusts in North Thames CRN, the allocated financial support to Whittington Health, in 2020/21 continued to be lower. This is then reflected in the number of research delivery staff employed within Whittington Health compared to other trusts. The income received from the CRN is pre-allocated for specific research delivery posts or for recharge to clinical support services. When referenced against overall recruitment it is clear North Middlesex and Homerton had a better Value for Money (VFM) outcome but having previously been in the top two acute trusts for VFM in pervious years we hope to improve on this outside the pandemic.



Graph 6. CRN funding provided for employment of research delivery staff & clinical support services 2020/21 (based on indicative figures as final figures for other trusts unavailable)

5 Grant applications submitted within 2019/20

5.1 Unfortunately, there were no Whittington led grant applications during the year though we have contributed to applications led by other organisations. This is a reflection of the pressures on staff as several bids were planned but not submitted due to the lack of capacity to give the required commitment. In order to ensure a greater chance of grant applications being made in subsequent years there is an intention to use Research Capability Funding (RCF) in 2021/22 to support Whittington Health Staff to build research capacity and capability with a view to future grant applications

5.2 It should be noted that RCF is generated by grant income. Trusts that hold no grants receive £20,000 provided they recruit 500 participants into NIHR portfolio studies. Whittington Health is the only acute trust in North Thames CRN to receive in excess of £20,000 as no other 'non-academic' acute trusts have successfully bid for any grants

6 Research Infrastructure in 2020-21

6.1 It has been possible to maintain research delivery team posts despite CRN funding cuts by applying for contingency funding in-year and using commercial income to meet the shortfall in salary costs. The team has continued to thrive, and the mix of experience and skills is broadening with the hope we can secure funding for additional posts in the following financial year.

6.2 Given that the trend of funding reductions is expected to continue strategies to secure other funding streams will need to be put in place to ensure a continuation of capacity and capability to deliver research within the trust.

7 Commercial Research

7.1 With the exception of one covid commercial study, we were unable to commit resources to deliver new commercial trials in year and the covid study was only able to proceed as a nurse was fully funded and identified by the sponsor. Commercial trials opened in previous years have continued and been successfully delivered across dermatology, haematology and gynaecology. There are studies in within haematology and dermatology the pipeline and sponsors awaiting our having the capacity to open their studies.

8 Raising the Profile of Research

8.1 Prior to the pandemic, International Clinical Trials Day, held in May each year has always been our best opportunity to engage with both staff and patients and to inform them of the research activity ongoing within the trust. Mid-pandemic, face to face and celebratory events weren't possible or appropriate but the pandemic itself, the need for evidence regarding transmission, treatment and vaccination has highlighted the importance of research as never before and there has been an increase in awareness among staff groups, patients and the public at large.

8.2 There is a need to increase patient awareness of research activity and opportunities within the trust which initially has been addressed by having research pages on the public facing website: https://www.whittington.nhs.uk/default.asp?c=41318&q= and further work will follow.

9 Patient feedback

9.1 Membership of the NT CRN requires us to be part of a national Patient Research Experience Survey (PRES). 98% of the 53 responses for the Trust said they would consider taking part in research again and 'friendly staff' were mentioned in several responses with 26 respondents having 'nothing' or no response to the question: what would have made your research experience better?

9.2 Responses to: What was positive about your research experience? included:

- Clear communications, courtesy from staff
- Being part of important study contributing to knowledge about Covid
- The study is well organised, and information is communicated well. Researchers are kind and supportive
- Staff are flexible (e.g., don't mind what time I attend) and explain everything clearly
- Staff are always very friendly. The appointments are efficient and arranged so that there is minimal waiting time. I don't feel under pressure to take part or to continue. I feel that I contribute to important research

10 Clinical Impact

10.1 The greatest achievement of research studies is to inform clinical care for the future. There is often a lag between the recruitment to a study and it is reaching a conclusion that changes practice, but this year is certainly an exception with results from trials being available in record time and informing policy makers and treatment protocols.

10.2 Without doubt, the identification of medications to treat patients with covid, identified through the RECOVERY trial have saved countless lives worldwide, primarily through the repurposing of dexamethasone which is inexpensive and easily available.

10.3A selection of papers generated by COVID-19 research we have participated in include:

RECOVERY Trial results:

Azithromycin in patients admitted to hospital with COVID-19 (RECOVERY): a randomised, controlled, open-label, platform trial RECOVERY Collaborative Group, The Lancet.
Findings: Patients admitted to hospital with COVID-19, azithromycin did not improve survival or other prespecified clinical outcomes. Azithromycin use in patients admitted to hospital with COVID-19 should be restricted to patients in whom there is a clear antimicrobial indication.

Association between administration of systemic corticosteroids and mortality among critically ill patients with Covid-19. A Meta-analysis RECOVERY Collaborative Group, JAMA.
Findings: In this prospective meta-analysis of clinical trials of critically ill patients with COVID-19, administration of systemic corticosteroids, compared with usual care or placebo, was associated with lower 28-day all-cause mortality.

Dexamethasone in hospitalised patients with COVID-19 RECOVERY Collaborative Group, The New England Medical Journal
Findings: In patients hospitalized with Covid-19, the use of dexamethasone resulted in lower 28-day mortality among those who were receiving either invasive mechanical ventilation or oxygen alone at randomization but not among those receiving no respiratory support.

Hydroxycholoroquine in hospitalised patients with COVID-19 RECOVERY Collaborative Group, The New England Medical Journal
Findings: Among patients hospitalized with Covid-19, those who received hydroxychloroquine did not have a lower incidence of death at 28 days than those who received usual care.

Lopinavir–ritonavir in patients admitted to hospital with COVID-19 (RECOVERY): a randomised, controlled, open-label, platform trial RECOVERY Collaborative Group, The Lancet
Findings: In patients admitted to hospital with COVID-19, lopinavir–ritonavir was not associated with reductions in 28-day mortality, duration of hospital stay, or risk of progressing to invasive mechanical ventilation or death. These findings do not support the use of lopinavir–ritonavir for treatment of patients admitted to hospital with COVID-19.

SIREN:

SARS-CoV-2 infection rates of antibody-positive compared with antibody-negative health-care workers in England: a large, multicentre, prospective cohort study (SIREN) The Lancet
Findings: A previous history of SARS-CoV-2 infection was associated with an 84% lower risk of infection, with median protective effect observed 7 months following primary infection. This time period is the minimum probable effect because seroconversions were not included. This study shows that previous infection with SARS-CoV-2 induces effective immunity to future infections in most individuals.

COVID-19: Past infection provides 83% protection for five months but may not stop transmission, study finds The BMJ
Findings: People who have previously been infected with covid-19 are likely to be protected against reinfection for several months, but could still carry the virus in their nose and throat and transmit it to others, according to a study which regularly tested thousands of healthcare workers.

GenOMICC:

Genetic Mechanisms of critical illness in COVID-19 Nature
Findings: The GenOMICC study has found four genes that make people susceptible to life-threatening COVID-19. In some cases, these lead directly to therapeutic targets used in the RECOVERY trial.

ISARIC CCP:

A novel coronavirus outbreak of global health concern The Lancet
Findings: Rapid information disclosure is a top priority for disease control and prevention. Education campaigns should be launched to promote frequent hand-washing, cough etiquette, use of personal protection equipment (eg, masks) when visiting public places. Also, the general public should be motivated to report fever and other risk factors for coronavirus infection, including travel history and close contacts with confirmed or suspected cases.

Features of 20,133 UK patients in hospital with COVID-19 using the ISARIC WHO clinical characteristic protocol: prospective observational cohort study The BMJ
Findings: Participant mortality was high, independent risk factors were increasing age, male sex, and chronic comorbidity, including obesity. The study has shown the increasing importance if pandemic preparedness and the need to maintain readiness to launch studies in response to outbreaks.

Development and validation of the ISARIC 4C deterioration model for adults hospitalised with covid-19: a prospective cohort study The Lancet
Findings: The 4C Deterioration model has strong potential for clinical utility and generalisability to predict clinical deterioration and inform decision making among adults hospitalised with COVID-19.

Outcomes of Coronavirus Disease 2019 (COVID-19) Related Hospitalization Among People With Human Immunodeficiency Virus (HIV) in the ISARIC World Health Organization (WHO) Clinical Characterization Protocol (UK): A Prospective Observational Study Clinical Infectious Diseases
Findings: HIV-positive status was associated with an increased risk of day-28 mortality among patients hospitalised for covid-19.

Risk stratification of patients admitted to hospital with COVID-19 using the ISARIC WHO CCP: Development and validation of the 4C mortality score. The BMJ
Findings: The 4C mortality score outperformed existing scores, showed utility to directly inform clinical decision making, and can be used to stratify patients admitted to hospital with covid-19 into different management groups.

Clinical characteristics of children and young people admitted to hospital with covid-19 in United Kingdom: prospective multicentre observational cohort study The BMJ
Findings: Severe disease was rare and death exceptionally rare in this is a large prospective cohort study of children admitted to hospital with laboratory confirmed COVID-19 Ethnicity seems to be a factor in both critical care admission and MIS-C.

Ethnicity and outcomes from COVID-19: the ISARIC CCP-UK prospective observational cohort study of hospitalised patients The Lancet
Ethnic Minorities in hospital with COVID-19 were more likely to be admitted to critical care and receive IMV than Whites, despite similar disease severity on admission, similar duration of symptoms, and being younger with fewer comorbidities. South Asians are at greater risk of dying, due at least in part to a higher prevalence of pre-existing diabetes.

6-month consequences of COVID-19 in patients discharged from hospital: a cohort study The Lancet
Findings: At 6 months after acute infection, COVID-19 survivors were mainly troubled with fatigue or muscle weakness, sleep difficulties, and anxiety or depression. Patients who were more severely ill during their hospital stay had more severe impaired pulmonary diffusion capacities and abnormal chest imaging manifestations and are the main target population for intervention of long-term recovery.

An evidenced-based framework for priority clinical research questions for covid-19 Pub Med
Findings: Based on a systematic review of other severe coronaviruses, we summarise the state of clinical research for COVID-19, highlight the research gaps, and provide recommendations for the

implementation of standardised protocols. Data based on internationally standardised protocols will inform clinical practice real-time.

Scope, quality and inclusivity of clinical guidelines produced early in the covid-19 pandemic: rapid review The BMJ
Findings: Guidelines available early in the COVID-19 pandemic had methodological weaknesses and neglected vulnerable groups such as older people.

10.4 A selection of papers generated by non-COVID-19 research we have participated in, published in year include:

The ATTIRE study:
A randomised trial of albumin infusions in hospitalised patients with cirrhosis The New England Medical Journal
Findings: Inpatients hospitalised with decompensated cirrhosis, albumin infusions to increase the albumin level to a target of 30 g per litre or more was not more beneficial than the current standard care in the United Kingdom

The DREAMY study:
Incidence of accidental awareness during general anaesthesia in obstetrics: A multicentre prospective cohort study Anaesthesia
Findings: Direct postoperative questioning reveals high rates of accidental awareness during general anaesthesia for obstetric surgery, which has implications for anaesthetic practice, consent and follow-up.

The SUMMIT study:
Delivering low-dose CT screening for lung cancer: a pragmatic approach The BMJ
Findings: CT scanning meant that 70% of the growths detected in people's lungs were identified when the disease was at stage one or two – a huge increase in the usual rate of early diagnosis.

P17 The SUMMIT study: results processing time Thorax The BMJ
Findings: Timely reporting of results is crucial in establishing wider roll-out of lung cancer screening in the UK. The majority of results are automated and are reliably sent as programmed. A minority require further clinical input and image review, prior to completion of an onwards referral.

11 Next Steps

11.1 Professor Hugh Montgomery the Director of Research and innovation with the Research Portfolio Manager are working to implement the revised research strategy (with the support of ROG).

11.2 Key strategic relationships with UCLP, UCL BRC and Industry have been developed and continue to grow and bring opportunities. Harnessing the interest and enthusiasm for research shown during the pandemic is important to drive research outputs within the Trust. Whittington Health is forming a partnership with the UCLH BRC.

12 Summary and Conclusion

12.1 In 2020/21, the Research team along with the Principal Investigators within Whittington Health continued to recruit patients into NIHR portfolio studies despite significant challenges. The recruitment number was pleasing, and priority studies have done very well and contributes to demonstrating our research reputation and gives us increased opportunities to learn and to contribute to wider scientific knowledge.

12.2 A second year of limited grant application activity is disappointing but not unexpected in the context of the workloads of staff through a year of the pandemic and we have plans to invest in building capacity and capability for the future as a result of Research Capability Funding being awarded in the next financial year.

12.3 There is scope for further development in many areas. The ambition of creating a commercial income stream to support clinical researcher posts has not yet been realised and will be revisited with other innovative approaches.

12.4 The research strategy refresh will be implemented in the coming year including defining the scope of our research ambition as a Trust and how best to achieve a critical mass of researchers and support staff to make this sustainable.

13 Recommendation

13.1 The Quality Assurance Committee is asked to consider and comment on the annual research report.

[i] Boaz A, Hanney S, Jones T, et al. Does the engagement of clinicians and organisations in research improve healthcare performance: a three-stage review. BMJ Open 2015; 5

NHS
Whittington Health
NHS Trust

Trust Board Public
25 November 2021

Infection Prevention and Control (IPC) Annual Report 2020-21

I·CARE

Infection Prevention and Control 2020-21 Activity

NHS Whittington Health NHS Trust

Summary presentation headlines:

- Infection Prevention and Control annual report for 2020/21.
  - COVID-19
  - Healthcare-associated infection surveillance and mandatory reporting
  - Clinical activity, incidents, and outbreaks
  - Mandatory training
  - IPC team development
  - FFP3 mask fit test programme
  - Perfect Ward Application audit platform
- The report is delayed due to the ongoing operational impact of the COVID-19 pandemic.
  - The pandemic continues beyond this reporting period.

NB: Key objective for all nosocomial incidents is to determine if there was a known cause of the infection and whether it could have been avoided. There is a clear focus on learning at a ward and team level to maintain safe standards around infection risks and prevention.

I·C A R E

Infection Prevention and Control

COVID-19 Pandemic

Whittington Health NHS Trust

- Healthcare-associated Infections (HCAI) - COVID-19
  - Identifying and managed 47 transmission incidents/outbreaks.
  - Nine of these outbreaks affected patients or patients and staff
  - 38 affected only staff.
- Staff COVID-19 vaccination started in December 2020
  - substantive staff vaccinated with second jab (81.8%).

	Community Acquired	Definite HAI	Probably HAI	Intermediate HAI	Grand Total
No of cases 2020-2021	1677	36	36	45	1794
No of deaths <=28 days	206	11	12	6	235

Figure 1:Classification of COVID-19 admissions and deaths 2020-21

NB: An outbreak can be defined as: Two or more related cases of an infective pathogen that are linked in time, place or common exposure. With microbiological culture evidence of being the same.

I·CARE

What Did We Do - COVID-19 Based on Trust Values I.CARE

Whittington Health NHS Trust

Innovation

- Reduction in transfer of micro-organisms between patients and staff using short-sleeved gowns and hand/arm hygiene in Intensive Care during the pandemic: this was a simulation based randomised trial
- COVID-19 tracker (Qlikview) (see next slide for example dashboard)

Compassion

- Patient and staff safety always at the forefront of clinical pathway development
- IPC support team – 13 redeployed staff working 7 days a week – awarded a Trust Star Award recognising their dedication

Accountable

- Clear and robust outbreak reporting and escalation processes

Respect

- Development and collaboration within the NCL DIPC group
- Oxford University Trust – applied research
- The IPC nurse joined the Shelford IPC nurse group to discuss topical issues especially related to COVID-19

Excellence

- Outbreak panel development (Key internal and stakeholders attending regularly)
- Established surveillance and investigative work pre-COVID adapted
- Education and training for COVID-19 including rapid PPE developments

I·C A R E

COVID-19 Tracker Qlikview

Whittington Health NHS Trust

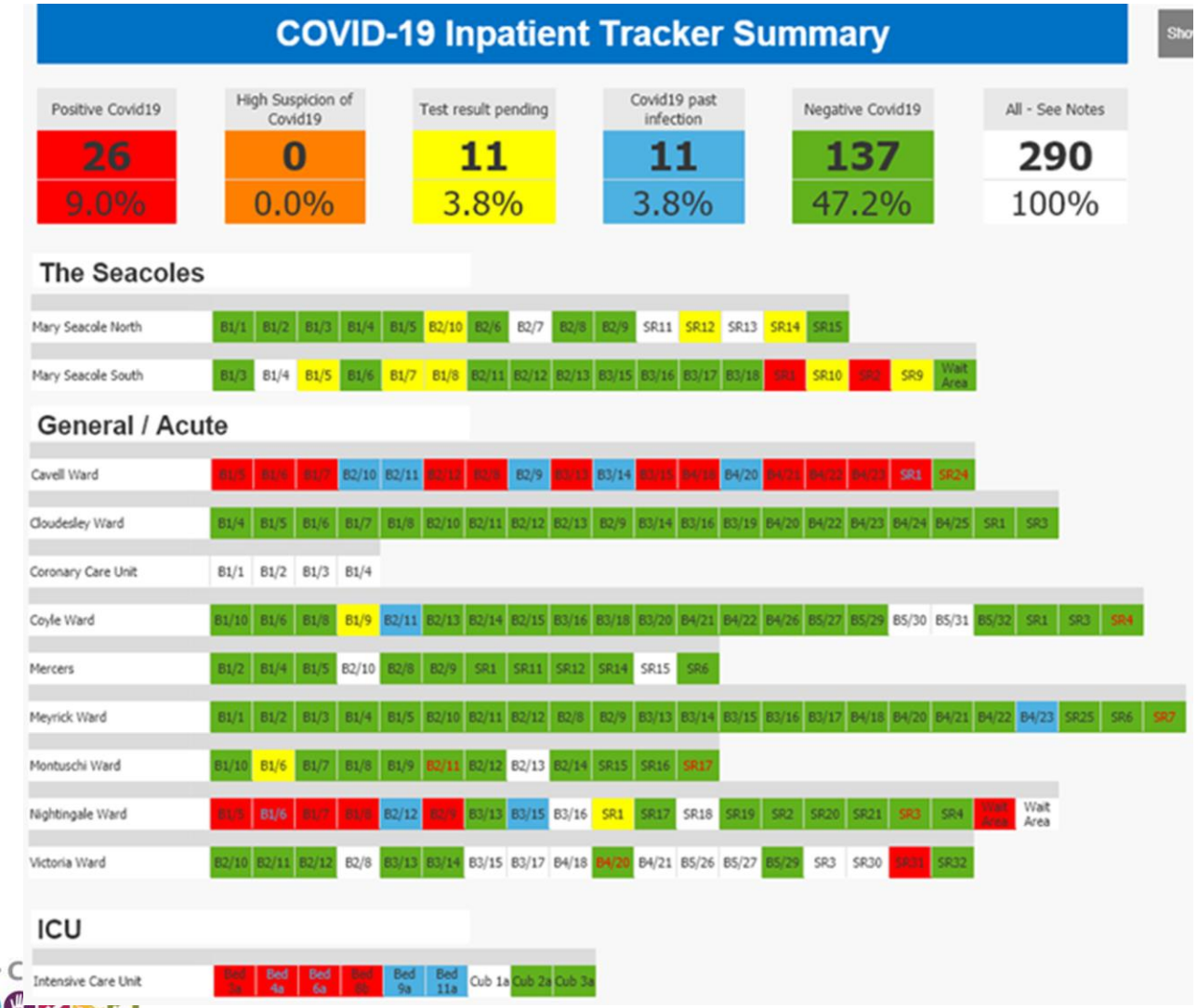


Figure 2: COVID-19 Inpatient tracker dashboard – live data

HCAI, Surveillance and Mandatory Reporting

Whittington Health NHS Trust

Non-COVID-19 clinical activity throughout 2020-21

- Reporting and learning related to patients who acquire Legionella, Staphylococcus Aureus, Extended-spectrum β-lactamases (ESBL) Klebsiella, Pseudomonas, ESBL Klebsiella Pneumoniae, Salmonella and Campylobacter

Clostridium Difficile Infection (CDI)

- 14 hospital-associated CDI cases [19 ceiling]
- No identified lapses in care related to cross-transmission or antibiotic choices

Blood stream infection (BSI)

- 2 hospital-associated MRSABSI in Quarter 4 [investigated as avoidable] – it was attributed to skin colonisation of MRSA, delayed suppression therapy and the presence of an intravascular device as being the causal factor.
- What went well - blood cultures were taken appropriately and duty of candour completed
- **Lessons learnt**
  - Inadequate documentation has led to a wider Trust review of electronic documentation to determine compliance, and this is on-going
  - The IPC team have developed tailor made a teaching package for Trust wide learning on cannula care and suppression therapy.

I·CARE

NB: Education on blood stream infections is a Trust priority

Clinical Activity, Incidents, and Outbreaks (1 of 2)

Whittington Health NHS Trust

Multi-Organism outbreak in Critical Care Unit (CCU) - April 2020

- 11 patients were affected with 3 organisms identified
  - Seven patients – Klebsiella {blood, sputum, line tips]
  - Three patients – Vancomycin-resistant Enterococci (VRE) [blood cultures]
  - Two patients with Enterobacter cloacae
- *Likely source*: cross-contamination from challenged appropriate standard precautions occurring during an unprecedented pandemic.
- *Influencing factors*
  - The critical care unit had to transition overnight from a ten bedded unit to a high risk COVID-19 unit with 24 beds
  - Nurse:Patient ratios increased from 1:1 at the height of the pandemic
  - Shared bed spaces and overcrowding
  - Redeployed staff from non-critical care backgrounds
- *Lessons learnt*:: Appropriate use of PPE and hand hygiene are essential in between both tasks and patients

NB: Adherence to basic infection control practices is essential and is imperative to reduce transmission of HCAIs.

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Clinical Activity, incidents, and outbreaks (2 of 2)

Whittington Health NHS Trust

Influenza season

- There was total of 13 positive specimens with no patients who died. The Trust staff flu campaign successfully vaccinated over 87% of the workforce.

Extended-spectrum β-lactamases (ESBL) Klebsiella colonisation – Neonatal Unit November 2020

- Inter-transfer from other London hospital (3 patients). Increase surveillance put in place and no further cases, no identified source.

Patients undergoing spinal surgery - infection incident September 2020

- Three patients with wound site infection who were linked by all having spinal surgery. The learning found that the education and training of redeployed staff in spinal procedures carried out by the orthopaedic team.

Legionella Urinary Tract Infection- May 2020

- One patient infected. Source unknown. No positive water outlets identified

Pseudomonas Estates / water – Neonatal Unit February 2020

- Higher counts than expected of pseudomonas in water samples in a number of sink taps. IPC / Micro action and Estates remedial action around Clinical Hand Wash Basins – No patients affected.

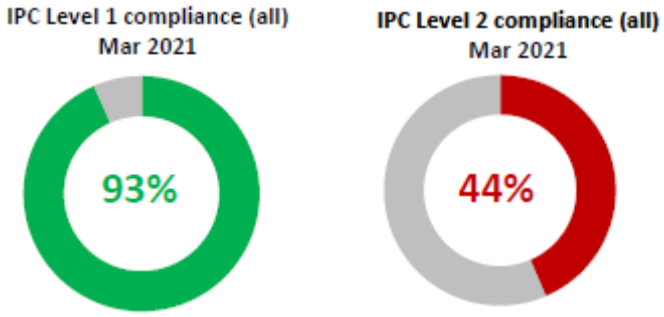
I·CARE

IPC Team progress

Whittington Health NHS Trust

Mandatory training

- the IPC Team continued with mandatory infection control training during the reporting year, also introduce new frequency for level 2 training from the national core skills framework, this meant that the compliance rate dropped and trajectory set to return to compliance. This is on target for 2022/23.



Team development

- Improved IPC nurse : patient ratio [1:100]
- Recruited band 7 education lead for IPC
- Opportunity to build on IPC model for Prevention
- Band 6 practice educator appointed
- FFP3 mask Fit Test program – May 2022
- Band 5 fit test lead and tester

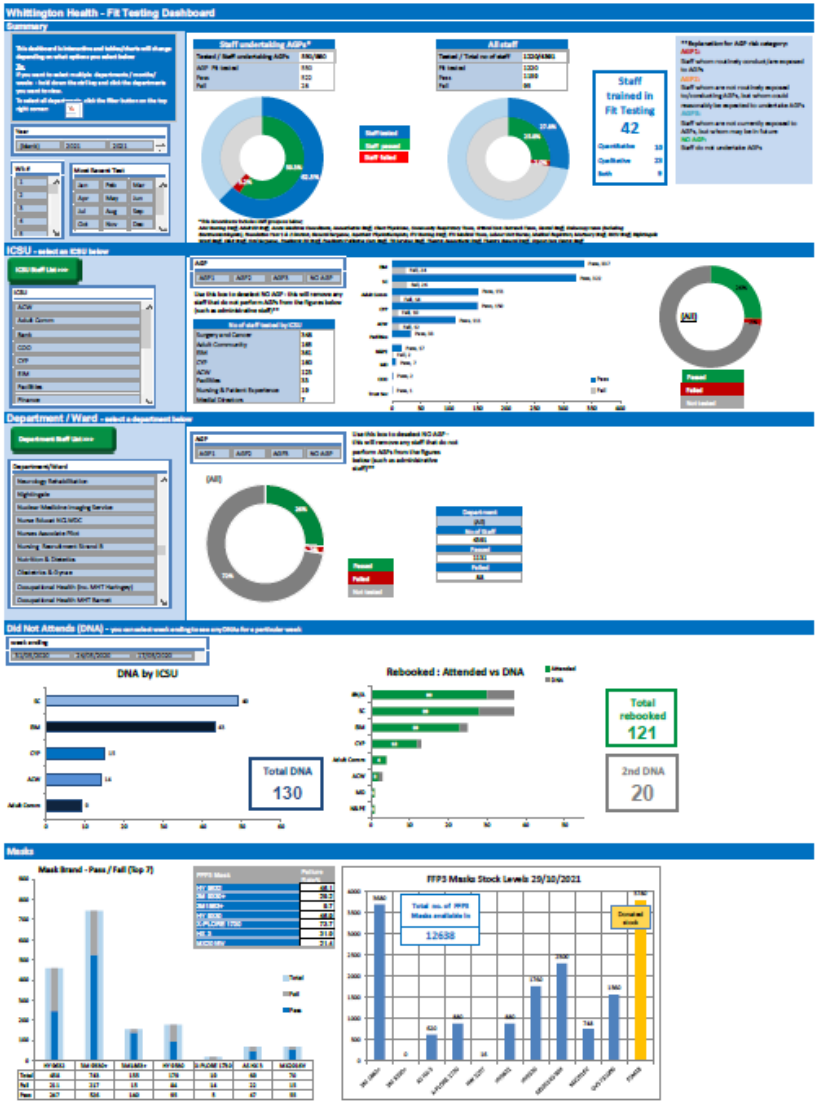
I·C A R E

FFP3 Mask Fit Test Programme

Whittington Health NHS Trust

FFP3 Mask Fit Test Programme

- Legal requirement
- 50% (2000 staff) meet requirement for fit testing as exposed to AGPs
- Additional staff trained to complete the test for Qualitative and Quantitative testing
- Compliance 63% rolling figures as staff rotate, join or leave - no staff go into areas where aerosol generating procedures are being performed without being fit testing.
- Internal / External reporting
  - Dashboard developed
  - NCL Providers Fit Testing Data Collection



Perfect Ward – Clinical IPC Audit

Whittington Health NHS Trust

- This audit tool was introduced replacing pen and paper audits used to record information regarding the quality of care provided.
- Staff record their audit findings directly into a smartphone or tablet and once completed, automated reporting enables teams to have an immediate view of what is working well and areas that need improvement
- The IPC team successfully commenced trialling and then following up with implementing fully this audit platform in January 2020 to replace the following IPC audits: for environmental, urinary catheter and vascular device.

I·C A R E

Meeting title	**Quality Assurance Committee**	**Date: 8 September 2021**
Report title	**Quarterly Learning from Deaths Report** Quarter 1, 1 April 2021 to 30 June 2021	**Agenda item:**
Executive director lead	Dr Clare Dollery, Executive Medical Director	
Report author	Dr Ihuoma Wamuo, AMD for Patient Safety & Learning from Deaths Vicki Pantelli, EA to Medical Director and Project Lead for Mortality	
Executive summary	During Quarter 1 of 2021/22 there were 92 Adult inpatient deaths reported at Whittington Health. There were 23 structured judgement reviews (SJRs) requested for the Quarter 1. Twelve Structured judgement reviews have been completed and presented at a department mortality meeting. No patient deaths have been assessed as being potentially an avoidable death. This quarter there were deaths of three patients with a serious mental illness. One patient had a learning disability. There was one neonatal death in the emergency department The SHMI is stable at 0.86. An overarching mortality review group meeting took place on 11 May 2021. The meeting reviewed the learning from death reports, were updated on the Medical Examiner service and considered the mortality review process as a whole. The backlog of mortality and Structured Judgement Reviews will be fed back to Clinical Directors of the relevant ICSU to resolve.	
Purpose:	The paper summarises the key learning points and actions identified in the mortality reviews completed for Q1, 1 April to 30 June 2021.	
Recommendation(s)	Members are invited to: • Recognise the assurances highlighted for the robust process implemented to strengthen governance and improved care around inpatient deaths and performance in reviewing inpatient deaths which make a significant positive contribution to patient safety culture at the Trust. • Be aware of the areas where further action is being taken to improve compliance data and the sharing of learning.	

Risk Register or Board Assurance Framework	Captured on the Trust Quality and Safety Risk Register
Report history	This quarter's report not previously presented. Previous Quarters from April 2017 onwards have been presented to Trust Board
Appendices	Appendix 1: NHS England Trust Mortality Dashboard

Quarterly Learning from Deaths Report
Quarter 1, 2021/22: 1 April to 30 June 2021

1. Introduction

1.1. This report summarises the key learning identified in the mortality reviews completed for Quarter 1 of 2021/22. This report describes:

- Performance against local and national expectations in reviewing the care of patients who have died whilst in this hospital. This report focuses on deaths in inpatients;
- The learning taken from the themes that emerge from these reviews;
- Actions being taken to both improve The Trust's care of patients and to improve the learning from deaths process.

2. Background

In line with the NHS Quality Board "National guidance on learning from deaths" (March 2017) the Trust introduced a systematised approach to reviewing the care of patients who have died in hospital.

https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

The Trust requires that all inpatient deaths be reviewed. All deaths should have a mortality review. The review should be by a consultant not directly involved with the patient's care.

A structured judgement review (SJR) should be undertaken by a trained reviewer who was not directly involved in the patient's care, if the case complies with one of the mandated criteria listed below:

- Bereaved families and carers have raised a significant concern about the quality of care provision;
- Staff have raised a significant concern about the quality of care provision;
- Medical Examiners have identified the case for structured judgement review;
- All deaths of patients with learning disabilities;
- All inpatient deaths of patients with a severe mental illness (SMI) diagnosis. SMI is defined as schizophrenia, schizoaffective disorders, bipolar affective disorder, severe depression with psychosis. In addition to where these diagnoses are recorded in a patient's records, the use of Clozapine, Lithium and depot antipsychotic medication are indicative of these diagnoses;
- All neonatal, children and maternal deaths;
- Serious incident requiring investigation involving a patient death;
- All deaths in a service where concerns have been raised either through audit, incident reporting processes or other mortality indicators;
- All deaths in areas where deaths would not be expected, for example deaths following elective surgical procedures;
- Deaths where learning will inform the provider's existing or planned improvement work, for example deaths where the patient had sepsis, diabetic ketoacidosis, or a recent fall;

- Deaths that are referred to HM Coroner's Office without a proposed Medical Certificate of Cause of Death (MCCD).

3. Mortality review Quarter 1, 2021/22

- During Quarter 1 of 2021/22 there were 92 adult inpatient deaths reported at Whittington Health. Table 1 shows the distribution of deaths by wards.
- Table 2a shows the total number of mortality reviews and Structured Judgement Reviews required and how many of these reviews are outstanding.
- Table 2b provides a breakdown of Structured Judgement Reviews required by department.

Table 1: Death by ward

Department/Team	Number of deaths
Acute Medicine (Mary Seacole wards)	10
Coronary Care Unit	4
Critical care Unit	12
Victoria	7
Nightingale	13
Coyle	5
Child/neonatal/maternity	0
Mercers	2
Cloudesley	13
Meyrick	19
Cavell	7
Total	**92**

Table 2a: Total number of Mortality reviews and structured judgement reviews required

	Number of reviews required	Completed Reviews	Outstanding reviews
Mortality review	69	11	58
Structured Judgement Review	23	12	11

Table 2b: Structured judgement reviews required for each department

Department	Number of Structured Judgement Reviews	Completed SJRs
Acute Medicine (Mary Seacole wards)	3	2
Care of Older Persons (Meyrick, Cloudesley and Cavell)	7	4
Coronary Care Unit	1	0
Critical Care Unit	5	4
Gastroenterology	2	1
Respiratory	1	1
Surgery	4	0
Child/Neonatal/maternity**	0	0
Total	**23**	**12**

****** Investigated as a Serious Incident, Internal Root Cause Analysis, Child Death Overview Panel (CDOP), Healthcare Safety Investigation Branch (HSIB) or perinatal mortality reviews

Table 3: Reasons for deaths being assigned as requiring a Structured Judgement Review (SJR) during Quarter 1, 2021/22

Criteria for structured review	Number of reviews identified	Completed SJRs	Comments
Staff raised concerns about care	0	0	
Family raised concerns about quality of care	1	0	
Death of a patient with Serious mental illness	3	2	One patient also had sepsis
Death in surgical patients	2	0	
Paediatric/maternal/neonatal/intra-uterine deaths	0	0	Investigated as a Serious incident, internal RCA investigation, HSIB*, CDOP** or perinatal mortality reviews
Deaths referred to Coroner's office	2	2	Excludes deaths in the Emergency Department and in other categories
Deaths related to specific patient safety or QI work e.g. sepsis and falls	8	4	
Death of a patient with a Learning disability	1	0	
Medical Examiner concern	6	4	
Total	**23**	**12**	

*Healthcare Safety Investigation Branch
** Child Death Overview Panel

3.1 Deaths requiring a Structured Judgement mortality review form (or equivalent tool) are reviewed by a second independent Clinician, not directly involved with the case. The case is then discussed in the department mortality meeting. Each SJR is fully reviewed to ensure all possible learning has been captured and shared.

3.2 The aim of this review process is to:

- Engage with patients' families and carers and recognise their insights as a source of learning, improve their opportunities for raising concerns;
- Embed a culture of learning from mortality reviews in the Trust;
- Identify and learn from episodes relating to problems in care;
- Identify and learn from notable practice;
- Understand and improve the quality of End of Life Care (EoLC), with a particular focus on whether patient's and carer's wishes were identified and met;
- Enable informed and transparent reporting to the Public Trust Board, with a clear methodology;

- Identify potentially avoidable deaths and ensure these are fully investigated through the Serious Incident (SI) process and are clearly and transparently recorded and reported.

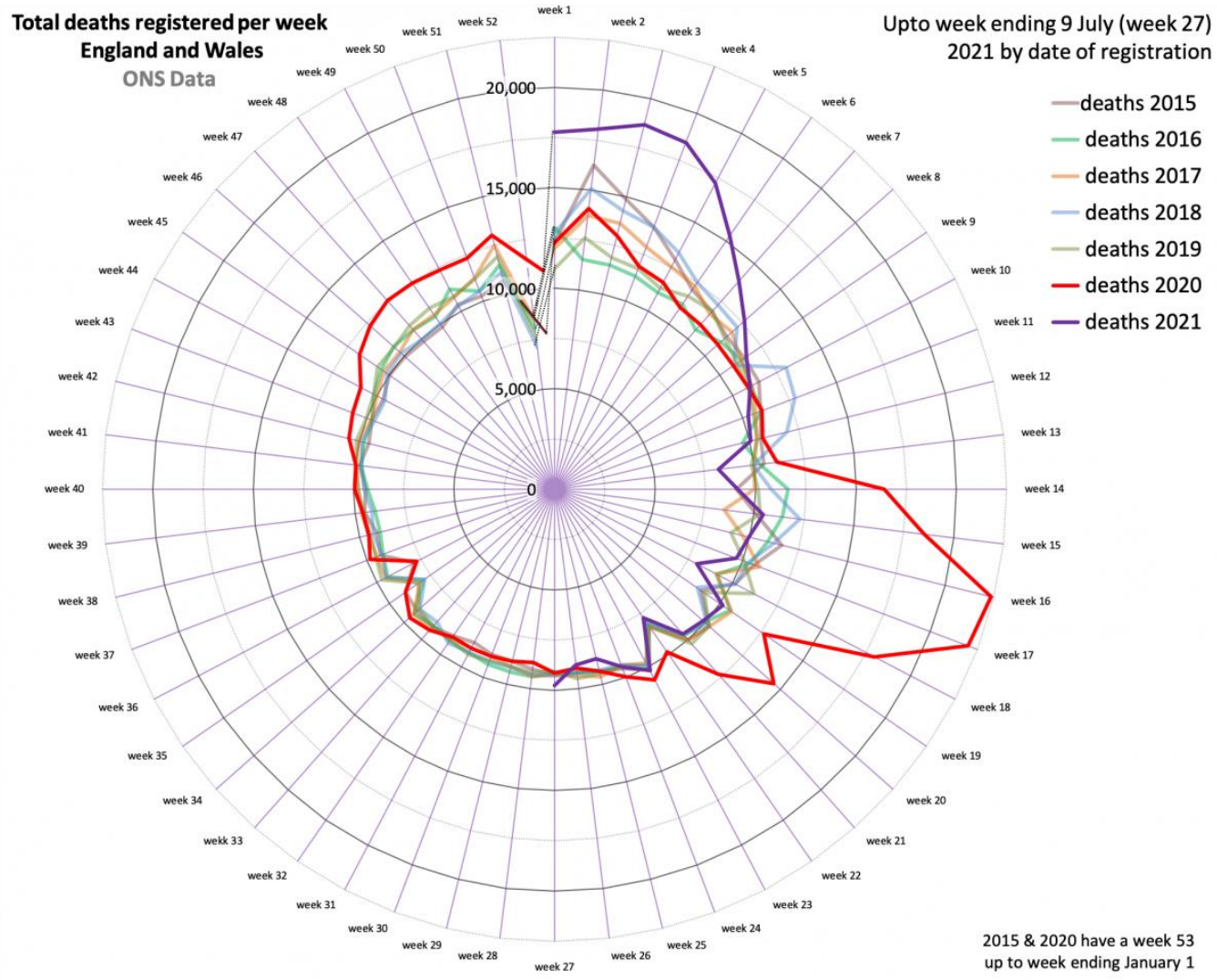
4. Q4 Mortality Dashboard

4.1 The National Guidance on Learning from Deaths gives a suggested dashboard which provides a format for data publication by Trusts. Whittington Health has chosen to adopt this dashboard locally. The dashboard is provided in Appendix 1 – NHS England Trust Mortality dashboard. This dashboard shows data from 1 April 2017 onwards.
There were 92 inpatient deaths recorded in Quarter 1, 2021/22.

4.2 **Graph 1 Source: Oxford The Centre for Evidence Based Medicine**
Total deaths per week England and Wales (19/03/2021)

The number of deaths a registered in England and Wales in week 27 was 9,752 (week ending 9 July): 6.4% above the five-year average (569 more deaths)

Of the Registered deaths in England and Wales, 183 mentioned COVID-19, 1.9% of all deaths.



4.3 **Graph 2: Crude Adult Mortality comparing previous years**

The radial graph below compares all causes of adult deaths (including Emergency Department deaths) in the Whittington Hospital in 2018-19, 2019-20 with the year considered in this report 2020 -21.

Table 4 reports the number of deaths each month.

The number of deaths in June 2021 was 37, compared with 22 deaths in June 2020. It is more in line with 40 deaths that occurred in June 2019.

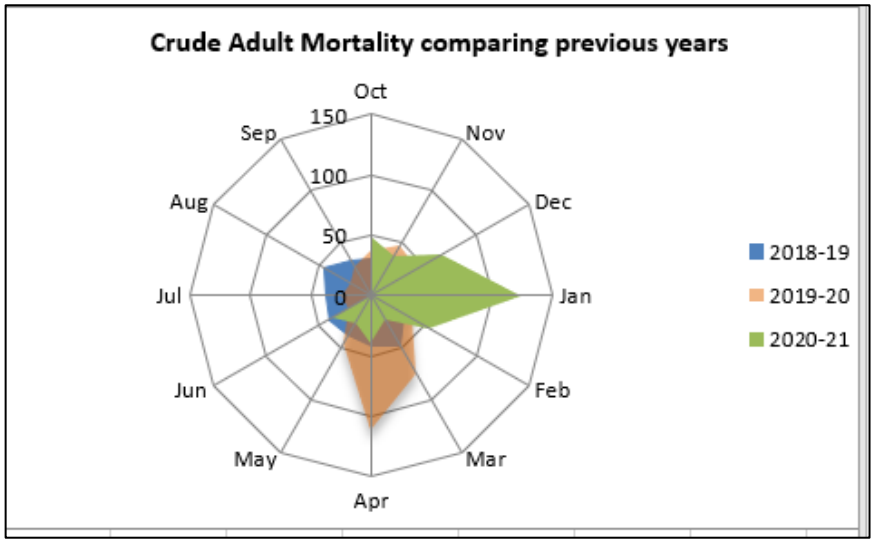


Table 4: number of deaths each month

Month	Oct 18 - Sep 19	Oct 19 - Sep 20	Oct20- June21
Oct	30	37	49
Nov	37	48	38
Dec	44	45	67
Jan	42	43	124
Feb	32	40	54
Mar	48	74	23
Apr	42	112	40
May	38	46	26
Jun	40	22	37
Jul	38	24	0
Aug	45	20	0
Sep	33	28	0

There were 40 deaths in April 2021 compared to the previous April where 112 deaths were recorded during the peak of the first COVID-19 surge.

5. Learning and actions from Mortality Reviews

5.1 Mortality reviews

Most completed reviews identified good practise with clearly written notes. Treatment escalation plan (TEP) discussions are well documented. There were examples of well managed anticipatory deaths in hospital with early end of life care management.

An SJR of a patient with serious mental illness (SMI) showed that their death from physical illness was not influenced by their mental health condition. The review identified the patient's mental health did not lead to a delay in investigations or treatment.

One review reflected a missed opportunity to fully discuss with the patient their options to avoid future readmission and plan for end of life care at home.

5.2 Documentation

The need to document on EPR where urgent actions on a management plan had not been possible to complete was as important as confirming their completion to avoid incorrect assumptions being made.

Clear written documentation on changes to plans in care of a patient, were discussed at one mortality meeting in order to provide good communication within teams and with patients' carers.

A patient had an opportunity to have their cancer diagnosed up to eight weeks earlier, due to missed appointments in radiology for chest radiographs. While the events are not thought to make a difference to the patient's outcome the Associate Medical Director is looking into this patient's pathway which crosses two Trusts.

5.3 Other causes of mortality during the quarter:

5.3.1 Cancer

There were 18 deaths recorded due to cancer during the quarter.

5.3.2 Sepsis

There were eight patients who had sepsis recorded for the quarter. A review of records has identified 3 cases where antimicrobials were given within the one-hour ideal national time frame. In one case a decision was made to palliate the patient and so no antibiotics were given. 2 patients received antibiotics no more than 10 minutes beyond the national 1 hour window and the two other records have not yet been located.

5.3.3 Deaths due to Respiratory conditions

There were 25 deaths identified due to respiratory diseases. One patient died of COVID-19.

8 patients had a hospital or community acquired pneumonia, 11 patients had aspiration pneumonia and 1 patient died with bronchopneumonia. 2 patients had bronchiectasis, 2 patients were diagnosed with respiratory failure secondary to fibrotic lung disorder, and 2 patients had exacerbations of COPD.

In all these cases there were no concerns in relation to quality of care that these patients received on the wards,

6. Backlog Mortality Reviews

The AMD for Patient Safety and Learning from Death has informed the Clinical Directors of the relevant ICSU where mortality reviews have not been produced.

There is a plan to set up workshops for the Mortality leads, led by the AMD for Patient Safety and Learning death, to refresh and re-embed the learning that comes from doing SJRs and mortality reviews.

7. Mortality Review Group

A Trust-wide Mortality Review Group was held on 11 May 2021. The group discussed the Q2 and Q3 deaths, the Mortality lead for COOP presented a review on the backlog of mortality reviews.

The group discussions included the importance of ensuring department mortality meetings are multidisciplinary. The AMD for Patient Safety and Learning from Death discussed the investigation plan for the definite hospital acquired COVID-19 deaths. The AMD for Patient Safety and Learning from death, Lead Medical Examiner and Project Lead for Mortality shared with group plans for developing a standardised process for capturing SJRs from the different departments.

8. Medical Examiner progress report

In Q4, 2020/21, 78% of patients were reviewed by the ME service, in line with 81% during Q3. 21 referrals were made to the coroner and 15 were accepted. There is a new electronic Coroner referral system and new systems within the Trust will need to be developed.

9. Conclusion and recommendations

The Trust board is asked to recognise the work from frontline teams, and to recognise the learning from mortality reviews.

Appendix 1: NHS England Trust Mortality Dashboard

Whittington Health: Learning from Deaths Dashboard - June 2021-22

Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
35	22	1	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
90	189	7	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
90	577	7	65	0	0

Time Series: Start date 2017-18 Q1 End date 2021-22 Q1

Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-	This Month	0	-
This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD	0	-
This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-	This Year (YTD)	0	-

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	2	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1	4	0	1	0	0

Meeting title	**Trust Board**	**Date:** 25.11.2021
Report title	**Staff wellbeing and support**	**Agenda item: 7**
Executive Director	Norma French, Director of Workforce	
Report author	Helen Kent, Assistant Director, Organisational Development	
Executive summary	Interest in the Trust culture and staff wellbeing over the last five years has increased notably during the pandemic. The Trust has previously considered reports in relation to staff support including whether there has been appropriate uptake of support available. This report summarises the range of support offered and provides available information on uptake and evaluation of the services in four sections: (i) Raising Awareness and Managing Events, including: • Anti-bullying training for managers and staff • 'Anti-Bullying Week' events • Talking About Race in the Workplace • Active Bystander to Upstander • British Sign Language Taster Sessions • Critical Incident Stress Debriefing facilitator training (ii) Resolution and Listening, including: • Freedom to Speak Up Guardian • Mediation services • Listening sessions • Staff Network listening • Schwartz Rounds (iii) Building Skills, including: • Coaching • Bespoke team support • Leadership development to support staff • Giving and receiving feedback • Resilience workbook and winter resilience programme sessions (iv) Prevention and Cure, including: • Health and Wellbeing Hub, Care and Support of Staff • Group Reflective sessions • Counselling • Staff Focus September • Staff Network training sessions • Sleep improvement sessions • Career development • Psychological and physical health support • Wellbeing Conversations Evaluation data that is available shows the services are useful and supportive. Take-up data shows an increase in using the support available, however, many staff struggle to find time to attend sessions.	

Purpose:	This paper is for discussion.
Recommendation(s)	Members of the Trust Board are asked to note and discuss: • the range of provision available to staff • the Trust monitoring of uptake wherever this is possible • the evaluation of services where available
Risk Register or Board Assurance Framework	People 1 and People 2 entries
Report history	Three papers have been provided to the Workforce Assurance Committee and Trust Management Group, on the availability and range of staff support, and an update on the uptake of support.
Appendices	A1. Audit: Staff Reflective Practice Sessions. A2. Recent Evaluation B. Evaluation: Employee Assistance programme C. Wellbeing Conversation guide and template

Staff Wellbeing and Support

1 Introduction

1.1 For the past five years the Trust has been actively listening to staff concerns about workplace culture, and embarked on a series of workstreams to address bullying, and equality and inclusion matters, including career development. The outcome of the workstreams has been reported through a variety of mechanisms including the NHS Annual Staff Survey, Quarterly Pulse Surveys, the Workforce Race and Disability Equality Standards (WRES and WDES).

1.2 During the pandemic, the need to support staff became more acute and specialist services were commissioned whilst the capacity of existing services were increased and made more accessible.

1.3 Since the start of the pandemic, the Workforce Assurance Committee (WAC) and Trust Management Group (TMG) have considered three reports on the range of staff support offered, and more recently, wherever data is available, the level of uptake and evaluation.

1.4 This report provides information on the range of support available under four headings:

- Raising awareness and managing events
- Resolution and listening
- Building skills and self-development
- Prevention and cure – staff wellbeing

Where possible, uptake and evaluation information is also provided; generally this is for services that are commissioned or provided by the Trust, and it is not available for national or regional service offers.

2 Raising Awareness and Managing Events

2.1 Staff resilience and wellness is at its lowest when staff feel bullied. Whilst the overall level of bullying is relatively low, the aim is to eliminate it completely. In the summer of 2019, the Trust commissioned a programme of anti-bullying training delivered by actors who are specialists in the subject. All managers were mandated by the Trust Executive Team to join a session, and 502 (approximately 76%) attended. The programmed 2019 sessions were cancelled at the start of the pandemic, and virtual sessions were first piloted, then rolled out in 2020 and 2021 for all staff. In 2020 118 people attended, and a further 292 have attended so far in 2021.

2.2 The Trust is committed to improving culture and maintains vigilance and support on bullying. During Anti-Bullying week, a range of events were promoted through communication channels, details of which can be found on the dedicated intranet page. This includes NHS England/Improvement resources provided by the Civility and Respect Team to show the link between respectful behaviours and empowering staff to challenge bullying, and links to events run centrally.

2.3 Interventions that specifically support the reduction and elimination of bullying at work are closely linked to Equality, Diversity, and Inclusion (EDI) issues and is an integral part of the offering as part of the Trust's Health and Wellbeing agenda. For the period March to November 2021, 137 employees attended 'Talking about Race in the Workplace' awareness sessions and 325 members of staff have attended 'Active Bystander to Upstander' Training.

2.4 A further training session is being offered to all preceptorship inductions, as a standalone module and as part of the ICARE Leadership offering 'Building and Inclusive Culture'. From March 2021 to October 2021, 132 members of staff have attended this training.

2.5 To further widen the scope of inclusion, the Trust commissioned 45 spaces for British Sign Language (BSL) taster sessions to run this winter which have all been taken-up, and budget has been set aside for those who would like to qualify in BSL.

2.6 To support staff who witness distressing incidents, a small cohort of facilitators has been trained in Critical Incident Stress Debriefing (CISD) during 2021. To date three requests have been made and two delivered. It is too early to analyse evaluations on this service.

3 Resolution and Listening

3.1 The Freedom to Speak Up Guardian (FSUG) sees on average seven people per month and the range is very variable with some months being noticeably busier than others (a range from two to 14). This is approximately double the number seen before the pandemic, and the evaluation describes him as welcoming and approachable.

3.2 Mediations increased during the pandemic (delivery almost doubled to 12 per year, and enquiries continue to rise). The number of team mediations and facilitated conversations have also increased. The cumulative success rate (an agreement was made) so far is 76 per cent. It is likely that this could be higher if the delay in referrals or requests is reduced. The Trust currently has five new accredited Mediators and 10 existing mediators.

3.3 TMG members have provided several fora for listening to staff, predominantly through the Black, Asian and Minority Ethnic (B.A.M.E) Staff Network. These discussions have provided important challenges and informed decisions on training and support provision.

3.4 The organisation has four staff networks which support staff through network meetings, awareness sessions and events with speakers from the NHS and beyond. All networks meet on a regular basis and are actively participating in awareness campaigns to promote health and wellbeing as well as eliminating bullying and harassment. These include:

- The *B.A.M.E.Network* offers on-going support through regular structured meetings and events which included raising awareness on key topics such as vaccination uptake for B.A.M.E. staff, wellbeing, bullying, engagement and one to one support for members. The network has held multiple events during October Black History Month
- The *Women's Network* has offered a series of monthly workshops that support with health and wellbeing, career development and coaching. Between March 2021 and October 2021, six sessions took place with an average attendance of 21 staff per session.
- The 'lesbian, gay, bi, trans, queer, plus' *(LGBTQ+) Network* held events to support the LGBTQ+ staff with key issues including mental health and shared experiences.
- Similarly, the *WhitAbility Network* has supported staff wellbeing by offering a series of meetings and webinars to shielding staff, those with a disability or long term condition.

3.5 The beneficial impact of Schwartz Rounds on organisational culture has been researched, and whilst they provide an opportunity for listening and to be heard, they are not intended to be problem-solving sessions. The Trust runs monthly Schwartz Rounds except in August and December covering various subjects such as 'Black Lives Matter', 'Guilt and Shame', 'In a Toxic Relationship with Work'. Because it is thought to be more effective when delivered face-to-face, attendance recently has reduced to an average of 20-35 due to distancing restrictions. The general feedback for Schwartz Rounds has been excellent.

4 Building Skills and Self Development

4.1 Coaching continues to be requested, however, numbers have significantly dropped from 77 per year at the peak, to 25 (dropped by two thirds) and 28 in the two years of the pandemic. Since the start of the pandemic, there has been an increase in requests for bespoke team support and interventions and team away days. This includes reflective time, building trust and resilience and developing action plans to support individual, and team needs.

4.2 Leadership support is being requested in different forms including bespoke development programmes. As a result the variety of I.CARE programmes will start to be offered as open modular sessions to enable managers to select appropriate items for their teams' specific needs. As part of the ICARE Leadership programme, specific modules have been designed to support managers in staff health and wellbeing with modules such as 'Leading Under Stress and Pressure' and 'Workplace Conflict'. The Managers' Forum has been rolled out on a two-monthly basis with a schedule of events advertised until the spring, covering key topics such as the 'wellbeing conversations'.

4.3 Building leadership capability is an essential part of supporting staff and the Trust's values based leadership courses continue to be delivered safely in virtual classrooms. This enabled an increase in the usual cohort number from 20 to 30. The programme includes two key modules: workplace conflict and resilience. The workplace conflict module looks at the causes of workplace conflict and helps leaders gain an understanding about workplace bullying a well as the difference between being a 'firm but fair manager vs bullying'. This is particularly important during a pandemic when managers and their teams are working under more than usual pressure. The resilience module explores the importance of leaders looking after themselves and their team in order to provide the best possible care to patients and service users.

4.4 A further three bespoke leadership programmes have been designed for nursing, midwifery and Allied Health Professionals that support elements of health and wellbeing for staff, such as 'Leading Under Stress and Pressure', 'Managing Change' and 'Resilience'. The Midwifery Leadership Development Programme has commenced in October 2021 with the rest scheduled to launch by April 2022.

4.5 As part of the leadership and management development offering, a 'Giving and Receiving Feedback' training will be launched to support managers and staff in having courageous conversations and tackling issues with compassion as and when they arise. The training will launch in December 2021 with two pilot sessions being held in Maternity.

4.6 A resilience workbook was created to enable staff to look after themselves, coach each other, and improve wellbeing. The workbook includes a range of different models to support staff during COVID-19 pandemic and to help staff seek solutions to challenges they face. The workbook has been well-received and offered to other NHS organisations who were keen to develop something similar. The workbook includes the following exercises:

- Circle of concern and influence – what is in our control that we can do something about
- Advice on building resilience – looking at perspectives, our values and strengths
- Managing energy levels – are our emotions generating positive or negative energy, and high or low energy
- Gratitude journal – a diary for staff to share what they are grateful for
- Stress container – a useful tool to help understand the stressors in our everyday life and what we can remove from our container
- Coaching questions for wellbeing

4.7 During winter, the Winter Resilience 1-hour workshops are offered to all staff to help them cope with winter pressures. The workshops incorporate tools and techniques to deal with stress, offers a space for staff to talk openly about their wellbeing, and presents new ideas for supporting and improving wellbeing and resilience. Approximately 100 staff are expected to attend the resilience workshops over November and December 2021. The six workshops for 2021 include the following modules:

- *Communicating with Empathy* - Explore empathic communication and its importance in life, by enabling us to resolve conflicts, build more productive teams, and to improve our relationships
- *Emotional Labour* - Recognise the different parts to emotional labour and how to have supportive conversations
- *Coping with Stress* - This session looks at managing worry and stress caused by burnout from the challenges of delivering and supporting care during times or pressures.
- *Harnessing your Energy* – "*Energy, not time, is our most precious resource*" Loehr and Schwartz. This session looks at your energy and offers you a peer-coaching technique to explore your energy zones.
- *Exploring Trust* - Recognise the role of trust when building resilience and how it can lead to psychological safety.
- *Self-Compassion and Setting Boundaries* - Explore the importance of self-compassion for wellbeing and how to practise it, along with setting boundaries in our personal life, whilst working from home and in the workplace.

4.8 In the run up to the Objective Structured Clinical Examination (OSCE), resilience workshops for International Nurses preparing for OSCE were provided, focusing on breathing techniques, managing worries and stress, as well as using cognitive behavioural therapy (CBT) methods to manage anxiety.

5 Prevention and Cure – Health and Wellbeing

5.1 The Health and Wellbeing Hub provides a wealth of support including:

- Practical support
- General resources and support including resilience workbook
- Support for specific staff groups
- Information on cultural bereavement practices
- Relationship support
- Access to counselling, chat rooms, and psychological wellbeing information resources
- Support for managers and building team resilience
- NHS wellbeing apps

5.2 The hub practical support includes who the relevant HR Business Partner (HRBP) is; where to hire and park bicycles; COVID testing; staff COVID risk assessments and much more. The Communications Team update the page so that staff can see what is new or updated.

5.3 Group reflective sessions have been run by the Trust's Clinical Health Psychology Team (evaluation at Appendix A) and Nafsiyat (a local culturally sensitive organisation offering individual and group therapy). During 2020, 34 sessions were run internally, reaching 238 people. Nafsiyat have run sessions hosted by the BAME Staff Network with a reach of 71 people. The Clinical Health Psychology Team also offer sessions entitled "In Your Own Words", giving voice to, and sharing, working experiences of working through the pandemic, delivered by actors on behalf of the staff contributors. There have been three sessions to date with another twenty sessions scheduled for November 2021, accessible to both community and hospital staff.

5.4 Counselling is offered through the Trust's Employee Assistance Programme (EAP), Nafsiyat and the Association of Group and Individual Psychotherapy (AGIP), a local service offered voluntarily to support NHS staff during COVID-19. Until the pandemic hit, staff were referred for EAP counselling through Occupational Health Service. With their increasing involvement in testing and risk assessment referrals, access was opened up and staff are currently able to refer themselves. Both AGIP and Nafsiyat are seeing nine people each. These are both

very recent offers and there is no evaluation or feedback on the service as yet. The data from the EAP demonstrates a very effective source of support for staff with an increase in staff take-up since the start of the pandemic (Appendix B).

5.5 "Staff Focus September" ran over the last three years at Whittington Health, and it is an initiative bringing together a range of staff-focused activities and messages and communicate with colleagues in a coherent and co-ordinated way. Each of the four weeks in September focus on a different theme, (Reflection, Wellbeing, Engagement and Diversity) and various development opportunities are being offering to staff. In September 2021 the following activities related to Health and Wellbeing were offered:

- Menopause Awareness
- Communicating with Empathy
- Self-Compassion and Setting Boundaries
- Pedometer Team Challenge
- Therapy dog visits (Dexter the Dog)
- Eye check promotions
- Mental Health First Aid training
- World Fitness Day
- Wellbeing Day for Nurses and Midwives

5.6 As well as providing an opportunity to listening and being heard, the Staff Network Meetings also provide information, training, development and reflection opportunities to build confidence, particularly in the areas of career development, personal confidence and empowerment to challenge.

5.7 The Trust has commissioned nine sleep sessions to support staff with wellbeing with an average attendance of 8-10 people per session. These are proving to be popular and are booking up quickly, and whilst it is too early to evaluate overall, early feedback suggests that this is a helpful session for staff whose sleep is affected by work or any other issues.

5.8 Several sessions on being at work with a disability have been hosted by the WhitAbility Network, and the trainer is now offering workplace 'in your desk or chair' yoga sessions to support physical and mental wellbeing.

5.9 The values-based ICARE Career classes (soon to be accompanied by a workbook) has been created to support staff confidence and facilitate career planning. Feedback from the staff survey demonstrates this is key to improving staff wellbeing and engagement at work.

5.10 The support hub provides a range of national psychological self-help resource links and chat rooms, provided by NHS Employers/Improvement (NHSEI) and private organisations. It has not been possible to collect data on Whittington Health employee take-up.

5.11 Virgin Pulse and NHSEI have visited the hospital site sign staff onto the "Virgin-Pulse Go" (VP-GO); a flexible 'challenge' wellbeing programme delivered via an app – for which the feedback was very positive. Other programmes include weight loss, support for managers, menopause, men's wellbeing, a variety of counselling resources and wellbeing apps. Attendance appeared to be good and we are awaiting the numbers of joiners.

5.12 The NHS People Plan sets out the importance of regular 'Wellbeing Conversations'. The Trust now has a template (Appendix C), based on the national version, to support managers conduct productive conversations about staff welfare and morale and identify supportive mechanisms and practices to enhance psychological health at work.

6 Conclusion and Recommendations

6.1 There is a wealth of variety and volume of support available for staff which is delivered in a range of methods including face-to-face, virtual classrooms, online chat-rooms, documented information, tips and advice.

6.2 The provision, where it has been possible to gather information, demonstrates that the services and information offered is of good value and worthwhile engaging with for those staff requiring support.

6.3 Whilst it is clear that there is increased uptake of supportive services, it is not clear from the data available that this increase is sufficient to support staff needs. More anecdotally the Trust is aware that staff do not have time to access the support. A report has been provided to the TMG to alert managers to the need to find time to enable staff to be released to access the support they need. A similar request to support staff in making such requests was made to the Partnership Group, Staffside Unions and staff representatives.

6.4 Where services are commissioned or provided by the Trust, information on take-up and evaluation is more readily available that other voluntarily given and national services for which there is no data.

6.5 Members of the Trust Board are asked to note and discuss the contents of this report including:

- the range of provision available to staff;
- the Trust monitoring of uptake wherever this is possible (; provided to the Workforce Assurance Committee and TMG);
- the evaluation of services where available;
- debating what additional offers can be made to support staff wellbeing at Whittington Health.

Appendix A1 – Uptake and Evaluation of EAP Services

Whittington Health Employee Assistance Programme (EAP) "People at Work"

- The EAP service provides a range of services including financial guidance and debt planning, citizens advice, careers coaching, planning for retirement, reviewing work-life balance and counselling services.

- Since April 2021 (to September inclusive), 121 employees have used counselling and online or telephone services, of whom a third self-referred and two-thirds were referred by Occupational Health (OH). There were no calls to the managers' support line. According to the evaluation survey, managers made staff aware of the service for 57 per cent of respondents. Twenty-nine per cent found out about the service from the intranet and 14 per cent from OH.

- Comparing 2020 and 2021 for the same period (April to September inclusive) uptake only, there is a 4.31 per cent increase in access to EAP services for 2021. The greatest referrals have come from Adults and Community Services (ACS), Children and Young People (CYP), and Women's Health, Patient Access and Clinical Support Services (ACW). The next highest referrals were made from Corporate Services. The lowest level of use was from Emergency and Integrated Medicine (EIM) and Surgery and Cancer (S&C).

- Twenty-five per cent of referrals were work-related; seventy-five per cent of referrals were personal matters affecting work performance. The most frequently occurring themes were stress, low mood and depression, bereavement, and carer difficulties. Also high were performance issues, and covid-related concerns.

- The take-up was evenly split by race, and representative in terms of gender and age.

- The impact of counselling was shown to be beneficial as shown by the following Table 1. Most importantly it enabled people to continue to work and reduced the potential for sickness absence as reported by the respondents. Twenty-nine per cent specifically stated that the counselling meant they could continue to work, whilst only 14 per cent had to take leave.

- When asked to rate the service, 57 per cent rated it very responsive and helpful, and 28 per cent rated it as a good service. Only 14 per cent described it as average and no-one thought it was poor.

Table 1 Self-Rating of Mental Health and Wellbeing Before and After Counselling

	Before Counselling	After Counselling
Poor and Very Poor	57%	14%
Coping	29%	14%
Good and Very Good	14%	72%

Appendix B – Audit of Staff Reflective Practice Sessions

Staff Reflective Practice – Audit
11/06/2020

OVERVIEW

Data collected from **34 different staff reflective practice sessions** that took place between 28/04/2020 and 11/06/2020

Duration	Range between 30-90 mins with an average duration of 63mins
Attendees	Range between 2-20 attendees, Average of 7 attendees
Platform	All sessions were conducted face to face (one participant joined one group via Microsoft Teams)
Facilitators	13 x sessions had 1 facilitator 21 x sessions had 2 facilitators _____ 7 x facilitators were from Whittington Health Clinical Health Psychology Team 4 x facilitators were from CAMHS

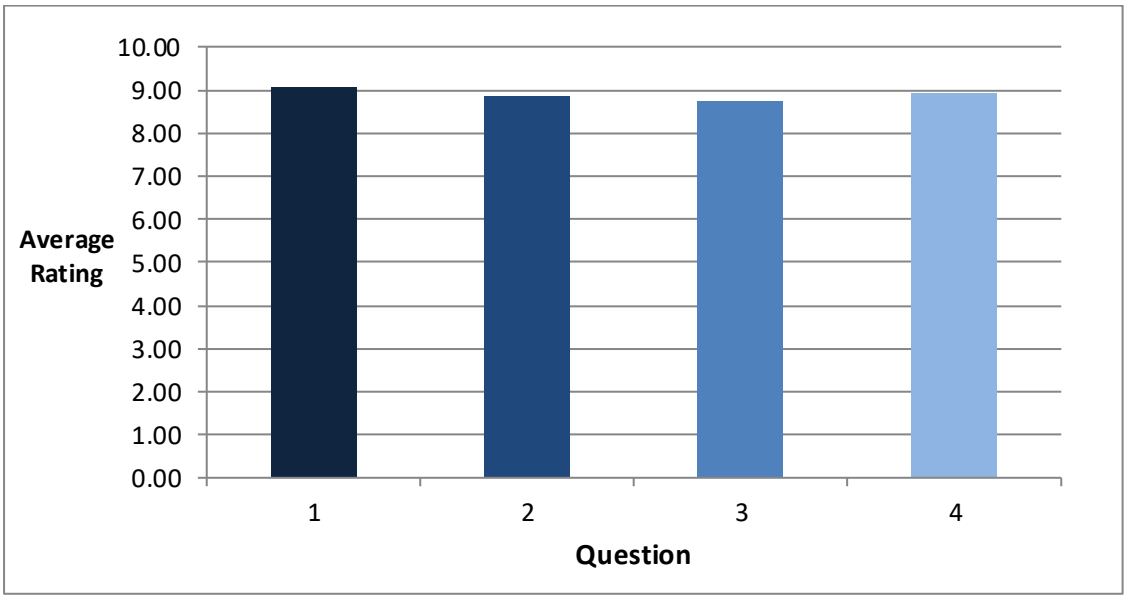
Group identities include:

- Acute medicine consultants
- Maternity services staff
- Cardiology MDT
- Respiratory MDT
- ITU Nurses
- ITU Doctors
- ITU Lead nurses
- Lead nurses for ICSU
- ITU Outreach nurses
- Nightingale nurses
- Core medical trainees
- Anaesthetic consultants
- Dieticians
- Cancer CNS
- CORE Teams
- Respiratory nurses
- Wingmen (volunteer airline staff)
- Orthopaedic Therapy Team
- Acute medical/surgical Therapy Team
- START Therapy Team

Profession and job titles include:

- Consultants
- Obstetricians
- Medical trainees
- Nurses
- Core medical trainees
- Sisters
- Health Care Assistants
- Occupational Therapists
- Physiotherapists
- Assistant therapists
- Midwives
- SHOs
- FY1 & FY2
- Volunteer staff
- Clinical nurse specialists
- Dieticians
- Nursery nurse

Evaluation of Reflective Practice Sessions



Q.1 Overall how helpful did you find this session? (0-10)

The **average** rating across all groups for this session was **9.1 out of 10**

Q.2 To what extent has attending the group today supported your wellbeing? (0-10)

The **average** rating across all groups for this session was **8.9 out of 10**

Q.3 To what extent has attending the group today supported me in managing the experience of work during the Covid response? (0-10)

The **average** rating across all groups for this session was **8.7 out of 10**

Q.4 To what extent has attending the group today facilitated how much my colleagues and I can support each other? 0-10

The **average** rating across all groups for this session was **8.9 out of 10**

Comments and feedback:

Very helpful, nice to be able to offload without feeling you are burdening / worrying friends and family. It would be useful to have sessions like this once a month or so **(Cardiology MDT)**

I really appreciate having this space to reflect and talk. I find it really grounding and help me check in with how I and my colleagues are doing **(Medical trainees)**

Excellent session, clear boundaries and goals at the start, allowed space, really helpful to have this **(Maternity services)**

This is very helpful and should not be a one off thing. Such support should be available **(Maternity services)**

Supportive to have heard others experience, Thanks to the facilitator **(Consultants – Acute Medicine)**

This is the first opportunity I have had to discuss my experience and how to move forward. It was very well facilitated and a hugely helpful session, I look forward to more! **(Lead nurses ICSU)**

It has been useful to spend some time separate to the clinical work of Covid to think about ourselves, and colleagues, and how we can support them and each other. Thank you. **(ITU Nurses)**

I did not know what to expect from the session today but I found it very useful. It provided a safe and calm environment to reflect on the experience and consider a way to move forward **(ITU nurse)**

Further sessions with different memos would be helpful **(Core medical trainees)**

Extremely useful - thank you very much! **(Medical trainees)**

Upcoming planned activity sessions for staff support (June & July)

- 3 x A&E team
- 8 x MSK Groups
- 1 x ITU core medical trainee group
- 2 x Cavell Ward
- 2 x Cancer team
- 1 x FY1 & FY2s
- 1 x Pharmacy team
- 1x Cloudsley ward
- 3 x ED consultant and doctors
- Ongoing monthly – Maternity doctors
- Ongoing weekly or monthly – Midwifery
- Attend ITU nurses away day
- 2-3hrs for nursing team and Doctors
- 20 x district nursing
- 1 x WEC reception team
- 1 x Anaesthetics MDT
- 1 x CORE MDT
- 2 x Nightingale ward nurses
- 1 x ICAT MDT

Appendix C – Guide to Wellbeing Conversations

Guide to Wellbeing Conversations

Whittington Health is committed to ensuring the **health**, **safety and wellbeing of all employees** and recognises that an effective organisation comprises a workforce that both feels well and is well-managed.

The **NHS People Plan 2020-21** sets out an ambition:

"From September 2020, every member of the NHS should have a health and wellbeing conversation and develop a personalised plan. These conversations may fit within an appraisal, job plan or one-to-one line management discussion, and should be reviewed annually. As part of this conversation, line managers will be expected to discuss the individual's health and wellbeing, and any flexible working requirements, as well as equality, diversity and inclusion."

See the NHS People website for more information Wellbeing Conversations.

What is a wellbeing conversation?

- Wellbeing conversations are intended to be regular, supportive, coaching-style, one-to-one conversations that focus on the wellbeing of NHS people.
- Wellbeing conversations can help create a culture where people feel heard and valued, and in which diversity is respected.
- Seek to consider the whole wellbeing of an individual such as their physical, mental, emotional, social, and financial sides, their lifestyle and their safety. They can help address areas where individuals need more support and signpost them to that support.
- Wellbeing conversations can be held with line managers or a trusted colleague.
- They can be held as standalone conversations with a colleague, or incorporated into existing conversations, such as 1:1s or during check-ins.

Who should hold the conversation?

- In most cases, a wellbeing conversation will be held by a line manager or supervisor, but in some instances, colleagues may feel more comfortable talking to another trusted colleague about their wellbeing.
  Tip: *for the individual holding a wellbeing conversation, it may feel daunting at first. It's important to remember that you are not being asked to provide clinical advice. Your role is to hold the conversation, actively listen to your colleague, be compassionate and signpost them to further support.*

How should I approach a wellbeing conversation?

- It can take place virtually or in person. It's important that the conversation is held in a safe, confidential space.
- Give your colleague the wellbeing conversation template to complete before you meet, so they have time to think about what they would like to discuss.
- Before starting the conversation, take a moment to reflect on any cultural considerations that may be relevant e.g. religious festivals or events that are taking place that may have an impact on the colleague's wellbeing, such as fasting during Ramadan.
- A great way to start the conversation is simply asking 'How are you?' and allowing your colleague time to reflect and respond.

Exploring Wellbeing:

Make sure the conversation allows you to explore their wellbeing. You can use open questions, such as:

- How is your general wellbeing at the moment?
- What might be having an impact on your health and wellbeing?
- How are things going, both inside and outside of work?
- Tell me more about that…?
- Can you give me some examples…

Remember to consider different aspects of wellbeing and remember to consider factors both inside and outside of work.

Identifying support:

Use open questions, such as:

- What are the sorts of things that you might be able to do to help yourself?
- What can I, the team or the organisation, do to support you?

Supportive Actions:

Work together to agree actions that both of you will take after the conversation. Encourage your colleague to complete the wellbeing action plan (page 2 of the wellbeing conversation template). Keep the conversation going by agreeing how and when you will review progress together.

Next steps:

Book in for a review meeting to follow up on the wellbeing action plan.

Useful wellbeing resources to be aware about:

Caring for Those Who Care: https://whittnet.whittington.nhs.uk/default.asp?c=6891
COVID-19 Staff Care and Support: https://whittnet.whittington.nhs.uk/default.asp?c=34022
Employee Support Services: https://whittnet.whittington.nhs.uk/default.asp?c=27381
Mental Health Support: https://whittnet.whittington.nhs.uk/default.asp?c=31324
Occupational Health and Wellbeing: https://whittnet.whittington.nhs.uk/default.asp?c=10756
Staff Equality and Inclusion Networks: https://whittnet.whittington.nhs.uk/default.asp?c=30133
Tackling Bullying and Harassment: https://whittnet.whittington.nhs.uk/default.asp?c=32149
Support available for our NHS people: https://www.england.nhs.uk/supporting-our-nhs-people/support-now/

Wellbeing Conversations Template

Name: **Date:**

Job Title: **Manager:**

Use this document as a tool for having supportive conversations around your wellbeing. You can complete this form before your meeting to help you think about what you would like to discuss.
Below are aspects of your health and wellbeing to consider when having your conversation:

- Occupational and work environment
- Your mental, emotional or psychological health, stress
- Your physical health, nutrition, rest, sleep, exercise, injury
- Home life and caring responsibilities
- Social life and relationships
- Learning and personal growth
- Cultural and spiritual considerations
- Personal safety
- Financial affairs
- Lifestyle

How am I feeling today?	**What helps me to stay healthy and look after my wellbeing at work?**
What usually works for me to maintain and/or improve my health and wellbeing?	**What hinders or reduces my wellbeing at work? What are the early warning signs?**

What steps can I take if I start to feel unwell?

What could be put in place at work to help me manage my wellbeing?

Complete this page with your manager/colleague:

Actions to maintain and improve my health and wellbeing include:	My manager, team and my organisation can support me by:

Line Manager:

Do you need any support from your line manager? If so, what support do you need?

What to look out for:

What are the triggers/signs that you may need support that your manager and colleagues should look out for (both now and thinking about the future)?

Reasonable Adjustments:

Are there any reasonable adjustments you need to discuss with your line manager?

Equality and Inclusion:

Do your manager and colleagues help you to feel included and supported at work? What would make this better?

Useful wellbeing resources to be aware about:

Caring for Those Who Care: https://whittnet.whittington.nhs.uk/default.asp?c=6891
COVID-19 Staff Care and Support: https://whittnet.whittington.nhs.uk/default.asp?c=34022
Employee Support Services: https://whittnet.whittington.nhs.uk/default.asp?c=27381
Mental Health Support: https://whittnet.whittington.nhs.uk/default.asp?c=31324
Occupational Health and Wellbeing: https://whittnet.whittington.nhs.uk/default.asp?c=10756
Staff Equality and Inclusion Networks: https://whittnet.whittington.nhs.uk/default.asp?c=30133
Tackling Bullying and Harassment: https://whittnet.whittington.nhs.uk/default.asp?c=32149
Support available for our NHS people: https://www.england.nhs.uk/supporting-our-nhs-people/support-now/

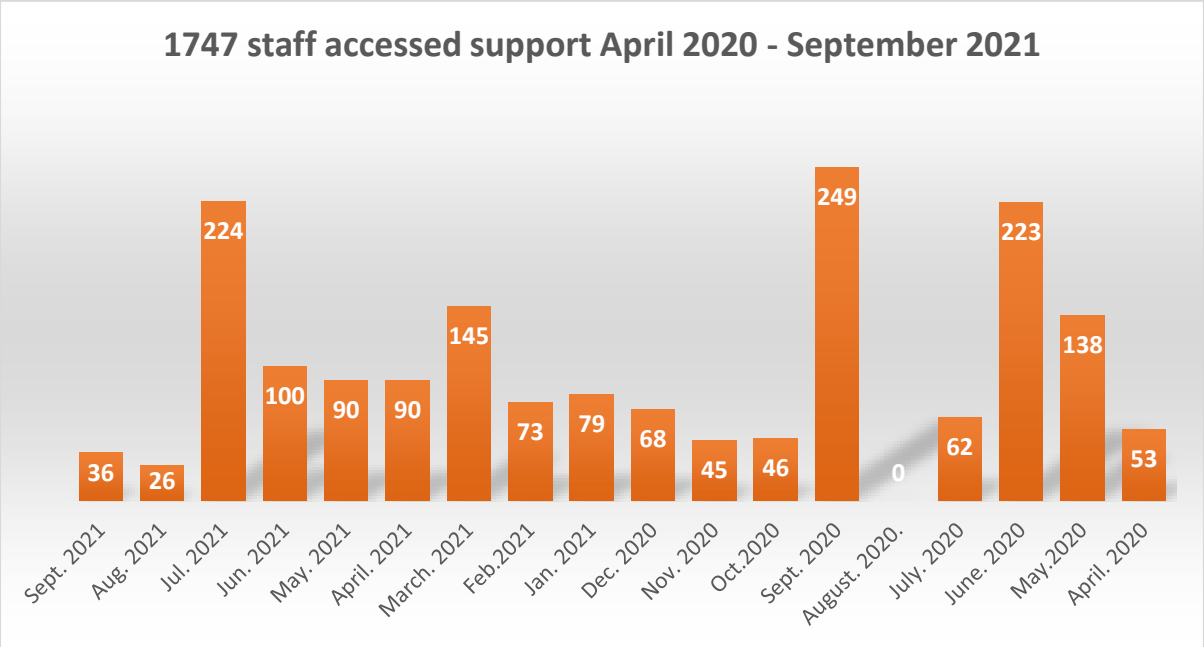
Clinical Health Psychology Staff Support Data

April 2020 – September 2021

Graphic Summary

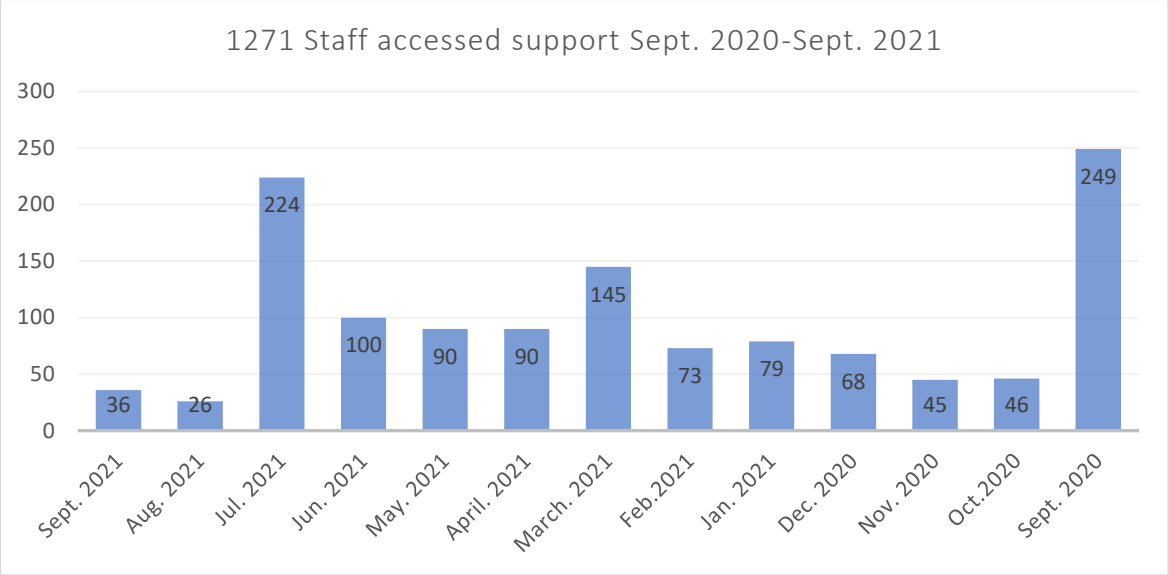
1. Number of Staff who accessed Staff Support Psychology

1.1 April 2020 – Sept 2021 (18 months)



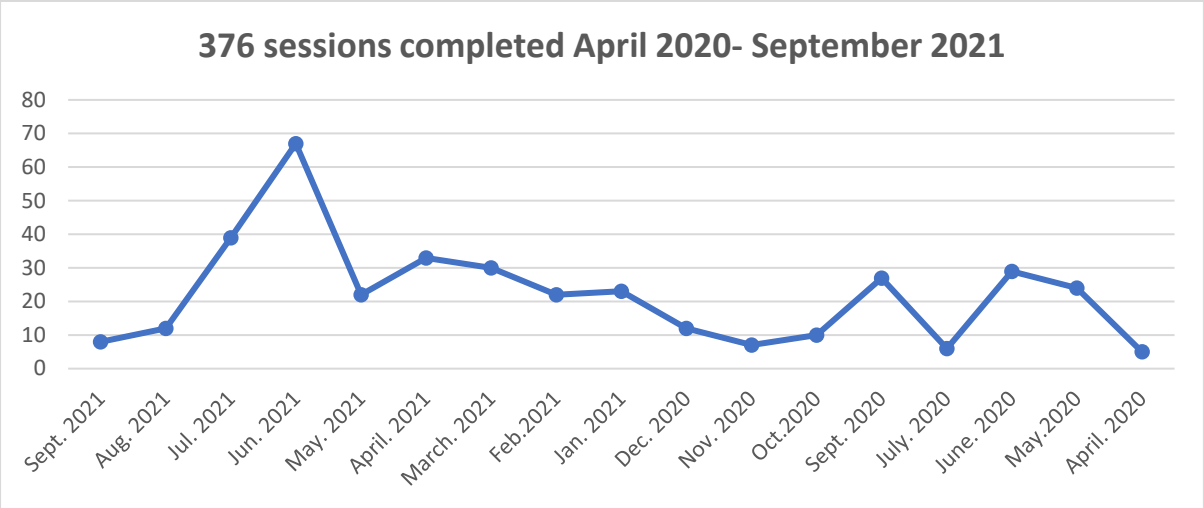
Please note: *August 2020 - missing data.*

1.2 Number of staff who accessed Staff support September 2020 - September 2021 (13 months)

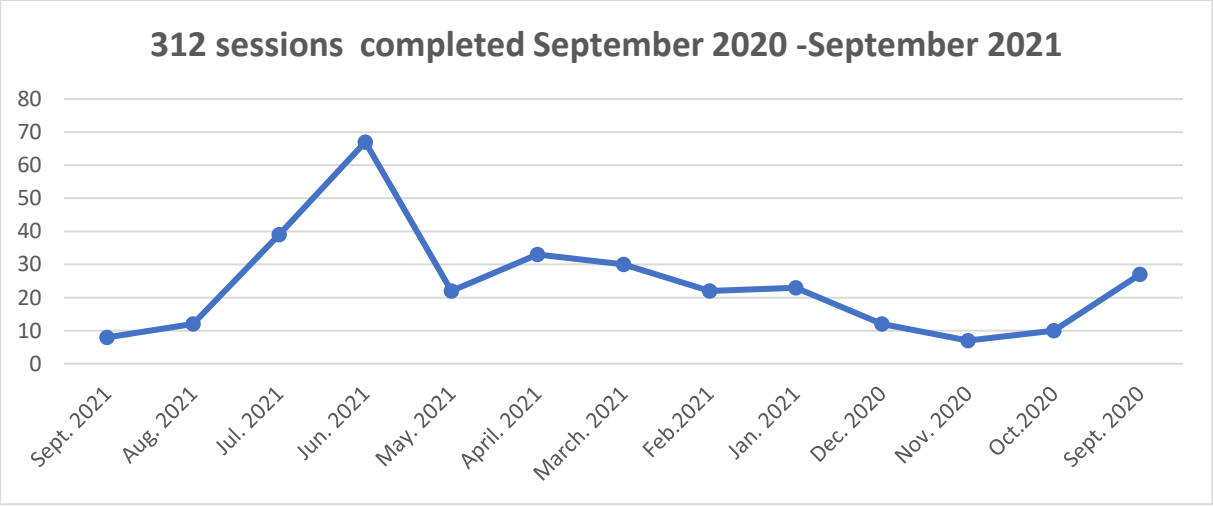


2. Number of Staff Support sessions offered by psychology

2.1 April 2020 – Sept 2021 (18 months)

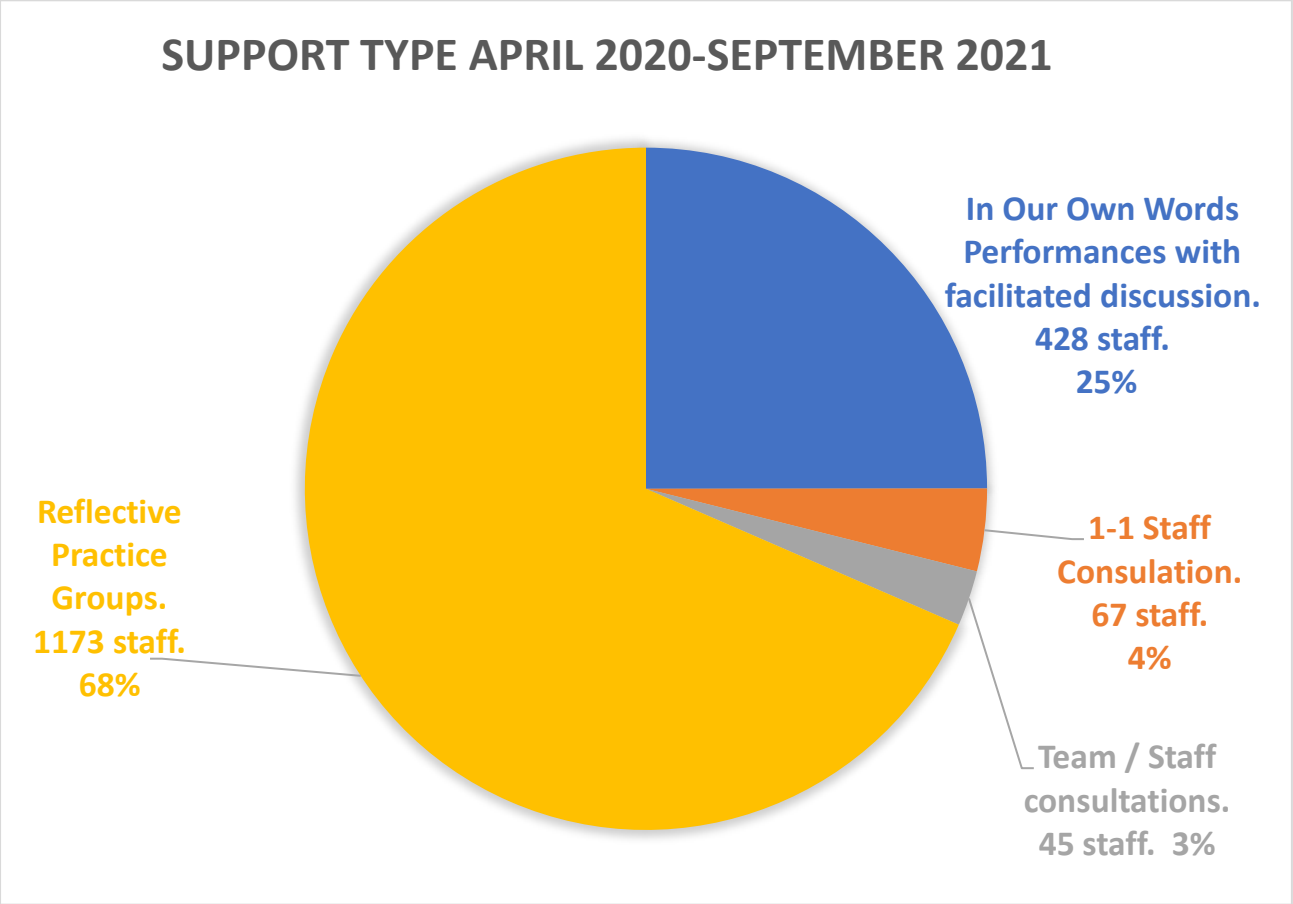


2.2 No. of Staff Support Sessions Sept 2020 – Sept 2021 (13 months)

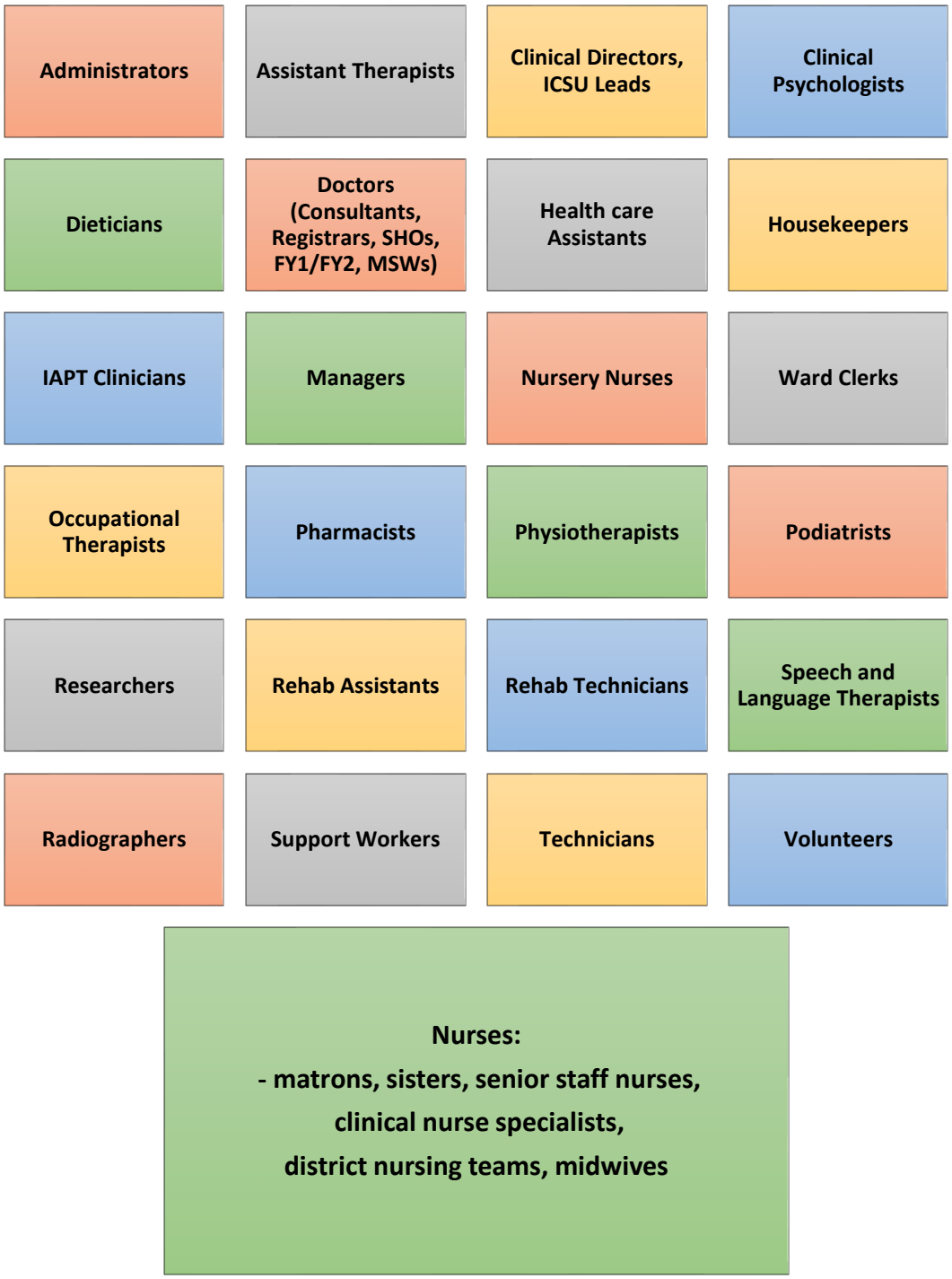


3. Type of support accessed

April 2020 – Sept 2021 (18 months)



4. Professional Groups Accessing Staff Support Psychology



5. Some of the Teams accessing Support

AAU nurses, ACS ISCU leads	Acute Medicine, Acute medical/ surgical therapy team,	ACW ISCU leads, A&E Doctors,	Anaesthetics, Cancer care CNS,
Cardiology MDT, Care home staff,	Cavell Ward, Cloudsley Ward,	Community rehab team, Continuing Healthcare Team, COOP therapy team,	CORE teams, Coyle Ward,
CPAP MDT, Dieticians,	District Nursing,Eating disorder team,	EIM leads,Emergency Department,	Executive Team, Gynaecology and Colposcopy,
Hackney Smoking Cessation team, Haringey IAPT,	Heart Failure Team, Haringey Learning Disabilities team,	HR team, ICRT team,	ICTT,
Imaging Team, Inpatient Physios,	Intensive Care Unit, /ITU	Mary Seacole Ward, Maternity Services,	Merrick Ward, Mobility and seating team,
MSK Physio Team, Nightingale Nurses,	Obstetrics & Gynaecology, Orthopaedic Therapy team,	Oncology Team, Palliative care team, Pharmacy	Podiatry, Porters and Housekeeping,
REACH team, Recruitment team,	Research Delivery team, Respiratory team,	START therapy team, WEC team,	Wingmen, Whittability network.

17.11.21 v2

Njinga Kankinza, Sue Gibbons

Meeting title	**Trust Board – public meeting**	**Date: 25.11.2.21**
Report title	Finance Report October (Month 7) 2021/22	**Agenda item: 8**
Executive director lead	Kevin Curnow, Chief Finance Officer	
Report author	Finance Team	
Executive summary	The Trust is reporting an actual deficit of £1.4m at the end of October 2021. This is a favourable variance of £0.2m against a planned deficit of £1.6m. The deficit position is being driven by slippage in expected savings and other expenditure overspends not covered by the H1 funding. Cash position at the end of October was £70.3m The Trust has spent £6.1m of its capital allocation year to date October 2021 which is £3.0m behind plan. This is largely due to phasing of the plan and the Trust is still forecasting to spend its capital allocation for 2021-22. Trust has submitted a deficit plan of £1.4m for H2	
Purpose:	To discuss the year-to-date performance.	
Recommendation(s)	To note the year-to-date financial performance, recognising the need for improve savings delivery.	
Risk Register or Board Assurance Framework	BAF risks S1 and S2	
Report history		
Appendices		

CFO Message

Finance Report M07

Trust reporting £1.4m actual deficit at the end of October – £0.2m better than plan

The Trust is reporting an actual deficit of £1.4m at end of October which is £0.2m better than plan. The planned deficit to end of October was £1.6m.

Key drivers for the £1.4m actual deficit are

- Slippage of Cost Improvement Programmes across the trust
- Additional costs relating to ongoing legal challenges relating to the Private Finance Initiative (PFI)
- Other cost pressures not covered by H1 (April 2021 to September 2021) funding including increased staffing for additional beds and agency premium.

Included in the year to date (YTD) actuals is £4.1m of Elective Recovery Fund (ERF) income. This is currently offsetting slippage in expected savings and other expenditure overspends not covered by H1 funding.

Cash of £70.3m at end of October

As at the end of October, the Trust's cash balance stands at £70.3m – an increase of £8.2m from the 1st of April 2021. The Trust's ongoing cash requirements have not changed materially in terms of staff pay and capital expenditure, although the Trust is striving to pay suppliers early in the current economic climate.

Capital plan for 2021/22 is £17.1m. YTD spend is £6.1m.

The Trust has a capital plan of £17.1m. This plan is in line with North London Partners Integrated Care System (ICS) allocation. At end of October the Trust has spent £6.1m of its capital allocation which is £3.0m behind plan. This is largely due to phasing of the plan and the Trust is still forecasting to spend its capital allocation for 2021-22.

Better Payment Practice Performance – 93.5% for non-NHS by value

The Trust is signed up to the NHS commitment to improve its Better Payment Practice Code (BPPC) whereby the target is to pay 95% of all invoices within the standard credit terms. Overall, the Trust's BPPC is 91.7% by volume and 92.3% by value. The BPPC for non-NHS invoices is 93.5% by value and 93.5% by volume.

Update on H2 funding – Block income to continue with higher savings requirement

Following confirmation of block income for H2, the trust has submitted a deficit plan of £1.4m for H2 (October to March) and a full year deficit plan of £2.4m to the Integrated Care System (ICS). The efficiency requirement included within the H2 funding envelope is 1.1%. Providers are expected to submit a financial plan for H2 on the 25th of November.

1. Summary of Income & Expenditure Position – Month 07

	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income						
NHS Clinical Income	23,939	23,763	(175)	171,399	170,752	(647)
High Cost Drugs - Income	689	1,021	332	4,825	6,132	1,306
ICS Funding M7-12	1,218	1,218	(0)	16,315	16,315	0
Non-NHS Clinical Income	1,114	1,157	43	7,799	7,768	(31)
Other Non-Patient Income	2,208	2,282	73	14,982	14,528	(454)
Elective Recovery Fund	946	1,020	74	5,470	4,076	(1,393)
	30,114	**30,461**	**347**	**220,790**	**219,572**	**(1,218)**
Pay						
Agency	(17)	(1,241)	(1,224)	(17)	(6,470)	(6,453)
Bank	(298)	(2,324)	(2,025)	(3,638)	(17,581)	(13,943)
Substantive	(21,488)	(18,985)	2,503	(154,428)	(132,312)	22,115
	(21,804)	**(22,549)**	**(746)**	**(158,083)**	**(156,363)**	**1,720**
Non Pay						
Non-Pay	(6,352)	(5,899)	453	(48,981)	(48,346)	635
High Cost Drugs - Exp	(843)	(850)	(7)	(4,713)	(5,787)	(1,074)
	(7,195)	**(6,749)**	**446**	**(53,694)**	**(54,132)**	**(438)**
EBITDA	**1,115**	**1,162**	**47**	**9,013**	**9,077**	**64**
Post EBITDA						
Depreciation	(946)	(929)	17	(6,618)	(6,579)	39
Interest Payable	(61)	(47)	14	(427)	(334)	93
Interest Receivable	0	0	0	0	0	0
Dividends Payable	(511)	(511)	0	(3,577)	(3,578)	(1)
	(1,518)	**(1,488)**	**30**	**(10,622)**	**(10,492)**	**130**
Reported Surplus/(deficit)	**(403)**	**(326)**	**78**	**(1,609)**	**(1,415)**	**194**

- The Trust reported a year-to-date deficit of £1.4m (excluding donated depreciation) at the end of October which is £0.2m better than plan.
- The planned deficit to the end of October was £1.6m excluding donated depreciation.
- YTD actuals includes £4.1m of ERF income that is currently mitigating unachieved CIPS and other expenditure overspends.

2.0 Income and activity

2.1 Income

- Income was £0.3m favourable to plan in October and £1.2m adverse year to date. In month overperformance is mainly driven by high-cost drug overperformance. The YTD underperformance relate to lower than planned performance on ERF for H1 and overseas visitors' income.

- Other Clinical Income NHS in month favourable position is mainly driven by additional income related to accelerated recovery funds that is offset by additional expenditure.

- Under performance in Other Operating Income of £0.5m is predominantly due to education and training income.

Income	In Month Income Plan	In Month Income Actual	In Month Variance	YTD Income Plan	YTD Income Actual	YTD Variance
	£000's	£000's	£000's	£000's	£000's	£000's
A&E	1,398	1,504	106	9,651	10,378	726
Elective	1,494	1,588	94	9,984	11,406	1,422
Non-Elective	4,769	4,402	(367)	32,921	32,271	(649)
Critical care	593	499	(94)	4,095	3,960	(136)
Outpatients	2,552	2,590	38	17,394	16,544	(849)
Direct Access	932	823	(109)	6,541	6,073	(469)
Community	6,144	6,144	0	43,006	43,006	0
Other Clinical income NHS	7,964	8,453	489	68,947	69,562	614
NHS Clinical Income	**25,846**	**26,003**	**157**	**192,540**	**193,199**	**660**
Non NHS Clinical Income	1,114	1,157	43	7,799	7,768	(31)
Elective recovery fund (ERF)	946	1,020	74	5,470	4,076	(1,393)
Income From Patient Care Activities	**27,906**	**28,179**	**273**	**205,808**	**205,044**	**(764)**
Other Operating Income	**2,208**	**2,282**	**73**	**14,982**	**14,528**	**(454)**
Revised Total	30,114	30,461	347	220,790	219,572	(1,218)

2.2 Month 7 Elective recovery fund (ERF) performance by ICSU

- Elective recovery fund (ERF) of £4.1m year to date is an estimate, as the final amount is based on ICS total performance.

- The basis for ERF payment has changed for months 7 to 12 (H2). It is now based on weighted RTT clock stops performance against a baseline of 89% of 2019/20 levels.

- Month 7 activity performance was 106% compared to the 89% weighted 2019/20 performance target. The activity levels were similar to month 6 activity, except for 4% increase in A&E activity, decreases in critical care (29%) and elective (12%).

- A&E activity was 6% higher than plan and critical care activity was 8% under plan.

- Outpatient activity is overperforming for each ICSU and is expected to improve due to late outcoming.

- Elective activity was 8% higher than plan, with overperformance in Paediatrics (96%), T&O (26%), and underperformance in medical oncology (20%) and gastroenterology (12%).

- Admitted activity was at the same activity level of 2019/20 and 35% higher than the weighted target. This was mainly driven by Trauma & orthopaedics (221% of 2019/20), Gynaecology (19%). All the other specialties were below the 89% target.

- Non admitted was 16% higher than 2019/20 activity and 11% higher than weighted target. The biggest drivers were ENT (268% of 2019/20), Thoracic Medicine (100%), T&O (150%) and Urology (139%). There is a significant underperformance in other (45%).

Month	Admitted/ Non-Admitted	Specialty	Activity Base	Activity Actual	Activity Diff	Weight Baseline	Weight Actual	Weight Diff	Performance %	Performance Target	Performance Diff
7	Admitted	Dermatology	3	2	(1)	£3,655	£2,668	(£986)	73%	89%	-16%
		General Surgery	5	3	(2)	£7,433	£4,378	(£3,055)	59%	89%	-30%
		Gynaecology	3	4	0	£9,811	£10,609	£798	108%	89%	19%
		Oral Surgery	0	2	2	£0	£1,927	£1,927	0%	89%	-89%
		Other	1	0	(0)	£2,859	£783	(£2,076)	27%	89%	-62%
		Trauma & Orthopaedics	2	5	3	£16,752	£37,027	£20,276	221%	89%	132%
		Urology	4	2	(2)	£10,893	£6,092	(£4,801)	56%	89%	-33%
	Admitted Total		**18**	**18**	**(0)**	**£51,402**	**£63,485**	**£12,083**	**124%**	**89%**	**35%**
	Non Admitte	Cardiology	6	6	0	£4,583	£4,619	£36	101%	89%	12%
		Dermatology	21	17	(4)	£13,429	£10,971	(£2,458)	82%	89%	-7%
		Ear, Nose & Throat (ENT)	9	24	15	£4,512	£12,114	£7,602	268%	89%	179%
		Gastroenterology	11	19	7	£6,240	£10,121	£3,882	162%	89%	73%
		General Medicine	1	1	(0)	£533	£428	(£105)	80%	89%	-9%
		General Surgery	16	36	21	£3,952	£9,226	£5,274	233%	89%	144%
		Geriatric Medicine	2	1	(1)	£1,153	£564	(£589)	49%	89%	-40%
		Gynaecology	23	20	(4)	£12,699	£10,766	(£1,934)	85%	89%	-4%
		Interface Services (Rheumat	(29)	0	29	(£34,410)	£0	£34,410	0%	89%	-89%
		Neurology	4	5	1	£2,072	£2,728	£656	132%	89%	43%
		Ophthalmology	11	6	(5)	£8,907	£5,095	(£3,812)	57%	89%	-32%
		Oral Surgery	0	0	0	£0	£154	£154	0%	89%	-89%
		Other	87	38	(49)	£103,590	£45,201	(£58,389)	44%	89%	-45%
		Plastic Surgery	0	0	0	£231	£253	£22	110%	89%	21%
		Rheumatology	4	4	0	£3,660	£4,098	£439	112%	89%	23%
		Thoracic Medicine	0	9	9	£0	£6,997	£6,997	0%	89%	-89%
		Trauma & Orthopaedics	14	21	7	£8,420	£12,662	£4,242	150%	89%	61%
		Urology	15	21	6	£8,451	£11,787	£3,336	139%	89%	50%
	Non Admitted Total		**195**	**229**	**34**	**£148,021**	**£147,785**	**(£236)**	**100%**	**89%**	**11%**
7 Total			**213**	**247**	**34**	**£199,423**	**£211,270**	**£11,848**	**106%**	**89%**	**17%**

3. Expenditure – Pay & Non-pay

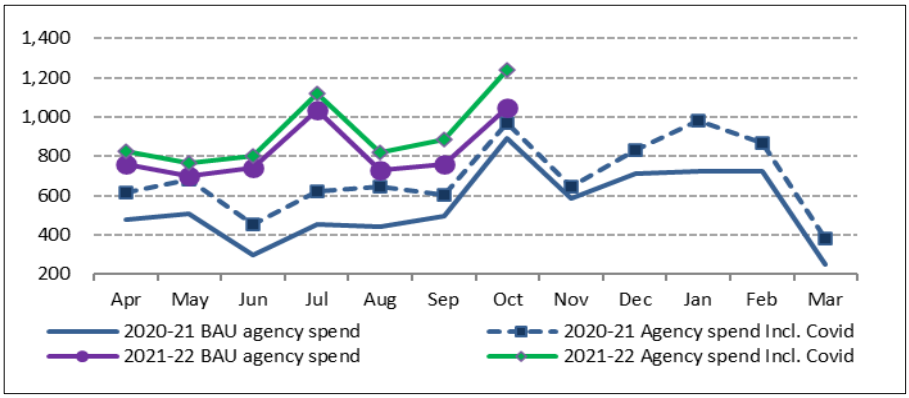
3.1 Pay Expenditure

Pay expenditure for October was £22.1m including £0.4m of costs coded to Covid-19. September substantive pay costs include 3% pay uplift and back pay uplift for April – August.

	2020-21					2021-22							
	Oct	Nov	Dec	Average	Average Uplifted	Apr	May	Jun	Jul	Aug	Sep	Oct	Mov^t
Agency	891	588	714	731	731	785	622	879	1,034	749	770	1,068	298
Bank	1,756	1,828	1,834	1,806	1,806	2,072	1,875	2,287	1,759	2,136	2,166	2,003	(163)
Substantive	17,902	18,186	18,119	18,069	18,159	18,201	18,259	18,336	17,970	18,218	20,942	18,841	(2,102)
Total Operational	**20,549**	**20,602**	**20,666**	**20,606**	**20,696**	**21,057**	**20,756**	**21,502**	**20,763**	**21,104**	**23,879**	**21,912**	**(1,967)**
Covid Costs						271	240	282	348	288	306	427	121
Non Operational Costs						221	1,007	498	458	194	639	211	(429)
Total Pay Costs						**21,549**	**22,004**	**22,282**	**21,569**	**21,586**	**24,824**	**22,549**	**(2,274)**

** (Excludes Chair & Non-Exec Directors)*
*** Oct 2020 to Dec 2020 pay used for comparison as the Covid impact and activity is similar to 2021*

Agency Spend



Agency spend for October was £1.24m which was £0.35m higher than previous month. The increase is offset by some reduction in bank staff costs.

In July agency spend was higher compared to other months mainly due to increase in Child Care packages estimated costs backdated to April

3.2 Non-pay Expenditure

Non-pay expenditure in October was £6.3m and included £0.09m of costs coded to Covid-19.

	2020-21				2021-22							
Excluding Covid	Oct	Nov	Dec	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Mov^t
Supplies & Servs - Clin	2,407	2,384	2,671	2,175	2,023	2,380	2,543	2,366	2,311	2,463	2,324	(139)
Supplies & Servs - Gen	298	249	281	169	226	217	253	245	225	262	282	19
Establishment	371	230	628	216	209	156	217	233	218	241	261	20
Healthcare From Non Nhs	48	59	59	161	265	568	(249)	185	201	426	84	(342)
Premises & Fixed Plant	1,642	1,746	1,946	2,292	1,952	2,138	2,151	1,972	1,859	2,361	1,256	(1,104)
Ext Cont Staffing & Cons	220	358	317	220	166	273	206	196	164	106	137	31
Miscellaneous	1,660	1,429	1,954	2,271	1,411	1,880	1,516	1,511	1,672	2,174	1,457	(717)
Chairman & Non-Executives	10	10	10	10	10	10	10	17	11	12	12	
Grand Total	**6,655**	**6,464**	**7,867**	**7,514**	**6,263**	**7,623**	**6,649**	**6,725**	**6,660**	**8,044**	**5,813**	**(2,232)**
Covid Costs					100	106	80	31	58	90	86	(4)
Total non-pay costs					**6,363**	**7,729**	**6,728**	**6,756**	**6,719**	**8,134**	**5,899**	**(2,235)**

Excludes high-cost drug expenditure. Included in miscellaneous is CNST premium, Transport contract, professional fees, and bad debt provision

3.3 Cost Improvement Programmes (CIP)

Year to date (YTD) Month 7 CIP delivery is predominantly in pay, delivering £1,974k of savings (38% of YTD trust target). The Trust devolved CIP targets to ICSUs and corporate areas to the end of October is £5,250k, so savings are currently £3,276k behind target.

	YTD				Annual			
ICSU	Trust CIP Target £'000	Trust CIP Actual Delivery £'000	Trust CIP Actuals Variance to Target (Shortfall) £'000	% CIP Actuals of Target	Trust CIP Target £'000	Trust CIP Forecast Delivery £'000	Trust CIP Forecast Variance to Target (Shortfall) £'000	% CIP Forecast of Target
ACS	613	**292**	(321)	48%	1,050	**563**	(487)	54%
ACW	928	**202**	(725)	22%	1,590	**430**	(1,160)	27%
CYPS	932	**781**	(151)	84%	1,598	**1,354**	(244)	85%
EIM	867	**323**	(544)	37%	1,487	**554**	(933)	37%
S&C	843	**13**	(830)	2%	1,445	**64**	(1,381)	4%
Corporate	540	**273**	(267)	51%	925	**627**	(298)	68%
E&F	528	**89**	(439)	17%	905	**253**	(652)	28%
Total	**5,250**	**1,974**	**(3,276)**	**38%**	**9,000**	**3,845**	**(5,155)**	**43%**

The Trust 2021/22 forecast savings are £3,845k as at Month 7 (43% of annual trust target). Pipeline savings proposals are continuing to be worked up in line with the Trust's Quality and Finance governance frameworks, though fewer new 2021/22 starting schemes are likely to be delivered as the Trust works through Winter plans.

H1 and H2 CIP Actuals/Forecast

The Trust's external financial plan required savings to the end of September (H1) of £1,808k. H2 CIP Plans will be submitted during November to NHSIE.

	Actual H1 £'000	Forecast H2 £'000
Pay efficiencies	1,060	1,372
Non-pay efficiencies	281	754
Income efficiencies	188	190
Total net efficiencies	**1,529**	**2,316**

4.0 Statement of Financial Position

The net Balance on the Statement of Final Position as at 31st of October 2021 is £216.7m, a minimal change in-month and £1.5m down from the year-end, most of which corresponds to the operating position at Month 7, and this is shown in the table below.

Statement of Financial Position as 31st October 2021

	BFWD 31 MAR 2020 (£000)	IN MONTH BALANCE (£000)	MOVEMENT IN YR (£000)
NON-CURRENT ASSETS:			
Property, Plant And Equipment	155,763	158,110	2,346
Property, Plant and Equipment: On-SoFP IFRIC 12	68,200	67,222	(978)
Intangible Assets	9,789	8,615	(1,174)
Trade & Other Rec -Non-Current	401	463	62
TOTAL NON-CURRENT ASSETS	**234,153**	**234,409**	**256**
CURRENT ASSETS:			
Inventories	2,195	2,261	65
Trade And Other Receivables	18,288	15,311	(2,977)
Cash And Cash Equivalents	61,527	70,313	8,785
NON-CURRENT ASSETS HELD FOR SALE			
Non-Current Assets Held for Sale	0	0	0
TOTAL CURRENT ASSETS	**82,011**	**87,885**	**5,874**
CURRENT LIABILITIES			
Trade And Other Payables	(52,181)	(57,408)	(5,227)
Borrowings: Finance Leases	(182)	(73)	109
Borrowings: Dh Revenue and Capital Loan - Current	(118)	(123)	(4)
Provisions for Liabilities and Charges	(566)	(315)	251
Other Liabilities	(1,908)	(5,131)	(3,224)
TOTAL CURRENT LIABILITIES	**(54,955)**	**(63,051)**	**(8,096)**
NET CURRENT ASSETS / (LIABILITIES)	**27,056**	**24,834**	**(2,222)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**261,209**	**259,243**	**(1,966)**
NON-CURRENT LIABILITIES			
Borrowings: Dh Revenue and Capital Loan - Non-Current	(1,856)	(1,798)	58
Borrowings: Finance Leases	(4,754)	(4,323)	431
Provisions for Liabilities & Charges	(36,437)	(36,437)	1
TOTAL NON-CURRENT LIABILITIES	**(43,047)**	**(42,558)**	**490**
TOTAL ASSETS EMPLOYED	**218,162**	**216,685**	**(1,477)**
FINANCED BY TAXPAYERS EQUITY			
Public Dividend Capital	106,191	106,191	0
Retained Earnings	20,577	19,493	(1,085)
Revaluation Reserve	91,393	91,001	(392)
TOTAL TAXPAYERS EQUITY	**218,162**	**216,685**	**(1,477)**

Meeting title	**Trust Board – public meeting**	**Date: 25 November 2021**
Report title	**Integrated performance report**	**Agenda Item: 9**
Executive director lead	Carol Gillen, Chief Operating Officer	
Report author	Paul Attwal, Head of Performance, and Roxanne Stevenson-Brown, Performance Team	
Executive summary	**Areas to draw to Board members' attention are:** **Emergency Department (ED) four hours' wait:** During October 2021, performance against the 4-hour access standard was 75.6%, higher than both the national average at 73.90% and the NCL average at 72.55%, but lower than the London average which was 76.40%. There was 1 non-mental health 12-hour trolley wait, and 2 mental health. Additional appendix item to provide further detail on Eliminating Ambulance Handover Delays. **Cancer** Compliance against the national cancer standards has not been achieved since April 2020. 62-day performance was at 64.9% for September 2021 down from 80.9% in August. The 2 week wait (2WW) standard was not achieved in September 2021 with 79.3% against a target of >93%. Additional appendix item to provide further detail on cancer performance. **Referral to Treatment: 52 + week waits** At the end of October 2021 there were 558 patients waiting more than 52 weeks for treatment, an improvement of 11 from the previous month. There has been an extremely high volume of 2WW referrals that have impacted the Trust's ability to further improve on this metric. Whittington Health has been acknowledged as the only provider in NCL that does not have any patients waiting more than 104 weeks. There is now an increased focus on patients waiting more than 73 weeks and management of clinical priorities. **Workforce** Appraisal rates for October 2021 are at 66.0% against a target of >90%. The compliance against Mandatory Training was 78.8% in October 2021, an increase of 1.5% from September 2021, against a target of >90%.	
Purpose:	Review and assurance of Trust performance compliance	

Recommendation(s)	That the Board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan
Risk Register or Board Assurance Framework	The following BAF entries are linked: Quality 1, Quality 2, People 1, and People 2.
Report history	Trust Management Group
Appendices	Appendix 1: Community performance dashboard Appendix 2: Community waiting times dashboard Appendix 3: Cancer performance – 62 day and 2 week wait by tumour group Appendix 4: Trust level activity Appendix 5: Eliminating ambulance handover delays, Quality Assurance Committee 11 November meeting report Appendix 6: Cancer service update

Performance Report
November 2021

Month 07 (2021 – 2022)

Date & time of production: 11/11/2021 13:10

Scorecard

Deliver outstanding safe, compassionate care

Indicator	21_22 Target	Reporting Mth	Step Change	Control Limit	Prev. Month	Reporting Mth	2021-2022
Emergency Department waits (4 hrs wait)	>95%	Oct			77.4%	75.6%	81.3%
Cancer - 14 days to first seen	>93%	Sep			82.3%	79.3%	78.7%
Cancer - 62 days from referral to treatment	>85%	Sep			80.9%	64.9%	70.6%
DM01 - Diagnostic Waits (<6 weeks)	>99%	Oct			97.0%	99.0%	94.4%
RTT - Incomplete % Waiting <18 weeks	>92%	Oct			76.0%	76.7%	74.3%
Referral to Treatment 18 weeks - 52 Week Waits	0	Oct			569	558	5089
Community - FFT % Positive	>90%	Oct			95.1%	96.5%	96.7%
% seen <=2 hours of Referral to District Nursing Night Service	>80%	Oct			94.4%	100.0%	94.5%
% seen <=48 hours of Referral to District Nursing Service	>95%	Oct			95.2%	97.0%	95.9%

Transform and deliver innovative, financially sustainable services

Indicator	21_22 Target	Reporting Month	Step Change	Control Limit	Prev. Month	Reporting Month	2021-2022
Theatre Utilisation	>85%	Oct			67.86%	69.25%	69.12%
Acute DNA % Rate	<10%	Oct			11.2%	10.4%	10.1%
Community DNA % Rate	<10%	Oct			7.6%	7.0%	7.2%
Outpatients New:FUp Ratio	2.3	Oct			1.77	1.72	1.84
Elective and Daycase		Oct			2002	1856	13587
Outpatient Attendances		Oct			27149	26349	182936
Community Face to Face Contacts		Oct			37843	39836	264389

Integrate care with partners and promote health and wellbeing

Indicator	21_22 Target	Reporting Mth	Step Change	Control Limit	Prev. Month	Reporting Mth	2021-2022
Breastfeeding Initiated	>90%	Oct			91.5%	91.4%	91.4%
% e-Referral Service (e-RS) Slot Issues	<4%	Oct			35.7%	28.8%	30.9%
% of MSK pts with Improvement in function (PSFS)	>75%	Oct			90.6%	93.8%	91.0%
Rapid Response - % of referrals with an improvement in care		Oct			81.1%	80.4%	82.6%

Empower, support and develop engaged staff

Indicator	21_22 Target	Reporting Month	Step Change	Control Limit	Prev. Month	Reporting Month	2021-2022
Appraisals % Rate	>90%	Oct			65.3%	66.0%	69.2%
Mandatory Training % Rate	>90%	Oct			77.3%	78.8%	76.4%
Permanent Staffing WTEs Utilised	>90%	Oct			88.1%	88.6%	88.1%
Staff FFT % recommended work	>50%	Oct					62.6%
Staff FFT response rate	>20%	Oct					18.4%
Staff sickness absence %	<3.5%	Sep			4.20%	4.34%	4.19%
Staff turnover %	<13%	Oct			14.3%	11.9%	11.8%
Vacancy Rate against Establishment	<10%	Oct			11.9%	11.4%	11.9%

Step Change	Where a new step change has been triggered by five consecutive points above or below the mean (average).
Control Limit	The Control Limit is where the latest reported month is above the upper confidence limit or below the lower confidence limit.

	If the step change or control limit icon is green, this suggests performance in changing in a positive
	If the Step change or Control Limit icon is red, this suggests performance is changing a negative

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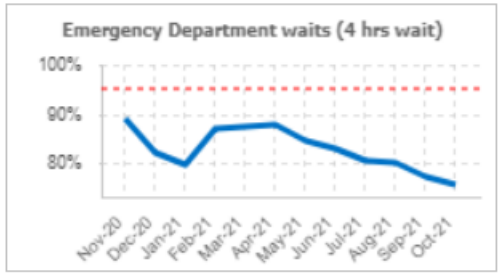
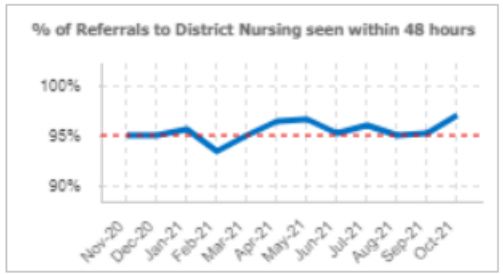
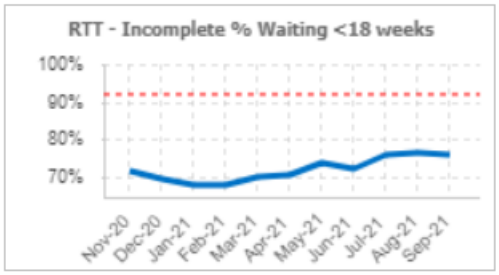
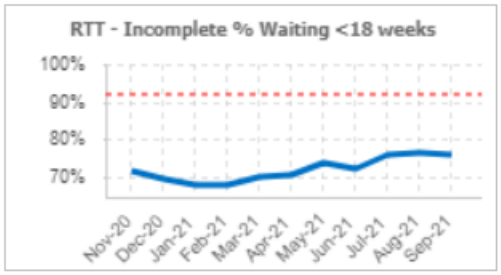
Summary

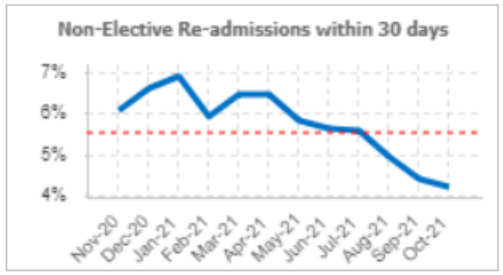
Category	Indicator	20_21 Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	2021-2022	
ED	Emergency Department waits (4 hrs wait)	>95%	88.8%	82.2%	79.8%	86.9%	87.6%	87.8%	84.7%	83.0%	80.5%	80.1%	77.4%	75.6%	81.3%	!
Cancer	Cancer - 14 days to first seen	>93%	95.4%	97.9%	91.2%	89.0%	91.9%	68.4%	75.0%	84.8%	81.4%	82.3%	79.3%		78.7%	!
Cancer	Cancer - 62 days from referral to treatment	>85%	67.8%	78.4%	67.4%	74.4%	77.5%	62.1%	71.1%	79.6%	71.4%	80.9%	64.9%		70.6%	!
Admitted	Non Elective Re-admissions within 30 days	<5.5%	6.04%	6.59%	6.93%	5.91%	6.45%	6.46%	5.83%	5.62%	5.56%	4.93%	4.40%	4.22%	5.31%	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<2.4%														
Access	RTT - Incomplete % Waiting <18 weeks	>92%	71.2%	69.3%	67.8%	67.6%	69.8%	70.5%	73.3%	71.9%	75.5%	76.1%	76.0%	76.7%	74.3%	!
Outpatients	Outpatients - FFT % Positive	>90%		96.6%	94.3%	96.9%	92.3%	89.5%	97.4%	97.0%	97.5%	97.7%	96.3%	75.0%	95.1%	
Community	Community - FFT % Positive	>90%		100.0%	98.0%	99.3%	99.6%	99.1%	99.1%	95.4%	97.1%	97.0%	95.1%	96.5%	96.7%	
Staff	Staff - FFT % Recommend Care	>70%		73.3%			77.3%			78.3%					78.3%	
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%	93.6%	84.9%	92.5%	95.8%	92.5%	85.2%	91.7%	100.0%	100.0%	100.0%	94.4%	100.0%	94.5%	
Community	% seen <=48 hours of Referral to District Nursing Service	>95%	95.1%	95.1%	95.6%	93.4%	95.0%	96.4%	96.7%	95.1%	96.1%	95.1%	95.2%	97.0%	95.9%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	93.9%	94.7%	95.1%	96.6%	91.4%	95.1%	93.5%	93.7%	94.1%	91.0%	91.5%		93.1%	!
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	94.2%	94.4%	96.5%	97.0%	98.4%	96.4%	96.1%	94.2%	95.2%	97.6%	94.4%		95.7%	

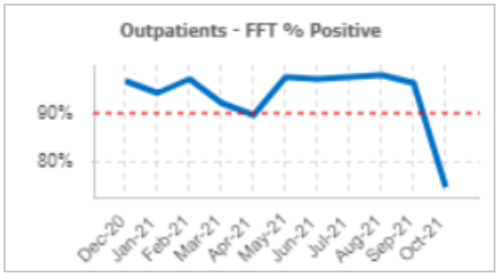












Safe | Caring | Effective | Responsive | Well Led

Indicator	20_21 Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	2021-2022	Performance
Admissions to Adult Facilities of pts under 16 yrs of age	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
HCAI C Difficile	<16	0	1	2	0	0	1	0	1	0	2	0	0	4	
Actual Falls	400	19	30	34	18	27	27	31	24	30	34	27	23	196	
Category 3 or 4 Pressure Ulcers	0	9	6	14	14	21	21	10	13	13	14	20	3	94	
Medication Errors causing serious harm	0	0	0	1	0	0	0	0	0	0	0	0	0	0	
MRSA Bacteraemia Incidences	0	0	0	1	0	1	0	0	0	0	0	0	0	0	
Never Events	0	0	0	0	0	0	0	0	0	0	1	0	1	2	
Serious Incidents	N/A	3	3	1	2	1	5	1	1	2	1	2	1	13	
VTE Risk Assessment %	>95%	76.4%	73.2%	66.4%	74.9%	76.9%	76.4%	73.1%	75.1%	73.9%	76.3%	77.0%	77.8%	75.6%	
Mixed Sex Accomodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	2	2	
Summary Hospital Level Mortality Indicator (SHMI)	1.14		0.87			0.84			0.85					0.85	

**Target has not been achieved for the past three months

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Category 3 or 4 Pressure Ulcers, Unstageable, Deep Tissue Injury and Devise Related Pressure Ulcers reported in 2021/2022 **Pan Trust Standard** 10% reduction in the total number of attributable PUs during 2020/21 compared to 2019/20 including a breakdown of Pressure Ulcers by category	**Variance against Plan:** 3 against 0 **Total Trust numbers of all reported Pressure Ulcers in October 2021:** 54 (+ 10 deep tissue injuries). A total number of 50 patients were affected. There was only 1 reported medical device related pressure ulcer. **Breakdown:** Category 2: 35 (15 in hospital, 20 in community) Category 3: 2 (hospital) Category 4: 1 (community) Unstageable: 16 (7 in hospital, 9 in community). Deep Tissue Injury: 10 (6 in hospital & 10 in community). 20 patients were affected in the hospital. 1 x category 3 was a medical device related pressure ulcer as result of proning secondary to Covid 19, the other pressure ulcer developed in a patient declining pressure relieving strategies. In the community setting 30 pressure ulcers and 5 deep tissue injuries developed, affecting 30 patients. The category 4 pressure ulcer to a deterioration of a pre-existing non-Whittington Health acquired category 3 pressure ulcer. **Action to Recover:** Learning and themes to to continue to be identified from ICSU investigated pressure ulcer investigations. The Pressure Ulcer Improvement plan continues with good progress of the work streams. The Trust Pressure Ulcer Prevention care plan has been modified to address learning from pressure ulcer incidents.	**Named Person:** Lead Specialist Nurse – Tissue Viability **Time Scale to Recover Performance:** April 2022

Never Events:	**Variance against Plan:** There was one never event declared in October 2021: 1. 2021.21349 Unintentional connection of a patient requiring oxygen to an air flowmeter	**Named Person:** Serious Incident Coordinator
VTE Risk Assessments:	**Update** Fourth month of modest improvement due to early QI work done by group but main change implemented 15/11/21 (transfer of recording of assessment from ICE to Careflow) expected to significantly improve performance.	**Named Person:** Associate Medical Director for Clinical Effectiveness and QI **Time Scale to Recover Performance:** Ongoing
Mixed Sex Accommodation Breaches:	**Variance against Plan:** 2 against 0 Both Trust breaches were reported on CCU: one being the inability to discharge a patient to an acute ward due to the shortage of an available bed, and the other caused by the lack of a speciality bed outside of the Trust.	**Named Person:** Deputy Chief Nurse **Time Scale to Recover Performance:** November 2021

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Indicator	20_21 Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	2021-2022	Performance
ED - FFT % Positive	>90%		86.0%	89.0%	87.6%	84.5%	83.9%	77.6%	76.1%	75.5%	77.8%	77.7%	78.0%	78.1%	
ED - FFT Response Rate	>15%		9.9%	10.8%	11.1%	10.1%	11.1%	11.0%	10.5%	11.0%	11.5%	10.6%	10.6%	10.9%	
Inpatients - FFT % Positive	>90%		98.6%	99.0%	98.0%	94.6%	95.9%	95.8%	95.2%	95.9%	96.4%	94.1%	94.7%	95.4%	
Inpatients - FFT Response Rate	>25%		8.3%	4.8%	12.6%	17.6%	17.0%	17.1%	15.1%	16.6%	13.8%	18.8%	18.1%	16.7%	
Maternity - FFT % Positive	>90%		99.1%	100.0%	100.0%	100.0%	98.5%	100.0%	99.6%	100.0%	100.0%		99.0%	99.6%	
Maternity - FFT Response Rate	>15%		9.3%	2.8%	8.2%	3.9%	10.2%	16.7%	22.3%	24.6%	2.2%	0.0%	16.1%	13.2%	
Outpatients - FFT % Positive	>90%		96.6%	94.3%	96.9%	92.3%	89.5%	97.4%	97.0%	97.5%	97.7%	96.3%	75.0%	95.1%	
Outpatients - FFT Responses	400	0	295	123	32	26	19	38	100	40	43	27	20	287	
Community - FFT % Positive	>90%		100.0%	98.0%	99.3%	99.6%	99.1%	99.1%	95.4%	97.1%	97.0%	95.1%	96.5%	96.7%	
Community - FFT Responses	1500	0	85	149	270	285	226	340	457	383	367	509	567	2849	
Staff - FFT % Recommend Care	>70%		73.3%			77.3%			78.3%					78.3%	
Complaints responded to within 25 or 40 working days	>80%	77.8%	80.0%	85.7%	76.2%	83.3%	78.3%	78.9%	80.0%	66.7%	66.7%	45.7%	63.0%	67.3%	
Complaints (including complaints against Corporate division)	N/A	9	15	7	21	24	23	19	35	24	36	35	27	199	

 **Target has not been achieved for the past three months

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
ED - FFT % Positive Response and Response Rate :	**Variance against Plan:** ED remains below target but is showing a slow but consistent improvement over the past four months for both response rate & positive responses **Action to Recover:** Plan to provide support from patient experience team continues	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** March 2022
Inpatients FFT Response Rate :	**Variance against Plan:** Response rate continues consistent upward trajectory overall; however, 4 areas still showing nil responses – Ifor, Mary Seacoles, Mercers & Victoria **Action to Recover:** Patient Experience team to provide support to areas with low/nil response rates NB good recovery from maternity services this month	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** January 2022
Community FFT Responses:	**Variance against Plan:** Community response rate remains very low against target (567 against 1500 target); response rate particularly poor for CYP & adult community nursing **Action to Recover:** QR codes to proceed for community FFT • The patient experience team have been able to recruit an additional volunteer to help uload paper FFT cards – long term approach is to have more accessible digital solutions	**Named Person:** Patient Experience Manager **Time Scale to Recover Performance:** March 2022
Complaints responded to within 25 or 40 days:	**Variance against Plan:** 63% against >80% The Trust had 31 complaints requiring a response in October 2021. Of these, 2 were de-escalated and 2 considered 'out-of-time' leaving 27 complaints with responses due out in October 2021 – with regard to the target of sending 80% of the responses on or before the due date, the Trust achieved a performance of 63% (17/27). **Action to Recover:**	**Named Person:** PALS & Complaints Manager

	Clinical staffing pressures and backlogs brought about by the pandemic, continue to impact on staff ability to investigate and provide timely responses to complaints, which has inevitably affected performance against the 80% target. However, the performance for October showed an upswing from 46% in September to 62%, therefore progress is being made to recover the position. The overall number of outstanding complaint responses is falling as ICSUs work through the backlog. The PALS team continue to work with complainants and ICSU colleagues to resolve as many concerns as possible in a timely manner without the need for a complaint investigation.	**Time Scale to Recover Performance:** December 2021

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Indicator	20_21 Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	2021-2022	Performance	
Hospital Cancelled Operations	0	1	2	0	0	1	0	6	7	4	4	16	15	37		!
Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	0	0	0	0	0	0		0		
Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0	0	0	0		0		
Theatre Utilisation	>85%	77.05%	75.13%	64.62%	50.19%	65.73%	68.80%	76.23%	75.13%	63.01%	63.23%	67.86%	69.25%	69.12%		!
Breastfeeding Initiated	>90%	93.0%	87.0%	92.6%	90.2%	93.5%	93.8%	91.9%	91.3%	90.2%	89.3%	91.5%	91.4%	91.4%		
Mortality rate per 1000 admissions in-months	14.4	6.7	11.9	28.2	11.7	4.2	6.9	4.8	6.8	8.0	8.8	7.3	8.1	7.2		
Community DNA % Rate	<10%	7.3%	7.7%	7.1%	6.7%	6.6%	6.6%	6.6%	7.2%	7.5%	8.2%	7.6%	7.0%	7.2%		
Community Services - Provider Cancellations	<8%	6.7%	8.5%	17.7%	7.7%	6.2%	6.6%	6.5%	7.3%	8.1%	7.6%	7.3%	7.6%	7.3%		
Acute DNA % Rate	<10%	8.8%	8.5%	8.3%	7.5%	8.1%	8.7%	9.2%	9.5%	10.3%	11.1%	11.3%	10.4%	10.1%		!
% e-Referral Service (e-RS) Slot Issues	<4%	28.7%	33.9%	27.4%	30.3%	44.2%	37.0%	29.7%	27.0%	31.1%	28.5%	35.7%	28.8%	30.9%		!
Outpatients New:FUp Ratio	2.3	1.96	1.95	2.05	1.93	1.93	1.93	1.87	1.86	1.87	1.84	1.76	1.70	1.83		
Delayed Transfers Of Care % of Occupied Bed Days	<2.4%															
Non Elective Re-admissions within 30 days	<5.5%	6.04%	6.59%	6.93%	5.91%	6.45%	6.46%	5.83%	5.62%	5.56%	4.93%	4.40%	4.22%	5.31%		
Rapid Response - % of referrals with an improvement in care		83.3%	84.7%	83.2%	85.5%	81.1%	84.7%	82.6%	84.3%	82.5%	83.3%	81.1%	80.4%	82.6%		

! **Target has not been achieved for the past three months

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Hospital Cancelled Operations:	**Variance against Plan:** 15 operations were cancelled on the day due to non-clinical reasons against a standard of zero. Reasons for cancellations: • Theatre staff not available : 10 • Surgeon unavailable : 4 (1 surgeon who was sick) • Anaesthetist unavailable : 1 Note: also collecting cancellations prospectively due to staffing issues from October 2021 **Action to Recover:** Ensuring that staffing is in place to undertake the scheduled lists checking lists in a number of days in advance and taking pro active action, which includes adjustment of theatre schedule where need be. Daily sit reps circulate to the senior management teams.	**Named Person:** GM Theatres & Critical Care **Time Scale to Recover Performance:** Review monthly, to recover end Feb 2022 once new theatre schedule in place.
Theatre Utilisation % Rates:	**Variance against Plan:** Utilisation is 69.25% against a standard of 85%, this is an increase from September 2021. Utilisation by speciality for October 2021 was: • Gen surgery 74% • T&O 71% • Urology 70% • Breast 69% • Anaesthetics 66% • Gynaecology 66% **Action to Recover:** There is a full theatre improvement plan which covers: recruitment, training, booking rates for admissions & POA, capacity & demand, safer staffing ratios, this continues to progress.	**Named Person:** GM Theatres & Critical Care **Time Scale to Recover Performance:** To increase utilisation by end of February 2022, with results of improvement plan

	Reduction in unused time at end of the session – making sure lists are fully booked. Plan devised to reduce a number of theatre lists, so that staffing is optimised then review in Feb/March 2022. Close management of bank and agency staff with Bankpartners so that as many theatre lists are booked as possible and avoid cancellations. Maximise patients sent to Independent sector as that is part of available Whittington Health capacity.	
Acute DNA % Rate:	**Variance against Plan:** 10.4% against <10% Acute DNA rates have decreased month-on-month for the first time since January 2021. Rates remain higher than the Plan as a result of continuously increasing face to face appointments and the impact of Covid 19. **Action to Recover:** This will continue to be monitored as part of the elective recovery programme.	**Named Person:** Head of Performance **Time Scale to Recover Performance:** Ongoing
Appointment Slot Issues:	**Variance against Plan:** Performace was at 28.8% against a target of <4%. There has been an improvement as services continue to reduce the number of patients waiting more than 13 weeks on the ASI list. There are 262 patients over 13 weeks, all of which are validated and being tracked to ensure patients receive their appointments in a timely way. There are no clinical concerns in this group of patients. **Action to Recover:** Data validation is ongoing to ensure the Trust maintains the 13 week target.	**Named Person:** Head of Performance **Time Scale to Recover Performance:** December 2021

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Indicator	Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	2021-2022	Performance
Emergency Department waits (4 hrs wait)	>95%	88.8%	82.2%	79.8%	86.9%	87.6%	87.8%	84.7%	83.0%	80.5%	80.1%	77.4%	75.6%	81.3%	
ED Indicator - median wait for treatment (minutes)	<60 mins	47	47	35	39	58	64	92	91	90	82	97	107	88	
Ambulance handovers waiting more than 30 mins	0	22	19	7	4	13	12	21	30	18	12	8	16	117	
Ambulance handovers waiting more than 60 mins	0	9	5	1	1	2	0	0	7	0	2	0	2	11	
12 hour trolley waits in A&E - Non Mental Health	0	0	2	10	0	0	0	0	0	0	0	1	1	2	
12 hour trolley waits in A&E - Mental Health	0	1	3	1	3	0	1	0	0	3	3	3	2	12	
Cancer - 14 days to first seen	>93%	95.4%	97.9%	91.2%	89.0%	91.9%	68.4%	75.0%	84.8%	81.4%	82.3%	79.3%		78.7%	
Cancer - 14 days to first seen - breast symptomatic	>93%	100.0%	100.0%	91.3%	60.0%	95.2%	62.5%	97.0%	88.9%	95.1%	97.6%	90.9%		92.9%	
Cancer - 62 days from referral to treatment	>85%	67.8%	78.4%	67.4%	74.4%	77.5%	62.1%	71.1%	79.6%	71.4%	80.9%	64.9%		70.6%	
Cancer ITT - Reallocated Breach Performance for 62 Day Pathways	>85%	66.7%	75.3%	63.8%	68.9%	77.1%	60.9%	68.9%	77.6%	67.3%	80.0%	65.3%		69.1%	
Cancer ITT - % of Pathways sent before 38 Days	>85%	76.9%	64.3%	36.4%	50.0%	60.0%	45.5%	44.4%	36.4%	14.3%	28.6%	44.4%		37.0%	
Cancer - % Pathways received a Diagnosis within 28 Days of Referral		78.8%	82.3%	71.6%	82.8%	83.4%	81.6%	82.8%	82.5%	81.1%	80.8%	72.6%		80.2%	
Cancer - 31 days to first treatment	>96%	96.9%	97.8%	100.0%	100.0%	100.0%	95.7%	100.0%	100.0%	100.0%	92.0%	95.6%		97.1%	
Cancer - 31 days to subsequent treatment - surgery	>94%														
Cancer - 62 Day Screening	>90%	100.0%	75.0%	100.0%	50.0%		100.0%	100.0%			100.0%	60.0%		80.0%	
DM01 - Diagnostic Waits (<6 weeks)	>99%	94.49%	92.54%	68.70%	81.96%	83.52%	92.23%	94.60%	93.73%	91.71%	92.17%	96.97%	98.96%	94.39%	
RTT - Incomplete % Waiting <18 weeks	>92%	71.2%	69.3%	67.8%	67.6%	69.8%	70.5%	73.3%	71.9%	75.5%	76.1%	76.0%	76.7%	74.3%	
Referral to Treatment 18 weeks - 52 Week Waits	0	379	507	793	1213	1324	1050	872	750	651	639	569	558	5089	
% seen <=2 hours of Referral to District Nursing Night Service	>80%	93.6%	84.9%	92.5%	95.8%	92.5%	85.2%	91.7%	100.0%	100.0%	100.0%	94.4%	100.0%	94.5%	
% seen <=48 hours of Referral to District Nursing Service	>95%	95.1%	95.1%	95.6%	93.4%	95.0%	96.4%	96.7%	95.1%	96.1%	95.1%	95.2%	97.0%	95.9%	
Haringey New Birth Visits - % seen within 2 weeks	>95%	93.9%	94.7%	95.1%	96.6%	91.4%	95.1%	93.5%	93.7%	94.1%	91.0%	91.5%		93.1%	
Islington New Birth Visits - % seen within 2 weeks	>95%	94.2%	94.4%	96.5%	97.0%	98.4%	96.4%	96.1%	94.2%	95.2%	97.6%	94.4%		95.7%	

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
ED - 4 Hour Wait Performance:	**Variance against Plan:** 75.6% against >95% The overall A&E performance for October 2021 was 75.6%, which is below the Trust's trajectory for the month but above both the national average at 73.90% and the NCL average at 72.55%. October saw 9432 presentations, similair to the same period in 2019, which was 9428 presentations. The volume of LAS conveyances was similar to the previous month (1511) which is 12% lower for this time of year. (-200 conveyances) Admission rates for conveyed patients however remains stable at 40%. Acuity in October was equally split between Majors and UTC the volume of Majors activity is above what is expected for in October (+400). The increased activity in Majors is solely driven by Paediatrics with 700 additional presentations when compared with the same period in 2019. **Action to Recover:** The Trust ran perfect weeks on the week of the 25th of October and the week of the 1st of November 2021. The primary forcus of the perfect weeks in ED was streaming. The first week saw a 28% increase in streaming to SDEC compared to previous week. Following on from this, the plan is to expand the direct referral list of symptoms to increase the scope of streaming to SDEC. As part of the Flow Improvement Programme, ED are focusing on streaming, redirection, optimising RAT and SDEC and escalation. As part of acute patient flow the focus is on criteria lead discagres and improved board rounds.	**Named Person:** ED General Manger **Time Scale to Recover Performance:** November/December
ED – 12 Hour Trolley Waits :	**Variance against Plan:** 3 against 0	**Named Person:** ED General Manager

	The month of October saw 1 acute and 2 mental health trolley breaches. The acute trolley breach was related to management of a complex spinal patient. The two mental health breaches were related to lack of bed availability. **Action to Recover:** 72 hour reports have been completed and action plans have been reviewed.	
Ambulance Hand Overs more than 30 minutes:	**Variance against Plan:** 16 against 0 There were 16x 30 minute breaches in October. **Action to Recover:** During the perfect weeks the service saw a LAS senior clinician working alongside the rapid assessment team reviewing handover processes with the aim of stream lining these process in the coming months. This includes changes to the infrastructure. The roll out of point of care (POC) COVID testing for the admission pathway is expected to be rolled out towards the end of November. Once rolled out the POC test will take 13 minutes to confirm COVID status compared to a minimum of 2 hours for the fast SAMBA test result. The ED and IPC teams are also working on rolling out of POC testing for high suspicious patients at the point of entry to enable efficient use of the Trust's isolation spaces and enable flow. Both these pathways are likely to have an impact on the LAS hand over times. The department has also reviewed the way data is collected on handover times to improve data quality. The Emergency department have reviewed their processes for the validation of LAS handover time (also referred to as offload time) due to changes in the handover processes during the COVID pandemic. Handover time is the time taken from the arrival of ambulance to the time	**Named Person:** ED General Manager **Time Scale to Recover Performance:** March 2022

	the patient is physically in a space within the Emergency department. Previously LAS handover time was validated based on time taken from Arrival to Triage. However, when it was not possible for the LAS to off load a patient into a space in ED, the clinicians in RAT would triage the patient while in ambulance. As a result of this, arrival to triage time did not reflect the true LAS handover time. In the current process when triage happens while patient is in the ambulance, this timed attendance activity is marked as triaged in LAS on careflow. When a space does become available, the patient is transferred to the allocated space and the is marked as another timed activity for the attendance. This data is used to validate against the data provided by LAS to ensure an accurate picture of handover times between LAS and Whittington Health. The validated data is sent back to LAS and the Trust information team.	
Ambulance Hand Overs more than 60 minutes:	**Variance against Plan:** 2 against 0 There were 2 LAS 60 minute breaches in the month of October. **Action to recover:** Please see action to recover LAS hand overs more than 30 minutes.	**Named Person:** ED General Manager **Time Scale to Recover Performance:** November/December
ED Indicator – median wait for treatment (minutes): <60 Minutes	**Variance against Plan:** 107 minutes against <60 Minutes The median time to treat was 107 minutes. This is a result of increased pressures in ED and downward flow. **Action to Recover:** The Flow Improvement Plan will seek to ensure median wait times do not increase and to keep any variance against plan to a minimum over the winter period.	**Named Person:** ED General Manager
Cancer Performance	**September Performance** **2WW Performance =** 79.3% against the standard of 93% • Continued 2WW capacity challenges across all tumour groups with breast & skin still experiencing high volumes of referrals • Extra clinic capacity conducted in colorectal & breast to accomade demand and minimise long waiters **Action to Recover:**	**Named Person:** GM Surgery & Cancer **Time Scale to Recover Performance:** Review Monthly

	• Alert to continue on colorectal to alert referrers, to manage demand and clear longwaiters and backlog • Extra clinics for pressured services short term in place • Project within the prostate service to improve the start of the 2WW pathway commencing December 2021 **28 day FDS Performance =** 71.7% against the standard of 83% • Capacity challenges within gynaecology, urology & colorectal reflected in performance **62 day Performance =** 65.3% against the standard of 85% • 37.5 treatments • 13 breaches **Action to Recover:** • Extra weekly results clinics in colorectal & urology for the next 6 - 12 weeks to meet the demand from referrals • Continued review of 62 and 104 day long waiters with prompt actions – challenging tumour groups urology & colorectal • Continued weekly senior review of cancer PTL • Continued escalation to Director of Operation with any items of concern n.b NCL to finalise Cancer Access policy by end of November 2021 – final comments and suggestions have been submitted for completion	
DM01 Diagnostics	**Update**: Performance against the national diagnostic waiting target for October 2021 has not been achieved. Performance was 98.96% against the 99% target which is an increase of 0.04% and closest performance the Trust has had since the start of the pandemic. Services continue to manage capacity to achieve DM01 diagnostic targets.	**Named Person:** Head of Performance **Time Scale to Recover Performance:** Ongoing
Referral to Treatment: **Incomplete % waiting < 18 weeks** **52 + week waits**	**Update:** Performance against the national standards for referral to treatment incomplete pathways below 18 weeks for September 2021 has not been achieved with performance at 76.7%. However this has improved by 0.7% since last month.	**Named Person:** Head of Performance **Time Scale to Recover Performance:** Ongoing

	At the end of October 2021 there were 558 patients waiting more than 52 weeks for treatment, a decrease of 11 from September 2021. The majority of patients are within the Surgery and Cancer ICSU, which has an ongoing plan to support compliance by the end of the financial year. **Action to Recover:** Ophthalmology patients waiting more than 52 weeks have been transferred to Moorfields. There are no 104-week breaches on the Trust PTL. As part of the H2 Elective Recovery, the Trust clock-stop position is compliant against the required threshold of 89%. This will be monitored on an ongoing basis as part of H2 Recovery. Performance for October including MSK and baseline is 96.4%. Excluding MSK is 109.4%.	
Haringey New Births Visits - % seen within 2 weeks	**Update:** There were 23 new birth visits not completed in timeframe in September in Haringey. The reasons for most late visits were parental choice or a baby being in hospital at day 14. Service leads are reviewing records to identify how more visits can be completed within target timeframe and working to ensure the approach to contacting families is consistent across teams. The number of late new births due to parental choice is expected to decrease over the coming months as system changes are embedded.	**Named Person:** Director of Operations, CYP

Indicator	20_21 Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	2021-2022	Performance
Appraisals % Rate	>90%	65.9%	67.0%	66.6%	66.2%	66.9%	69.9%	71.9%	70.6%	70.1%	70.1%	65.3%	66.0%	69.2%	
Mandatory Training % Rate	>90%	78.7%	76.0%	75.6%	76.2%	76.6%	75.3%	75.5%	76.1%	76.8%	74.7%	77.3%	78.8%	76.4%	
Permanent Staffing WTEs Utilised	>90%	88.3%	88.3%	88.6%	89.0%	89.1%	88.1%	88.7%	88.0%	87.6%	87.7%	88.1%	88.6%	88.1%	
Staff FFT % recommended work	>50%		66.3%			68.6%			62.6%					62.6%	
Staff FFT response rate	>20%		50.6%			6.6%			18.4%					18.4%	
Staff sickness absence %	<3.5%	4.00%	4.22%	5.62%	3.98%	3.46%	3.43%	3.82%	4.33%	4.12%	4.20%	4.34%		4.19%	
Staff turnover %	<13%	11.2%	10.0%	9.9%	10.0%	9.9%	10.2%	11.1%	11.0%	12.8%	11.6%	14.3%	11.9%	11.8%	
Vacancy % Rate against Establishment	<10%	11.7%	11.7%	11.4%	11.0%	10.9%	11.9%	11.3%	12.0%	12.4%	12.3%	11.9%	11.4%	11.9%	
Average Time to Hire (Days)	<63 Days	69	59	58	58	62	62	62	60	62	64	63	59	62	
Nursing Staff Average % Day Fill Rate - Nurses		83.4%	88.3%	89.7%	89.4%	85.0%	67.8%	93.9%	95.9%	95.3%	92.4%	83.8%	74.9%	84.2%	
Nursing Staff Average % Night Fill Rate - Nurses		88.7%	94.1%	93.2%	100.3%	95.5%	66.0%	91.4%	95.2%	94.5%	94.1%	91.3%	81.8%	85.2%	
Safe Staffing Alerts - Number of Red Shifts		3			19	16	5	8	5	3	33	33	36	123	
Safe Staffing - Overall Care Hours Per Patient Day (CHPPD)		10.9	10.4	9.2	10.7	10.9	5.9	10.1	9.9	10.0	11.0	11.7	9.1	9.2	

**Target has not been achieved for the past three months

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Appraisals % Rate :	**Variance against Plan: 66.0% against >90%** This is a slight improvement on the October report. **Action to Recover:** Work on bringing appraisals into elev8 continues and some success has been achieved, however, more work is required to simplify the solution for users.	**Named Person:** Assistant Director, Learning & Organisational Development **Time Scale to Recover Performance:** April 2022
Mandatory Training % Rate :	**Variance against Plan: 78.8% against >90%** This is an improvement of 1.5% on the October report. **Action to Recover:** elev8 is now live and those who have logged in to complete mandatory training praise the system. It is thought that once the message on the ease of navigation and use is shared, more people will manage the minor challenge of logging in and compliance will continue to rise. It should be noted that a recent review on whether to continue with face-to-face training advised specific courses be run virtually such as Safeguarding Adults and Conflict Management. Clinical training such as Moving and Handling, Resus and Basic Life Support needs to be delivered face-to-face and are challenged by the late opening of the WEC.	**Named Person:** Assistant Director, Learning & Organisational Development **Time Scale to Recover Performance:** April 2022 Given the need to prevent COVID outbreaks by delivering as much training virtually, and the accommodation delays, also impacts on the timescales for the delivery of those programmes that mus be delivered in person.
Permanent Staffing WTEs Utilised:	**Variance against Plan: 88.6% against > 90%** **Action to Recover:** Second month where there has been a marginal increase in permanent staffing utilised. The sector remains unstable and work continues across NCL to stabilise.	**Named Person:** Acting Deputy Director of Workforce **Time Scale to Recover Performance:** January 2022

Staff Sickness Absence %:	**Variance against Plan: 4.34% against < 3.5%** **Action to Recover:** Absence rate has increased by 0.14% from last month and continues to be above Trust target. This continues to be monitored. Recovery is a main focus, which includes support to staff at work who are already fatihued to help moving into winter.	**Named Person:** Acting Deputy Director of Workforce **Time Scale to Recover Performance:** January 2022
Staff Turnover Rates %:	**Variance against Plan: 11.9% against < 13%** **Action to Recover:** Turnover rate has dropped by 2.4% from last month and is now under the Trust target. This will continue to be monitored along side the vacancy rates.	**Named Person:** Acting Deputy Director of Workforce **Time Scale to Recover Performance:** January 2022
Vacancy Rates %:	**Variance against Plan: 11.4% against < 10%** **Action to Recover:** Vacancy rate has decreased slightly from last month but is still over the Trust target. NCL continues to see a higher rate of vacancies and hard to fill posts. This will be monitored along side the turnover rates.	**Named Person:** Acting Deputy Director of Workforce **Time Scale to Recover Performance:** January 2022
Safer Staffing **Aim for:** Zero Red shifts Trust CHPPD 9.6* *Peer Trusts Median (March 2021)	**Variance against Plan:** 36 shifts were reported as Red in October 21, and this represents an increase compared to previous months. Emergency and Integrated Medicine ICSU had 31 red shifts across several areas with Nightingale being the most challenged setting. 5 red shifts were recorded in Surgery & Cancer (Coyle ward). The main reasons for staffing challenges were sickness, unfilled vacant shifts with temporary staff, inadequate sourcing of additional staff due to poor staff availability for escalation beds and to cover for enhanced care and increased acuity. Care Hours per Patient Day (CHPPD) in Oct 21 reduced to 9.1 which is close to the median figure of Peer Trusts. The average CHPPD on the adult wards was 8. Fill rate for registered staff corelates with the number of red shifts.	**Named Person:** Lead Nurse for Safer Staffing

	The fill rate for unregistered staff exceeds 100% and is associated with enhanced care requirement as well as partial cover of some nursing vacant shifts. **Action to Recover:** • Senior Staff continue to monitor the number of the Red shifts and address high risk staffing issues as recommended in the Staffing Escalation policy. • Safer Staffing reviews are completed, and recommendations are being put forward to make changes to the establishment of a few clinical settings including ITU, and Nightingale ward. • Recruitment is ongoing for all nursing staff. Lead Nurse for Safer Staffing continues to monitor the activity of the wards and assess effectiveness of staff deployment	**Time Scale to Recover** **Performance:** Ongoing

Appendix 1. Community Performance Dashboard

Indicator	20_21 Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	2021-2022	Performance
IAPT Moving to Recovery	>50%	49.1%	51.1%	50.5%	48.1%	45.0%	51.8%	49.6%	54.7%	54.8%	51.3%	53.4%		52.5%	
IAPT Waiting Times for Treatment (% < 6 wks)	>75%	94.5%	94.6%	96.2%	92.2%	92.5%	94.2%	88.8%	92.6%	91.9%	92.1%	94.6%		92.3%	
Haringey - 8wk Review % carried out before child aged 8 weeks	N/A	84.7%	86.4%	80.0%	88.8%	92.3%	79.2%	85.3%	80.7%	86.7%	81.7%	78.3%		82.0%	
Haringey - HR1 % carried out before child aged 15 months	N/A	71.9%	73.2%	68.2%	81.5%	81.9%	79.0%	77.3%	76.6%	75.2%	74.0%	73.0%		75.9%	
Haringey - HR2 % carried out before child aged 30 months	N/A	58.4%	69.1%	70.1%	67.9%	70.1%	73.0%	72.4%	71.3%	75.0%	77.1%	76.4%		74.0%	
Islington - 8wk Review % carried out before child aged 8 weeks	N/A	89.9%	93.9%	87.5%	94.5%	90.7%	91.1%	92.8%	89.6%	87.1%	87.5%	86.5%		89.2%	
Islington - HR1 % carried out before child aged 15 mths	N/A	78.3%	83.7%	82.2%	82.4%	84.3%	79.6%	79.4%	85.0%	86.2%	86.3%	87.4%		83.9%	
Islington - HR2 % carried out before child aged 30 mths	N/A	76.8%	82.4%	81.1%	81.3%	81.6%	79.1%	83.1%	76.5%	82.5%	78.2%	77.0%		79.3%	
% of MSK pts with a significant improvement in function (PSFS)	>75%	88.2%	94.4%	100.0%		66.7%	100.0%	88.2%	89.5%	91.1%	89.7%	90.6%	93.8%	91.0%	
% of Podiatry pts with a significant improvement in pain (VAS)	>75%	100.0%	100.0%					100.0%	100.0%	92.3%	66.7%	100.0%	100.0%	94.7%	
ICTT - % Patients with self-directed goals set at Discharge	>70%	81.7%	74.8%	83.6%	70.7%	81.8%	83.8%	71.7%	78.0%	71.0%	79.3%	80.6%	77.0%	77.2%	
ICTT - % GAS Scores improved or remained the same at Discharge	>70%	92.1%	94.4%	92.2%	93.6%	91.7%	90.9%	94.4%	92.2%	93.9%	93.8%	96.3%	93.0%	93.3%	
REACH - % BBIC Scores improved or remained the same at Discharge	>75%	87.5%	85.7%	66.7%	100.0%	100.0%	100.0%	85.7%	85.7%	0.0%	100.0%	88.9%	50.0%	68.9%	
Nutrition and Dietetics - % Weight Loss Achieved at Discharge	>65%	66.7%	100.0%	100.0%			0.0%	50.0%	50.0%	100.0%	100.0%	100.0%	28.6%	55.6%	
Nutrition and Dietetics - % Weight Maintained or Gained at Discharge	>70%	100.0%	100.0%	100.0%	80.0%	83.3%	92.3%	88.9%	92.9%	85.7%	100.0%	100.0%	85.7%	91.7%	
Hackney Smoking Cessation: % who set quit date & stopped after 4 we...	>45%		59.3%			68.0%			183.9%			181.9%		183.0%	
Islington Self-Management - Average Increase in PAM Score	>=9														
Haringey Self-Management - Average Increase in PAM Score	>=9														

Indicator and Definition	Commentary and Action Plan	Named Person & Date Performance will Recover
Children community waiting times	**Islington Community Child and Adolescent Mental Health Services (CAMHS):** The service continues to see an increase in waiting times in some CAMHS services, specifically in the Trust's specialist CAMHS Therapy Teams and in the Neuro Developmental Pathway, both of which have recovery plans in place and additional funding has been secured to increase capacity. Primarily this is a combination of, increased numbers of referrals and recruitment pressures. Important to note that the vast majority of CAMHS services particularly those delivered in co located settings continue to deliver services within 8 weeks. **Islington Children Looked After (CLA):** Increase in waiting times due to a number of new Unidentified Adolescent Asylum Seekers (UAAS) due to refugee hotel in Islington this increase in referral is being discussed with CCG re additional funding which is ongoing. There has also been an increase in demand for Initial Health Assessment (IHA) for CYP who are placed out of borough. Alternative options are being reviewed, including telehealth and greater liaison with out of borough areas. **Islington Community Paediatrics:** Increase in waiting times this month due to ongoing long-term sickness with one full-time consultant, we are working to ensure cover for all urgent clinics. **Islington Occupational Therapy (OT):** We have secured additional OT capacity and should see the backlog reduce in line with agreed accelerated recovery trajectory. **Islington Social Communication Team (SCT):** Waiting times for SCT – autism have started to reduce due to ongoing use of blended offer for assessment and intervention, current waiting time is now 30 weeks. **Islington Dieteics:**	**Named person:** Director Operations CYP

	This service is on the risk register due to ongoing vacancies. Posts are in the process of being readvertised. All urgent clinics are covered within 2 weeks. **Islington Children's Community Nursing:** Waiting times reflect patient choice around when they are available for home visits. No other issues identified. **Haringey Community Paediatrics:** Waits for Neuro-developomental clinics have lengthened due to a reduction in staff available for clinics. The team continue to prioritise urgent referrals. Some additional temporary staffing is now in place and this should relieve some of the current pressure. **Haringey Community Paediatrics – SCC (Autism Assessment):** The impact of covid-19 continues to exacerbate existing challenges for this service. The long waits have been described as 'unacceptable' in the July 2021 Haringey SEND inspection report and providers and commissioners are working to reduce waits. Some short term funding has been allocated to help reduce long waits, the impact of this will be seen by March 2022. **Haringey Speech and Language Therapy (SLT):** Waits for initial appointments and provision of therapy in SLT continue to be challenging. Short term funding has been allocated to reduce waits and the teams are working to secure temporary staff to deliver additional blocks of therapy for children and young people. WH service leads are working with partners in the Council and CCG to develop a longer term plan for meeting speech, language and communication needs in Haringey. **Haringey Occupational Therapy (OT):** The OT service continues to experience longer waiting times due to gaps/changes in staffing and an increase in Education Healht and Care Plan (EHCP) advice requests. A plan is in place to address long waits and the impact of this will be seen by February 2022.	

Adult community waiting times	**Overall summary:** Focus of 4 key areas for recovery: MSK, Podiatry, Pulmonary Rehabiliation (PR) and Diabates Desmond programme. **MSK:** The service continues to experience wporkforce issues which has led to a slight deterioration in the waiting times and an slowing down related to clearing the backlog. However, 5 new members of staff started in October. They are currently being inducted and will improve the position buy December 2021 when there will be an improving picture. The plan is to clear the backlog by by March 2022. Average waiting time: • CATS – 9.9, down from 8.9 weeks in October • Routine – 8.4, down from 7.6 weeks in October **Podiatry:** Workforce issues continue to be the main issue with this service. Which means the waiting times to be seen have remainly largely unchanged to last month. The backlog continues to be addressed but an increase of 18 patients waiting for more than 12 weeks. All priority patients are being seen and the services is looking at innovative solutions such as groups on how to manage fungal infections. The services is also undergoing a redesign to improve productivity. Average waiting time : 8.4, marginally down from 8.5 weeks in October **Pulmonary Rehabilitation:** The respiratory service is back to pre covid state except for reduced numbers in group PR sessions. It is unlikely the backlog of PR will be cleared until end of March 2022. Average waiting time: 25.4 down from 32.8weeks in October. **Desmond:** Backlog now cleared. Additional virtual sessions at the weekend have helped to clear backlog.	**Named person:** Director of Operations, ACS

	Average waiting time : 4.1 down from 3.5 weeks in October **BBIC:** These patients are patients who have been stepped down and have no rehabilitaion goals. We may need to consider taking these patients out of the denomoinator **% Improvement on Weight Loss:** These are comparitively small numbers compared to pre pandemic. ie 3 in july, aug and sept and only 7 in Oct. We are picking up patienst from pre pandemic who have had no continuity and have strugglesd to continue their plan. We are about to restart group sessions for 6 weeks concurrently which we hope to imporve the outcome measures.	

Appendix 2. Community Waiting Times Dashboard

	ROUTINE REFERRALS							URGENT REFERRALS						
SERVICE	% Threshold	Target Weeks	Aug-21	Sep-21	Oct-21	Avg Wait (Oct)	No. of Pts Seen	% Threshold	Target Weeks	Aug-21	Sep-21	Oct-21	Avg Wait (Oct)	No. of Pts Seen
CAMHS	>95%	8	73.4%	66.0%	54.1%	10.5	74	>95%	2	100.0%	83.3%	80.0%	1.0	5
Child Development Services	>95%	12	100.0%	100.0%	100.0%	0.4	3	>95%	2		100.0%		-	0
IANDS	>95%	18	81.7%	73.1%	73.6%	13.1	110	>95%	-				-	0
Community Children's Nursing	>95%	2	69.7%	77.6%	70.2%	1.9	94	>95%	1	95.2%	83.3%	91.3%	0.4	23
Community Paediatrics Services	>95%	18	55.2%	60.2%	60.2%	16.9	83	>95%	-				16.9	0
Family Nurse Partnership	>95%	12	80.0%	87.5%	100.0%	2.9	5	>95%	-		-		-	0
Haematology Service	>95%	-				-	0	>95%	-				-	0
Looked After Children	>95%	4	84.6%	52.4%	65.2%	3.0	23	>95%	-				-	0
Occupational Therapy	>95%	18	25.0%	70.0%	42.1%	19.6	19	>95%	-				-	0
Physiotherapy	>95%	18	100.0%	98.4%	100.0%	6.6	73	>95%	-				-	0
PIPS	>95%	12	100.0%	100.0%	100.0%	3.7	14	>95%	-				-	0
School Nursing	>95%	12	73.5%	73.2%	92.4%	2.4	105	>95%	-				-	0
Speech and Language Therapy	>95%	8	44.0%	63.5%	74.3%	9.4	144	>95%	2	33.3%	28.6%	0.0%	25.6	2
Bladder and Bowel - Children	>95%	-				-	0	>95%	-				-	0
Community Matron	>95%	6	100.0%	96.0%	93.5%	1.3	31	>95%	-				-	0
Adult Wheelchair Service	>95%	8	100.0%	100.0%	100.0%	1.7	30	>95%	2	50.0%	100.0%	100.0%	0.0	4
Community Rehabilitation (CRT)	>95%	12	96.7%	85.3%	88.0%	5.1	92	>95%	2	63.3%	64.7%	50.0%	5.9	14
ICTT - Other	>95%	12	85.0%	72.3%	74.3%	6.1	175	>95%	2	55.6%	52.0%	55.1%	2.2	69
ICTT - Stroke and Neuro	>95%	12	50.0%	36.7%	57.9%	8.8	19	>95%	2	11.8%	37.5%	27.6%	2.8	29
Home-based Intermediate Care Se...	>95%	-	66.2%	38.0%	35.5%	10.9	62	>95%	-				-	0
Community Bed-based Intermediat...	>95%	6	77.8%	100.0%	100.0%	0.0	3	>95%	-				-	0
Paediatric Wheelchair Service	>95%	8	100.0%	100.0%	100.0%	3.5	4	>95%	-				-	0
Bladder and Bowel - Adult	>95%	12	81.8%	63.4%	62.1%	9.4	116	>95%	2	0.0%			-	0
Musculoskeletal Service - CATS	>95%	6	29.5%	24.3%	34.8%	9.7	368	>95%	2	17.6%	21.2%	5.0%	5.8	20
Musculoskeletal Service - Routine	>95%	6	36.2%	39.9%	37.3%	7.9	1094	>95%	2	6.5%	19.2%	15.2%	4.2	33
Nutrition and Dietetics	>95%	6	49.2%	70.0%	60.4%	6.7	144	>95%	2	100.0%	100.0%	100.0%	0.0	2
Podiatry (Foot Health)	>95%	6	59.2%	27.7%	27.7%	8.5	289	>95%	2	0.0%	0.0%		-	0
Lymphodema Care	>95%	6	100.0%	100.0%	100.0%	2.2	17	>95%	-				-	0
Tissue Viability	>95%	6	98.1%	100.0%	98.0%	2.3	50	>95%	-				-	0
Cardiology Service	>95%	6	100.0%	100.0%	100.0%	2.3	22	>95%	2	100.0%		66.7%	2.1	6
Diabetes Service	>95%	6	97.8%	96.7%	94.1%	4.5	68	>95%	-				-	0
Respiratory Service	>95%	6	66.7%	94.9%	51.7%	18.5	60	>95%	2		100.0%		-	0
Spirometry Service	>95%	6	100.0%	95.2%	94.0%	3.8	50	>95%	-				-	0

Appendix 2. Community Waiting Times Dashboard

Haringey

	ROUTINE REFERRALS							URGENT REFERRALS						
SERVICE	% Threshold	Target Weeks	Aug-21	Sep-21	Oct-21	Avg Wait (Oct)	No. of Pts Seen	% Threshold	Target Weeks	Aug-21	Sep-21	Oct-21	Avg Wait (Oct)	No. of Pts Seen
CAMHS	>95%	8	100.0%	100.0%	0.0%	30.1	1	>95%	-				-	0
Child Development Services	>95%	12	100.0%	100.0%	100.0%	0.4	3	>95%	2		100.0%		-	0
IANDS	>95%	18	100.0%	100.0%	100.0%	0.7	1	>95%	-				-	0
Community Children's Nursing	>95%	2	100.0%	87.5%	84.6%	1.0	13	>95%	1			100.0%	0.1	2
Community Paediatrics Services	>95%	18	48.9%	48.5%	53.4%	19.9	58	>95%	-				19.9	0
Family Nurse Partnership	>95%	-				-	0	>95%	-		-		-	0
Haematology Service	>95%	-				-	0	>95%	-				-	0
Looked After Children	>95%	4	75.0%	42.9%	70.0%	3.1	10	>95%	-				-	0
Occupational Therapy	>95%	18	30.0%	68.4%	41.2%	20.2	17	>95%	-				-	0
Physiotherapy	>95%	18	100.0%	98.3%	100.0%	6.7	71	>95%	-				-	0
PIPS	>95%	12	100.0%	100.0%	100.0%	4.2	12	>95%	-				-	0
School Nursing	>95%	12	85.2%	78.0%	84.2%	4.5	38	>95%	-				-	0
Speech and Language Therapy	>95%	8	21.5%	28.2%	46.4%	12.4	56	>95%	2	33.3%	28.6%	0.0%	25.6	2
Bladder and Bowel - Children	>95%	-				-	0	>95%	-				-	0
Community Matron	>95%	6	100.0%		100.0%	0.0	1	>95%	-				-	0
Adult Wheelchair Service	>95%	8	100.0%	100.0%	100.0%	1.8	29	>95%	2	50.0%	100.0%	100.0%	0.0	4
Community Rehabilitation (CRT)	>95%	12	100.0%	100.0%	100.0%	4.4	1	>95%	2		0.0%		-	0
ICTT - Other	>95%	12	84.6%	72.7%	73.5%	6.2	162	>95%	2	56.6%	50.0%	58.1%	2.2	62
ICTT - Stroke and Neuro	>95%	12	52.0%	37.0%	58.8%	8.4	17	>95%	2	6.7%	37.5%	26.9%	2.8	26
Home-based Intermediate Care Se...	>95%	-	0.0%		0.0%	25.1	1	>95%	-				-	0
Community Bed-based Intermediat...	>95%	-				-	0	>95%	-				-	0
Paediatric Wheelchair Service	>95%	8	100.0%	100.0%	100.0%	3.5	4	>95%	-				-	0
Bladder and Bowel - Adult	>95%	12	71.8%	60.9%	50.0%	10.6	46	>95%	-				-	0
Musculoskeletal Service - CATS	>95%	6	33.0%	25.5%	39.3%	9.4	219	>95%	2	12.5%	20.0%	14.3%	5.1	7
Musculoskeletal Service - Routine	>95%	6	33.5%	37.7%	36.0%	8.3	606	>95%	2	7.7%	21.3%	11.1%	5.3	18
Nutrition and Dietetics	>95%	6	48.7%	68.4%	60.7%	7.0	84	>95%	2	100.0%	100.0%		-	0
Podiatry (Foot Health)	>95%	6	60.3%	20.4%	25.9%	8.5	135	>95%	2	0.0%	0.0%		-	0
Lymphodema Care	>95%	6	100.0%	100.0%	100.0%	2.1	11	>95%	-				-	0
Tissue Viability	>95%	6	96.8%	100.0%	97.0%	2.3	33	>95%	-				-	0
Cardiology Service	>95%	6	100.0%	100.0%	100.0%	1.7	13	>95%	-				-	0
Diabetes Service	>95%	6	98.4%	100.0%	93.9%	4.6	49	>95%	-				-	0
Respiratory Service	>95%	6	68.0%	100.0%	37.9%	22.2	29	>95%	2		100.0%		-	0
Spirometry Service	>95%	6	100.0%	95.0%	93.9%	3.8	49	>95%	-				-	0

Appendix 2. Community Waiting Times Dashboard

Islington

	ROUTINE REFERRALS							URGENT REFERRALS						
SERVICE	% Threshold	Target Weeks	Aug-21	Sep-21	Oct-21	Avg Wait (Oct)	No. of Pts Seen	% Threshold	Target Weeks	Aug-21	Sep-21	Oct-21	Avg Wait (Oct)	No. of Pts Seen
CAMHS	>95%	8	73.3%	66.0%	52.9%	10.6	70	>95%	2	100.0%	83.3%	100.0%	0.6	4
Child Development Services	>95%	-				-	0	>95%	-				-	0
IANDS	>95%	18	80.9%	71.4%	73.8%	13.3	103	>95%	-				-	0
Community Children's Nursing	>95%	2	70.0%	76.7%	68.4%	2.0	76	>95%	1	95.2%	80.0%	88.9%	0.4	18
Community Paediatrics Services	>95%	18	81.8%	93.3%	73.9%	10.5	23	>95%	-				10.5	0
Family Nurse Partnership	>95%	12	80.0%	87.5%	100.0%	2.9	5	>95%	-				-	0
Haematology Service	>95%	-				-	0	>95%	-				-	0
Looked After Children	>95%	4	85.7%	71.4%	58.3%	3.2	12	>95%	-				-	0
Occupational Therapy	>95%	-				-	0	>95%	-				-	0
Physiotherapy	>95%	18	100.0%	100.0%	100.0%	4.3	2	>95%	-				-	0
PIPS	>95%	12	100.0%			-	0	>95%	-				-	0
School Nursing	>95%	12	50.0%	60.6%	98.0%	0.9	49	>95%	-				-	0
Speech and Language Therapy	>95%	8	82.9%	93.9%	93.3%	6.5	75	>95%	-				-	0
Bladder and Bowel - Children	>95%	-				-	0	>95%	-				-	0
Community Matron	>95%	6	100.0%	96.0%	92.9%	1.4	28	>95%	-				-	0
Adult Wheelchair Service	>95%	8	100.0%	100.0%		-	0	>95%	-				-	0
Community Rehabilitation (CRT)	>95%	12	96.4%	84.1%	90.4%	4.8	83	>95%	2	60.7%	65.6%	53.8%	5.3	13
ICTT - Other	>95%	12	100.0%	75.0%	90.0%	3.7	10	>95%	2	25.0%	50.0%	0.0%	4.0	2
ICTT - Stroke and Neuro	>95%	12	50.0%	50.0%	100.0%	12.0	1	>95%	2	0.0%	-	100.0%	1.3	1
Home-based Intermediate Care Se...	>95%	-	68.1%	37.3%	35.1%	10.8	57	>95%	-				-	0
Community Bed-based Intermediat...	>95%	6	77.8%	100.0%	100.0%	0.0	2	>95%	-				-	0
Paediatric Wheelchair Service	>95%	-				-	0	>95%	-				-	0
Bladder and Bowel - Adult	>95%	12	86.2%	64.4%	70.6%	8.7	68	>95%	2	0.0%			-	0
Musculoskeletal Service - CATS	>95%	6	26.0%	22.8%	28.0%	10.0	143	>95%	2	12.5%	22.2%	0.0%	6.2	13
Musculoskeletal Service - Routine	>95%	6	38.2%	41.7%	38.5%	7.4	449	>95%	2	5.9%	19.1%	27.3%	2.6	11
Nutrition and Dietetics	>95%	6	48.6%	74.0%	58.6%	6.3	58	>95%	2	100.0%	100.0%	100.0%	0.0	1
Podiatry (Foot Health)	>95%	6	58.4%	33.7%	30.3%	8.1	145	>95%	-				-	0
Lymphodema Care	>95%	6	100.0%	100.0%	100.0%	2.4	6	>95%	-				-	0
Tissue Viability	>95%	6	100.0%	100.0%	100.0%	2.4	16	>95%	-				-	0
Cardiology Service	>95%	6	100.0%	100.0%	100.0%	3.1	9	>95%	2	100.0%		66.7%	2.1	6
Diabetes Service	>95%	6	96.7%	86.7%	100.0%	4.0	18	>95%	-				-	0
Respiratory Service	>95%	6	65.2%	90.0%	65.5%	14.6	29	>95%	-				-	0
Spirometry Service	>95%	6	100.0%	100.0%	100.0%	3.0	1	>95%	-				-	0

Children's Community Waits Performance

SERVICE	ROUTINE REFERRALS							URGENT REFERRALS						
	% Threshold	Target Weeks	Aug-21	Sep-21	Oct-21	Avg Wait (Oct)	No. of Pts Seen	% Threshold	Target Weeks	Aug-21	Sep-21	Oct-21	Avg Wait (Oct)	No. of Pts Seen
CAMHS	>95%	8	73.4%	66.0%	54.1%	10.5	74	>95%	2	100.0%	83.3%	80.0%	1.0	5
Community Children's Nursing - Haringey	>95%	2		66.7%	100.0%	0.9	4	>95%	1				-	0
Community Children's Nursing - Islington	>95%	2	69.7%	77.9%	68.9%	1.9	90	>95%	1	95.2%	83.3%	91.3%	0.4	23
Community Paediatrics - Haringey (SCC)	>95%	18				-	0	>95%	1				-	0
Community Paediatrics - Haringey (NDC)	>95%	18	38.1%	37.0%	21.4%	22.0	14	>95%	-				-	0
Community Paediatrics - Haringey (Child Protection)	>95%	18	100.0%	100.0%	100.0%	0.6	16	>95%	-				-	0
Community Paediatrics - Haringey (Other)	>95%	18		100.0%	100.0%	0.6	8	>95%	-				-	0
Community Paediatrics - Islington	>95%	18	90.9%	92.3%	78.9%	10.1	19	>95%	-				-	0
Family Nurse Partnership - Islington	>95%	12	80.0%	87.5%	100.0%	2.9	5	>95%	-				-	0
Haematology Service - Islington	>95%	-				-	0	>95%	-				-	0
IANDS	>95%	18	100.0%	93.8%	92.3%	6.8	13	>95%	-				-	0
IANDS - SCT	>95%	20	9.1%	3.7%	0.0%	32.9	21	>95%	-				-	0
Looked After Children - Haringey	>95%	4	88.9%	45.5%	70.0%	3.1	10	>95%	-				-	0
Looked After Children - Islington	>95%	4	87.5%	75.0%	61.5%	3.0	13	>95%	-				-	0
Occupational Therapy - Haringey	>95%	18	25.0%	70.0%	42.1%	19.6	19	>95%	-				-	0
Occupational Therapy - Islington	>95%	18	0.0%	0.0%	25.0%	23.7	8	>95%	-				-	0
Paediatrics Nutrition and Dietetics - Haringey	>95%	12		100.0%	100.0%	0.4	1	>95%	2				-	0
Paediatrics Nutrition and Dietetics - Islington	>95%	12	88.2%	85.7%	85.7%	10.3	7	>95%	2				-	0
Physiotherapy - Haringey	>95%	18	100.0%	98.4%	100.0%	6.6	73	>95%	-				-	0
Physiotherapy - Islington	>95%	18	100.0%	96.5%	100.0%	7.1	56	>95%	-				-	0
PIPS	>95%	12	100.0%	100.0%	100.0%	3.7	14	>95%	-				-	0
SALT - Haringey	>95%	13	21.6%	37.0%	51.0%	12.1	49	>95%	2	33.3%	28.6%	0.0%	25.6	2
SALT - Islington	>95%	13	88.0%	97.4%	91.9%	6.6	62	>95%	-				-	0
SALT - MPC	>95%	18	76.9%	58.6%	91.7%	9.0	24	>95%	-				-	0
School Nursing - Haringey	>95%	12	87.1%	79.4%	84.4%	4.5	45	>95%	-				-	0
School Nursing - Islington	>95%	12	43.8%	60.6%	98.3%	0.8	59	>95%	-				-	0

Appendix 3. Cancer Performance - 62D and 2WW by Tumour Group

Cancer - 62D Performance by Tumour Group

Indicator	20_21 Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	2021-2022	Performance
Breast	>85%	54.5%	72.7%	75.0%	100.0%	66.7%	50.0%	86.7%	100.0%	57.1%	76.5%	25.0%		65.0%	
Gynaecological	>85%	0.0%	0.0%	0.0%	100.0%	33.3%	100.0%	100.0%	0.0%	0.0%	0.0%	50.0%		45.5%	
Haematological (Excluding Acute Leukaemia)	>85%	100.0%	100.0%	100.0%		100.0%	50.0%	100.0%	0.0%	100.0%		100.0%		75.0%	
Lower Gastrointestinal	>85%	85.7%	100.0%	80.0%	71.4%	86.7%	70.0%	60.0%	100.0%	75.0%	71.4%	100.0%		75.8%	
Lung	>85%	66.7%	40.0%	33.3%	100.0%	100.0%	37.5%	100.0%	100.0%	66.7%	100.0%	50.0%		60.0%	
Other	>85%			100.0%											
Skin	>85%	100.0%	100.0%	100.0%	100.0%	96.3%	100.0%	100.0%	100.0%	100.0%	100.0%	95.2%		98.6%	
Testicular	>85%		100.0%			100.0%	100.0%			100.0%				100.0%	
Upper Gastrointestinal	>85%		100.0%	0.0%	75.0%	75.0%	100.0%	66.7%	100.0%	0.0%	100.0%	50.0%		58.8%	
Urological (Excluding Testicular)	>85%	28.6%	66.7%	66.7%	33.3%	33.3%	28.6%	20.0%	61.5%	88.9%	85.7%	59.1%		57.3%	

Cancer - 2WW Performance by Tumour Group

Indicator	20_21 Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	2021-2022	Performance
Breast	>93%	99.0%	100.0%	85.4%	67.2%	84.0%	37.6%	42.0%	80.1%	96.7%	96.1%	96.0%		73.0%	
Childrens	>93%	100.0%	100.0%		100.0%				0.0%					0.0%	
Gynaecological	>93%	95.5%	97.3%	85.4%	94.7%	89.7%	94.7%	96.4%	88.3%	74.2%	92.4%	91.3%		89.8%	
Haematological	>93%	100.0%	85.0%	100.0%	100.0%	100.0%	96.2%	100.0%	100.0%	100.0%	96.2%	95.7%		98.0%	
Lower Gastrointestinal	>93%	89.3%	96.4%	93.2%	94.0%	88.9%	48.5%	81.0%	85.1%	61.8%	37.1%	22.0%		58.5%	
Lung	>93%	100.0%	100.0%	83.3%	100.0%	100.0%	33.3%	75.0%	80.0%	50.0%	100.0%	66.7%		70.0%	
Skin	>93%	99.4%	99.5%	98.6%	98.8%	99.6%	97.9%	96.2%	96.4%	95.6%	96.2%	92.9%		95.8%	
Upper Gastrointestinal	>93%	96.9%	100.0%	82.6%	87.5%	98.6%	98.6%	100.0%	91.7%	96.2%	98.5%	96.6%		96.7%	
Urological	>93%	91.2%	94.0%	97.4%	100.0%	98.0%	58.5%	61.9%	53.2%	58.9%	72.2%	54.2%		60.9%	

Appendix 4. Trust Level Activity

Category	Indicator	20_21 Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Activity
ED	ED Attendances	8285	7887	7748	6409	6304	8890	8861	9291	9663	9352	8532	9274	9432	
ED	ED Admission Rate %		17.3%	19.4%	21.8%	19.4%	15.9%	15.6%	13.8%	13.4%	13.7%	13.2%	12.6%	12.5%	
Community	Community Face to Face Contacts		41937	37413	31540	31855	39639	37173	40979	38985	36668	32887	37829	39790	
Admissions	Elective and Daycase		1663	1556	978	1167	1778	1815	1873	2052	2047	1942	2002	1855	
Admissions	Emergency Inpatients		2119	2186	2138	2025	2281	2234	2043	2179	2058	1937	1940	1973	
Referrals	GP Referrals to an Acute Service		11178	9503	8961	10008	12879	11973	12703	13836	13277	12166	12508	14682	
Referrals	% of GP Referrals that were completed via ERS		86.8%	83.1%	82.3%	85.3%	87.2%	88.3%	88.8%	86.7%	87.4%	87.5%	85.3%	86.8%	
Referrals	% e-Referral Service (e-RS) Slot Issues	<4%	28.7%	33.9%	27.4%	30.3%	44.2%	37.0%	29.7%	27.0%	31.1%	28.5%	35.7%	28.8%	
Maternity	Maternity Births	320	289	289	285	290	331	329	288	315	309	323	288	319	
Maternity	Maternity Bookings	377	411	418	397	359	391	458	356	322	369	306	327	319	
Outpatients	Outpatient DNA Rate % - New	<10%	8.8%	8.9%	8.8%	7.7%	8.8%	9.3%	10.1%	9.7%	10.8%	11.9%	11.9%	10.9%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	8.7%	8.2%	8.1%	7.4%	7.6%	8.3%	8.5%	9.3%	9.9%	10.4%	10.7%	10.0%	
Outpatients	Outpatient New Attendances		9179	8662	7278	7947	9437	8919	8668	9806	9329	8297	9800	9694	
Outpatients	Outpatient FUp Attendances		17964	16901	14954	15342	18220	17244	16193	18198	17448	15237	17277	16525	
Outpatients	Outpatient Procedures		5819	5413	4362	4690	5935	5571	5412	6165	5825	5261	5774	5689	

NHS
Whittington Health
NHS Trust

Meeting title	**Quality Assurance Committee**	**Date: 09/11/2021**
Report title	Eliminating Ambulance Handover Delays	**Agenda item:**
Executive director lead	Carol Gillen, COO	
Report author	Nicola Stephenson DoO - EIM	
Executive summary	Update to QAC on the actions being taken to reduce and eliminate ambulance handover delays in response to a letter received from NHSE	
Purpose:	Update to QAC	
Recommendation(s)	NA	
Risk Register or Board Assurance Framework	NA	
Report history	Not previously considered	
Appendices	I. Eliminating ambulance handover delays - table	

ELIMINATING AMBULANCE HANDOVER DELAYS		
Initiatives/ Must do's	**Yes/No**	**Commentary inc. next steps**
Establish surge capacity / priority admission unit to care for patients out with Ed following a decision to admit; this may require conversion of existing space, or temporary accommodation, within the acute trust to accommodate patients prior to admission to the appropriate ward	No	Currently, there are no plans to create a separate area outside of ED to care for patients who are waiting for admission. Some patients can wait for admission in EMU, which is in the AEC unit which is away from ED which can help to decompress ED. There is a focus on enhancing the acute discharge processes, concentrating on early discharge and reducing length of stay in order to ensure flow from ED to the wards. A breach report is done for all ambulances that wait over 60 minutes, which is managed through the Trusts weekly quality governance meeting.
Wherever practical implement fit-to-sit for patients that do not require a trolley	Yes	This is embedded practice. From arrival to discharge patients will be sat on chairs where clinically appropriate. Wheelchairs are available for LAS crews when handing over patients.
Ensure early access to clinical decision-makers to enable prompt admission / discharge	Yes	There is to be a doctor allocated to the Rapid Assessment and Treatment (RAT) area between the hours of 10am – 8pm however this can be challenging due to staffing levels and availability. The focus of November 2021 is to ensure this role is embedded into the medical rota to support the ED over winter.
Increase capacity of discharge lounge to free beds earlier in the day, accompanied by rapid support from non-emergency patient transport services	No	Currently there are no plans to create and staff a discharge lounge within Whittington Health. There is a focus on enhancing the acute discharge processes, concentrating on early discharge and reducing length of stay in order to ensure flow from ED to the wards.

Maximise discharge through following principles within the hospital discharge and community support: policy and operating model	Yes	The integrated discharged team is embedded in Whittington Health as is twice daily Multi-Agency Discharge Events (MADE) and a wider NCL MADE which is weekly. There is a Flow improvement programme which is focussing on early discharge (pre lunch), action focussed board rounds, criteria lead discharge and length of stay.
Increase direct access to GP streaming, SDEC, acute frailty services and medical / surgical assessment units from ambulance crews to reduce direct ED conveyance	Yes	The front of house streaming model is being enhanced as of November / December 2021. There is currently a streaming nurse 24 hours a day however the new model will consist of: Streaming nurse 24/7 EDA support 24/7 GP Navigator 1000 – 2000 Security staff member 24/7 The aim of this enhanced model is to optimise the use of alternative care pathways such as Ambulatory Care, Pharmacy, Women's Diagnostic Unit, GP, self-care by having a senior decision maker at the front door. Again this to maintain flow within the whole ED. LAS also have access to alternative care pathways such as the use of rapid response, direct communication with AEC and the ability to direct patients to UTC.
Match community and mental health service capacity and demand to enable reduced conveyance to ED for appropriate patients	Yes	MHCAS at St Pancras hospital is available for all patients presenting with a mental health complaint. This is accessible following medical review if it is necessary. There is a place of safety at Highgate Mental Health Unit for patients in NCL who require this care. This availability has dramatically reduced Mental Health attendances at the Emergency Department.
Work with two hours community crisis response teams to offer appropriate alternative pathways to an ambulance response	Yes	Whittington Health's Community Rapid Response team is embedded and takes referrals from 111, LAS and GPs to reduce conveyance to hospital and sees patients in 2, 4 or 24 hours given the needs of the patient.

Local agreement of staffing models e.g., using acute trust, ambulance service and community service staff in partnership to support surge capacity	Yes	Whittington Health is an ICO and therefore community and acute staff work in partnership to deliver pre, acute and post hospital care. Rapid response and virtual ward services are key to this along with district nursing. Staff from the wider ICS are also part of the MDT working such as social care and housing. A monthly A&E Delivery Board brings together representatives from the whole ICS to discuss and improve the whole emergency care pathway.
Making use of HALO staff to support handover of care, or working with ambulance services to explore whether Community First Responders are available to take on additional roles to support care for patients	Yes	Intelligence conveyancing is live across London via LAS. HALO staff attend Whittington Health ED when necessary. Regular conversations take place between WH/ NCL Surge Team and LAS to manage capacity and demand across the sector. There is ongoing improvement work between WH and LAS regarding flow at the front door which is also picked up in the acute front door flow improvement work.
Work with Provider Collaboratives and ambulance services to support boundary changes and diverts, where this will help to decompress a site	Yes	A recent pilot took place (8th November 2021) with LAS and provider trusts in NCL to re look at the postcode / conveyance boundaries across the sector. Intelligent conveyancing happens daily throughout the sector.

Appendix 6. Cancer Service Update

Cancer services: current context

Whittington Health NHS Trust

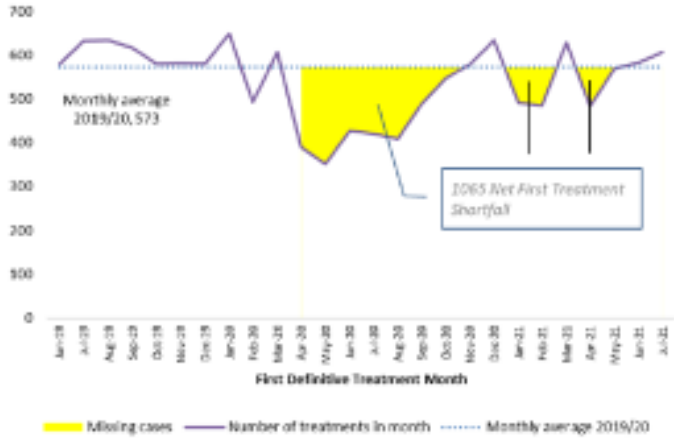
During the first year of the Covid pandemic, NCL witnessed a significant drop in 2ww referrals and in the number of treatments *(figure 1)*.

The sector has subsequently experienced an influx in demand – with volumes of referrals as high as 120-130% of 19/20 baseline levels throughout the summer, coinciding with staff leave.

This has put substantial pressure on services, and at the Whittington has particularly been impacted in Gynae, GI, Breast and Skin *(figure 2)*.

However, it has also encouraged further NCL sector collaboration including the creation of a weekly Cancer Acute Recovery Group, some demand-smoothing actions and cross-site staffing support.

1 Number of First Definitive Treatment by month - NCL



2 *2ww referrals volumes between March and August 2021 as a % of 2019 baseline levels*

	Mar-Aug 21vs19
Breast	116%
Breast Symptomatic	83%
Colorectal	116%
Gynaecology	120%
Haematology	173%
Lung	67%
Other	44%
Skin	124%
Upper GI	129%
Urology	99%
TOTAL	116%

Performance update and improvement plans

NHS Whittington Health NHS Trust

Performance against cancer standards has been challenging in Q1/2

- 2ww performance at ~80% against the 93% standard - driven by consistently high volumes of GP referrals
- 62 days to treatment at ~75% against 85% standard - driven by the high volume of referrals, backlogs across all Trust services & patient choice (where some still anxious about Covid opt to delay coming in)
- FDS performance has remained good at ~80% driven by our one-stop diagnostic model in key tumour groups

We are pursuing a range of plans to pull performance back in-line with standards over the next 6 months:

- Given the sustained high volume of referrals, we are working on some demand smoothing plans eg alerts to GPs if a service is busy
- Putting on extra clinics and Theatre lists in key specialties eg Breast
- Strengthening the triage part of the pathway – eg a new Urology triage nurse

2021/22		Q1				Q2			
	% Standard	Total	Compliant	Breached	%	Total	Compliant	Breached	%
Cancer 2WW	93%	2946	2251	695	76.4%	1892	1549	343	81.9%
Breast Symptomatic 2WW	93%	68	61	7	89.7%	83	80	3	96.4%
31 Day – 1st Treatment	96%	107	105	2	98.1%	53	51	2	96.2%
31 Day – Subsequent Treatment (Surgery	94%	7	6	1	85.7%	2	2	0	100.0%
31 Day – Subsequent Treatment (Drug)	98%	5	4	1	80.0%	1	1	0	100.0%
31 Day – Subsequent Treatment (Other)	–	0	0	0	–	0	0	0	–
62 Day Standard*	85%	80	56	24	70.0%	48	36.5	12	76.0%
62 Day – ITT Reallocated*	85%	79	54	25	68.4%	47	34.5	13	73.4%
31 Day – Rare Cancer	–	1	0	1	0.0%	1	1	0	100.0%
62 Day – Screening	90%	2	2	0	100.0%	0.5	0.5	0	100.0%
62 Day – Consultant Upgrade	–	21	20.5	0.5	97.6%	13	11.5	1.5	88.5%
28 Day FDS (2WW)	75%	2570	2108	462	82.0%	1720	1380	340	80.2%

2

Quality and patient experience update

NHS Whittington Health NHS Trust

The service has continued to rely on **locum consultants** which is not optimal for continuity of care – however, with the recent appointment of 3 **new joint substantive consultant posts with UCLH we are on track to resolve the issue**

We have a project manager in place for three years to deliver our **"personalised cancer care" objectives**. This will include a holistic assessment for each patient, remote follow-up of low-risk patients & health and well-being events.

There is a **new diagnosis support group** aimed at standardising the information given to patients, setting expectations about the service, prehab and patient modelling. **Menopausal symptoms group** will start for breast patients & a **prostate group** will commence focused on harder to reach groups (men & men from BAME groups).

Last year the National Cancer Patient Experience Survey was made voluntary during the pandemic & unfortunately we didn't have the capacity to run it. It is scheduled for this year and patients will be contacted soon.

3

Focus on the FDS standard

Whittington Health NHS Trust

The 'faster diagnosis standard' formally went live in October this year.

This is a new performance standard aiming to ensure 75% of patients receive a diagnosis within 28 days of referral from the GP.

We are already performing well on this metric (80% in Q2) driven by our effective 'one stop' diagnosis model in key tumour groups.

This is something we want to continue to excel at amongst our NCL peers. We are currently kicking off a project to improve our performance in Urology which is one area in which we do not yet meet this standard.

Measures	Reporting Period	Type	RFL	UCLH	WH	NMUH	RNOH	NCL Provider	NCL CCG
Faster Diagnosis Standard -Performance	Jul-21	75%	72.1%	69.0%	81.1%	59.9%	47.4%	70.8%	71.3%

4

Update on UCLH partnership plans

Whittington Health NHS Trust

Recap on the vision and the benefits of the partnership

The two Oncology teams are working together to develop a joint vision for the future of cancer care at the Whittington.

We will jointly employ 3 new joint Oncology consultant posts and increase the chemotherapy capacity at WH by ~30%.

Benefits include:

- Improved staffing stability at WH
- Better access to specialised expert care and research for WH patients
- Increased capacity across the sector

Recent progress and key next steps

Progress:

1. 3 joint consultants interviewed and appointed to start from Jan 22
2. Additional nursing staff in recruitment
3. Strong partnership project group in place

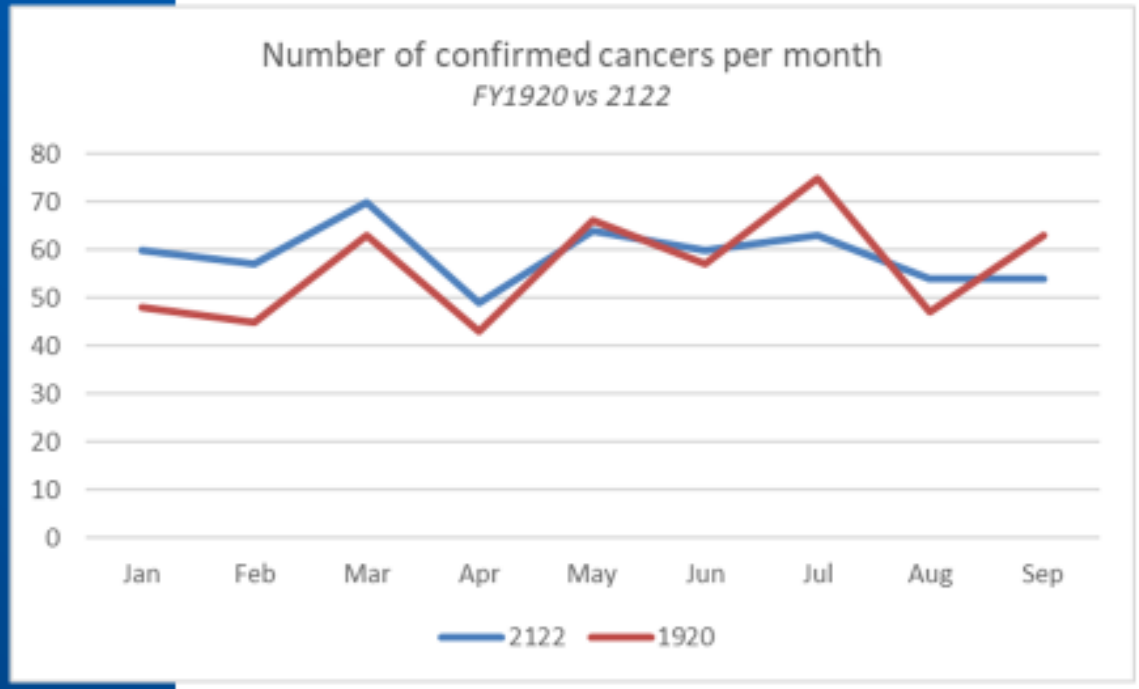
Key next steps:

1. Start Estates works
2. Articulate the cross-site SOP
3. Define the long-term partnership model

Key points for Board consideration

- The operating model is under discussion with the multidisciplinary team. There is a focus on delivering best practice, and excellent patient safety and experience.
- We will need to undertake some Estates work for the expanded unit (which is currently located in the old maternity ward Eddington) which will fit into the broader Estates project across the Trust

Appendix:
Volume of confirmed cancers has not spiked as substantially as the 2ww referral volumes



6

Appendix: Clinical harm reviews, 104 day breaches

NHS Whittington Health NHS Trust

Summary

Q4 Jan-March inc ITR (91.5 treatments,22.5 breaches)

- Over 104 day breaches = 6
- Harm grading: None

Q1 April - June inc ITR (85.5 treatments, 25 breaches)

- Over 104 day breaches = 4
- Harm grading: None

Tumour Group	Total Days	Treatment Type	Diagnosis	Narrative	Level of Harm	Month
Gynaecology	112	Total abdominal hysterectomy	Grade 1A endometrial Adenocarcinoma, MRI 4/12: NO LN , IUD in situ in left corneu, fibroid uterus. Intermediate signal within cavity , no deep myometrial invasion , Stage 1a	1.First GA on 5th hysteroscopy incompletely excised polypectomy, clinical decision was that this needed to be repeated. Second GA hysteroscopy on 16th November confirmed endometrial adenocarcinoma. The caused an additional 42 days in the pathway. This was clearly in the best interests of the patient. 2. Hysterectomy was delayed by the usual reduction in lists over Christmas and new year and exacerbated by the COVID surge that meant that due to staff shortages there were no lists the weeks before New year. The patient was operated on the first available list in the new year (5th January)	No Harm	January
Lung	125	Chemotherapy - Pembrolizumab	T3N3M1c = Stage 4b Metastatic Non-Small Cell of the right lung	Lung cancer diagnosed in 28days. Patient contracted Covid 19 and intubated & ventilation for Covid 19 pneumonia for 51 days. Delay in treatment was due to Covid 19 pneumonia where lung cancer progressed . Completed 4 cycles of 24 before patient passed away. No clinical harm as patient contracted Covid 19	No harm RIP 12/06/21	April
Urology	191	Hormone/ Endocrine	T2a Adenocarcinoma of left prostate		No Harm	February
Urology	161	Active Monitoring	T2b Adenocarcinoma of left prostate		No Harm	March
Urology	140	Active Monitoring	Bilateral T2 Adenocarcinoma of prostate		No Harm	March
Urology	134	Hormone/ Endocrine	Bilateral T2cNxM0 Adenocarcinoma of prostate		No Harm	April
Urology	169	Hormone/ Endocrine	Bilateral T2cN0M0 Adenocarcinoma of prostate		No Harm	April
Urology	129	Active Monitoring	Bilateral T1cN0M0 Adenocarcinoma of prostate		No Harm	June

7

Meeting title	**Trust Board – public meeting**	**Date: 25 November 2021**
Report title	**Digital strategy**	**Agenda item: 10**
Director lead	Jonathan Gardner, Director of Strategy & Corporate Affairs	
Report author	Sam Barclay, Chief Information Officer, and Jonathan Gardner	
Executive summary	At its 28 October seminar, Board members discussed and provided feedback on the draft digital strategy which is here for final ratification.	
Purpose:	Approval	
Recommendation(s)	Board members are asked to approve the digital strategy	
Risk Register or Board Assurance Framework	Sustainability 3	
Report history	Trust Management Group and Board seminar	
Appendices	1: Digital strategy	

NHS
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NHS Trust

Digital Strategy

2021-2024

Offering a rich patient and staff digital experience, which transforms integrated care and enables local people to live longer and healthier lives.

Version: v2.6
09.11.2021

Our mission is clear:

We help local people live longer, healthier lives by providing integrated community and hospital services focussed on women, children and the adult frail.

Delivering this mission is supported by digital technologies which empower our patients, staff and community.

Technology today has an ever-increasing impact on our everyday lives. The use of smartphones, wearable devices, smart home devices, voice activated assistance devices and web-delivered applications being just some of the consumer developments which have advanced at pace over recent years.

Alongside this, technology and information have become even more fundamental to the delivery of modern healthcare - within organisations and across a health economy. The processes of diagnosis, planning, care delivery and management are all critically dependent on access to the right information at the point it's needed. Each patient is unique and so is their record. To work safely, efficiently and effectively, healthcare professionals require records for each patient that are easily accessible, secure, accurate, contemporary and can be accessed in the multiple places where any patient may receive care. For each patient there should be a single version of the truth. Digital tools are essential in the delivery of 21st century healthcare.

Further, today's patients and their families have an expectation of seamless, integrated care between organisations providing that care. Sharing patient data between health and care settings is practically impossible to manage consistently without the right technology, deployed in the right way. Patients also have expectations to be able to use current technologies to engage with hospitals and their care providers, through virtual consultations, portals and apps. We need to adopt the opportunity offered by technology now to make remote, safe, clinical interaction with our patients a reality.

This strategy defines a clear 3-year vision and roadmap which builds upon our progress across both Community and Acute services, supports the Trust to deliver its strategic objectives, and to meet both patient and staff expectations, whilst also meeting the requirements of regional and national strategic drivers.

Within the term of strategy delivery, there will be the opportunity to consider the next phase of our digital journey and to undertake a strategic review of our EPR and clinical systems.

Contents

NHS
Whittington Health
NHS Trust

1. Our digital journey over the last three years.

In 2017, the Trust set out a digital strategy which covered the period to 2020. Before we set out our next digital strategy, we re-state the key areas of the previous strategy and review the progress made by the Trust over the last 3 years.

What did we set out to achieve between 2017 and 2020?

Whittington Health NHS Trust

Informed by our patients, staff, and both local and national drivers; our previous Digital Strategy set out a number of requirements to be delivered between 2017 and 2020; across the following four areas.

Digitally Connected Patients

We will transform our models of care by enabling patients to manage their own health using digital services.

Enable e-booking transactions to book and manage appointments at convenience.

Enable virtual consultations to have a choice between a physical or virtual consultation where appropriate.

Remote monitoring for preventive and self-care management to use on-line resources and wearable technology to manage health and care.

Access to a patient portal to view and input to my digital health record and to develop and manage personal care plan.

Digitally Enabled Workforce

We will transform our ways of working by giving staff access to digital services anytime, anyplace.

Enable electronic observations to use decision support tools to improve patient safety and quality of care.

Access to mobile devices and interoperable digital tools to operate digitally at the point of care and stop using paper based processes.

Access to a shared care record to view a real time, accurate, and complete integrated digital care record for patients and to develop and share care plans across health and social care.

Trust wide standardised care pathways to access best practice guidance to reduce clinical variation and improve outcomes.

Business Intelligence and Analytics

We will transform our decision making by developing an insights driven culture to improve patient quality, safety, outcomes and effectiveness.

Data mining and modelling tools to shift from a reactive response to historical data to proactive management using predictive data.

Real time access to performance, outcomes and effectiveness data to develop an adaptive learning culture to rapidly implement data driven quality improvements.

Access to a population health platform to improve population health outcomes and reduce inequalities.

Access to on-line resources and collaboration tools to collaborate with academia and industry to share knowledge, undertake research & drive innovation.

IT Infrastructure

We will transform our IT infrastructure by implementing a secure, resilient, and mobile operating platform.

Robust Cyber Security platform to protect the Trust's information assets from cyber security threats e.g. ransomware, malware.

Mobile devices and applications enable "mobile first-digital first" approach to access and capture data anytime, anywhere on any device.

Open supplier interfaces (APIs) and integration engine to support integration & interoperability to share clinical data across the Trust and externally.

Unified Communication platform to enable virtual communication and collaboration.

Real time data replication to provide resilience with near 100% availability.

What progress did we make over the last 3 years?

Whittington Health NHS Trust

In each of these areas, we have made significant progress which have helped us to deliver against our vision, to be the most digitally advanced integrated care organisation in the NHS, as well as our mission to empower patients and staff to securely access information at any time, any place and on any device.

Digitally Connected Patients

Our progress, in relation to the objectives:

The Trust is in the process of delivering e-Booking transactions and this is at an advanced stage. There is the opportunity for this to evolve to include all of Community and the platform will then be used to expand engagement with patients pre and post visit.

Remote monitoring is being piloted in the ISCUs and is being integrated with our work to develop virtual consultations. This will continue to evolve into the next phase. We will also move towards Group Consultations. Advice and Guidance is in use extensively to prevent unnecessary admissions and attendances.

Maturity of consumer market has led to slower progress in the use of wearables in the delivery of health and care across the Trust; but this will remain an area of focus. We foresee further consumer development and adoption of wearables, and will seek to integrate both the data from these devices and their use in to clinical pathways.

Digitally Enabled Workforce

Our progress, in relation to the objectives:

Shared Care Record has continued to evolve. The depth of the GP record has enhanced considerably. Clinical Workspace has also become widely adopted; and aggregates the view of all the clinical records we hold. This is in use both across acute and community services. We have expanded direct access to our Shared Care Record for community based staff.

Electronic observations are delivered across inpatients and children's; and work will continue to expand this further.

Standardised Trust documentation is in place for nurses, AHPs and doctors. Our approach has removed variation where it unwarranted. We will continue to standardise and optimise.

The Trust has a significant increase in a wide range of accessible and transformational end user devices, which have been matched to user requirements.

Business Intelligence and Analytics

Our progress, in relation to the objectives:

We are now in the position that all data captured through the front-end of our clinical systems can all be reported upon. We have also advanced our use of realtime dashboards to support operational planning across the Trust; including for discharge planning. Our focus has been to make the best use of data to drive improved clinical outcomes. This has required us to implement an enterprise data warehouse to support our increased use of data, and to support significant increase in volumes.

The Trust is working with the STP to support to achieving a wider-STP agenda in population health; including the provision of data and building appropriate infrastructure. This is likely to be an area of focus in to the next period.
Slower progress has been made in relation to data sharing with academia and for the purpose of research. We are also conscious of the sensitivities in these areas.

IT Infrastructure

Our progress, in relation to the objectives:

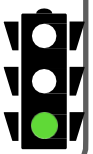
We have achieved significant levels of assurance from our auditors across the essential people, process and technology relating to cyber security. Our practices are strong and we continue to develop this area.

In addition to the rollout of new mobile-enabled devices, we have developed and implemented policies and infrastructure to support 'bring your own device' which has supported us to drive a mobile-first culture.

We have worked with our solution vendors to develop and implement advanced integration to support the extensive sharing of clinical data across application, and to achieve this at speed.

Unified communications have been significantly enhanced via our clinical communications and handover tool and online collaboration platforms.

Realtime data replication is in place with resilient storage and connectivity infrastructure across all key areas.



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NHS Trust

2. Measuring our progress.

Although this strategy aligns our priorities for development in digital with the wider Trust transformation agenda, it is important that we are able to measure our progress in relation to digital, and to assess how our level of digital maturity is developing. There are two models which we have illustrated within this strategy; the NHS England Digital Maturity Assessment and the HIMSS EMRAM Adoption Model.

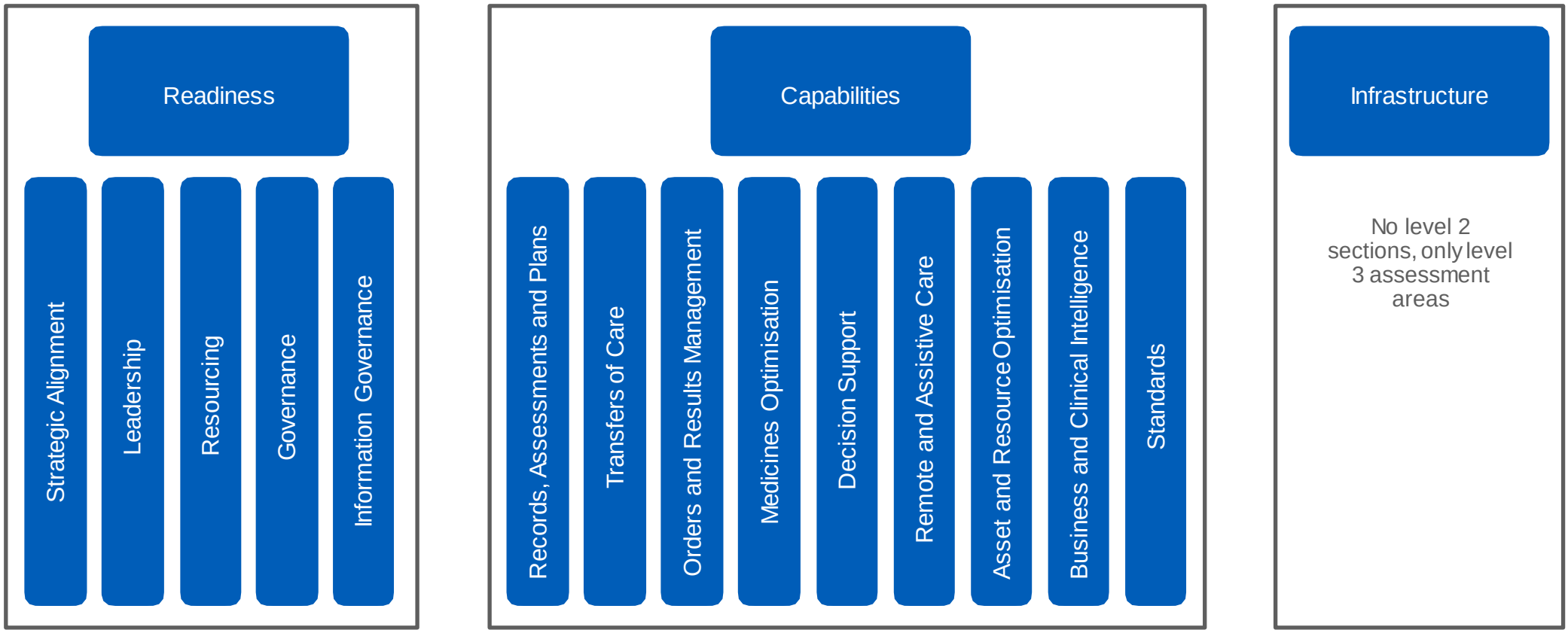
Assessment of digital maturity.

Whittington Health NHS Trust

NHS England Digital Maturity Assessment

The NHS England Digital Maturity Self-Assessment, illustrated below, measures how well care providers are making use of digital technology to achieve a health and care system that is paper-free at the point of care. The Digital Maturity Self-Assessment helps individual organisations identify key strengths and gaps in provision of digital services and provides an overview of progress across the country is doing as a whole. The Assessment measures maturity against the following key themes:

- **Readiness**: the extent to which providers are able to plan and deploy digital services
- **Capabilities**: the extent to which providers are using digital technology to support the delivery of care
- **Infrastructure**: the extent to which providers have the underlying infrastructure in place to support these capabilities



For full definitions: NHS England Digital Maturity Self Assessment Model

Assessment of digital maturity.

Whittington Health NHS Trust

NHS England Digital Maturity Assessment

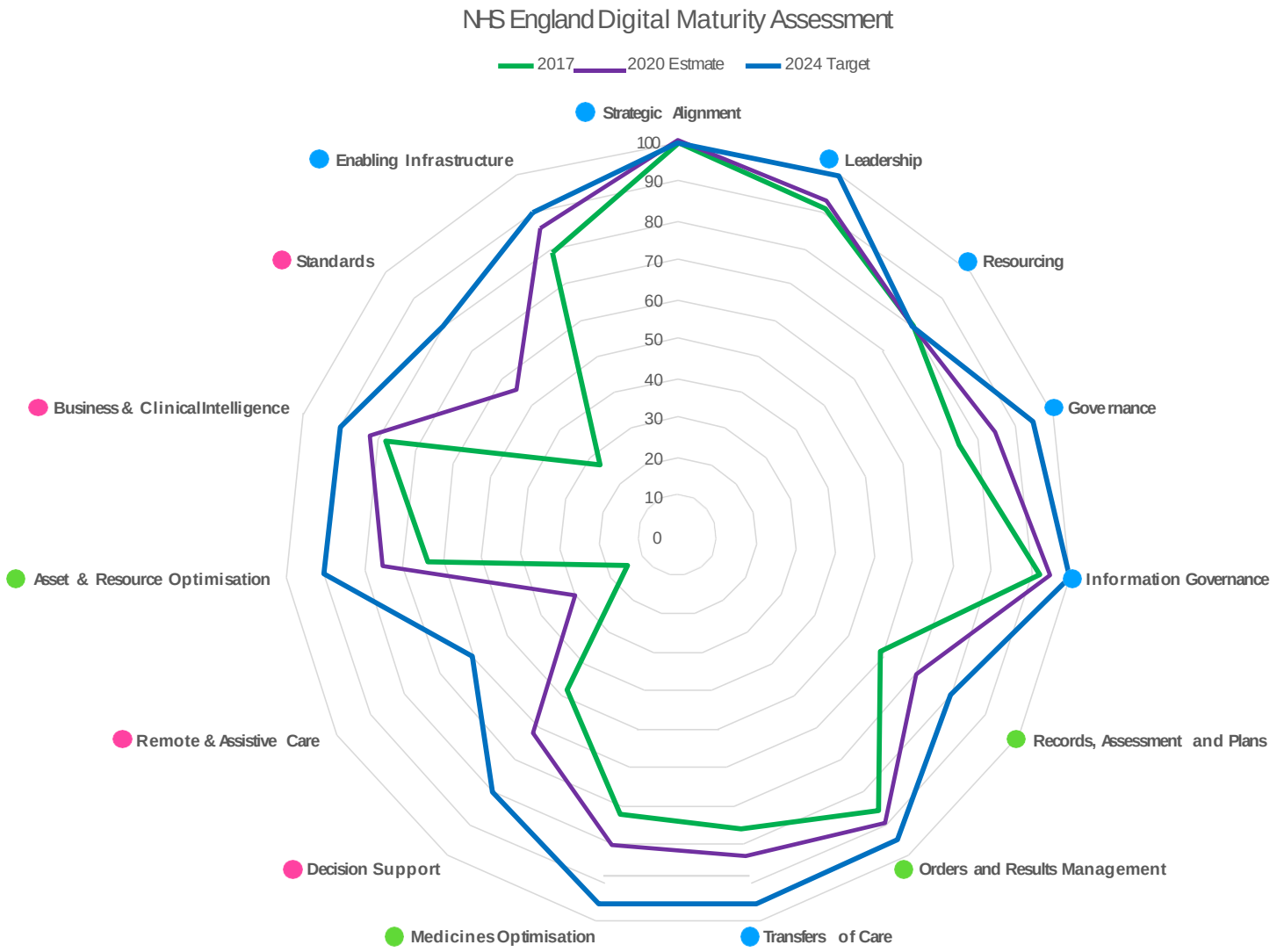
The Digital Maturity Self-Assessment can help providers by:

- Providing a framework to identify opportunities for improvement and further development.
- Encouraging knowledge sharing initiatives with similar organisations.

The Digital Maturity Self-Assessment can help system leaders by:

- Identifying common gaps among providers to support investment decisions.
- Informing joint procurement exercises.

This chart shows our Digital Maturity Self-Assessment using this NHS England model across 2017, current state in 2020 and target future state in 2024, as a result of executing this strategy.
Each of the aspects have been categorised as either foundational, evolutionary or revolutionary, depending on the extent to which they support the transformation of care. The illustration provides us with a good basis on which to focus both current and future strategic plans. As an example, it tells us that by the end of this strategy period we can expect to have made good progress in the foundational and evolutionary areas, yet still have the opportunity to progress some revolutionary areas, such as Remote and Assistive Care.



Assessment of digital maturity.

NHS Whittington Health NHS Trust

HIMSS EMRAM Model Assessment

HIMSS Analytics EMRAM

The HIMSS Electronic Medical Record Adoption Model (EMRAM) incorporates methodology and algorithms to automatically score hospitals around the world relative to their Electronic Medical Records (EMR) capabilities.

This eight-stage (0-7) model measures the adoption and utilisation of electronic medical record (EMR) functions across an organisation. Although official validation for a stage requires an activity to be undertaken in partnership with HIMSS, it is not unusual for NHS organisations to use it as a baseline for measuring digital maturity and progress with developing their maturity.

Current State Self Assessment

The table on the right illustrates our current state self assessment against the elements of functionality that should be adopted across the Trust in each of the EMRAM stages.

he Trust underwent a formal HIMSS assessment at the end of the Fast Follower Programme (2021) the outcome of which was obtaining Stage 5 status (achieving one of the Fast Follower Programme's goals).

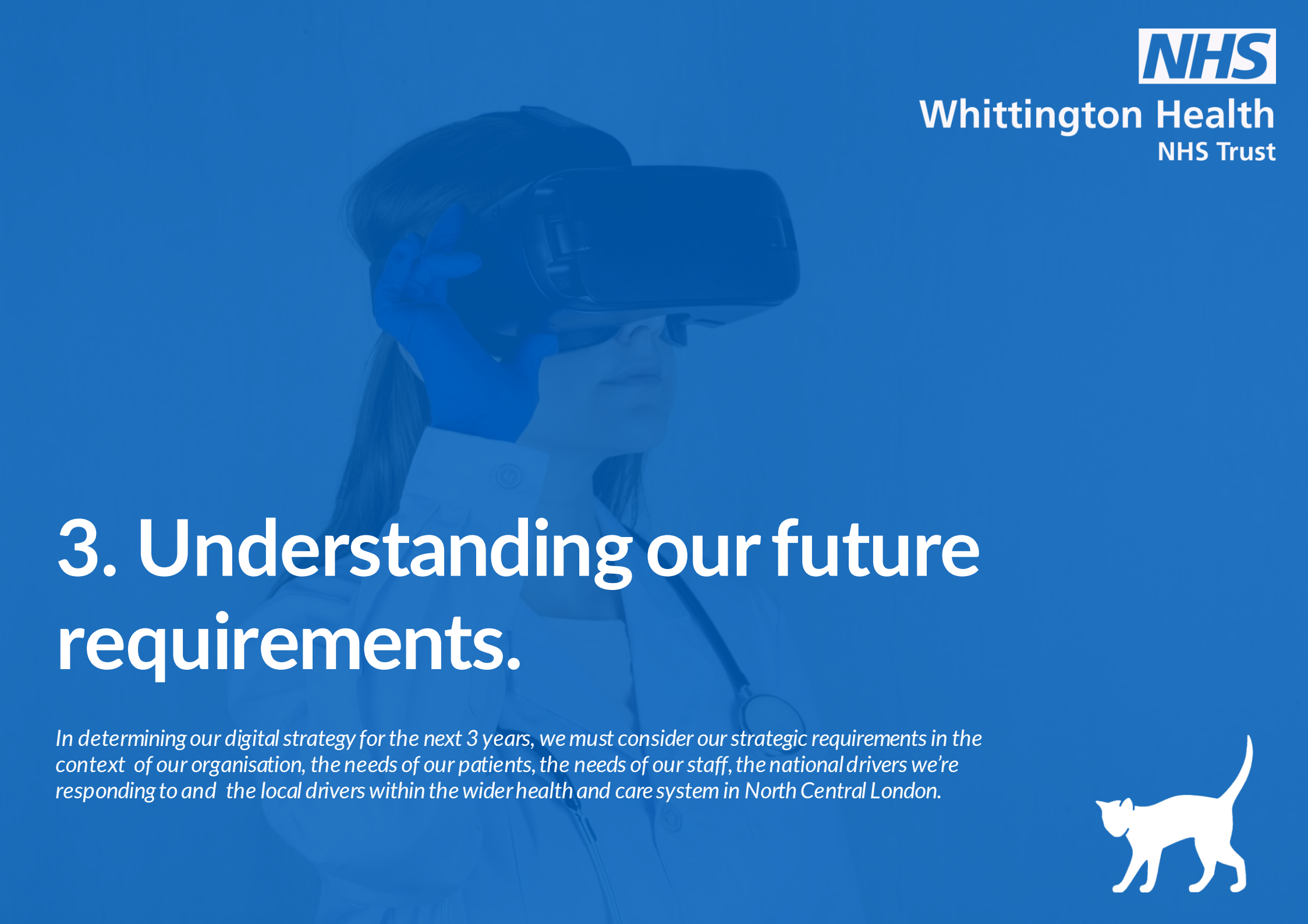
Target for 2024

Over the coming 3 years, through the delivery of our strategic plans, we would expect to have enhanced this position. We would expect to be considered at stage 7 within this model.

Note: It is recognised that the HIMSS EMRAM model is biased towards Acute services, however we believe it still to be a valuable tool to assess EPR maturity.

Stage	Element	Current Status
7	Complete Electronic Patient Record	Delivering in this phase
	External Health Information Exchange	Achieved 2017-20
	Data Analytics	Delivering in this phase
	Governance	Achieved 2017-20
	Disaster Recovery	
	Privacy and Security	
6	Technology Enabled Medication	Delivering in this phase
	Blood Products and Human Milk Administration	Delivering in this phase
	Risk Reporting	Delivering in this phase
	Full Commissioning Data Sets	Achieved 2017-20
5	Physician Clinical Documentation (using structured templates)	Achieved 2017-20
	Intrusion / Device Protection	Achieved 2017-20
4	Computerised Physician Order Entry with Clinical Decision Support	Achieved prior to 2017
	Nursing and Allied Health Documentation	Achieved 2017-20
	Basic Business Continuity	Achieved prior to 2017
3	Electronic Medication Administration Record	Achieved prior to 2017
	Role Based Security	
2	Common Drug Reference	Achieved prior to 2017
	Internal Interoperability	
	Basic Security	
1	Laboratory Information Management System	Achieved prior to 2017
	Radiology and Cardiology Information Systems	
	Pharmacy Stock Control	
	Picture Archiving Communication Systems	
	Digital non-DICOM Image Management	
0	No Ancillary Systems	Achieved prior to 2017

For full definitions: HIMSS EMRAM Model



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NHS Trust

3. Understanding our future requirements.

In determining our digital strategy for the next 3 years, we must consider our strategic requirements in the context of our organisation, the needs of our patients, the needs of our staff, the national drivers we're responding to and the local drivers within the wider health and care system in North Central London.

Our strategic digital requirements.

Whittington Health NHS Trust

What are the needs of our organisation?

We have an excellent reputation for being innovative, responsive and flexible to the changing clinical needs of the local population. We are treating more patients than ever before and are dedicated to improving services to deliver the best for our patients whether we see them in our hospital, our in our sites across North London or in their own homes. We have agreed that we are focussing on delivering integrated care over three key populations: women, children, and the adult frail.

Our Vision

Helping local people live longer, healthier lives.

Our Values

I-CARE guides us on how we act:

- Innovation;
- Compassion
- Accountability;
- Respect;
- Excellence.

Our Strategic Objectives

We have identified four areas to improve our value, efficiency and drive financial improvements:

- Deliver outstanding safe, compassionate care;
- Empower, support and develop staff;
- Integrate care with partners and promote health and wellbeing;
- Transform and deliver innovative, financially sustainable services.

Whittington Health is at the 'heart of the community' in Haringey and Islington, employing over 4000 staff many of whom are local. In partnership with patients, service users and other organisations, we want to begin to have an even greater impact on the health and wellbeing of our whole diverse population and reduce inequalities, through more joined up, improved services, prevention work and health advice and education.

We are an "integrated care provider". This means we provide community and hospital services in a joined up way to 500,000 people living in Islington and Haringey as well as other London boroughs including Barnet, Enfield, Camden and Hackney. We don't just want to provide these services as they always have been, but rather we want to lead the way across the country, creating innovative ways to integrate teams across the organisation and with our partners in the council, primary care, mental health and the voluntary sector.

We also provide several specialist services to broader geographies such as our community dentistry services in 10 boroughs of London and our internationally recognised Michael Palin Centre a specialist speech and language service which receives referrals from around the world.

Our organisation has a highly-regarded educational role. We teach undergraduate medical students (as part of UCL Medical School), nurses and therapists throughout the year, alongside providing a range of educational packages for postgraduate doctors and other healthcare professionals.

We have identified four key priorities over the coming years, which will support us to focus on value - on driving quality and financial improvements:

- Delivering quality and scale benefits through integration and system partnership;
- Maximising our potential to keep patients at home with out of hospital care;
- Streamlining elective patient pathway and communications;
- Reducing waste and going green.

We are focused on improving patient and staff experience, to change outcomes.

This digital strategy takes into account each of these priority areas to support the delivery of these Trust-wide activities.

I·C A R E

Our strategic digital requirements.

Whittington Health NHS Trust

What are the needs of our patients?

As defined within our Patient Experience Strategy, 2019, there is increasing evidence that positive patient experiences lead to positive clinical outcomes. The strategy lays out three ambitions, which should be taken into consideration when defining our digital roadmap:

Improvement of information: We will improve the way we engage with patients and carers across the system, digitally, through information we provide as well as enabling patients and carers to provide us with data to support care delivery, such as the capturing of Patient Reported Outcome Measures (PROMs).

Working in partnership: We will work in partnership with patients, families and carers to build a foundation for co-design and service improvement, and to support access to our digital services - both in terms of skills and languages.

Providing holistic care: We will improve our patients' journey ensuring we provide integrated holistic care, from the first contact and throughout their care.

Patients rightly assume that they'll receive the same digital experience in health and care that they receive elsewhere in their lives; and are dissatisfied when this isn't the case. Patients increasingly expect health and care providers to offer accessible digital tools and apps that support them not only to interact with the provider, but to also support them in taking ownership of their own health and wellbeing. Patient want to be able to book appointments online, check their personal health data and interact with care teams via messaging and online consultations. There are challenges with meeting these expectations, which include costs, solution integration, developing the right digital skills and ensuring that operations plans take these news ways of interacting in to account.

This strategy takes these considerations in to account, and ensures we continue to progress on our journey to meet the expectations of our patients.

What are the needs of our staff?

We have engaged closely with staff, and ICSU / Directorate teams to develop a clear understanding of the needs of our staff. We have identified the following themes of priority areas:

Supporting new ways of working: increasingly, our staff are working in a mobile way. They require intuitive, portable, rapid and real-time access to our digital tools which provide the clinical information they need at the point of care delivery. Data entry should be as simple as possible, and they require us to use intelligent planning tools to support their activity.

Access to a longitudinal care record: our staff need to be able to access the full and integrated care record at the point they need it - whether on a Trust site, during a home visit or an online consultation. This includes Trust care records and shared care records, including GP records.

Intelligent alerting systems: which notify key information at the point needed, drive workflow, and reduce fatigue by ensuring necessity and relevance.

Realtime collaboration tools: our staff need to be able to communicate with other care providers supporting the patient's care, in real-time and with convenience.

Virtual consultations: our staff increasingly need to be able to conduct an individual or group consultation whilst also being able to view the relevant care records.

Access to the right technology: our staff need us to match solutions and increased numbers of end user devices to the tasks we require them to undertake - and to ensure they're fully integrated into workflow.

'**Single front door' support:** our staff need us to provide simplicity in how they holistically access support, via a single shared help desk, which would include digital support.

Our strategic digital requirements.

Whittington Health NHS Trust

What national drivers are we embracing?

The Government has set out a series of digital drivers and strategies for the NHS to achieve over the coming years which have been published in a series of papers, such as the 'Five year Forward View', 'Personalised Health and Care 2020', the 'Lord Carter Report' and the 'Wachter Report'.

Most recently the latest NHS Strategy, the 'NHS Long Term Plan' (LTP) and the Health Secretary's Tech Vision, 'The Future of Healthcare', also place a significant focus on the practical delivery of digitally enabled care.

In January 2019 the NHS Long-term Plan was published to provide a new service model for the 21st century as medicine advances, health needs change and society develops. It recognises that that the NHS has to move forward continually so that in 10 years' time we have a service fit for the future.
The Plan emphasises the importance of Integrated Care Systems (ICS) in engaging with all the healthcare organisations in the geography to ensure collaboration and integration of care. It recognises that technology underpins the future NHS setting out the critical priorities that will support digital transformation and provide a step change in the way the NHS cares for patients.

The Plan is devoted to making digitally enabled care mainstream across the NHS and specifically calls out offering patients the option of 'virtual' outpatient appointments with the intention of reducing face to face appointments by a third. This is expected to be delivered through mobile and telehealth technologies.

As a result, our digital strategy takes accounts of key national drivers, to ensure that the Trust adopts and delivers against these national objectives.

The key digital deliverables from these national drivers are:

- Ensure that a comprehensive Electronic Patient Record is implemented within the organisation;
- Use decision support tools, including AI to help clinicians apply best practice, eliminate unwarranted variation, and support patients in managing their health and condition;
- Provide straightforward and secure digital access for patients to access and update their electronic records. Allowing engagement with services to help patients and cares manage their health;
- Ensure that clinicians can access patient records wherever they are and reducing the burden on staff so they can focus on the patient;
- Integrated care records to pass information between services both in and out of the NHS. Enabling improved outcomes across the heath and care system;
- Use intuitive tools to capture data as a by-product providing more time-time information and reducing administrative burden;
- Enable greater analysis of data to inform models of care;
- Adopt technology standards to ensure data is interoperable and accessible - and to support system integration;
- Improvement of patient safety and quality of care, through the use of technology;
- Use predictive techniques to support local care systems to plan care for populations.

Our strategic digital requirements.

Whittington Health NHS Trust

What regional drivers are we embracing?

North Central London (NCL) is a complex landscape of a single Clinical Commissioning Group which spans 5 Local Authorities and 12 acute, community, mental health and specialist providers who, until recently, have predominantly operated independently with no shared digital strategy.

Digital maturity across the health and care system is therefore variable and information exchange across the whole system is limited. Although individual organisations have collaborated on digital projects, working collectively across all organisations remains a relatively new endeavour and we continue to build the trust required to enable us to do so. This is reflected in a number of local achievements but no current whole system projects.

The 22 healthcare partner organisations and the North East London Commissioning Support Unit (NELCSU) have come together to agree how we can use digital technologies and information to move from our current models of care to deliver proactive, predictive, participatory, person-centred care for the population we serve in NCL. This has been outlined in the Local Digital Roadmap plan here.

This model requires NCL to completely transform the way digital services are currently delivered. These plans are based on developing an NCL Population Health Management Model which includes the technology, data and analytics required to manage the health and wellbeing of the NCL population, underpinned by a move from paper to digital care processes within provider organisations.

NCL's Sustainability and Transformation Plan sets out a digital roadmap which supports our STP prevention, service transformation and productivity objectives and will enable us to meet the national mandate of operating paper free at the point of care. Through this model we will move from a landscape of diversity and variation to one of shared principles, consolidation and joint working for the benefit of the population.

The NCL Digital Strategy, published in July 2021, identifies five key strategic themes. The NCL Digital Strategy serves as an enabler for information flow, use of data to support and deliver the ICS vision of a coordinated fair, equitable and efficient healthcare system, with an engaged citizen population.

Resident/Patient/Staff: strategic imperatives we aim to achieve

Enabling Digital Platforms: key digital components to support the ICS vision

Organisational Development: people and organisational capabilities required

Internal Processes & Governance: organisational mechanics we need to establish for strategy execution

Funding Aspects: how the system funds the digital strategy

The aim is to deliver:

- Better integrated care, at lower cost and greater quality;
- Addressed inequalities in care;
- Across Health, Care and Home settings.

Our strategic digital requirements.

Whittington Health NHS Trust

Digital Clinical Safety – nationally, regionally and locally

Echoing Dr Natasha Phillips, NHS X Chief Nursing Information Officer and Director of Patient Safety - '*Safety is everyone's responsibility*'.

Nationally:

In September 2021 NHS X, NHS Digital, NHS England and NHS Improvement published an addendum to the NHS Patient Safety Strategy outlining the case for improved digital clinical safety across health and social care. There were five national commitment

1. Collect information about digital clinical safety, including from the Learn from patient safety events (LFPSE) service and use it to improve system-wide learning.

2. Develop new digital clinical safety training materials and expand access to training across the health and care workforce.

3. Create a centralised source of digital clinical safety information, including optimised standards, guidelines and best practice blueprints.

4. Accelerate the adoption of digital technologies to record and track implanted medical devices through the Medical Devices Safety Programme

5. Generate evidence for how digital technologies can be best applied to patient safety challenges.

Regionally:

North London Partners (NLP) have a established a Clinical Safety Officer working group which meets on a regular basis to discuss ICS wide digital clinical safety issues with different projects and exchange best practice examples and ideas.

NLP Digital Strategy July 2021 also stipulates how the ICS intends to meet safe practice with clinical safety management, data stewardship and education.

Locally:

Since the start of the GDE Fast Follower Programme in 2017 Whittington Health has emphasised the importance of digital clinical safety through –

- Every digital clinical project go live requires a clinical safety case with associated hazard log (as per NHS Digital guidance and in accordance with DCB0160) which is reviewed with the Go/No Go documentation sign off at the appropriate Trust governance forum.
- Whittington Health has a MDT based approach to digital clinical safety assessments with a nurse, doctor, AHP and administrator as NHS Digital certified CSOs.

The overall requirement from these different strategies is :

- Digital technologies introduced and maintained for patients and staff to use at Whittington Health enable safe effective care to be delivered.

NHS
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4. Defining our Digital DNA.

Our Digital DNA defines the strategic considerations we make in defining and refreshing our Digital Strategy; and in appraising investments in digital transformation. These themes should be considered a common-thread throughout all investment in digital and are intended to have permanency beyond the term of this strategy.

Our Digital DNA.

Whittington Health NHS Trust

Fundamental to the development of our digital strategy has been the determination of our Digital DNA for the Trust.

Our Digital DNA defines the strategic considerations we make in defining and refreshing our Digital Strategy; and in appraising investments in digital transformation. These themes should be considered as our missions, and are intended to have permanency beyond the term of this strategy. They should stand the test of time and should provide a basis upon which to build future digital strategies and plans. We have used our Digital DNA to determine our vision and mission for all those involved in digital enablement, across the Trust, over the next three years.

Our Digital Vision

Offering a rich patient and staff digital experience, which transforms integrated care and enables local people to live longer and healthier lives.

Deliver outstanding safe, compassionate care

Enhancing patient safety and experience.

- Empowerment through shared decision-making and planning;
- Enable the personalisation of care;
- Facilitate ease of access of care;
- Increase quality of end-to-end care;
- Foster relationship development;
- Enable remote access of care;
- Enable patient choice.

Empower, support and develop engaged staff

Enhancing staff experience.

- Provide the right tools for the job;
- Deliver effective reliable access;
- Deliver efficiently;
- Deliver quality clinical information;
- Deliver insightful access to data;
- Enable new ways of operating with enhanced support for agile and remote working.

Integrate care with partners and promote health and wellbeing

Making the most of integrated data to connect services and people.

- Enable delivery of integrated services across our organisation and with partners;
- Identify opportunities to engage digitally with patients;
- Identify opportunities to enhance care pathways which span organisations;
- Learn from best practice;
- Learn from experiences;
- Embrace enthusiasm;
- Always through collaboration.

Transform and deliver innovative, financially sustainable services.

Encouraging innovation and agility.

- Ensure people-centred design;
- Deliver intuitive usability;
- Develop knowledge across Trust;
- Retain focus on intelligent alerting;
- Encourage digital curiosity;
- Develop capability across all teams;
- Incubate ideas to delivery;
- Adopt successes;
- Scan the horizon.

Deliver with clarity, Innovation and Agility

Delivering with clear direction, using repeatable methodologies, which adapt as we learn; develop knowledge across Trust and encourage digital curiosity; and develop capability across all teams.

Align with Clinical Strategy

Women's, Children and adult frail; support preventative care; support early intervention; reduce unwarranted variation; enhance safe, effective, quality care; develop cross boundary care; and support research.

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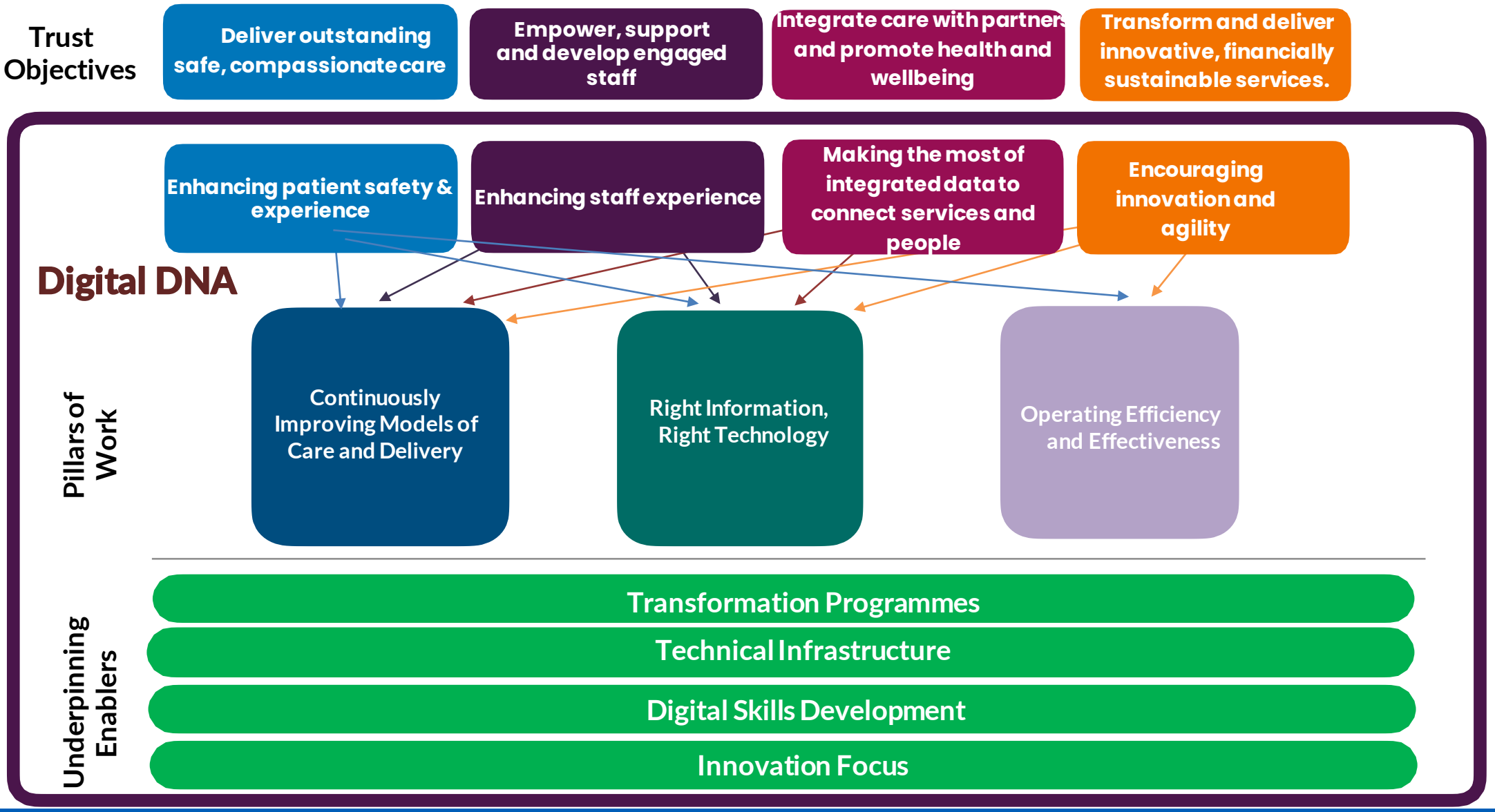
5. Our strategic direction.

Having established our Digital DNA and our strategic requirements, we now set out our strategic direction in relation to digital. The is structured in to pillars of work focused on priority areas that are aligned with the wider Trust transformation agenda, and underpinning enablers which are aligned with 'business as usual' activity within the Trust IM&T team.

Strategy framework.

Whittington Health NHS Trust

The diagram below illustrates how the seven components of this Digital Strategy piece together to support the delivery of the Trust strategic objectives, patient drivers, staff drivers, and national and regional drivers to deliver Our Digital Vision Offering a rich patient and staff digital experience, which transforms integrated care and enables local people to live longer and healthier lives.



Our digital objectives: the pillars of work.

Whittington Health NHS Trust

The diagram below expands upon each of the pillars of work defined within the strategy framework and details the proposed priority areas of work within each pillar of work; most of which will require the initiation of projects to deliver:

Continuously Improving Models of Care and Delivery

1.1. Digital Outpatients
- Implement outpatient clinical noting and group virtual consultations to produce a digital outpatient experience for staff and patients, across both acute and community services.

1.2. Remote Monitoring
- Develop a range of models of care, through the improved use of technology to improve how we support the management of long term conditions, and patient initiated follow up.
- Enhance interaction with patients, combined with advanced use of data to enable symptom identification and earlier intervention.

1.3. Community Careflow
- Providing the tools for multidisciplinary teams to improve the care they are able to offer to patients, and to cross traditional boundaries, including local authorities.

1.4. Cross Provider Services
- Enabling the care of patients across providers, through a digital experience.
- Digital support Shared Corporate Teams to improve workflow when engaging with partners and providers.

1.5 Enable Long Term Condition Research
- Advanced use of data to develop care for the management of conditions e.g. COPD.

1.6 Biomedical Research Centre
- As a research organisation partnering with the UCLH BRC to utilise data analytics to inform clinical pathway development.

Right Information, Right Technology

2.1. Patient Facing Services
- Using digital to increase and enhance engagement with patients, enabling increased choice, automating patient rebooking, enabling patient data entry and enabling patient-initiated follow up.

2.2. Community Estates Strategy
- Supporting the Trust to enable agile and remote working capability, which will reduce its requirement for disparate operating locations, and by providing the necessary infrastructure in hubs which will support this consolidation.

2.3. Right Supplies in the Right Place
- Using information and technology to support the Trust to ensure the right assets, resources and supplies are in the right place at the right time.

2.4. System-Wide Integration
- Digitally enabling the delivery of services across organisational boundaries, and enabling any necessary reconfiguration of services over time.

2.5 EPR Development
- Advancing the use of data from our Acute and Community EPRs to enhance personalised care.
- Disaggregating data from our EPRs, into a data layer which supports greater use and meets national objectives.

Operating Efficiency and Effectiveness

3.1. **Population Health Analytics**
- Adapt NLP Cerner Healthintent analytics tool to delivery of healthcare to local residents making targeted health interventions for the prevention and early intervention at the individual, household and locality levels.

3.2. Clinical Practice Standardisation
- Support reduction in unwarranted variation within elective pathways and improve throughput by providing digital support to the Getting It Right First Time initiative. Specifically improve clinical noting standardisation.

3.3. Key Performance Indicator Management
- Consolidate and utilise the vast data to which we have access, to support the introduction of additional KPIs e.g. target length of stay, clinic utilisation and smart visit scheduling.

3.4. Administrative Practice Standardisation
- Support Shared Corporate Teams to embed and maximise use of digital to support back office processes e.g. enhance recruitment process. Support the sharing of Corporate Services across North Central London.

3.5. End User Process Consolidation
- Support the introduction of a single Helpdesk which is established to support our staff across all areas of the Trust. Introduce intelligent process automation to improve efficiency and effectiveness.

Our digital objectives: the underpinning enablers.

Whittington Health NHS Trust

The diagram below expands upon each of the underpinning enablers defined within the strategy framework and details the proposed priority areas of work within each underpinning enabler; most of which provide a focus for business as usual activity:

Transformation Programmes

IM&T supporting operational teams, the Trust Transformation Team and the Trust Programme Management Office to embed the delivery of the objectives within the pillars of work within organisation-wide transformation programmes.

Technical Infrastructure

Solutions: Having invested heavily in deploying clinical solutions, we will continue to enhance these solutions to deliver the objectives of the strategy; including a strategic review of current-state, aligned with contract end dates e.g. our EPR and maternity systems.

Infrastructure: Ensuring the backbone of our digital solutions is fit for purpose and provides resilient, rapid access. This includes servers, storage, user management tools, cyber security measures and network connectivity. All key components to delivering digital service which support clinical services and future technology.

End User Devices: Not just PCs and laptops; this includes smartphones, and other devices which are used by our staff. We need to use an increased number of the best devices to utilise the systems we have available and to support care.

Patient Devices: Enabling patients to undertake the self management of their care and enabling our staff to make proactive intervention through technology such as home monitoring.

Business Intelligence and Data Warehouse: The importance of data to providing health and care will continue to exponentially grow as it is used to drive transformation, support population health and enable machine learning. Our Business Intelligence strategy will be key to ensuring we realise potential benefits, based on a strong foundation.

Integration: Continuing on our journey to deliver the complete, and realtime, view of a patient, we will continue to invest in integrating systems and devices within the Trust as well as between solutions across North Central London, and beyond. E.g. extending careflow connect to community based staff so handovers on patients can be shared across the ICO as well as augment carecentric to include community data so patient data is shared as well.

Digital Skills Development

The Trust has a wide variation in levels of digital skills across staff and patients, and our environment has an ever increasing requirement to support staff with digital skills, and develop use of data. Supporting our staff in their digital and data skills should be a priority for the Trust. We will also seek to work with partners to support our wider community to develop the skills needed to realise the benefits of our technologies and increased data.

Innovation Focus

We will ensure we continue to encourage innovation and horizon scanning. We will focus on areas such as clinical decision support, informing lifestyle choices, enabling self management of care, developing the workforce, enabling earlier intervention (such as in cardiovascular disease and cancer) and in developing access to services.

Our digital objectives: how they address our needs.

Whittington Health NHS Trust

The table below maps how the objectives within this strategy support the achievement of the identified organisational, patient and staff needs:

		Organisational Needs			Patient Needs			Staff Needs						
		Trust Strategy	National Drivers	Regional Drivers	Improvement of Information	Working in Partnership	Providing Holistic Care	Supporting New Ways of Working	Access to Longitudinal Care Record	Intelligent Alerting Systems	Realtime Collaboration Tools	Virtual Consultations	Access to the Right Technology	Single Front Door' Support
1.1	Digital Outpatients	◆	◆		◆		◆	◆	◆			◆	◆	
1.2	Remote Monitoring	◆	◆		◆		◆		◆	◆		◆		
1.3	Community Careflow	◆	◆	◆	◆		◆	◆	◆	◆	◆	◆		
1.4	Cross Provider Services	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆
1.5	Enable Long Term Condition Research	◆	◆	◆	◆	◆	◆	◆		◆		◆		
2.1	Patient Facing Services	◆	◆	◆	◆	◆	◆			◆	◆	◆		
2.2	Community Estates Strategy	◆		◆			◆	◆				◆	◆	◆
2.3	Right Supplies in the Right Place	◆						◆					◆	
2.4	System Wide Integration	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆
2.5	EPR Advancement	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	
3.1	Population Health Analytics	◆	◆	◆	◆	◆	◆	◆	◆	◆			◆	
3.2	Clinical Practice Standardisation	◆	◆	◆			◆	◆	◆	◆	◆	◆	◆	◆
3.3	KPI Management	◆		◆				◆	◆	◆				
3.4	Admin Practice Standardisation	◆		◆			◆	◆	◆	◆		◆	◆	◆
3.5	End User Process Consolidation	◆						◆	◆	◆			◆	◆
Transformation Programmes		◆	◆		◆	◆	◆	◆	◆	◆			◆	
Technical Infrastructure		◆						◆	◆	◆	◆	◆	◆	
Digital Skills Development		◆	◆	◆	◆	◆	◆	◆				◆	◆	
Innovation Focus		◆	◆	◆	◆	◆	◆	◆					◆	

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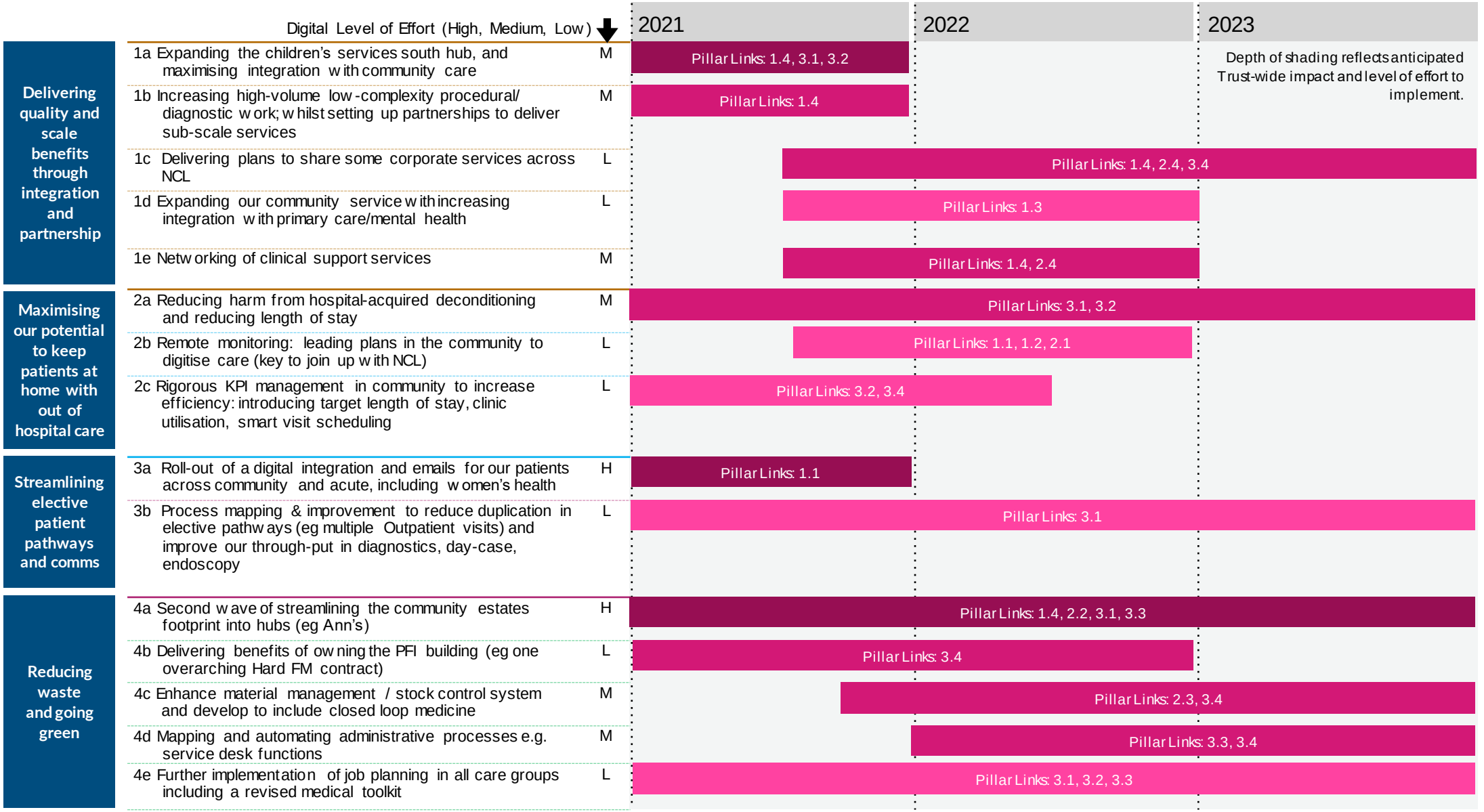
6. Our transformation priorities and digital roadmap.

Our digital roadmap aligns our pillars of work and developments in our underpinning enablers, to the wider transformation agenda within the Trust to create an integrated approach to delivery and benefits realisation.

Transformation priorities and indicative programme schedule.

Whittington Health NHS Trust

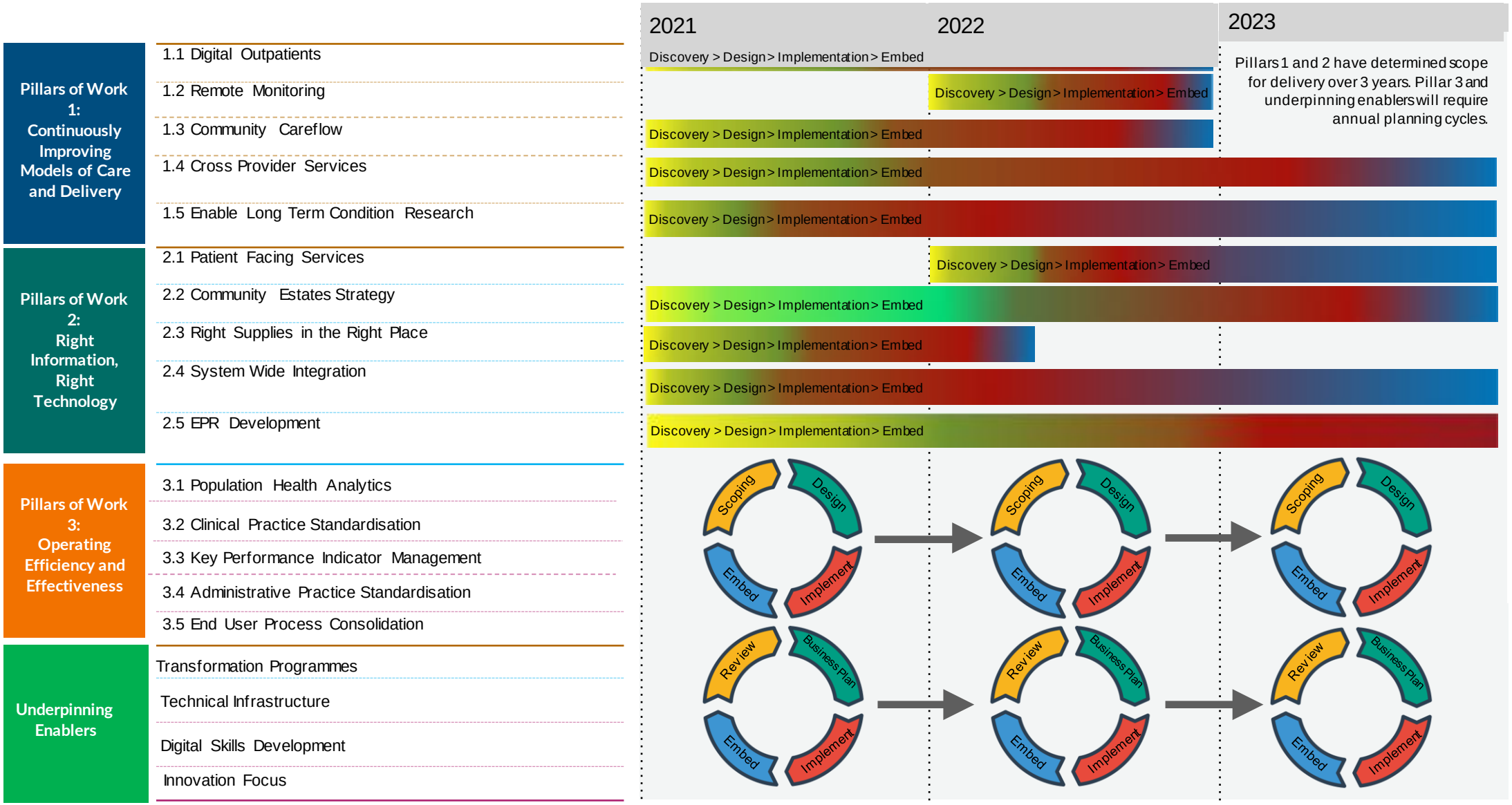
The diagram below provides an estimate of an indicative schedule for core activities relating to the Trust transformation priorities and also notes how each of these activities link to the pillars of work within this strategy:



Digital roadmap.

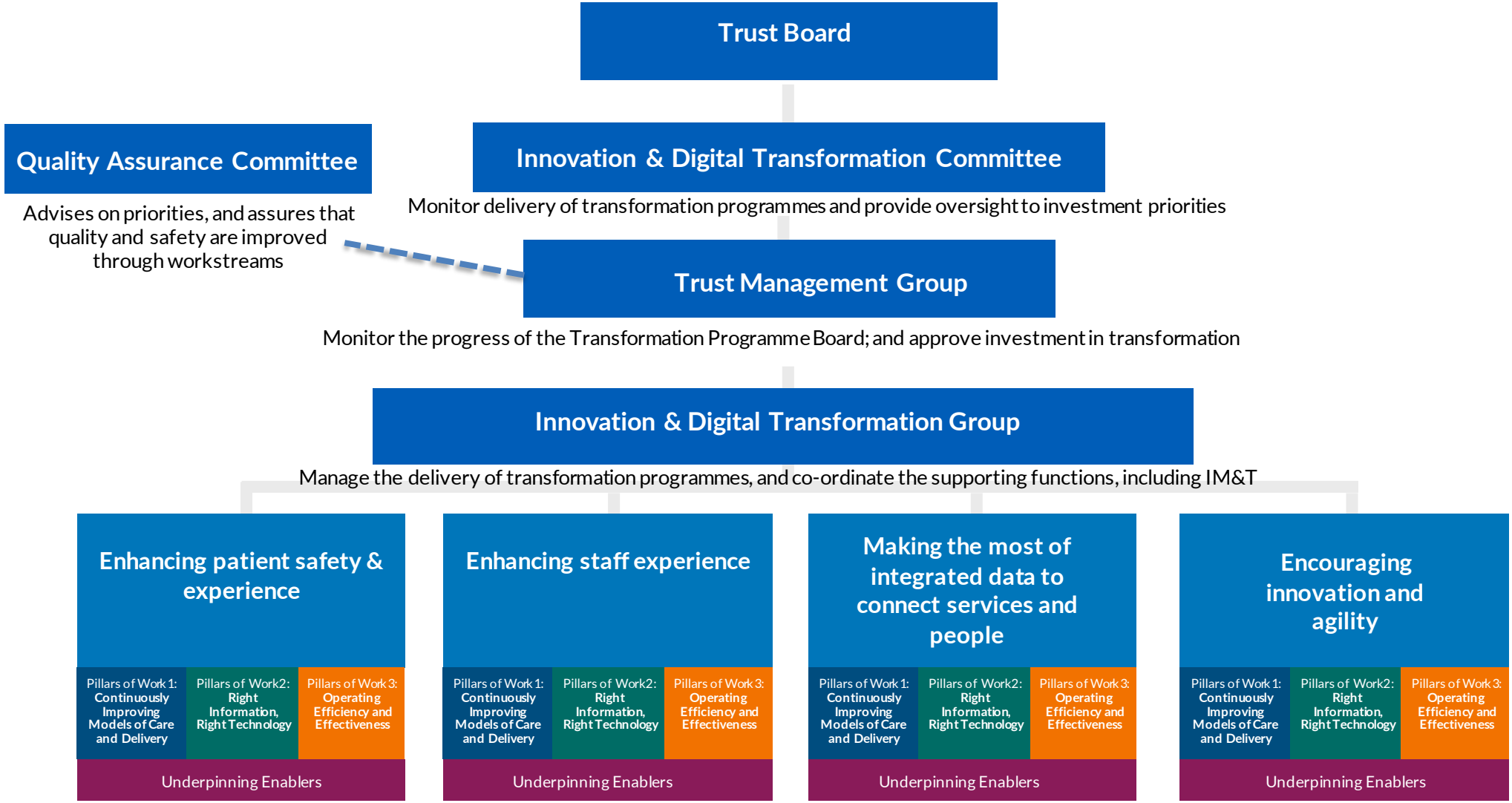
Whittington Health NHS Trust

The diagram below provides an estimate of the intended schedule for core activities relating to the delivery of this digital strategy, having considered how they align with supporting delivery of the Trust transformation priorities:



Proposed delivery governance structure

The diagram below illustrates the proposed governance structure the Trust could implement to oversee the delivery of transformation programmes; the achievement of which this digital strategy plays a keyrole:



Governance functions for multi-disciplinary transformation programme delivery, including digital

Learning from & Working with Others – Relationships and interdependencies.

Whittington Health NHS Trust

The delivery of this strategy will require close collaboration with a range of key stakeholders; as illustrated below.

Care Providers

We will work with care providers across the Trust and our partner organisations to deliver digital enabling solutions and services which are user- centred, based on real needs and which make the job of caring for local people easier - focusing on user adoption and ease of use.

Local People

We will work with local people to deliver increased citizen-facing digital solutions, to increase and improve their engagement with care providers and to enable our citizens to access digital services which help them to proactively live healthier and happier lives.

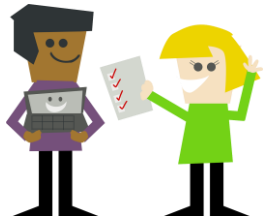
Healthcare Partners

We will work with healthcare partners to maximise the return on combined investment in digital, to work towards meeting the NHS long term plan and to develop the extent to which we achieve system-wide integration for the benefit of local people.

Wider System Partners

We will work with wider system partners, including local authorities, private and third sector partners to align both strategy and delivery, to ensure the maximum adoption, embedding and benefit from investment in digital solutions.

Solution Partners



We will work with solution partners to deliver digital technologies successfully, to develop sound commercial relationships based on collaborative working to deliver common objectives, and to deliver maximum return on investment.

Previous Example - The Global Digital Exemplar Programme (to which Whittington Health was a Fast Follower to University Hospitals Bristol NHS Trust) provided the Trust with an opportunity develop an operational, informatic and academic link to another organisation in sharing best practice in clinical informatics. The partnership proved a fruitful one with Whittington Health demonstrating its ability to design and deploy similar clinical transformation projects with a digital underpinning in half the time previously set by the other Trust as well as avoiding costly (in time and money) delays previously experienced. Whittington Health have also contributed to the NHS Futures Platform through Blueprints which will enable other organisations to benefit from our learning of deployment.

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7. What this will mean to our patients and staff.

Our digital vision for the Trust is to offer a rich patient and staff digital experience, which transforms care and enables local people to live longer and healthier lives. We therefore expect the delivery of this strategy to have a direct impact on the experience of our patients and our staff.

The impact of delivering our digital strategy.

Whittington Health NHS Trust

Our patients…

Our staff…

Interact with the Trust, and Care Providers Digitally
With increased and enhanced engagement, increased patient choice, automating patient rebooking, self serve patient data entry and patient-initiated follow up.

Experience a Transformation in Outpatient Appointments With extended use of virtual consultations for an increased number of outpatient appointments, patients will be able to receive healthcare advice from a location of their choice.

Receive Remote Support for Managing Long-Term Conditions
Through a range of digitally-enabled models of care, patients receive improved remote support with the management of long term conditions, and are able to self initiate a follow up.

Experience Continuity Across Care Providers
Less likely to need to provide duplicate information to care providers, and more likely to experience continuity in care delivery across traditional organisational boundaries.

Experience More Consistent Care
With increased standardisation in care pathways and reduction of unwarranted variation, we will enable the delivery of more consistent care and patient advice / guidance.

Access a More Comprehensive Patient Record
With the ability to access a richer and more comprehensive electronic patient record, care providers are better informed about the patient and better equipped to deliver continuity.

Access to the Right Tools and the Right Information
As our care delivery practice change, staff will have access to the right tools to deliver new models of care, and access to the right information at the point of care delivery; consistently.

Interact with Patients in New Ways
Through increased use of technologies such as virtual consultations, and remote monitoring, staff will be able to interact with patients proactively and more timely.

Receive Intelligent Alerts and Collaboration in Realtime With improved use of data to intelligently alert care providers with information that helps us to deliver improved care, and the ability to collaborate across organisational boundaries in realtime.

Access the Necessary Support More Effectively
With simplification of processes, tools and services, through which access support it will be easier for staff to access through a single Helpdesk, with routine support increasingly automated.

The impact of delivering our digital strategy.

Whittington Health NHS Trust

As an example, common musculoskeletal (MSK) conditions often do not require specific or specialist treatment . They may resolve if people follow simple, evidence-based advice. NHSX has gathered use-cases where digital technology has been used to provide immediate day-to-day support, while connecting people to their local MSK pathway and support services. By using technology, people are able to access trusted, evidence-based advice in a consistent and standardised way.

1. Self Management
We digitally provide immediate online guidance and support, which has the ability to connect local people to their MSK pathway and support services should it be required.

2. Self Referral
Conditions continue to cause concern, despite self management. We digitally provide the entry point for referral to ease access, save GP time and enable people to see a clinician much sooner when needed.

3. Virtual Review
An online appointment is made to triage the patient and provide immediate advice, then, if a clinic review is needed, to be seen at the right time by the right clinician, or amend self management.

4. Virtual Multi-Disciplinary Review
Digitally enable formal mechanism for multidisciplinary input into advising clinicians regarding ongoing management and care of patients, to ensure patients are seen in the right place at the right time.

5. Virtual Education and Exercise Programme
Delivering facilitated education discussion and exercise session virtually, allowing people to access the programme and continue to receive the necessary support with their condition.

6. Discharge
Following a further virtual review, satisfactory progress is being made to improve the condition. Electronic guidance material is provided to supporting the patient to manage their own condition following discharge

7. Patient-Initiated Follow-Up
Should it become necessary, the patient can digitally request a follow up appointment for further, advice and guidance, or for review which may result in intervention.

The impact of delivering our digital strategy.

Whittington Health NHS Trust

We plan to build on this MSK example to further transform the care we are able to provide, enabled by greater use of digital.

Prevention
Local residents use online MSK prevention programmes tailored to their sport or occupation.
Local resident develops MSK problem/ injury and accesses online tailored self care support.

Online Pre Assessment
If symptoms are ongoing, the local resident completes an online pre-assessment questionnaire, which would include being presented with a body chart, and the ability to add patient reported outcome measures.

Enhanced Digital Triage
Based on the Online Pre Assessment, an appointment booking for assessment with most appropriate MSK professional at time/place of their choice (virtual or face to face, as necessary)

Personalised Care Planning
If needed a digital personalised exercise programme with videos, progress checker, goal setting, common questions answered is prescribed including online self management advice with guided self help to support.

Reviews
Reviews scheduled as needed by clinical presentation – organised by patient/clinician virtually as necessary.

Medication Records
Prescriptions given from MSK Services should update GP records.

Diagnostics
If imaging/ investigations required patient able to book directly at suitable time and results go directly to clinician for appropriate action who can then easily text patients results and other info needed.

Onward Referral
If second opinion or onward referral is required it should be seamless booking into an MDT where all clinical information is available automatically to all participants to ensure timely clinical decision making.

Discharge
Discharge with full return to function. Should it become necessary, the patient can digitally request a follow up appointment for further, advice and guidance, or for review which may result in intervention.

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8. Inequality and Digital Divide

As a Trust, we are ambitious and we see the wider health and care agenda that needs to be achieved in order to transform the health and wellbeing of the local people we serve. During the delivery of this strategy, we must also seek to establish how we might make an impact beyond current plans, how we might connect communities, and how we might radically transform how we serve the health and wellbeing of local people by aiming to reduce the digital divide and inequality in the population we serve.

Targeting the digital divide and reducing inequality
Helping local people live longer, healthier lives

Whittington Health NHS Trust

Population Health Analytics provides a great opportunity to transform how we safeguard and enhance the health and wellbeing of local people, and address the health inequalities which exist and which are determined by wide ranging factors. For example, it has been identified that across Haringey, there is a 15 year gap in healthy life expectancy between the most and least 'well-off' parts of our community.

We want to bring operation, performative, clinical and outcomes data together through the ICS model to improve patient pathways, clinical decision making and drive analysis of population health needs to develop targeted interventions for patients most in need.

Here we provide a high level overview of some examples of key digital-related themes which the Trust could explore, with partners (primary, social, charity and commercially) across the ICS, alongside the development of the wider Trust strategy, and which could be transformational for the health and wellbeing of local people.

CONNECTED CARE - Developing ICS wide Connected Community Services

North Central London partners in health and care are working together to serve a population of c.1.6 million. The impact of wider determinants of health and wellbeing on citizens creates opportunity for constituent organisations of the ICS to work closely, and engage other community organisations to strengthen support for population health, further address inequalities and enhance its position as an integrated care system. Digital will unquestionably be an enabler in making this a reality - sharing data across services, and becoming increasingly and proactively insight driven.

ACCESS - Implementing Digital Hubs in the Community

As we continue to engage with our communities remotely, if we have an ambition to become the trusted place for local people to come for health advice, and to ensure we are well placed to fully realise the benefits of developing connected community services, we must ensure local people can access the technology they need to engage fully with us. Currently, not all local people are able to securely and safely engage with us remotely from their homes. As we seek to work with community partners, there is the opportunity to implement digital hubs to provide access to technology.

OPPORTUNITY - Enhancing the Digital Skills of Local People

A recent Ipsos MORI survey determined that c.11.7 million people in the UK lack the essential digital skills necessary for day-to-day life online, one in three have boosted digital skills during 2020, and around half of 18-34 year-olds have assisted others with digital skills. We know that this landscape will be reflected across the communities we serve. As we rely more on remote and assistive technologies to prevent, diagnose and treat, we should identify opportunities to work with partners to support local people to develop digital skills, to increase our ability to impact.

SELF MANAGEMENT - Digitally Activating Local People

There exists great opportunity to work with system partners to digitally activate local people to take greater ownership of their health. For example, what began as a limited number of health monitoring devices has transformed into a whole new sector in wearable technologies. These devices range from smartphones which encourage healthy lifestyles to fitness tracking devices which can perform ECGs and blood pressure monitoring, to new technologies embedded in to robotic limbs. Local people are more commonly taking ownership of their health and wellbeing, supported by consumer devices and applications.

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9. What We Want To Be Known For

As a Trust, we have a clinical strategy which states we want to be leading on integrated care with a particular focus on women, children and the frail elderly. This strategy sets out how we can deliver business as usual now and in the future for all the competing priorities at a local, regional and national level for the next few years. This leaves one particular question which is 'what do we want to be known for' for instance when a patient or clinician wants sector leading innovative care they think of us as their first port of call.

Our specialism or 'USP' – Digital Integration

Whittington Health have an industry respected track record on connecting systems across different workplaces through our shared care record Carecentric (primary, community, acute and social care settings). However this should just be the beginning. Therefore the underlying aim is–

To be the best in the UK at using integrated community and hospital data to improve care for frail elderly, women, and children.

- *For Frail elderly this will mean: in year one making community notes accessible to hospital staff, bringing community staff onto the shared MDT based integrated handover, and over the next year to two making data insights available to them to help improve anticipatory care*

- *For Women this will mean: in year one making maternity yellow notes digital for mothers to access, over the next three years building our skills to partner and innovate with the best technology to support continuity of carer teams, and improve the digital patient experience*

- *For Children this will mean: being open to opportunities as they present themselves through the NCL Start Well ambition over the next year and then refine the focus in year two.*

How do we do this:

- **Strategic Partnerships** – learn from the best in the world on how digital innovation and integration with is delivered at frontline clinical services (e.g. - Frailty and reduced hospital admissions)
- **Innovation Hub** – act as a startup host for those who can integrate with our systems
- **Sector Lead** – aim to deliver integrated care through digital transformation pathways joining up MDT care from community, primary, acute and social care.

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Meeting title	**Trust Board – public meeting**	**Date: 25 November 2021**
Report title	**Audit & Risk Committee Chair's Assurance report**	**Agenda item: 11**
Committee Chair	Rob Vincent, Non-Executive Director	
Executive director lead	Kevin Curnow, Chief Finance Officer	
Report author	Swarnjit Singh, Trust Secretary	
Executive summary	This report details areas of assurance from the items considered at the Audit and Risk Committee meeting held on 21 October 2021. **Areas of significant assurance:** • Board Assurance Framework • Internal audit review – risk management • Internal audit review – business continuity • Whittington Pharmacy Community Interest Company annual accounts • Debtors' report **Areas of moderate assurance:** • Internal audit progress report • Internal audit recommendations tracker recommendations for consultant job planning and medicines management • Special payments and losses **The Committee also discussed and received updates on:** • Corporate Risk Register • Tender waiver and breaches report • External Audit plan • Counter fraud progress report	
Purpose:	Noting	
Recommendation(s)	Board members are invited to note the Chair's assurance report for the Audit and Risk Committee meeting held on 21 October 2021	
Risk Register or Board Assurance Framework	All	
Report history	Public Board meetings following each Committee meeting	
Appendix	None	

Committee Chair's Assurance report

Committee name	Audit and Risk Committee
Date of meetings	21 October 2021
Summary of assurance:	

1. The Committee can report significant assurance to the trust Board in the following areas:

Board Assurance Framework
Committee members reviewed the full Board Assurance Framework (BAF). They noted the BAF entries had been reviewed and agreed by the Quality Assurance, Workforce Assurance, Finance & Business Development and Innovation and Digital Assurance Board Committees. The updated section on population health risks to the delivery of the Trust's Integration strategic objective was also noted. Committee members discussed whether the BAF should reflect the forthcoming statutory duty to tackle health inequalities and agreed that more would be known on this obligation once the Bill had been considered by the House of Lords in the New Year. Committee members also noted that the 8 October Board seminar had outlined work taking place to address local health inequalities and progress was also included within the performance indicators used to measure progress with the delivery of strategic and corporate objectives.

Internal audit review – risk management
The Committee took good assurance from the review's rating of *significant assurance with some improvement required* following the internal audit review of risk management arrangements. The review concluded that Whittington Health's strategy and policy were sufficiently detailed and appropriate. Committee members highlighted the need for a consistent approach by Integrated Clinical Service Units and corporate departments to the scoring and escalation of risks.

Internal audit review – business continuity
Committee members were pleased by the positive outcome to the review of the Trust's business continuity arrangements. The rating assessment was *significant assurance with some improvement required.* Good practice was evidenced by the regular review and updating of business continuity plans in line with lessons learnt by North Central London providers.

Whittington Pharmacy Community Interest Company annual accounts
Committee members noted this was the fourth year of trading and another successful year with a small amount of profit. The Whittington Pharmacy had received positive and clean external audit of its accounts. There had also been some innovations within the year and the Pharmacy had moved to an electronic system for outpatients. The Committee discussed the possibility of reinvesting any savings and VAT costs within the organisation and the need to consider the implications of developments in NCL collaboration, and agreed that this issue be included on a future agenda of the Finance & Business Development Committee.

	Debtors' report The Committee took good assurance from the continued positive performance in reducing the level of debts from NHS and non-NHS bodies. They noted a significant reduction in debts owed by Welsh NHS bodies.
2.	**The Committee is reporting moderate assurance to the Board on the following matters:** **2021/22 Internal audit progress report** The Committee reviewed progress with the internal audit plan. They noted that work was taking place to finalise reviews for the Capital planning and Business planning reviews – both were due to be issued in November. Committee members were also informed that the cyber security review would be issued in December. In terms of other planned reviews, the Committee noted there was good engagement by directors and managers with the reviews and was informed that: • A significant amount of work had already taken place for the Care Quality Commission follow-up review and a draft report would be generated at the end of October • The Data Protection and Security Toolkit review was likely to be available in the next week • The aim was for the review of postgraduate medical education to be issued in the next fortnight, if possible **Internal audit recommendations tracker recommendations for consultant job planning and medicines management** The Committee noted the progress achieved with 68% of relevant medial staff having completed job plans. The Medical Director together with ICSUs' Clinical Directors and the Programme Management Office monitored the completion of job planning arrangements. The Committee noted the update and agreed that an attention on the scope and timing of the next review of the activity. **Special payments and losses** The Committee reviewed a report from the Assistant Director, Financial Services. They noted the historical trend data from 2011 which showed there was an average of one item per month of c. £2k. The Committee was informed that efforts were focusing on late notifications and the addition of a declaration cycle for managers to sign to confirm they understood their responsibilities. Members agreed this was a good idea.
3.	**Other items considered** **Corporate Risk Register** Committee members reviewed the Corporate Risk Register and were updated on risks that were now closed. The noted the actions taken to mitigate the risk in relation to demand for ear, nose, and throat (ENT) patients who required a diagnostic test. Similarly, they welcomed the reduction in risk scores for the entries in relation to staffing within the Pharmacy Aseptic Services Unit and in Interventional Radiology.

	Tender waiver and breaches report The Committee noted a decrease in breaches compared with the previous two-month reporting period. Committee members welcomed the reduction in waive applications over the last year. **External Audit progress report** Committee members considered an update from KPMG and noted that the external audit plan would be considered at the Committee's January 2022 meeting. The Committee also noted the advise from KPMG that, while a lot of the groundwork was done last year, there would however, be additional fees incurred. **Counter fraud progress report** Committee members received an update on activity since the last meeting. they noted that data had been submitted to the NHS Counter Fraud Authority as part of the exercise into procurement fraud. They also discussed the outcome and learning from a timesheet fraud case. The Committee agreed that this issue be included in the work programme for the internal audit team. **Tribute** The committee noted that the meeting was the last that would be attended by Stephen Dunham and expressed their thanks for the quality of his work and advise over his period service at the Whittington.
4.	**Present:** Rob Vincent, Non-Executive Director (Committee Chair) Amanda Gibbon, Non-Executive Director Glenys Thornton, Non-Executive Director **In attendance:** Vivien Bucke, Business Support Manager Kevin Curnow, Chief Finance Officer Clare Dollery, Medical Director Stephen Dunham, Assistant Director, Financial Services Jerry Francine, Operational Director of Finance Jonathan Gardner, Director of Strategy, Development & Corporate Affairs Gillian Lewis, Associate Director, Quality Governance Fleur Nieober, Director, KPMG Ciaran McLaughlin, Director, Public Sector Assurance, Grant Thornton Phil Montgomery, Procurement Business Partner Stuart Richardson, Chief Pharmacist James Shortall, Local Counter Fraud Specialist, BDO Craig Waterman, Manager, KPMG **Apologies:** Carol Gillen, Chief Operating Officer Andy Conlon, Manager, Grant Thornton Swarnjit Singh, Trust Secretary

Meeting title	**Trust Board – public meeting**	**Date: 25 November 2021**
Report title	**Charitable Funds Committee Chair's Assurance report**	**Agenda item: 12**
Executive director lead	Kevin Curnow, Chief Finance Officer	
Report author	Swarnjit Singh, Trust Corporate Secretary	
Executive summary	In line with governance arrangements, this Committee Chair's report reports on areas of assurance on the items considered at the 23 September 2021 meeting of the Charitable Funds Committee. **Areas of significant assurance:** • Financial report • Consolidation of charitable funds • Fundraising report **Other key issues:** Committee members reviewed and approved applications for funding. There were no items covered at these meetings for which where the Committee is reporting limited assurance to the Trust Board.	
Purpose:	Note	
Recommendation(s)	Board members are invited to note the Chair's assurance report for the Charitable Funds Committee meeting held on 23 September and the applications for funding agreed.	
Risk Register or Board Assurance Framework (BAF)	Sustainability 1	
Report history	Public Board meetings following each committee meeting	
Appendices	None	

Committee Chairs' Assurance report

Committee name	Charitable Funds Committee
Date of meeting	23 September 2021
Summary of assurance:	

1. The committee can report significant assurance to the trust Board in the following areas:

Financial report

The Committee noted that income for 2021/22 was lower than the prior year as donations relating to Covid-19 had tailed off as the pandemic crisis had progressed. Expenditure to month 5 was £178k split between £88k for Charitable activities and £90k for staff and governance costs. The Charity generated £60k of income in quarter one . The Committee noted that some fund balances showing as negative where there were overspends and agreed on the need for a continued rationalisation of some very small accounts.

Consolidation of charitable funds

Committee members took good assurance from the work which had taken place with advice from BDP Pitmans to consolidate the more than 40 charitable funds in place. Once the consolidation work was completed the Trust would be left with eight restricted funds and eight designated funds. It was noted that the Charity would submit a report to the Charity Commission who would provide the final consent for the rationalisation of the various funds.

Fundraising report

The Committee was updated on work taking place on Trust and Foundation applications - an income stream that had previously been underutilised. Committee members noted this was a potential source of funding for the community. The Committee was also apprised of progress with the procurement of a new case management system and gave support for the replacement system.

2. Applications for funding

The Committee Chair also highlighted issue of NHS Central guidance on the emphasis for charitable investment to be used primarily for patient experience activities, rather than staff support. The latter would be acceptable if it clearly links to a better patient experience but there is a clear steer towards that switch in emphasis.

The Committee reviewed and approved bids received, including the following:

- £2.15k for the Trust's annual staff awards event
- £5k for a nursing and midwifery event
- £4.3k for an event in gynaecological services
- £2.3k for a video to be produced by gynaecological services
- £3k for an event for Allied Health Professionals
- £2k for the inaugural Allied Health Professionals' awards

3.	**Present:** Tony Rice, Non-Executive Director (Committee Chair) Kevin Curnow, Chief Finance Officer Clare Dollery, Medical Director Siobhan Harrington, Chief Executive Michelle Johnson, Chief Nurse & Director of Allied Health Professionals **In attendance:** Allison Ballsamo, Trusts & Foundations and Charity Projects Manager Faith Bulleyment, Creative Concern Vivien Bucke, Business Support Manager, Finance Sam Lister, Head of Charity Eddie Mitchell, Fundraising Manager Alex Ogilvie, Deputy Head of Financial Services Swarnjit Singh, Trust Secretary Sarah Williams, BDP Pitmans **Apologies:** Baroness Julia Neuberger, Non-Executive Director Jonathan Gardner, Director of Strategy & Corporate Affairs