NHS
Whittington Health
NHS Trust

## Trust Board meeting in Public Agenda

There will be a meeting of the Trust Board held in public on **Friday, 26 January 2024** from **09.15am to 10.50am** held in Rooms A1 and A2 in the Whittington Education Centre, Highgate Hill, London N19 5NF.

| Item | Time | Title | Presenter | Action |
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| | | **Standing agenda items** | | |
| 1. | *0915* | Patient story | Chief Nurse & Director of Allied Health Professionals | Note |
| 2. | *0930* | Welcome, apologies, declarations of interest | Trust Chair | Note |
| 3. | *0931* | 29 November 2023 public Board meeting minutes, action log, matters arising | Trust Chair | Approve |
| 4. | *0935* | Chair's report | Trust Chair | Note |
| 5. | *0940* | Interim Accountable Officer's report | Interim Accountable Officer | Note |
| | | **Quality and safety** | | |
| 6. | *1000* | Quality Assurance Committee report | Committee Chair | Note |
| 7. | *1010* | Impact of Industrial action | Acting Deputy Chief Executive | Note |
| 8. | *1015* | Maternity Incentive Scheme | Chief Nurse & Director of Allied Health Professionals | Approve |
| | | **Performance** | | |
| 9. | *1020* | Finance and capital report | Chief Finance Officer | Discuss |
| 10. | *1030* | Integrated performance scorecard | Chief Strategy, Digital & Improvement Officer | Discuss |
| 11. | *1040* | Q3 Delivery of corporate Objectives | Chief Strategy, Digital & Improvement Officer | Note |
| 12. | *1045* | Questions to the Board on agenda items | Trust Chair | Note |
| 13. | *1050* | Any other urgent business | Trust Chair | Note |

**Minutes of the meeting held in public by the Board of Whittington Health NHS Trust on 29 November 2023**

| **Present:** | |
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| Baroness Julia Neuberger | Non-Executive Director and Trust Chair |
| Junaid Bajwa | Non-Executive Director |
| Dr Clare Dollery | Acting Deputy Chief Executive Officer & Medical Director |
| Naomi Fulop | Non-Executive Director |
| Amanda Gibbon | Non-Executive Director |
| Nailesh Rambhai | Non-Executive Director |
| Baroness Glenys Thornton | Non-Executive Director |
| Rob Vincent CBE | Non-Executive Director |
| Terry Whittle | Chief Finance Officer |
| Sarah Wilding | Chief Nurse & Director of Allied Health Professionals |
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| **In attendance:** | |
| Mike Cooshnea | Deputy Chief Operating Officer |
| Norma French | Director of Workforce |
| Jonathan Gardner | Director of Strategy & Corporate Affairs |
| Tina Jegede MBE | Joint Director of Inclusion & Nurse Lead, Islington Care Homes |
| Marcia Marrast-Lewis | Assistant Trust Secretary |
| Andrew Sharratt | Associate Director of Communications and Engagement |
| Swarnjit Singh | Joint Director of Inclusion and Trust Company Secretary |
| Zoe Broadhead | Intensive Care Unit Nurse (item 1) |
| Kathleen Conneally | Senior Practice Development Nurse, Critical Care (item 1) |
| Louise Hayes | Senior Sister (item 1) |
| Dr Sarah Lunn | Clinical Psychologist (item 1) |
| Alex Negut | Patient Experience Manager (item 1) |

| **No.** | **Item** |
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| **1.** | **Patient experience story** |
| 1.1 | Sarah Wilding introduced Mr X who had attended to talk about the physical and psychological impact on him when he was an inpatient in the intensive care unit (ICU). |
| 1.2 | Mr X outlined the following points:<br>• He explained that he first presented at the accident and emergency department on 3 March with breathing problems. He was seen, prescribed steroids and discharged to go home.<br>• His breathing did not improve and he returned to the Accident & Emergency department the next day where he was diagnosed with suspected pneumonia or asthma and was told that, as he was not |

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| | asthmatic, it was difficult to diagnose asthma in adults. He was sent home with more medication, feeling reassured, but returned the next day on 5 March as his symptoms had become considerably worse.<br>• By the time he was seen by a consultant, Mr X was having a severe allergy-triggered asthma attack. On 5 March, he was admitted into the ICU with one to one nursing care, which reassured him that he was receiving the treatment that he needed.<br>• However, on 6 March, his condition deteriorated and he went into respiratory arrest. Mr X said that this was a very frightening experience as he had no idea of what was happening to him. He remembered begging for help but nothing more, as he fell into unconsciousness and was then placed into a medically induced coma.<br>• He awoke in the ICU, but was unable to move or communicate, as he had been ventilated. Mr X remembered seeing people around him and feeling very confused. He described the experience as surreal – it was as if he was stuck in his body - he could think but not speak. He felt reassured when a nurse came to him and told him he would be okay, and he felt even better when a doctor asked him to shake his hand.<br>• The days that Mr X spent in the ICU were hazy, as he could not remember conversations that he had with consultants, and did not understand what was happening to him.<br>• Mr X emphasised that he always felt reassured by the presence of the nursing staff and also when his family visited. After six days in the ICU, delirium set in and he suffered four seizures. Mr X said he was not sure why this happened, but slowly he regained perspective and his cognitive abilities.<br>• He said that having his first bowel movement after 14 days made him feel very happy. During his time in the ICU, Mr X felt that he was shown the utmost respect and that nurses treated him humanely and kindly. He was very thankful to the team for saving his life and, even when the medication made him psychotic, the team continued to help and support him. |
| 1.2 | Louise Hayes reported that she referred Mr X for respiratory counselling, which he needed to help manage the anxiety and depression he has experienced as a result of his illness. She explained that many patients who suffered respiratory distress and trauma required psychological support as well as physical treatment. Louise also confirmed that respiratory counselling was currently funded by the Charity and was an invaluable service needed to help patients, such as Mr X, make a full recovery.<br><br>**The Chair thanked Mr X for sharing his moving account of his experience in the intensive care unit with Board members.** |
| **2.** | **Welcome, apologies and declarations of interest** |
| 2.1 | The Chair welcomed everyone to the meeting. Apologies for absence were received from Chinyama Okunuga, Chief Operating Officer, and Helen Brown, Chief Executive Officer. |
| 2.2 | Glenys Thornton declared a new interest following her appointment as Shadow Minister for Digital, Culture, Media and Sport. Rob Vincent declared an interest |

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| | with his appointment as interim Chief Executive of the Electoral Commission from 1 December until 31 March 2024. Board members noted both declarations, which would be added to the register of interests. |
| **3.** | **Minutes of the previous meeting** |
| 3.1 | The minutes of the meeting held on 29 September 2023 were agreed as a correct record and the updated action log was noted. |
| **4.** | **Chair's report** |
| 4.1 | The Trust Board received and noted the Chair's report. |
| **5.** | **Chief Executive's report** |
| 5.1 | Clare Dollery took the report as read, and highlighted the following points:<br>• She thanked staff who had continued to work hard to ensure safety during industrial action and acknowledged the impact of the strikes on patients, particularly those on elective waiting lists. Clare Dollery confirmed that the British Medical Association would be putting the pay offer for consultants to a ballot of its members.<br>• The Trust had received correspondence from the Thirlwall Inquiry which was set up following the conviction of Lucy Letby for actions carried out at the Countess of Chester Hospital.<br>• A successful Allied Health Professionals' event was organised by the Chief Nurse and Deputy Director of Allied Health Professionals<br>• Professor Michael West spoke on compassionate leadership at the Trust and this was well received by the staff who joined this virtual event.<br>• The Community Diagnostic Centre had carried out its first MRI scan on 28 November. |
| 5.2 | In discussion, Board members raised these issues:<br>• Amanda Gibbon queried the level of staff flu and covid vaccination rates. In reply, Norma French explained that Whittington Health was performing slightly above the London average for the covid vaccine. She reported that, vaccination rates at the Trust were 30.5% for flu, against a London average of 31.7%, and 25.2% for covid-19 against a London average of 21.5%.<br>• Norma French provided assurance that, to help enable increased vaccination levels, the Trust had arranged static clinics on the acute site and roving clinics for community sites until 31 December. In addition, there were evening clinics for night staff as part of a significant vaccination campaign. Sarah Wilding added that vaccine uptake, particularly the covid-19 vaccine, was an issue across London, but that the Trust was doing everything that it could to encourage uptake.<br>• Julia Neuberger suggested there was more that could be done to ensure that vaccinators were more visible and made their presence known. Nailesh Rambhai commented that there was a general mistrust by ethnic minorities of the covid vaccine and wondered if this had affected staff take-up. Sarah Wilding agreed that there was a difference in vaccine take up between ethnic minority and white staff, which had also been seen in the uptake of the vaccines in community.<br>• Rob Vincent felt that the mistrust was in part likely to be driven by the media |

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| | as well the ongoing covid public inquiry. Clare Dollery added that many people felt that they did not need covid vaccine because they had contracted covid infections previously. She confirmed that there were incentives in place to encourage staff to get vaccinated.<br><br>**The Trust Board noted the Chief Executive's report and approved the cold weather plan.** |
| **6.** | **Quality Assurance Committee Chair's report** |
| 6.1 | Naomi Fulop presented the report. She advised that the Committee had met on 8 November when the Trust was in OPEL 4 and, given the significant operational pressure, a decision was made to reduce the length of the meeting to one hour to discuss the three most pressing issues: a never event, key risks at Simmons House and operational pressures which highlighted increased risks around infection control and patient experience. |
| 6.2 | Naomi Fulop confirmed that the remainder of agenda items that were not discussed at the meeting were considered separately and feedback was given, where requested, by email on specific items. Other agenda items on which assurance was required would be brought back to the next committee meeting in January, including the outcome of the Patient-Led Assessment of Care in the Environment (PLACE) Lite review where concerns were raised about cleanliness. |
| 6.3 | Clare Dollery updated Board members on the never event which related to a patient who required an operation to insert a ureteric stent as part of a non-elective presentation with urinary obstruction. The wrong site was mistakenly stented and the patient returned to the Accident & Emergency department a few weeks later with new symptoms. At that point, imaging clearly showed what had happened and the team had to promptly take the patient to theatre where the stent was removed and correct site stented. Clare Dollery stated that this type of mistake was known to happen at other Trusts and it was more difficult to prevent internal wrong site procedures, as organs were more difficult to mark. However, the team had developed a number of ideas to put to the Serious Incident panel to reduce the risk of repetition. Phillip Lee, Associate Medical Director for Patient Safety, would lead the investigation, which would consider human factors as well as process. The team would also be supported through the investigation with a focus placed on learning from the mistake. |
| 6.4 | Sarah Wilding confirmed that the Committee had considered the immediate response to the Serious Incident at Simmons House. Three areas of focus were highlighted: the safety of the young people in the unit, support for staff and the response and engagement with stakeholders and regulatory authorities.<br><br>**The Trust Board noted the Chair's assurance report for the Quality Assurance Committee meeting held on 8 November 2023** |

| 7. | Workforce Assurance Committee Chair's Assurance report |
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| 7.1 | Rob Vincent summarised the report for the meeting held on 25 October 2023. He drew attention to the following issues:<br>• The Committee discussed a progress report on the People Strategy which had been developed to improve support for the workforce and sought to develop an improved organisational culture, with the aim of better patient care and experience. The People Strategy was scheduled for submission to the Trust Board in December for approval.<br>• The statutory annual public sector equality duty (PSED) report. The Committee agreed that more attention needed to be given to improving workforce disability data and reporting on the Trust's anchor institution activities.<br>• A report from the Guardian of Safe Working Hours, where the Committee discussed the approach taken to address concerns related to stress, wellbeing and support for junior doctors. |
| 7.2 | In discussion, Board members raised the following points:<br>• Naomi Fulop observed that the annual equality report did not contain data related to patient access and interpreting and translation services, which was problematic across the NHS. Rob Vincent agreed that the lack of translators could raise safety issues for patients who could not speak English. Sarah Wilding provided assurance that performance on interpreting and translation services was monitored by the Patient Experience and Quality Assurance Committees.<br>• Nailesh Rambhai welcomed the patient data contained in the annual equality report, which he felt was very detailed. Turning to the workforce outcomes, he observed that an employee was more likely to suffer discrimination from staff rather than patients and queried the approach taken by the Trust to address bullying and harassment in the workplace. In response, Norma French explained that bullying and harassment was highlighted by the annual staff survey and, over a number of years, the Trust had implemented measures to change the culture of the organisation by improving staff engagement and investing in staff wellbeing.<br>• Tina Jegede assured the Trust Board that there was a real welcome for the new Staff Health and Wellbeing lead to help support staff engagement. She also reported on an initiative in Warwickshire where the NHS and local police force had worked together on a zero tolerance policy for incidents of bullying and harassment of staff by patients.<br>• Amanda Gibbon highlighted the scores achieved for the disabled which were significantly below the national average. Tina Jegede advised that a bid had been submitted for extra funding to increase the resources needed to focus on disability at the Trust.<br>• Clare Dollery confirmed that the Director of Medical Education and the Clinical Director for Emergency and Integrated Medicine would work together to address junior doctor wellbeing issues.<br><br>**The Trust Board:**<br>**i. noted the Chair's assurance report for the meeting of the Workforce Assurance Committee held on 25 October 2023; and**<br>**ii. approved the 20022/23 public sector equality duty report for** |

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| | **publication.** |
| **8.** | **Improvement, Performance & Digital Committee Chair's Assurance report** |
| 8.1 | Junaid Bajwa presented the report for the meeting held on 9 October 2023. He highlighted the following points:<br>• The work undertaken in respect of Electronic Patient Record (EPR) and the contract negotiations with System C were ongoing, with an update due at the next meeting in December. The Committee had endorsed the roll out of Badgernet as the next maternity EPR.<br>• The Committee held a deep dive into performance against cancer targets and discussed a presentation, which outlined the work needed to meet national standards and address the waiting list backlog.<br>• Committee members noted a report on information technology (IT) incidents caused by a local damaged telecommunications mast. The Committee was assured that IT incidents had not caused any patient safety issues and a further update on the issues would be provided at that next meeting.<br><br>**The Trust Board noted the Chair's assurance report for the meeting of the Improvement Performance and Digital Committee held on 9 October 2023.** |
| **9.** | **Audit and Risk Committee Chair's Assurance report** |
| 9.1 | Rob Vincent presented the report for the meeting held on 25 September 2023. He advised that:<br>• There had been a delay in delivery against some internal audit reviews due to serious illness being experienced by one of the auditors. At the meeting, the Committee received significant assurance from the internal audit review of preparedness for the Covid-19 public inquiry, which found that the Trust had implemented good processes to manage during the pandemic.<br>• The Committee received limited assurance from the internal audit review of the management of complaints. The review found significant shortcomings with the management of complaints at Integrated Clinical Service Unit (ICSU) level. |
| 9.2 | In discussion, Board members raised these points:<br>• Sarah Wilding confirmed that recommendations from the internal audit review would be implemented across the relevant ICSU, with support from the Quality Governance team.<br>• The Chair suggested that non-executive director colleagues should undertake a spot check of complaints, to understand the way in which each complaint was handled.<br>• Naomi Fulop commented that the elective care backlog was mirrored with the backlog of complaints and emphasised the importance of having a plan and trajectory in place to improve in both areas.<br>• Clare Dollery advised that she had responsibility for signing off complaint response letters, some of which accurately reflected the issues at the hospital. She added that, when there were pressures across the whole North Central London system and the hospital was in OPEL 4 status with patients in corridors and in the emergency department, more people would |

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| | register their dissatisfaction.<br><br>**The Trust Board noted the Chair's assurance report for the meeting of the Audit and Risk Committee held on 25 September 2023.** |
| **10.** | **Charitable Funds Committee Chair's Assurance report** |
| 10.1 | Amanda Gibbon reported on the meeting that took place on 21 September 2023 and explained that the Committee discussed:<br>• The transfer of the charity investments, which had taken some time due to the nature of the investment funds.<br>• The urgent assistance fund which had been established to help patients with small and low value requests. She thanked Board members for their contributions to the fund.<br>• The Philanthropy workshop arranged for senior leaders and clinicians on 27 November was well attended, and delegates learned how to make the most of philanthropic opportunities presented by patients, staff and external stakeholders. |
| 10.2 | Amanda Gibbon praised the efforts of the Charity Team to transform the profile of the Charity and looked forward to an exciting year ahead. She encouraged Board members to attend "an evening with Michael Palin" event to be held at Cadogan Hall on 24 April 2024, where all proceeds would be donated to the Michael Palin Centre for Stammering.<br><br>**Trust Board members noted the Chair's Assurance report of the meeting held on 21 September 2023 and agreed to circulate reminders in respect of the event on 24 April 2024.** |
| **11.** | **Integrated Performance Report** |
| 11.1 | Jonathan Gardner highlighted the following points from the report:<br>• Better outcomes for the improving access to psychological therapies service.<br>• Adult community waiting times for the podiatry service showed ongoing and steady improvement, with a reduction of 200 patients from the waiting list.<br>• Performance on the backlog in neuro-rehabilitation and bladder and bowel services was still challenged, and renewed efforts would be made to reduce these waiting lists.<br>• Improvements were starting to be seen in musculoskeletal services and in in occupational therapy waiting times.<br>• High referrals continued for therapies, including speech and language, and the expectation was that improvements would be seen in the next six months, in line with increased investment and the development of the new graduated offer.<br>• The number of clostridium difficile infections had risen to nine in October against a target of 13 for the year.<br>• Pressure ulcers in the community continued to be a concern and were discussed at performance reviews with teams. Efforts would continue to address the issue with equipment from suppliers and social care. Steps |

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| | had also been taken to raise the early identification of pressure ulcers with patients at home.<br>• In terms of access, performance against 62-day cancer targets continued to improve. However, performance against the 28-day target had slightly worsened.<br>• Referral to treatment waiting times had worsened.<br>• Diagnostic waiting times in audiology had improved significantly.<br>• Performance against emergency department metrics had also deteriorated. Mike Cooshnea explained that the extreme operational pressures experienced in the emergency department were shown in the 200 12-hour trolley waits.<br>• Performance on staffing indicators was green. |
| 11.2 | During discussion, Board members raised these issues:<br>• Junaid Bajwa asked whether challenges in the Emergency Department reflected the significant pressures experienced in primary care services and in the wider health and social care system.<br>• Mike Cooshnea explained that there were issues around access to primary care services, and the Trust was working to improve the streaming of patients through the urgent and emergency care pathway. In addition, there were specific challenges around ambulance diverts from North Middlesex University Hospital to Whittington Health and Barnet Hospital, which exacerbated the already extreme pressures faced across emergency care pathways through limited bed capacity and the discharge rates for medically optimised patients.<br>• Clare Dollery added that this was the focus of conversations at the North Central London Integrated Care System's Management Board and an area of concern for the Accountable Officer. She reported that Silver MADE meetings had been reinstated and would take place twice weekly, with participation from hospital trusts and social care partners.<br><br>**Board members noted the integrated performance report** |
| **12.** | **Finance and capital report** |
| 12.1 | Terry Whittle presented the Month 7 finance report, where the Trust reported:<br>• A deficit of £16.0m which was £4.3m worse than plan. Principal drivers for the deficit were:<br>  ○ the impact of industrial action, estimated at £5m for lost income and the cost of temporary staffing cover.<br>  ○ underperformance in the delivery of cost improvement savings<br>  ○ operational cost pressures in excess of funding for inflation and bed capacity. An additional £2m of funding had been secured to support bed capacity.<br>• The end-year forecast outturn had been updated and further discussions would take place following the Trust's H2 submission. A renewed focus on efficiency, productivity and a reduction in the backlog of elective care was needed to drive income.<br>• £12.7m had been spent from the 2023/24 capital expenditure plan. The forecast remained that the Trust utilise its entire capital plan this year. |

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| | Discussions were planned to ensure that large value schemes were delivered or capital funds reallocated to reduce the risk of unspent capital.<br>• The cash position at the end of October was £66.2m. It was expected that a significant portion of cash reserves would be used to reduce the forecast deficit position at the end of the year.<br><br>**The Trust Board noted the finance and capital expenditure report** |
| **13.** | **Questions from the public** |
| 13.1 | There were none. |
| **14.** | **Any other business** |
| 14.1 | There was none. |

**Trust Board, 29 November 2023 public meeting action log**

| Agenda item | Action | Lead(s) | Progress |
|---|---|---|---|
| Declarations of interest | Update the Board's register of declarations to reflect the interests reported by Glenys Thornton and Rob Vincent | Marcia Marrast-Lewis | Completed |
| Workforce Committee Chair's assurance report | Publish the annual public sector equality duty report on the Trust's webpages | Tina Jegede/Swarnjit Singh | Completed |
| Charitable Funds Committee Chair's assurance report | Circulate reminders to Board members for the fundraising event at Cadogan Hall in March 2024 for the Michael Palin Centre for Stammering | Sam Lister | Completed |

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| **Meeting title** | **Trust Board – public meeting** | **Date: 26.01.2024** |
| **Report title** | **Chair's report** | **Agenda item: 4** |
| **Non-Executive Director lead** | Julia Neuberger, Trust Chair | |
| **Report authors** | Swarnjit Singh, Joint Director of Inclusion and Trust Secretary, and Julia Neuberger | |
| **Executive summary** | This report provides an update and a summary of activity since the last Board meeting held in public on 29 November 2023. | |
| **Purpose** | Noting | |
| **Recommendation** | Board members are asked to note the report. | |
| **Board Assurance Framework** | All entries | |
| **Report history** | Report to each Board meeting held in public | |
| **Appendices** | None | |

## Chair's report

This report updates Board members on activities since the last Board meeting held in public.

I would like to start by wishing everybody a very Happy New Year and to thank our staff for their tremendous work over the Christmas and New Year to continue to maintain safe services, particularly during periods of high patient demand and during the industrial action which has of course adversely impacted elective services. I am deeply grateful for the leadership shown by Mat Shaw and Clare Dollery, and other members of the senior team, during this challenging time.

I am also very grateful to all colleagues who spent time on site thanking staff during the period between Christmas Day and New Year's Day. I know it was enormously appreciated.

### December private Board meeting

The Board of Whittington Health held a private meeting on 29 November. The agenda items discussed included a discussion on the new NHS patient safety incident response framework, the North Central London (NCL) system's Start Well review of maternity and paediatric services, a submission on activity and a revised end year financial outturn forecast made to the NCL Integrated Care System (ICS) on 23 November. In addition, Board members received a Chair's assurance report from the Finance and Business Development Committee.

### Re-appointment of non-executive directors

I am delighted to report that NHS England's appointments team have confirmed that Amanda Gibbon, Glenys Thornton and Rob Vincent are approved to serve a second term as non-executive directors of the Board. Their second terms will start on 1 May 2024 and end on 30 April 2026. All three are an enormous asset to the Trust and I look forward to continuing to work with them.

### Consultant recruitment panels

There were two recruitment and selection panel for consultant posts during this period as shown below:

| Post title | Non-Executive Director | Panel date |
|---|---|---|
| Consultant Diagnostic Imaging | Julia Neuberger | 24 January 2024 |
| Consultant Obstetrics and Gynaecology | Julia Neuberger | 24 January 2024 |

### Corporate induction

On 13 November 2023 and 8 January 2024, I took part in corporate induction training and welcomed new staff starting at the Trust.

I also participated in the following meetings:

- University College London Health Alliance Board
- Whittington Health Medical Committee

- Introductory meetings with Phil Wells, Interim Accountable Officer for the NCL ICS, Ellen Schroder, Chair of Great Ormond Street Hospital for Children NHS Foundation Trust and Marion Ridley, Trustee of The Children's Trust
- Catherine West MP and Emily Thornberry MP
- There were also many other informal meetings with staff and colleagues - I am grateful to everyone for their immense efforts in what has been an exceptionally busy and challenging time.

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| **Meeting title** | **Trust Board – public meeting** | **Date: 26.01.2024** |
| **Report title** | **Interim Accountable Officer report** | **Agenda item: 5** |
| **Executive lead** | Matthew Shaw, Interim Accountable Officer | |
| **Report authors** | Swarnjit Singh, Joint Director of Inclusion and Trust Secretary, and Matthew Shaw | |
| **Executive summary** | This report provides Board members with a report covering initial reflections at Whittington Health and important developments since the last Board meeting held in public on 29 November. | |
| **Purpose** | Noting | |
| **Recommendation** | Board members are invited to note the report | |
| **Board Assurance Framework** | All Board Assurance Framework entries | |
| **Report history** | Report to each Board meeting | |
| **Appendices** | None | |

## Interim Accountable Officer report

This is my first report to a Board meeting in public at Whittington Health NHS Trust. I am delighted to have joined the Trust to support the senior team over the next few months. I will be working at Whittington Health for two days each week while continuing to work for three days a week as Accountable Officer for Great Ormond Street Hospital for Children.

In this role, I am grateful to be supported by Clare Dollery, Acting Deputy Chief Executive and Medical Director, who will lead on day-to-day decision making, and by other colleagues in the senior team. My aim is to ensure that we continue to deal with the most pressing strategic and operational challenges and continue to provide a high quality, time, safe and effective care to patients. At this current time, the following priorities are my key areas of focus:

- Providing stability and leadership through setting clear priorities and agreeing those areas of work which can proceed at a slower pace
- Managing emergency department flow and improving our discharge of inpatients
- Delivering the best 2024/24 business plan we can that is both realistic in terms of financial and activity performance
- Helping to deal with knotty issues including performance

I would like to thank all of our staff for their hard work, particularly when faced with disruption caused by industrial action, as they have continued to show professionalism and dedication, especially in delivering safe services for patients.

**NHS Oversight framework**
I am pleased to report that the outcome of the 2023/24 segmentation under the NHS Oversight Framework was that Whittington Health would remain in segment two. The segmentation is based on a quantitative and qualitative assessment of areas set out in the Oversight Framework.

**NCL ICB – Start Well**
On 11 December, the North Central London Integrated Care Board (NCL ICB) opened the consultation on the future of maternity, neonatal and children's surgical services in North Central London. Whittington Health will be holding a mix of public meetings and events for staff to allow people to make their voices heard by responding to the consultation after Christmas. We will also be producing a range of materials which staff and our partners can use to quickly and easily encourage their friends, family and networks to take part and make their voices heard as well. I am glad that the initial patient and public receive so far is supportive of the recommendation to maintain maternity and neo-natal services at Whittington Health.

**Operational performance**
The integrated performance report is a separate item on the agenda. Headlines show these outcomes:

- Emergency care: performance against the four-hour access standard in December was 57.8% and represented a deterioration compared with

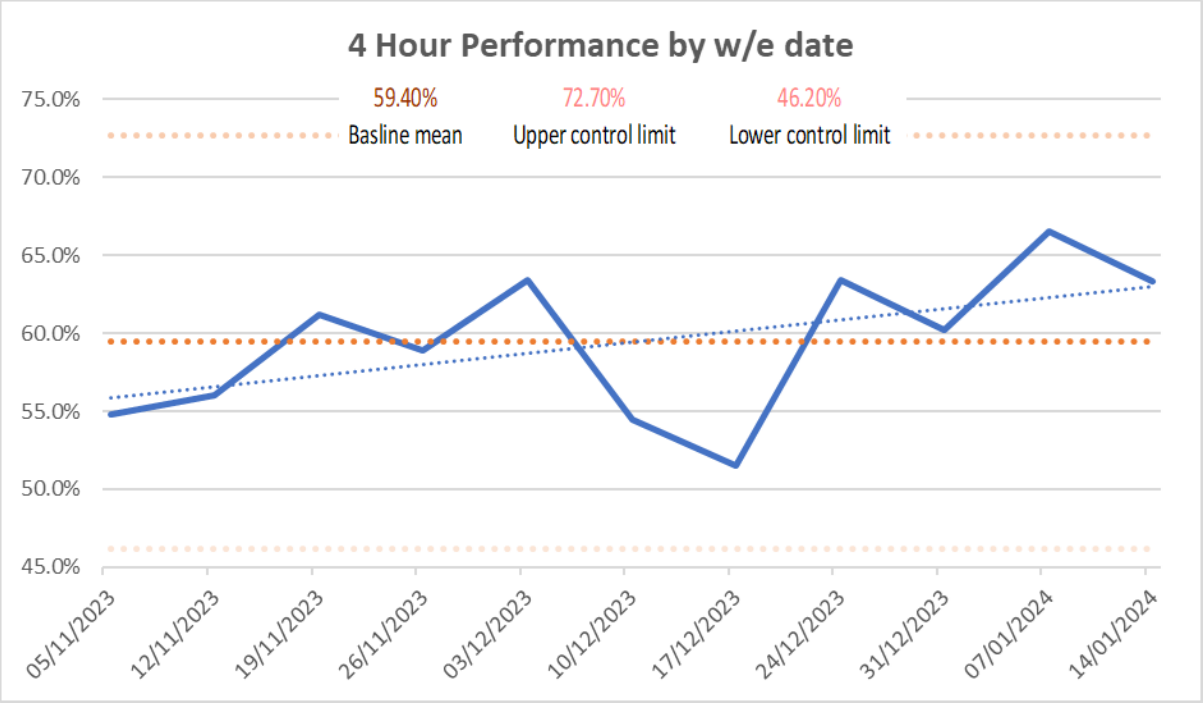
November's outcome. There were 322 12-hour trolley breaches in December 2023.

- Cancer care: performance against the 28 day faster diagnosis standard continued to show improvements in November 2023 with 66.3% which was up from the 62.3% achieved in October. There are encouraging signs that performance in January will be above the target of 75%
- Referral to treatment: performance against 18-week standard in December was 66.5%, representing a slight improvement from November's position. The Trust's position against on 52-week waits also has improved from 720 patients in November to 659 in December 2023. The Trust had 36 patients over 78 weeks at the end of November 2023 against a target of 0.

I wanted to also draw Board members' attention to two critical targets for MNHS providers to achieve by the end of this financial year: to have no patients who had waited longer than 78 weeks since their referral for treatment and to have no patients who had waited longer than 13 weeks for a diagnostic test. Operational teams are focused on delivering against both of these targets by 31 March 2024. Actions taken already to help improve performance have included a strengthening of the urgent treatment centre, the opening of a surge ward in mid-January and a focus on discharges. To help with the latter in the London Borrough of Haringey, I will be meeting with the Chief Executive of the council.

The graph below shows how the ED department has fared with meeting the four hour emergency access standard between 5 November 2023 and 14 January 2024.

**Performance against the 4 hour emergency department standard**



**Emergency preparedness, resilience and response**
I am pleased to the positive outcome from a review by NHS England and the North Central London Integrated Care Board's review of its emergency planning arrangements. Whittington Health was rated as substantially compliant with 58 green ratings and only four amber ratings for which is being taken forward.

**Financial challenges**
At end of December the Trust is reporting an actual deficit of £16.1m which is £3.5m adverse to plan. Key drivers for the adverse variance from plan include underperformance on elective activity, slippage on the delivery of the savings programme and other expenditure overspends such as escalation beds and strike costs for December. I am also pleased to report that the Trust received an additional £5m of capital funding in December for its fire remediation programme.

**All staff briefing**
On 11 January, I held a briefing for staff. The issues covered included an update on January's Improvement Delivery Week, the Start Well public consultation on maternity, neo-natal and paediatric surgery services, an update on pathology services and details of projects to reduce health inequalities in our adult community services.

**Staff vaccination rates**
The table below shows the percentage of staff who have had either the winter influenza or Covid-19 vaccination as of 14 January 2024 and compared with the vaccination rates for North Central London, London and England. The vaccination programme will continue to the end of January.

| | Whittington | NCL | London | England |
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| Covid-19 | 31.9% | 30.4% | 25.5% | 31.1% |
| Flu | 37.3% | 39.8% | 37.7% | 43.9% |

The update of each vaccine by staff occupational group is also shown below:

| Covid-19 by staff group | | Flu by staff group | |
|---|---|---|---|
| **Whittington** | **31.9%** | **Whittington** | **37.3%** |
| Administrative and clerical | 75.0% | Administrative and clerical | 75.0% |
| Medical and dental | 56.7% | Medical and dental | 60.3% |
| Allied Health Professionals | 40.5% | Allied Health Professionals | 44.8% |
| Nursing and midwifery registered | 29.0% | Nursing and Midwifery Registered | 35.2% |
| Add prof. scientific and technical | 28.3% | Add prof. scientific and technical | 29.6% |
| Healthcare scientists | 21.6% | Healthcare scientists | 29.5% |
| Additional Clinical Services | 20.8% | Additional clinical services | 27.4% |
| Students | 10.5% | Estates and ancillary | 19.6% |
| Estates and Ancillary | 9.8% | Students | 15.8% |
| **Grand total** | **31.9%** | **Grand total** | **37.3%** |

**2024/25 Business plans and Annual Plan submission**
The Trust is working to develop our draft annual plan submission and to have 2024/25 business plans in place for its clinical divisions and corporate teams. Alongside these plans, the Trust is developing a two to three year recovery plan to tackle its underlying financial deficit.

**Cleaning/estates**
In recognition of the concerns raised by Board members regarding estates and facilities and cleaning, the Trust is looking at short term mitigations on cleaning and new leadership arrangements are being established in this support service.

**Improvement weeks**
The Trust has now had held two improvement week initiatives designed to improve patient flow and performance, by focusing on the safe and timely discharge of patients supported by collaborative working from the new look Improvement Delivery team and corporate and integrated clinical service unit teams. The first week – Home for the Holidays – took place in December 2023 and concentrated on timely actions to support patient discharge, optimising same day emergency care (SDEC) and supporting flow from the emergency department (ED), whilst also capturing key learning for future improvement. On days when SDEC is not bedded, over 100 patients can be seen which helps to reduce the pressure on ED.

The second improvement week began on 15 January and looked at resetting the pathway discharge discussion, reviewing ward planning, with an escalation framework and tools provided to support this. Our North Central London system partners have also been working with us to review our patients who do not meet the criteria to reside. Guidance such as an escalation tool was produced to help support front line staff resolve discharge delays, with visible leadership and engagement throughout the week. The improvement week sits alongside plan-do-act-study methodology and other initiatives aligned to the flow programme, so that, on days such as Wednesday 17 January, when 69% of patients were discharged home by 5.00pm, it is possible to review the various interventions that day to help build for further improvements.

**King's New Year Honours List**
Congratulations go to Huda Mohamed who received a Member of the British Empire award for her services to midwifery. Huda has been our female genital mutilation (FGM) specialist lead midwife since 2016 and has worked with local communities, offering support to women and their families, local authorities and colleagues involved in safeguarding arrangements and other partners. During her time at the Trust, Huda has seen over 100 women with FGM, including asylum seekers and refugees, frequently deprived and vulnerable, and always seeks to bring about positive changes to their lives by ensuring holistic and empathetic care is provided. Ruth May, Chief Nursing Officer for England, visited our maternity unit on Thursday 18 January and also spent an afternoon shadowing Huda in her FGM clinic.

**Extra Mile Awards**
I am pleased to announce last month's winners of the Trust's Extra Mile awards. The individual winner was Margot Innocent. She was recognised for her work on staff engagement and inclusion, particularly initiatives including staff networks, See Me First, and Freedom to Speak Up. Margot exemplifies the Trust's values every day in her work.

The team winners are the Audiology team. At the start of 2023, acute and community audiology diagnostic performance was 35.5% within 6 weeks, well below the target of 99%, affecting over 900 patients. The stretched and understaffed team set about improving this. They showed great flexibility, working beyond their specialties and running overtime clinics. They rang patients ahead of appointments, to make the most of their face-to-face time. Thanks to this dedication, their November performance increased to 80.5%, with just 154 patients waiting more than 6 weeks for a hearing test – a significant 83% reduction. Beyond this, the team has also campaigned to increase awareness of the needs of the deaf and hard of hearing and has introduced a new referral pathway from the memory clinic in Haringey to our adult service, to help cut cognitive decline.

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| **Meeting title** | **Trust Board – public meeting** | **Date: 26 January 2024** |
| **Report title** | **Quality Assurance Committee Chair's report** | **Agenda item: 6** |
| **Committee Chair** | Naomi Fulop, Non-Executive Director | |
| **Executive leads** | Sarah Wilding, Chief Nurse & Director of Allied Health Professionals, Clare Dollery, Acting Deputy Chief Executive and Medical Director | |
| **Report author** | Marcia Marrast-Lewis, Assistant Trust Secretary | |
| **Executive summary** | The Quality Assurance Committee met on 10 January 2024 and was able to take significant or reasonable assurance from the following items considered:<br>• Winter Pressures Plan<br>• Q3 Board Assurance Framework<br>• Risk Register<br>• Impact of Industrial Action<br>• Controlled Drugs Update Report<br>• Maternity Incentive Scheme (MIS) Year 5 – submission update<br>• Safeguarding Training Compliance Update<br>• Biannual nursing establishment review<br>• PSIRF Implementation Update and PSIRF Policy<br>• Learning from Deaths Reports Q1 & Q2<br>• Bi-Annual Health and Safety<br>• Q2 Uro-Oncology Report<br><br>Committee members took moderate assurance from the following agenda items:<br>• Simmons House update report<br>• Chair's assurance report, Quality Governance Committee<br>• Patients admitted to hospital under the Mental Health Act<br>• PLACE Update<br>• Anti-ligature assessment report<br>• Serious Incident Board report<br>• Patient Experience Report<br>• Q2 Quality report<br><br>The Committee also received a presentation the Surgery & Cancer Integrated Clinical Support Unit on 'Sip Til Send'. | |

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| | Following discussion, the following four key risks were identified to be reported to the Trust Board:<br>1. Cleaning, including recruitment of domestic staff, training and the timeframe for improvement.<br>2. Services for patients with mental health issues across the organisation<br>3. Safety concerns around unfunded flex beds<br>4. The impact of industrial action. |
| **Purpose** | Approval |
| **Recommendations** | Board members are asked to note the Chair's assurance report for the meeting held on 10 January 2024 and to approve the draft Patient Safety Incident Response Framework policy |
| **BAF** | Quality strategic objective entries and the Integration 2 entry |
| **Appendices** | 1. Patient safety incident response framework paper, policy and response plan<br>2. Safer staffing<br>3. Q2 Quality report<br>4. Patient experience report<br>5. 2023/24 Q1 learning from deaths report<br>6. 2023/24 Q2 learning from deaths report |

**Committee Chair's Assurance report**

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| **Committee name** | Quality Assurance Committee |
| **Date of meeting** | 10 January 2024 |
| **Summary of assurance:** | |

**The Committee confirms to the Trust Board that it took either significant or reasonable assurance from the following agenda items:**

**Winter pressures plan**

The Committee discussed the 2023/24 Winter Plan which had been developed with North Central London (NCL) and local colleagues in response to national guidance issued by NHS England (NHSE). The key focus of the plan was to create additional surge capacity, protect elective capacity and ensure medical and nursing capacity. The plan supported limited use of same day emergency care (SDEC) and recovery and maximisation of ambulatory care and virtual wards.

The Committee was informed that bed capacity was increased with the opening of Victoria ward and plan to open Eddington ward on 15/1/24. The total number of beds for the 2 wards is 42 beds. Eddington ward would open as a Nurse and Allied Health Professional led unit. Work would continue to increase discharge and reduce the number of patients that did not meet the criteria to reside. On-going recruitment continues across nursing and allied health professionals. Additional registrars and general practitioner cover for the emergency department had been recruited together with a discharge consultant and a discharge co-ordinator. The Committee was assured that additional funding for winter pressures had been secured and would be fully utilised to drive improvement.

The Committee discussed the support required from local authority partners for social care, discussions with the London Borough of Haringey were in progress to embed social workers to be shared between the Trust and North Middlesex University Hospital (NMUH).

**The Committee noted the report.**

**Board Assurance Framework (BAF)**

The Committee considered quarter four BAF entries Quality 1, Quality 2 and Integration 2 entries. The Committee agreed that the scores against the risks against the delivery of the Trust's strategic quality and Integration objectives would remain unchanged. The Committee also approved the revision to the risk descriptor for the Quality 2 BAF entry which would now read as:

"Due to a lack of capacity and continuing pressures (e.g., industrial action), there is an inability to meet elective recovery and clinical performance targets, resulting in a deterioration in service quality and patient care such as:

- long delays in the emergency department and an inability to place patients to appropriate beds
- patients not receiving the timely elective care they need across acute and community health services

- patients on a diagnostic and/or treatment pathway at risk of deterioration and the need for greater intervention at a later stage"

**The Committee approved the Board Assurance Framework and the revision to the risk descriptor for the Quality 2 BAF entry.**

**Risk Register**

The Committee reviewed the Trust risk register which had been updated to 31 December 2023. The Committee noted 23 fully approved high risks scored at 15 and above on the risk register with 4 risks awaiting executive approval. There were no downgraded risks. Two risks were closed which related to, the disruption of LV supply to A Block which was now complete, and the risk of Surgery and Cancer ICSU not meeting its' cost improvement savings target and financial balance. There was one medium risk that had been increased to a high risk related to the inadequate capacity to meet musculoskeletal demand in community services. The risk would be discussed with the Executive Management Team. The Committee was informed that the Risk Management Policy had been approved at the Trust Management Group and risk review meetings were held with ICSUs and corporate departments.

T**he Committee noted the report**

**The Impact of Industrial Action**

The Committee received a report on the impact of eight strikes by junior doctors and consultants between March and October 2023. The Committee was informed that the impact on clinical services had been variable across each strike which was linked to the amount of notice given and sequencing of each strike. A broad approach was therefore taken with the collation of data.

Over the 8 strikes the following impact was seen

- 2075 junior doctor shifts lost, 100 consultant workdays lost, there were fewer consultant strikes and urgent and emergency care was not affected.
- 6177 outpatient appointments were unavailable for use.
- 768 inpatient procedures were unavailable for use.
- No serious incidents were declared, several lower impact events had to be urgently mitigated when detected – overall incident reporting increased during the strike periods.
- No deaths attributable to industrial action were reported with variable numbers of deaths.
- There were 8 patient advice and liaison concerns related to industrial action and no complaints were received.

The Committee received verbal update on the latest strikes that took place in late December and early January. It was reported that in December good levels of medical cover were planned across departments. There were challenges in Emergency and Integrated Medicine ICSU as there were high numbers of junior doctors that did strike or were needed to support on-call rotas and ward areas. The strike in January was also challenging as the weekend of 6 and 7 of January was particularly difficult to cover. Emergency cover was secured from clinical directors, advanced clinical practitioners, and consultants working outside their usual specialties. The Committee was advised that currently, notice for future strikes had not yet been received and that the mandate for

industrial action for junior doctors would expire at the end of February. The outcome of the most recent ballot for consultant contract offer is not yet known, the mandate for consultant industrial action has been extended to June 2024.

**The Committee noted the report and its' thanks to staff for their hard work during the strikes**.

**Surgery and Cancer ICSU presentation**

The Committee welcomed a presentation on 'Sip til send' a new approach to fasting for patients before surgery. It was explained that the rules for food remained the same, but patients were now encouraged to sip small amounts of water until they were sent to theatre, or 15 minutes before the induction of a general anaesthetic. The evidence had shown a reduction in post operative vomiting, patients felt better, there were less metabolic issues and less delirium in the elderly. There was also less confusion for nurses about giving oral medications. The 'Sip til Send' protocol had been adopted by over 50 hospitals nationally and it was implemented at the Trust in September for elective patients in the day treatment centre with no adverse effects. The plan was to roll out the protocol across the entire hospital following the appropriate governance process.

The Committee was assured that implementation of the protocol would be audited. Limited data had been collected which indicated that elective patients were previously deprived of water for an average of 4.5 hours before surgery and emergency patients an average of 12 hours. The findings on patient experience would be reported to the Patient Safety Committee.

The Committee recognised that challenges around reframing the 'nil by mouth' principle and was assured that communication of the new approach to fasting would be carried out by posters, champions across the hospital and educational forums.

**The Committee thanked Tim Blackburn for his informative presentation.**

**Controlled drugs update report**

The Committee considered an update on an incident related to the potential diversion of medicines of abuse (schedule 5 drugs) declared as a Serious Incident on the 14 April 2023. Concerns were uncovered across the organisation and work was carried out to:

- Reduce supplies of dihydrocodeine, co-dydramol and codeine thereby decreasing the use of the drugs.
- Increased security of drug rooms with swipe card access.
- Reclassify codeine and dihydrocodeine to schedule 2 drugs (upgraded from schedule 5) in ITU
- Inform the Controlled Drugs Accountable Officer for London and the London Police Controlled Drugs Liaison Officer
- Revise the administration process by nurses of the drugs.
- Offer confidential help to staff who may find themselves with a drug dependency concern.

The Committee discussed the impact of the measures, where it was advised that there were less orders for the controlled drugs, storage had been tightened

which had reduced the amount available for use. There had been no impact on patient care.
**The Committee noted the report.**

**Maternity Incentive Scheme (MIS) Year 5 – submission update**
The Committee discussed the report and received assurance that out of the 10 safety actions the Trust was fully compliant on three safety actions and was on track for full compliance on 6 actions. At the time of the meeting investigation was ongoing on one action, which will be concluded before submission to the Board.

The Committee acknowledged the considerable amount of work needed to complete the submission and evidence, particularly when industrial action had impacted training compliance. The Committee was assured that further scrutiny of completed actions and action plans would be taken forward at the Maternity and Neonatal Governance Meeting. Specific items would also be submitted to the Trust Board to demonstrate compliance with MIS.

CD asked for an additional meeting to review the assurance in the medical staffing action plan.

The Committee approved the following action plans subject to review at Maternity and Neonatal Governance Committee:

- Implementation of the Royal College of Obstetricians and Gynaecologists' guidance on compensatory rest related to safety action 4.
- Training for maternity emergencies and multi-professional training (PROMPT) for consultant anaesthetists and anaesthetic trainees
- Neonatal basic life support training for neonatal nurses attending births.

**The Committee supported the recommendation to submit the Year 5 MIS Compliance submission to the Trust Board for approval on 26 January 2024 subject to assurance on the Medical Staffing action plan.**

**Patient Safety Incident Response Framework (PSIRF) Implementation & Policy**
The Committee received assurance that the roll out of PSIRF was on track for 1 April 2024.

The Committee reviewed the draft policy which would be presented to the Trust Management Group (TMG) for approval to be published on the Trust website for public consultation and then to the Integrated Care Board (ICB) for final approval. The framework was presented to the Trust Board, TMG and staff at the Chief Executive's briefing. The roll out of training would commence on 24 January 2024. A business case for funding for training of executives was also in progress.

**The Committee approved the Policy subject to the inclusion of the correct policy template and noted the update on the roll out of PSIRF.**

**Bi-Annual Health and Safety Report**
The Committee considered the report which covered the period April to September 2023 which highlighted:

- Incident reporting achieved 95% against a target of 85%, there were 629 reported incidents 47% were related to abusive violent and disruptive behaviour and self-harm. The incidents were managed by the Managing Challenging Behaviour Group
- There were 14 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) incidents, related to musculoskeletal, falls, scalding and needle stick injuries.
- The Health and Safety, Fire and Security Policies review was at 79% against a target of 100%.
- Two safety alert notices remained open, allergens in food safety which would be completed in June 2024 and anti-barricade, works were in progress across the related wards funded out of the current capital programme.
- Good progress had been made with fire safety due to increased resources deployed in the fire safety department. Fire risk assessments on the acute site was 95%, community 86% and shared sites 26% against a target of 100%. A focus on shared sites would be taken forward and reported at the next meeting of the Committee.
- There were now 500 trained fire wardens across the organisation.

The Committee discussed ongoing transport issues with DHL and were informed that a working group had been set up to resolve and manage issues collaboratively with DHL.

The Committee was assured that the backlog of PAT testing had been addressed and would be completed by the end of January. A report on equipment that failed the PAT tests would be made available in February.

**The Committee noted the report.**

**Cleanliness Standards**
The Committee received a verbal report on concerns raised in relation to cleanliness standards across the organisation. Focussed work on causes and solutions had been undertaken and an external company had been commissioned to undertake cleaning in outpatients and imaging departments. The Committee was informed that domestic staff shortages had been mitigated by offering overtime over a significant period but was correlated to the drop in standards of cleanliness. Recruitment of bank staff had also proved difficult and the Trust would approach external agencies to fill existing domestic vacancies. An external provider had been secured to take forward a specialist programme of training for NHS organisations.

**The Committee noted the report and agreed that progress would be monitored through the Quality Governance Committee**

**Safeguarding Training Compliance Report**
The Committee received a summary of work undertaken to improve safeguarding training compliance for both adults and children. The Committee received assurance that improvements had been made:

- Safeguarding Adults Level 1 staff trained,90% compliance rate.
- Safeguarding Adults Level 2 staff trained, 85% compliance rate
- Safeguarding Children Level 1 staff trained,90% compliance rate.

- Safeguarding Children Level 2 staff trained, 82% compliance rate
- Safeguarding Children Level 3 staff trained, 85% compliance rate
- Safeguarding Children Level 4 staff trained, 100% compliance rate

**The Committee was pleased to note that safeguarding adults and children training compliance had achieved target and welcomed continued improvement.**

**Bi-Annual Nursing Establishment Review**

The Committee considered the mid-year review to comply with the statutory requirement to review safe nursing and midwifery staffing levels. The report highlighted several business cases had been put forward for substantive posts across ICSUs:

- In surgery and cancer applications for substantive funding for 1.2 whole time equivalent (WTE) clinical nurse specialists in cancer pathways and 1.5 WTE cancer support workers in patient experience which had previously been staffed on a fixed term basis.
- Emergency and Integrated Medicine had developed a business case for 16.3 WTE health care support workers to mitigate risks related to long waits in the ED, pressure ulcer care, nutrition and hydration and improve efficiency at the front door. More work was needed to strengthen the model of enhanced care across the organisation.
- In Children and Young People funding requests for 2.62 WTE registered nurses to support transitional care had been submitted.

The Committee was assured that sickness rates and staff turnover had decreased and more work would be undertaken to progress career development for healthcare support workers.

**The Committee noted progress made to maintain safe staffing levels and approved the establishment adjustment subject to approval of the business cases.**

**Uro-Oncology Update**

The Committee received a verbal update on the progress of Uro-Oncology service which was moving to UCLH. A clinic would be on site to dispense hormone therapy to prostate patients and prostate patients that needed chemotherapy, would attend UCLH during the transition phase. Final arrangements would be made to transfer the oncologist from UCLH to the Trust and prostate surgery patients would be repatriated from Guys and St Thomas's NHS Foundation Trust (GSTT).

There were some internal discussions about good consultant representation in the multidisciplinary meeting, a locum consultant had committed to attend in the meantime.

The Committee received assurance that good progress had been made to establish a partnership with UCLH for the uro-oncology service and the repatriation of prostate surgery from GSTT at the request of themselves.

**The Committee noted the update.**

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| | **Learning from Deaths Report**<br>The Committee discussed the quarter one and quarter two reports which advised:<br>• In quarter 1, there were 108 adult inpatient deaths (excluding deaths in ED) reported at the Trust versus 129 in Q4 2022/23.<br>• In quarter 2 there were 123 adult inpatient deaths (excluding deaths in ED) reported.<br>• There were 12 adult structured judgement reviews (SJRs) were requested for Quarter 1 of which 8 of had been completed and presented at department mortality meetings.<br>• In quarter two 10 adult structured judgement reviews (SJRs) were requested 9 of these have been completed and presented at department mortality meetings.<br>• The Summary Hospital-level Mortality Indicator (SHMI) for the data period July 2022 to June 2023 at Whittington Health was 0.94 which had increased from 0.90 since the last reported period. The increase was a concern as the number of admissions had decreased for the same period.<br>• There were no concerns related to avoidable deaths.<br><br>The Committee discussed end of life care issues highlighted in the SJRs which found that fast tracking electronic system for discharge in the end-of-life care pathway was slower than standard discharge processes. The issues had been addressed with the Commissioners and NCL and it was hoped that a solution would soon be made available**.**<br><br>**The Committee noted the report.** |
| **2.** | **Committee members took moderate assurance from the following agenda items:**<br><br>**Chair's assurance report, Quality Governance Committee**<br>The Committee reviewed the report of the items covered at the meeting held on 13 December 2023 where significant or reasonable assurance was taken from most of the items discussed.<br><br>The Committee took significant assurance from the following agenda items:<br>1. Emergency & Integrated Medicine (EIM) Integrated Clinical Support Unit (ICSU) report<br>2. Surgery & Cancer ICSU Report<br>3. Patient Safety Incident Response Framework \|(PSIRF) Implementation Update<br>4. Infection and Prevention Control Committee<br>5. Drugs and Therapeutics Committee<br>6. Simmons House Update Report<br>7. Controlled Drugs Update Report<br>8. >15 Risk Register<br>9. Bi-Annual Nursing Establishment Review<br>10. External Review Update Report<br>11. Maternity Incentive Scheme (MIS) Year 5 – submission update<br><br>The Committee took limited assurance from the following items**:** |

1. Emergency Planning, Winter pressures on the organisations and as a consequence on the pathways; and COVID-19
2. Mental Health Administration and Ligature Assessment Report

The Quality Governance Committee recommended the following top four quality risks for escalation to the Quality Assurance Committee:

1. Ligature risks was acknowledged there was ongoing work to mitigate this risk across the organisation.
2. Cleaning across the organisation, standards had not yet been met.
3. Winter pressures and lack of system funding, where funding for one ward was time limited and substantive funding for the second escalation ward was yet to be secured.
4. Care of mental health patients in the emergency department related to Section 136 of the Mental Health Act and increased length of stay

The Committee received assurance that work would be carried out to ensure a governance framework around external reviews was in place.

The Committee discussed the increase in the number of hospital-acquired infections which occurred through a combination of crowded patient areas and cleanliness issues across the hospital. The number of clostridium difficile infections had risen to 14 against a trajectory of 13 and there was one recorded incident of methicillin-resistant staphylococcus aureus in December. The Committee was informed that work with the Infection Prevention Control Team was underway which included, a review of the Boarding Policy, ongoing visibility of the Team in all medical areas, close work with estates and microbiologists and clinical representation on cleaning audits.

**The Committee noted the report.**

**Simmons House update**

The Committee considered an update on the latest developments on Simmons House which included its' temporary closure on 22 December and the redeployment of staff from the unit.

The Committee was advised that an investigation into the attempted suicide of a separate young person had begun and investigators from the Tavistock and Portman Team had visited the site before the start of building works. A follow-up meeting was scheduled with Commissioners on the 15 January 2024

The Committee was informed that letters of complaints had been received from the families of the last two patients at the unit about their transfer to another unit.

**The Committee noted the report.**

**Patient-Led Assessments of the Care Environment (PLACE) Update**

The Committee considered the summary of the findings, following the recent PLACE assessment which took place on 17 October 2023. The assessment covered 12 wards, seven outpatient clinics, emergency paediatrics and the Urgent Emergency Care departments. A food assessment was also undertaken. Overall, the outcome was positive and patients were highly complimentary of the standard of care received. The lack of cleaning in the emergency department was highlighted as a cause for concern as well as the need for redecoration in

some parts of the estate. Good staff engagement was recorded and improvement was also noted in food.

The Committee was informed that a detailed action plan was in place and an update on progress would be reported through the Patient Experience Group and Quality Governance Committee.

**The Committee noted the report.**

**Patients admitted to hospital under the Mental Health Act**

The Committee discussed the report on the treatment of patients attending hospital with mental health conditions. Several ongoing issues were highlighted:

- The number of patients attending the A&E with mental health issues had grown substantially.
- Between June and November 2023 an average of 180 patients presented to the A&E department and an average of 30 patients were admitted to hospital under Section 136 of the Mental Health Act. This also reflected the increase mental health issues across the NCL sector
- The Trust had two identified mental health rooms in the A&E department but up to 8 patients could be present at the time. Mitigations were in place for patients who were placed outside the mental health rooms
- There is nationally a shortage of specialist mental health nurses.
- More training on mental health was required Training was currently accessed from Camden & Islington NHS Foundation Trust (C&I) who provided 20 hours per annum of training.

The Committee was informed that specific work would be undertaken to understand the issues raised to:

- Prioritise the development of a strategy for mental health.
- Take forward the outputs of the NCL project work around the de-escalation process for patients with challenging behaviour predominantly in the ED.
- Review the training contract with C&I to increase the hours needed for training.
- Carry out a piece of work to understand the disparity between mental health conditions ethnicity and gender.
- Exploit opportunities with partners to significantly improve the care of patients.

The Committee acknowledged that the growth in the demand for mental health services had yet to be matched by mental health providers in the sector. The Committee welcomed the review of the anti-ligature policy which would be submitted to the TMG for approval.

**The Committee noted the report and would look forward to an update on progress in due course.**

**Anti- Ligature Assessment Report**

The Committee considered the report of the anti-ligature assessment work carried out at the Trust. Key issues were identified around high and medium risk areas which were reviewed to determine progress of improvement actions and work to be carried out. A Working Group had been set up to take the work forward.

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| | **The Committee noted the report**<br><br>**Serious Incidents report**<br>The Committee received serious incident reports covering the period August to September and October to November. The Committee was informed of serious incidents related to the:<br>• supply of equipment by NRS Healthcare<br>• suicide of a young person at Simmons House<br>• absconsions of young people from Simmons House<br>• intracranial haemorrhage of baby following a forceps delivery<br>• Never Event related to a wrong side ureteric stent.<br><br>The Committee was informed that there were nine completed investigations. At the end of November there were three overdue SI investigations.<br><br>**The Committee noted the report.**<br><br>**Patient experience report**<br>The Committee received limited assurance on patient experience activities carried in Q2 2023/24, key areas discussed included:<br><br>• Complaint response timescales remained below the 80% target at 55%. Progress had been made on the action plan developed by internal auditors with five out of the seven actions complete.<br>• National Inpatient 2022 survey results raised a number of areas for improvement. A task and finish group has been created to work through an action plan which builds into a wider Trust action plan on patient experience.<br>• During Q2 22 new volunteers were recruited, taking the total number to 53. Volunteers were available to meet and greet patients, supporting patients in clinical areas and assisting with the collection of friend and family feedback.<br>• The introduction of patient information boards in wards and sleep packs which had been well received by patients.<br><br>**The Committee was pleased to receive a separate patient experience report and would look forward to future reports on progress.**<br><br>**Quarterly Quality Report – Quarter 2**<br>The Committee was advised that the current report was out of date and that quarter three data was available for analysis. The Committee noted one Grade 4 pressure ulcer in in the community in December which would be included in the quarter three report. It was confirmed that the mandated dementia audit would be reported through the Quality Governance Committee.<br><br>**The Committee noted the report and would look forward to Quarter three reporting.** |
| **3.** | **Present:**<br>Naomi Fulop, Non-Executive Director (Committee Chair)<br>Chinyama Okunuga, Chief Operating Officer<br>Baroness Glenys Thornton, Non-Executive Director<br>Sarah Wilding, Chief Nurse & Director of Allied Health Professionals |

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| | Dr Clare Dollery, Acting Deputy Chief Executive and Medical Director<br><br>**In attendance:**<br>Paddy Hennessey, Deputy Director of Estates & Facilities<br>Clarissa Murdoch, Deputy Medical Director<br>Phillip Lee, Associate Medical Director for Patient Safety<br>Sarah Gillis, Associate Medical Director for learning from deaths.<br>Erum Jamall, Associate Medical Director Quality Improvement & Clinical Effectiveness<br>Isabelle Cornet, Director of Midwifery<br>Theresa Renwick, Adult Safeguarding lead<br>Karen Miller, Children's safeguarding lead<br>Anne O'Connor, Interim Associate Director of Quality Governance<br>Kamilla Bessessar, Clinical Site Manager<br>Swarnjit Singh, Director of Inclusion/Trust Company Secretary<br>Kat Nolan-Cullen, Compliance and Quality Improvement Manager<br>Marcia Marrast-Lewis, Assistant Trust Secretary<br>Dr Tim Blackburn, Consultant Anaesthetist<br>Nicola Sands, Deputy Chief Nurse<br>Carolyn Stewart, Executive Assistant to the Chief Nurse<br><br>**Apologies:**<br>Swarnjit Singh, Joint Director of Inclusion & Trust Secretary<br>Tina Jegede, Joint Director of Inclusion and Lead Nurse, Islington Care Homes<br>Amanda Gibbon, Non-Executive Director |

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| **Meeting title** | **Quality Assurance Committee** | **Date: 10/01/2024** |
| **Report title** | Patient Safety Incident Response Framework (PSIRF) | **Agenda item: 4.6** |
| **Executive director lead** | Dr Clare Dollery – Medical Director | |
| **Report author** | Richard Matthews – PSIRF Project Lead<br>Louise Roper – Head of Patient Safety | |
| **Executive summary** | PSIRF is the new NHS Framework for learning from patient safety incidents. It replaces the Serious Incident Framework (SIF). Its key aims are:<br>1. More compassionate engagement with staff and patients effected by incidents.<br>2. More proportionate and considered responses.<br>3. A focus on human factors and systems thinking.<br>4. Supportive oversight focussed on learning and system improvement.<br>The PSIRF requires us to focus more effort on learning and improving and less on repetitive investigations. Whittington Health therefore needs to develop proactive improvement plans around our local patient safety priorities.<br><br>The Trust will also be required to provide specialist training in 'human factors / systems thinking' and 'engaging with patients and families. A business case has been submitted to obtain the required funding to deliver this through an externally accredited provider. Only specific staff will require this training, namely, those leading learning responses, those in oversight roles and staff engaging with patients and families after a patient safety incident has occurred.<br><br>Currently, significant work is in progress to implement the PSIRF which is planned for completion by the end of March 2024 - this is a similar position to most Trusts nationally. A project plan is in place to ensure all aspects of the framework are delivered and operationalised through the required training, policy development, analysis of data to identify local improvement priorities, and recalibration of governance / oversight systems and structures.<br><br>The PSIRF represents a significant culture shift for the Trust and NHS more widely. A number of significant changes will be required in how the Trust responds to, learns from, and receive assurance about learning from patient safety incidents and events. These changes will include:<br><br>• Fewer PSII / Serious Incident investigations<br>• Reports and analysis no longer focussed on 'levels of harm'.<br>• Greater focus on improvement plans and oversight of these. | |

| | |
|---|---|
| | • Expansion of QI methodology<br>• Greater patient and staff engagement<br>• ICB no longer responsible for overseeing investigations / learning responses.<br>• New learning response tools – After Action Review (AAR), Swarm Huddle, MDT Review<br>• More local decision making by subject matter experts.<br>• Patient Safety Partners – volunteers from the community, to provide scrutiny, challenge, and the patient voice.<br>• Greater focus on human factors, systems thinking - discontinuation of Root Cause Analysis (RCA) |
| **Purpose:** | Approval |
| **Recommendation(s)** | To note the progress in implementation of PSIRF and approve the plan and policy |
| **Risk Register or Board Assurance Framework** | Quality and safety category risks on risk register |
| **Report history** | *Quality Governance Committee – 13th December 2023* |
| **Appendices** | Appendix 1 – PSIRF policy – for approval<br>Appendix 2 - PSIRF plan – for approval |

## 1 Introduction: The Patient Safety Incident Response Framework (PSIRF)

The Patient Safety Incident Response Framework (PSIRF) establishes the NHS's approach to the development and maintenance of mechanisms for responding to patient safety incidents (PSIs) to maximise learning and improvement. It replaces the Serious Incident Framework (SIF). The PSIRF is a contractual requirement and is mandatory for providers of NHS-funded care.

The PSIRF represents a fundamental, paradigm shift from the SIF. The framework is essentially a learning and improvement model based on human factors and system thinking methodology.

The PSIRF, is built on 4 key, founding principles:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement

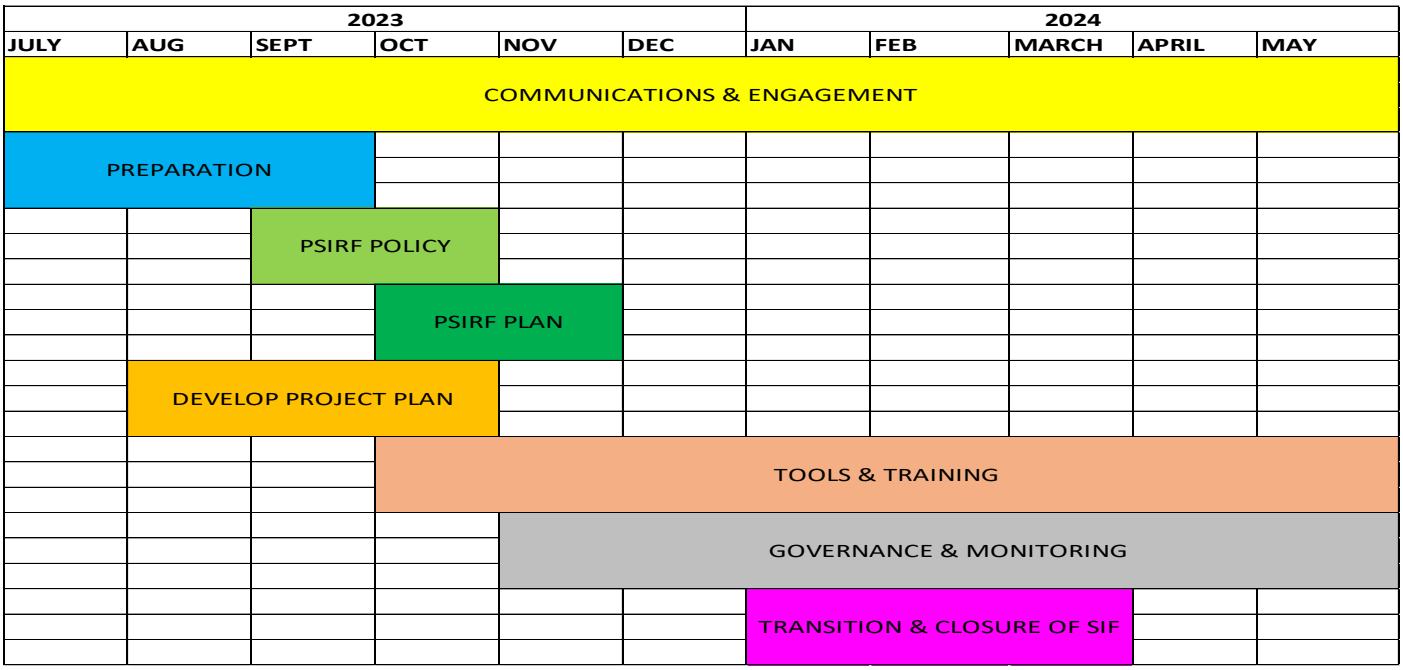
Additionally, PSIRF builds on, and augments, existing guidance in relation to:

- Just culture
- Being Open & Duty of Candour
- Quality Improvement Methodology
- 'Making Data Count' Principles
- Transparency, Freedom to Speak Up and Incident Reporting
- Patient Involvement and Experience
- Addressing Health Inequalities

## 2 Implementation of PSIRF at The Whittington

Dr Clare Dollery, is the Executive Lead and project sponsor for implementation of PSIRF supported by Dr Philip Lee, Associate Medical Director. Operational implementation is led by Anne O'Connor, Associate Director of Governance and Louise Roper, Head of Patient Safety. A comprehensive project implementation plan is in place and project management expertise has been established to drive this forward for implementation in April 2024. The key elements of the project plan are illustrated in the info-graphic below with indicative timescales.

An Implementation Group of key stakeholders (including the ICB) has been formed and is chaired by Dr Dollery, to oversee progress and make decisions as required. Several task and finish sub-groups have also been set up, with representation from colleagues across the Trust, focussed on implementation of specific elements of the PSIRF, such as training, governance and data analysis.




## 3 Local Improvement Priorities

As referred to above, a key component of the PSIRF approach is to ensure that improvement work and activities are established for the key local priorities and patient safety risks identified through the analysis of historic data and information. This will mean that incidents relating to these well investigated concerns may not need any further investigation and the focus will be on driving forward improvements to address system issues giving rise to these risks. The priorities identified are as follows:

1. Deteriorating patient (especially NEWS and Fluid Balance)
2. Delayed Treatment & Diagnosis (especially cancer pathways)
3. Patient Falls
4. Pressure Ulcers (Trust acquired & deterioration)
5. Unsafe Discharge & Delayed Transfers
6. Medication Safety (especially Controlled Drugs and Critical Meds)

Work will progress to ensure each priority has a sub-committee who will be responsible for the governance and oversight processes to monitor improvement.

## 4 Training and 'Learning responses'

Under the PSIRF, 'root cause analysis' (RCA) will no longer be a methodology for investigating patient safety incidents. Furthermore, the decision to investigate an incident will not be triggered by the 'level of harm' as it was under the SIF. Instead, organisations must select incidents which have the greatest potential for new learning regardless of the perceived level of harm assigned to an incident. It maybe that some 'near-miss' or 'no and low harm' incidents have greater potential for new learning, and conversely incidents resulting in serious harm may present little or no new learning opportunities. It is therefore important that ICSU's have clear oversight processes in place for all incidents to identify which, if any, require a further learning response. The flowchart in appendix 1 illustrates the proposed process for this which has been agreed through the Implementation Group. The new weekly Exec led oversight group, Wittington Improvement and Safety Huddle (WISH - previously SIEAG) will have operational oversight of this process.

In order to complete learning responses utilising human factors analysis and systems thinking, staff who will be leading the investigations, those in oversight roles, and those engaging with patients and families following an incident, will be required to undergo

specialised externally accredited training. The table below summarises the training required, which has now been commissioned, with the first tranche scheduled for late January and early February.

| **Systems approach to learning from patient safety incidents**<br>**(2 days)** | **Systems approach to learning from patient safety incidents oversight training**<br>**(1 day)** | **Engaging with patients, families, and staff following a patient safety incident training**<br>**(1 day)** | **National Patient Safety Syllabus e-Learning, level 1 & 2**<br>**(30 mins per course)** |
|---|---|---|---|
| All learning response leads & all those in PSIRF oversight roles: Provider board members (MD & CN) | All those in PSIRF oversight roles: Key Execs / Directors and Non-executive Directors. | All engagement leads<br>All those in PSIRF oversight roles | **Level 1** - Required learning for all staff.<br>**Level 2** – Required for ≥ Band 6 and non- foundation year doctors |

Staff who have completed the Systems Approach to Learning from Patient Safety Incidents will then be able to use one of the chosen methodologies below to facilitate a learning response with the appropriate colleagues:

| | |
|---|---|
| **Swarm Huddle** | Swarm-based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk. |
| **After-Action Review (AAR)** | An After-Action Review (AAR) usually takes the form of a facilitated discussion following an event or activity. It enables understanding of the expectations and perspectives of all those involved, and it captures learning, which can then be shared more widely. |
| **Multi-disciplinary Team (MDT) Review** | Multi-disciplinary Team review where after an event (maybe a significant time has passed) staff groups from various disciplines get together to review events and discuss what happened, the learning and possible improvements. |

A comprehensive case-based Patient Safey Incident Investigation (PSII) can still be completed if this level of investigation is deemed necessary due to the circumstances of the incident. It will also be required for some nationally mandated incident types, specifically:

- Never Events
- LeDeR (learning disability) criteria incidents
- Screening programme incidents
- Healthcare Safety Investigation Branch (HSIB) criteria incidents
- Unexpected deaths due to omissions in care
- Child deaths

## 5 Governance and Oversight

*"When working under PSIRF, NHS providers, should design their systems for oversight in a way that allows organisations to demonstrate improvement, rather than compliance with prescriptive, centrally mandated measures."*

The focus from compliance to learning and improvement is a significant culture shift for Trusts and the NHS more broadly. Assurance reporting will look very different, and Boards

and Oversight Committee's will need to adapt their focus accordingly. As referred to above and in appendix 1, work is in progress to re-design these systems and processes, though it is accepted this must evolve as we move forward on our PSIRF journey.

It should also be noted that the Integrated Care Board (ICB) will no longer be responsible for the approval and scrutiny of learning response/patient safety investigations. This becomes the responsibility of the Trust Board, however, the ICB will still have an oversight role with respect to learning and improving safety at a system wide level. Some of the detail with regards to the role of the ICB is still being developed locally and nationally and, as with the general PSIRF philosophy, will evolve and develop as we transition. The PSIRF is very much a journey not a destination.

## 6 A summary of progress to date

- Recruitment of Patient Safety Partners (PSP), who are volunteers from the local community to provide the 'patient voice' in the 'design of safer healthcare at all levels in the organisation'.
- Identification of key local improvement priorities from analysis of 3 years of historic data in relation to incidents, complaints & concerns, risks, patient & staff feedback, claims and inquests
- Securing of funding for PSIRF mandatory training and commissioning of its provision.
- A range of (ongoing) engagement and communication activities with key stakeholders across the Trust and the ICB.
- Curation of the PSIRF Policy and Plan (currently under consultation) - these 2 policy documents detail the 'what' and the 'how' for the Trust's implementation of PSIRF and will require public consultation
- Ongoing development of new governance / oversight processes and structures through a series of workshops with key ICSU governance colleagues, to focus more on learning and improvement.
- Mapping of current quality improvement and service development projects and activities against the PSIRF priorities.

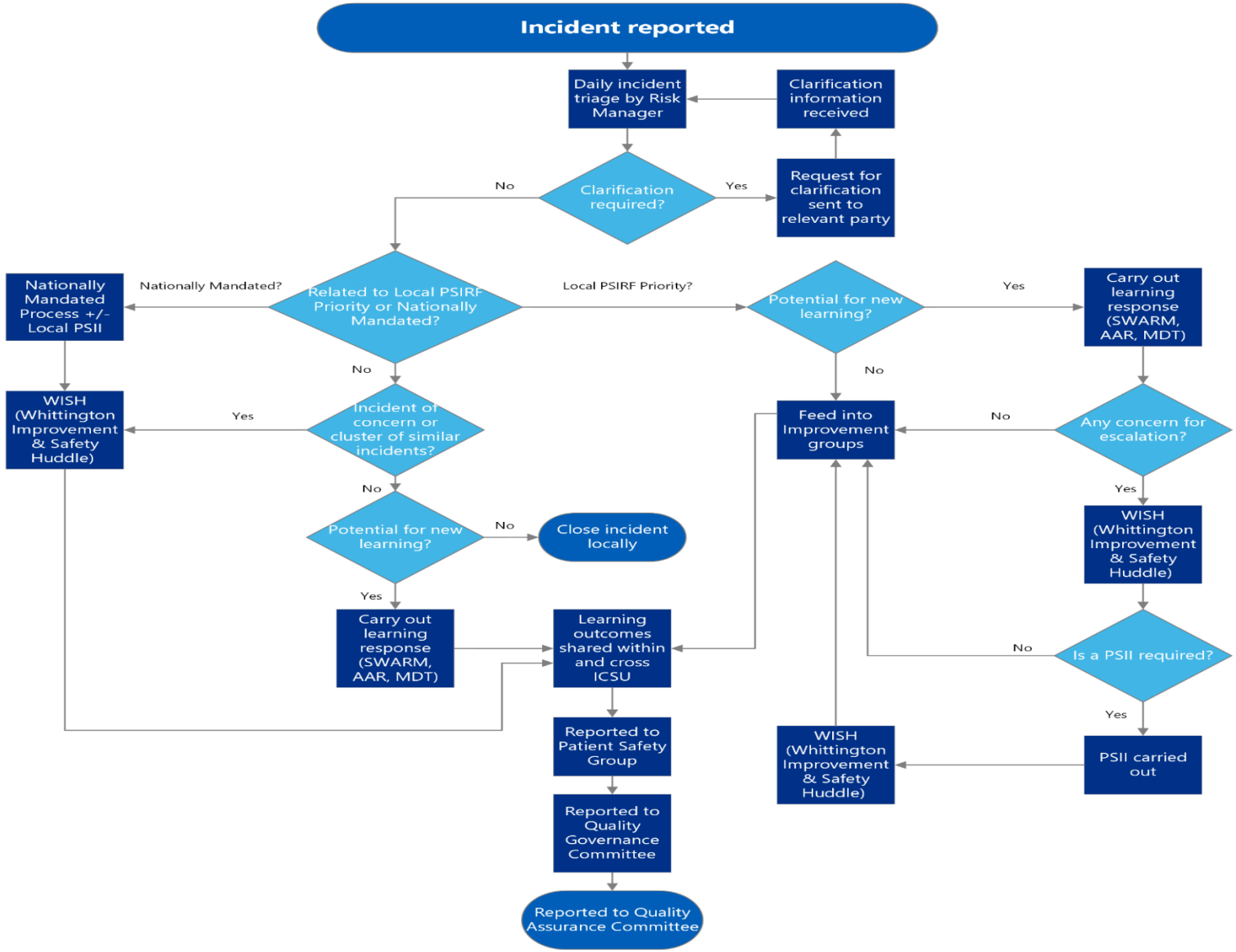
## 7 Key Changes Under The PSIRF

- Fewer PSII/Serious Incident investigations
- Discontinuation of Root Cause Analysis (RCA) as a methodology
- Reports and analysis no longer focussed on 'levels of harm'
- Greater focus on improvement plans and oversight of these
- Expansion of QI methodology
- Greater knowledge and application of human factors and systems thinking
- Greater patient and staff engagement
- ICB no longer responsible for overseeing investigations / learning responses. Trust Board will be the accountable body
- Different learning response tools – AAR, Swarm Huddle, MDT Review
- Governance focusses on improving outcomes not compliance with process – changes to structures and terms of reference
- More local decision making by subject matter experts

## 8 Recommendation

QAC is asked to note the progress in implementing PSIRF and approve the policy and plan.

**Appendix 1** – PSIRF Incident Response Flowchart



# Patient safety incident response policy

Effective date: TBC

Estimated refresh date: TBC

| | NAME | TITLE | SIGNATURE | DATE |
|---|---|---|---|---|
| **Author** | **Louise Roper** | **Head of Patient Safety** | | |
| **Reviewer** | **Anne O' Connor** | **Associate Director of Quality Governance** | | |
| **Authoriser** | **Clare Dollery** | **Medical Director** | | |
| **Version** | **1.1** | | | |
| **Status** | **Draft** | | | |
| **Reviewed by:-** | **PSIRF Implementation Group** | | | |
| | **Integrated Care Board (ICB)** | | | |
| | **Executive Trust Board** | | | |

| Version No | Date amendments made | Description of change |
|---|---|---|
| 1 | | *Provide a summary of the changes made to the policy* |
| | | |
| | | |
| | | |

**CONTENTS**

## 1.0 Introduction

The Whittington Health NHS Trust (the Trust), is fully committed to making Patient Safety its' number one priority, adhering to the Duty of Candour principles of being open and transparent and doing so within a supportive environment.

This policy supports the requirements of the NHS England's (NHSE) Patient Safety Incident Response Framework (PSIRF) (NHSE,2022 https://www.england.nhs.uk/patient-safety/incident-response-framework) and sets out the Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The existing Serious Incident Framework, with its thresholds for investigation and set timelines, is being replaced by a more flexible, improvement-focused system called the Patient Safety Incident Response Framework (PSIRF).

Under the PSIRF, healthcare organisations will no longer be talking about serious incident investigations or root causes. In their place will be a more flexible, system-focused approach, with improvement and engagement with patients/families/staff taking centre stage. This new system aims to channel resources where they will have most impact, rather than committing most time and effort to delivering incident investigation reports in every case.

PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident responses within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management, increasing focus on understanding how incidents happen rather than apportioning blame.

Supporting the principles outlined in the PSIRF, this policy will develop and maintain an effective patient safety incident response system that integrates the four key aims:

- compassionate engagement and involvement of those affected by patient safety incidents.
- application of a range of system-based approaches to learning from patient safety incidents.
- considered and proportionate responses to patient safety incidents and safety issues.
- supportive oversight focused on strengthening response system functioning and improvement.

By ensuring compliance with the training requirements outlined by NHSE, the Trust will promote a system-based approach and considering human factors when investigating patient safety incidents or risks in supporting the development of a Just Culture. This will identify where changes need to be made and then monitored within the system to improve patient safety.

This policy should be read in conjunction with the Whittington Health NHS Trust Patient Safety Incident Response Plan (PSIRP) which sets out how this policy will be implemented. This can be found on the Trust website.

## 2.0 Objective

This policy describes:

- How the Trust will promote a climate that fosters a restorative and just culture and the work planned or underway to improve safety culture. It includes what is being done to

support open and transparent reporting and the development of a restorative and just culture.

- How the Trust will engage Patient Safety Partners (PSP) in the patient safety incident response policy and plan, development, and maintenance.
- How the Trust's patient safety incident response processes will support health equality and reduce inequality.
- How the Trust will engage with those affected by patient safety incidents, including their involvement in a learning response
- How Duty of Candour will be upheld in line with the PSIRF
- How the Trust will take a proportionate approach to patient safety incident responses
- How patient safety incident responses will be delivered, including ensuring adequate training for those undertaking the responses
- What steps the Trust took to develop the PSIR plan, including stakeholder engagement, how patient safety incident records and safety data was analysed, described the safety issues demonstrated by the data, and how improvement work underway was identified in relation to safety issues and agreeing response methods.
- The process for reviewing our patient safety incident response policy and plan
- What internal and external notification requirements will be for the reporting of patient safety-related incidents
- The processes in place to decide how to respond to patient safety incidents as they arise, including how decisions take into account the Trust's patient safety incident response plan
- The process to recognise incidents or issues that require a cross-system learning response, including how the Trust will seek the views of local partners to ensure learning responses are co-ordinated at the most appropriate level of the system
- How learning from incident responses will be used to inform improvements and how safety actions will be monitored
- The Trust's approach to oversight and how the relevant patient safety incident response standards will be met.

## 3.0 Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all specialities within:

- Emergency & Integrated Medicine
- Surgery & Cancer
- Children & Young Persons
- Adult Community Services
- Acute Patient Access, Clinical Support Services and Women's Health (including Maternity)

Learning responses under this policy follow a systems-based approach. The focus of a system-based approach is examining the components of a system (eg person(s), tasks, tools and technology, the environment, the wider organisation) and understanding their interdependencies (ie how they influence each other) and how those interdependencies may contribute to patient safety that is, safety is provided by interactions between components and not from a single component. Responses under PSIRF do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident ( *Patient Safety Incident Response Framework supporting guidance Guide to responding proportionately to patient safety incidents, August NHSE 2022)*

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement.
Where other processes' principal aims differ from a patient safety incident response they will be deemed to fall outside the scope of this policy and include:

- Complaints (Unless an incident is raised)
- Professional standards investigations
- Coronial inquests
- Criminal investigations
- Claims management
- Financial investigations and audits,
- Safeguarding Incidents, where they fall under Section 42 of the Care Act 2014

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

## 4.0 Definitions

**PSIRF - Patient Safety Incident Response Framework**
This is a national framework applicable to all NHS commissioned services outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

**PSIRP - Patient Safety Incident Response plan**
The Trust 's local plan sets out how PSIRF will be carried out the locally including the list of priorities. These have been developed by analysis of local data, consideration of other safety priorities and consultation with stakeholders.

**PSIRF Project Plan**
The project work plan that sets out all the work streams and tasks for all ongoing work in relation to the implementation of PSIRF.

**Learning Responses:**
The system-based learning response methods available for the Trust and its staff to respond to a patient safety incident or cluster of incidents.

**Patient Safety Incident Investigation (PSII)**
A PSII is an in-depth investigation undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. A PSII investigation uses the Systems Engineering Initiative for Patient Safety (SEIPS) framework to understand outcomes within complex systems and which can be applied to support the analysis of incidents and safety issues more broadly. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can.

## 5.0 Whittington Health's Patient Safety Culture

The Trust is committed to creating an open and fair culture in which staff members are confident about reporting incidents and near misses. Evidence suggests that by creating a fair reporting culture, organisations can improve their ability to learn when things go wrong and improve patient safety. The Trust supports an open and transparent reporting culture by way of policies which promote and encourage reporting, such as our incident reporting and whistleblowing policies. Additional fields have been included in the Trust's reporting system to encourage safety ideas in response to incidents by those reporting incidents.
In addition, the Trust has a Freedom to Speak Up Guardian and Speak Up Advocates, to support staff to highlight safety concerns and a Restorative and just culture group.
The Trust is committed to:

- Promoting a fair, open, inclusive, and just culture that will focus on the systems in which staff work, to understand how incidents happen with a focus on effective learning and improvement.
- Learning from patient safety incidents and events
- Improving communication and the development of a mature safety culture, encouraging a positive approach to the reporting and investigation of patient safety incidents.
- Openness and transparency in the reporting process and handling of patient safety incidents follows the Duty of Candour and the trust's Being Open policy.
- Justifiable accountability and a zero tolerance for inappropriate blame, with the NHS Improvement 'Just Culture' guide being used to determine a fair and consistent course of action towards staff.

## 6.0 Duties and Responsibilities

6.1 The overall responsibility for ensuring implementation and PSIRF standards are met is the Trust Board. The Trust Board is responsible and accountable for effective patient safety incident management. This includes supporting and participating in cross system/multi-agency responses and/or independent patient safety incident investigations (PSIIs) where required.

6.2 The PSIRF Executive Director lead is the Medical Director with the following delegated responsibilities:

- Ensure the Trust meets the standards expected by the PSIRF
- The PSIRF Executive Lead, supported by the Trust Board, will oversee the development, review and approval of this policy and plan for patient safety incident response, ensuring that expectations set out in the patient safety incident response standards are met
- Ensure that the PSIRF is central to the Trust's overarching clinical and quality governance arrangements
- Provide quality assurance and oversight of learning response to the Trust Board and Quality Assurance Committee
- Ensuring the Trust Board has access to relevant information about the organisation's preparation for and response to patient safety incidents, including the impact of changes following incidents. It is the PSIRF Executive Director Lead's responsibility to ensure:
    - patient safety incident reporting and response data, learning response findings, safety actions, safety improvement plans, and progress are discussed at the Quality Governance Committee on behalf of the Board
    - roles, training, processes, accountabilities, and responsibilities of staff are in place to support an effective organisational response to incidents.
- Ensure that mechanisms for the ongoing monitoring and review of the patient safety incident response plan, delivery of safety actions and improvement forms part of the

overarching quality governance arrangements and that it is supported by clear financial planning to ensure appropriate resources are allocated to PSIRF activities and safety improvement.

- Ensure the Board will monitor the balance of resources going into patient safety incident response versus improvement. Repeat responses should be avoided when sufficient learning is available to enable the development and implementation of a safety improvement plan.
- Ensure updates to the PSIRF policy and plan are made as required as part of regular oversight processes and that overall review of the patient safety incident response policy and plan will be undertaken within 12- 18 months, alongside a review of all safety actions
- Ensure appropriate levels of training are delivered across the Trust, dependent on the roles assigned within the framework.
- Quality assure learning response outputs - a final report should be produced for all individual PSIIs, and this reviewed and signed off as complete. The PSIRF Executive Director Lead is responsible for reviewing PSII reports in line with the patient safety incident response standards and signing off as finalised on behalf of the Board. They may be supported by another executive colleague or subject mater expert.

### 6.3 **ICSU (Integrated Clinical Service Units) and Corporate Senior Leads**

6.3.1 Directors of each ICSU (Clinical Director, Associate Director of Nursing & Director of Operations) will:

- Ensure this policy and the associated trust documents are implemented within their areas of responsibility
- Report, escalate and review patient safety incidents in accordance with this policy and associated plan
- Ensure compliance with the policy for the analysis of patient safety data and sharing of learning from responses through ICSU governance arrangements on a monthly basis
- Develop and implement safety improvement plans and ensure that actions are completed following an investigation response or quality improvement initiative, promoting and upholding the principles of the PSIRF and a restorative and just culture within the ICSU
- Overseeing compliance with Duty of Candour in line with the Being Open and Duty of Candour policy
- Ensure staff are compliant with the relevant national PSIRF training requirements.

6.3.2 Associate Director of Quality Governance and Head of Patient Safety

- Working closely with the Medical Director ensure the implementation of the PSIRF policy and plan. Ensure updates to the PSIRF policy and plan are made as required as part of regular oversight processes and that overall review of the patient safety incident response policy and plan will be undertaken within 12-18 months alongside a review of all safety actions
- Provide advice and support to the ICSU leads on implementation of the PSIRF
- Regularly report on progress against the Trust PSIRF plan to the Medical Director and Quality Governance and Assurance committees.

6.3.3 Learning Response Leads.

Learning response leads are staff who are leading a learning response to a safety incident using system-based approaches to capture learning to inform safety actions for improvement and will:

- Be fully compliant with the relevant National PSIRF training requirements prior to undertaking any PSII
- Contribute to a minimum of two learning responses per year
- Communicate developments and progress with the PSIRF, including any consultation exercise to respective ICSUs and corporate committees/groups
- Keep up to date with PSIRF developments and participate in local and national network meetings
- Participate in trust wide PSIRF learning and development events as a presenter/facilitator/attendee

6.3.4 Managers and Heads of Departments

Managers and Heads of Departments will:
- Foster an environment in which staff are encouraged to report incidents and discuss them constructively and openly

6.3.5 Risk Managers
- Review patient safety incidents and gather further information required in relation to the incident reporting and investigation policy
- Refer to the Duty of Candour and Being Open policy to ensure requirements are met
- Escalate any incidents of concern (no and low harm incidents as well as moderate harm and above) to the Patient Safety Team and ICSU leads

6.3.6 All staff
All staff have the responsibility to:
- Report incidents in accordance with the trust's incident reporting policy and actively participate in PSIRF learning and development as required

**6.4.1 The following committees/groups oversee patient safety:**

- **ICSU Quality and Safety meetings**
  The ICSU Quality and Safety meeting is a sub-committee of the ICSU Board meeting. It provides assurance to the ICSU Board on all matters relating to patient safety and risk, patient experience, clinical effectiveness, and quality improvement. This in turn reports to the Trust Quality Governance Committee

- **Incident Review Meeting**
  This meeting is attended by ICSU Quality & Risk Managers, Maternity Clinical Governance Manager, the Legal Team and Medicines Safety Pharmacist. This meeting reports to the Weekly Incident Safety Huddle (WISH)

- **Whittington Incident Safety Huddle (WISH)**
  The group provides weekly incident governance and oversight. It reports trends, learning and new investigations monthly to the Trust Management Group and bi-monthly to the Quality Governance Committee and Quality Assurance Committee.

- **Patient Safety Group**
  The purpose of this group is to seek assurance on the implementation of patient safety arrangements in compliance with clinical best practice, regulatory and statutory

requirements, and internal risk management and governance processes. This group will track the implementation safety improvement plans.
The overarching group has a wide membership from across the Trust and reports to the Quality Governance Committee

- **Quality Governance Committee**
  This committee oversees all areas of patient safety from subgroups and reports to the Quality Assurance Committee, subcommittee of the Trust Board

- **Quality Assurance Committee**
  The role of the Quality Assurance Committee is to provide assurance to the Board of Directors on the continuous and measurable improvement in the quality of services through the following key areas:
  - Patient safety and clinical risk
  - Clinical audit and effectiveness
  - Patient experience
  - Health and safety and
  - Quality improvement

- **Integrated Care Board (ICB) and partnership working:**
  The ICB currently meet with the Patient Safety Team to monitor investigations under the current Serious Incident Framework. The ICB will collaborate with the Trust in the development, maintenance and review of the patient safety incident response policy and plan. They will oversee and support the effectiveness of our systems to achieve improvement following patient safety incidents and will support the co-ordination of cross-system learning responses.

## 7.0 Patient Safety Partners (PSPs)

PSPs will be appointed as part of the Trust's commitment to patient involvement and engagement as an integral part of the principles of PSIRF. Their knowledge and experience will support the Trust to build a proactive patient safety culture and will provide an unbiased and uncompromised view of what it feels like to receive care and will substantiate where personalised change is necessary.

As a key part of the Patient Safety Team, PSPs will:

- Represent patients, their families, and carers in the Trust to ensure that the patient voice is central to all we do
- Bring ideas and strategies that will make a difference to patient experience and focus the trust's thinking on "what would the patient or family think of what has have discussed today"?
- Challenge the Trust in the way that it works with patients and carers to promote a culture of openness and transparency and to ensure there is a culture of continuous improvement.
- Play an active part in key conversations and meetings trust wide that address patient safety and experience
- Help design and develop patient safety and involvement initiatives

## 8.0 Addressing Health Inequalities

The Trust recognises the importance of reducing the health inequalities of the population that are served by Whittington Health Hospital by ensuring services are designed around the needs of the local population, ensuring equality of access.

Under the Equality Act (2010), as a public authority, the Trust has statutory obligations for which there is commitment to deliver on. Data which identifies any possible patient safety risks or incidents which disproportionately affects certain cohorts of the population will be proactively gathered and analysed. This will be included in the PSIRF plan.

The Trust is committed to supporting effective communication by compliance with the Accessible Information Standard alongside use of supportive tools such as easy read, translation, and interpretation services. The Trust's Learning Response Leads and will engage with patients, families, and staff following a patient safety incident, for inclusion. This will be considered under the engaging staff and patients' policy which is being developed as part of the PSIRF plan.

## 9.0 Engaging and involving patients, families and staff following a patient safety incident

Under the PSIRF there will be greater engagement with those affected by an incident, including patients, families, and staff ensuring they are treated with compassion and able to be part of any investigation.

Replacing '*Being Open*' as the national standard for engaging those affected by a patient safety incident, the NHSE guidance '*Engaging and involving patients, families and staff following a patient safety incident, 2022*' details advice on how to involve patients, carers, and staff in the incident response process. Aligned with this guidance, the Trust will ensure compassionate engagement and involvement through a process that enables patients, families and healthcare staff to contribute to a learning response and develop a shared understanding of what happened and potentially how to prevent a similar incident in the future.

## 10.0 Duty of Candour

The current Duty of Candour policy and practice legislation requires the Trust to ensure that when things go wrong which cause in moderate, severe harm, or death, patients and their families are informed. The Trust is currently required to:

- Notify the patient in person that a notifiable safety incident has occurred and apologise
- Provide an account of all the facts known about the incident
- Advise the relevant person what further enquiries into the incident are believed to be appropriate
- Provide an offer of reasonable support to the patient
- Document the above in writing
- Follow up with a written notification confirming information provided and containing results of further enquiries (i.e. outcome or findings of any investigation) and apology

Whilst previously under the Serious Incident Framework, a distinction was made between serious incidents and all other incidents, PSIRF seeks to cover all incidents which caused, or had the potential to cause harm with the focus on opportunities for learning. This change in approach will require careful communication and engagement with staff, patients, and their

families to explain the reasons why an incident, which would have required an investigation previously, may not on this occasion be carried out, as other tools for learning will be adopted instead.

These messages may at times be difficult to deliver and could be challenged. Details on the plan to achieve the development of the approach in communicating these more complex issues to ensure that patients and their families are satisfied and feel reassured by the Trust's approach can be found in the PSIRF plan. The Duty of Candour policy will also be updated accordingly.

### 11.0 Patient Safety Incident Response Planning

The PSIRF enables the Trust to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on pre-defined definitions of harm. Beyond nationally set requirements, the Trust will explore patient safety incidents relevant from the perspective of a local context, around the population which the Trust serves.

### 11.1 Resources and training to support patient safety incident response

The PSIRF standards have defined the competencies required for individuals leading on the implementation of PSIRF.

All staff leading on the learning responses or being engagement leads or those with oversight roles will have undertaken the PSIRF stipulated training programmes. Resources have been allocated for this training which will be recurrent to meet need.

### 11.2 Patient Safety Incident Response Plan

The Patient Safety Incident Response Plan sets out how the Trust intends to respond proportionately to patient safety incidents, this will be reviewed every 12-18 months or more frequently as required to reflect changes in the trust or patient safety priorities. The review process will involve key stakeholders and will be published on the trust website.

In developing and reviewing the plan, the PSIRF Implementation Group included key internal and external stakeholders to identify the Trust's patient safety incident priorities.
Data was taken from Datix and IQVIA over a three-year period (2019 – 2022/23) and included no and low harm incidents, and moderate harm and above incidents. This data was analysed by categories and sub-categories, using the Pareto Principle and charts to extract and interpret the top themes. Family & Friends Test data was captured using IQVIA, generating a statistical correlation chart that ranks responses by importance. In addition to this, opinion was sought from each ICSU on their top areas of concern in relation to patient safety.

Key themes were also analysed by sub-categories data from:

- Patient Advice and Liaison Service (PALS)
- GP concerns
- Complaints
- Risk register Legal: Claims & Coroners inquests
- Freedom to Speak Up (FTSU)
- Staff survey
- Claims
- Coroners Inquests
- Safeguarding

- Quality related reports

### 11.3 Reviewing our patient safety incident response policy and plan

The Trust's PSIRF policy document sits alongside the PSIRF plan and guides the trust's responses to patient safety incidents. The plan is a proposal which covers how the Trust intends to respond to patient safety incidents over a period of 12 to 18 months however both the policy and plan will be reviewed regularly at the Patient Safety Group to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing the response capacity, mapping the services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

## 12 Responding to Patient Safety Incidents

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare. The Trust is committed to creating an open and fair culture in which staff members are confident when reporting incidents and near misses. There is a clear procedure for reporting incidents, exploring and understanding the circumstances leading to events, and recording learning as well as monitoring processes which are set out in the incident reporting policy.

### 12.1 Patient Safety Incident Reporting Arrangements

All patient safety incidents will be recorded on Datix, the trust's local risk management system. Using Datix, all staff can:

- Record information about things could have or did affect the safety of patients, or things that have gone well, to support learning and safety improvement
- Access, review, and update incident records they have permission to edit, and undertake governance activities to support local patient safety response and improvement
- View and download data about what patient safety incidents have been recorded within their own organisation to the new Learn From Patient Safety Events service

### 12.2 Patient safety incident response decision-making

The PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm.

- Quality and Risk Managers within each ICSU will review reported incidents and escalate any incidents of concern to the Triumvirate as appropriate.

- The Patient Safety Team will review incidents reported on the local risk management system and support ICSU governance leads, if necessary, to agree the type of response required. This may include a learning response, patient safety incident investigation (PSII) or local management, in accordance with the patient safety incident response plan (PSIRP).

- WISH will discuss and agree the response to incidents, based on the following options described in the PSIRF and plan:
  - Contributory (system) factors not well understood - learning response indicated. The PSIRF plan will outline the types of responses available and will promote learning. These are aligned with the PSIRF toolkit for types of learning response.

- Safety issues well understood and/or improvement plans are in place and robust – consider not undertaking an investigation as no additional learning is likely to be identified
- Unclear whether a learning response is required – the group will discuss and agree response based on information provided and opportunity for learning / improvement or present to the WISH for a decision
- When potential patient safety incidents are identified through the complaints, clinical negligence or the Inquest process, the PALS (Patient Advice & Liaison Service), Medical Examiners, learning from death reviews, or Legal Services teams, an incident review will take place and escalated as appropriate, for discussion and consideration at the WISH.
- Resources will be allocated to support responses to emergent issues not included in the patient safety incident response plan on a case-by-case basis.

### 12.3 Responding to Cross-System Incidents/Issues

- The Trust has designed an oversight process in collaboration with the ICB, to enable the Trust to demonstrate improvements in patient safety. (See section 6.4.1)

- Local teams within each ICSU will identify cross-system incidents or issues as they occur and escalate to the WISH for consideration.

- Identified incidents presenting potential for significant learning and improvement for another provider will be sent directly to that organisation's patient safety team or equivalent. Where required, summary reporting can be used to share insight with another provider about their patient safety profile.

- The Trust will work with partner providers and the relevant ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The Patient Safety Team will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.

- The Trust will defer to the ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. The Trust will look to the ICB to give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

- The ICB can commission an investigation or any other learning response, that is independent of the Trust, if the ICB considers that:

  - The Trust does not have adequate staff resource in order to provide an objective response and analysis
  - an investigation independent of the Trust, is deemed necessary to ensure public confidence in the integrity of the investigation
  - in the case of a multi-agency incident, no single provider is the clear lead to undertake the investigation
  - the incident(s) represent significant wider learning potential regionally or nationally

- All multi-agency incidents and those representing significant learning potential for the region or nationally, including all incidents of mental health related homicide, will be discussed with the RIIT (NHS England Regional Independent Investigation Team).

### 12.4 Timeframe for Learning Responses

- Timescales should be set where possible, with a response being started as soon as practicable after an incident is identified. It should usually be completed within one to three months and no longer than six months, depending on the type and complexity of the incident.
- The timeframe for completing a PSII should be agreed with those affected by the incident and this will form part of the terms of reference for the local response.
- Should local responses undertaken by the Trust, take more than six months or exceed the timeframes agreed, then the Trust will review the processes being followed to understand how timeliness can be improved.
- In exceptional circumstances such as when a partner organisation requests an investigation is paused, a longer timeframe may be needed to respond to an incident and this will be agreed with all parties involved in the investigation.
- Where external bodies or those affected by patient safety incidents, cannot provide information to enable the Trust to complete enquiries into an incident within six months or within the agreed timeframe, the learning response leads will work with the information, which is available, to complete the response to the best of their ability. Responses might be revisited in the event that new information comes to light that indicates need for further investigation. .

The WISH will monitor timescales and progress of PSIIs and other learning responses.

### 12.5 Safety Action Development and Monitoring Improvement

The Trust will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022).

It will ensure that systems and processes are in place to design, implement and monitor safety actions. This will be part of the process of any learning response which might result in the identification of the Trust's systems where change could reduce risk or potential harm.

Best practice advises that learning responses should not describe recommendations as this can lead to premature attempts to devise a solution. Any safety action devised in response to a defined area for improvement will be dependent on factors and constraints that sit outside of the scope of a learning response. To achieve successful safety actions, their development will be devised in a collaborative way with a flexible approach from the ICSU as well as with support from the quality improvement team and other subject matter experts in the area.

The monitoring and review of safety action development and improvement from learning will be in line with the quality improvement programme.

Further details of safety action development and improvement will be outlined in the Trust's plan.

### 12.6 Safety Improvement Plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues.

The Trust will have:

- An organisation-wide safety improvement plan summarising improvement work
- Individual safety improvement plans that focus on a specific service, pathway or location
- Review output from learning responses to single incidents when it is felt that there is sufficient understanding of the underlying, interlinked system issues
- A safety improvement plan for broad areas for improvement (ie overarching system issues).

Plans will be revised in response to any new learning, so they represent the latest and best approach to dealing with a particular patient safety issue. This includes revising improvement plans where evidence indicates that measures are not having the anticipated impact.

## 13.0 Complaints

The Trust recognises that there will be occasions when patients, relatives, carers or their representative might be unhappy with some aspects of a learning response that they might have been involved in. In the first instance patients, relatives, carers or representatives should raise their concerns directly with their dedicated engagement lead to see if their concerns can be resolved. If they are still not satisfied, they should be referred to the Trust complaints policy. Staff feedback and any concerns will be addressed via the engaging and involving patients, their families and staff following a patient safety incident group.

## 14.0 Dissemination & Communication

The policy will be published on the WHT public website to enable and allow patients, visitors and others outside the Trust to access the policy. The policy may be available in a format that complies with the Accessible Information Standards on request.

## Appendix 1 Associated Policies and Procedures

(*Note these links are internally accessible only, external stakeholders can request a copy if required)*

Duty of Candour and Being Open policy
https://whittnet.whittington.nhs.uk/document.ashx?id=768

Incident reporting and investigation policy
https://whittnet.whittington.nhs.uk/document.ashx?id=2518

Complaints handling policy
https://whittnet.whittington.nhs.uk/document.ashx?id=1193

Learning from deaths policy
https://whittnet.whittington.nhs.uk/document.ashx?id=11502

Legal Services policies and procedures
https://whittnet.whittington.nhs.uk/default.asp?c=9893

Freedom to speak up/raising concerns
https://whittnet.whittington.nhs.uk/?c=21429

Whittington Health NHS Trust

# Patient safety incident response plan

**Effective date:** TBC

**Estimated refresh date:** TBC

| | NAME | TITLE | SIGNATURE | DATE |
|---|---|---|---|---|
| **Author** | **Richard Matthews** | **PSIRF Project Lead** | | |
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| **Version** | **1.1** | | | |
| **Status** | **Draft** | | | |
| **Reviewed by:-** | **PSIRF Implementation Group** | | | |
| | **Integrated Care Board (ICB)** | | | |
| | **Executive Trust Board** | | | |

| Version No | Date amendments made | Description of change |
|---|---|---|
| 1 | | *Provide a summary of the changes made to the policy* |
| | | |

## INTRODUCTION

**The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework. This document is the Patient Safety Incident Response Plan (PSIRP). It provides the detail of how we will implement the requirement of the PSIRF as set out in our associated Patient Safety Incident Response Policy.**

The Serious Incident Framework provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. PSIRF is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through how we respond to patient safety incidents.

One of the underpinning principles of PSIRF is to do fewer "investigations" but to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation.

Carrying out investigations for the right reasons can and does identify learning. Removal of the serious incident process and threshold does not mean "do nothing", it means responding in a proportionate way to incidents and striking the right balance between investigation and learning and improvement. PSIRF recognizes that under the old SI framework too much time and resource was spent investigating incidents based on a predefined threshold, such as subjective level of harm, when there may be little learning to be gained. PSIRF provides the framework to shift focus to provide a better balance between investigating and learning and improvement to improve patient safety.

A risk to successfully implementing PSIRF is continuing to investigate and review incidents as we did before, but simply giving the process a new label. The challenge is to embed an approach to investigating that forms part of the wider response to patient safety incidents whilst allowing time to learn thematically from the other patient safety insights.

Compassionate engagement and a 'just culture' are the foundation of PSIRF. We need to ensure we have support structures for staff and patients involved in patient safety incidents. Part of which is the fostering of a psychologically safe culture championed by our leaders, our trust-wide strategy and our reporting systems.

We have developed our understanding and insights over the past three years, including regular discussions and engagement through our committees and group. We have also completed a detailed analysis of themes and trends arising from a range of information sources over the last 3 years, such as Incidents, complaints and concerns, GP enquiries, risk registers, coronial inquests, patient feedback (Friends & Families Test), legal claims and staff concerns. This plan provides the mechanisms of how PSIRF will be implemented at The Whittington.

# The scope of PSIRP and our vision



There are many ways to respond to an incident. This document covers responses conducted solely for the purpose of systems-based learning and improvement.

There is no remit within this Plan or PSIRF to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. This plan augments and reinforces existing guidance and best practice in relation to 'Just Culture' and professional accountability.

It is outside the scope of PSIRF to review circumstances relating to complaints, HR matters, legal claims and inquests which must be pursued through the appropriate guidance and policies.

This Plan explains the scope for a systems-based approach to learning from patient safety incidents. We will identify incidents to review through nationally and locally defined patient safety priorities. An analysis of which is explained later within this document.

Our vision: *"Helping local people live longer, healthier lives"* supported by our 'ICARE' values: (Innovation, Compassion, Accountability, Respect and Excellence), along with our strategic aims:

- *Deliver outstanding safe, compassionate care in partnership with patients*
- *Empower, support and develop an engaged staff community*
- *Integrate care with partners and promote health and wellbeing*
- *Transform and deliver innovative, financially sustainable services*

will sit at the heart of our implementation and delivery of this PSIRP.

**Our Values:** **Innovation** **Compassion** **Accountability** **Respect** **Excellence**


| | | | | |
|---|---|---|---|---|
| **PSIRF Strategic Aims:** | Improve the safety of the care we provide to our patients | Improve the experience for patients, their families and carers wherever the need for a learning response is identified. | Improve the use of valuable healthcare resources. | Improve the experience of staff when involved in patient safety incident investigations. |

# System overview of Whittington Health NHS Trust



We have reviewed our local system to understand the people who are involved in patient safety activities across the Trust, as well as the systems and mechanisms that support them.

Our local care system is a complex with many interrelated components that are crucial to ensuring everything works. We have reviewed all patient safety activities and engaged closely with our network of key stakeholders and partner agencies who are integral to the Patient Safety agenda.

This Trust has a Corporate Directorate. The central Patient Safety Team works closely with other Corporate Teams, particularly the Patient Experience Team, Quality Improvement Team, Clinical Effectiveness Team and Legal Services Team.

There are 5 Integrated Care Service Units (ICSU's) providing clinical services across the Trust:

1. Acute Patient Access, Clinical Support Services and Women's Health (ACW)
2. Adult Community Health Services (ACS)
3. Children and Young People Services (CYP)
4. Emergency and Integrated Medicine (EIM)
5. Surgery and Cancer (SC)

Core patient safety activities undertaken include:

- NHS Patient Safety Strategy
- Patient Safety Programme
- Patient Safety Incident Response Framework
- Patient Safety Partners involvement
- Risk Management
- Central Alert System (CAS)
- Quality Improvement

Other activities within the Trust that provide insights to patient safety include Structured Judgement Reviews, Learning from Deaths, complaints and feedback, legal claims and inquest responses.

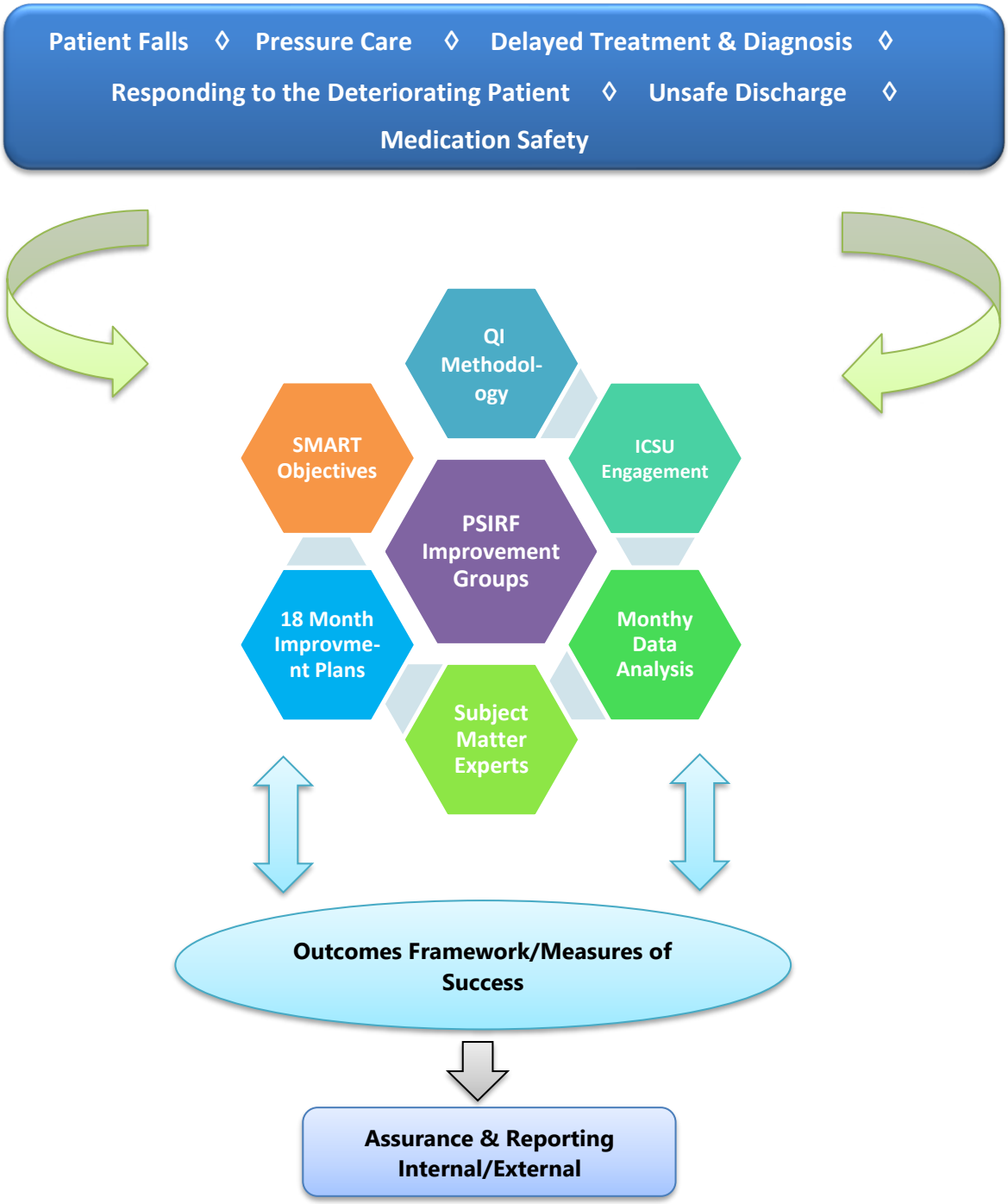
The operational 'work-as-done' for these patient safety activities is predominantly owned by our colleagues within the operational Integrated Care Support Unit (ICSU's). Each ICSU is supported by a small governance team who provide local expertise and advice on patient safety matters with support from the Corporate Teams and Patient Safety Specialist.

This emergent system has been built to respond to the needs of our patients, services, and structures we work in. This involves key people & teams within the Trust who are integral in facilitating our patient safety system and patient safety culture. This system is not static and will evolve and adapt further as we embark on our PSIRF journey.

# System overview – our priorities & structure



## Patient Safety Priorities for PSIRF



# Situational Analysis of Patient Safety Activity



In the last three years, more than 12,000 patient safety incidents have been reported by the Trust with around 1% (1200) of these meeting the threshold for consideration as a Serious Incident under the previous Serious Incident Framework.

A significant amount of time and resource is consumed in completing serious incident investigations, ensuring action plans are completed and providing assurance of learning and improvement internally and to commissioners.

It has been recognised in the PSIRF, that a disproportionate amount of time and effort is required to carrying out serious incident investigations, significantly limiting time to learn thematically from the other 99% of patient safety incidents. In short, the burden of effort is placed on fewer than 1% of all patient safety incidents.

A significant risk to successfully implementing PSIRF is continuing to investigate as many things as possible within Serious Incident Framework but simply calling them something else.

A key part of developing the new national approach is to understand the amount of patient safety activity the trust has undertaken over the last few years. This enables us to plan appropriately and ensure that we have the people, system and processes to support the new approach.

The patient safety investigation and learning related activity undertaken prior to PSIRF can be broken down as follows:

| Patient Safety Activities | Activity | Definition | Av. of prev. 3 calendar years | Last calendar year |
|---|---|---|---|---|
| **National Priorities** | Incident resulting in death | Serious incident requiring investigation which met the standard investigation timeframe and resulted in patient's death. | 6 | 3 |
| | Never Events | Incident meeting criteria for never events framework and reported to STEIS | 3 | 1 |
| **Local Patient Safety Activities** | Serious Incident Investigations (SI's) | Serious incident requiring investigation (SIRI) which met the standard investigation timeframe. | 50 | 19 |
| | 72 Hour reviews | Including moderate harm incidents meeting the requirement for Statutory Duty of Candour, or other incidents of concern. | 173 | 59 |
| | Patient Safety Incident Validation | Patient safety incidents of low/no harm requiring validation at department/ward level. | 4100 | 5813 |

In order to identify our key improvement priorities we analysed 3 years of data up to 31/12/2022 relating to the following activities:

- Reported incidents (including low and no-harm incidents)
- Complaints, concerns and patient feedback through the Friends and Families Test (FFT)
- Risks and risk registers
- Legal claims and inquests
- Staff and GP concerns/enquiries

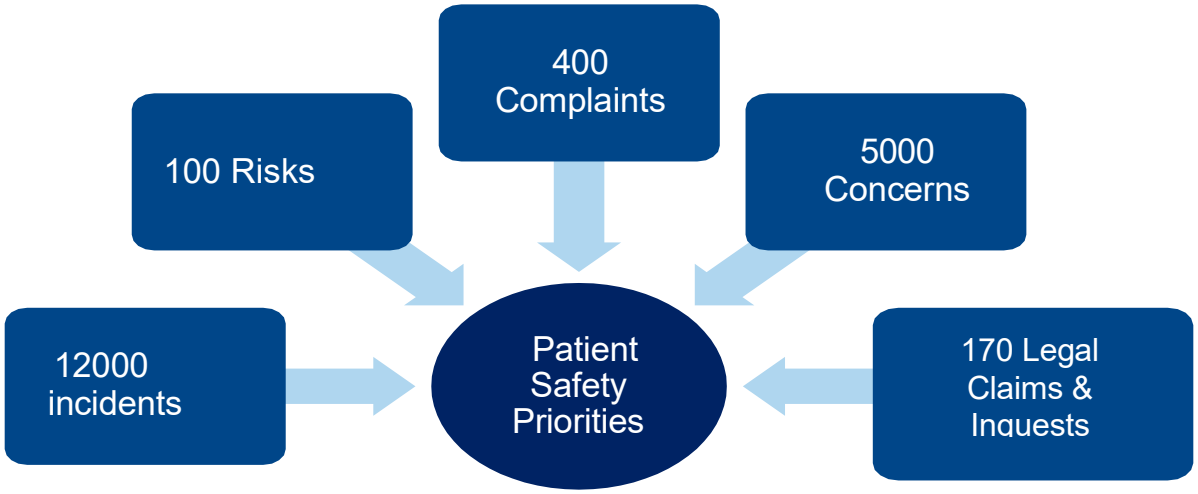
The data and analysis presents a complex picture with significant variation between ICSU's as would be expected given the diverse nature of services provided. From analysis of incident data, it was clear, as would be expected for an acute hospital trust, that falls, pressure ulcers, medication safety, transfer/discharge issues and harm related to delayed treatment were the most significant categories of incidents in the low or no-harm categories.

Clinical incidents resulting in moderate or above harm levels presented a slightly different picture with more incidents relating to pressure ulcers, falls, delays in cancer treatment, infection control and resuscitation. As would be expected. there are considerable variations between ICSU's and specialties in terms of incident reporting profiles and numbers of incidents reported.

Legal claims and inquests provide a different perspective with failure to treat/diagnose, complications from treatment and labour/delivery issues being the most frequent categories of claims.

Data and information from complaints/concerns presented a more nuanced picture based more on perceptions of patients or relatives, such as communication issues, delays/waiting times, care needs not being met and perceptions of staff attitude.

Analysis of risk registers highlighted the key operational challenges that impact upon quality and safety of patient care. These relate primarily to system capacity to deliver services such as: staffing shortages, patient flow, medical equipment, infection control and issues relating to estate and facilities. As PSIRF requires a more holistic assessment of patient safety it is recognised that governance of the risk framework should be more closely aligned with patient safety at a strategic and operational level in future. Improvement plans and risk mitigation should be co-terminus with patient safety priorities to maximise efficiency and improvement outcomes.



# Our Patient Safety Priorities



Through the analysis of our patient safety insights, based on both the original thematic analysis and the updated incident review, there are seven patient safety priorities which will be the focus on for the next two years. It is recognised that some of the themes relating to issues such as estates, staffing levels, IT system failures and patient flow would be best managed through the operational management structures, rather than the patent safety agenda.

These patient safety priorities form the foundation for how we will decide to conduct Patient Safety Incident Investigation (PSII) and learning responses, and also where no further investigation is required.

The patient safety priorities were agreed at the PSIRF Implementation Group in August 2023.

| Theme | Key Theme | Key Risks from Activity |
|---|---|---|
| 1 | Patient Falls | Consistently a high number of incidents across inpatient areas and wards. Many resulting in patient harm. |
| 2 | Medication / Safety | Administration of medicines, omitted or delayed doses, high risk drugs (especially insulin and anticoagulation). |
| 3 | Responding to a deteriorating patient | NEWS & PEWS scores, fluid balance management, stepdown to ward level care. |
| 4 | Pressure related skin damage | Trust acquired or deterioration in pressure damage. There is also a key link with self-neglect and vulnerable adult/safeguarding issues in the community. |
| 6 | Delayed Treatment & Diagnosis | Particularly in relation to cancer treatment pathways, patient tracking systems and patients lost to follow up. Incorrect diagnosis. |
| 7 | Unsafe discharge | A range of concerns identified from across ICSU's particularly relating to delays in transfer, learning disability patients and discharge medications and equipment. |

# How we will respond to patient safety incidents



**Deciding what to investigate through a PSII or other learning response such as an After-Action Review, SWARM or MDT review will be a flexible approach, informed by the local and national priorities. Our objective is to facilitate an approach based on decision making by those best placed to understand the incident circumstances, environment, and contributory factors, rather than centrally mandated rules and compliance with rigid procedures. Under PSIRF incidents will not be selected for further learning responses based on the level of harm, instead incidents that provide the greatest opportunity for new learning will be selected for further learning responses.**

At the onset, we will use existing structures to support the process of decision making. There is an established weekly executive- led incident review meeting (formally SIEAG but now called WISH – Whittington Incident Safety Huddle), where potential serious incidents and other emerging patient safety issues across the Trust are discussed. ICSU's have local arrangements to ensure incidents are reviewed daily and key risks and concerns identified.

Our medium to longer term aim is to support each ICSU to have more autonomy to find the most appropriate and proportion approach to investigate and learn from incidents. This will evolve through our implementation of the PSIRF and the associated training and professional development in human factors and systems thinking. A move away from centrally mandated rules and thresholds governing what should be investigated is central to the PSIRF principles.

As we transition into PSIRF, the Patient Safety Team will continue to work closely with the ICSU Quality and Risk teams to develop and support this approach. In PSIRF, the approach of investigating incidents by their level of harm will no longer apply, and we will focus on incidents that provide opportunities for new learning and quality improvement, as well as the national and local patient safety priorities as illustrated below

National guidance recommends that 3-6 learning responses (which may include PSII) per priority theme are conducted each year. When combined with patient safety incident investigations from the nationally mandated priorities this will likely result in around 15-20 investigations per year. Attempting to do more than this will impede our ability to focus more time and effort on improving patient safety and less on investigating incidents, particularly where contributory factors are well understood, and improvement work is in progress. This is the very essence of the PSIRF approach.

## Patient safety incidents that must be investigated under PSIRF

The following types of incidents will still require a comprehensive PSII investigation:

1. Patient safety incident is a Never Event
2. Deaths more likely than not due to problems in care. This can be identified through an incident and/or the learning from deaths process.
3. Emerging National priorities for investigations (at the time of developing this plan, there are none apart from those already listed above. We will include any new priorities as they emerge).

Apart from the mandated incidents listed above, the following questions must be considered when deciding which incidents require further investigation or a learning response.

- Is the patient safety incident linked to one of the Trust's Patient Safety Priorities that were agreed as part of the situational analysis?

- Is the patient safety incident an emergent area of risk? For example, a cluster of patient safety incidents of a similar type or theme may indicate a new priority emerging. In this situation, a proactive investigation can commence, using a single or group of incidents as index cases.

**Incidents that meet the statutory Duty of Candour thresholds:**
There is no legal requirement to investigate a patient safety incident. Once an incident that meets the statutory Duty of Candour threshold has been identified, the legal duty, as described in Regulation 20 states we must:

1. Tell the person/people involved (including family where appropriate) that the safety incident has taken place.
2. Apologise. For example, "we are very sorry that this happened"
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.
5. Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.
6. Keep a secure written record of all meetings and communications.

This legal duty will not be affected by the implementation of the PSIRF, though the way we communicate and type of information we share with patients, carers or relatives may change depending on the type of learning response utilised. Additionally, there should also be more opportunities to involve patients and carers/families more closely in our learning responses with the learning tools / methods available.

## Patient safety incidents that have resulted in severe harm:

These incidents would have automatically been investigated as a 'serious incident' under the Serious Incident Framework. It is crucial that these incidents are not routinely investigated using the PSII process, otherwise we will be re-creating the Serious Incident Framework. The criteria of '*providing significant opportunities for new learning*' will determine whether a learning response (including PSII) is required and not the level of harm.

The routine response to an incident that results in severe harm will be to follow the Statutory Duty of Candour requirements. This will both provide insights to thematic learning and provide information about the events to share with those involved.

# How we will respond to patient safety incidents



Patient Safety Event Occurs

Patient Safety Incident Investigations

Patient Safety Review

| | Event | Approach | Improvement |
|---|---|---|---|
| National Priorities | Incidents meeting each baby counts criteria. | Referred to Healthcare Safety Investigation Branch (HSIB) | Respond to recommendations from external referred agency/organisation as required. |
| | Incidents meeting maternal death criteria. | | |
| | Child death | Initiate child death review process | |
| | Death of person with learning disabilities | Reported and reviewed by Learning Disabilities Mortality Review (LeDeR) | |
| | Safeguarding incidents meeting criteria | Reported to named safeguarding lead | |
| | Incidents in screening programmes | Reported to Public Health England (PHE) | |
| | Death of patients in custody/prison/probation | Reported to Prison and Probation Ombudsman (PPO) | |
| | Incidents meeting the Never Event criteria. | Patient Safety Incident Investigation | Create local organisational recommendations and actions. |
| | Deaths caused by treatment issues / omission. | | |
| Trust Priorities | • Patient Falls<br>• Pressure Care<br>• Deteriorating patient<br>• Unsafe discharge<br>• Delayed treatment / diagnosis<br>• Medication Safety<br>• Emerging areas of risk / concern | Local response and inform improvement programme.<br><br>Consider a learning response (including PSII) if significant potential for new learning. | Create local organisational recommendations and actions feeding into patient safety priority improvement programmes. |
| Local Level | Other incidents of concern or which present significant opportunities for new learning. | Locally agreed learning response or escalation for possible PSII | Inform thematic analysis to identify new patient safety risks. |
| | All other incidents. | Manage at service level and close. No further learning response. | |

Under the PSIRF a suite of learning responses will be available to investigate different types of incidents depending on their circumstances. Central to all learning responses/investigations will be a focus on human factors and systems thinking and a move away from root causes and the actions of individuals. The PSIRF framework requires the Trust to provide additional training, education and availability of resources in relation to these new methodologies and frameworks.

A detailed training needs analysis has been completed to identify the right level of training for key staff groups such as senior leaders overseeing PSIRF; staff who will be completing investigations and learning responses; and staff who will be engaging with patients, carers and families following a patient safety incident. A programme of externally facilitated training will be delivered to all required staff prior to our transition to the PSIRF which will cover the following key modules:

| **Systems approach to learning from patient safety Incidents 2-day 12 hours** | **Systems approach to learning from patient safety incidents oversight training 1-day 6 hours** | **Engaging with patients, families and staff following a patient safety incident training 1 day- 6 hours** |
|---|---|---|
| For:<br>• All Learning Response Leads<br>• All those in PSIRF oversight Roles | For:<br>• All those in PSIRF Oversight Roles; Provider Boards | For:<br>• All Engagement Leads<br>• All those in PSIRF oversight roles |

**Additionally, all staff identified above will need to complete the NHSE, Patient Safety Syllabus level 1 and level 2 e-Learning.** This is available to all staff and provides an introduction to the key principles and methodologies that are covered in more depth in the externally facilitated training.

## Types of Learning Response

The Trust will initially adopt the 4 learning response methodologies below. Trained investigators will decide which incidents require a learning response and which tool is most appropriate for the circumstances of the incident on a case-by-case basis. **It must be recognised that many incidents will not require any further learning response and can be dealt with at a local level or at sub committees for specific categories where there are already existing improvement plans in place, or where they relate to one of the key improvement themes & workstreams.**

Patient safety incident investigations (PSII's) - are comprehensive investigations conducted to identify the circumstances and systemic, interconnected, causal factors that result in patient safety incidents. These are usually the most detailed and in-depth investigations, similar to 'serious incident' (SI) investigations conducted under the old framework. As detailed above, this methodology will still be required for some types of nationally mandated incidents and can be

used to investigate any incidents locally where this approach is deemed the most appropriate. For example, complex incidents where contributory factors are not well understood and the potential for new learning is high.

After-Action Review (AAR) - An after-action review method of evaluation usually takes the form of a facilitated discussion following an event or activity. It enables understanding of the expectations and perspectives of all those involved and it captures learning, which can then be shared more widely.

SWARM huddle - Swarm-based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.

Multidisciplinary team (MDT) review - The MDT review supports health and social care teams to:

- identify learning from multiple patient safety incidents
- agree the key contributory factors and system gaps in patient safety incidents
- explore a safety theme, pathway, or process
- gain insight into 'work as done' in a health and social care system.

More detailed information on learning response tools can be found on the NHSE website at : https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/

*"Where an incident type is well understood – for example, because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at the contributory factors are being implemented and monitored for effectiveness – resources may be better directed at improvement rather than repeat investigation (or other type of learning response)."*

*(PSIRF supporting guidance, Guide to Responding Proportionately to Patient Safety Incidents. NHSE 2022)*

# Support for patients, carers and families following an incident



We recognise the significant impact patient safety incidents can have on patients, their families, and carers.

The patient voice is very much an integral part of our work at the Trust. Our Patient Safety Partners will be a valuable source of information and feedback to ensure the patients voice is integral to PSIRF.

As detailed above, engagement with families and patients is a central principle of the PSIRF. It also supports and augments existing guidance under the Duty of Candour requirement. In line with the PSIRF guidance the Trust will endeavor to put patient involvement at the heart of our PSIRF implementation by:

- Recruiting Patient Safety Partners into the organisation to provide insight, support and scrutiny in relation to our patient safety arrangements and agenda.
- Reviewing and updating our Duty of Candour policies and procedures to ensure they are in line with the principles of the PSIRF.
- Delivering required PSIRF training to all engagement leads on 'engaging with patients, families and staff following a patient safety incident'.
- Regularly seeking feedback through existing arrangements such as local focus groups, surveys, FFT and patient stories.
- Triangulation of patient safety data and information with data and intelligence from the Patient Experience team / agenda.

As part of our new policy framework, we are developing procedures and guidance to support staff in how to discuss incidents with patients and family.

# Support for staff following an incident



We are on a journey at the Trust to ensure it is a safe and fair place, where everyone's voice is encouraged, valued, and listened to, helping us to continually learn, inspire change and improve.

When a colleague reports an incident or is providing their insights into the care of a patient for an investigation, we will actively encourage a safe space to discuss the events, explore the system in which they work and listen openly without judgement. Our new policy, procedures and guidance will support this in practice.

We recognise that many staff will be involved with a patient safety incident at some point in their careers and this can be a distressing and traumatic experience. We have a wealth of excellent psychological, wellbeing and support services for individuals. Additionally, our managers, supervisors and leaders are committed to the Trust values of compassion and respect, to our staff as well as our patients. The learning response methodologies, detailed above, that the Trust will employ under the new framework, will also ensure staff are fully engaged and supported throughout the process of investigation and learning.

Additionally, the Trust's associated policies and procedures in relation to Just Culture and Freedom to Speak Up, augment the principles and methodologies detailed in this plan. The implementation of the PSIRF will provide an opportunity to refresh and revisit these in an inclusive and collaborative way.

Several existing approaches to supporting staff and staff teams following an incident are already established, as detailed below. These will continue to be promoted and facilitated within our teams and services.

Debrief: An unstructured, moderated discussion.

Safety huddle proactive: A planned team gathering to regroup, seek advice, talk about the day.

Safety huddle reactive: Triggered by an event to assess what can be learned.

# Governance and oversight in the new system



Governance, oversight and assurance under PSIRF will need to shift its focus to learning, improvement and compassionate engagemnt, rather than compliance with process, targets and thresholds under the SIF. The Trusts approach will be to retain existing governance structures and committees. However, reports, terms of reference and agenda's will be reviewed and amended to reflect the new approach. It is recognised that this element of PSIRF especially will evolve and develop as we progress on our journey.

The **Trust Management Group** oversees the delivery of clinical services, informed by the outcomes from review meetings between ICSU's and the Executive Team.

The **Quality Governance Committee** is chaired the Executive Medical Director. This meeting will have strategic oversight of the PSIRF. This will include assurance that improvement plans are progressing and learning responses are being conducted effectively, consideration of any emerging risks and mitigations required and any other significant activity or exceptions reported by Patient Safety Group or WISH.

The **Patient Safety Group** will have operational of PSIRF including: progress and approval of PSIIs, progress with safety actions arising from learning responses, analysis of data and information relating to patient safety and improvement, identification of emerging risks, and to have supportive oversight of improvement plans for the key local priorities.

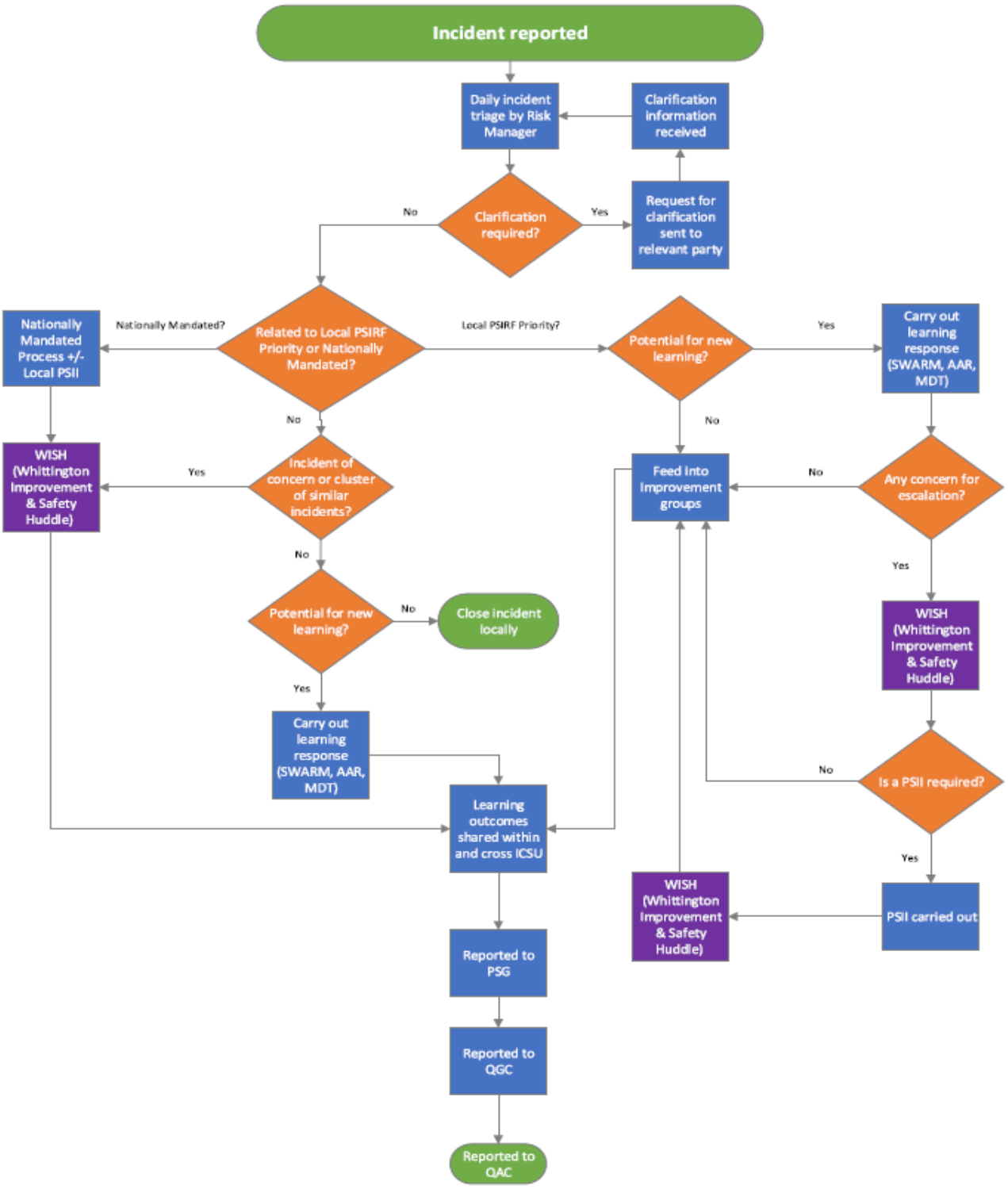
The **Patient Experience Group** chaired by the Deputy Chief Nurse and supports the Board oversight in this area.

The **Whittington Incident Safety Huddle (WISH)** will review incidents and risks on a weekly basis and seek assurance from ICSU's that incidents are being managed in line with the PSIRP (see flowchart below). The group will consider any escalations from ICSU's and the Risk and Safety Team and agree any incidents of concern that require PSII level investigation.

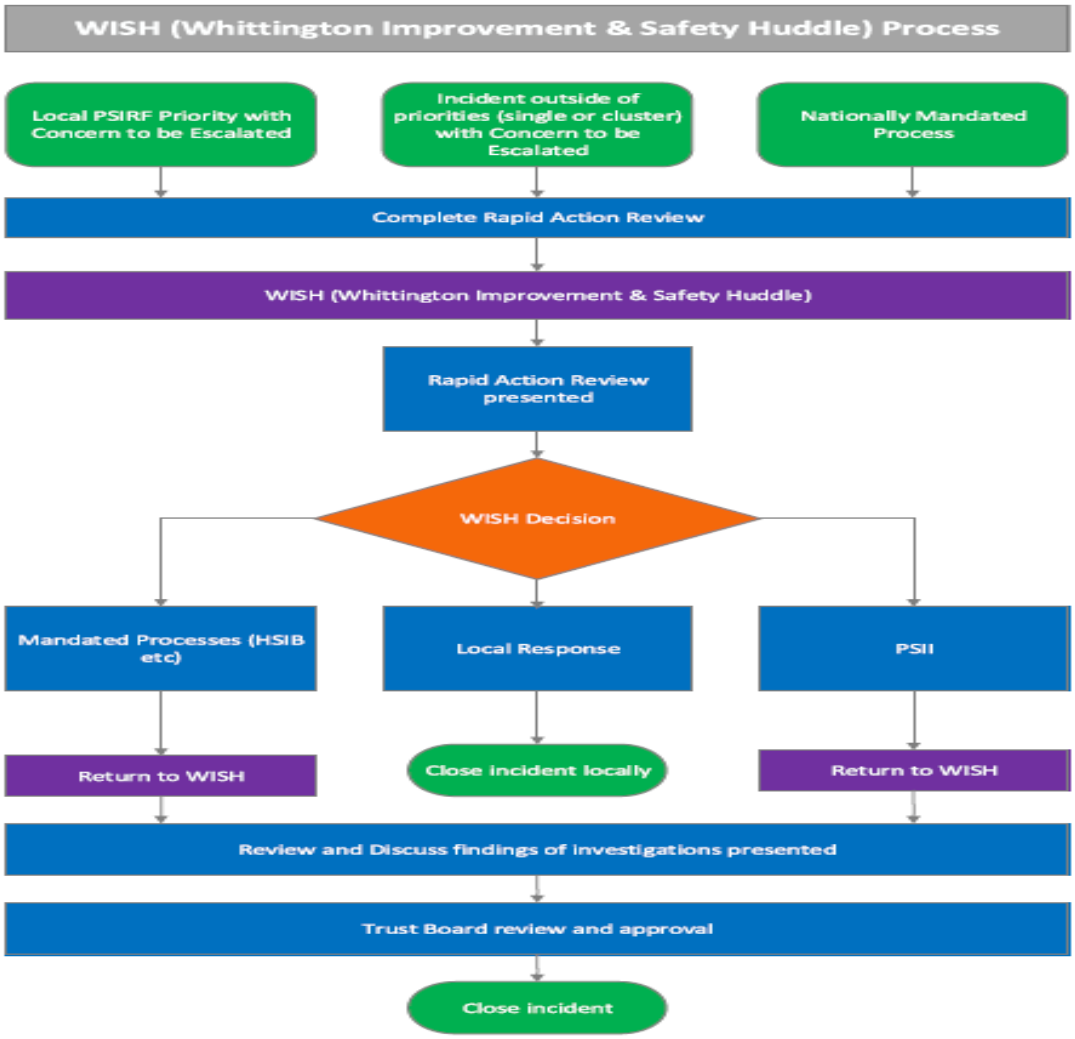
The **Trust Board** seeks assurance that high quality services are being delivered through its sub-committees and presentation of reports, data and information.

## Incident response Process – ICSU to WISH

The flowchart below illustrates the patient safety incident governance and decision-making process for review and decision making.



## Incident response Process – WISH



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| **Meeting title** | **Quality Assurance Committee (QAC)** | **Date: 10th January 2024** |
| **Report title** | **Nursing and Midwifery 6 monthly Safer Staffing Review Report (March 2023-August 2023 data)** | **Agenda item: 4.7** |
| **Executive director lead** | Sarah Wilding, Chief Nurse & Director of Allied Health Professionals | |
| **Report authors** | Marielle Perraut Assistant Chief Nurse<br>Maria Lygoura, Lead Nurse for Safer Staffing and Roster Utilisation | |
| **Executive summary** | • In line with National Quality Board (NQB) guidance (2016), the Bi-Annual Nursing and Midwifery Establishment Review report outlines Whittington Health's response to the statutory requirements to have safe Nursing and Midwifery staffing levels.<br>• This Mid-Year review report includes the following:<br>○ A summary of the review meetings held with all 5 ICSUs in November 2023<br>○ An update on actions from the last 6 monthly establishment review undertaken in Summer 2023<br>○ The key findings from the 6 monthly Establishment Review of the Nursing and Midwifery workforce based on the Safer Nursing Care Tool (SNCT) and Mental Health Optimal Staffing Tool (MHOST) audits collected in June 2023 for all inpatient areas and Emergency Department (ED)<br>○ Recommendations and actions to prepare for the next 6 monthly Establishment Review that will take place in Summer 2024<br>• Where added investment requirements have been identified since last review, and supported in principle by the Deputy/Chief Nurse, the ICSUs will progress as part of their local operational actions/business planning and details included in the report narrative: | |

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| | **Surgery and Cancer (S&C)**<br><br>○ Business cases are currently being developed by the ICSU leadership team to recommend substantive funding for posts currently funded as fixed term by Macmillan and NCL Cancer Alliance:<br><br>➢ 0.5 WTE Lung CSW Funding ends December 2023<br><br>➢ 0.5 WTE Lung CNS Contract ends February 2024<br><br>➢ 0.5 WTE Urology CSW Contract ends February 2024<br><br>➢ 0.5 WTE UGI CSW Contract ends May 2024<br><br>➢ 0.5 WTE Urology CNS Contract ends 2025.<br><br>➢ 0.2 WTE Gynaecology CNS Contract ends March 2024<br><br>**Emergency and Integrated Medicine**<br><br>○ A Business case is currently being developed by Emergency and Integrated Medicine (EIM) and S&C ICSUs leadership teams for substantive funding for a joint Enhanced Care (Band 3) Team. WTE to be confirmed.<br><br>○ A Business case is currently being developed by EIM ICSU Leadership team for 16.3 WTE band 3 HCSW for ED. This was identified as an action following the last establishment review recommendations.<br><br>○ EIM 1.8 WTE band 8B Advanced Clinical Practitioner ACP) Lead is required and will need to be funded from the medical budget as agreed prior to the start of the programme.<br><br>• The following services have identified establishment amendment requirements. The Chief Nurse/Deputy Chief Nurse were not able to support these until further work, detailed in report, is completed by the respective ICSUs.<br><br>○ Montushi -2.6 WTE band 2 HCSW for night shift cover<br><br>○ AAU (North and South)- 5.2 WTE band 2 HCSW to increase HCSW cover by 1 on day and 1 on night shift. |

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| | ○ Nightingale -10.3 WTE band 2 HCSW to increase HCSW cover by 2 on days and 2 on night shifts.<br><br>**Children and Young People (CYP)**<br><br>○ Neonatal ICU -2.62 WTE band 6 RN to support Transitional Care on Celliers Ward (this is currently temporarily funded from Ockendon)<br><br>○ Neonatal ICU- 0.5 Advanced Nurse Practitioner (ANP) band 8A needs to be supported by the medical budget as per programme recommendation.<br><br>○ Ifor Ward- 0.5 WTE band 7 Practice Development Nurse (PDN) to support current 0.5 WTE in post.<br><br>○ Children Ambulatory Care (CAU)- 0.6 WTE band 3 HCSW<br><br>○ Children Daycare and Outpatients- 1WTE band 5 RN due to the increase in dental activity and leadership and 3.8 WTE band 3 HCSW as this service is HCSW and Nursing Associate led. |
| **Purpose:** | • As per the National Quality Board (2016) (NQB) 'Expectation 1: Right Staff' and NHS Improvement (2018), 'The planning cycle'; this report seek to give assurance to the Board that the mid-year establishment review took place for Nursing and Midwifery between March and June 2023. |
| **Recommendation** | The Quality Governance Committee is asked to:<br><br>(i) Review that the proposal with the appropriate level information is provided.<br>(ii) Approve the establishment adjustments that have been recommended by individual ICSUs and supported by the Senior Nursing and Midwifery Leadership team. |
| **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. |

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| | 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. Establishment review meetings with Deputy Chief Nurse, Assistant Chief Nurse, Safer Staffing Lead Nurse, Associate Directors of Nursing and Midwifery (ADoN/M), Deputies, Matrons and Healthroster Team (Director of Operations present for CYP and EIM meeting) (November 2023)<br>2. QGC (13th December 2023)<br>3. Nursing and Midwifery Leadership Group (NMLG)<br>4. TMG<br>5. QAC 10th January 2024 |

## 6 monthly Nursing and Midwifery Establishment Review Report

## 1. INTRODUCTION

1.1 This paper provides the Quality Governance Committee (QGC) with an overview of the 6 monthly Nursing and Midwifery Establishment Reviews that took place in November 2023 and an update on proposed actions from the July 2023 report.

1.2 In October 2023, ESR reported that Whittington Health Nursing and Midwifery establishment represented 1901.21 WTE (1305.02 WTE Registered and 596.19 WTE Unregistered staff). This is a 1.95% increase from April 2023 (+ 1.7% Registered and +0.5% unregistered) from August. This increase comes from the investment in Acute Community services following the restructure.

1.3 The NQB's 3 priorities that form the basis to making staffing decisions are as below.

- Right staff
- Right skills
- Right place and time

1.4 Safer staffing and skill mix reviews were undertaken the following clinical areas based on Safer Nursing Care Tool (SNCT) audits undertaken in June 2023:

- Inpatient adult and children wards (EIM, S&C and CYP)
- Simmons House (CYP)
- Emergency Department (ED) (EIM)
- Critical Care Unit (CCU) (S&C)
- NICU (CYP)

Exploratory reviews have been undertaken in clinical areas that have currently no recognised national audit tools. Those establishment reviews were undertaken based on activity, acuity and ERoster metrics.

- Theatres and Recovery (S&C)
- Day Treatment Centre- DTC (S&C)
- CCU Outreach Team (S&C)
- Chemotherapy suite and CNS teams (S&C)
- General Outpatients and Gynaecology outpatient (ACW)
- Endoscopy (EIM)
- Children Ambulatory care/Day Care and Outpatient (CYP)
- Health Visiting (CYP)
- School Nurses (CYP

Maternity services and Adult Community services (ACS):

- The outcome of the Midwifery Birthrate will be available December 2023 and will be reviewed at the next establishment review.

- Community services have just undergone a restructure and the new Community Nursing Safe Staffing Tool (CNSST) Audit was piloted in March 2023 in 4 District Nursing teams. CNSST audit tool training will start in January 2024 to prepare the teams for an ICSU wide audit in Spring 2024.

## 2. ESTABLISHMENT REVIEW PROCESS AND METHODOLOGY

2.1 Whittington Health adheres to the recommendations set out in the "Safe staffing for nursing in adult inpatient wards in acute hospitals" guideline (National Institute for Health and Care Excellence, 2014).

2.2 NHS Improvement published the Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing (October 2018). This guidance addresses any gaps around safe workforce planning and recommendations to ensure a consistent approach to achieve:

- Effective workforce planning
- Staff deployment by using evidence-based tools.
- Governance considerations when redesigning roles/skills mix.
- Responding to unplanned workforce challenges

The NQB recommend the use of other quality data to inform professional judgement including acuity and dependency tools, incident data, health roster KPIs, Workforce KPIs, quality indicators and peer/national benchmarking.

In addition to the safe staffing processes used, Clinical Specialties national guidelines were referenced for this establishment review.

For the purpose of this review, data was collected from Electronic Staff Record (ESR), QlikView®, HealthRoster® (Now called Optima®) and SafeCare® .and were assessed against workforce performance KPIs and targets as detailed in table below:

| Indicator | Appraisals % Rate | Mandatory Training % Rate | Staff Sickness absence % | Staff Turnover % | Vacancy % Rate against establishment |
|---|---|---|---|---|---|
| | >85% | >85% | <3.5% | <13% | <10% |

Table 1: Workforce KPIs and Performance targets

2.3 The guiding principles for the inpatient ward establishments are outlined below:

1. RN/NA skill mix ranging from 50/50 to 90/10 (national recommendation 65/35 but varies according to speciality and acuity)

2. Uplift within establishment to cover annual leave, sickness and study leave allowances. It is important to consider that there will be variation from 20.4% to 27% across areas. This is due to different mandatory educational requirements according to specialism and national recommendations.

3. The nurse-to-patient ratio as recommended by NICE (1:8) was used where appropriate. Professional judgement was applied, having considered the specialism of each setting, acuity, and quality/safety indicators.

## 3. WORKFORCE KEY PERFORMANCE INDICATORS (KPI) FINDINGS AND ACTIONS

3.1 Oversight of safe staffing across the Whittington Health remains a challenge due to short notice staff availability, and increased establishment requirements to support services increased acuity and creation of additional capacity. This is managed through the Trust daily site meetings.

The now embedded safe staffing morning meeting allows early actions and mitigations to inform the Site/operational meetings at later times. This has proved beneficial as it promotes mutual aid internally. It also helps identify opportunities to reduce extra temporary staffing expenditure by finding internal mitigations.

The role of the Safer Staffing Lead Nurse has expanded to include Eroster utilisation to support the Eroster and clinical teams.
The safer Staffing Lead Nurse and ERoster manager are planning a series of Rostering challenge meeting with the ICSUs from early 2024.
This will strengthen our rostering governance, safe staffing and identify gaps and training needs.

3.2 The overall staff turnover remains above target (13%) with a marginal increase from 14.25% at the last review, to 14.5% for March 23-August 23. This is still a marked improvement for the same period last year, where staff turnover was 16.5%. Unregistered staff turnover remains high at 15.7%, versus registered staff at 13.3% averaging over the 6 months period.

From the recent 2022 staff survey results, lack of career recognition, education opportunities and poor pay for lower bands are cited as the main reasons for the turnover rates. For registered staff, the main contributors appear to be level of pay, increasing work demands and lack of work-life balance.

Initiatives such as the HCSW programme, induction tailored for international recruitment, Preceptorship, Trainee Nursing Associate (TNA) pathways, amongst other opportunities, are helping to value our workforce and promote retention and better staff experience.

Scoping work is also underway to appraise the feasibility of re-evaluating clinical band 2 HCSW to band 3, as part of NHS England’s work on recruitment and retention of this group of staff.

Recruitment and retention (vacancy target below 10 %) remains a challenge and marginally improved from 14.1% to 13.6% in the last 6 months.
The unregistered workforce vacancy rate has deteriorated from 14.3% to 15% and targeted recruitment events held by the Trust continue, but the cost of living and opportunities to progress, has impacted retention. It is expected that the targeted work with HCSW will improve this going forward.
The registered workforce substantive vacancies remain static at 11%.

3.3 Staff sickness related absence is above the Trust target of (3.5%) at 4.3% over the last 6 months, but there is a continued improvement noted of 0.8% compared to the preceding establishment review.
Mental health and musculoskeletal (MSK) disorders remain the top 2 reasons for long term sickness (over 4 weeks). It is worth noting that there has been a 4% improvement in staff reporting MSK problems over the previous 12 months.

All ICSUs report effective working with HR and Occupational Health in supporting colleagues to return to work, or to accommodate reasonable adjustments.
Return to work interviews and support plans are in place to maximise work attendance, provide support as well as continued review of flexible working arrangements.

3.4 Overall Mandatory training scores remain within 85% target across the organisation with registered staff averaging 90% and unregistered staff 86%

Appraisal rates show performance below the current target, overall, 76%, but an improvement from 73.3% at the last review. The 2022 staff survey (Nursing and Midwifery, registered and unregistered) also reported that 81% had received an appraisal compared to 78% in 2021.
However, there is still work to do to ensure that this has a positive impact on workforce as only 30% on average felt that this had a positive impact on their work/career.

Managers should be supported to attend the appraiser training to be able to conduct meaningful appraisals going forward.

## 4. ICSU REVIEWS AND ANALYSIS

### 4.1 **Children and Young People**

The ICSU has several services across acute and community settings. This review primarily addresses Ifor ward, CAU, NICU and Simmons House.
Health Visiting and School Nursing did not have a formal review as there is currently no formal national tool available, but discussions included recruitment, retention and ways to measure demand and capacity in future reviews.

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| **Progress against actions from last review** | ○ Reconfiguration of acute paediatric services is ongoing, but it was identified that leadership was needed to support and give momentum to the project. |

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| | ○ Recruitment of 2 Mental Health HCSW for Ifor ward was successful. The RMN posts have not been recruited to, but interviews are planned for the near future.<br><br>○ Review of recruitment for Health Visitors in Highbury and Islington still in progress.<br><br>○ Simmons House was allocated NCL budget for extra resources from the last review and are being recruited. |
| **Establishment update** | ○ Community School Nurses and Health Visitors establishments are correct for the activity to be delivered, but recruitment is challenging. Teams are working to promote student retention once they graduate. Staffing for these specialities remain on the risk register.<br><br>○ **Added investment required:**<br><br>➢ Neonatal ICU- 2.62 WTE band 6 RN to support Transitional Care on Celliers Ward (This is currently temporarily funded from Ockendon). This role will be a partnership with Maternity to meet Ockendon recommendations and promote continuity of care.<br><br>➢ Neonatal ICU- 0.5 WTE band 8A ANP should be invested in to add to the current 1WTE. Options should be explored for this to be subsidised by the medical budget as the role has been implemented to provide support for medical workforce.<br><br>➢ Ifor Ward- 0.5 WTE band 7 PDN to support the current 0.5 WTE in post. CNSs also provide training support, but the teaching they deliver is concentrated around clinical skills and competencies. PDNs offer a more holistic support that include preparing band 5 RGNs for more senior roles and enhanced responsibilities.<br><br>➢ Childrens Ambulatory Care (CAU)- 0.6 WTE band 3 HCSW. 2.62 WTE require to efficiently support the unit and only 2WTE currently in place.<br><br>➢ Children Daycare and Outpatient -1WTE band 5 RN required and 3.8 WTE band 3 HCSW required due to the significant increase in dental activity. This service is HCSW and Nursing Associate led, and the increase will enable the service to safely staff for increasing the service from half a day a week, to 2 full days. |
| **Workforce data** | ○ The sickness rate has improved from an average of 5.1% last review, to 4.8% from March to August 2023. Although remaining |

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| | above the Trust target of 3.5%, the leadership team have a robust plan in place to continue this improvement.<br>○ Turnover remains high at 18.3%. As part of restructure, there are opportunities for junior workforce to rotate across all clinical settings, so they are supported to gain confidence and competencies.<br><br>○ Mandatory training rates are over 90% and appraisal rates 80% from 83% in the last period.<br><br>. |
| **Activity & Acuity impacting on staffing** | ○ Enhanced Care needed to support the increased acuity in Simmons House and Ifor ward incurred a financial overspend. There has been a consistent need for Enhanced Care in Simmons House for last 6 months. Activity reduced as expected in Ifor ward in the Summer months but increased acuity and complex social admissions contributed to the need for Enhanced Care provision.<br><br>○ The seasonal increase from 15 beds to 17 is not within funded establishment and is a cost pressure due to the use of temporary staff. Consideration should be given to including this business planning as a recurrent cost for the Winter months.<br><br>○ The restructure of the department and investment in RMNs will be instrumental in further mitigating the bank/agency costs. |
| **Roster Management and safe deployment of staff** | ○ Increased number of flexible working requests related to shift pattern.<br>The historical arrangements are prioritised for review.<br><br>○ CAU rota template currently under review to allocate nurse in charge (NIC) shifts and remove night shift tiles.<br><br>○ Matrons to review current rota writing pattern to ensure improved approval lead time and finalisation.<br><br>○ Overall, the current daily staff allocation is accurate. The staffing ratio will change accordingly if the requested investment is approved. |
| **Quality and safety** | ○ There were 2 pressure ulcers reported in community between March and August 2023. These were children with complex care needs. Staff training and education is ongoing.<br><br>○ Themes of complaints are clinical care and access to therapies.<br><br>○ Learning from Complaints:<br>➢ Information shared with staff via staff notice boards & emails.<br>➢ Effective communication and managing expectations previous topic of the month. |

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| | ➢ Simmons House has created a pathway for all new starters to complete their medication management competency, assessment and calculations test within two weeks of starting to follow a medication error.<br>➢ Health visiting teams have adopted a more robust process for checking patients records before adding new information to them and amended the processes to include confirmation of NHS number at every new birth contact.<br><br>o Serious incidents and learning:<br>**skull Fracture 5wk old baby.**<br>➢ Interprofessional effective verbal communication.<br>➢ Ensuring training and supervision includes references to key statutory safeguarding guidance and how to apply in practice.<br>➢ Staff to be supported in discussing what they observe e.g., marks/bruises as they could be potential safeguarding indicators / concerns however small.<br><br>**Eating disorder in-patient lost 3.7kg in a week.**<br>➢ Nursing handover documentation has been standardised: all aspects of essential handover covered in a structured approach for the team to use.<br>➢ All staff to complete eating disorder training.<br>➢ Undertake fluid balance audits with the aim to implement a fluid balance chart specifically for eating disorders.<br>➢ Introduced complex weekly handover tool for the consultants. |
| **Succession planning** | o Review of the Epilepsy service based on national guidance.<br><br>o Review HCSW workforce in the community to ensure they complete the HCSW Care Certificate.<br><br>o Ongoing recruitment for international nurses in partnership with GSTT<br><br>o The ICSU has an older CNS cohort and a junior workforce across acute paediatrics: PDNs and senior staff to mentor junior nurses to develop leadership skills.<br><br>o Areas of workforce risks in CYP: Recruitment in Community setting (Health Visitors)<br><br>o CYP is exploring the creation of apprenticeship workforce model to create new nursing pathways within the ICSU to support Nursing Associates. |
| **Planning next review** | o Ongoing targeted intervention to recruit in community services. |

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| | ○ Progress the posts agreed in principle when formally agreed by the Trust.<br><br>○ Repurpose some of the vacancies.<br><br>○ Review job plans and identify multiskilling opportunities.<br><br>○ Review Rota templates<br><br>○ Review CNSs job plans to formally include education to support PDNs and junior staff.<br><br>○ All teams to prioritise completion of Care Certificate for HCSW. |

4.2 **ACW- Maternity services, General Outpatient services, Gynaecology outpatient services**

Maternity services: The last Birthrate Plus local update was undertaken in January 2023 across inpatient and outpatient areas. Based on the birthing activity at the time, it identified a shortfall of 6WTE band 6 Midwives. The next review is due in December 2023, but it is essential to use this this report as a way to track actions and progress from last establishment review.

Outpatient services (Gynaecology and General): There is currently no national audit tool for safer staffing in outpatient areas.
To enable outpatient services to raise their workforce profile, escalate workforce concerns or identify investment requirements an exploratory review was undertaken. Activity mapping is undertaken locally to identify gaps and opportunities with support from Corporate Nursing leadership in preparation for next review.

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| **Progress against actions from last review** | ○ Band 7 1 WTE Midwife funding identified within current budget and interview planned for November 2023 |
| **Establishment update** | ○ In Maternity services, currently all services within the acute setting are meeting service needs pending a refresh from Birthrate plus due to take place in December 2023.<br><br>○ Gynaecology outpatients. There is a need to increase establishments to meet the demand for additional Nurse Led clinics and to be fully compliant with guidance for Colposcopy clinics. A business case is being written. |
| **Workforce data** | ○ Vacancy/turnover:<br>➢ Retirement and internal recruitment were cited as the reason for high vacancies in Maternity. This is mitigated with international recruitment.<br>➢ There are no vacancies currently in Gynaecology Outpatients.<br>○ Sickness remains over 3.5 %. |

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| | ➢ Sickness management is in place to support both managers and staff to remain or return to work safely.<br>➢ The main themes are stress and musculoskeletal complaints. |
| **Activity & Acuity impacting on staffing** | ○ Incidents reported related to compromised skill mix in Maternity and insufficient staffing in Gynaecology outpatients.<br><br>○ Trends that have impacted on staffing over last 6 months:<br>➢ Birth Centre has been suspended 19%<br>➢ Homebirth services not available 38%.<br>➢ Opening of 2nd Theatre-7 occasions |
| **Roster Management and safe deployment of staff** | ○ 80% of staff have flexible working hours in Maternity services. This may affect safety and the deployment of staff within the unit. HR is supporting Managers undertake reviews of requests.<br><br>○ All rota templates need to be reviewed to ensure hours are allocated appropriately and reflect accurate staff deployment across the ICSU. |
| **Quality and safety** | ○ **Complaints**: Themes identified are linked to:<br>➢ Communication<br>➢ Clinical Decision making (Drs)<br>➢ Lack of weekend scanning<br>➢ Joint complaints with maternity/ ED<br>➢ Consent<br>➢ Birth experience<br><br>○ **Serious Incident:**<br>➢ Orthopaedic clinic template update – new documentation and wound care update following sutures not removed 14 days post operation. |
| **Succession planning** | ➢ At the time of the establishment review meeting (November 2023) plans are:<br>➢ A restructure of the maternity workforce is planned for Spring 2024<br>➢ Active international midwifery recruitment has taken place and there are currently 10 WTE staff in post with a further 4 to start later in the year.<br>➢ Outpatient services exploring feasibility of recruiting international nurses in the future.<br>➢ Maternity is reviewing the number of staff nearing retirement, midwifery vacancy rates, preceptees rotating to community and ongoing recruitment campaign for band 6 Midwives and Community Midwives.<br>➢ Review retention planning as junior band 6 Midwives leave when they have finished their preceptorship. |

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| | ➢ Outpatient exploring training posts for highly specialist roles (Uro-gynae, Hysteroscopy nurse)<br>➢ Support flexi-retirement options for all staff planning retirement. |
| **Planning next review** | ○ Across the ICSU, inform the eRostering team of changes to the team and update the Roster templates 6 monthly as required.<br>○ Maternity to continue to repurpose existing budget to create new roles/position until Birthrate rate plus (BR+) report is issued.<br>○ Include Continuity of Care team in next BR+ review<br>○ Gynae Outpatient and General outpatient senior leadership team to liaise with Corporate Senior nurses to review proposal to increase establishment. |

4.3 **Surgery and Cancer**

Inpatient areas (Mercers, Coyle, CCU), Theatres, DTC, Critical Care Outreach (CCOT) and Chemotherapy services were examined in this establishment review.

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| **Progress against actions from last review** | ○ Review of the externally funded Cancer Nurses is in progress.<br>○ Review of CCU bed base, required establishment followed by recruitment has been achieved.<br>○ S&C and EIM are writing a business case for central funding for Enhanced Care. |
| **Establishment update** | ○ Mercers and Coyle: The current establishments meet the service needs.<br>○ CCU: At the time of meeting, the establishment meets the service needs following an increase in establishment due to the additional 2 beds opening for Winter.<br>○ CCOT-there is a need to review the establishment as currently it does not meet the increase in activity and acuity. The team's educational and governance duties are not included in the current job plans and the team is working with Safer Staffing Lead Nurse to collect data internally and externally to benchmark. There will be a formal review at the next establishment review or before if a business case is ready for submission.<br>○ Cancer external funding ending early 2024 have business cases being progressed. |

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| | ➢ 0.5 WTE Lung CSW funding ends December 2023<br>➢ 0.5 WTE Lung CNS contract ends February 2024<br>➢ 0.5 WTE Urology CSW contract ends February 2024<br>➢ 0.5 WTE UGI CSW contract ends May 2024<br>➢ 0.5 WTE Urology CNS contract ends 2025.<br>➢ 0.2 WTE Gynaecology CNS contract end March 2024 |
| **Workforce data** | ○ S&C has experienced a marked improvement in most metrics in last 6 months.<br>○ Vacancies and turnover overall are within range, respectively 10% and 13%<br>○ Mandatory training improved from low 80s% to 90.5% exceeding the target for both registered and unregistered staff.<br>○ Appraisal at the last review was 57.5%. Although this remains under target, there has been an improvement to 79% (84% for registered and 74% for unregistered staff)<br>○ Sickness average for March 23-August 23 period remains 3.2% |
| **Activity & Acuity impacting on staffing** | ○ Red Flags: No unresolved red shift across S&C over last 6 months.<br>○ Enhanced Care spend between March and August 2023 is equivalent to 3WTE band 3 HCSW. The Matron is working with the EIM Matron to collate data to support a shared business case. |
| **Roster Management and safe deployment of staff** | ○ The ICSU needs to prioritise the lead approval time of 56 days for ERoster to allow staff to access their upcoming pattern with enough notice.<br>○ There are a high number of flexible working requests, with the highest identified in Theatres and CCU. The team feels that the management of these is improving and there is good support from HR. |

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| | ○ All rota demand templates need to be reviewed on 6 months basis. |
| **Quality and safety** | ○ There is an improvement in some quality metrics (falls and pressure ulcers) which is attributed to improved staffing levels and engaged leadership in clinical areas.<br><br>○ **Falls** reduction from 49 to 26 in last the 6 months. Most were low harm; none were moderate or severe harm.<br><br>○ **Pressure ulcers**:56 were reported across the ICSU (reduced from 71 at last review) of which 6 were graded moderate harm, mainly on Coyle and CCU.<br><br>○ Complaint themes include delays in treatment, documentation, and communication.<br><br>○ Use of the Recovery area due to lack of available inpatient beds overnight needs to be noted as a risk and data will be collected over the next few months to assess trends and patient impact.<br><br>○ **Serious incidents**: These 2 incidents were not directly nursing attributed, but the shared learning is:<br><br>➢ Non-contributory delay in the follow up of a patient with metastatic cancer.<br>There was a missed opportunity to communicate with relevant teams/the patient's GP when the patient was discharged and there was a lack of documentation regarding discharge on 20th April 2022<br>A position needs to be created to assist with the tracking of patients. A business case will be presented when completed.<br><br>➢ Missing CD medication in CCU<br>Investigation has concluded and a final report is in progress. |
| **Succession planning** | ○ Further development of ANPs across both cancer and non-cancer with an increase in nurse led activity will potentially reduce medical spend in Oncology, Dermatology and Orthopaedics.<br><br>○ Flexible workforce across Theatres with staff able to multiskill (Scrub side and anaesthetics)<br><br>○ Recurrent funding for activity peaks and winter pressures in CCU to maintain a stable and skilled workforce.<br><br>○ Support retire and return scheme within at-risk areas. |

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| | ○ Repurpose available budget band 5 RN from Coyle following the bed base reduction, to create a phototherapy Nurse role to free other Dermatology CNS for further nurse-led activity and teaching.<br><br>○ Developmental roles to increase skill set – this has worked well in the chemotherapy unit and the aim is to replicate this in other areas in S&C |
| **Planning next review** | ○ Completion of the business cases for externally funded Cancer Nurses<br><br>○ Assess and monitor the use of Recovery overnight for a possible further establishment review.<br><br>○ Focus on appraisal across all staff groups.<br><br>○ Implementation of rota meetings with the Healthroster team.<br><br>○ Review of the staffing in Chemotherapy and DTC post activity review<br><br>○ CCOT to continue collecting data to evidence investment agreed in principle. |

4.4 **Integrated and emergency medicine (EIM)**

The establishment review assessed the emergency floor, inpatients, and endoscopy services.

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| **Progress against actions from last review** | ○ Uplift to be increased to reflect the extra mandatory training for ED staff to reflect acuity and specialism: This will be reviewed at the annual establishment review later this year. The National Quality Board (NQB), p15, Royal College of Nursing and Royal college of Emergency Medicine recommends that the headroom on average Should be 25%<br>This has been actioned as part of the wider Trust review. The uplift varies according to roles, role-specific educational requirement, number of bank holidays over the year etc.<br><br>○ Demand for 6 HCSW in ED per shift (16.3WTE): Business case in progress |

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| | ○ Review of Enhanced Care and better utilisation: Data collection in progress in partnership with S&C.<br>○ 10 WTE to be put back into ED budget: Actioned.<br>○ Plan to separate COOP cost centres for clarity in spend: Actioned but access for Matrons to new codes (AAUL, AAAC) remains a challenge which has been escalated by ADoN. |
| **Establishment update** | ○ **ED:**<br>➢ ICSU developing a business case to fund 16.3WTE additional band 3 HCSW/TNAs to meet the current deployment supporting the new RAT process, and to support the increased enhanced care needs for mental health patients. The current establishment is for 13 WTE. The model is currently delivered as a cost pressure.<br>➢ Temporary spend remains a challenge with an equivalent of 33.3 WTE (13 WTE HCA and 20.3 WTERN) spend average over March-August 23. This exceeds the vacancy rate for this period. This is due to the need for more enhanced care, corridor care (patients stranded in ED due to lack of available beds or cubicles), increased acuity, and unavailability of staff.<br>○ **SDEC**<br>➢ Medical staffing remodelling in progress to include extended hours and 7 day working. The nursing staffing model will be dependent on the proposal outcome. The current establishment is to remain unchanged until then.<br>○ **Mary Seacole (North and South):**<br>➢ Due to difficulties backfilling band 4 Nursing Associates, the proposal is to reduce this budget line and repurpose in the band 5 budget line. There will be an internal review to explore why band 4 retention is problematic.<br>➢ AAU (North and South) 5.2 WTE band 2 HCSW to increase the numbers by 1 on day and 1 on night shift. However, the recommendation is to review any underspend across the ICSU and to reassess the need for enhanced care and Baywatch.<br>○ **Montuschi**<br>➢ Requesting 1 HCSW at night (2.6WTE) from zero. This is due to the ward layout and the increase in the need for Baywatch and enhanced care for patients at risk of falls. The ICSU will review current underspend to see if this can be repurposed for this |

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| | request.<br><br>○ **Nightingale**<br><br>➢ Requesting 10.3 WTE band 2 HCSW to increase deployment by 2 on days and 2 on night shifts. Following SIs and significant harm from falls, the ward now complies with strict Baywatch. The recommendation is to review the underspend across EIM ICSU review the current request for the number requested.<br><br>○ **Endoscopy**<br><br>➢ All staff in establishment are on fixed term contracts as funding is based on activity.<br><br>➢ There is no request for investment, but there is a recommendation to convert some income into workforce and to consider recruitment of an 8A Nursing post to strengthen leadership.<br><br>○ **Enhanced Care**<br><br>➢ The current budget is for 23 WTE, but usage is 50-60 WTE for EIM only. The plan to review this is described earlier in the report.<br><br>○ **ICSU Wide**<br><br>➢ 1.8 WTE band 8B Advanced Clinical Practitioner (ACP) Lead is required and will need to be funded from the medical budget as agreed prior to the start of the programme. |
| **Workforce data** | ○ The average appraisal rate is above target with marked improvement for ED and AAU. There is ongoing work for Enhanced Care and Endoscopy, who average 83%<br><br>○ There are no areas of concern for mandatory training, with the average for March-August 86.5%<br><br>○ Sickness has also improved in the 6-months. It remains over target at 4.2% (improved 0.5%)<br>The main themes for long term sickness are stress, mental health and pregnancy related ailments. |
| **Activity & Acuity impacting on staffing** | ○ Red flags reporting has markedly improved with 19 unresolved events compared to 57 in the previous review period. This reflects the improvement in staffing levels, reduced sickness, and seasonal improvement. |

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| | ○ Actual Vs Planned hours in deficit. Each month the rota plans for set number of shifts/staff hours. In EIM some departments report a deficit with actual hours worked/extra shifts exceeding the planned hours The contributary factors are enhanced care and longer induction period for supernumerary international nurses. |
| **Roster Management and safe deployment of staff** | ○ Flexible working requests are increasing, and some grievances have been submitted when departments are unable to accommodate a request due to service needs.<br><br>○ Approval lead time needs to improve as a priority to allow staff to plan work-life balance in advance. The Trust target is 56 days, with the ICSU having a 19-day lead approval. However, all ICSUs need to improve this overall. |
| **Quality and safety** | ○ **Falls**:<br>➢ There were a high number (24) in ED between March and August 23 and lower numbers (6) in AAUs due to Baywatch. Overall, numbers are trending down, but there is still work to be done.<br><br>○ **Pressure ulcers:**<br><br>➢ Across EIM we observed a downward trend of pressure ulcers between April and September 2023. Between April and September there were no stage 4 pressure ulcers reported, and no unstageable ulcers since June 2023.<br>➢ Between April and June 2023, 5 grade 3 pressure ulcers were reported and 1 reported between July and September.<br>➢ The plan is to continue follow pressure ulcer prevention measures, such as regular repositioning and maintaining personal hygiene for patient.<br>➢ Understand risk factors of developing a pressure ulcer - the role of nutrition and mobility.<br>➢ All pressure areas must be inspected and assessed on daily washing.<br><br>○ **Complaints**:<br>➢ Themes cluster around admission, transfer arrangements and discharges<br>➢ Other themes related to 'attitude' 'inconsiderate/uncaring/dismissive' cited as the reasons.<br>➢ Complaint related to 'nursing care' with 'poor standard of care provided' cited as the reason. |
| **Succession planning** | ○ Number of CNS required, and job plans being reviewed.<br><br>○ Ongoing training for ACPs for frailty, acute medicine and ED. |

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| | Working on an ACP strategy to employ a band 8b ACP lead, cited earlier in the report.<br><br>o Actively recruiting and retaining Internationally Educated Nurses. Currently employing 40 WTE across the ICSU, with 10 WTE to start in the next 3 months. |
| **Planning next review** | o Review the Housekeeper WTE and discuss moving the cost to Facilities to free budget for nursing investment request.<br><br>o All nursing budgets to be reviewed ICSU wide to identify any potential for repurposing before the CNO agrees investments in principle (Montushi, Nightingale and AAU)<br><br>o Progress business cases for Enhanced Care and ED 16.3WTE band 3 HCAs<br><br>o Include TB services in the next establishment review. |

4.5 **Adult community services (ACS)**

This is the first time that ACS has been part of the establishment review.
The National Community Nursing Safer Nursing Tool (CNSNT) was introduced in the Trust this year. The team opted to pilot it in 4 district nurse teams (Islington North, Islington Urgent Response, Haringey Central and Haringey Urgent Response). Since then, the ACS ICSU has undergone a sizeable restructure and will require restarting audit training at a larger scale beginning in January 2024 to allow meaningful audit data collection in the early establishment review in Summer 2024.

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| **Establishment update** | o Following the restructure all existing team establishments meet the service needs. |
| **Workforce data** | o The sickness rate for March 23- to August 23 averages 4.5% across the ICSU.<br><br>o Vacancy remains a challenge across the ICSU with a vacancy rate of 16%. Some of the reason is the recruitment within newly formed /merged teams and hard to recruit areas in Community District Nurse teams.<br><br>o Mandatory training rates are within range and are over 90%<br><br>o Appraisal rates need to improve as the average is 74% with Islington North Team 55%<br><br>. |

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| **Roster Management and safe deployment of staff** | ○ Teams need to ensure Eroster demand templates are reviewed on a 6 monthly basis.<br>○ Due to the restructure, all daily deployment information will need to be provided to the Safer Staffing Lead Nurse.<br>○ The ACS team need to share any escalation daily to the central team as part of escalation process. |
| **Succession planning** | ○ Continue active and targeted band 5 RN recruitment to support reducing temporary staffing expenditure. The team reports a productive partnership with universities to recruit graduates.<br>○ Team promotes the top up degree for Nursing Associates to become Registered Nurses.<br>○ Active recruiters of International Nurses, currently hosting 17 and planning to recruit 6 in next 12 months.<br>○ Actively engaging with Community Safer Staffing Nursing tool audit to help planning for the future and to understand needs better.<br>○ Promotes flexi retirement for older experienced nurses. |
| **Planning next review** | ○ Review Rota Demand templates<br>○ Ensure all staff undertake audit training for safer staffing.<br>○ Review the number of Trainee Nursing Associate and capacity to employ Nursing Associates once the programme has finished. |

## 5. RECOMMENDATIONS

- The proposed investments detailed in the executive summaries and report narrative are supported to progress through local business planning and business cases.
- The Nursing and Midwifery establishments will formally be reviewed again at the bi-annual-review in April 2024. The data collection and audits for this period will start in December 2023. All safe staffing metrics will continue to be monitored monthly via performance meetings, safe staffing governance meetings and upcoming rostering challenge meetings.
- Community services will continue to be assessed against all metrics the other ICSUs are measured against, but also by embedding the Community Safer Nursing Staffing Tool where appropriate.

- CCOT will continue to work with the Safer Staffing Lead Nurse to collect data to evidence establishment change requirements.

- The general and Gynaecology outpatient services will undergo a separate establishment review from Maternity services in the 2024 establishment review, based on work locally undertaken. Support from the Safer Staffing Lead Nurse will help determine any establishment changes and future investment requests.

- All the establishment reviews are used as part of the tools to assess changing demand and capacity to advise on ICSUs strategies. This ongoing work should inform some of the recommendations in the next establishment review.

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| **Meeting title** | **Quality Assurance Committee** | **Date: 10th January 2024** |
| **Report title** | **Quality Report: Q2 2023/24** | **Agenda item: 4.14** |
| **Executive director lead** | Dr Clare Dollery, Medical Director<br>Sarah Wilding, Chief Nurse and Director of Allied Health Professionals | |
| **Report author** | • Anne O' Connor; Associate Director of Quality Governance<br>• Antoinette Webber, Head of Patient Experience<br>• Erum Jamall, Associate Medical Director Clinical Effectiveness<br>• Louise Roper, Head of Patient Safety<br>• Sarah Crook, Head of Clinical Effectiveness<br>• Kat Nolan-Cullen, Compliance and QI Manager<br>• Iona MacDonald, Quality Improvement Lead<br>• Tracey Groarke, Infection Prevention & Control Nurse - Operational lead | |
| **Executive summary** | This is the regular quarterly paper to provide an overview of quality across the organisation, covering patient safety, patient experience, clinical effectiveness, quality improvement and assurance. This report will cover Q2 2023/24, key highlights include:<br><br>• There has been a decrease in the number of recorded pressure ulcers compared to previous quarters. There has been a reduction in full thickness pressure damage and levels of harm; there has been no hospital acquired category 4 pressure ulcers since February 2023. However, the incidence of full thickness pressure damage remains a concern in the community.<br>• There have been 21 definite and eight probable COVID-19 Health Care Acquired Infections, no MRSA or MSSA infections and one Clostridium Difficile infection hospital onset hospital acquired (compared to seven C. Diff Hospital onset / Hospital Acquired in Q1). This brings to a total of 8 cases against an annual trajectory of 13.<br>• The Trust reported two Serious Incidents in Qtr2 with investigations underway and submitted six completed SIs to the Integrated Care Board (ICB). – See separate SI report<br>• As of 30/09/23 there were 68 (9.4%) incidents between March 2022 and September 2023 that have outstanding Duty of Candour requirements. The downward trend continues with 201 in Q4 22/23 and105 Q1 23/24.<br>• Complaint response timescales remain below the 80% target at 55% | |

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| | • Outlier status confirmed for NICE quality standard 33 (2013 version, stating that patients referred with suspected persistent synovitis should be seen within three weeks of referral.The<br>• Inpatient survey results were disappointing, indicating a number of areas for improvement with an action plan in place.<br>• During Q2 an additional 37 new volunteers were recruited, taking the total number of volunteers to 91 |
| **Purpose:** | Discussion and approval for Trust Board. |
| **Recommendation(s** | Members are asked to approve for Trust Board:<br>• Identify key issues of good practice to highlight to the Board.<br>• Escalate any concerns where there is insufficient assurance to the Board. |
| **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** | This report comprises elements that have been report to the Quality Governance committee in extended form |

## 1. Introduction

The Quality Governance quarterly report is designed to demonstrate Whittington Health's commitment to continuous learning and improvement. This report provides a systematic analysis of intelligence from patient experience, patient safety and clinical effectiveness, including key performance metrics, as well as themes and trends for Q2 2023-2024. This aggregated approach allows the Trust to proactively identify any underlying concerns and to allocate resources accordingly to drive improvement.

## 2 Patient Safety

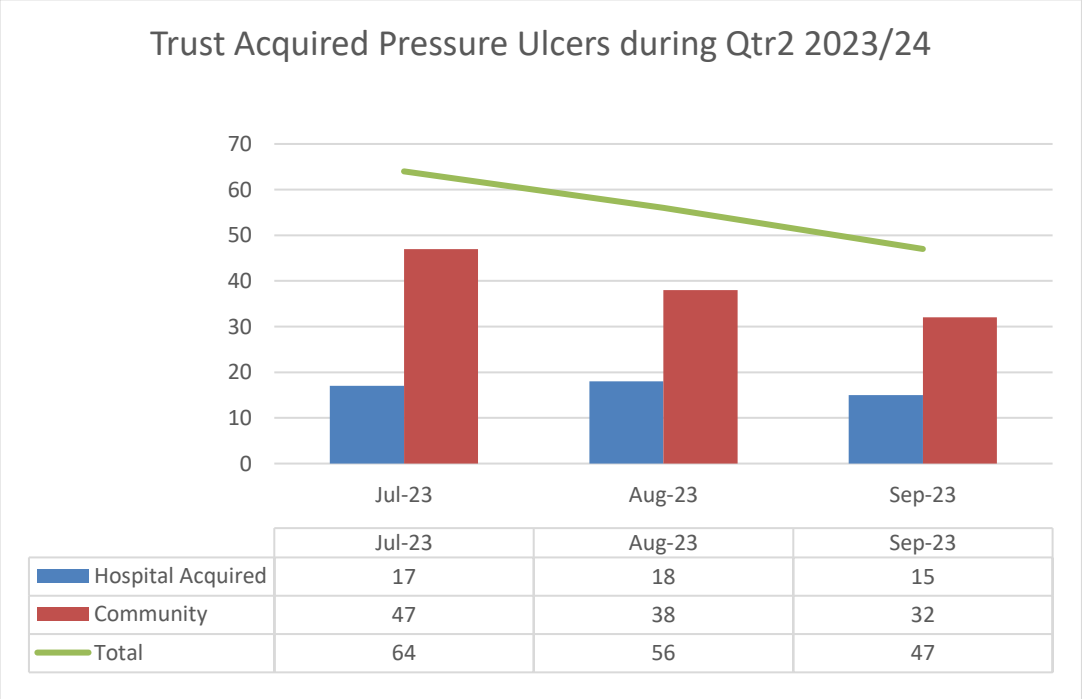
### 2.1 Exception reports

#### 2.1.1 Pressure Ulcers

The data presented in this report does not include moisture lesions and category 1 pressure ulcers but does include Cat 2-4, mucosal, deep tissue injury, and unstageable pressure ulcers, which are reportable externally.

- The Trust has a target to reduce overall Trust attributable pressure damage by 20%, and full thickness pressure damage by 50% in 2023/2024.
- There has been a decrease in the total number of recorded pressure ulcers in Q2 2023 (167) compared to Qtr1 2023 (217).
- There has also been a decrease in actual numbers comparing Qtr2 2022 (210) to Qtr2 2023 (167), in line with the Trust target of 20%.

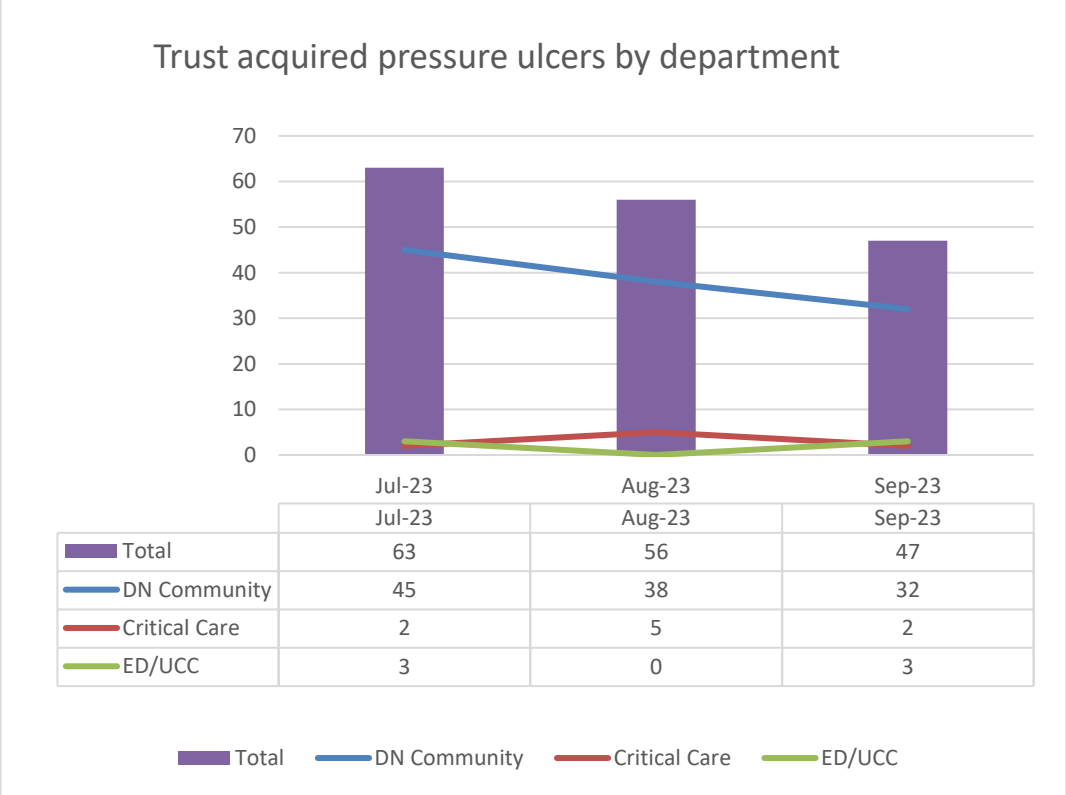
**Fig 1: Total number of Trust acquired Pressure Ulcers during Qtr2**




| | Jul-23 | Aug-23 | Sep-23 |
|---|---|---|---|
| Hospital Acquired | 17 | 18 | 15 |
| Community | 47 | 38 | 32 |
| Total | 64 | 56 | 47 |

- Community acquired pressure damage remains the highest area for reported incidents with critical care and the Emergency Department reporting the highest numbers within the acute setting. To note that ED reports pressure damage on admission, not necessarily as acquired.

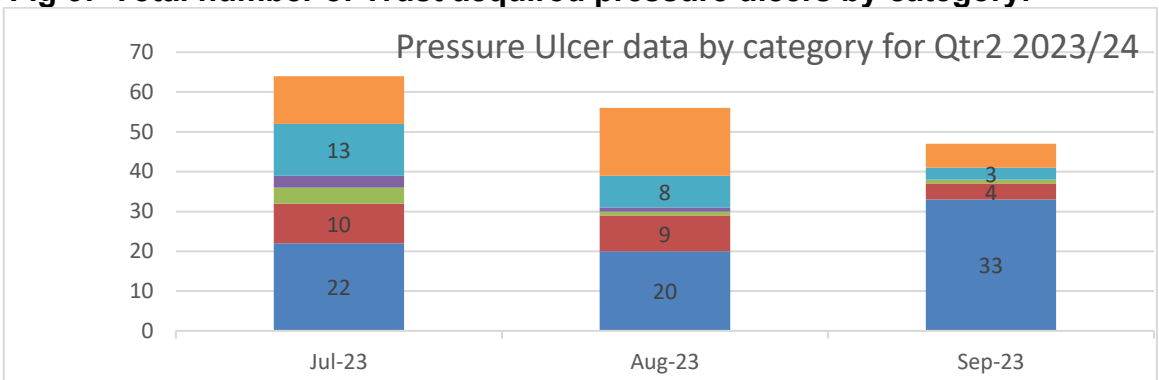
**Fig 2 :Total number of Trust acquired pressure ulcers recorded comparing ED, district nursing and CCU for Qtr2**




| | Jul-23 | Aug-23 | Sep-23 |
|---|---|---|---|
| Total | 63 | 56 | 47 |
| DN Community | 45 | 38 | 32 |
| Critical Care | 2 | 5 | 2 |
| ED/UCC | 3 | 0 | 3 |

- Following the implementation of the Trust Pressure Ulcer Improvement plan, the Trust has demonstrated a success in reducing the incidence pressure ulcers, particularly full thickness pressure damage and levels of harm; there has been no hospital acquired category 4 pressure ulcers since February 2023.

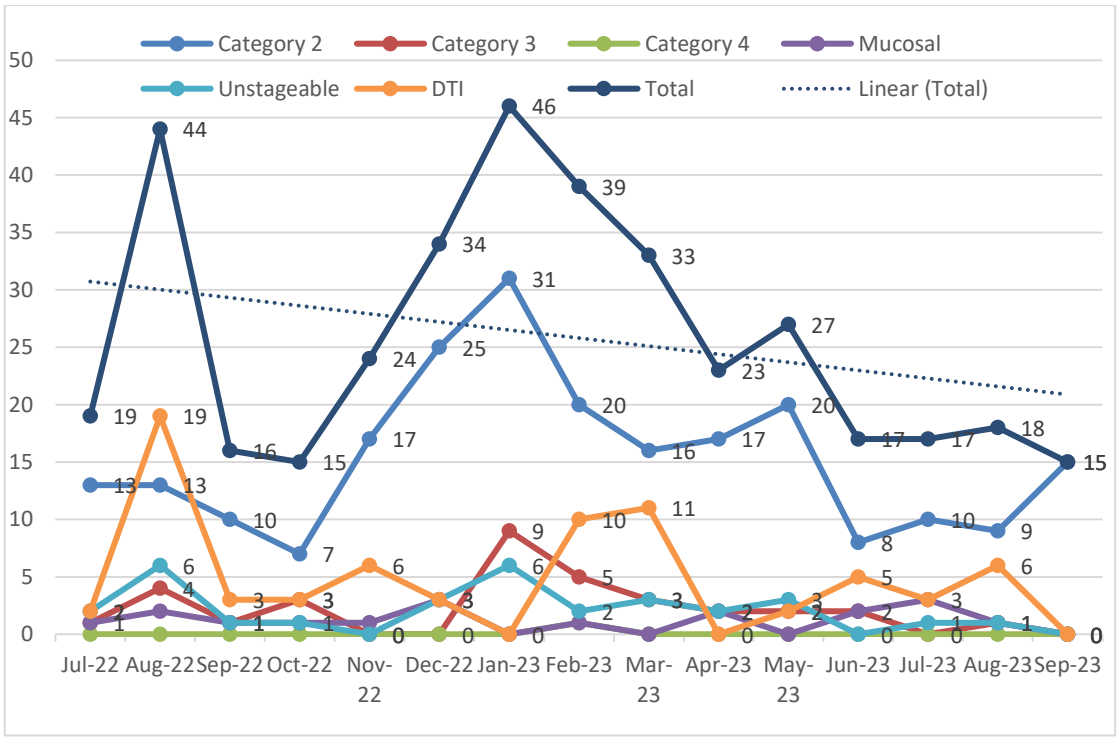
**Fig 3: Total number of Trust acquired pressure ulcers by category.**




| | Jul-23 | Aug-23 | Sep-23 |
|---|---|---|---|
| DTI | 12 | 17 | 6 |
| Unstageable | 13 | 8 | 3 |
| Mucosal | 3 | 1 | 0 |
| Category 4 | 4 | 1 | 1 |
| Category 3 | 10 | 9 | 4 |
| Category 2 | 22 | 20 | 33 |

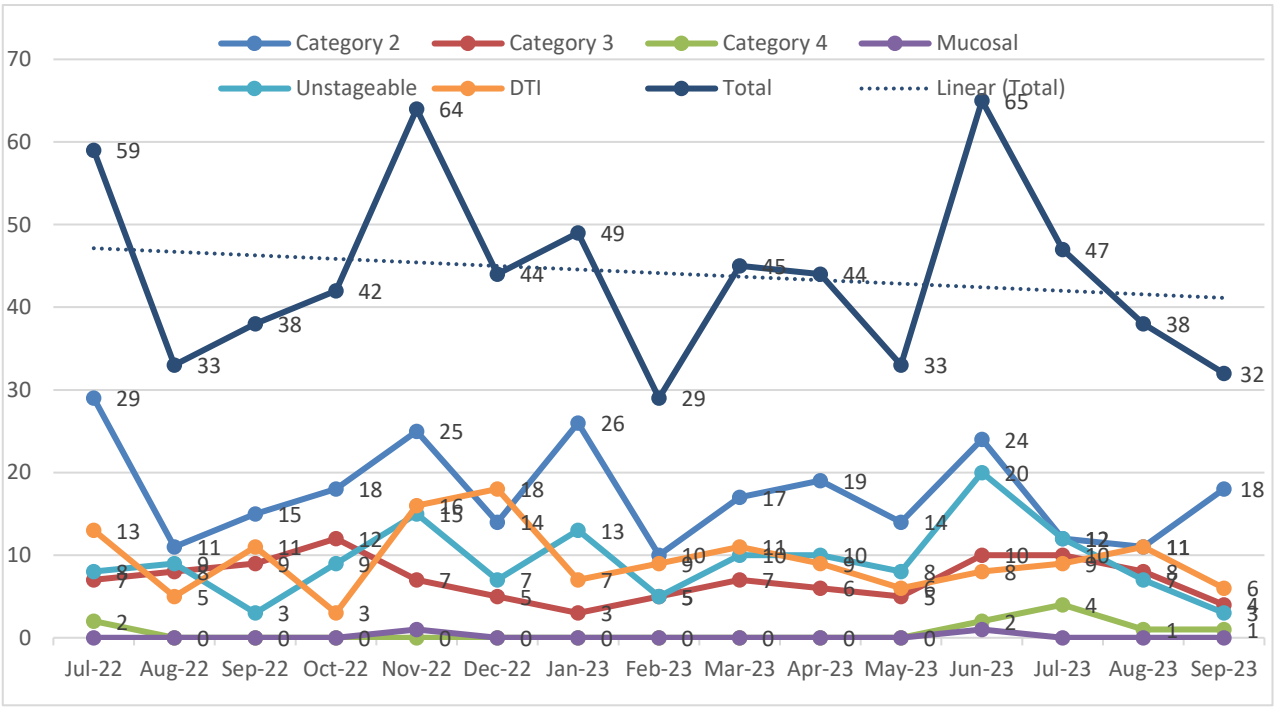
- The acute hospital setting has seen a decreasing trajectory over the last six months mainly attributable to achievements from the Trust Pressure Ulcer Improvement Plan

**Fig 4 : Hospital attributable pressure damage July 2022 – September**



- There was a sharp rise in community acquired pressure damage in the Qtr1, with the highest number of full thickness pressure ulcers since April 2022, although this is now on a decreasing trajectory in Qtr2.
- An area of concern has been the increased incidence of full thickness category 4 pressure damage in the community setting; there have been a number of contributory factors for this including equipment delivery issues, carer involvement and patient engagement challenges.
- There are known issues with NRS (pressure ulcer relieving equipment company) for a number of equipment types since the contract implementation. Concerns were escalated to the Integrated Care Board (ICB) and the commissioners of this service, although there has been some improvements it remains inconsistanttant. This is also recorded on the Trust risk register.

**Fig 5: Community attributable pressure damage July 2022 – September 2023**



**Actions to recover.**

- Trust Pressure Ulcer Group to monitor and support recovery.
- There is a pressure ulcer improvement plan to prevent and reduce Trust acquired pressure ulcers which will be monitored by the Pressure Ulcer Group. There are five key aims:
  - Assessment
  - Planning care
  - Equipment
  - Education & Training
  - Quality & Risk:
- Work on integrating pressure area care documentation into the Trust electronic platforms is progressing.

### 2.1.2 Patient Falls

- Compared to Qtr2 last year, the number of patient falls has decreased by16 incidents with a reduction in no harm incidents (20). There was a slight decrease in moderate harm incidents (1) during 2023 however an increase in low harm (4) and death not caused by the incident (1). 72-hour reports were completed for four incidents. Two were presented at Serious Incident Executive Action Group (SIEAG) and closed with no further action required. One incident will be investigated by a Swarm huddle. The fall where death was not caused by the incident, was presented at SIEAG on 22 September and a structured judgement review (SJR) was requested.

**Fig 6: Number of patients falls by category of harm**

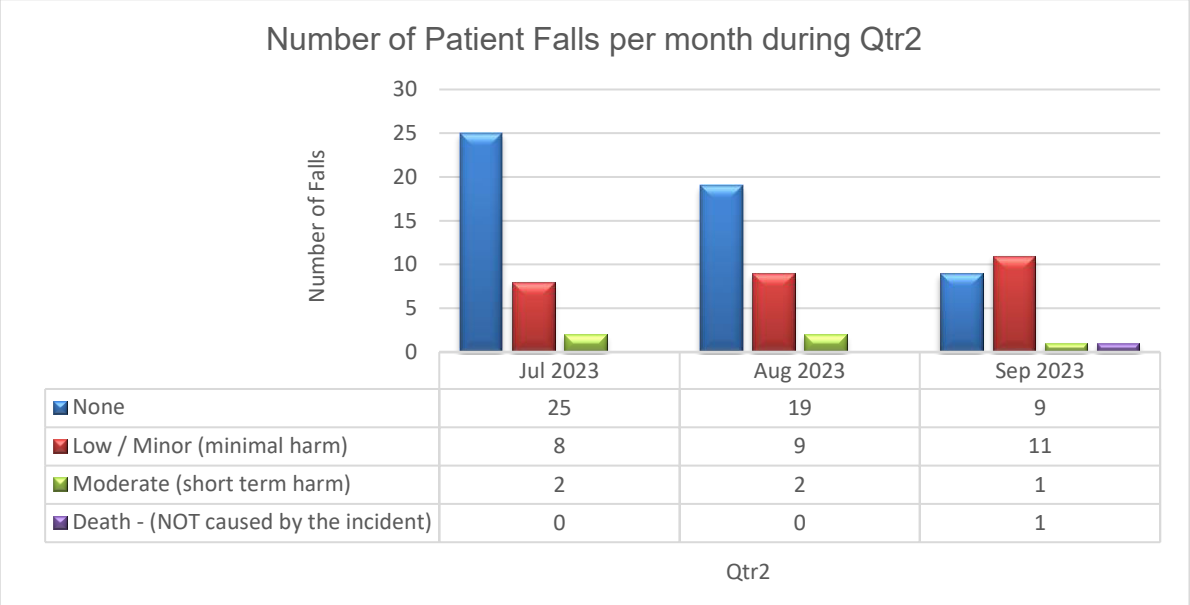
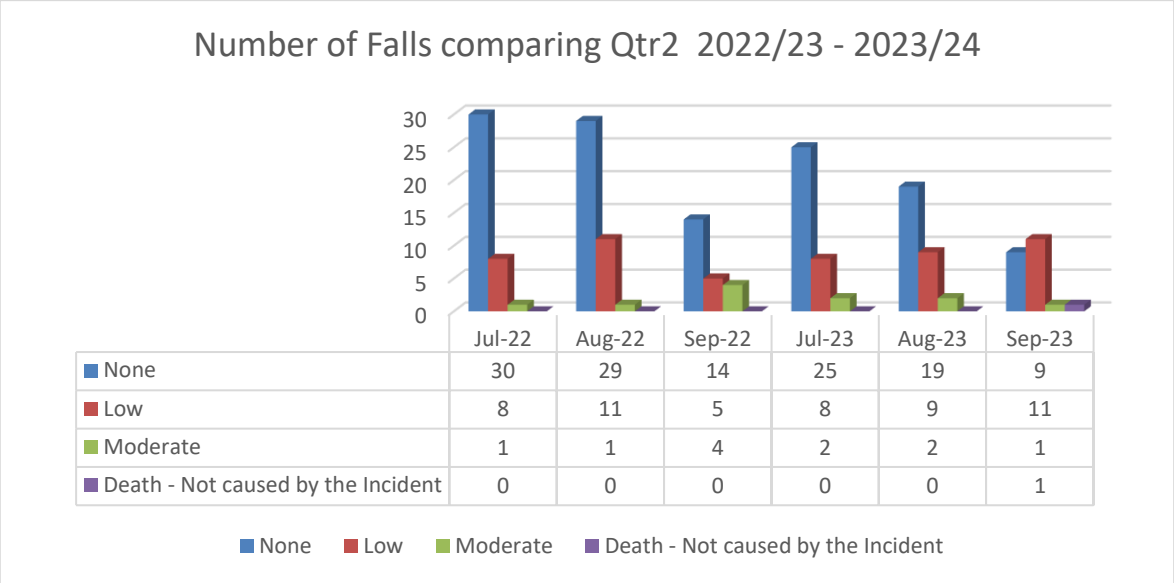


**Fig 7: patient falls by level of harm comparing Q2 2022 & Q2 2023**




| | Jul-22 | Aug-22 | Sep-22 | Jul-23 | Aug-23 | Sep-23 |
|---|---|---|---|---|---|---|
| None | 30 | 29 | 14 | 25 | 19 | 9 |
| Low | 8 | 11 | 5 | 8 | 9 | 11 |
| Moderate | 1 | 1 | 4 | 2 | 2 | 1 |
| Death - Not caused by the Incident | 0 | 0 | 0 | 0 | 0 | 1 |

- The highest number of falls were on Acute Medical wards (19) which is an increase from Q1. Care of Older Persons (COOP) wards (11) had a 31% decrease compared to Q1(16). Emergency department and Surgical wards also saw an increase compared to Q1, acute medical wards (15) and surgical wards (12) which is a considerable decrease for COOP wards compared to Qtr4; 27% decrease.

**Table 1 : Highest number of Falls by department; data taken from Datix for Qtr2**

| Department | Jul 2023 | Aug 2023 | Sep 2023 | Total | Compared to Qtr1 |
|---|---|---|---|---|---|
| Acute Medical Wards (Nightingale, Montuschi, Victoria) | 7 | 11 | 1 | 19 | ↑ (15) |
| Emergency Department | 3 | 5 | 8 | 16 | ↑ (12) |
| Surgical Wards (Coyle and Mercers) | 7 | 6 | 3 | 16 | ↑ (12) |
| Care of Older People Wards (Cloudesley, Meyrick, Cavell) | 4 | 5 | 2 | 11 | ↓ (16) |

**Key Learning from Falls Incidents**

- Communication to improve between nursing staff and Physiotherapists.
- Multi-disciplinary training for post fall protocol.
- Continue Baywatch for patients who are high risk of falls.
- Continue focusing on falls prevention.

### 2.1.3 Mixed Sex Breaches

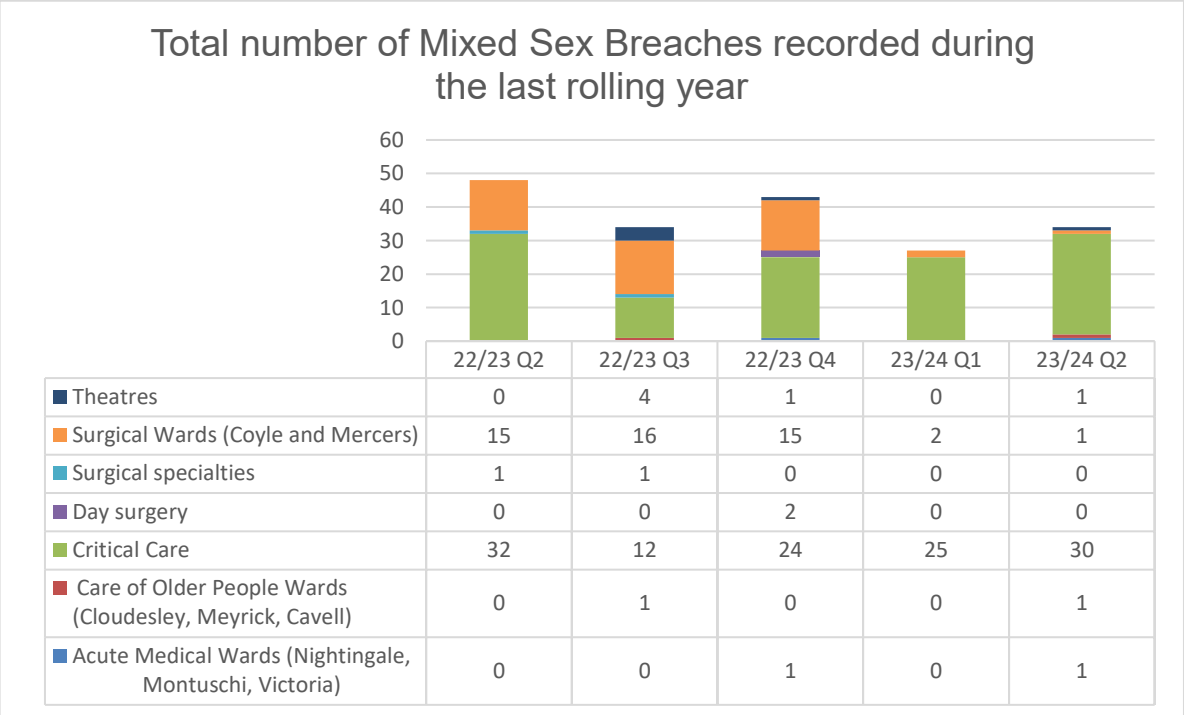
- There has been an increase in the number of mixed sex breaches compared to Qtr1 (27).

**Table 2: Mixed Sex Breaches by area Q2 2023/24**

| | Jul 2023 | Aug 2023 | Sep 2023 | Total |
|---|---|---|---|---|
| Acute Medical Wards (Nightingale, Montuschi, Victoria) | 0 | 0 | 1 | 1 |
| Care of Older People Wards (Cloudesley, Meyrick, Cavell) | 0 | 0 | 1 | 1 |
| Critical Care | 5 | 9 | 16 | 30 |
| Surgical Wards (Coyle and Mercers) | 0 | 1 | 0 | 1 |
| Theatres | 0 | 0 | 1 | 1 |
| Total | 5 | 10 | 19 | 34 |

- The number of recorded mixed sex breaches on the surgical wards over the last rolling year has reduced considerably during Qtr1 & Qtr2 2023/24.
- The number of mixed sex breaches in Critical Care remain high due to patients who test positive for infections, resulting in the need to place patients in beds according to infectious status rather than gender.

**Fig 8: Mixed sex breaches on quarter22/23 – 23/24**




| | 22/23 Q2 | 22/23 Q3 | 22/23 Q4 | 23/24 Q1 | 23/24 Q2 |
|---|---|---|---|---|---|
| Theatres | 0 | 4 | 1 | 0 | 1 |
| Surgical Wards (Coyle and Mercers) | 15 | 16 | 15 | 2 | 1 |
| Surgical specialties | 1 | 1 | 0 | 0 | 0 |
| Day surgery | 0 | 0 | 2 | 0 | 0 |
| Critical Care | 32 | 12 | 24 | 25 | 30 |
| Care of Older People Wards (Cloudesley, Meyrick, Cavell) | 0 | 1 | 0 | 0 | 1 |
| Acute Medical Wards (Nightingale, Montuschi, Victoria) | 0 | 0 | 1 | 0 | 1 |

## 2.2 Patient Incident data and themes

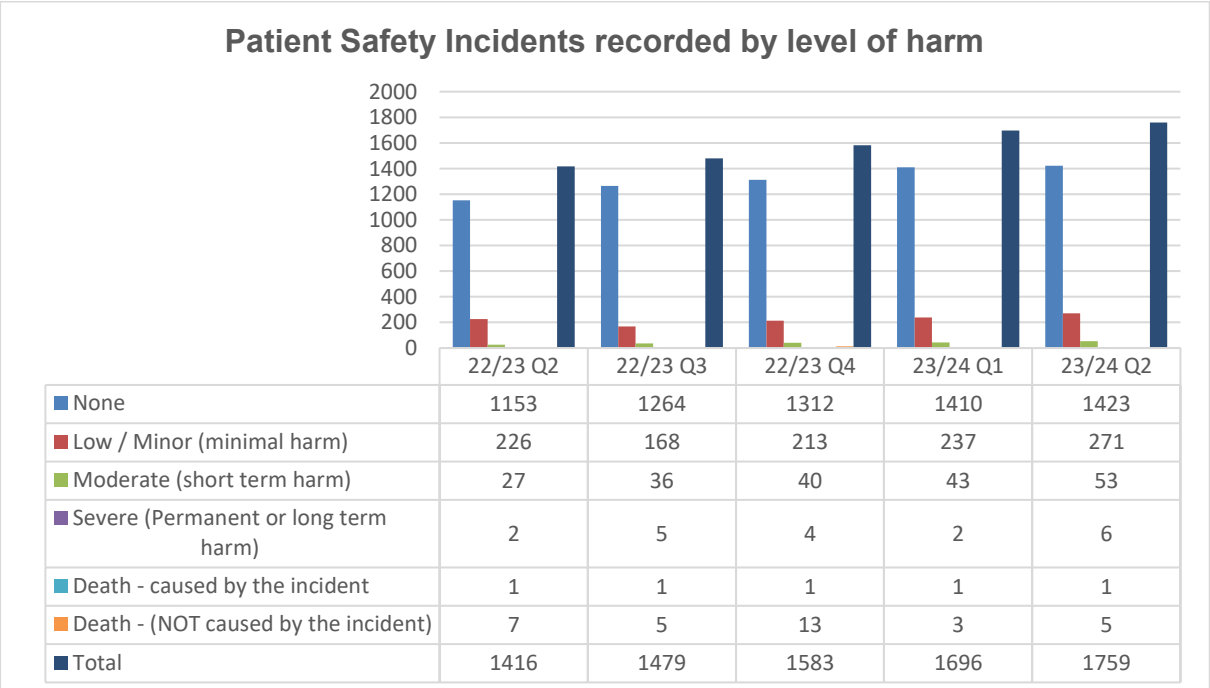
- During Qtr2 there were 1759 patient safety incidents recorded on Datix with 65 being recorded as moderate harm and above. (Please note that due to inconsistences in data capture of pressure ulcers attributable and non-attributable to WHT, the below data does not include this category for this quarter).

**Table 3: Patient Safety incidents Q2 23/24***

| | Jul 2023 | Aug 2023 | Sep 2023 | Total |
|---|---|---|---|---|
| None | 436 | 487 | 500 | 1423 |
| Low / Minor (minimal harm) | 112 | 89 | 70 | 271 |
| Moderate (short term harm) | 16 | 22 | 15 | 53 |
| Severe (Permanent or long-term harm) | 0 | 4 | 2 | 6 |
| Death - caused by the incident | 0 | 0 | 1 | 1 |
| Death - (NOT caused by the incident) | 2 | 0 | 3 | 5 |
| Total | 566 | 602 | 591 | 1759 |

- The number of incidents reported in Qtr2 continues to increase in the no, low and moderate harm categories with 270 more reports of no harm incidents, 45 more low harm and 36 more moderate harm incidents compared with Q2 a year ago.

**Fig 9: Patient Safety Incidents by level of harm, 2022-23**




| | 22/23 Q2 | 22/23 Q3 | 22/23 Q4 | 23/24 Q1 | 23/24 Q2 |
|---|---|---|---|---|---|
| None | 1153 | 1264 | 1312 | 1410 | 1423 |
| Low / Minor (minimal harm) | 226 | 168 | 213 | 237 | 271 |
| Moderate (short term harm) | 27 | 36 | 40 | 43 | 53 |
| Severe (Permanent or long term harm) | 2 | 5 | 4 | 2 | 6 |
| Death - caused by the incident | 1 | 1 | 1 | 1 | 1 |
| Death - (NOT caused by the incident) | 7 | 5 | 13 | 3 | 5 |
| Total | 1416 | 1479 | 1583 | 1696 | 1759 |

- The top three categories remain the same as Qtr1 although in a different order due to number of reported incidents. The fourth (abusive behaviour) and fifth (Medication) categories are no longer being reported in the top five categories, being replaced by implementation of care/ongoing monitoring and review and accident that may result in personal injury.

**Table 4: Top 5 Categories of incident reported Q2**

| | Qtr2 | Share of Incidents as a % |
|---|---|---|
| Security | 435 | 22 |
| Admission, Appointment, Discharge, Transfer, Transport | 203 | 10 |
| Pressure Ulcer / Moisture Associated Skin Damage | 165 | 8 |
| Implementation of care / ongoing monitoring / review | 147 | 7 |
| Accident that may result in personal injury | 117 | 6 |

- Table 5 below shows the breakdown of category by detail; Implementation & ongoing monitoring/review – other had 93 incidents reported and the next highest detail was delay/failure to monitor (34).

**Table 5: Breakdown of category Implementation of care / ongoing monitoring/review by detail**

| Category: Implementation of care / ongoing monitoring / review | Jul 2023 | Aug 2023 | Sep 2023 | Total |
|---|---|---|---|---|
| Implementation & ongoing monitoring/review - other | 29 | 35 | 29 | 93 |
| Delay / failure to monitor | 12 | 7 | 15 | 34 |
| Delay/failure in acting on complication of treatment | 1 | 0 | 2 | 3 |
| Failure/delay to order correct tests, image etc | 2 | 0 | 1 | 3 |
| Delay / difficulty in obtaining clinical assistance | 1 | 1 | 0 | 2 |
| Diabetic Foot Ulcer (Hospital patients only) | 0 | 2 | 0 | 2 |
| Failure to follow up | 0 | 1 | 1 | 2 |
| Diagnostic images or Lab tests not available when required | 0 | 0 | 1 | 1 |
| Documentation (including records, identification) other | 0 | 1 | 0 | 1 |
| Failure to act on adverse symptoms | 0 | 0 | 1 | 1 |

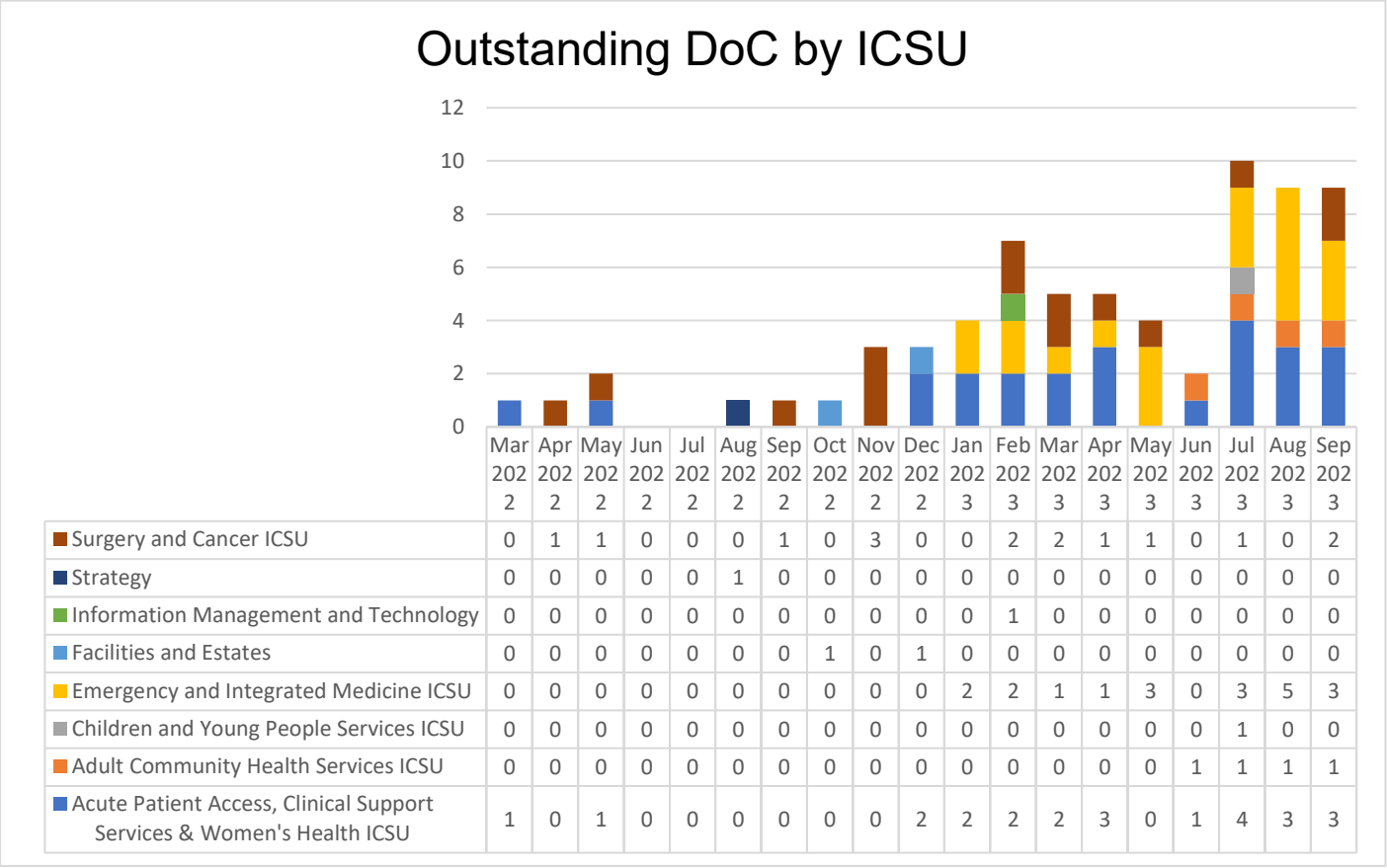
| | | | | |
|---|---|---|---|---|
| Failure to act on adverse test results or images | 1 | 0 | 0 | 1 |
| Failure to discontinue treatment | 0 | 1 | 0 | 1 |
| Return to Theatre | 0 | 1 | 0 | 1 |
| Unsafe / inappropriate clinical environment | 0 | 1 | 0 | 1 |
| (Pre-LFPSE 2023) Other - Infection control incident | 0 | 0 | 1 | 1 |
| Total | 46 | 50 | 51 | 147 |

- The Quality Governance Team continues to support staff to increase reporting through Datix training and sessions modelled on the Essentials of Patient Safety from the National Patient Safety Syllabus.

### 2.3 Duty of Candour

- As of 30/09/23 there were 68 (9.4%) incidents between March 2022 and September 2023 that have outstanding Duty of Candour requirements. The downward trend continues with 201 in Q4 22/23 and105 Q1 23/24.
- Of the 109 incidents eligible for DOC in Qtr2, the Trust has discharged 81 (74%) of its statutory duty of candour requirements.

**Fig 10: Outstanding Duty of Candour from Q1 2022/23 -Q2 2023/24**




| | Mar 2022 | Apr 2022 | May 2022 | Jun 2022 | Jul 2022 | Aug 2022 | Sep 2022 | Oct 2022 | Nov 2022 | Dec 2022 | Jan 2023 | Feb 2023 | Mar 2023 | Apr 2023 | May 2023 | Jun 2023 | Jul 2023 | Aug 2023 | Sep 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Surgery and Cancer ICSU | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 3 | 0 | 0 | 2 | 2 | 1 | 1 | 0 | 1 | 0 | 2 |
| Strategy | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Information Management and Technology | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Facilities and Estates | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Emergency and Integrated Medicine ICSU | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 1 | 1 | 3 | 0 | 3 | 5 | 3 |
| Children and Young People Services ICSU | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| Adult Community Health Services ICSU | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 1 |
| Acute Patient Access, Clinical Support Services & Women's Health ICSU | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 2 | 2 | 3 | 0 | 1 | 4 | 3 | 3 |

- The ICSU's continue to review historic DOC requirements with data cleansing occurring where removing those incidents where DOC does not apply. In addition where a verbal DOC had been applied and it was not deemed appropriate to send a follow up written response following a significant time lapse, these incidents have been closed.
- Monthly update meetings with ICSU leads, Deputy Chief Nurse and Associate Director of Quality Governance to further progress DOC, complaints responses and risk register have been arranged.

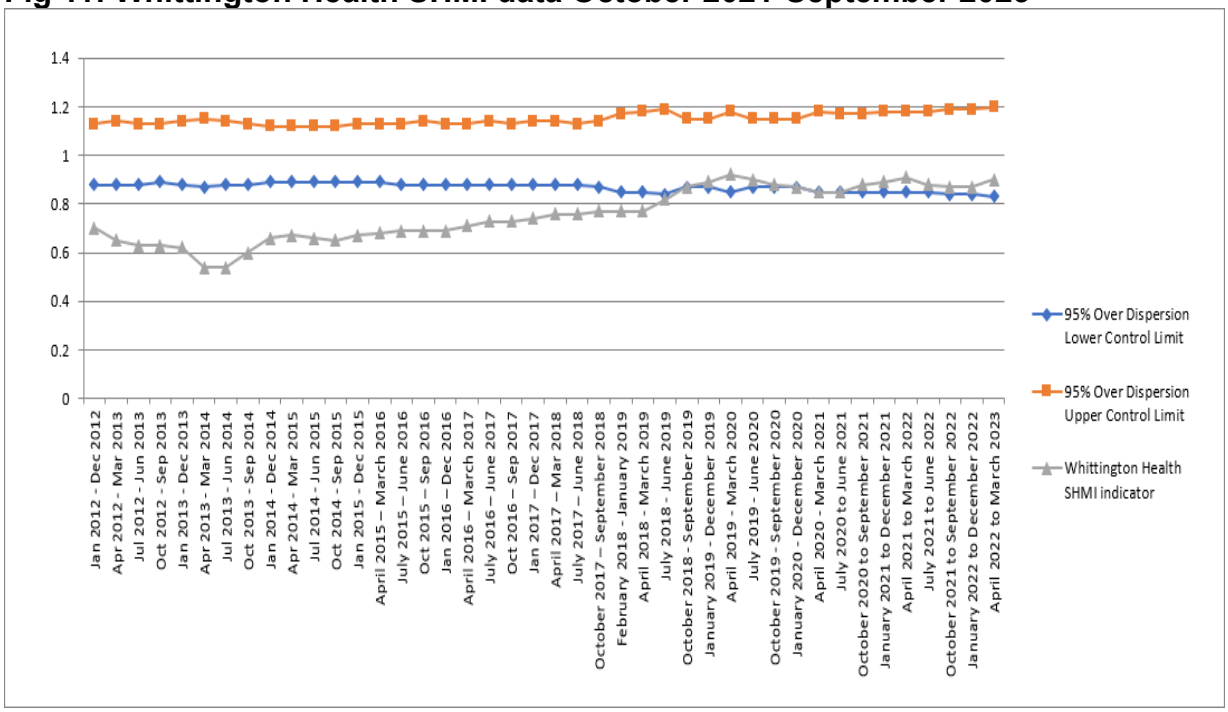
## 2.4 Mortality

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

The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated. It covers all deaths reported of patients who were admitted to non-specialist acute Trusts in England and either die while in hospital or within 30 days.

The SHMI for the data period April 2022 to March 2023 is 0.90 which is as expected for this period.

**Fig 11: Whittington Health SHMI data October 2021-September 2023**




## 2.5 Infection Prevention and Control

### 2.5.1 Health Care Acquired Infections – COVID-19

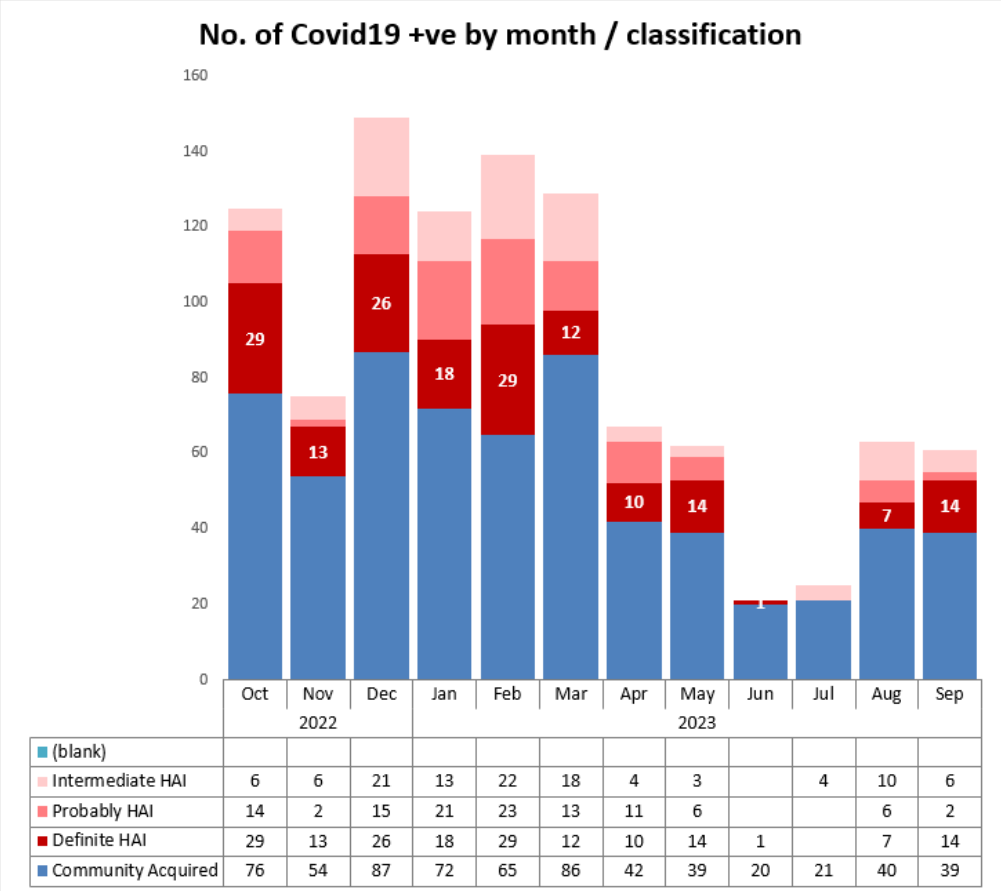
May 2023 guidance introduced from 30th March UKHSA/NHSE letter. https://whittnet.whittington.nhs.uk/document.ashx?id=16528 which recommends no Covid19 test required if patient is asymptomatic (unless being discharged to care

home-LFT then required). Patients who have respiratory symptoms should have a PCR.

- Total Number of positive cases 01/07 – 30/09/23 - **149**
- Community Acquired - Pre-admission or up to day 2 - **100**
- Intermediate HAI - Day 3 – 7 (hospital onset) - **20**
- Probably HAI - Day 8 – 14 (hospital onset) - **8**
- Definite HAI - Day 15 or more (hospital onset) - **21**

- There were five cases of COVID-19 in Cavell ward during August. One case tested positive and was isolated with other cases testing positive in subsequent two days.
- There were four cases of COVID-19 in Coyle ward during August in one bay within two days. One bay affected initially with other cases testing positive in other bays in the subsequent days.
- There were three cases of COVID-19 in Cloudesley ward during September in one bay. Other cases positive in subsequent two days.
- There were two cases of COVID-19 in Nightingale ward during September in one bay.
- There were seven cases of COVID-19 in Meyrick ward during September. One case tested positive and was isolated with other cases testing positive in subsequent days.

**Fig 12: Number of COVID-19 positive cases by month/classification October 2022-September 2023**




| | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2022 | | | | | | 2023 | | | | |
| (blank) | | | | | | | | | | | | |
| Intermediate HAI | 6 | 6 | 21 | 13 | 22 | 18 | 4 | 3 | | 4 | 10 | 6 |
| Probably HAI | 14 | 2 | 15 | 21 | 23 | 13 | 11 | 6 | | | 6 | 2 |
| Definite HAI | 29 | 13 | 26 | 18 | 29 | 12 | 10 | 14 | 1 | | 7 | 14 |
| Community Acquired | 76 | 54 | 87 | 72 | 65 | 86 | 42 | 39 | 20 | 21 | 40 | 39 |

### 2.5.2 Other Health Care Acquired Infections

a) Trust attributable blood stream infection (BSI) Qtr2
   - MRSA = 0 (zero tolerance)
   - MSSA = 0 (There is no national threshold)

b) There was no community onset hospital acquired (COHA) of Clostridium difficile Infections (CDI).

c) There was one hospital onset hospital acquired (HOHA) Clostridium difficile Infection during Qtr2. At the MDT meeting it was agreed this was an unavoidable case, however the preliminary severity classification was increased from mild to moderate based on the subjective presentation of the patient given by the medical consultant in addition to the CDI criteria of the post infection review (PIR). This compares to seven HOHA in Q1 23/24 and a total to date of 8 against an annual trajectory of 13.

**Key learning points for Clostridium difficile infection**

- Frequently prescribed laxative due to constipation, it is not known if this solely caused the diarrhoea or the CDI.
- Other symptoms such as 'feeling awful, bloated etc' were felt and expressed by the patient which the consultant felt should be a part of this review.
- From the first negative sample near admission there was no further stool sent until positive three weeks later. Agreed further education needed on other signs and symptoms of infection such as trends, olfactory, mucous, inflammatory markers to ensure patient on laxatives are not sitting in bay undetected of infection.

d) E. coli Blood Stream Infections (BSI)

**Table 6: Location of E.coli BSI**

| Ward | Jul | Aug | Sep | Total for the year (2023/24) |
|---|---|---|---|---|
| MSNO | | | | **1** |
| Nightingale | | | 1 | **2** |
| Victoria | 1 | 1 | 1 | **4** |
| Coyle | 2 | | | **3** |
| Cloudesley | 1 | | | **1** |
| Thorogood | 1 | | | **1** |
| Meyrick | | | 1 | **1** |
| Total | **5** | **1** | **3** | **13** |

e) Klebsiella Blood Stream Infections

**Table 7: Location of Klebsiella BSI**

| Ward | Jul | Aug | Sep | Total for the year (2023/24) |
|---|---|---|---|---|
| Nightingale | | | | **1** |
| Victoria | 1 | | | **2** |
| ITU | | | | **1** |
| Meyrick | 1 | | | **1** |
| MSSO | 1 | | | **1** |

f) Pseudomonas Blood Stream Infections

**Table 8: Location of Pseudomonas BSI**

| Ward | Jul | Aug | Sep | Total for the year (2023/24) |
|---|---|---|---|---|
| CCU | 0 | 0 | 0 | 1 |

g) MSSA Blood Stream Infections

**Table 9: Location of MSSA Blood Stream**

| Ward | Jul | Aug | Sep | Total for the year (2023/24) |
|---|---|---|---|---|
| | 1 | 0 | 1 | 2 |
| **TOTAL** | 1 | 0 | 1 | 2 |

## 2.6 Clinical harm reviews

2.6.1 Harm reviews give assurance to patients, carers, commissioners, and the public as to whether patients have been harmed, or at risk of harm, as well as helping to avoid future harm to patients (NHSE, 2016)

2.6.2 For Qtr1 and Qtr2, there were no Priority 2 patients on an admitted pathway who breached 78 Weeks.

2.6.3 Cancer 104 day breeches are not validated until the month after the end of the quarter, therefore Qtr2 data will be reported in Qtr3 patient safety report.

For Qtr1, the Trust reported 18 cancer breaches and after reallocation, there were 11.5 breaches (due to shared treatments). The table below shows the distribution of harm.

**Table 10: 104 day Cancer Harm**

| Speciality Pathway | How many 104-day breaches Patients on admitted pathways only | How many harm reviews were completed | Number outstanding | How many resulted in harm to the patient | What level of Harm (Please insert number) | | Action taken |
|---|---|---|---|---|---|---|---|
| April | Breast – 1<br>Colorectal – 2<br>Urology – 2 | Breast – 1<br>Colorectal – 2<br>Urology – 0 | Breast – 0<br>Colorectal – 0<br>Urology – 0 | Breast – 0<br>Colorectal – 0<br>Urology – 0 | No harm | 5 | Breach review meetings implemented |
| | | | | | Minor harm | | |
| | | | | | Moderate harm | | |
| | | | | | Severe/ Catastrophic/ Death | | |
| May | Breast – 1<br>Gynaecology – 1<br>Lung – 2 | Breast – 1<br>Gynaecology – 1<br>Lung – 2 | Breast – 0<br>Gynaecology – 0<br>Lung – 0 | Breast – 0<br>Gynaecology – 0<br>Lung – 0 | No harm | 6 | Gynae – review of p/way/processes for PT that went to RNOH. Breach review meetings implemented |
| | | | | | Minor harm | 2 | |
| | | | | | Moderate harm | | |
| | | | | | Severe/ Catastrophic/ Death | | |
| June | Colorectal – 3<br>Gynaecology – 1<br>Lung – 1<br>Upper GI – 1<br>Urology – 3 | Colorectal – 3<br>Gynaecology – 1<br>Lung – 1<br>Upper GI – 1<br>Urology – 3 | Colorectal – 0<br>Gynaecology – 0<br>Lung – 0<br>Upper GI – 0<br>Urology – 0 | Colorectal – 0<br>Gynaecology – 0<br>Lung – 0<br>Upper GI – 0<br>Urology – 0 | No harm | 7 | Breach review meetings implemented |
| | | | | | Minor harm | 2 | |
| | | | | | Moderate harm | | |
| | | | | | Severe/ Catastrophic/ Death | | |

## 2.7 Safety Alerts

2.7.1 The Patient Safety Team have oversight of all Central Alerting System (CAS) alerts, however responsibility for actioning and monitoring progress sits with the respective responsible meeting groups/committees. In addition to National Patient Safety Alerts, which are monitored via the Patient Safety Group, these include Estates and Facilities Alerts (EFAs) and medical devices and supply alerts (monitored via Health and Safety Group), Medicines and Healthcare products Regulatory Agency (MHRA) alerts (monitored via Drugs and Therapeutic Committee).

2.7.2 The Trust received five new National Patient Safety Alerts (NatPSAs) in Qtr2.

**Table 11: National Patient Safety Alerts received in Q2 2023/24**

| Date Issued | Reference | Alert Title | Status | Deadline |
|---|---|---|---|---|
| 18/07/2023 | **NatPSA/2023/008/DHSC** | Shortage of GLP-1 receptor agonists | Alert sent to pharmacy 18/07, no response received yet. | 18/10/2023 |
| 26/07/2023 | **NatPSA/2023/009/OHID** | Potent synthetic opioids implicated in heroin overdoses and deaths | Action Completed, Alert Closed | 04/08/2023 |

| Date Issued | Reference | Alert Title | Status | Deadline |
|---|---|---|---|---|
| 31/08/2023 | **NatPSA/2023/010/MHRA** | Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls | Alert lead identified and with them to action. | 01/03/2024 |
| 27/09/2023 | **NatPSA/2023/011/DHSC** | Shortage of methylphenidate prolonged-release capsules and tablets, lisdexamfetamine capsules, and guanfacine prolonged-release tablets. | 1 action outstanding. | 11/10/2023 |
| 28/09/2023 | **NatPSA/2023/012/DHSC** | Shortage of verteporfin 15mg powder for solution for injection | Action Completed, Alert Closed | 20/10/2023 |

2.7.3 During Q2 there was three new Device Safety Alerts (DSI).

**Table 12: Device Safety Alerts Q2**

| Date Issued | Reference | Alert Title | Status | Deadline |
|---|---|---|---|---|
| 03/08/2023 | **DSI/2023/007** | EyeCee One and EyeCee One Crystal preloaded intraocular lenses (IOLs): update of previous quarantine advice after identification of likely cause | Device not used at the Trust – Action not Required. | N/A |

| | | | | |
|---|---|---|---|---|
| 22/08/2023 | **DSI/2023/008** | Ethypharm Aurum pre-filled syringes are incompatible with some manufactured needle-free connectors: risk of delay in administering potentially lifesaving medication | Action Completed, Alert Closed | N/A |
| 04/09/2023 | **DSI/2023/009** | No-React® cardiovascular bioprosthesis implantables | Information Only - Staff Informed, Alert Closed | N/A |

2.7.4 At the end of Q2, five safety alerts remain open.

**Table 13: Open Safety Alerts at the end Q2**

| Date Issued | Reference | Alert Title | Status | Deadline |
|---|---|---|---|---|
| 27/06/2023 | **NatPSA/2023/007/MHRA** | Potential risk of underdosing with calcium gluconate in severe hyperkalaemia | Actions currently being completed by Pharmacy team. | 01/12/2023 |
| 18/07/2023 | **NatPSA/2023/008/DHSC** | Shortage of GLP-1 receptor agonists | Actions awaiting final overview from diabetes team.<br>Once viewed all actions will be complete. | 18/10/2023 |

| | | | | |
|---|---|---|---|---|
| 31/08/2023 | **NatPSA/2023/010/MHRA** | Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls | Alert currently with lead to complete actions. | 01/03/2024 |
| 27/09/2023 | **NatPSA/2023/011/DHSC** | Shortage of methylphenidate prolonged-release capsules and tablets, lisdexamfetamine capsules, and guanfacine prolonged-release tablets. | One action outstanding, awaiting feedback on action completion. | 11/10/2023 |
| 29/01/2020 | **EFA/2020/001** | Allergens Issues - Food Safety In The NHS | Action plan sent to E&F leads on 11/05/2023, however only 2 actions from the alert are complete, 4 ongoing (to be monitored via audits) and 2 actions unassigned.<br><br>Follow up email sent 03/07/2023, no response received. | **12/02/2021** |

2.7.5 Five safety alerts were closed in Q2.

## 2.8 Headlines from Patient Safety Group sub-groups

The following groups reported to the Patient Safety Group in August 2023 with key headlines from their reports highlighted below:

### 2.8.1 Blood Transfusion Group

- A national annual short report for 2022 has recently been published and key messages include:
  - Transfusion delays and Transfusion-associated circulatory overload (TACO) continue to be the leading causes of transfusion-related deaths in the UK.
  - ABO-incompatible red cell transfusions continue to occur and often result from failure to identify the patient at the time of blood sampling (wrong blood in tube) or administration to the wrong patient.

- The Trusts contract with Learnpro expired and there is now a new blood transfusion e-learning program developed by NHSBT available on Elev8.
- Free fetal DNA testing is now available and has been developed with a robust standard operating procedure (SOP).
- The laboratory has retained United Kingdon Accreditation Services (UKAS) accreditation after recent inspection. No major issues were flagged by the inspection team.
- The National Audit report of blood sampling and labelling has been published:
  - Most errors (Labelling error on tube or request forms) recorded are from Nurses and Midwives, most were being made in A&E department and Outpatients/ Preop clinic.
  - Most request forms are not being signed compared to nationally. The Hospitals lab does not reject samples received with request forms not signed as long as all identifiers match on the sample and request form. This has been highlighted on the noticeboard and staff computer screensavers to remind staff that all request forms must be fully completed and signed before sending to the lab for processing.

### 2.8.2 VTE/Coagulation Group

- A new pharmacist has been appointed to replace the previous staff member. They are due to start in September. Due to being without a VTE prevention pharmacist for around 1-2 months there is no VTE risk assessment data to present.
- Aim to ensure sustainability of VTE pharmacy role by trying to make it full time – pursuing options with pre-op assessment.
- VTE lead to go on maternity leave. Some locum services have been secured to cover.

### 2.8.3 Point of Care Testing Group

- The COVID-19 Platform – Samba will continue the free service and maintenance, UKHSA funded Samba tests for this financial year. The Samba II platform will be replaced with Samba III mid 2024.
- The rapid response team has purchased 4 Abbott i-STAT Anility devices which tests for U/E/C. These devices have passed the accuracy study.
- NICU has purchased 2 bilimeters. The equipment accuracy study is under review.
- There is a supply disruption of the Hologic Fetal Fibronectin due to quality control issue with raw material. The estimated recovery by the company is end of June 2023.

Maternity has sufficient supply to last until end of this year. Alternative testing platform has been selected if the supply issue is not resolved.

- The provision of pathology services within the organisation will change as the laboratory is in tender process. The changes are in the planning stages and unclear exactly how this will affect the POC support for the organisation.
- An additional Radiometer Blood Gas Analyser was installed in AE Rapid Assessment in January 2023
- The percentage of staff trained in Victoria for blood ketone meter is below the required number to safely install the device. The training goal is 80% and this has been fed back to ward managers.

## 3 Clinical Audit and Effectiveness

### 3.1 Q2 2023/24 clinical audit and service evaluation project status.

**Table 14: Progress for 2023/24 audits Q2**

| Project Category: | Complete | Completed - report outstanding / data submitted | On target | Not on Target | Not Participating | Not due to start | Total |
|---|---|---|---|---|---|---|---|
| Mandatory National Audits | | 6 | 47 | 1 | 1 | 7 | **62** |
| National Audits | | 1 | 9 | | | 2 | **12** |
| Local Audits | 21 | 3 | 40 | 6 | | 3 | **73** |
| National Service Evaluations | 1 | 2 | 3 | | | | **6** |
| Local Service Evaluations | 8 | | 16 | 1 | | | **25** |
| **Total** | **30** | **12** | **115** | **8** | **1** | **12** | **178** |

### 3.2 Mandated National Audit 2023: KEY NOTES

#### 3.2.1 National Audit on Dementia; Care in general hospitals

The request for Round 6 deferral, as endorsed by the Clinical leadership team and CEG was ultimately rejected by the Quality Assurance Committee due, primarily to its' mandated status. It was acknowledged that the late publication of the National Round 5 report allows no time for local quality improvement initiatives, prior to the commencement of a new round of data collation. Data collection for Round 6 is therefore underway.

#### 3.2.2 National Diabetes Inpatient Safety Audit (Harms)

The primary objective of this national audit is to record the details of any adult inpatient experiencing one of the following four avoidable diabetic complications:

- Hypoglycaemic Rescue
- Diabetic Keto Acidosis (DKA)
- Hyperglycaemic Hyperosmolar State (HHS)
- Diabetic foot ulcer

Since 1 April 2023, no Trust data has been recorded.

To ascertain whether no avoidable harms have occurred during this timeframe or whether there is an inherent problem with the data process, the Clinical Lead for Diabetes and Endocrinology, was contacted. The response is summarised below:

**Current status:**

- Obligation to participate acknowledged by the clinical team; recently addressed during a consultant meeting.
- Succession planning following previous lead retirement is in progress. As a result, consultants are working above plans to address the workforce gap , primarily in DCC which has been significantly impacted by industrial action.
- Currently, there are no consultants who feel able to lead on this national audit while the post remains unfilled, without activity being cancelled.
- Proposition that an incoming SpR (October 2023) would be able to lead on this with consultant support. Discussion with Education Supervisor required.

**Action:** Ongoing monitoring is required. Relevant corporate and clinical staff are aware. To re-visit in November, once incoming SpR is in post.

### 3.2.3. National Early Inflammatory Arthritis Audit (NEIAA) Outlier Notification

On 25 September 2023, the Trust received notification of 'Alarm level' outlier status confirmed for NICE quality standard 33 (2013 version, stating that patients referred with suspected persistent synovitis should be seen within three weeks of referral).

**Action**

The Trust has been asked to comment on data inaccuracies, but data are still felt to be inaccurate.

Senior operational and clinical leadership will be working with the Rheumatology team to address this issue. Ongoing monitoring is required, and updates will be included in future reports.

### 3.3 Q2 national audit report publications:

**Table 15: National audit publications**

| Quarter | Published | Responses received to date | Comments |
|---|---|---|---|
| **2** | 9 | 5 | 3 responses due by end October. 1 overdue and being followed up. |

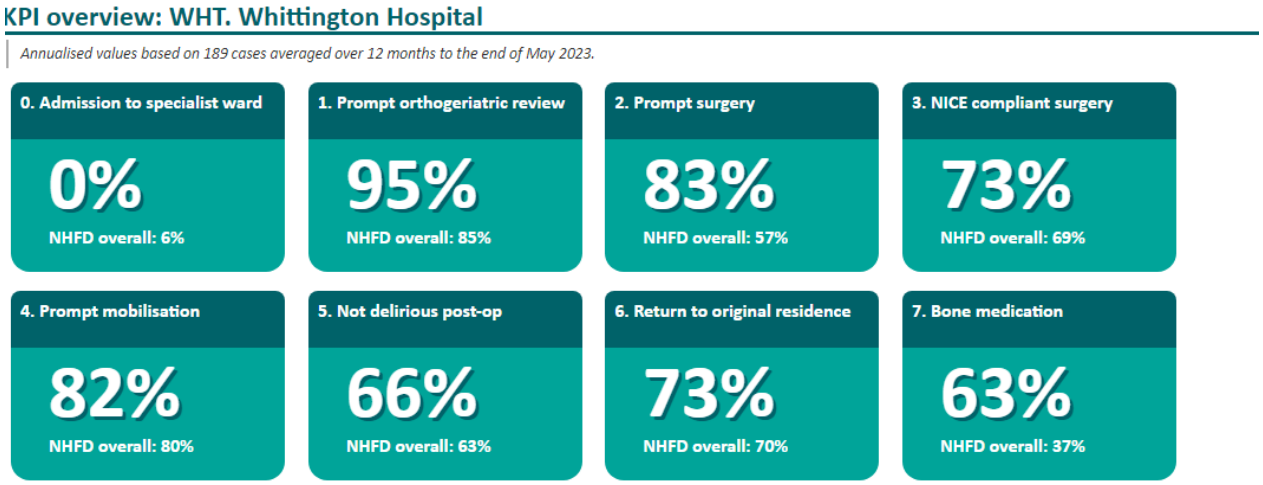
### 3.4 Q2 National Clinical Audit Report publication: Example with overall assurance rating and proposed actions:

FFAP: Hip fracture database

The overall assurance from this report is **Amber.**

The FFAP are no longer producing annual reports for the National Hip Fracture Database. Each hospital can download and review its data from the website. The Clinical Lead undertook WH data review in July 2023.

The results for Whittington Hospital are as follows:




Actions to be taken:

- Ongoing training to improve high pressure ulcer rate.
- Ongoing training to ensure AMTS on admission.
- To work with Orthopaedic team(s) to ensure accurate classification and all doctor awareness of NICE guidelines in relation to surgery.
- Ongoing training with all disciplines involved (surgeons, juniors, anaesthetic team, nurses and therapy staff) to ensure we meet the best practice tariff standards where possible.

### 3.5 Q2 Local audit: Examples of good practice/ identified actions:

3.5.1 Audit on Optimal Cord Management

In August 2022, the Trust was notified of negative outlier status for the National Neonatal Audit Programme NNAP 2021 measures.

The outlier status referred to the audit standard for Deferred cord clamping, and for which the Trust was a number of standard deviations from the expected measure.

From January to July 2022, the deferred cord clamping standard improved from 3.8% to 33% and the Trust instituted additional measures to further improve compliance, to

include intensive training of obstetric and neonatal staff including a presentation at a perinatal meeting, and simulation exercises.

A local audit has been undertaken to ascertain progress.

Whilst the results did not meet the standard of 80%, there was a continuous improvement noted, as demonstrated below:

- 46% of babies <34 weeks gestation had DCC in period Jan – March 2023
- 59% of babies <34 weeks gestation had DCC in period Apr – Jun 2023

Actions to be taken:

- Continuous education programme to raise awareness especially with the new trainees.
- Concord resuscitation trolley acquisition.
- A pre-term checklist for Neonatologists.
- Establishment of pre-term champions.

3.5.2 Major haemorrhage protocol audit: The collection of emergency blood

- Criteria and Standards
  1. 100% Adherence with the protocol to collect and deliver 2 units upon the activation of a MH.
  2. 100% of RBC units are returned to the laboratory within 30min if not needed.
- Results of audit April-May 2023 returned results of 43% adherence to the protocol. Re-training of porters was carried out in June and July 2023 and the results in Table 14 indicates significant improvement.

**Table 16: Results of Major haemorrhage protocol audit: The collection of emergency blood June/July 2023**

| Criterion | Result | |
|---|---|---|
| Adherence with the protocol to collect and deliver 2 units upon the activation of a MH | 87.5% | Collection of 2 units happened on 7 occasions out of 8 MH calls |
| Adherence with the protocol to return RBC units within 30min if not needed | 100% | Only one unit was returned on time |

3.5.3 Q1 Local audit retrospective – update on Rapid Tranquillisation re-audit

The Q1 summary report included a local audit example: Rapid Tranquillisation in the Emergency Department. The re-audit date, subsequent to targeted interventions was scheduled for April 2024, however upon review it was felt that further assurance was required. This has now been rescheduled for January 2024.

## 3.6 National Confidential Enquiry into Patient Outcome and Death (NCEPOD):

The following seven NCEPOD studies are 'live':

1. **Transition from child to adult health services**: to explore the barriers and facilitators in the process of the transition of young people with complex chronic conditions from child to adult health services. **Report published. Disseminated with table of key recommendations. Response in progress.**

2. **Crohn's disease:** to review of remediable factors in the quality of care provided to patients aged 16 and over with a diagnosis of Crohn's disease who underwent a surgical procedure. This is the first NCEPOD study to proactively investigate the effect of COVID-19 on the service.

   Case submission complete, the organisational and clinical questionnaire returned. Report published, appropriately disseminated, and awaiting response.

3. **Community acquired pneumonia:** to identify and explore avoidable and modifiable factors in the care of adults presenting to hospital with a presumed diagnosis of community acquired pneumonia.
   Case submission complete. Report publication expected Winter 2023

4. **Testicular Torsion:** To review the complete pathway and quality of care provided to children and young people 2 – 24 years of age who present to hospital with testicular torsion.
   Case submission complete. Organisational questionnaire completed and submitted. Local Trust guideline reviewed and updated.

5. **Endometriosis**: To review remediable factors in the quality of care provided to patients aged 18 and over with a diagnosis of endometriosis between the 1st of February 2018 - 31st July 2020.
   Case submission completed. Organisational questionnaire completed in advance of deadline.

6. **Juvenile Idiopathic Arthritis**: To review the quality of care in children and young adults (0-24 years) with Juvenile Idiopathic Arthritis (JIA).
   Patient spreadsheet population complete.

7. **End of Life Care:** To identify and explore areas for improvement in the end-of-life care of patients aged 18 and over with advanced illness, focusing on the last six months of life.
   Patient spreadsheet population complete.

Further to the above 'live' studies, the following studies are in the design phase for launch later this year:

1. Rehabilitation following critical illness.

2. Blood sodium

Three further new studies have seen chosen for next year:

1. Acute lower limb ischaemia
2. Acute illness in people with a learning disability*
3. Emergency surgery in children

Note: * The Trust has also registered for the NHS England Learning Disability Improvement Standards Benchmarking project for NHS Trusts - Year 6, and this should both align with, and inform our returns for the later NCEPOD study.

### 3.7 National data opt out:

Several programmes commissioned by HQIP have been made exempt from the national data opt-out following advice from the Confidentiality Advisory Group at the Health Research Authority.

Other programmes have received a policy deferral of up to 12 months. This is to allow for an application for an exemption.

### 3.8 Quality Improvement Programme, Q2

3.8.1 Quality Account (QA):

Progress has continued with the priorities, with key highlights including:

Transport:

DHL has confirmed that once completed, the Transport eligibility form is valid for a month, eliminating the need to complete a form for every appointment within that month.

A new Transport Service Group is being implemented, due to start in October, aiming to improve engagement with clinical users. Patient service users will continue to be directed to PALS for any concerns.

Nutrition:

An increase in the percentage of nutritional screening across the wards has been noted following awareness raising of Back to the Floor. The Nutrition Steering Group are continuing to monitor this change to determine whether this improvement will be sustained.

There will be a renewed focus on Nutrition on acute wards with newly recruited Band 6s being identified as Nutrition Champions.

Speech and Language Therapy (SLT) and dietetic documentation has been updated to include dietary preference, cultural and allergy considerations. This change will also be implemented into new nursing admission documentation to ensure this information is obtained on admission.

Pressure Care:

Nursing Admission Documentation is under review, with the aim of creating a central document that directs to assessments and care plans needed. As well as providing direction to users completing the document, it will also allow for more accurate data collection to measure the effectiveness of the document, which was previously free text.

Sickle Cell Disease:

Documentation has been updated to allow for analgesia timings to be accurately recorded, eliminating the previous data collection inaccuracies. The Sickle Cell improvement group continue to work on improving time to analgesia and training, however, have faced challenges in adding e-learning to Elev8 due to reduced staffing and capacity within Learning and Development (L&D). This has been escalated to the Head of Talent & Development with a request to prioritise this e-learning implementation given the link to the Quality Account and Trust Objectives regarding health inequalities. No response has been received to this request.

3.8.2 Quality Improvement Projects:

- A total of 12 new QI projects have been registered that highlight Clinical Effectiveness as a key priority.
- The QI Lead continues to be involved directly in QI initiatives and improvement groups, including Back to the Floor: themes aiming to link with Trust Objectives and Quality Account Priorities, Laryngectomy Care Project, Pressure Care Improvement Group, PSIRF (Patient Safety Incident Response Framework) implementation, Tendable working group.
- QI Training:
  A total of 9 training sessions have been delivered to a range of audiences (totalling 105 staff members), including training in response to requests for bespoke sessions to CAMHS and Patient Experience.

- QI Celebration/Awards:
  The QI Celebration afternoon took place on 24th October in the Whittington Education Centre . A total of 21 submissions were received, and 10 projects shortlisted for presentation.

## 3.9 Sub-Committee updates:

3.9.1 Clinical Guidelines, Q2

- COVID-19 Guidelines: remain quality assured and categorised as ‘current’, ‘archived’ and ‘obsolete’. Guideline updates are dependent upon disease and case progression.
  The emergence of a new variant and increase in case presentation at WH during Q2 may result in new and updated COVID-19 treatment guidelines. The Hub remains ‘Live’ and receptive to new requirements.

- National COVID Inquiry and WH COVID-19 Guideline Hub
  Work is now complete to determine the level of forensic information we would be able to provide to the National Covid Inquiry, should this become necessary.
- Local clinical management guideline review timeframe extension agreed:
  Due to the exceptional circumstances of the past 3 years and resultant clinical pressures, a two-year extension to clinical guideline review dates has been agreed. For note, this should not preclude proactive requests to update a guideline following new best practice evidence or local incident.

  During Q2, the Head of Clinical Effectiveness and Senior IT colleagues led discussion to identify and enact the most efficient way to communicate the two-year extension.

  A clear caveat has been introduced to both the 'parent' clinical guidelines page and to each of the individual speciality pages. Message inclusion in the Trust Noticeboard was arranged and clinical leads and individual authors have and continue to be updated about the extension.

- Clinical guideline speciality reviews complete, Q2:
  During Q2, the following guidelines have been reviewed and agreed, to replace existing Intranet versions:

  - Stress Ulcer Prophylaxis in Critical Care Patients
  - Testicular torsion
  - When to call a consultant – Anaesthetics

- Priority for Q2: “Top 20 Most Accessed Clinical Guidelines”
  Despite the extension to guideline review dates, the Head of Clinical Effectiveness initially sought to ensure our top 10 most accessed clinical guidelines are reviewed to ensure ‘current’ status.

  During Q2, this objective has been increased to cover the top 20 most accessed guidelines. Cumulatively, these top twenty guidelines have been accessed 125,973 times. The initial quality check has demonstrated a pre-existing 80% compliance with review timeframes.

- Drug & Therapeutics Committee guideline ratifications, Q2:

- Hyperkalaemia (update)
- Sedative premedication
- Rituximab- Supply and Administration for Adult Rheumatology Patients on the Rheumatology infusion day unit

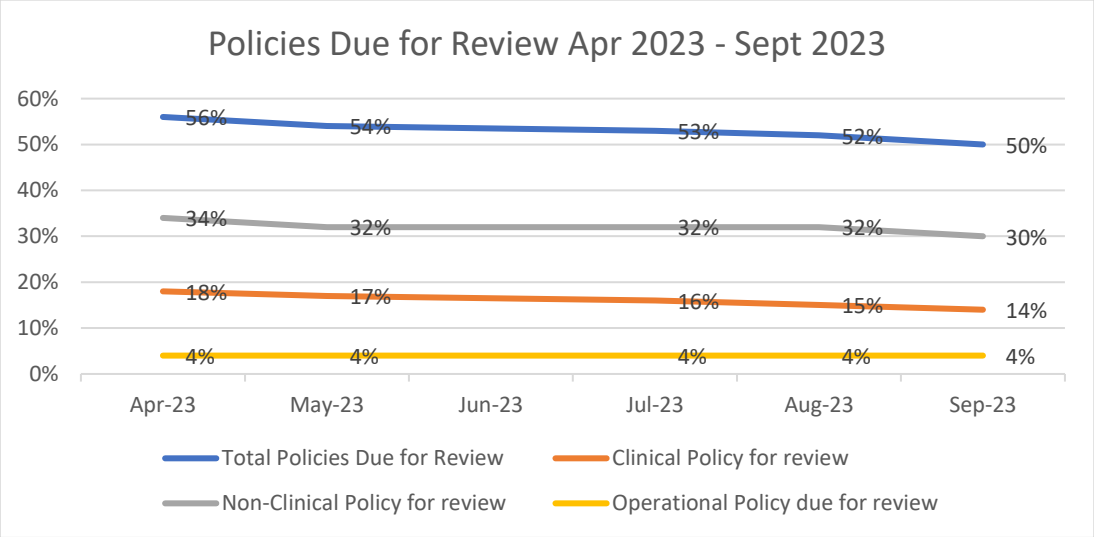
- Clinical Guidelines Committee reviews, Q2:
  - MEDL Delirium
  - MEDL Acute Pulmonary Embolism
  - MEDL Hyperkalaemia

3.9.2 Policies, Q2

There are currently 271 online documents, 358 documents have been taken offline.

Of the 271 online documents the following chart and pivot table shows the number of policies due for review by category.

**Fig 13: Policies due for review Q2**




The percentage overdue has remained consistent, with some minor progress made during the last two months; the overdue documents have been consistently sent to ICSUs for review and updating.

Clinical policies have come down to 14% in September from 18% in April and non-clinical polices have reduced to 30% in September, from 34% in April. The majority of these overdue policies sit with Estates and Facilities. The recruitment of two substantive Band 7 rolesls into that area should see an improvement in this area over the next quarter. Overall, overdue documents have reduced to 50% in September, from 54% in April. These are moving in the right direction, however more work is needed to ensure all documents are up to date.

An additional temporary staff member in the Compliance Team is now assisting the Compliance and Quality Improvement Manager with formatting policy documents and sending reminders. The Deputy Chief Nurse and Associate Medical Director for Clinical Effectiveness will chair the Policy Approval Group from October 2023, in an effort to expediate ratification of the outstanding clinical policies.

### 3.10 NICE guidance, Q2

3.10.1 A total of 41 documents have been published during Q2 with 13 necessitating a formal response. This represents a notable decrease in quarterly publications.

A retrospective will be provided in the Q3 report.

**Table 17. Full list of NICE publications, Q2:**

| Q2 2023/24 | July | August | September | Total |
|---|---|---|---|---|
| NICE Guidance | 3 | 5 | 5 | **13** |
| COVID Guidance | | | 1 | **1** |
| Highly Specialised Technology Guidance | 1 | | 1 | **2** |
| Diagnostic Guidance | 1 | 1 | | **2** |
| Interventional Procedure Guidance | 1 | 1 | 3 | **5** |
| Medical technology guidance | 1 | | | **1** |
| Technology Appraisal Guidance | 5 | 1 | 3 | **9** |
| Health Technology Evaluation | | 1 | 4 | **5** |
| Quality Standard | 1 | | 2 | **3** |
| Evidence Summary | | | | |
| MIB - Medtech innovation briefing | | | | |
| **Total** | **13** | **9** | **19** | **41** |

*(Reporting status: NICE clinical guidelines are mandated for a formal response. HTAs mandatory for formulary addition if service applicable).*

3.10.2 NICE action plan for Q2:

It is rare that a clinical response identifies significant actions to be taken forward. However, in the event that it does, these actions will require discussion at ICSU Board level. A new NICE action plan has been developed for completion and submission to the ICSU Clinical Director, Director of Operations and Associate Director of Nursing.

3.10.3 Receipt of outstanding response:

During Q2, a full clinical response to the: Suspected Cancer: recognition and referral NICE guidance was received and for which the Trust practice is entirely compatible.

3.10.4 Q1 2023-24 Retrospective:

During Q1 there were 10 NICE Clinical guidelines published for mandated response, of which 9 have been responded to (90%). The final outstanding response has mitigating factors due to clinical staff leave. This has not significantly exceeded review timeframe but has been chased.

## 3.11 Organ Donation

- 100% referral rate for both DBD and DCD.
- Grand Round on Organ donation undertaken.
- Form for diagnosing death by neurological criteria now available on CareFlow
- Link nurses for ODC appointed from both ICU and ED

## 4. Patient Experience

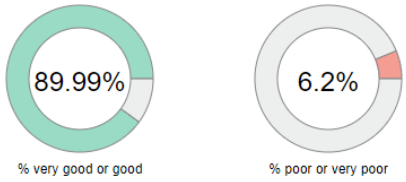
### 4.1 Friends and Family Test (FFT)

Overall

The Trust remained above the 80% benchmark in “very good or good” responses, scoring 89.99%. It remains an outlier against the NHS benchmark of 5% in “poor and very poor” responses, scoring an average of 6.2%, as shown below (Fig 15 & 16), however, the Trust is scoring a lower percentage in poor and very poor responses by 0.45% compared to Q1 (6.65%). The patient experience team will meet mid-quarter to review FFT data and offer guidance and support to services.
The number of Trust responses has seen a slight decrease on Q1, from 7,368 to 7,246 in Q2, a decrease of 122, the decline is particularly seen in the community, actions to improve this is discussed in point 4.1.5

**Figure 14: FFT Overall Trust Results – Responses and Survey Completion**

Percentages of Very good/good and poor/very poor
(FFT - All, 1/7/2023 to 30/9/2023)




FFT response breakdown
(FFT - All, 1/7/2023 to 30/9/2023)

| Response | Percentage | Number of times response selected |
|---|---|---|
| Very good | 74.23% | 5379 |
| Good | 15.76% | 1142 |
| Neither good nor poor | 3.19% | 231 |
| Poor | 2.47% | 179 |
| Very poor | 3.73% | 270 |
| Don't know | 0.62% | 45 |

Export

Number of surveys completed each month
(FFT - All From 1/7/2023 to 30/9/2023)
7246 Surveys

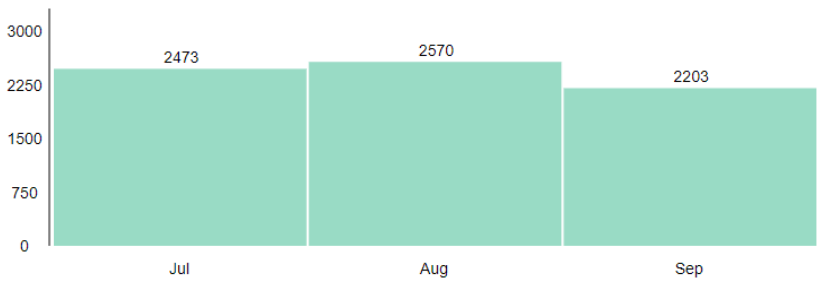
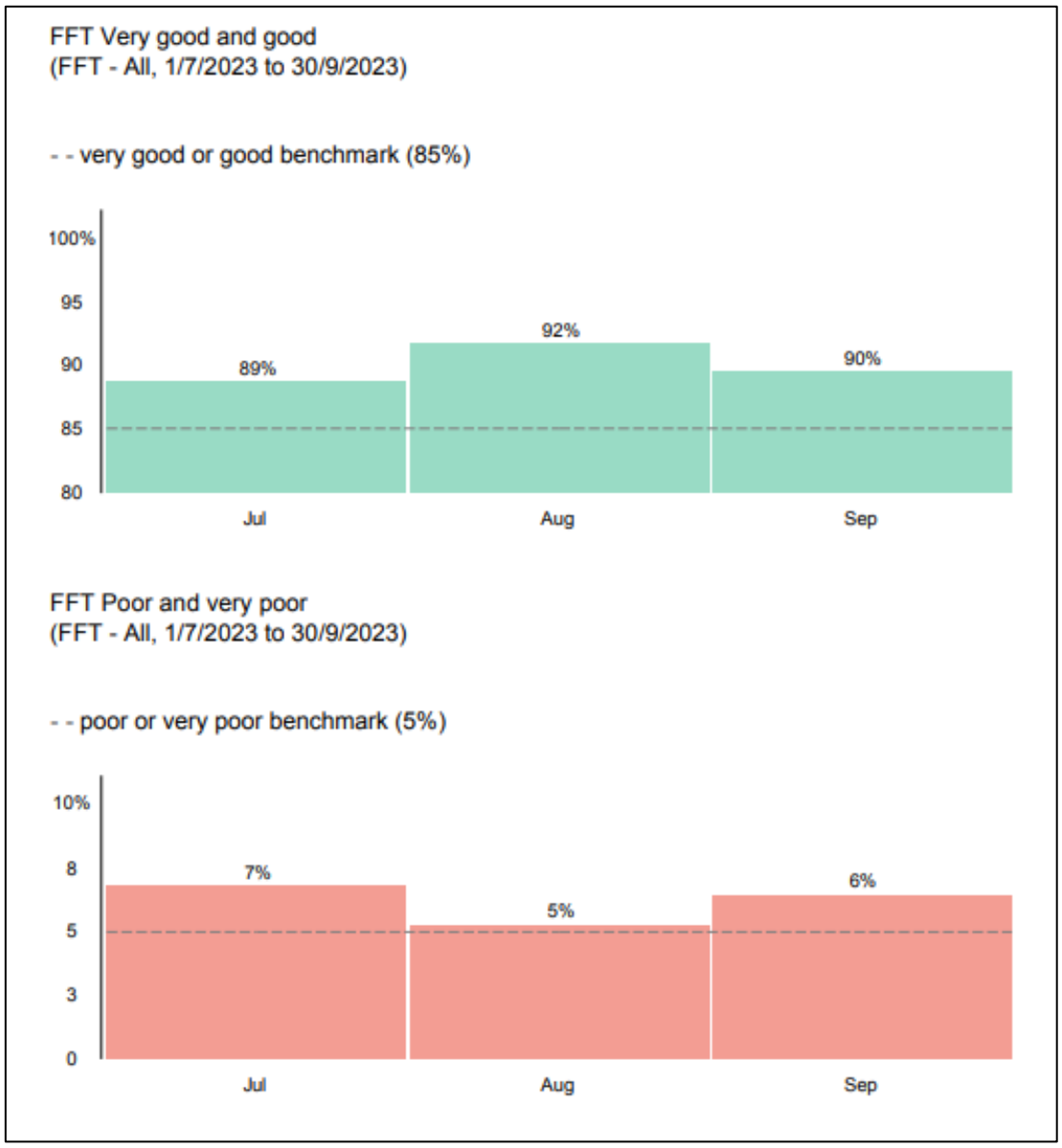


**Figure 15: FFT Overall Trust Results – Comparison against benchmarks**




4.1.2 Outpatients

Response rates for Outpatients in Q2 has seen a significant increase on Q1, with 358 more responses, as shown in (fig 21). The increase is due to focussed support from volunteers gathering responses via iPads. The patient experience team is in the process of obtaining 2 new iPads and expanding the process in other areas requiring support.

There were 21 “very poor” responses recorded, compared to 34 in Q1, 5 of which mentioned staff attitude, in line with complaints and PALs feedback. Other areas of poor feedback were long waiting times, letters being sent too late to arrive to patients,

information unclear on letters, and the lack of data privacy on the phlebotomy screens where patients are called into a room , which display patient names.

Actions:

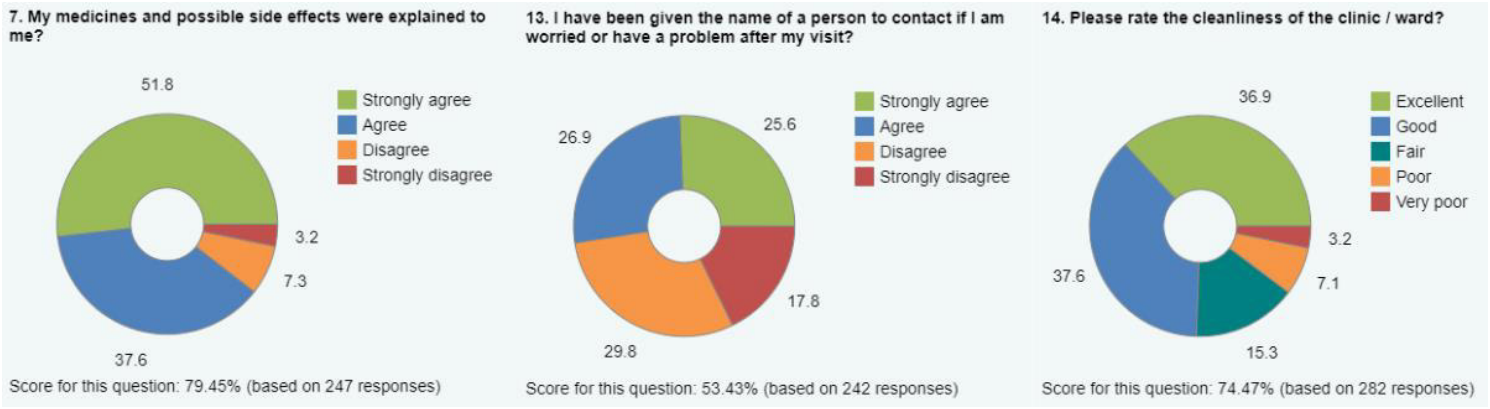
- In relation to poor staff attitude, PALs and complaints manger having routine meetings with service managers to address these issues and provide feedback on complaints themes and where appropriate inviting a patient to give feedback on their experience.
- Head of Patient Experience will meet with OPD operational lead to understand and address the issues with delayed appointment letters.

### 4.1.3 Emergency Department

Response rates within the Emergency Department have maintained at the same level from the previous quarter. The Trust is still experiencing a high percentage of poor and very poor responses (Fig. 23), at 13.86%, almost 10% above the NHS benchmark of 5%; however, the percentage of poor and very poor responses has dropped 1% from Q1 (14.71%). A large proportion of negative comments accompanied by the low scores were about prolonged waiting times, staff attitude, and cleanliness, as with our adult inpatient survey 2022 and UEC national survey. Work is taking place with the support of an action plan for the UEC survey.

The SMS survey link has been updated on September 12th, which now includes an additional 14 questions, which will allow for a better understanding of our patients' experience and areas of concern. Below are the questions which scored below 80% on the survey in September (Fig.1).

**Fig16: Emergency Department Questions**




### 4.1.4 Inpatient

Inpatient results remain stable in Q2 compared to Q1. Negative feedback related to cancelled or delayed procedures, and long waiting times in line with complaint and PALs related enquiries.

4.1.5 Community

Community response rates have seen a decrease of 503 from Q1 (2,819) to Q2 (2,316).

The Patient Experience team met with ADON for community and discussed options to improve FFT feedback. iPADs are the preferred option to collect data followed by QR cards, these will be discussed with the teams. SMS is not considered a popular option.

Previous concerns within the community survey in Q1 were split between Wood Green Community Diagnostic Centre and Haringey Talking therapies.

**Wood Green Community Diagnostic Centre:** The percentage of "very poor" & "poor" responses for the phlebotomy service in Wood Green CDC is now 54.55% (out of 11 response), compared to 57.14% in Q1 (out of 7 responses). Currently patients are notified of long waiting times and are given a pager, which allows them to leave the centre, which is based in the shopping mall, until their appointment. The patient experience team will be working alongside CDC to help improve response rates and scores.

**Haringey Talking therapies:** The percentages of "very poor" and "poor" responses for talking therapies is 15% in Q2 (out of 180 responses). During Q3, the patient experience team will work with Haringey Talking Therapies to develop an action plan and monitor progress against poor responses and feedback related to patients not being treated with empathy.

4.1.6 Maternity

During Q2 maternity data experienced issues with response rates in July. This issue was rectified in August.

Maternity monthly responses have increased by 100% in Q2 compared to Q1. The patient experience team will look at further improving response rates in Q3 and a scoping the use of SMS.

The results for Q2 returned positive results at 97.57% for very good or good.

**4.2 Patient Stories:**

Patient stories continue to be a successful and emotive way of presenting the patients' experience to Trust Board and include both positive stories and areas where there is an opportunity for learning and improvement. As part of our commitment to reduce health inequalities, the Patient Experience team continues to actively recruit stories from a variety of groups including those with learning disabilities, mental health conditions, and carers.

On 21st July 2023, Trust Board heard the story of a patient who has been using Whittington Health services since 2014. Currently under the care of Endocrinology and Ophthalmology, the patient's sister and his carer, who walked us through his journey when engaging with our services and highlighted the importance of equal access to healthcare for patients with Autism and Learning Disabilities.

On 29th September 2023, the patient story was presented within the Annual General Meeting. The patient has been under the care of Cardiology and Urology since 2012 and has had various urological procedures done at the hospital, including endoscopic litholapaxy and bladder neck incision. The patient expressed gratitude for the high level of care he continuously received and feels that the staff went above and beyond in looking after him.

### 4.3 National Patient Surveys

NHS England produces and uses a range of different surveys as a valuable source of feedback directly from patients, service users and NHS staff about the care that they receive or provide.

Information from patient experience surveys is one way to understand what service users think about their recent care and treatment. Survey results can be used to check progress and improvement of care providers, and to hold them to account for the outcomes they achieve. The results are used by the CQC when planning to evaluate services and inspections.

#### 4.3.1 Urgent & Emergency care 2022

This survey is undertaken every two years and looks at the experiences of people who attended Type 1 or Type 3 urgent & emergency care (UEC) services in September 2022. The 2022 survey involved 122 trusts with a Type 1 accident and emergency (A&E) department and was published nationally in July 2023.

UEC had 29 questions in which they scored “about the same” with other trusts, 3 better than expected” 4 “somewhat better than expected” and 1 “worse than expected,” with none being “much worse than expected”.

<u>Top Five scores</u>

Whittington Health’s Urgent & Emergency Care Survey results 2022 were top of the league table for the region nationally in both waiting and doctors and nurses.
UEC were also in the top five for care and treatment, tests and respect and dignity.
Areas for improvement were leaving A&E, environment and facilities, doctors, and nurses.

<u>Bottom five scores</u>

Q42. Before you left the hospital, did a member of staff discuss your transport arrangements for leaving A&E?

Q43. Did hospital staff discuss with you whether you may need further health or social care services after leaving?

Q31. In your opinion, how clean was the A&E department?

Q18. Did doctors or nurses talk to each other about you as if you weren’t there?

Q44. After leaving A&E, was the care and support you expected available when you needed it?

Actions:
A task and finish group including EIM leads and the patient experience team, have reviewed the bottom areas for improvement, and actions required. An action plan is in place which will be worked through monthly. Oversight is via EIM Quality committee and the Patient Experience Group.

### 4.3.2 Cancer Patient Experience 2022

Annual survey conducted by NHS England, involving 133 NHS Trusts. Distributed in Autumn, results compiled by Summer. Aims to gather feedback and evaluate experiences of individuals diagnosed with cancer. The results were published in July 2023.

**Questions Above Expected Range**

| | Case Mix Adjusted Scores | | | National Score |
|---|---|---|---|---|
| | 2022 Score | Lower Expected Range | Upper Expected Range | |
| Q7. Patient felt the length of time waiting for diagnostic test results was about right | **89%** | 69% | 88% | **78%** |
| Q8. Diagnostic test results were explained in a way the patient could completely understand | **90%** | 69% | 88% | **78%** |

**Questions Below Expected Range**

| | Case Mix Adjusted Scores | | | National Score |
|---|---|---|---|---|
| | 2022 Score | Lower Expected Range | Upper Expected Range | |
| Q9. Enough privacy was always given to the patient when receiving diagnostic test results | **88%** | 89% | 100% | **95%** |
| Q19. Patient found advice from main contact person was very or quite helpful | **90%** | 91% | 100% | **95%** |
| Q33. Patient was always involved in decisions about their care and treatment whilst in hospital | **52%** | 53% | 86% | **70%** |
| Q37. Patient was always treated with respect and dignity while in hospital | **73%** | 76% | 100% | **88%** |
| Q46. Patient was given information that they could access about support in dealing with immediate side effects from treatment | **78%** | 78% | 94% | **86%** |

Actions taken following the survey and in response to FFT.

1. Volunteer has started conducting FFT with cancer patients weekly on the chemotherapy unit, providing an increase in FFTs, more rich data to analyse to listen to what our patients are saying.
2. Oncology and breast cancer now to carry out joint patient and staff surveys.
3. Clinic 4a quiet room available . Engaging with an interior design company to carry out improvement works to any patient comfort areas with the aim of creating a more therapeutic space that is dignified and comfortable.
4. Secret shopping CNS telephone and feeding back to CNS group at our staff meetings.
5. Recurrent funding of Acute Oncology Lead Nurse approved this role is essential to provide the link and coordination from our patients on the ward or in ED to the tumour specific team.
6. UGI pathway development for patients with a suspected UGI malignancy. The CNS is already developing this with acute medicine.

7. Discussions re cancer at ‘back to the floor’, to really emphasise across the wards needs of cancer patients and how to meet them.
8. Oncology clinical contact list has been circulated at Whittington with ward teams, ED, and clinics to help our colleagues across the trust contact the team.
9. Complimentary therapies approved by WH Charity; we are developing a patient feedback form to monitor the quality of this.
10. CNS posters in wards, clinics and ED with contact details

### 4.3.3 National Adult Inpatient Survey 2022

The Adult National Inpatient survey is held every year, fieldwork for the 2022 survey took place in November 2022. The findings were published nationally on 12 September 2023.

It is worth noting that this survey took place while there were significant challenges with nursing vacancies on the wards and large numbers of escalation beds that were opened and not substantively funded. A recruitment drive has resulted in filling most of these positions.

Highlights

- Medication on discharge
- Views sought on the quality of care.
- Self-administration of medication
- Information relating to condition.
- Communication from doctors

Areas for improvement

- Accessing food outside of mealtimes
- Noise at night
- Communication post procedure
- Cleanliness
- Inclusion in conversations with nursing staff

The patient experience team will support the action plan with matrons in Q3 and Q4 to address areas for improvement, including the introduction of sleep well packs to address noise at night. Monitoring of the associated action plans will be via the respective ICSU's with oversight from the Patient Experience Team and assurance through the Quality Governance committee.

Actions taken to date:

- Sleep well packs have been delivered to all wards with an accompany poster for patients asking" if they are disturbed at night by noise, they can request a sleep well pack".
- Ward patient information leaflets are being developed for each ward and is in draft format. The ward patient leaflet for each bedside/patient includes who to contact if you have a concern with named staff, obtaining food outside mealtimes, carers information, FFT, sleep well packs and dignity, including having sensitive conversations and modesty gowns. The contents will be approved at the task and finish group, which meets on the 10th November and consists of matrons, facilities, the patient experience team, AHP's and is chaired by the deputy chief nurse.
- Ward boards will be implemented for patients and visitors, which includes information on falls, IPC, staffing levels, complaints, compliments, FFT and you said we did. The patient experience team have created a draft ward board and are obtaining quotes from companies to produce these boards.

**4.3.4 The National Survey Programme 2023** is as below; and will start work in November 2023 with the adult inpatient 2023. Dissent posters will be displayed in November on inpatient wards. Sampling will take place in December 2023 and January 2024, and the field work will happen between January and April 2024.

**Table 17: National Surveys planning Dec 2023 – September 2024**

| National Survey | Stage | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Adult Inpatient | Sampling | | | | | | | | | | |
| | Field Work | | | | | | | | | | |
| Maternity | Sampling | | | | | | | | | | |
| | Field Work | | | | | | | | | | |
| Urgent & Emergency | Sampling | | | | | | | | | | |
| | Field Work | | | | | | | | | | |
| Children & Young People | Sampling | | | | | | | | | | |
| | Field Work | | | | | | | | | | |

**2023 surveys**

2023 Maternity: fieldwork April – June 2023, publication November 2023 (TBC)

2023 Community mental health: fieldwork August – November 2023, publication March 2024 (TBC)

2023 Adult inpatients: fieldwork January – April 2024, publication August 2024 (TBC)

**2024 surveys**

2024 Children and young people: fieldwork July – October 2024, publication March 2025 (TBC)

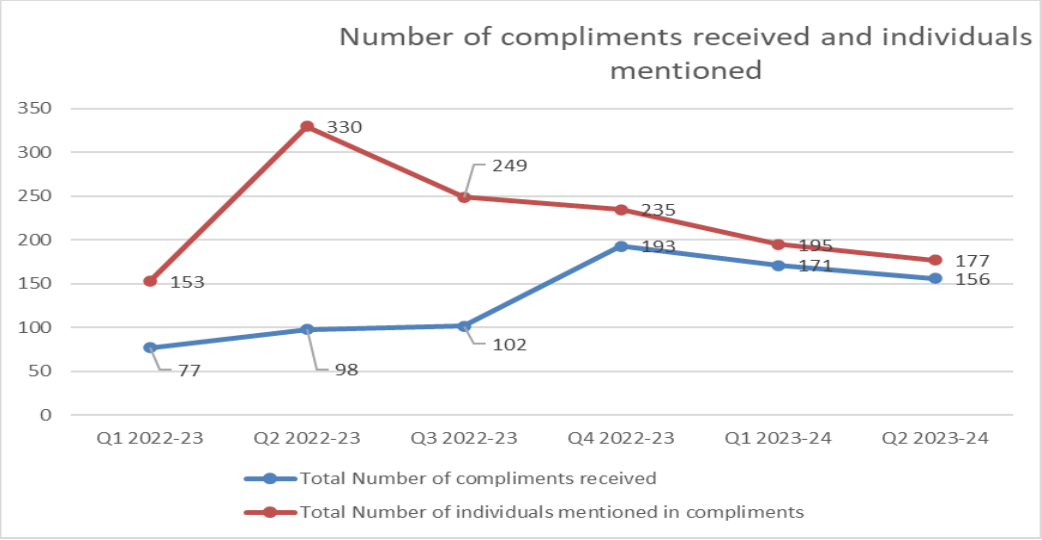
## 4.4 Compliments and Complaints

### 4.4.1 Compliments

In Q2 the Trust received 156 compliments sent to the Chief Executive and/or the PALS office (thanking 177 areas/individuals). It should also be noted that each ICSU receive a large number of compliments directly from patients and families, that are not captured in the numbers

The compliments in Q2 were received by S&C (37%), E&IM (22%), ACW (20%), ACS (11%), CYPS (4%), Estates & Facilities (4%) & Corporate (inc. PALS) (3%).

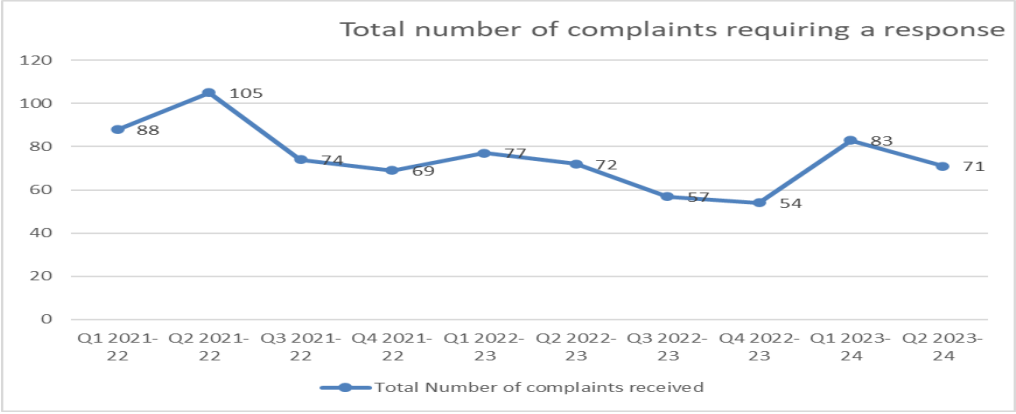
**Figure 18 Compliments 2022-23**




### 4.4.2 Complaints

During Q2 the Trust had 87 complaints, 16 of these were de-escalated leaving 71 complaints where a response was required in Q2.

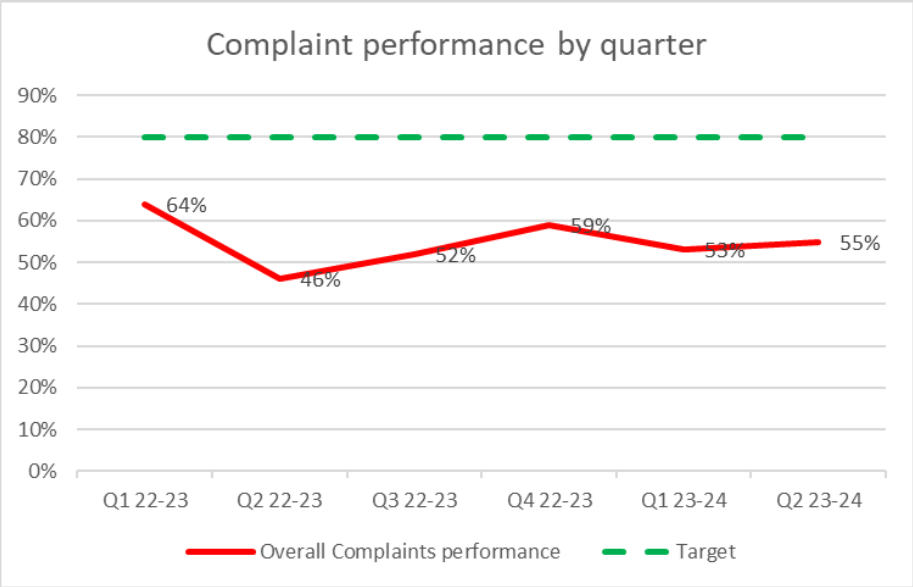
**Figure 19: Complaint Volume Comparison by quarter**



### Complaint response timescales

Performance against the 80% target for response within 25 or 40 days (depending on complexity of the complaint) has continued to be adversely affected during Q2 and the performance figure for the quarter was 55%, a small improvement on Q1 (53%) (*fig 19).* This metric result continues to give concern and is reflected in a recent internal audit which reviewed the processes to manage and respond to complaints in a timely manner. An action plan to improve this metric, led by the Patient Experience team in association with the ICSU's, has been developed and will be monitored through the Patient Experience group.

**Fig 20. Complaint response by target time**

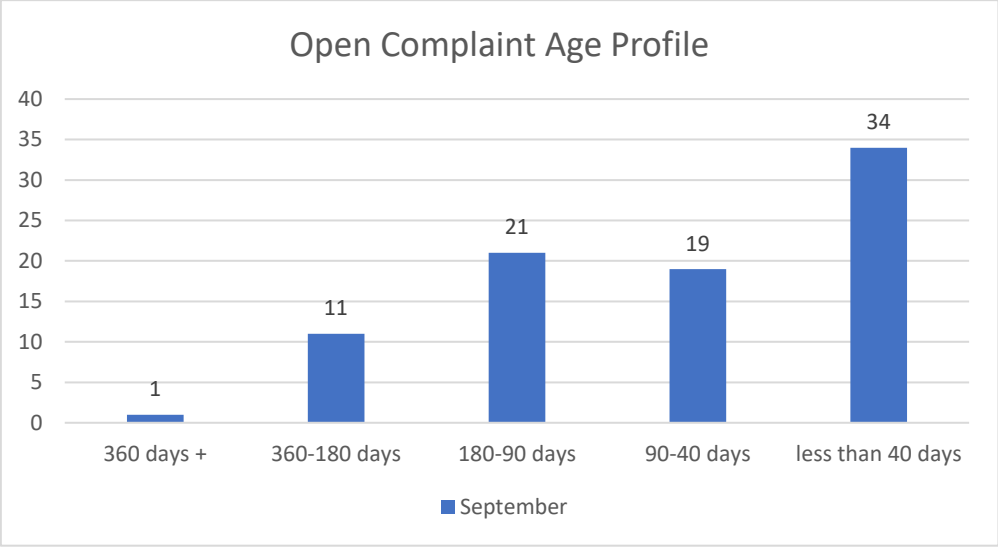



Of the complaints that closed during Q2, 28% of complaints were fully upheld, 46% were partially upheld and 26% were not upheld, meaning that 74% of complaints were upheld in one form or another. This is broadly in line with previous quarters where around 80% of complaints had been upheld in one form or another.

### Complaint backlog

*Figure 21* gives a summary of the age of the complaint investigation regarding open complaints awaiting a response.

**Fig 21. Complaint response backlog age profile as of End September 2023**




**Complaint Themes**

The three main themes identified from the complaints during Q2 were as follows:

- 23 complainants raised concerns about 'medical care' with the main theme that the treatment provided was 'inadequate'.
- 17 complainants raised concerns about 'communication', with the main themes being complainants concerned about 'clarity & confusion' & 'inadequate communication about treatment'.
- 13 complainants raised issues about 'attitude', with the main theme being about 'inconsiderate/uncaring/dismissive'.

Work will take place to address complaint themes and the complaints process in a QI project during Q3 & Q4.

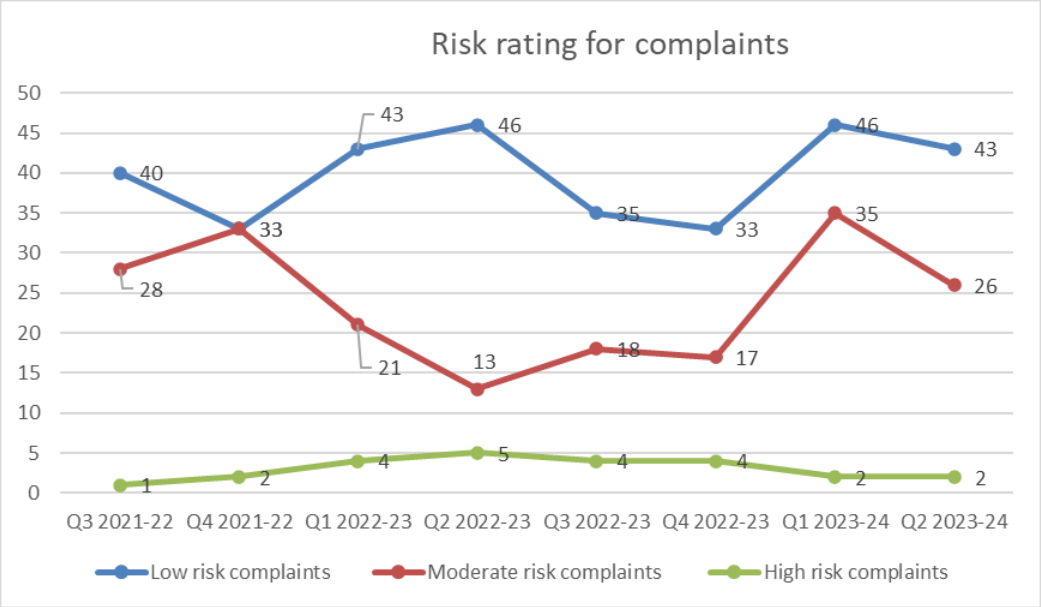
**Acknowledgement performance**

Of the complaints received during Q2, 98% were acknowledged within the required 3 working days, exceeding the Trust target of 90%

**Risk-rating**

Figure 21 shows the risk rating split for complaints in Q2, (as measured by the NHS Risk Management Matrix), the majority of which are considered low risk.

**Figure 22: Risk Rating for Complaints**




**Dissatisfied Complaints**

The number of 'dissatisfied' complaints where further comment, information or clarification was required following the complaint response, is broadly in line with previous quarters at 7%. All responses continue to undergo additional scrutiny before being sent to the complainants, although there will inevitably be a small number of complainants who will remain dissatisfied irrespective of the accuracy or thoroughness of a response.

**Learning from Complaints**

All complaints that are either upheld in any way, require actions taken to be outlined in the response to demonstrate any learning that has been identified by the investigating ICSU.

By way of example, we received a complaint from a patient who attended the Emergency Department with swelling in their left leg & thigh and was thought to have a musculoskeletal problem rather than a possible DVT, despite the patient's brother who was with them advocating on their behalf. It was only the brother's insistence that a doppler scan was undertaken, which showed an extensive DVT.

As a result of the complaint, ED initiated a comprehensive review of the protocols for diagnosing and managing venous thromboembolism (VTE) in the department as well as reiterating the importance of listening to patients and their advocates.

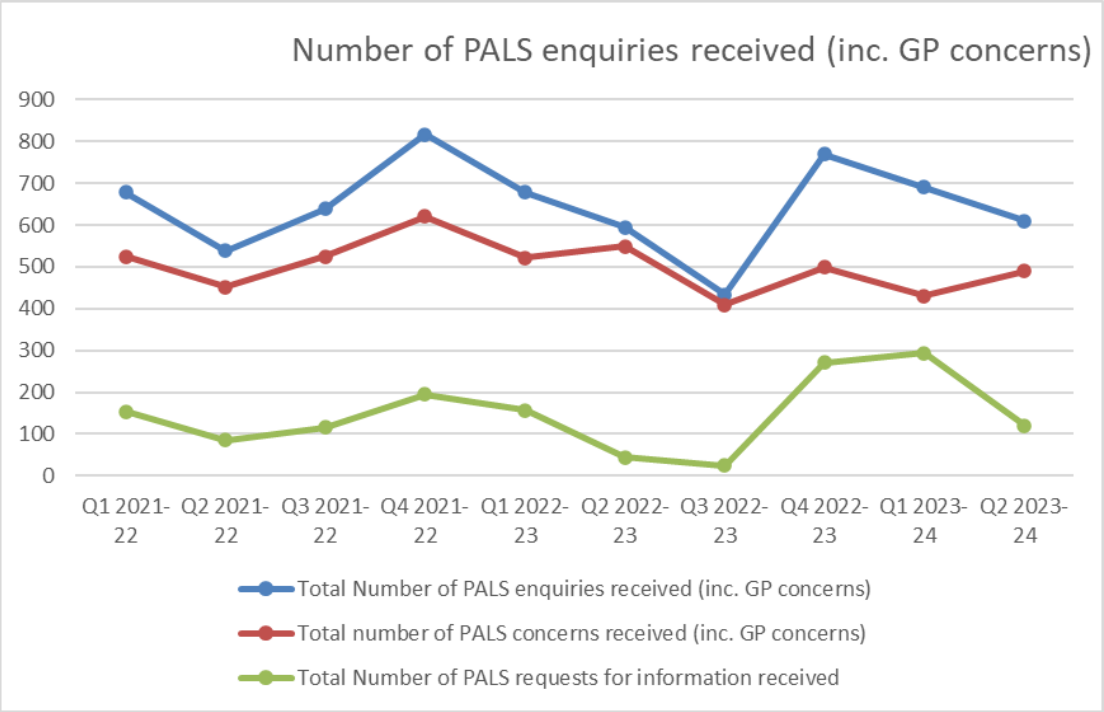
**Parliamentary & Health Service Ombudsman**

The Trust received seven requests for information during Q2 from the PHSO. Two of these have proceeded to a full investigation. We are awaiting further updates from the Ombudsman service on the other five cases as to whether these cases will proceed to a full Ombudsman investigation.

## 4.6 Patient Advice and Liaison Service (PALS)

During Q2 the Trust received 610 PALS contacts (including 20 concerns from GP practices). Of the contacts received, 490 (80%) related to concerns and 120 (20%) related to requests for help/information.

**Fig 23: Total PALS enquiries**




The demand on the PALS service remains high, particularly around patients not being able to contact outpatient clinics directly to make appointments or obtain information. All concerns or requests for information have been shared promptly with the relevant service and responses sent. As seen in previous quarters, the most common themes raised in the PALS (and GP) were concerns related to 'communication' 'delay' and 'appointments. The PALS team will be providing sessions for outpatients' staff as a way to under their role and themes from patients. An update on how we will address the issues raised will be provided in Q3.

## 4.7 Volunteer Service

**Recruitment**

- During Q2 an additional 37 new volunteers were recruited, taking the total number of volunteers to 91. Currently volunteers are assigned to various roles: welcoming guides, collecting FFT responses, and admin within the PALS team which complements the work of staff. During the application process, volunteers

share skillsets and areas in which they would like to develop. This information is used to match them with suitable roles. Volunteers are encouraged to commit to a minimum of 6 months.
- Demographic data related to volunteering has commenced and will be presented from Q3 onwards.

**Team Updates**

During Q2 the volunteering team:

- Attended 2 community engagement and networking events with Voluntary Action Islington and Volunteer Centre Camden & Islington. The aim is to promote and encourage volunteering and patient involvement partners within the Trust.
- Held our first group induction since 2020 of which there were 11 participants. Volunteer induction provide new and prospective volunteers with need-to-know information and mandatory training to support their undertaking their role safely. These will continue monthly in the Whittington Education Centre for face-to-face inductions. Feedback forms are provided to attendees to monitor quality of service for both the team and volunteers. The team received compliments about the induction being clear, very welcoming, and inclusive.
- Updated and introduced the privacy policy for data collection for the volunteer application process.
- During Q3, the volunteering team will be introducing the Guide to Volunteering booklet, which will promote volunteering roles, how to apply, and ways our community can get involved.

## 4.8 Patient Information and Interpreting

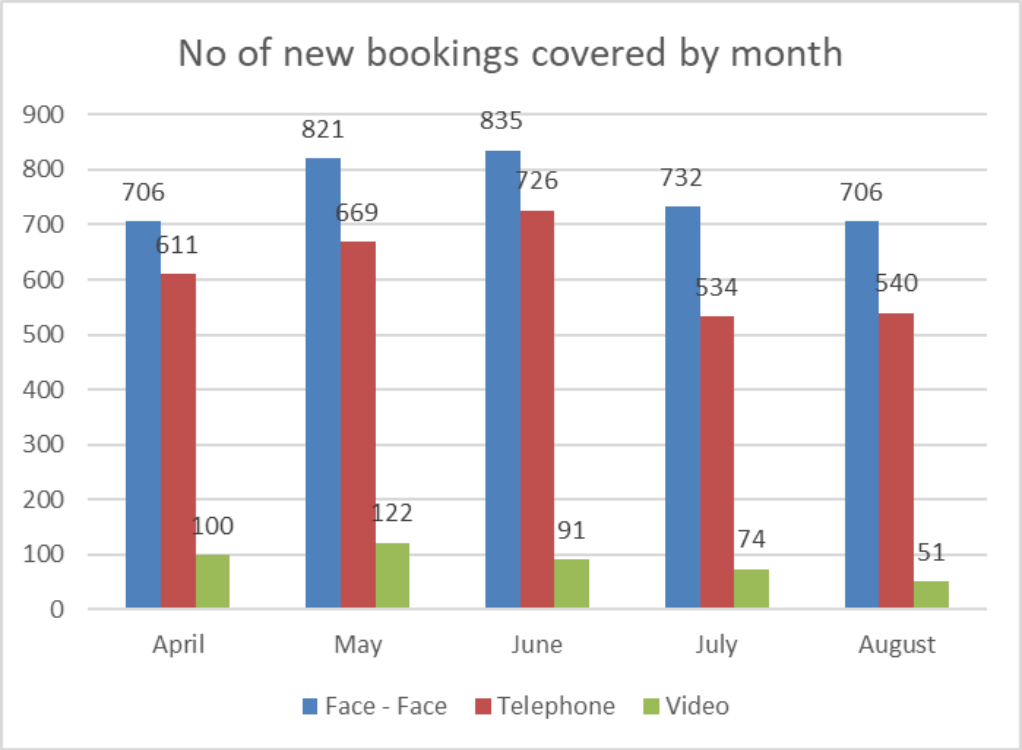
### 4.8.1 Interpreting services Overview

The number of interpreting referrals (Telephone Interpreting TI, Face to Face F2F and Video Interpreting VI) received inhouse during July and August was 4,551, a total of 2,637 were fulfilled, where we were able to provide an interpreter, either F2F, TI, VI or outsourced.

This includes (totals for July and August only):

- F2F 1,438
- TI 1,074
- VI 125

**Fig 24: Interpreter bookings by type April – August 2023**




**Triumphs**

- The tender for the interpreting service outsourcing provision across NCL trusts was awarded to DA Languages. For Whittington Health, implementation started in August and is being staggered. DA languages have provided cover for a small percentage of prebooked F2F and VI bookings. On demand TI will be rolled out in late September, with on demand VI to follow. The provision includes translations, British Sign Language and Braille.
- The new interpreting booking system for staff (via the online platform eLangServ) has been implemented Trust wide. The new booking system allows for staff across the organisation to book an interpreter directly onto an online portal, this should demonstrate a decrease in the administration tasks for the interpreting service team, allowing the team to focus on obtaining feedback and improvement projects. A management system for the interpreting team to administer referrals has been implemented. Both systems have been in operation since 31 July.
- The new system allows for clinicians to provide feedback on their encounter with the interpreter on punctuality, impartiality, communication, and the professionalism of the interpreter. At the time of writing this report, only 1 response had been received, giving 10 out of 10 to an interpreter in all aspects and praising her for being ‘amazing in a very complex and very challenging home visit’.
- 1 compliment was also received by email, for an inhouse bank interpreter. The midwife praised the interpreter for her flexibility, availability and her team working skills.
- The service undertook 2 translations of medical records across the Trust, these were 2 for Child Protection in Dari and Pashto.

**Challenges**

- VI appointments continued to decrease this quarter, with a particular challenge from clinicians within the acute setting who only want F2F. Work will take place with DA Languages and as part of a Quality Improvement programme to support more video interpreting as this provides a better service to patients with a greater availability of languages and is a better use of resources which is more cost effective for the Trust.
- Face to face requests is seeing an increase, these are difficult to fulfil due to many of the in-house bank interpreters only offering services virtually and in line with a reduction in F2F interprets across the country.
- During July and August, 12 complaints were received of which 9 (75%) related to the outsourced providers – 8 related to The Big Word (TBW) and 1 to DA Languages. The main issues were around the lack of availability of F2F interpreters, especially in hard to recruit languages or late cancellations from TBW and supports our work to move predominantly to video interpreting to ensure that patients have access to communication support.

### 4.8.2 Patient Information Leaflets

**Overview**

The Trust understands from national surveys, complaints and FFT that communication is an area of concern. Work to improve the process for patient information and leaflets commenced with the development of a Patient Information Group, which includes representation from the Trust Library, Communications, Healthwatch Haringey, Adult Learning Disabilities and the Patient Experience team. The groups remit will be to review all leaflets and develop a process to ensure that all patient information follows a clear set of guidelines, governed through an approval process. The Patient Information Standard Operating Procedure (SOP) is under review as part of the group. A progress update will be provided in the next Patient Experience Q3 report. As part of this work the group will review leaflets alongside information in accessible formats such as videos produced internally or externally.

Nine patient information leaflets were approved throughout July and August, compared to 35 in Q1.

These are broken down by service/speciality:

- 2 Maternity/Women's Health
- 1 Patient Advice and Liaison Service
- 1 Patient Advice and Liaison Service Easy Read version
- 2 Community Children's Nursing
- 2 Dental Services
- 1 Imaging

There were no requests for leaflet translation were received in Q2, compared to 19 in Q1.

### 4.9 Patient Experience Strategy 2022-25

The 2023-25 Patient Experience and Engagement Strategy focuses on identifying what the Trust will work to achieve over the next three years. It outlines the commitments to improve patient and carer experience and enhance opportunities for meaningful engagement. As an organisation we are committed to providing patients with the best possible experience of care by:

1) enabling our patients and carers to work with us

2) supporting and empowering our staff

3) working alongside our local partners

**Ambition 1**: FFT questions are accessible to as many patients and carers as possible to ensure the responses reflect the opinions of our diverse patient population.

Individual FFT survey QR codes have been trialled to provide a better opportunity for our patients to provide feedback and for staff to encourage patients from seldom heard groups to provide feedback. Dynamic QR codes, are being trialled in ED, the Chemotherapy unit, and Ambulatory Care which allows us to track how many times a QR code has been used, giving us a better understanding of response rates and how we can improve them. We will be extending dynamic QR codes to Imaging and DTC in Q3. However, a constraint with the QR codes is that they do not provide information on the demographics of those completing the survey.

The survey now includes 15 questions, which will allow understanding on experiences around cleanliness, privacy, and levels of trust towards staff and are in line with national survey questions. The Trust receives on average 700 ED feedback responses per month via SMS.

The patient experience team undertook staff engagement and the introduction of QR cards in Q2. A total of 30 QR cards were distributed amongst ED staff to collect feedback.

**What this means for our patients**: Patients are now offered the opportunity to provide feedback at the point of care. Asking patients about their whole experience allows us to understand areas for improvement and are in line with national surveys.

**Ambition 2**: To increase patient involvement and participation throughout the Trust at all levels. Patient Stories are now fully embedded into our Patient Experience Group, presented by the two reporting ICSU's for that quarter. Members of PEG share a patient story and discuss learning and successes.

**What this means for our patients**: Hearing the experience of our patients, from our patients is a good way to understand the impact of our services on patients, carers and their relatives and identifies areas for learning and celebrate successes.

**Stream 3**: Work alongside our local partners to improve patient experience. Through the Patient Information Group and collaboration with Healthwatch Haringey, ensuring our leaflets are written in plain English and in a way that meets the needs of our diverse community including easy read is a core remit for the group.

**What this means for our patients**: Healthwatch collects information and represents the views on health and social care in Haringey. They are committed to ensuring that services put local people at the heart of care. As such Healthwatch Haringey are members of the Trust's Patient Information and Leaflet Group, which looks at improving leaflets' accessibility, information for patients and provides additional advice and scrutiny from a patient perspective.

## 5. Quality Assurance

### 5.1 External Quality Reviews

There were no external reviews conducted in Q2.

### 5.2 CQC

5.2.1 CQC action plan

- 28 actions now closed, with ongoing monitoring via Tendable and ICSU Quality meetings and via walk rounds to ensure quality standards are maintained (see below for Tendable)
- 6 actions open, of which six are long-term projects related to, external transfer training, medical record completion, CYP waiting times are being monitored through the better never stops meeting and ICSU Quality meetings.
- Four actions for immediate action relate to the redecoration of the 136 suites in ED, ensuring consultant reviews take place on surgical wards, and consultant presence at board rounds, are being monitored through the better never stops meeting and ICSU Quality meetings.
- A review of the current actions is undertaken with each ICSU on a monthly basis; evidence of action completion is being collated regularly. The full CQC action plan is available in Appendix 1.
- The action relating to consultant reviews on surgical wards is a risk at present for Gynaecology. There is still a lack of consultant led reviews for Gynaecology patients on surgical wards. Reviews are currently SpR led which is not sufficient to close the action.
- CQC maternity action plan has 5 outstanding actions relating to audit of modified Early Obstetric Warning Score (MEOWS) due 31/03/24, 42 guidelines requiring updating a 'Guideline midwife position is awaiting job evaluation, , restructure of midwifery workforce plans due for implementation 31/01/24 and redesign of the bereavement room.
- All actions following MHA review have been closed.

5.2.2 CQC Readiness

- An external contractor has been brought in to assist with CQC preparedness. She will support with the peer review program and evidence gathering ahead of a potential CQC visit.
- The Better Never Stops meetings are being refreshed to focus efforts on preparing ahead of a CQC visit.
- Service deep dives will be conducted with the ICSU's, starting with areas in the Trust that are rated as 'requires improvement' before moving on to the 'good' and 'outstanding' rated areas. These will provide evidence for the ICSU's in the event of a CQC inspection and will target the areas that require the most support and focus to improve.

- An evidence base is being developed to ensure that any required evidence from previous inspections is kept centrally and is easy to locate should a CQC inspection occur.
- The CQC are developing a new regulatory model based on a single assessment framework, which they will implement later in 2023. Alongside this work the CQC are also developing a new provider portal, due to launch in 2023.

### 5.2.1 Better Never Stops Peer Reviews and Tendable implementation and usage.

- Hand hygiene and anti-microbial audits not achieving a score over 90% will need to redo their audits on a weekly basis until the recommended score is achieved. This is because these audits are achieved by observing staff conforming to the hand hygiene and anti-microbial protocols. Targeted support from the IPC and Pharmacy teams is offered to areas of low compliance.
- The other suite of audits (minus hand hygiene and anti-microbial) generates actions for improvement, these actions must be completed ahead of a re audit to increase the overall score.
- Timelines and next steps for Tendable

    1. CYP to be the pilot ICSU for Tendable relaunch – August 2023 (Completed)
    2. Acute Trust and Community to relaunch Tendable – October 2023

## 6.0 Recommendations

The Quality Assurance Committee is asked to note the three key quality messages from the Q1 Quality report:

- Ongoing challenges exist in responding to complaint responses within national timeframes with actions and number of outdated Trust policies requiring review and ratification with proposed actions in place to reduce back logs.
- Pressure ulcer incidents, relate to the new NRS contract, which continues to be monitored across NCL.
- The inpatient survey yielded disappointing results, with some areas for improvement already being actioned and others under review.

| | | |
|---|---|---|
| **Meeting title** | **Quality Assurance Committee** | **Date: 10 January 2024** |
| **Report title** | **Quality Report: Q2 2023/24** | **Agenda item: 4.15** |
| **Executive director lead** | Sarah Wilding, Chief Nurse and Director of Allied Health Professionals | |
| **Report author** | • Nicola Sands, Deputy Chief Nurse<br>• Anne O' Connor; Associate Director of Quality Governance<br>• Antoinette Webber, Head of Patient Experience | |
| **Executive summary** | This quarterly paper will provide an overview of patient experience and covers Q2 2023/24, key highlights include:<br><br>• Complaint response timescales remain below the 80% target at 55%<br>• National Inpatient 2022 survey results highlight a number of areas for improvement. A task and finish group has been created to work through an action plan which builds into a wider Trust action plan on patient experience.<br>• During Q2 an additional 22 new volunteers were recruited, taking the total number of volunteers to 53 | |
| **Purpose:** | Update Committee members | |
| **Recommendation(s** | Members are asked to note the contents of 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** | This report brings together all patient experience elements that have been report to the Quality Governance committee in one report | |

## 1. Introduction

The Patient Experience quarterly report is designed to demonstrate Whittington Health's commitment to continuous learning, improvement, and a commitment to patient experience. This report provides a systematic analysis of intelligence from patient experience, including key performance metrics, as well as themes and trends for Q2 2023-2024.

## 2. Patient Experience

### 2.1 Friends and Family Test (FFT)

Overall - The Trust remained above the national NHS 80% benchmark benchmark in "very good or good" responses, scoring 89.99%. However, we remain an outlier against the national NHS benchmark of 5% in "poor and very poor" responses, scoring an average of 6.2%, as shown below (Fig 1 & 2). The Trust is scoring a lower percentage in poor and very poor responses by 0.45% compared to Q1 (6.65%). The patient experience team meet mid-quarter to review FFT data and offer guidance and support to services.

The number of Trust responses has seen a slight decrease on Q1, from 7,368 to 7,246 in Q2, a decrease of 122. The decrease is particularly seen in the community, actions to improve this is discussed in point 2.1.5. The patient experience team are working with maternity to introduce SMS in community postnatal and will include a question related to the national maternity 2023 results, currently embargoed until February 2024. QR cards have been issued to a number of areas including imaging, ED and outpatients.

**Figure 1: FFT Overall Trust Results – Responses and Survey Completion**

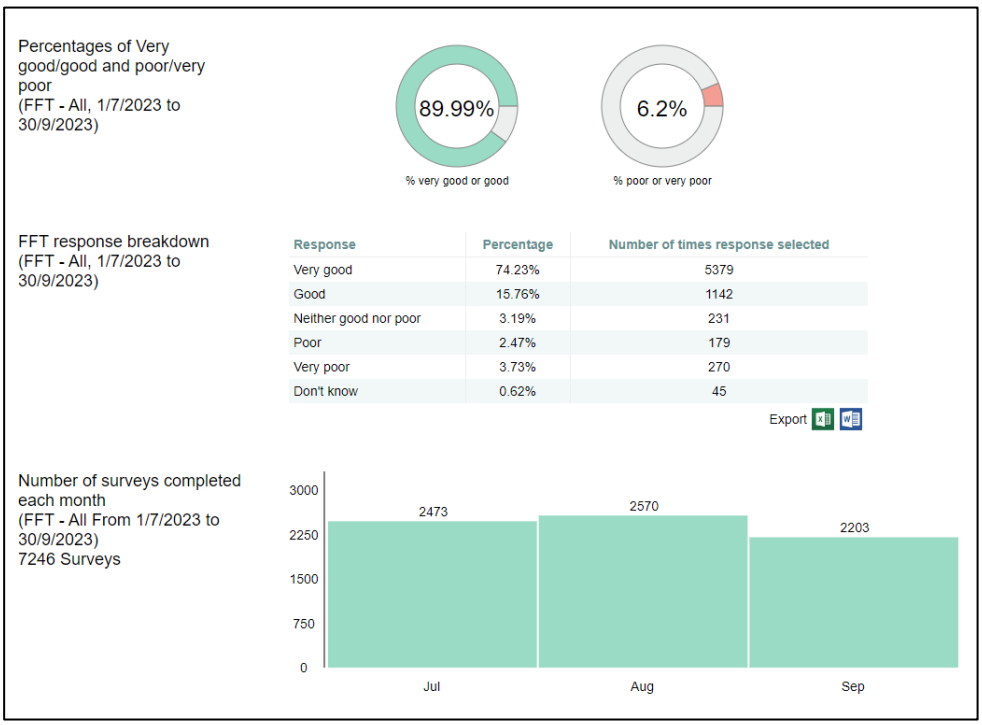
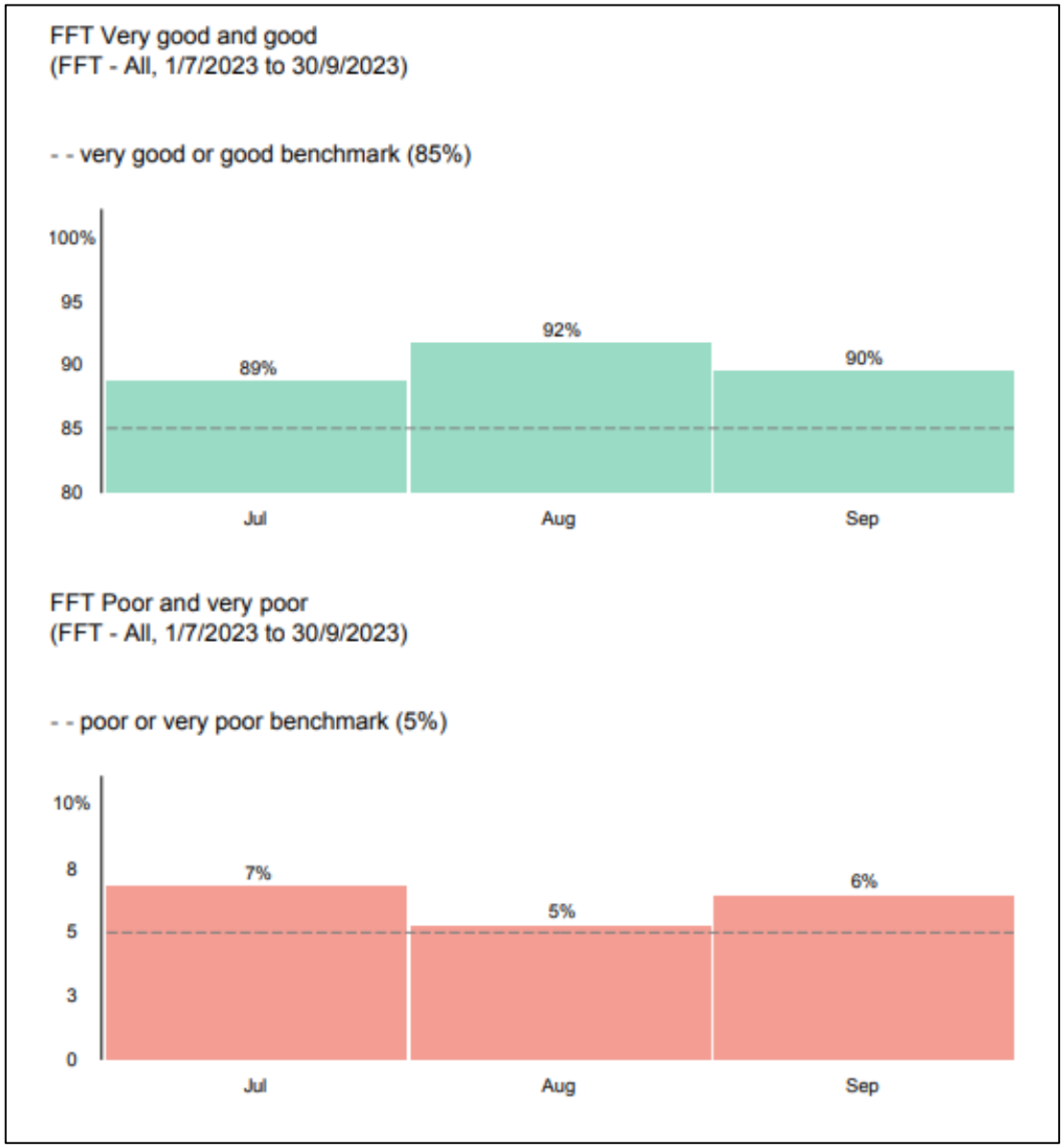


**Figure 2: FFT Overall Trust Results – Comparison against internal benchmarks**




### 2.1.2 Outpatients

Response rates for Outpatients FFT in Q2 (1,121) has seen a significant increase on Q1 (702), with 475 more responses. The increase is due to focussed support from volunteers gathering FFT feedback via iPads. The patient experience team have obtained 2 additional iPads to assist services where scores are low, and the team are continuously recruiting FFT/feedback volunteers to support the whole organisation.

"Very good and good" was above the national NHS benchmark 80% benchmark at 94.38% as with Q1 94.02% both "poor and very poor" for Q2 was 3.03% below the

national NHS benchmark 5% benchmark. There were 34 “very poor” responses recorded in Q2, compared to 25 in Q1, 5 of which mentioned staff attitudes, in line with complaints and PALs feedback. Other thematic feedback centred on long waiting times, letters arriving late to patients and information unclear on letters.

Actions:

- In relation to poor staff attitudes and other themes, the complaint facilitators share monthly PALS summaries to each ICSU ADONS, the Clinical Director, general managers and service managers related to all PALS feedback. During Q4 the service managers will be asked to ensure that the information is disseminated with the relevant wards and departments.
- Complaints facilitators share monthly complaints narrative to ICSU’s on complaint volumes, performance, themes, and a RAG rating of complaints.
- The Head of Patient Experience raised concerns related to outpatient communication with the Chief Information Officer and a patient communication working group is being created to look at delays in letters being received by patients, the content of the letters, and the impact of Zesty in particular for those who do not have English as a first language, those with a disability or those who are not comfortable with technology.

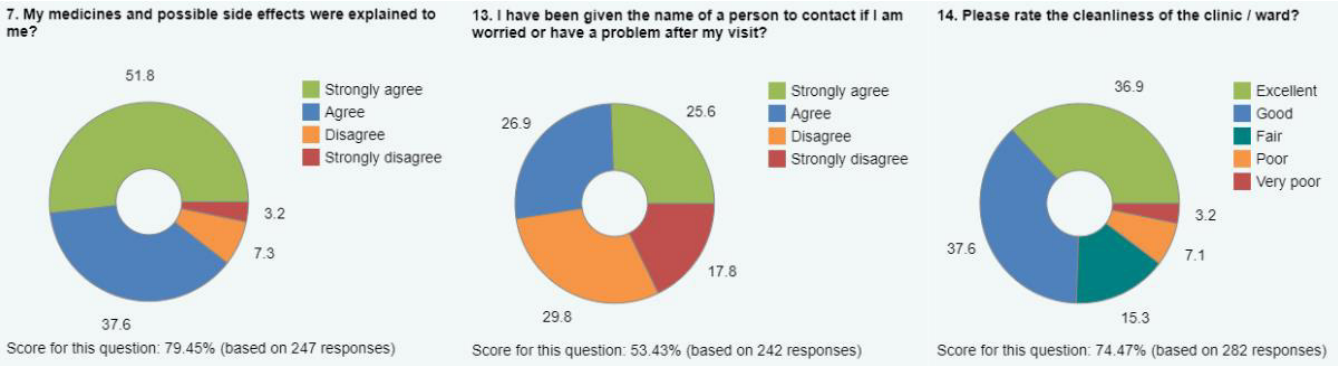
### 2.1.3 Emergency Department

Response rates for “very good and good” within the Emergency Department have remained the same on the previous quarter at 80.44% (Q1 80.1%). ED is still experiencing a high percentage of “poor and very poor” responses at 13.86%, almost 10% above the national NHS benchmark of 5%; a decrease of 1% from Q1 (14.71%). A significant proportion of comments accompanied by the low scores were about prolonged waiting times, staff attitudes, and cleanliness, as with our National Urgent & Emergency Care 2022 survey.

Actions:

- Work is taking place with the support of an action plan for the National UEC survey which addresses areas of concerns as detailed in section 2.2.1.
- The ED FFT SMS survey was updated on September 12th, and now comprises of an additional 14 questions, including kindness and compassion, involved in care, privacy and dignity, medicines, confidence in doctors and nurses and feeling included in the conversations. The additional questions will allow for a better understanding of our patients’ experience and areas of concern. The questions which scored below 80% on the survey in September can be seen in (Fig.3).

**Fig 3: Emergency Department Questions**




### 2.1.4 Inpatient

Inpatient results saw a decrease of 65 in Q2 (1,386) from Q1 (1,451) and a slight decrease in positive response rates from 94.35% Q1 to 92.64% Q2. Negative feedback was below the national NHS benchmark of 5% at 2.62% Q2. Qualitative feedback related to cancelled or delayed procedures, and long waiting times in line with complaint and PALs related concerns.

### 2.1.5 Community

At the time of initially writing this report the community response rates had seen a decrease of 503 from Q1 (2,819) to Q2 (2,316). However, reviewing the data in December shows the results have changed significantly (Q1 3,530) and (Q2 2,428) an increase of 122 on Q2 and 711 on Q1. The difference is due to the late submission of FFT paper forms which are to be uploaded to the IQVIA portal. The patient experience team will work with the communications team to promote a Trust wide awareness of the importance of timely submissions of paper FFT forms.

The patient experience team met with the ADON for ACW and discussed options to improve FFT feedback response rates within community settings. iPads are the preferred option to collect data followed by QR cards, these will be discussed with the community teams as they already have access to iPads when working in the community. SMS is not considered a popular option, however, will be explored.

**Haringey Talking therapies:** The percentages of "very poor" and "poor" responses for talking therapies is 15% in Q2 (out of 180 responses), 10% above the national NHS benchmark.

<u>Actions</u>

- During Q3 and Q4, the patient experience team will work with Haringey Talking Therapies to develop an action plan and monitor progress against poor responses and feedback related to patients not being treated with empathy.

- Patient Experience team to support a Trust wide awareness of FFT submission dates for paper forms and the importance of having these uploaded by the last day of the month.

### 2.1.6 Maternity

For Q2 positive results were 97.57% for very good or good. Maternity monthly responses have increased over 100% in Q2 (322) compared to Q1 (116). Previous issues related to maternity responses which showed a significant number being incorrectly reported as “don’t know”. The patient experience team worked with Maternity and IQVIA to investigate the issue. This was resolved in July, through the development of a new maternity survey. The patient experience team are supporting maternity services in the development of FFT SMS for community postnatal. The SMS will include a question “were you provided with enough information about feeding your baby?” following the national maternity 2023 survey results, (embargoed) until February 2024.

### 2.1.7 Patient Stories:

As part of our commitment to reduce health inequalities, the patient experience team continues to actively recruit stories from a variety of groups including those with learning disabilities, mental health conditions, and carers.

On 21st July 2023, Trust Board heard the story of a patient who has been using Whittington Health services since 2014. Currently under the care of Endocrinology and Ophthalmology, the patient’s sister, walked us through his journey when engaging with our services and highlighted the importance of equal access to healthcare for patients with Autism and Learning Disabilities.

On 29th September 2023, the patient story was presented to the Annual General Meeting (AGM). The patient has been under the care of Cardiology and Urology since 2012 and has had various urological procedures at the hospital, including endoscopic litholapaxy and bladder neck incision. The patient expressed gratitude for the high level of care he continuously received and feels that the staff went above and beyond in looking after him.

## 2.2 National Patient Surveys

NHS England produces and uses a range of different surveys as a source of feedback directly from patients, service users and NHS staff about the care that they receive or provide.

Information from national surveys is one way to understand what service users think about their recent care and treatment. Survey results can be used to check progress and to hold us to account for the outcomes we achieve. The results are used by the

CQC when planning to evaluate services and inspections and are used to benchmark organisations who provide similar services.

### 2.2.1 National Urgent & Emergency Care 2022

This survey is undertaken every two years and looks at the experiences of people who attended Type 1 or Type 3 urgent & emergency care (UEC) services during September 2022. The 2022 survey involved 122 trusts with a Type 1 accident and emergency (A&E) department and the results were published nationally in July 2023.

UEC had 29 questions in which they scored "about the same" with other trusts, 3 better than expected," 4, "somewhat better than expected" and 1 "worse than expected," with none being "much worse than expected".

Successes

Whittington Health's Urgent & Emergency Care Survey results 2022 were top of the league table for the region nationally in two questions in the categories waiting and doctors and nurses. UEC were also in the top five for care and treatment, tests and respect and dignity.

Bottom five scores

Q42. Before you left the hospital, did a member of staff discuss your transport arrangements for leaving A&E?

Q43. Did hospital staff discuss with you whether you may need further health or social care services after leaving?

Q31. In your opinion, how clean was the A&E department?

Q18. Did doctors or nurses talk to each other about you as if you weren't there?

Q44. After leaving A&E, was the care and support you expected available when you needed it?

Actions:

- A task and finish group including EIM leads and the patient experience team, have reviewed the bottom 5 areas for improvement, and actions against each question created. An action plan is in place which is worked through monthly. Governance is through EIM Quality Board and the Patient Experience Group.
- Head of Patient Experience to join cleaning audits with facilities.
- Patient Experience and Facilities working group to review feedback from national surveys and FFT to include food, cleanliness, and signage.

### 2.2.2 National Cancer Patient Experience survey 2022

The National Cancer Patient Experience survey (CPES) takes place annually and is conducted by NHS England, involving 133 NHS Trusts. The sample for the survey included all adults (aged 16 and over) NHS patients, with a confirmed primary diagnosis of cancer, discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April, May and June 2022. The fieldwork for the survey was undertaken between November 2022 and February 2023 with results being published in July 2023.

**Questions Above Expected Range**

| | Case Mix Adjusted Scores | | | National Score |
|---|---|---|---|---|
| | 2022 Score | Lower Expected Range | Upper Expected Range | |
| Q7. Patient felt the length of time waiting for diagnostic test results was about right | **89%** | 69% | 88% | **78%** |
| Q8. Diagnostic test results were explained in a way the patient could completely understand | **90%** | 69% | 88% | **78%** |

**Questions Below Expected Range**

| | Case Mix Adjusted Scores | | | National Score |
|---|---|---|---|---|
| | 2022 Score | Lower Expected Range | Upper Expected Range | |
| Q9. Enough privacy was always given to the patient when receiving diagnostic test results | **88%** | 89% | 100% | **95%** |
| Q19. Patient found advice from main contact person was very or quite helpful | **90%** | 91% | 100% | **95%** |
| Q33. Patient was always involved in decisions about their care and treatment whilst in hospital | **52%** | 53% | 86% | **70%** |
| Q37. Patient was always treated with respect and dignity while in hospital | **73%** | 76% | 100% | **88%** |
| Q46. Patient was given information that they could access about support in dealing with immediate side effects from treatment | **78%** | 78% | 94% | **86%** |

Actions taken following the survey and in response to FFT.

1. A volunteer has started conducting FFT with cancer patients weekly on the chemotherapy unit, providing an increase in FFTs, more rich data to analyse and listen to what our patients are saying.
2. Oncology and breast cancer now to carry out joint patient and staff surveys.
3. Clinic 4a quiet room available. Engaging with an interior design company to carry out improvement works to any patient comfort areas with the aim of creating a more therapeutic space that is dignified and comfortable.
4. Secret shopping CNS telephone and feeding back to CNS group at our staff meetings.
5. Recurrent funding of Acute Oncology Lead Nurse approved this role is essential to provide the link and coordination from our patients on the ward or in ED to the tumour specific team.
6. UGI pathway development for patients with a suspected UGI malignancy. The CNS is already developing this with acute medicine.
7. Discussions re cancer at 'back to the floor', to really emphasise across the wards needs of cancer patients and how to meet them.
8. Oncology clinical contact list has been circulated with ward teams, ED, and clinics to help our colleagues across the trust contact the team.

9. Complimentary therapies approved by WH Charity; we are developing a patient feedback form to monitor the quality of this.
10. CNS posters in wards, clinics, and ED with contact details

### 2.2.3 National Adult Inpatient Survey 2022

The Adult National Inpatient survey is held every year, the patient cohort for the 2022 were patients who had spent one night or more in hospital during November 2022 and fieldwork in January – April 2023. The findings were published nationally on 12 September 2023.

It is worth noting that this survey took place while there were significant challenges with nursing vacancies on the wards and large numbers of escalation beds that were opened and not substantively funded. A recruitment drive has resulted in filling most of these positions.

Highlights

- Medication on discharge
- Views sought on the quality of care.
- Self-administration of medication
- Information relating to condition.
- Communication from doctors

Areas for improvement

- Accessing food outside of mealtimes
- Noise at night (being disturbed by other patients)
- Communication post procedure
- Cleanliness
- Inclusion in conversations with nursing staff

The patient experience team will support the action plan in Q3 and Q4 to address areas for improvement, including the introduction of sleep well packs to address noise at night. Monitoring of the associated action plan will be within the task and finish group, which consists of matrons, facilities, the patient experience team, AHP's and is chaired by the Deputy Chief Nurse and meets fortnightly. The Patient Experience Group (PEG) will have oversight of the action plan and assurance through the Quality Governance Committee (QGC). The groups remit will form part of the Trust's response to improving patient experience.

Actions:

- Sleep well packs have been delivered to all wards with an accompanying poster for patients notifying them that if they are disturbed at night by noise, they can request a "sleep well pack" promoted for staff through the communications team.
- The patient experience team made a successful charities bid to purchase additional sleep well packs to ensure that there is a constant supply available to our patients. The sleep well packs include a postcard of tips to aide a restful night's sleep.
- Ward patient information leaflets are being developed for each ward. The inpatient ward leaflet will be available at every patient bedside and includes who to contact if they have a concern, how to obtain food outside mealtimes, carers information, sleep well packs, bedside handovers, and staff uniforms.
- Welcome to the ward boards will be implemented for patients and visitors, which includes information on falls, IPC, staffing levels, complaints, compliments, FFTs, national surveys and you said we did. The welcome to the ward boards comprises of 3 boards, and include meet the team, get involved and a staff quality board for the staff areas. The patient experience team have created a draft ward board and are obtaining quotes from companies to produce these boards.
- Following a Back to the Floor session in October to discuss the 2022 results and action plan and raise awareness of the patient cohort for the 2023 survey resulted in the patient experience team creating a dedicated survey page. The page has been created specifically to raise staff awareness and knowledge around the national surveys programme and can be found here

### 2.2.4 The National Adult Inpatient Survey 2023

The national adult inpatient survey programme started in November 2023 for the patient cohort for the 2023 survey. Dissent posters were displayed in November on inpatient wards. Sampling will take place in December 2023 and January 2024, and the field work will happen between January and April 2024.

**2023 surveys**

- 2023 Adult Inpatients: fieldwork January – April 2024, publication August 2024 (TBC)
- 2023 Maternity: fieldwork April – June 2023, publication November 2023 (TBC)
- 2023 Community mental health: fieldwork August – November 2023, publication March 2024 (TBC)

**2024 surveys**

- 2024 Children and young people: fieldwork July – October 2024, publication March 2025 (TBC)
- Urgent & Emergency Care

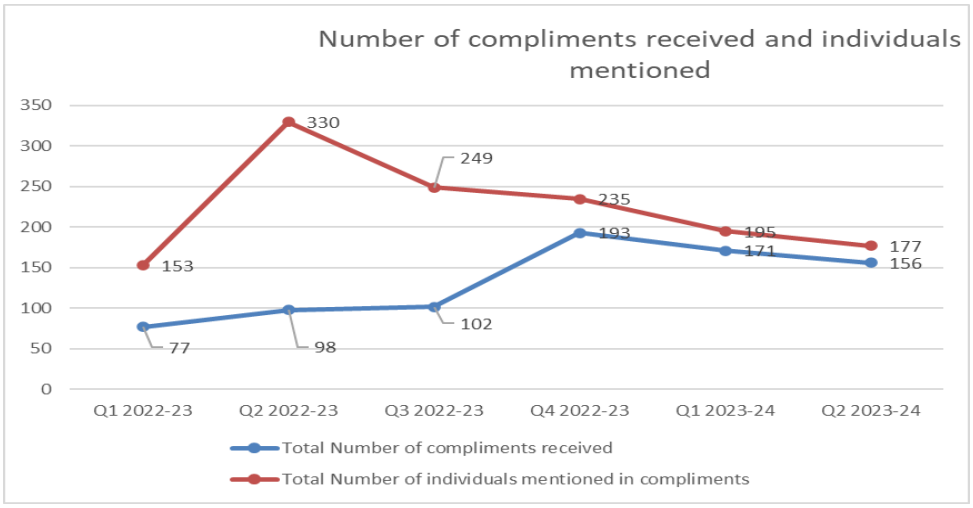
## 2.3 Compliments and Complaints

### 2.3.1 Compliments

In Q2 the Trust received 156 compliments sent to the Chief Executive and/or the PALS office (thanking 177 areas/individuals). It should also be noted that each ICSU receive a large number of compliments directly from patients and families, that are not captured in the numbers.

The compliments in Q2 were received by S&C (37%), E&IM (22%), ACW (20%), ACS (11%), CYPS (4%), Estates & Facilities (4%) & Corporate (inc. PALS) (3%).

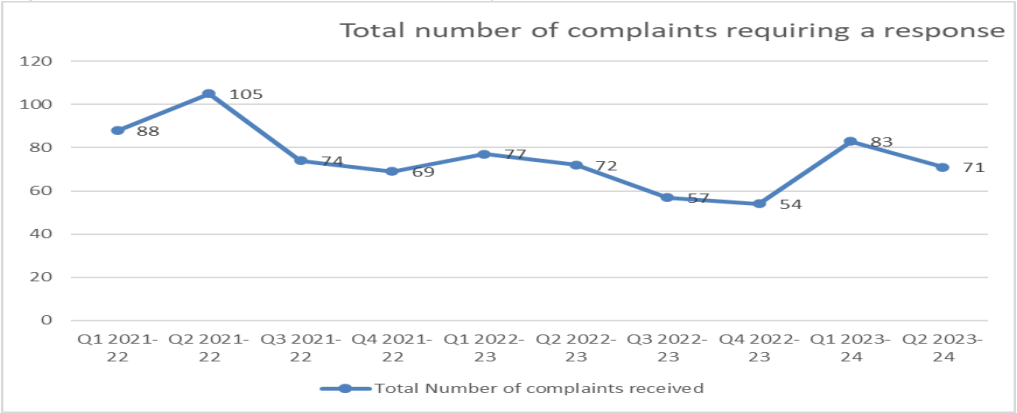
**Figure 4 Compliments 2022-23**




### 2.3.2 Complaints

During Q2 the Trust had 87 complaints, 16 of these were de-escalated leaving 71 complaints where a response was required in Q2 (fig 5).

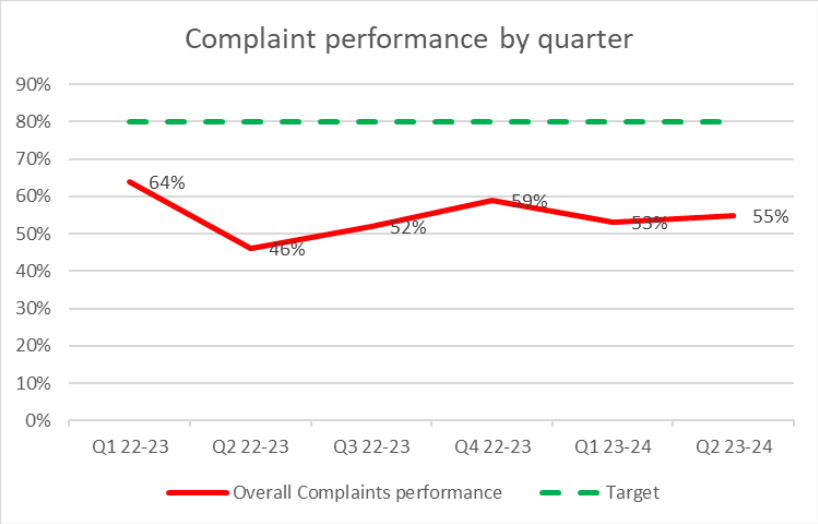
**Figure 5: Complaint Volume Comparison by quarter**



## Complaint response timescales

Performance against the 80% target for response within 25 or 40 days (depending on complexity of the complaint) has continued to be adversely affected during Q2 and the performance figure for the quarter was 55%, a small improvement on Q1 (53%) (*fig 6).* This metric result continues to give concern and is reflected in a recent external audit which reviewed the processes to manage and respond to complaints in a timely manner. An action plan to improve this metric, led by the Patient Experience team in association with the ICSU's, has been developed and will be monitored through the Patient Experience Group.

**Fig 6. Complaint response by target time**

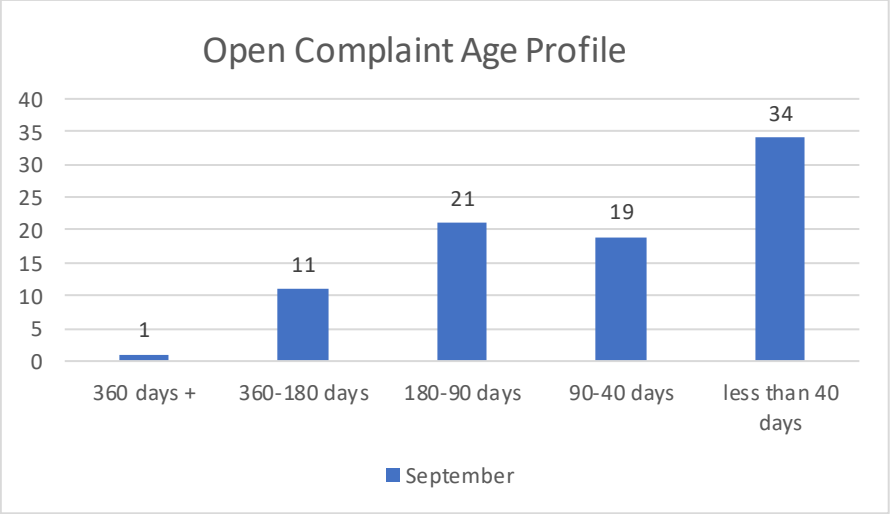



Of the complaints that closed during Q2, 28% of complaints were fully upheld, 46% were partially upheld and 26% were not upheld, meaning that 74% of complaints were upheld in one form or another. This is broadly in line with previous quarters where around 80% of complaints had been upheld in one form or another.

## Complaint backlog

*Figure 7* gives a summary of the age of the complaint investigation regarding open complaints awaiting a response.

**Fig 7. Complaint response backlog age profile as of End September 2023**




## Complaint Themes

The three main themes identified from the complaints during Q2 were as follows:

- 23 complainants raised concerns about 'medical care' with the main theme that the treatment provided was 'inadequate'.
- 17 complainants raised concerns about 'communication', with the main themes being complainants concerned about 'clarity & confusion' & 'inadequate communication about treatment'.
- 13 complainants raised issues about 'attitude', with the main theme being about 'inconsiderate/uncaring/dismissive'.

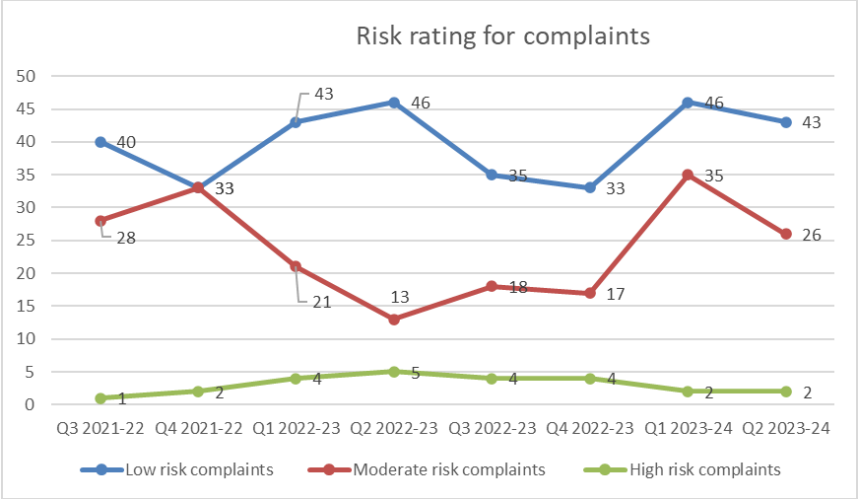
## Acknowledgement performance

Of the complaints received during Q2, 98% were acknowledged within the required 3 working days, exceeding the Trust target of 90%

## Risk-rating

Figure 8 shows the risk rating split for complaints in Q2, (as measured by the NHS Risk Management Matrix), the majority of which are considered low risk.

**Figure 8: Risk Rating for Complaints**




## Dissatisfied Complaints

The number of 'dissatisfied' complaints where further comment, information or clarification was required following the complaint response, is broadly in line with previous quarters at 7%. All responses continue to undergo additional scrutiny before being sent to the complainants, although there will inevitably be a small number of complainants who will remain dissatisfied irrespective of the accuracy or thoroughness of a response.

## Learning from Complaints

All complaints that are upheld in any way, require actions taken to be outlined in the response to demonstrate any learning that has been identified by the investigating ICSU.

By way of example, we received a complaint from a patient who attended the Emergency Department with swelling in their left leg & thigh and was thought to have a musculoskeletal problem rather than a possible DVT, despite the patient's brother who was with them advocating on their behalf. It was only the brother's insistence that a doppler scan was undertaken, which showed an extensive DVT.
As a result of the complaint, ED initiated a comprehensive review of the protocols for diagnosing and managing venous thromboembolism (VTE) in the department as well as reiterating the importance of listening to patients and their advocates.

Actions:

- As part of the external complaints audit and associated action tracker, a template has been created for the complaints process, starting with the PALS through to completion, with any outstanding actions recorded. The complaints

facilitators discuss outstanding actions with the ICSU leads to ensure that these are completed, updated onto Datix and incorporated for learning.

- Complaints Policy – reviewed and includes the management of allegations against staff policy and an amendment to the previous process to ensure all complainants receive a call regarding their complaint from the investigators. The call provides an opportunity to clarify the complainants concerns and try to deescalate with an aim to resolve the complaint informally.
- Weekly ICSU meetings include an agenda of outstanding complaints, investigators provide an update on responses. The complaints team are working with the ICSU's to support complaints responses being completed in a timely manner. The meetings are also an opportunity to review complaints and discuss any queries/questions.

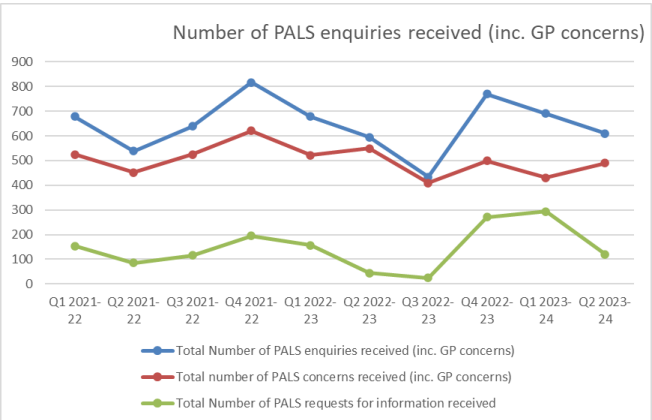
**Parliamentary & Health Service Ombudsman**

The Trust received seven requests for information during Q2 from the PHSO. Two of these have proceeded to a full investigation. We are awaiting further updates from the Ombudsman service on the other five cases as to whether these cases will proceed to a full Ombudsman investigation.

## 2.4 Patient Advice and Liaison Service (PALS)

During Q2 the Trust received 610 recorded PALS contacts (including 20 concerns from GP practices). Of the contacts received, 490 (80%) related to concerns and 120 (20%) related to requests for help/information.

**Fig 9: Total PALS enquiries**




The demand on the PALS service remains high, particularly around patients not being able to contact outpatient clinics directly to make appointments or obtain information. All concerns or requests for information have been shared promptly with

the relevant service and responses sent. As seen in previous quarters, the most common themes raised in the PALS (and GP) were concerns related to 'communication' 'delay' and 'appointments.

Actions:

The PALS team will be providing sessions for outpatients' staff as a way to understand their role and themes from patients PALS concerns.

**2.5 Voluntary Service**

Recruitment

- During Q2 an additional 22 new volunteers were recruited, taking the total number of volunteers to 53. Currently volunteers are assigned to various roles: welcoming guides, collecting FFT responses, and admin, one within the PALS team which complements the work of staff. During the application process, volunteers share skillsets and areas in which they would like to develop. This information is used to match them with suitable roles; however, the focus is on our patients need and supporting patient experience. Volunteers are encouraged to commit to a minimum of 1 year.
- Demographic data related to volunteering has commenced and will be presented from Q4 onwards.
- A volunteer database has been created to manage volunteer activity and personnel records for governance purposes. The database tracks onboarding information, governance, volunteer location and roles and allows for precise data on the number of volunteers active.

During Q2 the volunteering team:

- Attended 2 community engagement and networking events with Voluntary Action Islington and Volunteer Centre Camden & Islington. The aim is to promote and encourage volunteering and patient involvement partners within the Trust.
- Held their first group induction since 2020 of which there were 11 participants. Volunteer induction provide new and prospective volunteers with need-to-know information and mandatory training to support their undertaking their role safely. These will continue monthly in the Whittington Education Centre for face-to-face sessions. Feedback forms are provided to attendees to monitor quality. The team received compliments about the induction being clear, very welcoming, and inclusive.
- Updated and introduced the privacy policy for data collection for the volunteer application process.

## 2.6 Patient Information and Interpreting

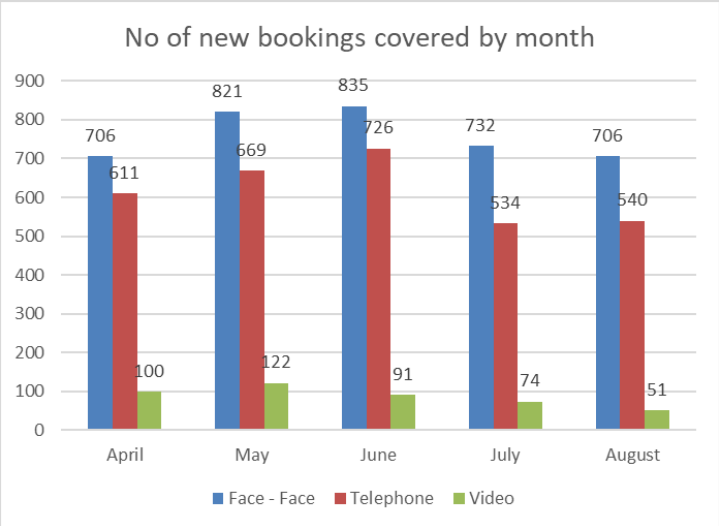
### 2.6.1 Interpreting services Overview

The number of interpreting referrals (Telephone Interpreting TI, Face to Face F2F and Video Interpreting VI) received inhouse during July and August was 4,551, a total of 2,637 were fulfilled, where we were able to provide an interpreter, either F2F, TI, VI or outsourced.

This includes (totals for July and August only):

- F2F 1,438
- TI 1,074
- VI 125

**Fig 9: Interpreter bookings by type April – August 2023**




### Triumphs

- The tender for the interpreting service outsourcing provision across NCL trusts was awarded to DA Languages. For Whittington Health, implementation started in August. DA languages who are our secondary provider have covered a small percentage of prebooked face to face (F2F) and Video Interpreting (VI) bookings. On demand Telephone Interpreting (TI) was rolled out in late September, with on demand VI to follow. The provision includes translations, British Sign Language and Braille.
- The new interpreting booking system for staff (via the online platform eLangServ) has been implemented Trust wide. The new booking system allows for staff across the organisation to book an interpreter directly onto an online portal, this should demonstrate a decrease in the administration tasks for the interpreting service team, allowing the team to focus on allocating requests, obtaining feedback and improvement projects. A management system for the interpreting team to administer

referrals has been implemented. Both systems have been in operation since 31 July.

- The new system allows for clinicians to provide feedback on their encounter with the interpreter on punctuality, impartiality, communication, and the professionalism of the interpreter. At the time of writing this report, only 1 response had been received, giving 10 out of 10 to an interpreter in all aspects and praising her for being 'amazing in a very complex and challenging home visit'.
- 1 compliment was also received by email, for an inhouse bank interpreter. The midwife praised the interpreter for her flexibility, availability and her team working skills.
- The service undertook 2 translations of medical records across the Trust, these were 2 for Child Protection in Dari and Pashto.

**Challenges**

- VI appointments continued to decrease this quarter, with a particular challenge from clinicians within the acute setting who only want F2F. Work will take place with DA Languages to support more video interpreting as this provides a better service to patients with a greater availability of languages and is a better use of resources and more cost effective for the Trust.
- Face to face requests is seeing an increase, these are difficult to fulfil due to many of the in-house bank interpreters only offering services virtually and in line with a reduction in F2F interpreters across the country.
- During July and August, 12 complaints were received of which 9 (75%) related to the outsourced providers – 8 related to The Big Word (TBW) and 1 to DA Languages. The main issues were around the lack of availability of F2F interpreters, especially in hard to recruit languages or late cancellations from TBW and supports our work to move predominantly to video interpreting to ensure that patients have access to language support.

### 2.6.2 Patient Information Leaflets

**Overview**

The Trust understands from national surveys, complaints and FFT that communication is an area of concern. Work to improve the process for patient information and leaflets commenced with the development of a Patient Information Group, which includes representation from the Trust Library, QI, Communications, Healthwatch Haringey, Adult Learning Disabilities and the Patient Experience team. The groups remit will be to review all leaflets and develop a process to ensure that all patient information follows a clear set of guidelines, governed through an approval process. As part of this work the group will review leaflets alongside information in accessible formats such as videos produced internally or externally.

Nine patient information leaflets were approved throughout July and August, compared to 35 in Q1. Patient information leaflets are requested directly by the service, this includes the implementation of new or revised leaflets.

These are broken down by service/speciality:

- 2 Maternity/Women's Health
- 1 Patient Advice and Liaison Service
- 1 Patient Advice and Liaison Service Easy Read version
- 2 Community Children's Nursing
- 2 Dental Services
- 1 Imaging

### 2.7 Patient Experience Strategy 2022-25

The 2023-25 Patient Experience and Engagement Strategy focuses on identifying what the Trust will work to achieve over the next three years. It outlines the commitments to improve patient and carer experience and enhance opportunities for meaningful engagement. As an organisation we are committed to providing patients with the best possible experience of care by:

1) enabling our patients and carers to work with us

2) supporting and empowering our staff

3) working alongside our local partners

**Ambition 1**: FFT questions are accessible to as many patients and carers as possible to ensure the responses reflect the opinions of our diverse patient population.

- Individual FFT survey QR cards have been trialled to provide a better opportunity for our patients to provide feedback and for staff to encourage patients from seldom heard groups to provide feedback. The cards are worn with lanyards and acts as a reminder to staff to offer patients the opportunity to provide feedback by scanning the QR code on the card.
- Dynamic QR codes, are being trialled in ED, the Chemotherapy unit, and Ambulatory Care which allows us to track how many times a QR code has been used, giving us a better understanding of response rates and how we can improve them. We will be extending dynamic QR codes to Imaging and DTC in Q3. However, a constraint with the QR codes is that they do not provide information on the demographics of those completing the survey.
- The ED survey now includes 15 questions in total, which will allow understanding on experiences around cleanliness, privacy, and levels of trust towards staff and are in line with national survey questions. The Trust receives on average 700 ED feedback responses per month via SMS.

- The patient experience team undertook a staff engagement and the introduction of QR cards in Q2 to ED. A total of 30 QR cards were distributed amongst ED staff to collect feedback.
- An easy read FFT survey has been created and is currently under review with the LD lead nurse and community SLT teams.
- The patient experience team are aware of measures by the ICSU's which have a positive impact and that we are working on a process to capture all these actions.

**What this means for our patients**: Patients are now offered the opportunity to provide feedback at the point of care. Asking patients about their whole experience allows us to understand areas for improvement and are in line with national surveys. Work continues to produce a child friendly FFT.

**Ambition 2**: To increase patient involvement and participation throughout the Trust at all levels.

- Patient Stories are now fully embedded into our Patient Experience Group, presented by the two reporting ICSU's for that quarter. Members of PEG share a patient story and discuss learning and successes.

**What this means for our patients**: Hearing the experience of our patients, from our patients is a good way to understand the impact of our services on patients, carers and their relatives and identifies areas for learning and celebrate successes.

**Stream 3**: Work alongside our local partners to improve patient experience.

- Through the Patient Information Group and collaboration with Healthwatch Haringey, ensuring our leaflets are written in plain English and in a way that meets the needs of our diverse community including easy read is a core remit for the group.

**What this means for our patients**: Healthwatch collects information and represents the views on health and social care in Haringey. They are committed to ensuring that services put local people at the heart of care. As such Healthwatch Haringey are members of the Trust's Patient Information and Leaflet Group, which looks at improving leaflets' accessibility, information for patients and provides additional advice and scrutiny from a patient perspective.

| | PATIENT EXPERIENCE DASHBOARD | | Target | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FFT | Overall Positive experience | Emergency and Integrated Medicine (EIM) | >85% | 85% | 83% | 79% | 82% | 78% | 86% | 82% | 80% | 87% | 82% | 83% | 81% | 86% | 84% |
| | | Children and Young People (CYP) | >85% | 95% | 97% | 94% | 95% | 99% | 97% | 96% | 96% | 99% | 97% | 99% | 95% | 100% | 98% |
| | | Surgery and Cancer (S&C) | >85% | 98% | 97% | 97% | 98% | 97% | 96% | 95% | 96% | 97% | 97% | 97% | 97% | 98% | 93% |
| | | Adult Community Services (ACS) | >85% | 94% | 81% | 95% | 92% | 90% | 91% | 90% | 89% | 95% | 93% | 92% | 91% | 91% | 93% |
| | | Access Clinical Support & Women's Health (ACW) | >85% | 99% | 95% | 98% | 97% | 96% | 95% | 98% | 95% | 89% | 95% | 94% | 93% | 95% | 94% |
| | Overall Negative Experience | Emergency and Integrated Medicine (EIM) | <5% | 11% | 10% | 14% | 13% | 16% | 9% | 12% | 12% | 9% | 13% | 12% | 14% | 9% | 10% |
| | | Children and Young People (CYP) | <5% | 3% | 2% | 3% | 2% | 0% | 0% | 3% | 2% | 1% | 0% | 0% | 0% | 0% | 1% |
| | | Surgery and Cancer (S&C) | <5% | 1% | 1% | 2% | 1% | 1% | 2% | 3% | 3% | 2% | 2% | 2% | 1% | 1% | 3% |
| | | Adult Community Services (ACS) | <5% | 4% | 11% | 3% | 4% | 6% | 3% | 5% | 6% | 2% | 0% | 3% | 3% | 6% | 4% |
| | | Access Clinical Support & Women's Health (ACW | <5% | 1% | 2% | 1% | 3% | 3% | 2% | 2% | 4% | 6% | 4% | 4% | 5% | 2% | 4% |
| FFT Focussed areas | Overall Positive experience | ED | >85% | 80% | 80% | 70% | 75% | 73% | 83% | 75% | 76% | 84% | 79% | 78% | 77% | 83% | 81% |
| | | Maternity | >85% | 99% | 98% | 99% | 99% | 98% | 98% | 100% | 99% | 95% | 98% | 100% | 0% | 97% | 96% |
| | | Outpatients | >85% | 88% | 90% | 96% | 89% | 96% | 90% | 92% | 91% | 95% | 88% | 95% | 94% | 96% | 93% |
| | Overall Negative Experience | ED | <5% | 15% | 14% | 21% | 19% | 20% | 11% | 17% | 16% | 12% | 16% | 16% | 16% | 12% | 14% |
| | | Maternity | <5% | 0% | 0% | 0% | 1% | 1% | 0% | 0% | 1% | 0% | 2% | 0% | 100% | 0% | 2% |
| | | Outpatients | <5% | 10% | 9% | 3% | 9% | 3% | 6% | 6% | 5% | 4% | 6% | 3% | 3% | 2% | 4% |
| Complaints Performance | Complaints | Emergency and Integrated Medicine (EIM) | >80% | 20% | 50% | 75% | 67% | 50% | 67% | 33% | 0% | 33% | 40% | 60% | 63% | 50% | 57% |
| | | Children and Young People (CYP) | >80% | 50% | N/A | 100% | 100% | 75% | 100% | 100% | 100% | 100% | 83% | 50% | 100% | 50% | 50% |
| | | Surgery and Cancer (S&C) | >80% | 50% | 25% | 0% | 25% | 33% | 17% | 0% | 50% | 33% | 17% | 40% | 44% | 0% | 20% |
| | | Adult Community Services (ACS) | >80% | 100% | 100% | N/A | 60% | 100% | N/A | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 50% |
| | | Access Clinical Support & Women's Health (ACW) | >80% | 0% | 66% | N/A | 67% | 33% | 50% | 50% | 67% | 71% | 50% | 67% | 75% | 100% | 63% |
| | | Corporate | >80% | 100% | N/A | 100% | N/A | N/A | N/A | 100% | N/A | N/A | 100% | N/A | N/A | N/A | N/A |
| | | Estates & Facilities | >80% | 0% | 0% | N/A | 0% | 0% | N/A | 100% | 50% | 33% | 67% | 100% | N/A | 0% | 100% |
| | | **Trust** | >80% | **35%** | **47%** | **62%** | **50%** | **45%** | **56%** | **56%** | **65%** | **50%** | **49%** | **61%** | **63%** | **48%** | **55%** |

| | | |
|---|---|---|
| **Meeting title** | **Quality Assurance Committee** | **Date: 10th January 2024** |
| **Report title** | **Quarterly Learning from Deaths (LfD) Report** Q4, 1 April to 30 June 2023 | **Agenda item: 4.5** |
| **Executive director lead** | Dr Clare Dollery, Executive Medical Director | |
| **Report authors** | Dr Sarah Gillis, Associate Medical Director LfD<br>Ruby Carr, Project Lead for Learning from Deaths | |
| **Executive summary** | During Quarter 1, 1st April to 30th June 2023, there were 108 adult inpatient deaths (excluding deaths in ED) reported at Whittington Health (WH) versus 129 in Q4 2022/23.<br><br>12 adult structured judgement reviews (SJRs) were requested for Quarter 1 and 8 of these have been completed and presented at department mortality meetings.<br><br>Key themes in learning from reviews were:<br>a) The importance of using the microguide app to access antibiotic guidance and seeking advice from the microbiology team.<br>b) Learning from end-of-life care and treatment escalation planning was that early opportunities to have sensitive conversations during admissions prior to actual end of life phase could be helpful and that near end-of-life anticipatory medicines should be actively considered to avoid any delays in relief of patients' symptoms and prioritisation of their comfort. This included evidence of excellent communication with mental health teams for a patient with serious mental health problems.<br>c) Reviews of patients with learning disabilities highlighted the importance of multi-team advanced planning for complex patients.<br>d) Second opinions are helpful to some families coming to terms with a relative at end of life alongside pastoral and palliative care support.<br>e) Fast tracking palliative care requires 3 forms to be filled in. There is an 'in reach' nurse who can check these forms.<br>f) An example where excellent MDT communication in hours regarding a patient being at end of life, was not carried through out of hours resulted in active treatment such as antibiotics, IV fluids and high flow nasal oxygen (HFNO) being started illustrates the importance of consistency of approach and referring to the existing treatment planning and TEP decisions.<br><br>The Summary Hospital-level Mortality Indicator (SHMI) for the data period October 2021 to September 2022 at Whittington Health is 0.90 which is as expected. | |
| **Purpose:** | The paper summarises the key learning points and actions identified in the mortality reviews completed for Q1, 1 April to 30 June 2023. | |

| | |
|---|---|
| **Recommendation(s)** | Members are invited to:<br>• 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.<br>• 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** | Reviewed at Mortality review group 17/10/23 |
| **Appendices** | Appendix 1: NHS England Trust Mortality Dashboard<br>Appendix 2 : Newsletter |

**Quarterly Learning from Deaths Report**
**Q4 2022/23**

## 1. Introduction

1.1 This report summarises the key learning identified in the mortality reviews completed for Quarter 1 of 2023/24. 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 of 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

2.1 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/nqb-national-guidance-learning-from-deaths.pdf

2.2 The Trust requires that all inpatient deaths be reviewed. The mortality 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:

- Deaths where families, carers or staff have raised concerns about the quality-of-care provision.
- All inpatient deaths of patients with learning disabilities (LD)
- All inpatient deaths of patients with severe mental illness
- Deaths recommended by the Medical Examiner service as needing further review.
- 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 during elective surgical procedures.
- Deaths where learning will inform the provider's existing or planned improvement work, for example deaths where the patient had treatment relating to blood transfusion.
- All inpatient paediatric, neonatal and maternal deaths

## 3. Mortality Review Quarter 1, 2023/24

3.1 During Quarter 1, 2023/24 there were 108 adult inpatient deaths reported at Whittington Health versus 129 in Q4 of 2022/23.

3.2 During Quarter 1, 2023/24 there were 3 paediatric deaths reported at Whittington Health. 2 related to congenital abnormalities in under 1-year olds and one relates to sepsis in a teenager.

3.3 Table 1 shows the distribution of deaths by departments/teams.

**Table 1:** *Death by Department/Team*

| Department/Team | Number of deaths |
|---|---|
| Acute Admissions Unit (Mary Seacole North and South) | 22 |
| Cavell | 12 |
| Cloudesley | 13 |
| Meyrick | 16 |
| Critical Care Unit/ITU | 9 |
| Nightingale | 18 |
| Coronary Care Unit | 2 |
| Thorogood | 2 |
| Victoria | 13 |
| Coyle | 1 |
| Mercers | 0 |
| Theatres Recovery | 0 |
| Child/neonatal | 3 |
| Maternal | 0 |
| **Total:** | **108 Adults**<br>**3 paediatric** |

3.4 Table 2a shows the total number of mortality reviews and SJRs required and how many of these reviews are outstanding.

**Table 2a:** *Total number of Mortality reviews and SJRs required.*

| | Number of reviews required | Completed Reviews | Outstanding reviews |
|---|---|---|---|
| **Adult Mortality Reviews** | 108 | 20 | 88 |
| **Paediatric Mortality Reviews** | 3 | 0 | 0 |
| **SJR** | 12 | 8 | 4 |

Feedback from mortality leads is that the ongoing Industrial Action has contributed to delays in completing these reviews.

3.5 Table 2b provides a breakdown of SJRs required by department.

**Table 2b:** *SJRs required for each department/ team*

| Department | Number of SJRs | Number outstanding |
|---|---|---|
| Acute Admissions Unit (Mary Seacole North and South) | 3 | 0 |
| Cavell | 2 | 1 |
| Cloudesley | 0 | 0 |
| Meyrick | 0 | 0 |
| Critical Care Unit | 2 | 0 |
| Nightingale | 1 | 1 |
| Coronary Care Unit | 0 | 0 |
| Victoria | 1 | 1 |
| Coyle | 0 | 0 |
| Mercers | 0 | 0 |
| ED | 2 | 1 |
| Thorogood | 1 | 1 |
| **Total:** | **12** | **4** |

**Table 3:** *Reasons for deaths being assigned as requiring an SJR during Quarter 1, 2023/24*

| Criteria for SJR | Number of SJRs identified | Completed SJRs | Comments |
|---|---|---|---|
| Staff raised concerns about care | - | - | |
| Family raised concerns about quality of care | - | - | |
| Death of a patient with Serious mental illness | - | - | |
| Death in surgical patients | 1 | 0 | This patient was also a coroner's referral – not included in coroners total below |
| Paediatric/maternal/neonatal/intra-uterine deaths | - | - | |
| Deaths referred to Coroner's office without proposed cause of death | 3 | 3 | |
| Deaths related to specific patient safety or QI work e.g. sepsis and falls | 4 | 0 | |
| Death of a patient with a Learning disability | 4 | 4 | |
| Medical Examiner concern | - | - | |
| Serious Incident investigations | - | - | |
| Unexpected Death | - | - | |
| Concerns raised through audit, incident reporting or other mortality indicators | - | - | |
| Definite COVID-19 Health Care Acquired Infection (HCAI) | 1 | 1 | |
| Probable COVID-19 HCAI | - | - | |
| Intermediate COVID-19 HCAI | - | - | |
| **Total including Neonatal Deaths** | **13** | **8** | |

3.6 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.

3.7 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.

3.8 Plan for recovery of SJRs:

- Discussion at Mortality Review Group
- Review of LFD report at MRG prior to submission to Quality Governance committee
- Grand round on 18/10/2023 to present information from LfDs. Plan to do produce newsletter re outcomes of SJRs
- Discussion with teams who have given feedback that SJRs are taking a whole day to complete. Clearly SJRs need to be thorough, but this must be balanced with the amount of time that can be allocated.

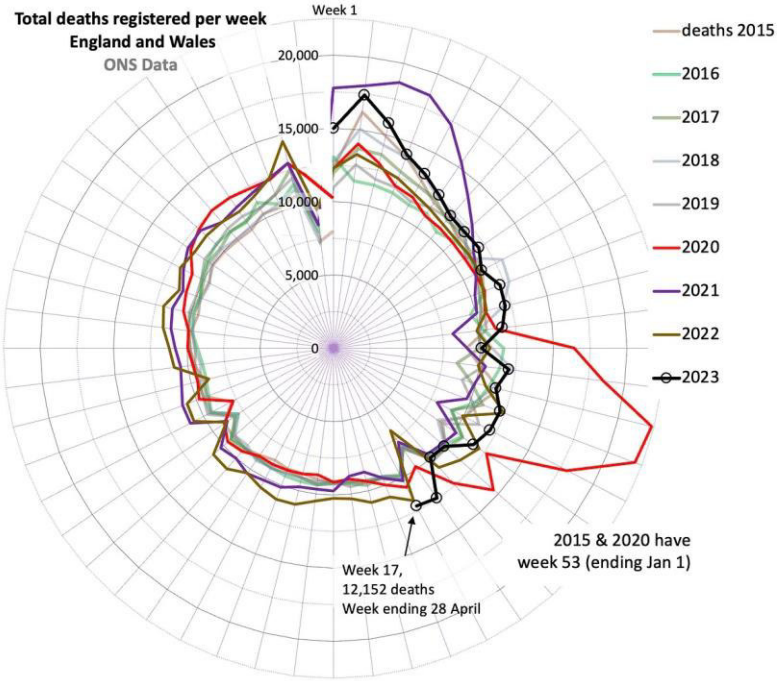
## 4. Mortality Dashboard

4.1 There were 108 inpatient adult deaths recorded in Quarter 1, 2023/24 at Whittington Health.

4.2 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.

4.3 In the week ending 16 June 2023 (Week 24), 10,700 deaths were registered in England and Wales; 156 of these deaths mentioned novel coronavirus (COVID-19), accounting for 1.5% of all deaths. This was a decrease in all deaths compared with the week ending 9 June 2023 (Week 23), when the number of all-cause deaths registered was 10,940; COVID-19 accounted for 211 of these deaths (1.9%). Of the 156 deaths involving COVID-19 in Week 24, 68.6% (107 deaths) had this recorded as the underlying cause of death, which was a higher proportion when compared with Week 23 (64.5%).

**Graph 1:Total Deaths Registered per week in England and Wales**

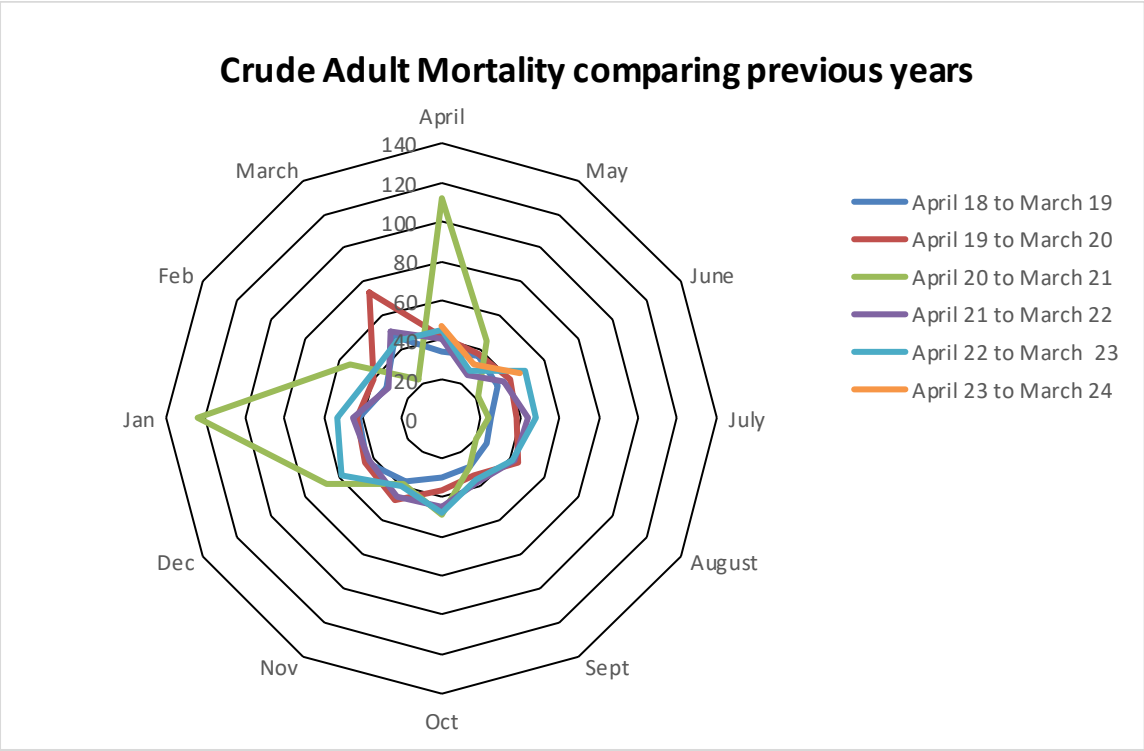



4.7 The radial graph below compares all causes of deaths (including ED deaths) in the Whittington hospital in 2018-19, 2019-20, 2020-21, 2021-22 with the year considered in this report 2022-23.

4.8 The number of inpatient and ED deaths in Q1 2023/24 was 125

4.9 There were 4 learning disability deaths during Quarter 1.

**Graph 2: Crude Adult Mortality at Whittington Health comparing previous years (April-December 2022)**




4.10 Table 4 reports the number of inpatient and ED deaths each month.

**Table 4: Number of inpatient and ED deaths each month over the past 5 years**

| Month | April 18 to March 19 | April 19 to March 20 | April 20 to March 21 | April 21 to March 22 | April 22 to March 2023 | April 23 to March 2024 |
|---|---|---|---|---|---|---|
| April | 34 | 42 | 112 | 40 | 45 | 47 |
| May | 37 | 38 | 46 | 26 | 28 | 32 |
| June | 33 | 40 | 22 | 37 | 49 | 46 |
| July | 25 | 38 | 24 | 44 | 48 | |
| August | 26 | 45 | 20 | 43 | 42 | |
| Sept | 29 | 33 | 28 | 37 | 36 | |
| Oct | 30 | 37 | 49 | 45 | 48 | |
| Nov | 37 | 48 | 38 | 46 | 40 | |
| Dec | 44 | 45 | 67 | 42 | 59 | |
| Jan | 42 | 43 | 124 | 45 | 53 | |
| Feb | 32 | 40 | 54 | 31 | 42 | |
| March | 48 | 74 | 23 | 51 | 46 | |

## 5. Summary Hospital-level Mortality Indicator (SHMI)

5.1 The Summary Hospital-level Mortality Indicator (SHMI) for the data period October 2021 to September 2022 at Whittington Health is 0.90 which is as expected.

## 6. Themes and learning from mortality reviews Quarter 1 of 2023/2024

6.1 As a point of good practice there were multiple teams involved in treatment escalation plan (TEP) and do not attempt cardiopulmonary resuscitation (DNACPR) discussions of a young adult with learning difficulties and complex medical problems who arrived in the ED in multiple organ failure.

6.2 Another case review showed evidence of excellent care including TEP and DNACPR discussions in a final admission to hospital. Acute care was excellent, but the reviewer highlighted possible missed opportunities in previous admissions to address care planning.

6.3 Good early discussions re TEP and DNACPR involving acute medical team. Additionally, they sought early input from respiratory and critical care around these decisions.

6.4 Another case showed there was recognition that patient was nearing EoL. Concerns were raised that despite this poor prognosis that the patient was felt not to require anticipatory medications which may be an opportunity to recognise for future patients.

6.5 One SJR highlighted the complexity of managing frail comorbid patients with rib fractures. Careful titration of analgesics is necessary and early involvement of acute pain, anaesthetic and critical care teams. There was good recognition of difficulties in achieving good pain control and a move to concentrating on end-of-life care (EoLC).

6.6 A patient with LD had an out of hospital cardiac arrest. The patient was referred early and appropriately to the Specialist Nurse for organ donation. However, sadly as there was no next of kin they were unable to proceed to organ donation. Documentation of death was filled in correctly but on paper and it was highlighted that there is now an electronic version of death by neurological criteria which should be used. There was good communication with the patient's carers including them observing brain stem testing. Unfortunately, the chaplaincy service was not available when requested.

6.7 In one case a patient developed aspiration pneumonia. The patient was actively treated with IV antibiotics and fluids. There were multiple reviews which were well documented in the notes as the family found accepting death was imminent was difficult. A second opinion was offered and initially refused. Palliative care and spiritual support were requested.

6.8 MRG reviewed the Q4 2022/23 report and highlighted the importance of antibiotic prescribing including using microguide and consultation with the microbiology team.

6.9 Fast tracking discharge for palliative care patients requires 3 forms to be filled in. There is an 'in reach' nurse who can check these forms.

6.10 Despite excellent MDT communication in hours regarding a patient being at end of life, out of hours active treatment such as antibiotics, IV fluids and high flow nasal oxygen (HFNO) were started on one patient.

## 7. Dissemination of Learning

7.1 This report is considered at the Mortality Review Group attended by the mortality leads from each specialty which allows them to disseminate onwards lessons.

7.2 Lessons from mortality reviews are included in the Trust-wide newsletter Safety Matters and specific cases have been the subject of patient safety forum presentations. A new brief newsletter is being trialled.

7.3 Teams hold mortality review meetings to discuss local cases and share wider learning between teams and jointly review cases.

7.4 Grand round on 18/10/2023

7.5 Newsletter (proposed 1st newsletter attached)

## 8. Mortality Review Group

8.1 A Mortality Review Group meeting took place on 16th October2023.The meeting reviewed the learning from death reports, and the MMBRACE report. The meeting was attended by some of the newer mortality leads.

## 9. Conclusion and recommendations

9.1 The Quality Governance Committee is asked to recognise the significant work from frontline teams and to recognise the learning from mortality reviews. Discussion with the specialty mortality leads has highlighted the difficulties in completing SJRs with the ongoing industrial action

## Appendix 1

**NHS** Whittington Health: Learning from Deaths Dashboard - September 2023-24 — Department of Health

**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 |
| 37 | 47 | 5 | 10 | 0 | 0 |
| This Quarter (QT | Last Quarter | his Quarter (QT | Last Quarter | his Quarter (QTD | Last Quarter |
| 128 | 121 | 26 | 20 | 0 | 0 |
| This Year (YTD | Last Year | This Year (YTD | Last Year | This Year (YTD) | Last Year |
| 249 | 504 | 46 | 71 | 0 | 1 |

Time Series: Start dat 2017-18 Q1 End date 2023-24 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 ( | 0 | - | This Quarter ( | 0 | - | This Quarter (Q | 0 | - | This Quarter (QT | 0 | - | This Quarter (QT | 0 | - | This Quarter | 0 | - |
| This Year (YTI | 0 | - | This Year (YTI | 0 | - | This Year (YTD) | 0 | - | This Year (YTD) | 0 | - | This Year (YTD) | 0 | - | This Year (Y | 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 |
| 1 | 1 | 1 | 1 | 0 | 0 |
| This Quarter (QTD) | Last Quarter | his Quarter (QT | Last Quarter | his Quarter (QTD | Last Quarter |
| 3 | 4 | 3 | 2 | 0 | 0 |
| This Year (YTD | Last Year | This Year (YTD | Last Year | This Year (YTD) | Last Year |
| 7 | 2 | 5 | 0 | 0 | 0 |

| | | |
|---|---|---|
| **Meeting title** | **Quality Assurance Committee** | **Date: 10th January 2024** |
| **Report title** | **Quarterly Learning from Deaths (LfD) Report** Q2, 1st July to 30th September 2023 | **Agenda item: 4.5.1** |
| **Executive director lead** | Dr Clare Dollery, Executive Medical Director | |
| **Report authors** | Dr Sarah Gillis, Associate Medical Director LfD<br>Ruby Carr, Project Lead for Learning from Deaths | |
| **Executive summary** | During Quarter 2, 1st July to 30th September 2023, there were 123 adult inpatient deaths (excluding deaths in ED) reported at Whittington Health (WH) versus 108 in Q1 2023/24.<br><br>10 adult structured judgement reviews (SJRs) were requested for Quarter 2 and 9 of these have been completed and presented at department mortality meetings.<br><br>There is a more detailed look at themes in section 5 of this report, but key themes in learning from reviews were:<br><br>• Ongoing importance of recognition of impending death and good communication to patients and families by clinicians is evident from many SJRs.<br>• Ensuring good EOLC for patients including prescription of anticipatory medications.<br>• Good multispecialty reviews of patients with complex problems and high risk of death, and regular senior reviews of patients are evident.<br>• Scoring system use is important and now regularly used, but also important to reflect that scoring systems may not encompass all risks such as frailty.<br>• Importance of ensuring samples are collected and sent as promptly as possible.<br>• Importance of ensuring patients are aware of the risks of discharge/ leaving ward areas.<br>• A case also highlighted the importance of ensuring that all teams have in place recommendations about when to call a consultant.<br><br>The Summary Hospital-level Mortality Indicator (SHMI) for the data period July 2022 to June 2023 at Whittington Health is 0.94 which is as expected. | |
| **Purpose:** | The paper summarises the key learning points and actions identified in the mortality reviews completed for Q2, 1st July to 30th September 2023. | |
| **Recommendation(s)** | Members are invited to:<br>• 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.<br>• 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** | First reported here and then will proceed to Quality Assurance Committee |
| **Appendices** | Appendix 1: NHS England Trust Mortality Dashboard |

**Quarterly Learning from Deaths Report**
**Q2 2022/23**

## 1. Introduction

1.1 This report summarises the key learning identified in the mortality reviews completed for Quarter 2 of 2023/24. 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 of 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

2.1 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/nqb-national-guidance-learning-from-deaths.pdf

2.2 The Trust requires that all inpatient deaths be reviewed. The mortality 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:

- Deaths where families, carers or staff have raised concerns about the quality-of-care provision
- All inpatient deaths of patients with learning disabilities (LD)
- All inpatient deaths of patients with severe mental illness
- Deaths recommended by the Medical Examiner service as needing further review
- 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 during elective surgical procedures
- Deaths where learning will inform the provider's existing or planned improvement work, for example deaths where the patient had treatment relating to blood transfusion
- All inpatient paediatric, neonatal and maternal deaths

## 3. Mortality Review Quarter 2, 2023/24

3.1 During Quarter 2, 2023/24 there were 123 adult inpatient deaths reported at Whittington Health versus 108 in Q1 of 2023/2024.

3.2 During Quarter 2, 2023/24 there no paediatric deaths reported at Whittington Health

3.3 Table 1 shows the distribution of deaths by departments/teams.

**Table 1:** *Death by Department/Team*

| Department/Team | Number of deaths |
|---|---|
| Acute Admissions Unit (Mary Seacole North and South) | 20 |
| Cavell | 14 |
| Cloudesley | 14 |
| Meyrick | 14 |
| Critical Care Unit/ITU | 14 |
| Nightingale | 25 |
| Coronary Care Unit (Montushci) | 3 |
| Thorogood | 0 |
| Victoria | 12 |
| Coyle | 5 |
| Mercers | 2 |
| Theatres Recovery | 0 |
| Child/neonatal | 0 |
| Maternal | 0 |
| **Total:** | **Adults**<br>**123**<br>**Paediatric**<br>0 |

3.4 Table 2a shows the total number of mortality reviews and SJRs required and how many of these reviews are outstanding.

**Table 2a:** *Total number of Mortality reviews and SJRs required*

| | Number of reviews required | Completed Reviews | Outstanding reviews |
|---|---|---|---|
| **Adult Mortality Reviews** | 123 | 42 | 81 |
| **Paediatric Mortality Reviews** | - | - | - |
| **SJR** | 10 | 9 | 1 |

Feedback from mortality leads is that the ongoing Industrial Action has contributed to delays in completing these reviews.

3.5 Table 2b provides a breakdown of SJRs required by department.

**Table 2b:** *SJRs required for each department/ team*

| Department | Number of SJRs | Number outstanding |
|---|---|---|
| Acute Admissions Unit (Mary Seacole North and South) | 3 | 0 |
| Cavell | - | |
| Cloudesley | - | |
| Meyrick | 1 | 0 |
| Critical Care Unit (ITU) | 2 | 0 |
| Nightingale | 2 | 1 |
| Coronary Care Unit (Montuschi) | - | - |
| Victoria | 1 | 0 |
| Coyle | - | - |
| Mercers | - | - |
| ED | 1 | 0 |
| Thorogood | - | - |
| **Total:** | **10** | **1** |

**Table 3:** *Reasons for deaths being assigned as requiring an SJR during Quarter 2, 2023/24*

| Criteria for SJR | Number of SJRs identified | Completed SJRs | Comments |
|---|---|---|---|
| Staff/Clinician raised concerns about care | 2 | 2 | |
| Family raised concerns about quality of care | - | - | |
| Death of a patient with Serious mental illness | 1 | 0 | |
| Death in surgical patients | - | - | |
| Paediatric/maternal/neonatal/intra-uterine deaths | - | - | |
| Deaths referred to Coroner's office without proposed cause of death | 1 | 1 | |
| Deaths related to specific patient safety or QI work | - | - | |
| Death of a patient with a Learning disability | 3 | 3 | One of these patients was also a coroner's referral – not included in coroners total above |
| Medical Examiner concern | 1 | 1 | |
| Serious Incident investigations | 2 | 2 | |
| Unexpected Death | - | - | |
| Concerns raised through audit, incident reporting or other mortality indicators | - | - | |
| Definite COVID-19 Health Care Acquired Infection (HCAI) | - | - | |
| **Total including Neonatal Deaths** | **10** | **9** | |

3.6 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.

3.7 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.

3.8 Update on plan for recovery of SJRs:

- The measures described in the prior quarterly report coincide with an improvement in completion of SJRs. The measures were
    - Discussion at Mortality Review Group (MRG)
    - Review of LFD report at MRG prior to submission to Quality Governance committee
    - Grand round booked to present information from LfDs. Plan to do produce newsletter re outcomes of SJRs.
    - Discussion with teams who have given feedback that SJRs are taking a whole day to complete. Clearly SJRs need to be thorough, but this must be balanced with the amount of time that can be allocated.

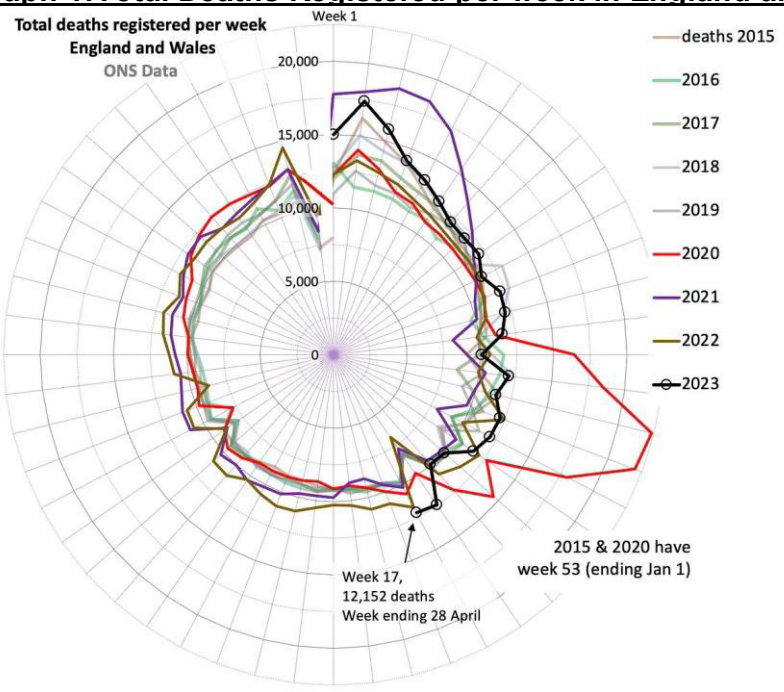
## 4. Mortality Dashboard

4.1 There were 123 inpatient adult deaths recorded in Quarter 2, 2023/24 at Whittington Health.

4.2 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.

4.3 In the week ending 16 June 2023 (Week 24), 10,700 deaths were registered in England and Wales; 156 of these deaths mentioned novel coronavirus (COVID-19), accounting for 1.5% of all deaths. This was a decrease in all deaths compared with the week ending 9 June 2023 (Week 23), when the number of all-cause deaths registered was 10,940; COVID-19 accounted for 211 of these deaths (1.9%). Of the 156 deaths involving COVID-19 in Week 24, 68.6% (107 deaths) had this recorded as the underlying cause of death, which was a higher proportion when compared with Week 23 (64.5%).

**Graph 1:Total Deaths Registered per week in England and Wales**

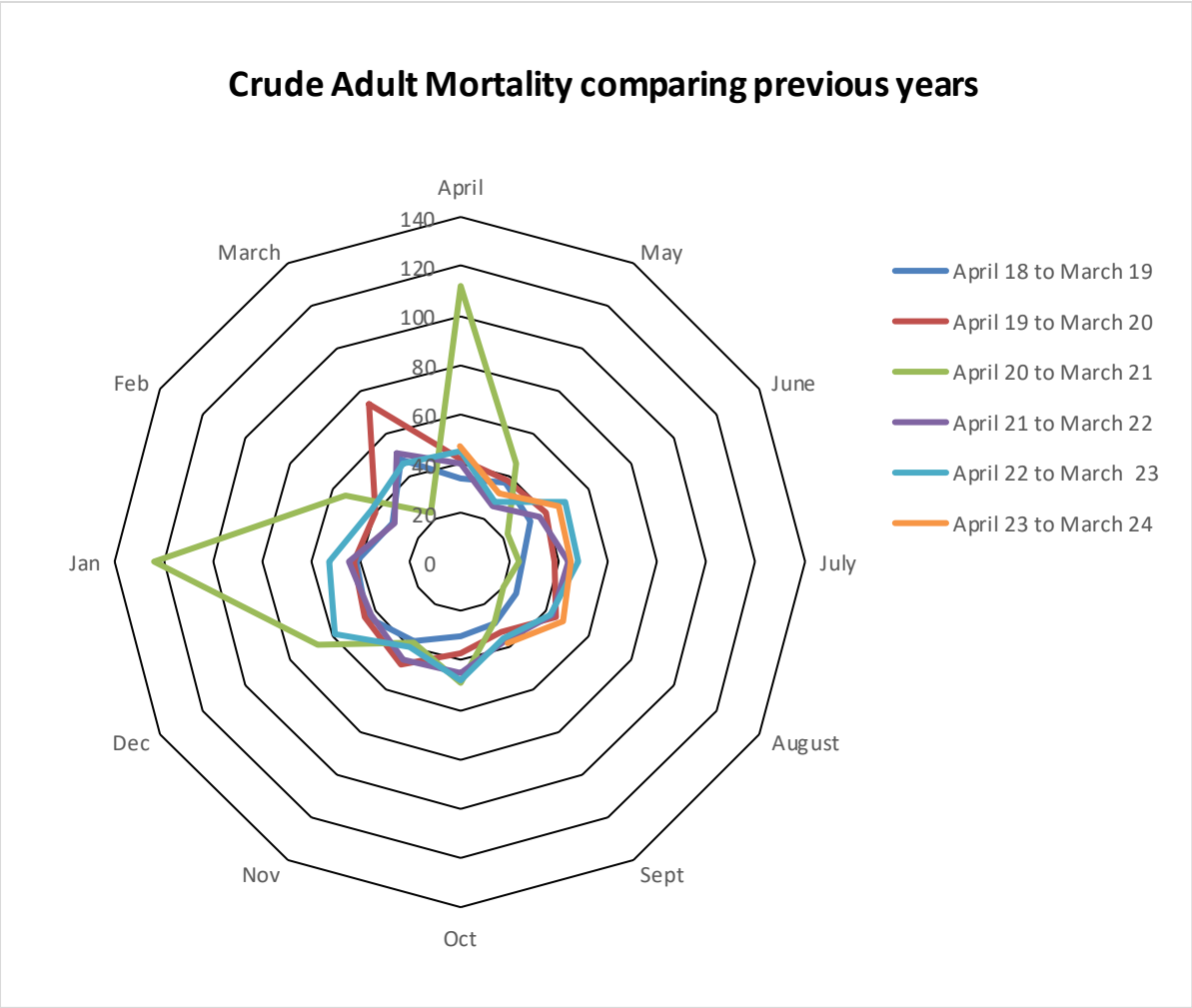


4.7 The radial graph below compares all causes of deaths (including ED deaths) in the Whittington hospital in 2018-19, 2019-20, 2020-21, 2021-22 with the year considered in this report 2023-24.

4.8 The number of inpatient and ED deaths in Q2 2023/24 was 130.

4.9 There were 3 learning disability deaths during Quarter 2.

**Graph 2: Crude Adult Mortality at Whittington Health comparing previous years (April-December 2022)**



4.10 Table 4 reports the number of inpatient and ED deaths each month.

**Table 4: Number of inpatient and ED deaths each month over the past 5 years**

| Month | April 18 to March 19 | April 19 to March 20 | April 20 to March 21 | April 21 to March 22 | April 22 to March 2023 | April 23 to March 2024 |
|---|---|---|---|---|---|---|
| April | 34 | 42 | 112 | 40 | 45 | 47 |
| May | 37 | 38 | 46 | 26 | 28 | 32 |
| June | 33 | 40 | 22 | 37 | 49 | 46 |
| July | 25 | 38 | 24 | 44 | 48 | 45 |
| August | 26 | 45 | 20 | 43 | 42 | 48 |
| Sept | 29 | 33 | 28 | 37 | 36 | 37 |
| Oct | 30 | 37 | 49 | 45 | 48 | |
| Nov | 37 | 48 | 38 | 46 | 40 | |
| Dec | 44 | 45 | 67 | 42 | 59 | |
| Jan | 42 | 43 | 124 | 45 | 53 | |
| Feb | 32 | 40 | 54 | 31 | 42 | |
| March | 48 | 74 | 23 | 51 | 46 | |

## 5. Summary Hospital-level Mortality Indicator (SHMI)

5.1 The Summary Hospital-level Mortality Indicator (SHMI) for the data period July 2022 to June 2023 at Whittington Health is 0.94 which is as expected but has increased.

## 6. Themes and Learning from Mortality Reviews Quarter 2 of 2023/24

6.1 A patient who had either cellulitis or necrotising fasciitis showed the importance of frequent and senior reviews by the different teams of clinicians caring for patients when there are diagnostic dilemmas present. It also highlighted the importance of tissue samples being sent from theatre promptly. Unfortunately, the patient died post operatively after a later visit to theatre despite resuscitation in critical care. Senior clinical review is needed both regularly and in emergency settings for these patients who have a high mortality risk.

6.2 A patient who had multiple comorbidities died from a community acquired pneumonia. Postmortem a sample demonstrated resistance to the antibiotic used demonstrating the importance of prompt sampling from all patients where requested.

6.3 A frail older adult had a catastrophic injury from an unwitnessed fall at home. The prompt trauma assessment by ED and their recognition of this being a terminal event leading to compassionate and effective care for the patient and family should be commended.

6.4 A patient was recognised to have had a cardiac event. The patient decided to leave the hospital to get food. This was advised against by nursing staff to the patient, but the medical team were unaware and there was a missed opportunity for the medical team to communicate risks and check for competency. The patient unfortunately had a cardiac arrest while out of the hospital. There is a

better chance of a good outcome if a person arrests in hospital rather than out of hospital, although mortality risk is high for both.

6.5 A general surgical patient died post operatively on critical care. Prior to surgery there was good evidence of multi-specialty discussions regarding risks and likely outcome. Risk was calculated using the National Emergency Laparotomy Audit (NELA) preoperatively, and it is important to understand that NELA can underestimate the risk of death in frail patients, as frailty is not considered in this scoring system, and this should be communicated to patients and families. This case also highlighted the importance of ensuring that all teams have in place recommendations about when to call a consultant.

6.6 A patient was discharged and readmitted the following day, the patient needed ne observations and assessment, but these were not done.

6.7 There were SJRs highlighting good end of life care. In one patient there was good documentation regarding the ceilings of care. Another case where there was excellent communication to the family, however, highlighted the importance of prescribing anticipatory medications at end of life.

## 7. Dissemination of Learning

7.1 Newsletter to all doctors and dissemination of this report via departmental mortality meetings.

7.2 Key learning points for dissemination are:

- Ensure adequate time is given to teams to do prepare reports in their job plans.
- Continue teaching/ grand rounds regarding how to deliver good EOL care.
- Ensure and encourage good multispecialty working by encouraging multidisciplinary Morbidity & Mortality meetings (M&Ms) e.g. ITU/ anaesthetics/ surgery.
- All teams should have in place recommendations about when to call a consultant.

## 8. Mortality Review Group

8.1 Plan is for this report to go Mortality Review Group (MRG) first for discussion prior to coming to this committee in the future. We are hopeful that this will be the case moving forward. We have sought to widen attendance at MRG and hopefully will have the lead nurse for the Critical Care Outreach Team (CCOT) attending, plus 2 of our junior doctors. At our next MRG we will be having a presentation on a national report of deaths in patients with learning difficulties which we can compare to a summary that was collated from deaths at the Whittington for Apr 22 - March 23. We will also be having an update from paediatrics hopefully ensuring our local mortality process is comprehensive.

## 9. Conclusion and recommendations

9.1 QAC is asked to note the learning from deaths in the Trust in Q2 2023/24.

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## Appendix 1

**NHS** Whittington Health: Learning from Deaths Dashboard - September 2023-24

Department of Health

**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 |
| 37 | 47 | 5 | 10 | 0 | 0 |
| This Quarter (QTI | Last Quarter | his Quarter (QTI | Last Quarter | his Quarter (QTD | Last Quarter |
| 128 | 121 | 26 | 20 | 0 | 0 |
| This Year (YTD) | Last Year | This Year (YTD) | Last Year | This Year (YTD) | Last Year |
| 249 | 504 | 46 | 71 | 0 | 1 |

Time Series: Start dat 2017-18 Q1 End date 2023-24 Q2


**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 (( | 0 | - | This Quarter (( | 0 | - | This Quarter (Q | 0 | - | This Quarter (QT | 0 | - | This Quarter (QT | 0 | - | This Quarter | 0 | - |
| This Year (YTI | 0 | - | This Year (YTI | 0 | - | This Year (YTD) | 0 | - | This Year (YTD) | 0 | - | This Year (YTD) | 0 | - | This Year (Y | 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 |
| 1 | 1 | 1 | 1 | 0 | 0 |
| This Quarter (QTD) | Last Quarter | his Quarter (QTI | Last Quarter | his Quarter (QTD | Last Quarter |
| 3 | 4 | 3 | 2 | 0 | 0 |
| This Year (YTD) | Last Year | This Year (YTD) | Last Year | This Year (YTD) | Last Year |
| 7 | 2 | 5 | 0 | 0 | 0 |

| | | |
|---|---|---|
| **Meeting title** | **Trust Board – public meeting** | **Date: 26.01.2024** |
| **Report title** | **Impact of 2023 Junior Doctor and Consultant Industrial Action** | **Agenda item: 7** |
| **Executive lead** | Dr Clare Dollery, Executive Medical Director | |
| **Report authors** | Dr Clare Dollery, Executive Medical Director, Rowena Welsford, Associate Director of Workforce, Kemi Ogunseitan Medical staffing HR Business Partner, and Paul Attwal Head of Performance | |
| **Executive summary** | This paper considers the quality impact of the eight periods of industrial action between March 2023 and October 2023. It does not consider the action taken in December 2023 or January 2024.<br><br>The approach to providing services during the industrial action has been focused throughout on the prioritisation of patient safety. A secondary, but important objective, is to maintain long term team relationships between all professional groups taking or ensuring safety during industrial action, in order to have teams can come back together after industrial action ends to deliver safe high quality patient focused health services.<br><br>Over the eight strikes covered in this report, the following impact was seen:<br>• A loss of 2,075 junior doctor shifts and 100 consultant work days<br>• 6,177 outpatient appointments not available for use<br>• 768 inpatient procedures not available for use<br>• No serious incidents were declared, a number of lower impact events had to be urgently mitigated when detected – overall incident reporting increased during the strike periods.<br>• No deaths attributable to industrial action were reported with variable numbers of deaths<br>• There were eight patient advice and liaison concerns related to industrial action and no complaints were received<br><br>Nursing, allied health professionals, and operational management teams have worked very hard to ensure safety through the strikes. The professionalism of the multidisciplinary team throughout this period is to be commended.<br><br>The flexibility of consultant medical teams to act down or out of their usual area of speciality has been key to safe cover. | |

| | |
|---|---|
| | The British Medical Association's industrial action has had significant adverse impact on patients waiting times for outpatient and inpatient care – the full impact is as yet unknown.<br><br>Staff have stepped up to ensure immediate patient safety in difficult circumstances with ongoing fatigue and some impact on morale. |
| **Purpose:** | Discussion |
| **Recommendation(s)** | The Trust Board is asked to note this report and to consider the quality impacts of the industrial action by consultants and junior doctors |
| **Board Assurance Framework** | BAF Quality 1 entry - quality and safety of services |
| **Report history** | 10 January, Quality Assurance Committee |
| **Appendices** | None |

## 1. Introduction

1.1. This paper undertakes an analysis of the safety impact of the 2023 junior doctors' and consultants' Industrial Action (IA) drawing on activity, workforce, and patient and staff feedback data, as well as after-action reviews conducted at intervals. It considers the strikes to the end of November but not the most recent industrial action in December 2023 and January 2024.

## 2. Background

2.1. The industrial action undertaken via the British Medical Association (BMA) is outlined in the table below.

***Table 1 Industrial action dates***

| Date | Staff group | Nature of Action |
|---|---|---|
| 13 – 16 March | Junior Doctors | Full walkout |
| 11 – 15 April | Junior Doctors | Full walkout |
| 14 – 17 June | Junior Doctors | Full walkout |
| 13 – 18 July | Junior Doctors | Full walkout |
| 20 – 22 July | Consultants | Christmas day service |
| 11-15 August | Junior Doctors | Full walkout |
| 19 September | Consultants | Christmas day service |
| 20 September | Joint Junior Doctors/Consultants | Christmas day service |
| 21 September | Junior Doctors | Full walkout |
| 22-23 September | Junior Doctors | Full walkout |
| 2–5 October | Joint Junior Doctor/Consultants | Christmas day service |

2.2. The BMA had a positive mandate following a national ballot for junior doctors to take industrial action during specific dates from March 2023 to October 2023. There was also a positive ballot for consultants to take industrial action in conjunction with the juniors during July, September, and October 2023.

2.3. For dates in March-August pertaining to the junior doctor industrial action the BMA had a national mandate and there was no derogation of services, except for arrangements to recall staff in the event of a mass casualty incident. All services in all NHS organisations employing junior doctors were affected.

2.4. The Consultant strikes had a national derogation that a Christmas day service was maintained which meant urgent and emergency care pathways and usual out of hours on call services were staffed. The underlying principle for the Trust services impacted by the industrial action was that all elective activity was cancelled. Some consultants elected to tell the Trust that they were not intending to take industrial action and asked that their clinical work was modified or retained – whichever was appropriate to the team skill mix needed to deliver the type of care.

2.5. Joint junior doctor and consultant action also followed a Christmas day service national derogation.

2.6. The Trust response was led by the Medical Director and the Chief Operating Officer who is responsible for emergency planning, with the Director of Workforce and their teams as well as the ICSU triumvirates and vital support services such as pharmacy, radiology, information management and technology and pathology. Planning commenced as soon as each action was announced, with a focus on keeping patients safe, delivering high standards of care in urgent and acute services that could not be stood down, and supporting those colleagues providing essential cover.

2.7. Long term team relationships between all professional groups taking action or ensuring safety during industrial action have been prioritised throughout to ensure that teams can come back together after industrial action ends to deliver safe high quality patient focused health services.

## 3. Junior Doctor and Consultant Absences

3.1. Methods to exactly measure those choosing to take strike action are imperfect. National returns were subject to change as strike action evolved and were frequently required on short deadlines which may have led to both under and overestimates of staff taking industrial action. The changing nature of derogations across the different periods of IA also make comparison of the periods unhelpful.

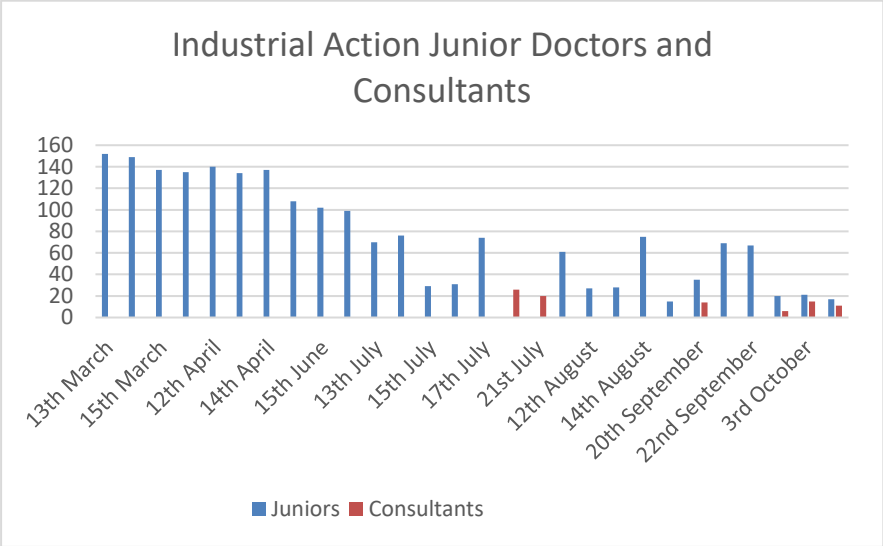
3.2. Data from the human resources teams used to inform payroll actions is presented in Graph One. This data derives from returns made by the doctors or management teams.

3.3. Higher number of individuals took action during the early part of the year, July and August trends reduced but may have been attributed to annual leave and August would have seen a junior doctor rotation within the Trust.

3.4. The highest level of junior's absences in early March, represents 53% of juniors taking industrial action. Consultants in July represents 10% of consultants taking action understanding that some were ineligible to take IA due to the Christmas day derogation.

3.5. In total 2,075 work days for junior doctors and 100 work days for consultants were lost due to industrial action.

***Graph One breakdown of junior doctors' and consultant absences during IA***




## 4. IA Planning

4.1. Prior to each round of industrial action in the lead up to the strike days, Operational, Clinical and Corporate teams came together at daily meetings, chaired by either the Medical Director in the planning phase or the Chief Operating Officer during the emergency (IA) period.

4.2. The purpose of these meetings was to ensure the safety of patient services via receipt of RAG ratings on the pre planning and in particular the fill rates of the medical rotas that were being put in place within each ICSU. This planning group included Clinical Directors, Directors of Operations or their deputies and representatives from HR, nursing, pharmacy, radiology, IM and T, and pathology etc. This team approach has been critical to ensuring safety through the IA. The Whittington Health Clinical Advisory Group has also received regular updates on the strike planning.

4.3. During the actual days of industrial action, this group met daily for operational check in calls and all clinical leads were invited to attend to understand the dynamic level of risk on the sites.

4.4. The COO and Executive Medical Director also attended system update calls across NCL.

4.5. The Medical Director or deputy walked the inpatient wards each day of the strikes to update and thank the multidisciplinary team for their work.

4.6. Elective activity was cancelled or curtailed and multi-disciplinary teams came together to provide additional support. Support for IT was delivered with “floor walkers” to aid consultant support on systems when juniors took action.

4.7. Pharmacy staff worked additional shifts to ensure additional support was present on wards and to fast track TTAs.

4.8. Senior nurses provided visible leadership across the clinical areas and other nursing colleagues took on additional work as needed.

4.9. Vacant medical shifts were covered wherever possible by Bank and agency, however the law changed in August 2023 and no agency staff were allowed to be booked to cover strike action. Staff continued to be booked to cover pre-existing vacancies and sick absence.

4.10. No Trust specific derogations were requested during the periods of industrial action. The process to submit derogations was held nationally by the BMA and in general were not agreed.

4.11. Prior to each round of industrial action a strike committee met with staff side representatives from the BMA and local reps to discuss operational practicalities of the action and to ensure that those who chose to take action were supported.

**5. Reduction of activity**

5.1. Staffing of acute inpatient and emergency services required a significant step down of elective activity, including outpatient appointments, inpatient procedures and day case surgery.

5.2. The minimum legal two weeks’ notice was given for most strikes with some giving longer periods of notice. The pattern of patients being cancelled therefore changed as the strikes continued with pre-emptive action taken not to book patients for strike dates which give an

appearance that cancellations have reduced. In order to reflect the activity that usually is carried out, average activity for a four week index period outside industrial action was taken as a comparator.

5.3. Table 2 contains details of stand down of bookings ahead of the strikes as well as direct patient cancellations of already booked activity. Table 2 shows that 87.9% of all outpatient activity was undertaken on the strike days including non-medical led clinic activity. This is 6,177 fewer appointments than expected for the relevant index periods.

5.4. Where possible two week wait clinics have not been cancelled and target endoscopy has been maintained.

***Table Two. Outpatient Activity Comparison***

| **Type of activity** | **Total Outpatients** | | |
|---|---|---|---|
| **Activity Undertaken** | **Strike** | **Average** | **%** |
| Mon 13/03/2023 | 1680 | 1895 | 88.7% |
| Tue 14/03/2023 | 1719 | 1984 | 86.6% |
| Wed 15/03/2023 | 1618 | 2040 | 79.3% |
| Tue 11/04/2023 | 1647 | 1932 | 85.2% |
| Wed 12/04/2023 | 1656 | 2017 | 82.1% |
| Thu 13/04/2023 | 1534 | 1828 | 83.9% |
| Fri 14/04/2023 | 1533 | 1558 | 98.4% |
| Sat 15/04/2023 | 398 | 342 | 116.4% |
| Wed 14/06/2023 | 1714 | 1886 | 90.9% |
| Thu 15/06/2023 | 1662 | 1706 | 97.4% |
| Fri 16/06/2023 | 1376 | 1487 | 92.5% |
| Thu 13/07/2023 | 1469 | 1700 | 86.4% |
| Fri 14/07/2023 | 1144 | 1455 | 78.6% |
| Sat 15/07/2023 | 383 | 405 | 94.6% |
| Sun 16/07/2023 | 198 | 176 | 112.5% |
| Mon 17/07/2023 | 1628 | 1808 | 90.0% |
| Tue 18/07/2023 | 1701 | 1804 | 94.3% |
| Thu 20/07/2023 | 1395 | 1700 | 82.1% |
| Fri 21/07/2023 | 1234 | 1455 | 84.8% |
| Fri 11/08/2023 | 1183 | 1466 | 80.7% |
| Sat 12/08/2023 | 283 | 353 | 80.2% |
| Sun 13/08/2023 | 108 | 148 | 73.0% |
| Mon 14/08/2023 | 1606 | 1778 | 90.3% |
| Tue 15/08/2023 | 1902 | 1839 | 103.4% |
| Thu 24/08/2023 | 1536 | 1654 | 92.9% |
| Fri 25/08/2023 | 1279 | 1466 | 87.2% |
| Tue 19/09/2023 | 1535 | 1743 | 88.1% |
| Wed 20/09/2023 | 1550 | 1632 | 95.0% |
| Thu 21/09/2023 | 1355 | 1607 | 84.3% |
| Fri 22/09/2023 | 1285 | 1213 | 105.9% |
| Mon 02/10/2023 | 1491 | 1766 | 84.4% |
| Tue 03/10/2023 | 1300 | 1722 | 75.5% |
| Wed 04/10/2023 | 1354 | 1742 | 77.7% |
| Thu 05/10/2023 | 1386 | 1712 | 81.0% |
| Total | 44842 | 51019 | 87.9% |

5.5. Table 3 below demonstrates the comparison of elective inpatient procedural activity, contrasting number of procedures undertaken on strike days with average procedure numbers. This shows that 71% of average activity took place, a reduction from 2685 to 1917 procedures- that is 768 procedures were lost over this period.

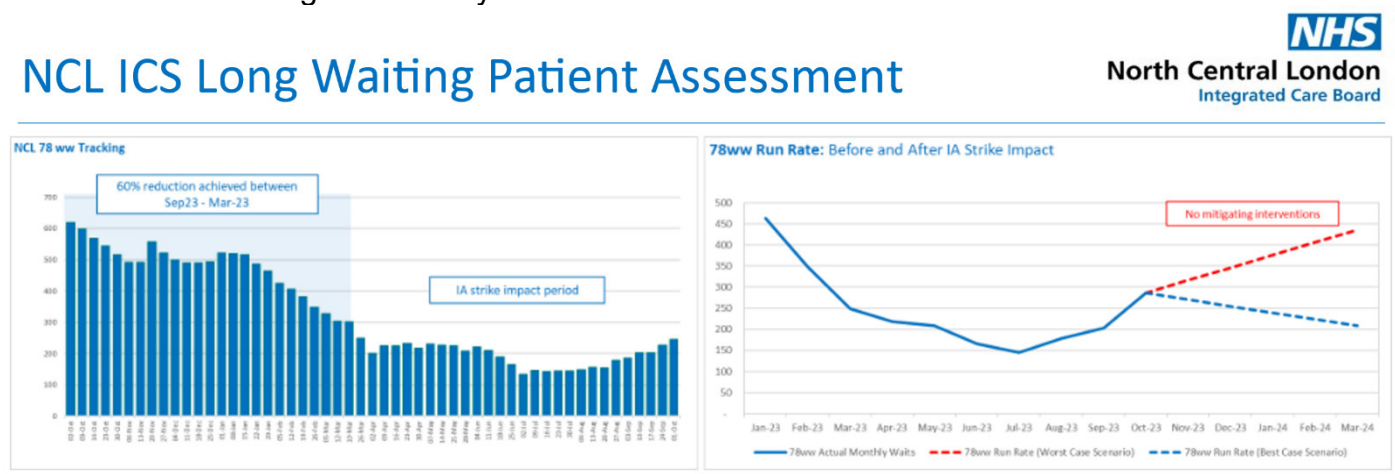
***Table Three Elective Inpatient Activity Comparison***

| Type of activity | Total Elective | | |
|---|---|---|---|
| **Activity Undertaken** | **Strike** | **Average** | **%** |
| Mon 13/03/2023 | 43 | 80 | 53.8% |
| Tue 14/03/2023 | 42 | 83 | 50.6% |
| Wed 15/03/2023 | 66 | 91 | 72.5% |
| Tue 11/04/2023 | 52 | 106 | 49.1% |
| Wed 12/04/2023 | 78 | 97 | 80.4% |
| Thu 13/04/2023 | 66 | 102 | 64.7% |
| Fri 14/04/2023 | 66 | 101 | 65.3% |
| Sat 15/04/2023 | 7 | 4 | 175.0% |
| Wed 14/06/2023 | 81 | 98 | 82.7% |
| Thu 15/06/2023 | 90 | 107 | 84.1% |
| Fri 16/06/2023 | 84 | 100 | 84.0% |
| Thu 13/07/2023 | 79 | 82 | 96.3% |
| Fri 14/07/2023 | 47 | 63 | 74.6% |
| Sat 15/07/2023 | 7 | 4 | 175.0% |
| Sun 16/07/2023 | 1 | 3 | 33.3% |
| Mon 17/07/2023 | 46 | 85 | 54.1% |
| Tue 18/07/2023 | 88 | 101 | 87.1% |
| Thu 20/07/2023 | 74 | 82 | 90.2% |
| Fri 21/07/2023 | 46 | 63 | 73.0% |
| Fri 11/08/2023 | 68 | 66 | 103.0% |
| Sat 12/08/2023 | 0 | 6 | 0.0% |
| Sun 13/08/2023 | 3 | 2 | 150.0% |
| Mon 14/08/2023 | 55 | 95 | 57.9% |
| Tue 15/08/2023 | 91 | 88 | 103.4% |
| Thu 24/08/2023 | 65 | 98 | 66.3% |
| Fri 25/08/2023 | 42 | 66 | 63.6% |
| Tue 19/09/2023 | 66 | 105 | 62.9% |
| Wed 20/09/2023 | 68 | 93 | 73.1% |
| Thu 21/09/2023 | 59 | 99 | 59.6% |
| Fri 22/09/2023 | 51 | 97 | 52.6% |
| Mon 02/10/2023 | 64 | 108 | 59.3% |
| Tue 03/10/2023 | 62 | 90 | 68.9% |
| Wed 04/10/2023 | 72 | 110 | 65.5% |
| Thu 05/10/2023 | 88 | 110 | 80.0% |
| Total | 1917 | 2685 | 71.4% |

5.6. In addition to the on-the-day impact, the cancellations of activity on the strike days will have a negative impact on the size of waiting lists, resulting in longer waits for patients. This will be reflected in future performance reports.

## 6. NCL impact on waiting lists

6.1. The following graphic gives a North Central London view on the impact of industrial action on waiting lists. The number of patients waiting 78 weeks or more had been steadily falling but had then plateaued as industrial action commenced and has since risen somewhat. All Trusts are taking action to try to reduce these waits.




## 7. Incidents, Mortality Data and Patient Experience

7.1. In order to have an overall assessment of impact on reported incidents or deaths a sample period spanning the strike dates with a 1 week margin before and after the actual IA has been measured. A comparator period from February shows the number of reports prior to industrial action. To provide a comparison, the same data are also given for the period between 8-20th February. Both are 15-day periods.

### 7.2. Incidents

7.2.1. Overall, in the first IA period similar numbers of incidents were reported to the comparator period but during and around the subsequent IA higher numbers were reported. The severity profile of incidents was similar.

7.2.2. One incident was noted in which a patient was monitored less closely than intended but was judged not to have effected their outcome. During the post easter strike several patients deteriorated on a ward caring for medically optimised patients and staff or patients needed to be moved to reinstate safety.

7.2.3. Through the hard work of staff from all the professions who were working, safety was otherwise maintained with no serious incidents occurring.

***Table 4 Incidents***

| Date | Whose action | Sample period | No of patient safety incidents |
|---|---|---|---|
| Comparator period | NA | 8-20th February | 297 |
| 13 – 15 March | Junior Doctors | 8 – 20 March | 292 |
| 11 – 15 April | Junior Doctors | 6 – 20 April | 315 |

| | | | |
|---|---|---|---|
| 14 – 16 June | Junior Doctors | 9 – 21 June | 403 |
| 13 – 21 July | Joint Junior Doctors/Consultants | 8 – 26 July | 474 |
| 11 - 15 August | Junior Doctors | 6 – 20 August | 389 |
| 19 - 22 September | Joint Junior Doctors/Consultants | 14 – 27 September | 375 |
| 2 October – 5 October | Joint Junior Doctor/Consultants | 28 September – 10 October | 393 |

7.3. **Mortality data**

7.3.1. The number of deaths in the 2 weeks surrounding industrial action was considered with the same methodology as that used for incidents. The numbers are quite variable making interpretation difficult.

7.3.2. No concerns have been raised via the Trust's Medical Examiners about deaths impacted by industrial action.

***Table 5 Deaths***

| Date | Whose action | No. of deaths plus 5 days either side of industrial action |
|---|---|---|
| 8 – 20 February | NA | From 8 February to 20 February<br>**15 inpatient deaths** (including ED) |
| 13 – 15 March | Junior Doctors | From 8 March to 20 March<br>**25 inpatient deaths** (including ED) |
| 11 – 15 April | Junior Doctors | From 6 April to 20 April<br>**18 inpatient deaths** (including ED) |
| 14 – 16 June | Junior Doctors | From 9 June to 21 June<br>**20 inpatient deaths** (including ED) |
| 13 – 21 July<br>(NB: 19 July was not a strike day but included to simplify dates however there were 0 deaths on 19 July) | Joint Junior Doctors/ Consultants | From 8 July to 26 July<br>**12 inpatient deaths** (including ED) |
| 11-15 August | Junior Doctors | From 6 August to 20 August<br>**28 inpatient deaths** (including ED) |
| 19 -22 September | Consultants | From 14 September to 27 September<br>**16 inpatient deaths** (including ED) |
| 2 October – 5 October | Joint Junior Doctor/ Consultants | From 28 September to 10 October<br>**9 inpatient deaths** (including ED) |

**Patient feedback**

7.3.3. Eight PALS concerns specifically related to industrial action have been logged. Seven were in surgery and cancer ICSU and one in ACW. 5 have been closed after information was given to the patient or relative – three are under further investigation. Concerns related to cancelled procedures and appointments and included patients worried they had incurred costs or taken time off work for appointments that were cancelled close to the expected date. One related to a 2 week wait pathway. No formal complaints were received.

7.3.4. Overall there were surprisingly few complaints or concerns received about the impact of industrial action.

***Table 6 Patient complaints***

| Date | Whose action | Information required for this whole period please | No of complaints received | No of PALS concerns received |
|---|---|---|---|---|
| 13 – 15 March | Junior Doctors | 8 – 20 March | 16 – None about strikes/industrial action | 119 - **1** about strikes/industrial action |
| 11 – 15 April | Junior Doctors | 6 – 20 April | 16 – None about strikes/industrial action | 125 - **1** about strikes/industrial action |
| 14 – 16 June | Junior Doctors | 9 – 21 June | 8 – None about strikes/industrial action | 148 - **1** about strikes/industrial action |
| 13 – 21 July | Joint Junior Doctors/Consultants | 8 – 26 July | 16 – None about strikes/industrial action | 162 - **4** about strikes/industrial action |
| 11 - 15 August | Junior Doctors | 6 – 20 August | 23 – None about strikes/industrial action | 117 - None about strikes/industrial action |
| 19 - 22 September | Joint Junior Doctors/Consultants | 14 – 27 September | 12 – None about strikes/industrial action | 152 - **1** about strikes/industrial action |
| 2 October – 5 October | Joint Junior Doctor/Consultants | 28 September – 10 October | 8 – None about strikes/industrial action | 99 - None about strikes/industrial action |

## 8. Staff wellbeing

8.1. There is a recognition that the industrial action is impacting on all colleagues involved, including both those taking action and those working differently to support services and patient care whilst action is ongoing.

8.2. Nursing, allied health professionals, and operational management teams have worked very hard to ensure safety through the strikes. In addition to nursing colleagues the pharmacy, radiography and IM and T teams have been key. The professionalism of the multidisciplinary team throughout this period is to be commended.

8.3. The flexibility of consultant medical teams to act down or out of their usual area of speciality has been key to safe cover. This has included consultant staff resident first on

call overnight for ICU, NICU, obstetrics, the general medical take and wards, and ED. Medical ward cover has been particularly stretched with some wards operating with one doctor and senior nurse but in general two doctors per ward area. In some strikes one of the consultants has been a general medical consultant on their home ward but the second doctor has stepped up to work outside their usual remit which might be outpatient rheumatology, haematology or dermatology.

8.4. It is important to acknowledge ongoing fatigue resultant from the industrial action and a gradual erosion of good will.

## 9. Impact on Patient Care

9.1. Colleagues are concerned about the impact on elective care as well as those patients who were treated during the strike. There is an acute awareness that the patients who are not booked or cancelled related to industrial action remain on waiting lists and may suffer harm or express dissatisfaction with future episodes of care due to erosion of their goodwill and faith in the NHS.

9.2. In most strike periods senior decision making throughout pathways has reduced ED waits and admissions while increasing some discharges – this likely reflects that higher level of risk that can safely be taken with the benefit of a consultant's experience. This is also reflected in fewer out of hours requests for tests.

## 10. Other impacts

10.1. This paper has specifically not included the financial impact of industrial action which has already been reported elsewhere.

10.2. Negotiation of rates of pay for consultants acting down and bank rates for other staff groups have been the subject of intense debate locally, regionally and nationally. The position the Trust has taken is to try to set principles across the Trust or region. The negotiations with medical staff were led by the Medical Director and HR Director or Associate Director. The HR teams have carried a very significant additional work load to ensure appropriate remuneration with new systems required in the setting of an emergency response.

## 11. Conclusion

11.1. The BMA industrial action has had significant adverse impact on patients waiting times for outpatient and inpatient care – the full impact is as yet unknown.

11.2. Staff have stepped up to ensure immediate patient safety in difficult circumstances with ongoing fatigue and some impact on morale.

## 12. Recommendation

12.1 Trust Board is asked to note this report and to consider the quality impacts of the industrial action by consultants and junior doctors

| | | |
|---|---|---|
| **Meeting title** | **Trust Board – public meeting** | **Date: 26.01.2024** |
| **Report title** | **Maternity Incentive Scheme (MIS) Year 5 Submission** | **Agenda item: 8** |
| **Executive lead** | Sarah Wilding, Chief Nurse and Director of Allied Health Allied Health Professionals and Trust Board Maternity Safety Champion | |
| **Report authors** | Isabelle Cornet, Director of Midwifery, Helen Taylor, Clinical Director for ACW-ICSU, and Carolyn Paul, Obstetric Lead | |
| **Executive summary** | Obstetric incidents can be catastrophic and life-changing, with related claims representing the Clinical Negligence Scheme for Trusts' (CNST) biggest area of spend. Of the clinical negligence claims notified to NHS Resolution in 2021/22, obstetrics claims represented 12 per cent of clinical claims by number but accounted for 62 per cent of the total value of new claims - almost £6 billion.<br><br>The Maternity Incentive Scheme supports and rewards Trusts who have taken action to improve maternity safety. It sets out 10 Safety Actions for which Trusts have to evidence compliance, in order to receive the financial rebate.<br><br>The declaration form for the submission was published by NHS Resolution in November 2023, and the submission date is noon on 1 February 2024.<br><br>The submission update for Whittington Health NHS Trust, with the details in the Declaration Form is attached as **Appendix 1**:<br><br>- Safety Action 1 (PMRT) : Fully Compliant<br><br>- Safety Action 2 (MSDS): Fully Compliant<br><br>- Safety Action 3 (Neonatal Unit): Fully Compliant<br><br>- Safety Action 4 (Clinical Workforce): Fully Compliant<br>o As a plan forward, audit criteria 1 & 2 will be part of the quarterly maternity report to Board.<br>o Action plan established for the implementation of the compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day (**Appendix 3**). | |

| | |
|---|---|
| | - Safety Action 5 (Midwifery Workforce): Fully Compliant<br>  o A consultation of the maternity workforce structure is planned for 2024 with the aim to increase the number of labour ward and flow coordinators to ensure appropriate cover for the unit. This will allow the presence of two senior midwives at all times and strengthen the supernumerary status of the coordinator.<br><br>- Safety Action 6 (SBLCB v3): Fully Compliant<br><br>- Safety Action 7 (MNVP): Fully Compliant<br><br>- Safety Action 8 (Multi-Professional Training): Fully Compliant<br>  o Action Plan established and approved at the Quality Assurance Committee to ensure 90% of Obstetric Anaesthetic Consultants and 90% of Obstetric Anaesthetic doctors (staff grades and anaesthetic trainees) are compliant with the Maternity Emergencies and multiprofessional training by 23 February 2024.<br>  o Action Plan established and approved at the Quality Assurance Committee to ensure 90% of Neonatal Nurses (who attend any births) are compliant with the Neonatal Basic Life Support training by 23 February 2024.<br><br>- Safety Action 9 (Board Governance): Fully Compliant<br>-<br>- Safety Action 10 (HSIB & EN): Fully Compliant<br><br>Joint Presentation Set attached as **Appendix 2** is compliant with requirement within the guidance tab of the Declaration Form. |
| **Purpose** | - Action plan for the compensatory rest to be approved and minuted (**Appendix 3**).<br><br>- For Trust Board to approve and sign-off the submission of the MIS Year 5 Declaration Form to NCL LMNS and NHS Resolution by 1 February 2024, at 12:00 (noon). The LMNS sign-off is scheduled for the 29 January 2024. |
| **Recommendation(s)** | The Trust Board is asked to approve and sign-off the submission of the MIS Year 5 Declaration Form to NCL LMNS and NHS Resolution by noon on 1 February 2024. |
| **BAF** | Quality 1 |
| **Report history** | • Maternity Clinical Governance and Safety Champion Meeting – 16th August 2023, 16th November 2023 and 14th December 2023.<br>• ACW ICSU Board & Commissioners – 19th October 2023 and 16th November 2023.<br>• Maternity and Neonatal Transformation Programme Board – 24th October 2023. |

| | |
|---|---|
| | • Quality Governance Committee – 26th October 2023 and 14th December 2023.<br>• Quality Assurance Committee – 10th January 2024.<br>• TMG – 16th January 2024. |
| **Appendices** | Appendix 1 – MIS Year 5 Board Declaration Form - NHS Resolution.<br><br>Appendix 2 – Position and Progress against Maternity Incentive Scheme (MIS) Year 5 – Joint Presentation as required by the MIS Guidance.<br><br>Appendix 3 – Obstetric Workforce Action Plan. |

## Maternity Incentive Scheme - Board declaration form

| | |
|---|---|
| **Trust name** | **Whittington Hospital NHS Trust** |
| **Trust code** | **T221** |

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

| | Safety actions | Action plan | Funds requested | Validations |
|---|---|---|---|---|
| Q1 NPMRT | Yes | | - | |
| Q2 MSDS | Yes | | - | |
| Q3 Transitional care | Yes | | - | |
| Q4 Clinical workforce planning | Yes | | - | |
| Q5 Midwifery workforce planning | Yes | | - | |
| Q6 SBL care bundle | Yes | | - | |
| Q7 Patient feedback | Yes | | - | |
| Q8 In-house training | Yes | | - | |
| Q9 Safety Champions | Yes | | - | |
| Q10 EN scheme | Yes | | - | |
| **Total safety actions** | **10** | - | | |
| **Total sum requested** | | | - | |

**Sign-off process confrming that:**

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2023/24) or the previous financial year (2022/23)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.
* If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

| | |
|---|---|
| **Electronic signature of Trust Chief Executive Officer (CEO):** | |
| **For and on behalf of the Board of** | Whittington Hospital NHS Trust |
| **Name:** | |
| **Position:** | |
| **Date:** | |

| | |
|---|---|
| **Electronic signature of Integrated Care Board Accountable Officer:** | |
| **For and on behalf of the board of** | Whittington Hospital NHS Trust |
| **Name:** | |
| **Position:** | |
| **Date:** | |

ICARE EQUITY

NHS Whittington Health NHS Trust

## Compliance with Guidance.

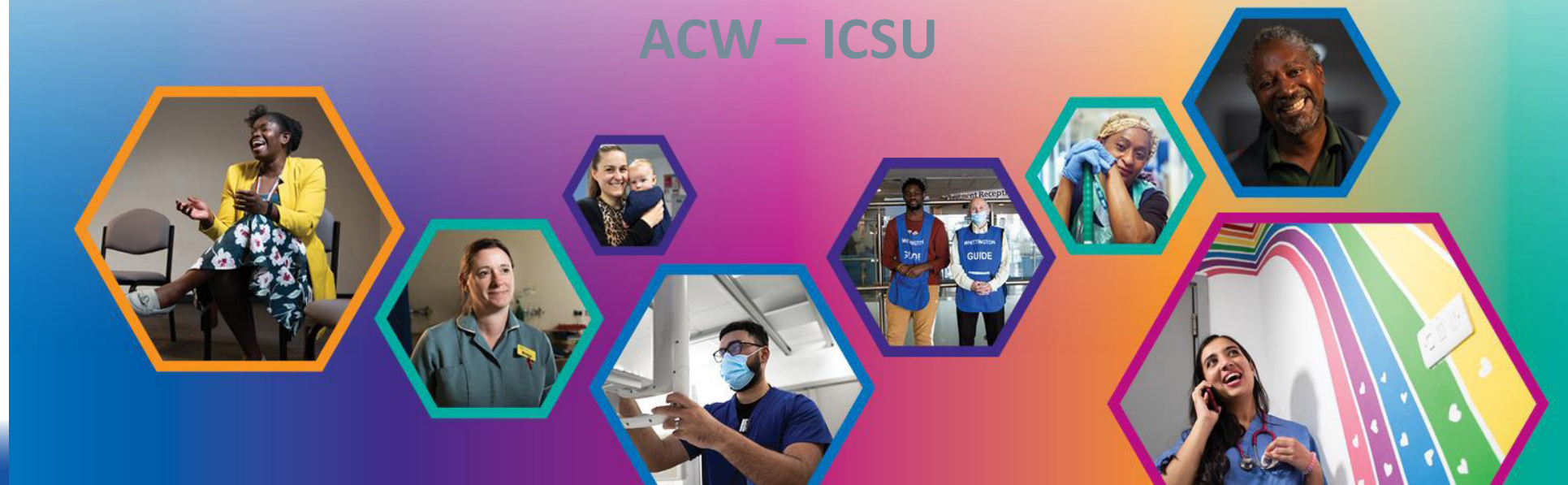
# Position and Progress against Maternity Incentive Scheme (MIS) Year 5.


Joint Presentation Set from:

Isabelle Cornet – Director of Midwifery

Dr Helen Taylor – Clinical Director for Maternity Services,

ACW – ICSU


26th January 2024

# Quality Assurance Process

- Maternity Clinical Governance and Safety Champion Meeting – 16th August 2023, 16th November 2023 and 14th December 2023.
- ACW ICSU Board & Commissioners – 19th October 2023 and 16th November 2023.
- Maternity and Neonatal Transformation Programme Board – 24th October 2023.
- Quality Governance Committee – 26th October 2023 and 14th December 2023.
- Quality Assurance Committee – 10th January 2024.
- TMG – 16th January 2024.
- Trust Board – Sign-Off – 26th January 2024.
- LMNS Sign-Off planed for the 29th January 2024.

# Safety Action 1

## Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| 1 | Have all eligible perinatal deaths from 30 May 2023 onwards been notified to MBRRACE-UK within seven working days? | Yes |
| 2 | For deaths from 30 May 2023, was MBRRACE-UK surveillance information completed within one calendar month of the death? | Yes |
| 3 | For at least 95% of all deaths of babies who died in your Trust from 30 May 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions? | Yes |
| 4 | Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 30 May 2023 been started within two months of each death?<br>This includes deaths after home births where care was provided by your Trust. | Yes |
| 5 | Were 60% of these reviews completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death? | Yes |
| 6 | Were 60% of the reports published within 6 months of death? | Yes |
| 7 | Were PMRT review panel meetings (as detailed in standard C) rescheduled due to the direct impact of industrial action, and did this have an impact on the MIS reporting compliance time scales? | N/A |
| 8 | Is there an action plan approved by Trust Boards to reschedule these meetings to take place within a maximum 12-week period from the end of the MIS compliance period. | N/A |
| 9 | If PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many meetings in total were impacted? | N/A |
| 10 | PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many cases in total were impacted? | N/A |
| 11 | Have you submitted quarterly reports to the Trust Executive Board from 30 May 2023 onwards? This must include details of all deaths reviewed and consequent action plans. | Yes |
| 12 | Were quarterly reports discussed with the Trust maternity safety and Board level safety champions? | Yes |

# Safety Action 2

## Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| 1 | Was your Trust compliant with at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023? Final data for July 2023 will be published during October 2023. | Yes |
| 2 | Did July's 2023 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001) | Yes |
| Has the Trust Board confirmed to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics: | | |
| 3 | i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks also have the Continuity of Carer (CoC) pathway indicator completed. | Yes |
| | **If maternity services have suspended all Continuity of Carer (CoC) pathways, criteria ii is not applicable:** | |
| 4 | ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided. | N/A |
| 5 | Did the Trust make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023? | Yes |
| 6 | Has the Trust at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust? | Yes |

# Safety Action 3

## Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care. | | |
| 1 | Was the pathway(s) of care into transitional care jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies?<br><br>Evidence should include:<br>• Neonatal involvement in care planning<br>• Admission criteria meets a minimum of at least one element of HRG XA04<br>• There is an explicit staffing model<br>• The policy is signed by maternity/neonatal clinical leads and should have auditable standards.<br>• The policy has been fully implemented and quarterly audits of compliance with the policy are conducted. | Yes |
| 2 | Are neonatal teams involved in decision making and planning care for all babies in transitional care? | Yes |
| b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB. | | |
| 3 | Is there evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks? | Yes |
| 4 | Is there an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks? | Yes |
| 5 | Is there evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan? | Yes |
| 6 | Is there evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan? | Yes |
| c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway. | | |
| 7 | Is there a guideline for admission to TC that include babies 34+0 and above and data to evidence this occuring? | Yes |
| 8 | OR An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation? | |

# Safety Action 4

## Can you demonstrate an effective system of clinical workforce planning to the required standard? (page 1 of 2)

| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| **a) Obstetric medical workforce** | | |
| Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas after February 2023 following an audit of 6 months activity : | | |
| 1 | a. Locum currently works in their unit on the tier 2 or 3 rota? | Yes |
| 2 | **OR**<br>b. they have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)? | N/A |
| 3 | **OR**<br>c. they hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums? | N/A |
| 4 | Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance? | Yes |
| 5 | **OR**<br>Was an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and Local Maternity and Neonatal System (LMNS) meetings?<br>https://rcog.org.uk/media/uuzcbzg2/rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf | N/A |
| 6 | Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance? | No * |
| 7 | **OR**<br>Has an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings?<br>https://www.rcog.org.uk/media/c2jkpjam/rcog-guidance-on-compensatory-rest.pdf | Yes |
| 8 | Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person? | Yes |
| 9 | Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance? | Yes |
| Do you have evidence that the Trust position with the above has been shared: | | |
| 10 | At Trust Board? | Yes |
| 11 | With Board level safety champions? | Yes |
| 12 | At LMNS meetings? | Yes |

* See Action Plan in Appendix 3

# Safety Action 4

## Can you demonstrate an effective system of clinical workforce planning to the required standard? (page 2 of 2)

| | | |
|---|---|---|
| **b) Anaesthetic medical workforce** | | |
| 13 | Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) | Yes |
| | The rota should be used to evidence compliance with ACSA standard 1.7.2.1 (A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients) | |
| **c) Neonatal medical workforce** | | |
| 14 | Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing and is this formally recorded in Trust Board minutes? | Yes |
| 15 | If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies.<br>If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies.<br>Does the Trust have evidence of this? | N/A |
| Was the agreed action plan shared with: | | |
| 16 | LMNS? | N/A |
| 17 | ODN? | N/A |
| **d) Neonatal nursing workforce** | | |
| 18 | Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing? And is this formally recorded in Trust Board minutes? | Yes |
| 19 | If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies.<br>If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies.<br>Does the Trust have evidence of this? | N/A |
| Was the agreed action plan shared with: | | |
| 20 | LMNS? | N/A |
| 21 | ODN? | N/A |

# Safety Action 5

## Can you demonstrate an effective system of midwifery workforce planning to the required standard? (page 1 of 2)

Whittington Health NHS Trust

| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| 1 | a) Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed?<br><br>Evidence should include:<br>A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated | Yes |
| 2 | b) Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated in a) above?<br><br>Evidence should include:<br>● Midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.<br>● Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.<br>● The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.<br>● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing.<br>● The midwife to birth ratio<br>● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. | Yes |

# Safety Action 5

## Can you demonstrate an effective system of midwifery workforce planning to the required standard? (page 2 of 2)

| | | |
|---|---|---|
| 3 | c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.<br><br>Can you provide evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating **100% compliance** with supernumerary labour ward co-ordinator status?<br><br>The Trust can report compliance with this standard if failure to maintain supernumerary status is a one off event, however **the Trust cannot report compliance with this standard if the coordinator is required to provide any 1:1 care for a woman and/or care in established labour during this time.**<br><br>If the failure to maintain supernumerary status is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in an action plan. This plan must include mitigation/escalation to cover any shortfalls. Please note - Completion of an action plan will not enable the Trust to declare compliance with this standard. | Yes |
| 4 | d) Have all women in active labour received one-to-one midwifery care? | Yes |
| 5 | If you have answered **no** to standard d, have you submitted an action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour? | N/A |
| 6 | Does the action plan include a timeline for when this will be achieved and has this been signed off by Trust Board? | N/A |
| 7 | e) Have you submitted a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period? | Yes |

# Safety Action 6

## Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?

| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| 1 | Have you provided assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024? | Yes |
| 2 | Do you hold quarterly quality improvement discussions with the ICB, using the new national implementation tool?<br><br>Confirmation is required from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust using the implementation tool that included the following:<br><br>● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.<br>● Progress against locally agreed improvement aims.<br>● Evidence of sustained improvement where high levels of reliability have already been achieved.<br>● Regular review of local themes and trends with regard to potential harms in each of the six elements.<br>● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts. | Yes |
| 3 | Using the new national implementation tool, can the Trust demonstrate implementation of 70% of interventions across **all** 6 elements overall? | Yes |
| 4 | Using the new national implementation tool, can the Trust demonstrate implementation of at least 50% of interventions within **each** of the 6 individual elements? | Yes |

# Safety Action 7

## Listen to women, parents and families using maternity and neonatal services and coproduce services with users

| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| 1 | Is a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) in place which is in line with the Delivery Plan? | Yes |
| 2 | Has an action plan been co-produced with the MNVP following annual CQC Maternity Survey data publication (January 2023), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board? | Yes |
| 3 | Is neonatal and maternity service user feedback collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions? | Yes |
| 4 | Can you provide minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from co-production between service users and staff? | Yes |
| 5 | Do you have evidence that MNVPs have the infrastructure they need to be successful such as receiving appropriate training, administrative and IT support? | Yes |
| 6 | Can you provide the local MNVP's work plan and evidence that it is funded? | Yes |
| 7 | Do you have evidence that the MNVP leads (formerly MVP chairs) are appropriately employed or remunerated (including out of pocket expenses such as childcare) and receive this in a timely way? | Yes |
| 8 | Can you provide evidence that the MNVP is prioritising hearing the voices of families receiving neonatal care and bereaved families, as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation? | Yes |

# Safety Action 8

## Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?



| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| 1 | A local training plan is in place for implementation of Version 2 of the Core Competency Framework | Yes |
| **Can you evidence that the plan has been agreed with:** | | |
| 2 | Quadrumvirate? | Yes |
| 3 | Trust Board? | Yes |
| 4 | LMNS/ICB? | Yes |
| 5 | Has the plan been developed based on the four key principles as detailed in the "How to" Guide for the second version of the core competency framework developed by NHS England? | Yes |
| 6 | Can you evidence service user involvement in developing training? | Yes |
| 7 | Can you evidence that training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports? | Yes |
| 8 | Can you evidence that you promote learning as a multidisciplinary team? | Yes |
| 9 | Can you evidence that you promote shared learning across a Local Maternity and Neonatal System? | Yes |

# Safety Action 8

## Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?



| | | |
|---|---|---|
| **Can you demonstrate the following at the end of 12 consecutive months ending December 2023?<br>80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) will be accepted, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period.<br>In addition, evidence from rotating obstetric trainees having completed their training in another maternity unit during the reporting period (i.e. within a 12 month period) will be accepted.<br>If this is the case, please select 'Yes'** | | |
| **Fetal monitoring and surveillance (in the antenatal and intrapartum period)** | | |
| 10 | 90% of obstetric consultants? | Yes |
| 11 | 90% of all other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)? | Yes |
| 12 | 90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres? | Yes |

# Safety Action 8

## Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?



| Maternity emergencies and multiprofessional training | | |
|---|---|---|
| 13 | 90% of Obstetric consultants? | Yes |
| 14 | 90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota? | Yes |
| 15 | 90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives? | Yes |
| 16 | 90% of maternity support workers and health care assistants attend the maternity emergency scenarios training? | Yes |
| 17 | 90% of obstetric anaesthetic consultants? | Yes |
| 18 | 90% of all other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota? | Yes |
| 19 | Can you demonstrate that **at least one** emergency scenario is conducted in a clinical area or at point of care? | Yes |
| 20 | Can you demonstrate that 90% of all team members have attended an emergency scenario in a clinical area<br>**or**<br>does the local training plan (Q1) include a plan to implement attendance at emergency scenarios in a clinical area for 90% of all team members? | Yes |

# Safety Action 8

## Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?



| Neonatal basic life support | | |
|---|---|---|
| 21 | 90% of neonatal Consultants or Paediatric consultants covering neonatal units? | Yes |
| 22 | 90% of neonatal junior doctors (who attend any births)? | Yes |
| 23 | 90% of neonatal nurses (Band 5 and above who attend any births)? | Yes |
| 24 | 90% of advanced Neonatal Nurse Practitioner (ANNP)? | Yes |
| 25 | 90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)? | Yes |
| 26 | All trusts must have an agreed plan in place, including timescales, for registered RC-trained instructors to deliver the in-house basic neonatal life support annual updates and their local NLS courses by 31st March 2024. | Yes |
| 27 | Have you declared compliance for any of Q10-Q25 above with 80-90%? | Yes |
| 28 | If you are declaring compliance for any of Q10-Q25 above with 80-90%, can you confirm that an action plan has been approved by your Trust Board to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period? | Yes |

# Safety Action 9

## Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues? Page (1 of 2)

| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| 1 | **Required Standard A.**<br>**Evidence that all six requirements of Principle 1 of the Perinatal Quality Surveillance Model have been fully embedded and specifically the following:-** | Yes |
| 2 | Does your Trust have evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues? | Yes |
| 3 | Does your Trust have evidence that a review of maternity and neonatal quality is undertaken by the Trust Board at every Trust Board meeting, using a minimum data set to include a review of the thematic learning of all maternity Serious Incidents (SIs)?<br>It must include:<br>• number of incidents reported as serious harm<br>• themes identified and action being taken to address any issues<br>• Service user voice feedback<br>• Staff feedback from frontline champions' engagement sessions<br>• Minimum staffing in maternity services and training compliance | Yes |
| 4 | Do you have evidence that the perinatal clinical quality surveillance model has been reviewed in full in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife? And does this evidence show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need. | Yes |

# Safety Action 9

## Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues? Page (2 of 2)

| | | |
|---|---|---|
| **Have you submitted evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of:** | | |
| 5 | The Trust Board? | Yes |
| 6 | LMNS/ICS/Local & Regional Learning System meetings? | Yes |
| 7 | Do you have evidence that the progress with actioning named concerns from staff feedback sessions is visible to staff? | Yes |
| 8 | Do you have evidence that Trust's claims scorecard is reviewed alongside incident and complaint data? Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trust's Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting. | Yes |
| 9 | **Required standard C.**<br>**Have you submitted evidence that the Maternity and Neonatal Board Safety Champions are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures?** | Yes |
| 10 | Have you submitted the evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace with confirmation of specific resources accessed and how this has been of benefit? | Yes |
| 11 | Have there been a minimum of two quarterly meetings between board safety champions and quadrumvirate members between 30 May 2023 and 1 February 2024? | Yes |
| 12 | Have you submitted evidence that the meetings between the board safety champions and quad members have identified any support required of the Board and evidence that this is being implemented? | Yes |

# Safety Action 10

## Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| 1 | Complete the field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated. | Yes |
| 2 | Have you reported all qualifying cases to HSIB/CQC/MNSI from 6 December 2022 to 7 December 2023? | Yes |
| 3 | Have you reported all qualifying EN cases to NHS Resolution's EN Scheme from 6 December 2023 until 7 December 2023? | Yes |
| | **For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that:** | |
| 4 | The family have received information on the role of HSIB/MNSI and NHS Resolution's EN scheme | Yes |
| 5 | There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour | Yes |
| | **Can you confirm that the Trust Board has:** | |
| 6 | Sight of Trust legal services and maternity clinical governance records of qualifying HSIB/MNSI/EN incidents and numbers reported to HSIB/MNSI and NHS Resolution? | Yes |
| 7 | Sight of evidence that the families have received information on the role of HSIB/MNSI and the EN scheme? | Yes |
| 8 | Sight of evidence of compliance with the statutory duty of candour? | Yes |

# Thank you

**Acknowledgments:**
- Alicia StLouis, Head of Midwifery (Interim)
- Filipa Braga, Women's Health Clinical Governance Manager
- Dr Carolyn Paul, Obstetric Lead
- The whole Multi Disciplinary Maternity and Neonatal Team.

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# Maternity Incentive Scheme
## Safety action No. 4
## Can you demonstrate an effective system of clinical workforce planning to the required standard?

ICARE EQUITY

NHS Whittington Health NHS Trust

| Safety action requirements | Requirement met ? |
|---|---|
| 1. Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas after February 2023 following an audit of 6 months activity : | |
| a. Locum currently works in their unit on the tier 2 or 3 rota?<br>OR<br>b. they have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)?<br>OR<br>c. they hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums? | Yes. Prospective checks agreed with Bank Partners. See evidence in action plan. (slide 2) |
| Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance? | Yes |
| OR<br>Was an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and Local Maternity and Neonatal System (LMNS) meetings?<br>https://rcog.org.uk/media/uuzcbzg2/rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf | Yes - Any long term locums and Trust doctors are subject to formal application and interview process. See evidence in action plan. (slide 2) |
| Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance? | No |
| OR<br>Has an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings? https://www.rcog.org.uk/media/c2jkpjam/rcog-guidance-on-compensatory-rest.pdf | Action plan in place (slide 3). To be presented to Trust Board, LMNS, Maternity and Safety Champions Governance meeting |
| Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person? | Yes - audits undertaken. |
| Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance? | Yes |
| Do you have evidence that the Trust position with the above has been shared: | Future plan |
| At Trust Board? | January 2024 Trust Board |
| With Board level safety champions? | December Maternity and Safety Champions Governance meeting |
| At LMNS meetings? | January 2024 |

# Action Plan


Whittington Health NHS Trust

| No. | Recommendation | Key Action(s) | Completion Date | Responsible Lead(s) | Progress on actions and dates: | Evidence of implementation and date of implementation |
|---|---|---|---|---|---|---|
| 1 | Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas after February 2023 following an audit of 6 months activity : | A retrospective review of all the doctors who have worked since February 2023 undertaken | November 2023 | HR manager | Completed | HR response |
| | | Prospective checks have been put in place by Bank Partners to ensure all checks are in place and provide assurance | November 2023 | HR manager | Completed | |
| 4 | Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance? | All in place though the processes described as evidence. | In place | CD | complete | We have no bank or agency that have worked longer than 2 weeks.<br><br>Any long-term locums and Trust doctors are subject to formal application and interview process.<br><br>JD, person Specifications and job interview dates.<br><br>Job plans agreed on commencement.<br><br>Training given on systems eg EPMA and medway maternity. |

| No. | Recommendation | Key Action(s) | Completion Date | Responsible Lead(s) | Progress on actions and dates: | Evidence of implementation and date of implementation |
|---|---|---|---|---|---|---|
| 6 | **Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance?** | Weekend on call has been split to a Friday and Sunday or a Saturday only. On that basis Friday and Saturday are compliant. | June 2023 | Clinical Lead and CD | completed | **Oncall rota started in June 2023** |
| | | A review of job plans to understand what clinical duties are planned on Mondays or the day after their weekday oncall. | November 2023 | Clinical lead and General manager | Completed | |
| | | Review and explore the possibility to change consultant oncall day so that it precedes their day off and impact. If this is possible this will be implemented over the next 6 months. | June 24 | Clinical lead and CD | Consultant meeting 18th January 1st discussion to explore this approach. | **Change in job plans if undertaken** |
| | | Diary card exercise to be undertaken to understand the extent of calls and requirements on site between 10pm and 6am. | April 24 | Clinical Lead and CD | Consultant meeting 18th January 1st to launch | **Diary card results** |
| | | Each weekday oncall team is made up of 4 consultants. The plan is to discuss with the teams if it would be possible to manage compensatory rest on an adhoc basis within teams as required. If this is possible this will be implemented by the beginning of April 24. | If agreed it will be formally in place from April 24 based on the findings of the diary card exercise. | Clinical lead and CD | Discussion to be undertaken 18th January to explore options. **This support is currently in place in as an informal Whats App group.** | **Outcome recorded in governance meeting.** |
| | | Explore how buddying of consultants for theatre lists could facilitate compensatory rest whilst reducing the impact on patients. | March | Clinical Lead and CD | Review with Gynaecology Lead and alongside job planning work. | Rota when set up. |

| | | |
|---|---|---|
| **Meeting title** | **Trust Board – public meeting** | **Date: 26.01.2024** |
| **Report title** | **Finance report November (Month 09) 2023/24** | **Agenda item: 9** |
| **Executive director lead** | Terry Whittle, Chief Finance Officer | |
| **Report author** | Finance Team | |
| **Executive summary** | The Trust is reporting a deficit of £16.1m at the end of December which is £3.5m worse than plan. The planned deficit to end of December was £12.6m.<br><br>The year-to-date adverse financial performance to plan is mainly driven by:<br>• The non-delivery of savings on Cost Improvement Programmes (CIP).<br>• The unfunded escalation beds, endoscopy fourth room and the cost of strike cover.<br>• Elective recovery fund (ERF) underperformance.<br>• Other expenditure overspends.<br><br>The cash position at the end of December 2023 was £61.8m.<br><br>Trust has spent £17.6m on capital to end of December. | |
| **Purpose** | Discussion of December performance. | |
| **Recommendation** | To note December financial performance, recognising the need to improve savings delivery. | |
| **Board Assurance Framework** | BAF risks S1 and S2 | |
| **Report history** | Trust Management Group | |
| **Appendices** | None | |

**Trust reporting £16.1m deficit at the end of December - £3.5m worse than plan**

The Trust is reporting a deficit of £16.1m at the end of December which is £3.5m worse than plan. The planned deficit to end of December was £12.6m.

Key drivers for year-to-date financial performance are.

- Year to date slippage on saving delivery of £6.5m. The Trust delivered £5m savings year to date against a target of £11.5m. The target for the year plan is £18.0m.
- The year-to-date cost of escalation beds in Thorogood (£0.8m prior to initial closure on the 18th August), 4th endoscopy room (£0.9m), re-opening of Thorogood as a medical ward (£0.2m), Eddington ward (£0.3m of which £0.1m is for fire remediation works), winter surge costs (£0.2m), cover for December 2023 strike action (£0.2m), and provision of enhanced care (£1.0m). The cost of escalation beds is partly offset by the additional winter pressures funding that the trust received. (£500k for December).
- Elective recovery activity (ERF) is below plan by £1.7m year to date. The underperformance relates from April to October. The Trust is reporting performance is in line with plan from November onwards.
- The Trust spent £11.7m on agency staff, 4.9% of total pay costs, this is £1.1m above the year-to-date target set by NHSE. The Discretionary Spend Scrutiny panel is continuing work with the ICSUs to control and monitor agency spend.

**Cash of £61.8m as at end of December**

As at the end of December, the Trust closed with a cash balance of £61.8m, which is £4.5m lower than the balance at 30 November.

**Additional capital allocation (CRL) from the ICS**

Internally funded capital plan for 2023-24 is £20.1m including a £9.0m allocation to support investment in power and fire remedial works. Capital expenditure at end of December was £17.6m, of which £7.5m is related to nationally funded projects, £9.5m for internally funded projects and £0.6m for IFRS 16 costs. The Trust received a further £5m capital funding towards fire remediation. Nationally funded projects include Community Diagnostic Centre and TIF allocation for elective recovery.

**Better Payment Practice Performance – 98.1% 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 97.9% by volume and 95.2% by value. The BPPC for non-NHS invoices is 98.1% by volume and 98.1% by value.

**H2 reforecasting submission of £1.1m surplus**

Following the national H2 reforecasting exercise, the Trust submitted a surplus forecast of £1.1m. This forecast is £0.9m adverse to plan. The H2 submission included an underlying assumption of no further industrial action from November onwards. Hence impact of ongoing industrial action on costs and activity will impact on the trust's ability to deliver the forecast. The Trust is continuing to review its forecast to identify both recurrent and non-recurrent mitigations to help deliver its financial plan for 2023-24.

## 1. Summary of Income & Expenditure Position – Month 9

| | In Month | | | Year to Date | | | |
|---|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | Actual | Variance | Annual Budget |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Income** | | | | | | | |
| NHS Clinical Income | 24,558 | 27,176 | 2,618 | 221,601 | 233,710 | 12,109 | 295,534 |
| High Cost Drugs - Income | 817 | 1,247 | 430 | 7,352 | 9,186 | 1,833 | 9,803 |
| Non-NHS Clinical Income | 2,067 | 2,160 | 93 | 16,694 | 18,051 | 1,357 | 24,869 |
| Other Non-Patient Income | 2,085 | 2,665 | 579 | 18,600 | 20,694 | 2,093 | 24,811 |
| Elective Recovery Fund | 3,896 | 3,896 | 0 | 40,935 | 39,274 | (1,661) | 55,137 |
| | **33,424** | **37,144** | **3,721** | **305,182** | **320,914** | **15,732** | **410,154** |
| **Pay** | | | | | | | |
| Agency | (52) | (1,226) | (1,175) | (101) | (11,651) | (11,550) | (229) |
| Bank | (318) | (2,195) | (1,877) | (2,959) | (24,162) | (21,203) | (3,913) |
| Substantive | (23,912) | (23,094) | 818 | (219,776) | (204,302) | 15,474 | (285,239) |
| | **(24,282)** | **(26,515)** | **(2,234)** | **(222,836)** | **(240,115)** | **(17,279)** | **(289,381)** |
| **Non Pay** | | | | | | | |
| Non-Pay | (7,345) | (9,147) | (1,802) | (70,064) | (73,079) | (3,016) | (84,962) |
| High Cost Drugs - Exp | (803) | (882) | (79) | (7,201) | (7,678) | (477) | (9,610) |
| | **(8,148)** | **(10,029)** | **(1,881)** | **(77,265)** | **(80,758)** | **(3,493)** | **(94,571)** |
| **EBITDA** | **994** | **600** | **(394)** | **5,082** | **42** | **(5,040)** | **26,201** |
| **Post EBITDA** | | | | | | | |
| Depreciation | (1,578) | (1,617) | (39) | (14,016) | (13,839) | 177 | (18,749) |
| Interest Payable | (79) | (65) | 14 | (714) | (595) | 119 | (952) |
| Interest Receivable | 104 | 289 | 184 | 937 | 2,617 | 1,679 | 1,250 |
| Dividends Payable | (429) | (479) | (50) | (3,858) | (4,311) | (453) | (5,750) |
| P/L On Disposal Of Assets | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **(1,982)** | **(1,872)** | **109** | **(17,650)** | **(16,128)** | **1,522** | **(24,201)** |
| **Reported Surplus/(Deficit)** | **(988)** | **(1,273)** | **(285)** | **(12,568)** | **(16,086)** | **(3,518)** | **2,000** |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| IFRS & Donated | (8) | (5) | 3 | (69) | (45) | 24 | (92) |
| **Reported Surplus/(Deficit) after Impairments and IFRIC12** | **(995)** | **(1,278)** | **(282)** | **(12,637)** | **(16,131)** | **(3,494)** | **1,908** |

- The Trust year to date financial position as at the end of December is a deficit of £16.1m (excluding donated asset depreciation and impairments) against a planned deficit of £12.6m. This is £3.5m adverse to plan.

- The main drivers for this position are the under delivery on CIP (£6.5m adverse variance), higher temporary staffing costs, Industrial action costs (£2.4m) which are partially offset by interest received (£1.7m).

- The reported position includes non-recurrent benefit of £3.0m. The normalised position excluding non-recurrent benefit is £19m deficit which is £6.5m worse than the plan

## 2.0 Income and Activity Performance

### 2.1 Income Performance – December

| Income | In Month Income Plan £000's | In Month Income Actual £000's | In Month Variance £000's | YTD Income Plan £000's | YTD Income Actual £000's | YTD Variance £000's |
|---|---|---|---|---|---|---|
| A&E | 1,746 | 1,729 | (16) | 15,487 | 14,987 | (500) |
| Elective | 1,836 | 1,797 | (39) | 19,560 | 18,368 | (1,192) |
| Non-Elective | 4,929 | 5,471 | 543 | 43,744 | 43,428 | (316) |
| Critical care | 516 | 310 | (206) | 4,574 | 3,950 | (624) |
| Outpatients | 3,681 | 3,954 | 273 | 39,338 | 39,704 | 366 |
| Ambulatory | 613 | 524 | (89) | 5,440 | 4,556 | (884) |
| Direct access | 981 | 1,475 | 494 | 10,501 | 13,495 | 2,994 |
| Community | 6,499 | 6,499 | 0 | 58,489 | 58,489 | 0 |
| Other clinical income NHS | 4,576 | 6,664 | 2,088 | 31,819 | 45,866 | 14,047 |
| **NHS Clinical Income** | **25,375** | **28,423** | **3,048** | **228,953** | **242,844** | **13,891** |
| Non NHS clinical income | 2,067 | 2,160 | 93 | 16,694 | 18,051 | 1,357 |
| Elective recovery fund (ERF) | 3,896 | 3,896 | 0 | 40,935 | 39,274 | (1,661) |
| **Income From Patient Care Activities** | **31,338** | **34,480** | **3,141** | **286,582** | **300,169** | **13,587** |
| **Other Operating Income** | **2,085** | **2,665** | **579** | **18,600** | **20,746** | **2,145** |
| Total | 33,424 | 37,144 | 3,721 | 305,182 | 320,914 | 15,732 |

- Year to date Income is £15.7m over plan, driven mainly by £13.9m NHS clinical income and offset by £1.7m underperformance in ERF income.

- £13.9m NHS clinical income is driven by £6.2m pay awards, £2.2m funding for industrial action, £1.0m winter monies and risk, £1.6m drugs overperformance, £1.4m foundation trust income (£0.5m CAMHS) and £1.3m various additional NCL ICB income streams. The additional income is offset by additional expenditure.

- £1.4m non-NHS clinical income is driven by £1.1m local authority, (£1.0m neurodevelopment ADHD hub income)

- £2.1m other operating income is mainly driven by £1.0m education & costing income, £0.5m R&D, £0.2m COVID-19 reimbursement income and remainder across corporate.

### 2.2 Elective recovery fund (ERF) – December

- ERF showing £1.7m underperformance year to date. In month variance is on plan due to guidance suggesting no underperformance clawback from November onwards.

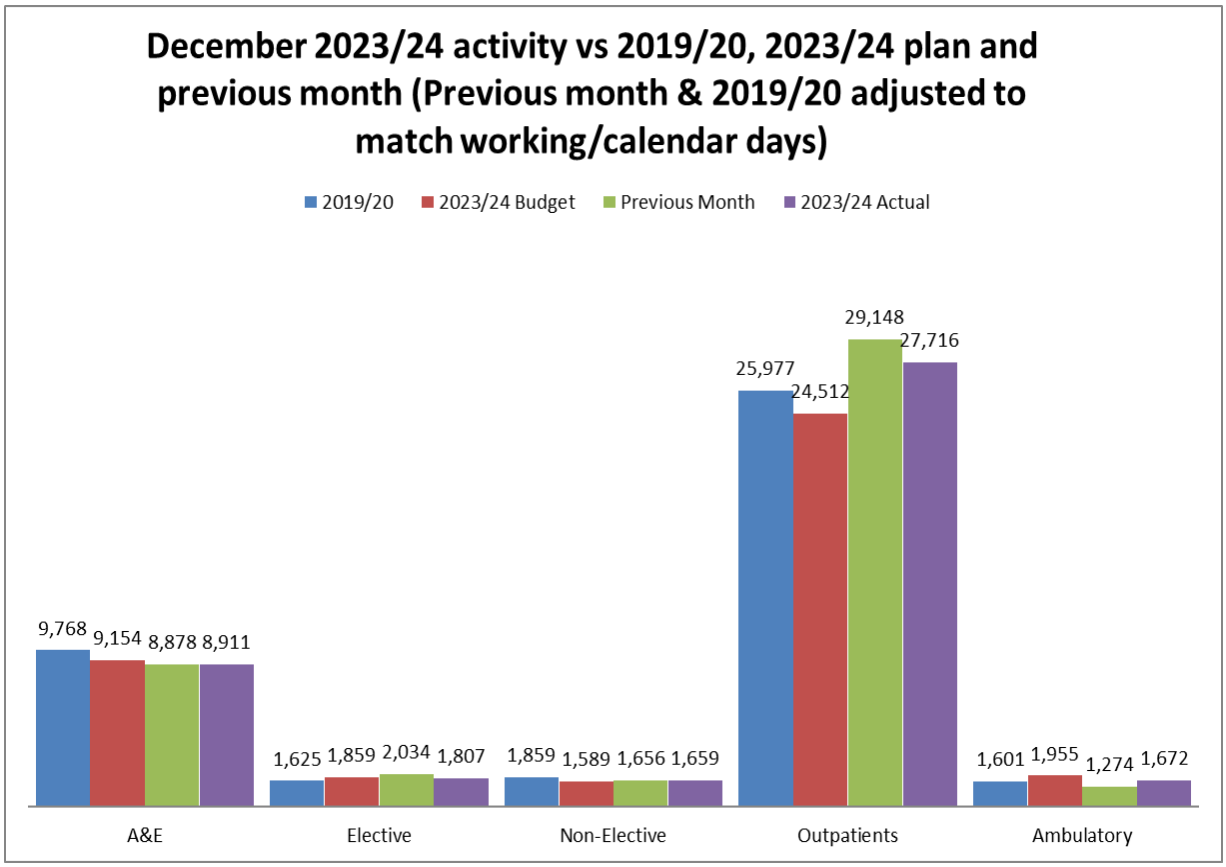
| ICSU | Annual Plan £000's | In Month Income Plan £000's | In Month Income Actual £000's | In Month Income Variance £000's | YTD Income Plan £000's | YTD Income Actual £000's | YTD Income Variance £000's |
|---|---|---|---|---|---|---|---|
| Acw | 6,528 | 453 | 381 | (72) | 4,849 | 3,997 | (852) |
| Adult Community | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Children & Young People | 6,862 | 478 | 529 | 50 | 5,098 | 4,612 | (487) |
| Emergency & Integrated Medicin | 20,656 | 1,491 | 1,512 | 21 | 15,373 | 14,355 | (1,018) |
| Surgery & Cancer | 23,243 | 1,629 | 1,426 | (202) | 17,274 | 15,297 | (1,977) |
| Corporate Central | (2,152) | (155) | 48 | 202 | (1,659) | 1,013 | 2,672 |
| Grand Total | 55,137 | 3,896 | 3,896 | 0 | 40,935 | 39,274 | (1,661) |

## 2.3 Activity Performance – December

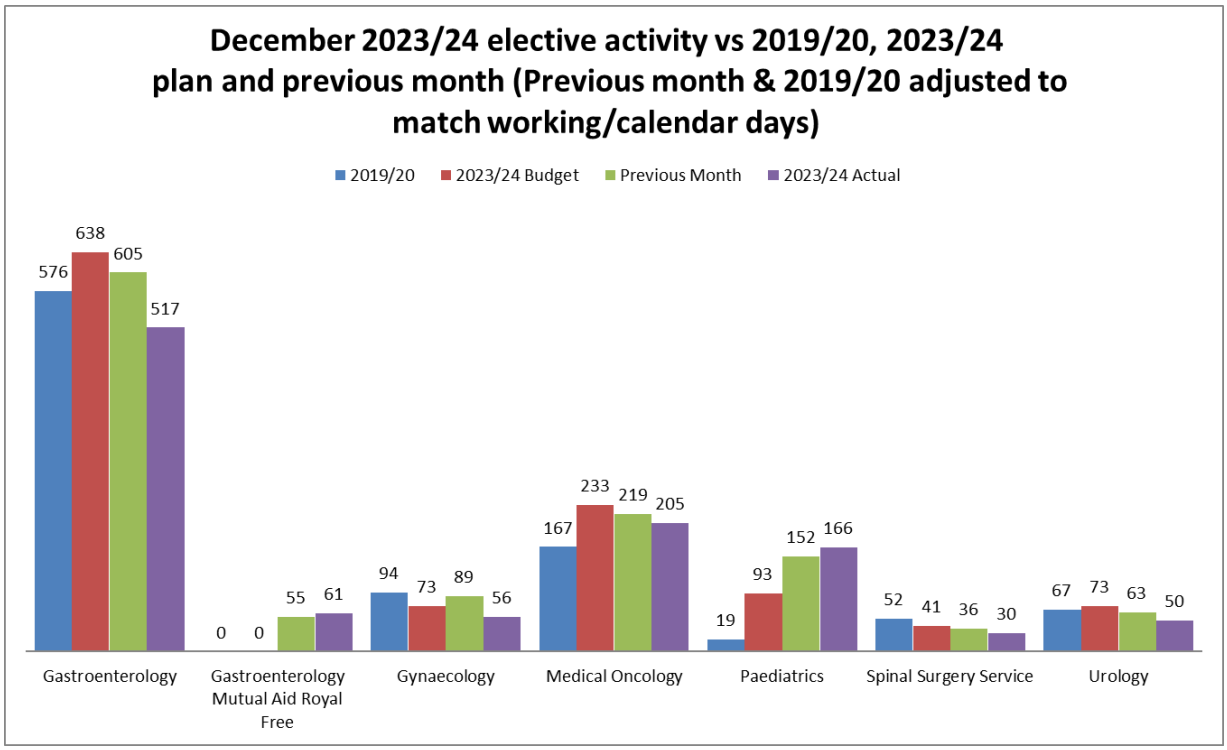
- Activity continues to be underperforming against plan in A&E, ambulatory, critical care and elective inpatients. There was overperformance in outpatients and non-elective. Direct access continued overperformance is mainly due to Pathology.

| Activity | In Month Activity Plan | In Month Activity Actual | In Month Variance | In month Activity Diff% | YTD Activity Plan | YTD Activity Actual | Activity Diff | YTD Activity Diff% |
|---|---|---|---|---|---|---|---|---|
| A&E | 9,154 | 8,911 | (243) | (3%) | 81,204 | 77,261 | (3,943) | (5%) |
| Elective | 1,860 | 1,814 | (46) | (2%) | 19,894 | 19,151 | (743) | (4%) |
| Non-Elective | 1,589 | 1,661 | 72 | 5% | 14,098 | 13,296 | (802) | (6%) |
| Critical care | 314 | 246 | (68) | (22%) | 2,783 | 2,790 | 7 | 0% |
| Outpatients | 24,515 | 27,717 | 3,203 | 13% | 262,295 | 276,034 | 13,740 | 5% |
| Ambulatory | 1,955 | 1,672 | (283) | (14%) | 17,341 | 14,532 | (2,809) | (16%) |
| Direct Access | 79,877 | 122,564 | 42,686 | 53% | 855,237 | 1,107,783 | 252,546 | 30% |

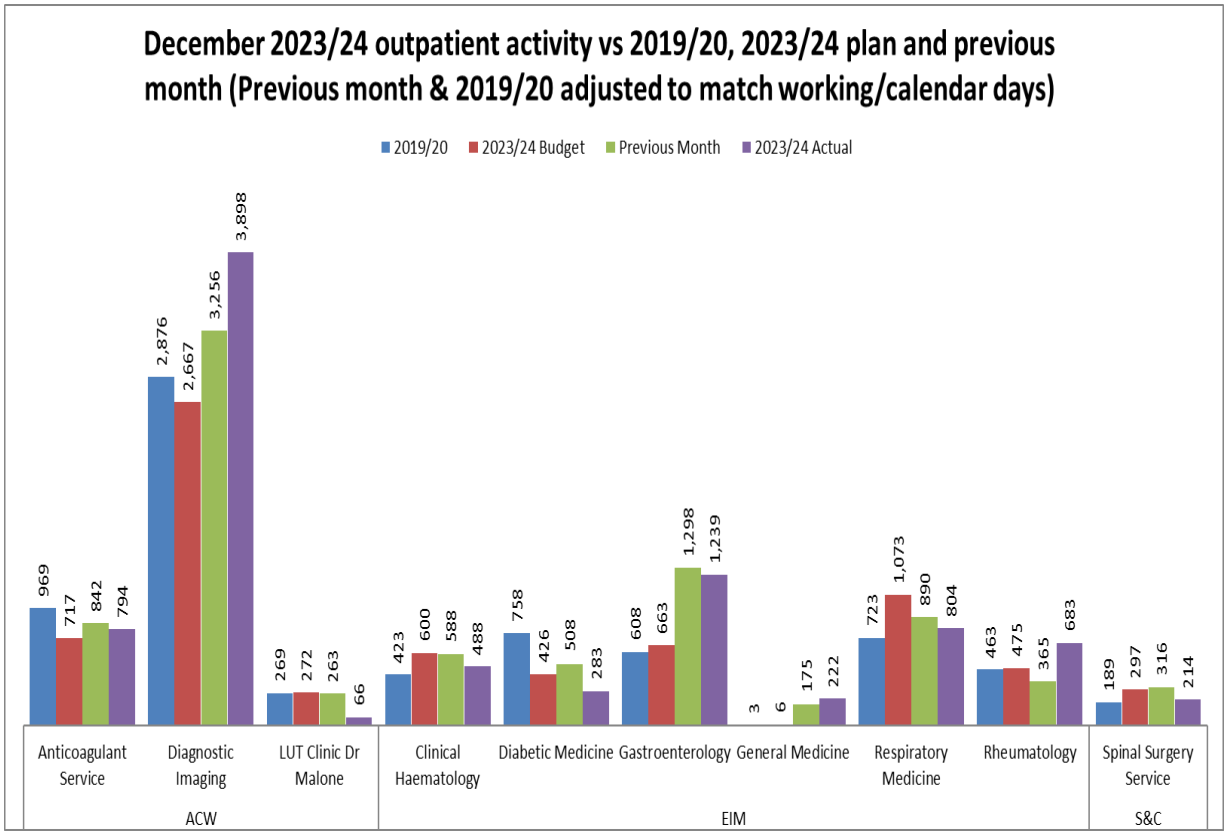
- Activity is in line with November (adjusted for working/calendar days) across all points of delivery.



- Elective activity is slightly under plan. The largest in month drivers were urology (31%), gastroenterology (9% including RFH), medical oncology (12%), spinal surgery (26%) and gynaecology (235). Offset by overperformance in paediatrics (78%)




Outpatients over plan. The main drivers are diagnostic imaging (46%), gastroenterology (87%), rheumatology (44%), anticoagulant (11%), and general medicine. Offset by underperformance in LUTS (76%), respiratory medicine (25%), clinical haematology (19%) diabetic medicine (34%) and spinal surgery (28%)



## 3. Expenditure – Pay & Non-pay

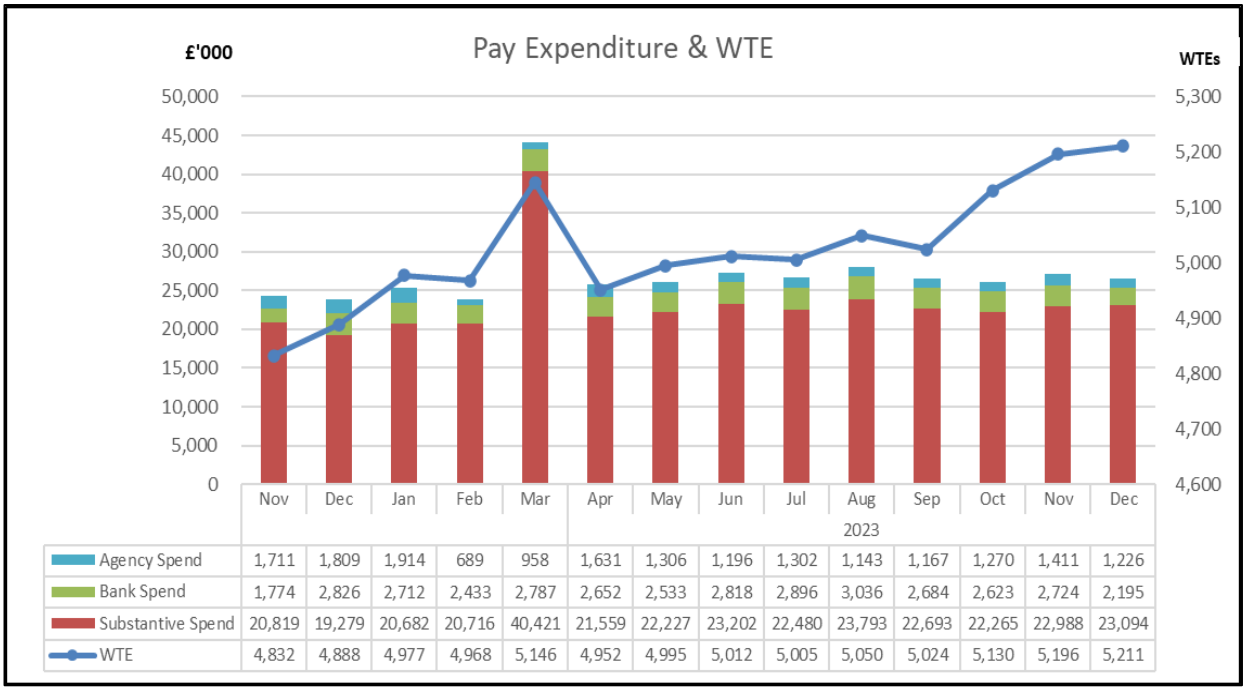
### 3.1 Pay Expenditure

Pay expenditure for December was £26.5m, a decrease of £0.6m from the M8 position mainly due to non-recurrent benefit included in non-operational pay costs.

Movement in operational pay costs is also due to escalation beds and continued supernumerary costs in maternity and medical wards within EIM due to the success in substantive recruitment. Other operational movements are from unachieved CIPs across all ICSUs which is partly being offset by vacancies and slippages in some of the planned investments.

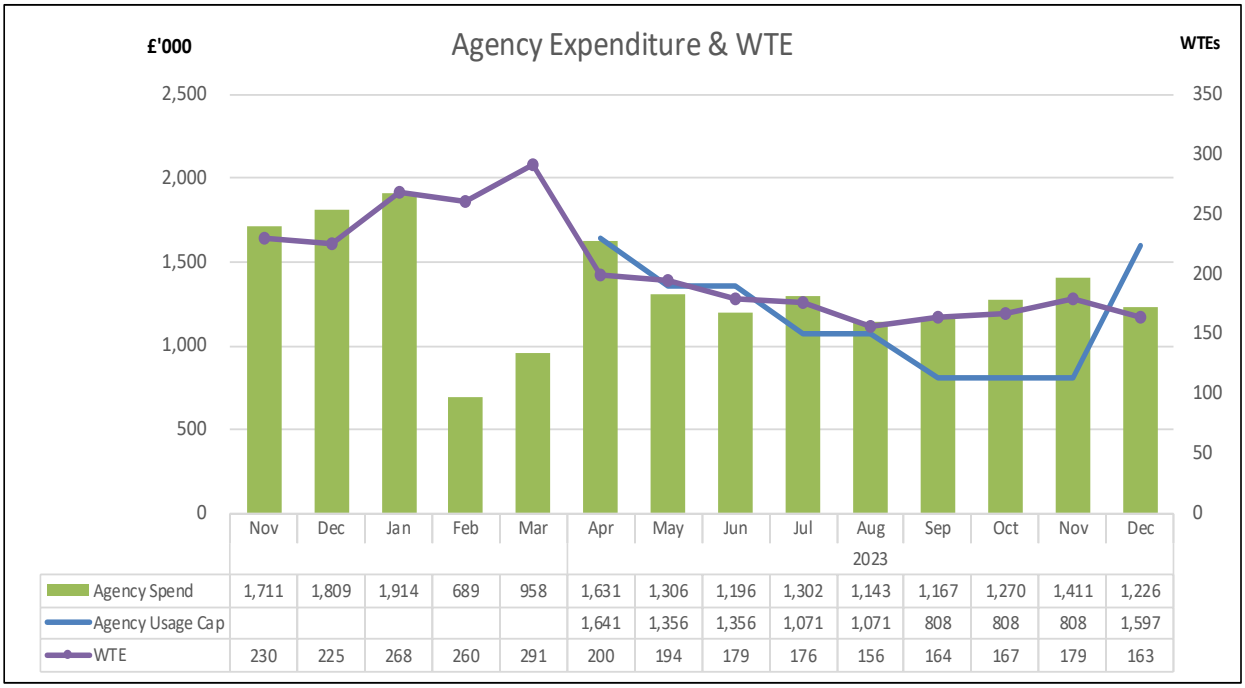
The month-on-month difference in non-operational pay category is due to the release of the non-recurrent benefits in month.

| | 2023-24 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Mov^t |
| Agency | 1,631 | 1,234 | 1,223 | 1,302 | 1,143 | 1,167 | 1,270 | 1,411 | 1,226 | (184) |
| Bank | 2,651 | 2,533 | 2,817 | 2,894 | 3,034 | 2,684 | 2,634 | 2,728 | 3,031 | 303 |
| Substantive | 20,561 | 20,960 | 24,015 | 21,847 | 22,448 | 23,751 | 22,566 | 22,868 | 22,974 | 106 |
| **Total Operational Pay** | **24,842** | **24,726** | **28,055** | **26,043** | **26,624** | **27,602** | **26,470** | **27,006** | **27,231** | **225** |
| **Non Operational Pay Costs** | 999 | 1,340 | (839) | 635 | 1,348 | (1,057) | (312) | 117 | (716) | (832) |
| | | | | | | | | | | 0 |
| **Total Pay Costs** | **25,841** | **26,066** | **27,216** | **26,678** | **27,973** | **26,544** | **26,158** | **27,123** | **26,515** | **(607)** |




| | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Agency Spend | 1,711 | 1,809 | 1,914 | 689 | 958 | 1,631 | 1,306 | 1,196 | 1,302 | 1,143 | 1,167 | 1,270 | 1,411 | 1,226 |
| Bank Spend | 1,774 | 2,826 | 2,712 | 2,433 | 2,787 | 2,652 | 2,533 | 2,818 | 2,896 | 3,036 | 2,684 | 2,623 | 2,724 | 2,195 |
| Substantive Spend | 20,819 | 19,279 | 20,682 | 20,716 | 40,421 | 21,559 | 22,227 | 23,202 | 22,480 | 23,793 | 22,693 | 22,265 | 22,988 | 23,094 |
| WTE | 4,832 | 4,888 | 4,977 | 4,968 | 5,146 | 4,952 | 4,995 | 5,012 | 5,005 | 5,050 | 5,024 | 5,130 | 5,196 | 5,211 |

March 2023 substantive pay costs included £11m additional pension contribution from Department of Health and cost of 2022/23 non-consolidated pay award £8.5m.




*2023-24 agency usage cap figures issued by NHSE. Lower spend in Feb & March is due to release of non-recurrent provisions.

## 3.2 Non-pay Expenditure

Non-pay spend for December was £9.1m, a £1.1m increase from November spend. This is made up of net movement across various non pay categories including research and development costs which is offset by grants, utilities and reactive maintenance costs within Premises & Fixed Plant.

| | 2023-24 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Non-Pay Costs** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Mov^t** |
| Supplies & Servs - Clin | 3,112 | 3,161 | 3,514 | 3,523 | 3,087 | 3,182 | 3,214 | 3,262 | 3,455 | 193 |
| Supplies & Servs - Gen | 333 | 376 | 442 | 310 | 440 | 341 | 391 | 332 | 456 | 123 |
| Establishment | 263 | 240 | 284 | 237 | 273 | 324 | 320 | 334 | 293 | (41) |
| Healthcare From Non Nhs | 95 | 79 | 85 | 76 | 80 | 75 | 75 | 56 | 75 | 18 |
| Premises & Fixed Plant | 2,286 | 1,924 | 2,431 | 2,628 | 2,030 | 2,507 | 2,037 | 2,287 | 2,709 | 421 |
| Ext Cont Staffing & Cons | 193 | 388 | 265 | 13 | 169 | 218 | 127 | 16 | 152 | 136 |
| Miscellaneous | 1,821 | 1,836 | 1,295 | 1,942 | 669 | 1,255 | 1,868 | 1,732 | 1,997 | 265 |
| Chairman & Non-Executives | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 11 | 11 | (1) |
| Non-Pay Reserve | 42 | 388 | (251) | (178) | (5) | 5 | 0 | 0 | 0 | 0 |
| **Total Non-Pay Costs** | **8,155** | **8,400** | **8,075** | **8,559** | **6,753** | **7,917** | **8,041** | **8,031** | **9,147** | **1,116** |

*Excludes high-cost drug expenditure and depreciation.*
*Included in miscellaneous is CNST premium, Transport contract, professional fees, and bad debt provision.*

## Miscellaneous Expenditure Breakdown

| | 2023-24 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Miscellaneous Breakdown** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Mov^t** |
| Ambulance Contract | 175 | 206 | 185 | 172 | 199 | 139 | 207 | 137 | 174 | 37 |
| Other Expenditure | 155 | 85 | 166 | 100 | (483) | 66 | 92 | 60 | 120 | 59 |
| Audit Fees | 15 | 12 | (17) | 11 | 13 | 11 | 11 | 11 | 11 | 0 |
| Provision For Bad Debts | 65 | 94 | (238) | 250 | (596) | (212) | 57 | (34) | 34 | 68 |
| Cnst Premium | 821 | 821 | 821 | 821 | 821 | 577 | 780 | 778 | 765 | (13) |
| Fire Security Equip & Maint | 5 | 5 | 6 | 10 | 7 | 13 | 4 | 47 | 2 | (45) |
| Interpretation/Translation | 27 | 8 | 31 | 21 | 14 | 21 | 10 | 102 | 36 | (66) |
| Membership Subscriptions | 125 | 159 | 117 | 161 | 135 | 146 | 146 | 149 | 61 | (88) |
| Professional Services | 355 | 354 | 115 | 288 | 495 | 399 | 387 | 389 | 374 | (15) |
| Research & Development Exp | (1) | (1) | (1) | 4 | 12 | (1) | 8 | 6 | 286 | 280 |
| Security Internal Recharge | 10 | 11 | 14 | 13 | (0) | 12 | 10 | 7 | 10 | 3 |
| Teaching/Training Expenditure | 66 | 77 | 92 | 89 | 49 | 84 | 152 | 73 | 124 | 51 |
| Travel & Subs-Patients | 2 | 4 | 4 | 1 | 4 | 0 | 5 | 7 | 0 | (6) |
| Work Permits | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Write Down Of Inventories | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Non-Pay Costs** | **1,821** | **1,836** | **1,295** | **1,942** | **669** | **1,255** | **1,868** | **1,732** | **1,997** | **265** |

## 3.3 Cost Improvement Programmes (CIP)

The CIP target for 2023-24 is £18.0m. The targets have been allocated to ICSU and corporate divisions as part of 2023-24 budgets.

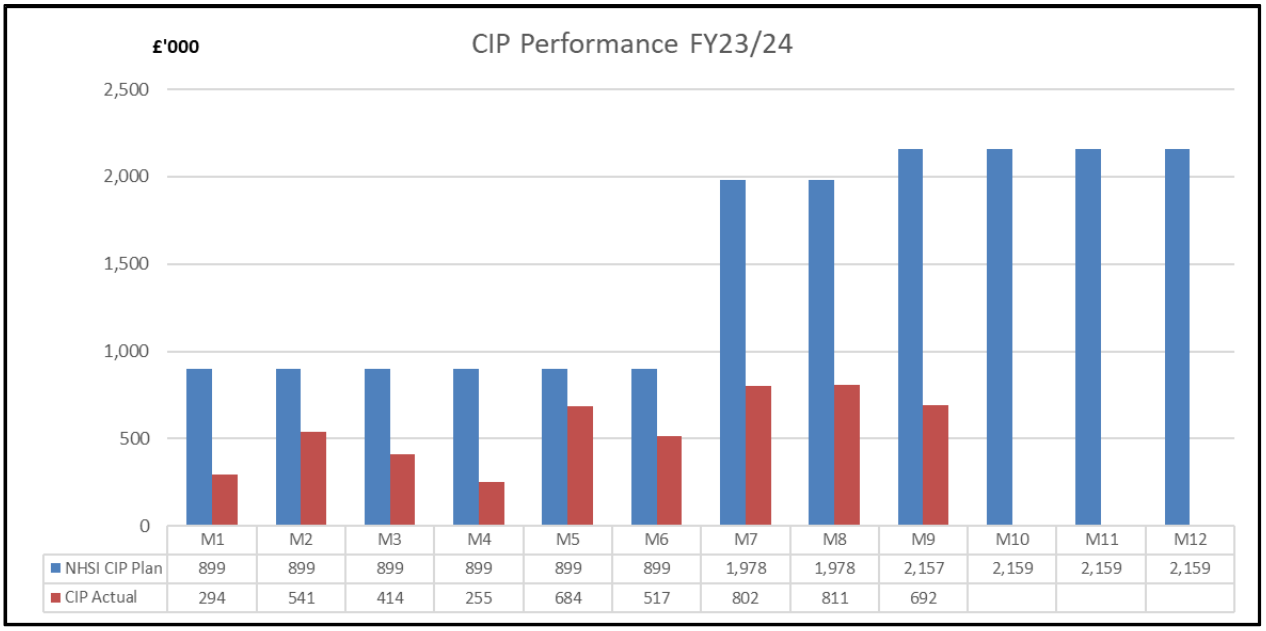
| ICSU | 23/24 CIP Target Allocated £'000 |
|---|---|
| ADULT COMMUNITY | 1,683 |
| CHILDREN & YOUNG PEOPLE | 2,525 |
| EMERGENCY & INTEGRATED MEDICINE | 3,171 |
| SURGERY & CANCER | 3,054 |
| ACW | 3,424 |
| **ICSU TOTAL** | **13,857** |
| CORPORATE SERVICES TOTAL | 4,127 |
| **CIP GRAND TOTAL** | **17,984** |

| CORPORATE DIRECTORATES | 23/24 CIP Target Allocated £'000 |
|---|---|
| CHIEF OPERATION OFFICER | 131 |
| ESTASTES & FACILITIES | 2,130 |
| FINANCE | 355 |
| ICT | 511 |
| MEDICAL DIRECTOR | 130 |
| NURSING & PATIENT EXPERIENCE | 352 |
| TRUST SECRETARIAT | 139 |
| WORKFORCE | 325 |
| PROCUREMENT | 54 |
| **CORPORATE TOTAL** | **4,127** |

### Year to Actuals

At the end of December, the Trust is reporting actual delivery of £5.0m year to date of CIP against a target of £11.5m (56% under YTD plan).

| ICSU | 23/24 CIP Target Allocated £'000 | YTD Plan £'000 | YTD Actuals £'000 | YTD Variance £'000 | YTD Actuals vs YTD Plan % |
|---|---|---|---|---|---|
| ADULT COMMUNITY | 1,683 | 1,077 | 738 | (339) | 68.5% |
| CHILDREN & YOUNG PEOPLE | 2,525 | 1,616 | 1,047 | (569) | 64.8% |
| EMERGENCY & INTEGRATED MEDICINE | 3,171 | 2,029 | 199 | (1,831) | 9.8% |
| SURGERY & CANCER | 3,054 | 1,955 | 597 | (1,358) | 30.5% |
| ACW | 3,424 | 2,191 | 921 | (1,270) | 42.0% |
| **ICSU TOTAL** | **13,857** | **8,868** | **3,502** | **(5,367)** | **39.5%** |
| CORPORATE SERVICES | 1,943 | 1,244 | 1,201 | (42) | 96.6% |
| ESTATES & FACILITIES | 2,130 | 1,363 | 306 | (1,057) | 22.5% |
| PROCUREMENT | 54 | 35 | - | (35) | 0.0% |
| **CIP GRAND TOTAL** | **17,984** | **11,510** | **5,010** | **(6,500)** | **43.5%** |




| | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NHSI CIP Plan | 899 | 899 | 899 | 899 | 899 | 899 | 1,978 | 1,978 | 2,157 | 2,159 | 2,159 | 2,159 |
| CIP Actual | 294 | 541 | 414 | 255 | 684 | 517 | 802 | 811 | 692 | | | |

## 4.0 Statement of Financial Position (SoFP)

The net balance on the Statement of Final Position as of 31st December 2023 was £234.9m, which is £1.3m lower than November 2023, as shown in the table below.

| Statement of Financial Position as at 31st December 2023 | 2022/23 M12 Balance | 2023/24 M8 Balance | 2023/24 M9 Balance | Movement in Month |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **NON-CURRENT ASSETS:** | | | | |
| Property, Plant And Equipment | 230,044 | 231,438 | 230,504 | (934) |
| Intangible Assets | 7,051 | 6,492 | 6,269 | (223) |
| Right of Use Assets | 36,444 | 41,148 | 40,798 | (350) |
| Assets Under Construction | 31,917 | 36,521 | 38,814 | 2,293 |
| Trade & Other Rec -Non-Current | 584 | 556 | 548 | (8) |
| **TOTAL NON-CURRENT ASSETS** | **306,040** | **316,155** | **316,933** | **778** |
| **CURRENT ASSETS:** | | | | |
| Inventories | 942 | 1,081 | 1,072 | (9) |
| Trade And Other Receivables | 25,881 | 16,520 | 18,200 | 1,680 |
| Cash And Cash Equivalents | 72,991 | 66,245 | 61,755 | (4,490) |
| **TOTAL CURRENT ASSETS** | **99,813** | **83,846** | **81,028** | **(2,818)** |
| **CURRENT LIABILITIES** | | | | |
| Trade And Other Payables | (80,777) | (77,379) | (78,651) | (1,272) |
| Borrowings: Finance Leases | (808) | (113) | (26) | 87 |
| Borrowings: Right of Use Assets | (4,370) | (4,370) | (4,370) | 0 |
| Borrowings: Dh Revenue and Capital Loan - Current | (116) | (116) | (116) | 0 |
| Provisions for Liabilities and Charges | (1,774) | (1,737) | (1,727) | 9 |
| Other Liabilities | (2,701) | (6,558) | (4,955) | 1,604 |
| **TOTAL CURRENT LIABILITIES** | **(90,545)** | **(90,273)** | **(89,845)** | **428** |
| | | | | |
| **NET CURRENT ASSETS / (LIABILITIES)** | **9,268** | **(6,427)** | **(8,817)** | **(2,390)** |
| | | | | |
| **TOTAL ASSETS LESS CURRENT LIABILITIES** | **315,309** | **309,728** | **308,116** | **(1,613)** |
| **NON-CURRENT LIABILITIES** | | | | |
| Borrowings: Dh Revenue and Capital Loan - Non-Current | (1,624) | (1,566) | (1,566) | 0 |
| Borrowings: Finance Leases | (3,011) | (3,011) | (3,011) | 0 |
| Borrowings: Right of Use Assets | (32,250) | (37,073) | (36,738) | 335 |
| Provisions for Liabilities & Charges | (31,963) | (31,886) | (31,886) | 0 |
| **TOTAL NON-CURRENT LIABILITIES** | **(68,848)** | **(73,536)** | **(73,201)** | **335** |
| | | | | |
| **TOTAL ASSETS EMPLOYED** | **246,460** | **236,193** | **234,915** | **(1,278)** |
| **FINANCED BY TAXPAYERS EQUITY** | | | | |
| Public Dividend Capital | 120,707 | 125,293 | 125,293 | 0 |
| Retained Earnings | 25,454 | 10,600 | 9,322 | (1,278) |
| Revaluation Reserve | 100,300 | 100,300 | 100,300 | 0 |
| **TOTAL TAXPAYERS EQUITY** | **246,460** | **236,193** | **234,915** | **(1,278)** |

The most significant movements in the month to 31st December 2023 were as follows:

### Non-current assets

**Asset Under Construction** closed at £38.8m in December, an increase of £2.3m mainly Wood Green Community Diagnostics Centre Phase 2.

### Current assets

**Trade and Other Receivables** closed at £18.2m in December, an increase of £1.7m, mainly income Community Diagnostic Centre accrued income of £1.5m and NHS NWL income accrual of £0.3m

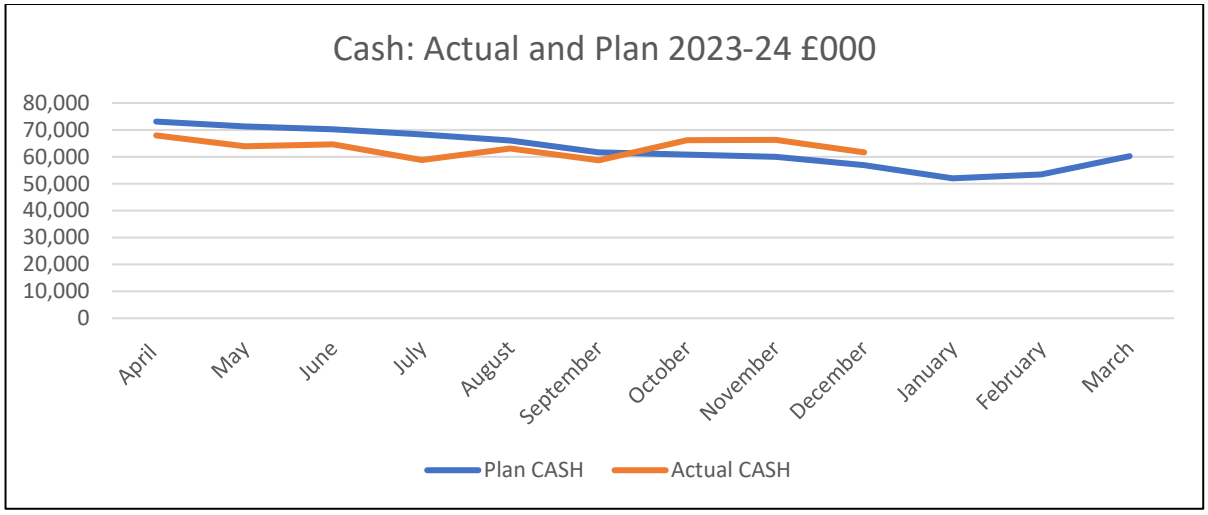
**Current liabilities**

**Trade and Other Payables** closed at £78.7m in December, an increase of £1.3m. Goods Received Not Invoiced (GRNI capital) £0.8m and current AP creditors £0.8m.

**Other Liabilities** closing at £5.0m in December 23, a decrease of £1.6m. This is mainly deferred income from Health Education England Learning and Development Agreement.

**Cash**

As at the end of December, the Trust closed with a cash balance of £61.8m, which is £4.5m lower than the balance at 30 November.




The Trust continues to monitor its actual and forecast cash position against Plan. The table below summarises the position at 31st December. Forecast cash at 31st March 2024 is £39.0m lower than originally planned owing to the factors shown. The principal variance arises in respect of capital expenditure: the £14.0m of additional CRL awarded is non-cash backed, and the Trust has paid down the very significant capital creditors which existed at 31 March 2023, as the receipted orders were invoiced and paid.

| | 2023-24 | | | |
|---|---|---|---|---|
| | **Plan** | **Forecast at Month 9** | **Variance: Forecast to Plan** | **Factors** |
| **Opening Cash** | **75,377** | **72,990** | **(2,387)** | |
| I&E as Plan Soci | 1,908 | 1,908 | 0 | |
| Underlying deficit | | | | |
| CIP | | | | |
| Capital expenditure | (24,359) | (45,212) | (20,853) | Additional capital of £9m strategic projects and £5m fire are both non-cash backed. Paydown of capital creditors £6.9m |
| Working capital change | (4,000) | (3,850) | 150 | Lower closing creditors projected as Trust BPPC performance improves |
| Reduction in provisions and accruals | (13,600) | (29,500) | (15,900) | Achievement of planned surplus in light of underperformance against CIPs achieved through greater than planned balance sheet impacts |
| Depreciation and Amortisatio | 14,628 | 14,628 | 0 | |
| FL interest | (672) | (672) | 0 | |
| Reduction of FL creditor | (997) | (997) | 0 | |
| PDC drawdown | 12,148 | 12,148 | 0 | |
| Loan repayments:principal | (116) | (116) | 0 | |
| Loan repayments: interest | (52) | (52) | 0 | |
| **Closing Cash** | **60,265** | **21,275** | **(38,990)** | |

**Interest Received**

Year-to-date interest received is £2.6m which is favourable to Plan by £0.9m. The Plan was set with an anticipated peak to interest rates around Month 6-7 of the 2023-24 financial year and expected reduction in cash balances during the year. Work with the PMO team determined that the amount of £0.4m can be identified as CIP with minimal risk, whilst having regard to interest rate and cash balance reductions as the year progresses. This will be reviewed for further CIP opportunities if the higher interest rates continue.

## 5.0 Capital Expenditure

Capital expenditure on 31st December was £17.6m, of which £7.5m related to PDC (and other external) funded, £9.5m to internally-funded projects and £0.6m to IFRS16 leases.

Table below details progress against internally-funded capital, including performance against M9 forecast. Significant slippage was observed against M9 forecasts for Maternity & Neonatal, Power, Air Handling, and Window Replacement. This was offset in part by significantly better than forecast spend against Fire Remediation in month. The risk around slippage against forecast is managed through regular meetings with the project leads and Capital Monitoring Group chaired by the CFO. For Month 9, the most significant projects at risk of under-delivering are subject to separate, dedicated reviews with the Chief Finance Officer.

| | YTD Actuals | Annual Plan | Project lead Forecast outturn | YTD spend as % of Annual plan | M9 Actuals | Forecast for M9 | Variance from M9 forecast |
|---|---|---|---|---|---|---|---|
| | £(000) | £(000) | £(000) | | £(000) | £(000) | £(000) |
| ***Internally Funded:*** | | | | | | | |
| **Estate** | | | | | | | |
| Estates 2324 | 840 | 2,292 | 2,271 | 36.6% | 88 | 254 | (165) |
| Estates PY 2223 | 1,527 | 1,208 | 1,610 | 126.4% | 4 | 23 | (18) |
| | | | | | | | |
| **Strategic Projects** | | | | | | | |
| M & N | 768 | 1,000 | 2,000 | 76.8% | 148 | 365 | (217) |
| Power | 1,686 | 7,240 | 6,159 | 23.3% | 36 | 337 | (301) |
| Fire Safety A and L Blocks | 2,780 | 5,000 | 5,000 | 55.6% | 1,241 | 802 | 439 |
| Salary recharge capital | 231 | 250 | 331 | 92.5% | 19 | 28 | (8) |
| Salix | 21 | 0 | 48 | | 21 | 0 | 21 |
| | | | | | | | |
| ICT | 263 | 512 | 535 | 51.3% | 8 | 82 | (74) |
| Equipment | 535 | 500 | 535 | 107.1% | 20 | 0 | 20 |
| Contingency | 62 | 260 | 258 | 23.7% | 11 | 0 | 11 |
| MES Enabling work | 644 | 860 | 802 | 74.9% | 91 | 58 | 33 |
| Pathology | 44 | 600 | 600 | 7.4% | 0 | 120 | (120) |
| ICSUs | 112 | 355 | 350 | 31.4% | 28 | 0 | 28 |
| **Total Internally Funded** | **9,514** | **20,077** | **20,500** | **47.4%** | **1,716** | **2,067** | **(352)** |

The Trust accepted a £5m increase to CDEL for fire remediation towards the end of December 2023, and discussions continue as to whether cash will be made available for this. The TIF project underspent its Month 9 in-month forecast by £0.2m, and there is a risk that the Trust will underspend its TIF allocation for the financial year.

Within the above figures, purchase orders have been raised for the MES Enabling project, which carries a £0.7m accrual to budget, and is expected to complete by 31st March 2024.

| | YTD Actuals £(000) | Annual Plan £(000) | Project lead Forecast outturn £(000) |
|---|---|---|---|
| ***Externally funded (PDC):*** | | | |
| Wood Green CDC | 6,318 | 8,350 | 7,860 |
| LIMS & Interoperability | 0 | 44 | 44 |
| DDC: Image Sharing | 0 | 72 | 72 |
| TIF: Relocation of Recovery | 649 | 3,595 | 3,595 |
| Fire Safety A and L Blocks | 0 | 0 | 5,000 |
| Digital Pathology | 0 | 87 | 0 |
| | | | |
| ***Externally funded (Other):*** | | | |
| Wood Green Hub | **571** | 0 | 860 |
| | | | |
| **Total Externally Funded** | **7,538** | **12,148** | **17,431** |
| | | | |
| ***ROU funded (Leases):*** | | | |
| MES finance lease untrasound | 0 | 480 | 480 |
| Wood Green CDC 2 RoU | 579 | 579 | 579 |

| | | |
|---|---|---|
| **Meeting title** | **Trust Board – public meeting** | **Date: 26.01.2024** |
| **Report title** | **Integrated Performance Report** | **Agenda item: 10** |
| **Executive lead** | Jonathan Gardner, Chief Strategy, Digital and Improvement Officer | |
| **Report owner** | Paul Attwal, Head of Performance, Jennifer Marlow, Performance Manager | |
| **Executive summary** | Board members should note that all metrics are shown in summary, but only certain measures have been highlighted for further analysis and explanation based on their trajectory, importance, and assurance.<br><br>This report should be read in the context of considerable pressures of high demand in our urgent care and elective care pathways as a result of industrial action. The organisation has put considerable effort at every level to mitigate these issues where possible.<br><br>**Emergency Care Flow**<br>During December 2023, performance against the 4-hour access standard was 57.8%, which is lower than the NCL average of 65.43%, and lower than the London average of 70.59% and the national average of 69.44%. There were 322 12-hour trolley breaches in December 2023.<br>**12-hour trolley breaches show the numbers of patients who waited longer than 12 hours to be admitted to the ward following a decision to admit (DTA)*<br><br>**Cancer**<br>28 Day Faster Diagnosis was at 66.3% in November 2023 against a standard of 75%, this is an improvement of 4% compared to 62.3%.in October 2023. Early review of December performance indicates further improvement and likely achievement of the 75% target.<br><br>62-day referral to treatment performance was at 48.8% for November 2023 against a target of 85%. This is a worsening of 2.2% compared to 51% in October 2023<br><br>At the end of December 2023, the Trusts position against the 62-day backlog was ahead of trajectory with 73 against a target of 80.<br><br>**Referral to Treatment: 52+ Week Waits**<br>Performance against 18-week standard for December 2023 was 66.5%, this is an improvement of 0.45% from November's performance of 66.1%.<br>The Trust position against the 52-week performance has improved from 720 patients waiting more than 52-weeks for treatment in November 2023 to 659 in December 2023. The Trust had 36 patients over 78 weeks at the end of December 2023 against a target of 0.<br><br>**Workforce**<br>Appraisal rates for December 2023 were at 79.4%, this is an improvement of 0.5% from November's performance of 78.9%. Work continues to support service areas to improve overall compliance. | |

| | |
|---|---|
| | December's performance for mandatory training was not available at time of publication.<br><br>**Complaints**<br>Complaints Responded to Within 25 or 40 Working Days has worsened from 45% in November 2023 to 26.1% in December 2023, which remains below the required standard of 80%. The Complaints Team continue to work closely with the ICSUs to support with the completion of these and all complaint investigations. |
| **Purpose** | Review and assurance of Trust performance compliance |
| **Recommendation** | That the Board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan |
| **Board Assurance Framework** | The following BAF entries are linked: Quality 1; Quality 2;<br>People 1; and, People 2. |
| **Report history** | Trust Management Group |

# Whittington Health NHS Trust

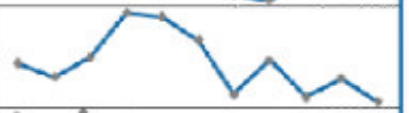
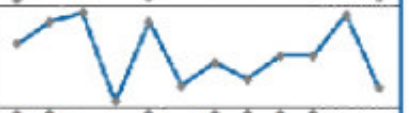
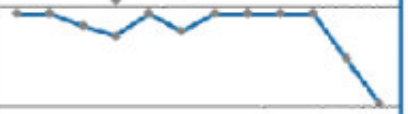
## Performance Report

**January 2024**

**Month 9 (2023-2024)**

# Community - Performance Dashboard

Whittington Health NHS Trust

| Indicator | Target | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | 2023-2024 | Activity |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IAPT Moving to Recovery | 50.0% | 53.1% | 50.7% | 52.5% | 48.7% | 50.0% | 49.9% | 44.5% | 43.8% | 46.8% | 45.5% | 45.2% | | 46.9% |  |
| IAPT Waiting Times for Treatment (% <6 wks) | >75% | 92.9% | 92.0% | 93.3% | 96.2% | 95.9% | 94.4% | 90.9% | 93.1% | 90.7% | 91.9% | 90.4% | | 92.9% |  |
| % Of Msk PTS With a Significant Improvement in Function (PSFS) | >75% | 90.7% | 74.4% | 91.5% | 81.7% | 75.8% | 83.3% | 77.5% | 79.8% | 84.7% | 79.5% | 74.8% | 71.3% | 78.4% |  |
| % Of Podiatry PTS With a Significant Improvement in Pain (VAS) | >75% | 91.7% | 89.5% | 87.5% | 83.3% | 75.0% | 59.5% | 79.2% | 72.7% | 66.7% | 75.0% | 94.1% | 57.1% | 72.3% |  |
| Ictt - % Patients With Self-Directed Goals Set at Discharge | >70% | 70.1% | 72.8% | 75.3% | 77.4% | 70.4% | 74.3% | 70.9% | 71.6% | 72.0% | 71.2% | 73.9% | 70.4% | 72.1% |  |
| Ictt - % Gas Scores Improved or Remained the Same at Discharge | >70% | 92.7% | 94.7% | 95.5% | 87.7% | 94.7% | 89.1% | 91.1% | 89.7% | 91.7% | 91.7% | 95.3% | 88.9% | 91.3% |  |
| REACH - % BBIC Scores Improved or Remained the Same at Discharge | >75% | 100.0% | 100.0% | 85.7% | 75.0% | 100.0% | 80.0% | 100.0% | 100.0% | 100.0% | 100.0% | 50.0% | | 90.3% |  |
| Hackney Smoking Cessation: % Who Set Quit Date and Stopped After 4 Weeks | >45% | >45% | | | 54.3% | | | 51.9% | | | 54.8% | | | 53.4% | |

ICARE EQUITY

# Adult Community - Waiting Times

Whittington Health NHS Trust

| Indicator (Routine Appointments) | Target | Target Weeks | Oct-23 | Nov-23 | Dec-23 | Average Wait (Latest Month) | No. of Patients Seen |
|---|---|---|---|---|---|---|---|
| Community Matron | >95% | 6 | 87.5% | 100.0% | 100.0% | 1.2 | 14 |
| Adult Wheelchair Service | >95% | 8 | 100.0% | 100.0% | 100.0% | 1.6 | 33 |
| Community Rehabilitation (CRT) | >95% | 12 | 82.8% | 78.8% | 78.7% | 10.7 | 47 |
| ICTT - Other | >95% | 12 | 98.8% | 96.3% | 100.0% | 3.3 | 132 |
| ICTT - Stroke and Neuro | >95% | 12 | 37.5% | 60.0% | 77.8% | 9.7 | 9 |
| Home-based Intermediate Care Service | >95% | - | 75.9% | 81.1% | 92.2% | 2.8 | 64 |
| Paediatric Wheelchair Service | >95% | 8 | 100.0% | 100.0% | 100.0% | 2.5 | 6 |
| Bladder and Bowel - Adult | >95% | 12 | 56.1% | 53.6% | 41.7% | 12.1 | 96 |
| Musculoskeletal Service - CATS | >95% | 6 | 31.8% | 25.3% | 24.8% | 14.2 | 443 |
| Musculoskeletal Service - Routine | >95% | 6 | 31.1% | 28.2% | 34.4% | 17.2 | 1097 |
| Nutrition and Dietetics | >95% | 6 | 97.0% | 94.9% | 97.7% | 2.7 | 128 |
| Podiatry (Foot Health) | >95% | 6 | 19.5% | 27.4% | 29.5% | 9.3 | 407 |
| Lymphoderma Care | >95% | 6 | 65.0% | 48.0% | 15.4% | 10.5 | 13 |
| Tissue Viability | >95% | 6 | 100.0% | 100.0% | 97.9% | 1.6 | 47 |
| Cardiology Service | >95% | 6 | 97.6% | 95.9% | 98.2% | 2.0 | 55 |
| Diabetes Service | >95% | 6 | 100.0% | 100.0% | 100.0% | 3.3 | 112 |
| Respiratory Service | >95% | 6 | 100.0% | 61.3% | 33.3% | 11.3 | 87 |
| Spirometry Service | >95% | 6 | 100.0% | 100.0% | 100.0% | 2.5 | 46 |
| Integrated MDT | >95% | 6 | 93.0% | 87.5% | 92.1% | 2.1 | 152 |
| Indicator (Urgent Appointments) | | | | | | | |
| Adult Wheelchair Service | >95% | 2 | 100.0% | 100.0% | 100.0% | 0.0 | 3 |
| Community Rehabilitation (CRT) | >95% | 2 | 57.7% | 48.7% | 42.9% | 9.9 | 21 |
| ICTT - Other | >95% | 2 | 5.9% | 0.0% | 0.0% | 10.7 | 11 |
| ICTT - Stroke and Neuro | >95% | 2 | 11.1% | 60.0% | 55.6% | 2.0 | 9 |
| Home-based Intermediate Care Service | >95% | - | 87.1% | 90.6% | 92.1% | 0.8 | 63 |
| Musculoskeletal Service - CATS | >95% | 2 | 23.1% | 25.0% | 25.0% | 3.8 | 12 |
| Musculoskeletal Service - Routine | >95% | 2 | 46.8% | 54.5% | 57.8% | 2.7 | 83 |
| Nutrition and Dietetics | >95% | 2 | 100.0% | 100.0% | 100.0% | 0.0 | 1 |

## Adult Community Waiting Times

### Podiatry:

Overall improvements were being made but have stalled over Christmas period due to leave and sickness, recovery is expected to pick up again as plan.

### Islington Community Neuro-Rehabilitation (ICRT):

Waiting times for neuro and stroke rehabilitation have grown due to the pandemic's lasting effects and extended length of stay. Agency staff have been recruited to manage the backlog temporarily. Several resignations posed a potential threat to recovery, however they have now been recruited to and awaiting staff starting in post. The Parkinson's Warrior class has now restarted and should impact on recovery should soon be felt.

### Bladder and Bowel Service:

Recovery plans are underway and group consultations have restarted and are being evaluated for impact. There has been limited progress in recent months due to staffing, resolution of this is in progress.

### Musculoskeletal (MSK):

MSK faces a backlog due to triaging and patients added to the waiting list. There has been some progression total numbers waiting for both MSK CATS and MSK Physio since November The service has recruited a new service manager, MSK CATS Clinical lead and MSK Physio clinical lead and is now fully staffed and has a detailed recovery plan underway including ongoing agency usage, more super Saturdays, waiting list cleansing and validation, expansion of digital self-management 'GetUBetter' tool usage, 2 Community Appointment days are planned for February to trial a different 'what matters to you' approach and we will evaluate the impact. There are monthly recovery meetings scheduled with ACS Directors and the MSK leadership team.

ICARE EQUITY

# Children's Community – Waiting Times

Whittington Health NHS Trust

| Indicator (Routine Appointments) | Target | Target Weeks | Oct-23 | Nov-23 | Dec-23 | Average Wait (Latest Month) | No. of Patients Seen |
|---|---|---|---|---|---|---|---|
| CAMHS | >95% | 8 | 75.4% | 59.8% | 57.6% | 11.1 | 99 |
| Community Children's Nursing | >95% | 6 | 85.7% | 87.5% | 98.2% | 1.1 | 56 |
| Community Paediatrics - Haringey | >95% | 18 | 86.7% | 75.8% | 94.1% | 7.0 | 51 |
| Community Paediatrics - Islington | >95% | 18 | 100.0% | 100.0% | 100.0% | 2.6 | 10 |
| Haringey - SCT | >95% | 20 | 0.0% | 0.0% | 0.0% | 58.7 | 13 |
| Islington SCT (0-5s) | >95% | 20 | 6.3% | 3.0% | 0.0% | 54.2 | 20 |
| CLA Initial Assessments - Haringey | >95% | 4 | 60.0% | 83.3% | 80.0% | 2.7 | 5 |
| CLA Initial Assessments - Islington | >95% | 4 | 100.0% | 100.0% | 66.7% | 16.9 | 6 |
| Occupational Therapy - Barnet | >95% | 18 | 85.7% | 98.0% | 75.0% | 19.8 | 16 |
| Occupational Therapy - Haringey | >95% | 18 | 92.3% | 93.3% | 94.1% | 9.6 | 17 |
| Occupational Therapy - Islington | >95% | 18 | 55.6% | 66.7% | 66.7% | 17.9 | 9 |
| Paediatrics Nutrition & Dietetics Haringey | >95% | 12 | 50.0% | 89.5% | 100.0% | 2.5 | 5 |
| Paediatrics Nutrition & Dietetics Islington | >95% | 12 | 100.0% | 100.0% | 100.0% | 3.1 | 24 |
| Physiotherapy - Barnet | >95% | 18 | 100.0% | 100.0% | 97.0% | 10.2 | 33 |
| Physiotherapy - Haringey | >95% | 18 | 96.5% | 94.7% | 100.0% | 6.8 | 61 |
| Physiotherapy - Islington | >95% | 18 | 100.0% | 97.5% | 100.0% | 3.3 | 43 |
| PIPS | >95% | 12 | 100.0% | 95.0% | 100.0% | 4.3 | 9 |
| SALT - Barnet | >95% | 18 | 52.9% | 50.0% | 33.3% | 25.2 | 57 |
| SALT - Camden | >95% | 6 | 75.5% | 69.4% | 72.9% | 5.2 | 48 |
| SALT - Haringey | >95% | 13 | 21.6% | 47.9% | 35.6% | 19.9 | 59 |
| SALT - Islington | >95% | 13 | 95.1% | 64.7% | 76.9% | 10.4 | 26 |
| SALT - MPC | >95% | 18 | 92.6% | 96.4% | 94.4% | 5.5 | 18 |
| School Nursing - Haringey | >95% | 12 | 93.7% | 97.1% | 97.2% | 2.3 | 71 |
| School Nursing - Islington | >95% | 12 | 91.4% | 97.5% | 96.9% | 1.6 | 65 |
| **Indicator (Urgent Appointments)** | | | | | | | |
| CAMHS | >95% | 2 | 90.9% | 100.0% | 88.2% | 0.9 | 17 |
| Community Children's Nursing | >95% | 1 | 100.0% | 100.0% | 100.0% | 0.0 | 6 |

| Indicator | Target | Current Month | | Previous Month | 2023-2024 |
|---|---|---|---|---|---|
| Haringey New Birth Visits - % Seen Within 2 Weeks | >95% | Nov | 92.0% | 92.2% | 92.3% |
| Islington New Birth Visits - % Seen Within 2 Weeks | >95% | Nov | 93.0% | 93.3% | 94.9% |

## Children's Community Waits

### Autism Assessments:

- In Islington staffing challenges have had an impact on waiting times for 0-5 autism assessments. On a positive note, the new assessment pathway means the team are able to carry out more assessments with fewer staff than was possible last year.
- In Haringey the waiting time for autism assessments has reduced over the past year though waits are still too long. Recently vacancies and strikes have impacted on capacity. New staff are joining the team over the next 2 months which will increase the capacity for assessments. The increased referral rate continues to be challenging.

### Therapies:

- Speech and Language Therapy (SLT) waiting times in Barnet have increased due to capacity not matching high demand. Recruitment to newly funded roles is progressing and temporary staff are in place to support provision.
- It continues to be challenging to meet waiting time targets for Occupational Therapy (OT) in Islington. The service continues to strengthen the Universal offer, increase the training offer and working with local partners to ensure needs are met.
- In Haringey the new Speech Language and Communication Needs pathways for early years and primary schools have launched and we anticipate this having an impact on reducing referrals to the service over the next year. In the meantime, we are still managing a backlog of referrals and some staffing gaps.

ICARE EQUITY

# Safe

| Indicator | Target | Current Month | | Previous Month | 2023-2024 | Variation | Assurance |
|---|---|---|---|---|---|---|---|
| Admissions to Adult Facilities of Patient <16 Years | 0 | Dec | 0 | 0 | 0 | | |
| HCAI C Difficile | <13 | Dec | 1 | 3 | 12 | | |
| Actual Falls | 400 | Dec | 31 | 27 | 248 | | |
| Category 3 or 4 Pressure Ulcers | 64 | Dec | 11 | 11 | 93 | | |
| Medication Errors Causing Serious Harm | 0 | Dec | 0 | 0 | 1 | | |
| MRSA Bacteraemia Incidences | 0 | Dec | 1 | 0 | 1 | | |
| Never Events | 0 | Dec | 0 | 1 | 2 | | |
| Serious Incidents | N/A | Dec | 0 | 2 | 8 | | |
| VTE Risk Assessment % | >95% | Dec | 93.8% | 95.3% | 95.2% | | |
| Mixed Sex Accomodation Breaches | 0 | Dec | 12 | 7 | 72 | | |
| Summary Hospital Level Mortality Indicator (SHMI) | 1.14 | July 2022 - June 2023 | 0.94 | | 0.93 | | |

## Category 3 or 4 Pressure Ulcers - *Target 0*

**December Performance – 11**

**Category 3 = 8 (3 in Community)**
**Category 4 = 3 (3 in Community)**

**Issues:**

5 hospital acquired full thickness pressure ulcers occurred on a total of 5 patients. 5 full thickness pressure ulcers developed in the community including all category 4 pressure ulcers, affecting 6 patients. All category 4 pressure ulcers were previously reported as unstageable. Delays in appropriate equipment provision (delivery and repairs), ability to effectively reposition patients and issues with carer input and sub-optimal skin assessment checks were key contributory factors.

**Actions:**

Ongoing implementation of Trust Pressure Ulcer Improvement action plan. Increased access to multi-format education programmes. Development of media resources for carers on pressure area care. Continued escalation and monitoring on NRS community equipment issues

## Summary Hospital Level Mortality Indicator (SHMI) - *Target <1.14*

SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die.

**(July 2022-June 2023) Performance – 0.94**

This is a worsening of 0.4 from (April 2022-March 2023) performance of 0.9

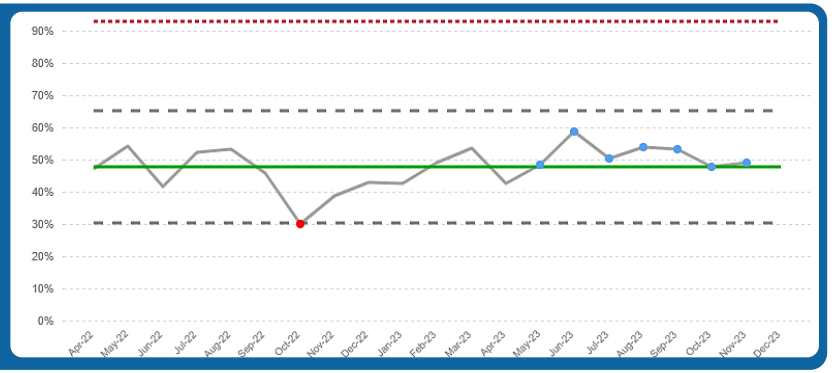
The SHMI has increased but at the lower end of the as expected range. The mortality review group are working with Dr Foster to review mortality data and how it is impacted by coding and other issues.

# Responsive - Access

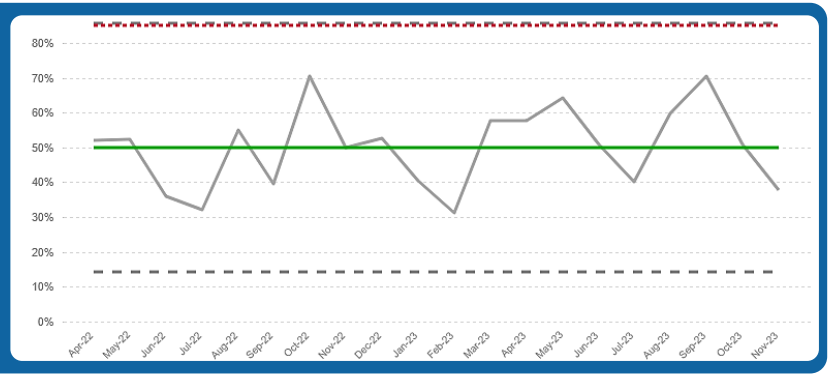
NHS Whittington Health NHS Trust

| Indicator | Target | Current Month | | Previous Month | 2023-2024 | Variation | Assurance |
|---|---|---|---|---|---|---|---|
| Cancer - 14 Days to First Seen | >93% | Nov | 49.2% | 47.8% | 50.6% | | F |
| Cancer - 14 Days to First Seen - Breast Symptomatic | >93% | Nov | 10.5% | 4.0% | 7.6% | L | F |
| Cancer - 62 Days From Referral to Treatment | >85% | Nov | 37.7% | 51.0% | 53.2% | L | F |
| Cancer ITT - Reallocated Breach Performance for 62 Day Pathways | >85% | Nov | 34.6% | 49.1% | 50.5% | L | F |
| Cancer ITT - % Of Pathways Sent Before 38 Days | >85% | Nov | 29.4% | 22.2% | 19.3% | | F |
| Cancer - % Pathways Received a Diagnosis Within 28 Days of Referral | >75% | Nov | 66.3% | 62.3% | 64.8% | | F |
| Cancer - 31 Days to First Treatment | >96% | Nov | 92.2% | 85.3% | 94.7% | | |
| Cancer - 62 Day Screening | >90% | Nov | 0.0% | 33.3% | 45.2% | L | F |
| DM01 - Diagnostic Waits (<6 Weeks) | >99% | Dec | 89.2% | 92.0% | 84.9% | | F |
| RTT - Incomplete % Waiting <18 Weeks | >92% | Dec | 66.5% | 66.1% | 66.2% | | F |
| Referral to Treatment 18 Weeks - 52 Week Waits | 0 | Dec | 659 | 720 | 6400 | | F |
| % Seen <=48 Hours of Referral to District Nursing Service | >95% | Dec | 92.0% | 92.7% | 89.9% | | F |
| % Of Rapid Response Urgent Referrals Seen Within 2 Hours of Referral | | Dec | 71.6% | 65.1% | 73.8% | | |

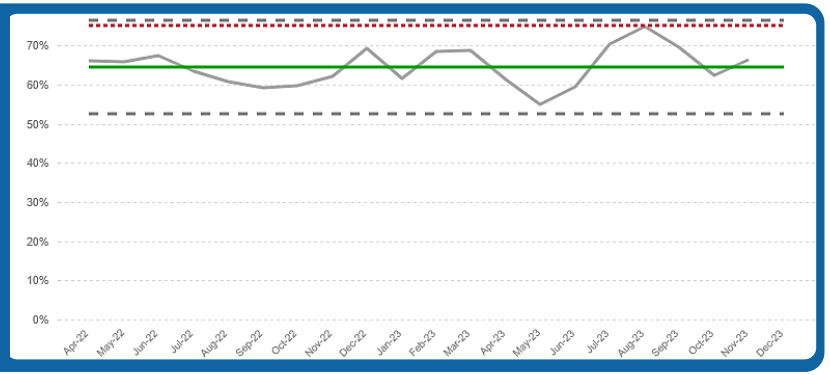
Cancer - 14 Days to First Seen




Cancer - 62 Day Performance




Cancer - 28 Day FDS




ICARE EQUITY

# Responsive - Access

NHS Whittington Health NHS Trust

| What the Data Tells Us | Issues | Actions |
|---|---|---|
| **Cancer: 14-Days to First Seen - *Target >93%***<br>*No. of pts first seen by a specialist within two weeks of referral.*<br>**November Performance – 49.2%**<br>This is an improvement of 1.4% compared to 47.8%.in October 2023 | • Breast performance remained the same in November at 11.7% due to the impact of IA from September & October<br>• Skin performance increased to 44% in November from 34.6 % in October.<br>• Gynaecology performance improved from 10% in October to 74.4% in November<br>• Urology performance decreased to 66.3% for November from 78.9% in October | • Demand and capacity planning began in September within the breast service to identify additional capacity requirements needed to reduce first appointment wait time, FDS and 62 days – Modelling complete and finance approval was given in December to start Waiting list initiatives. WLI list have been well utilised at 123% capacity and 96% respectively<br>• Dermatology continues additional weekday and weekend capacity lists to meet referral demand, this continued throughout November and December. Demand capacity modelling took place in November to support longer term workforce planning with support from the IS planned from January 2024 to support demand referrals<br>• Continuation of additional capacity for Rapid Access Clinics for Gynaecology funded by NCL Cancer Alliance till March 2024<br>• Continue to monitor referral patterns throughout all tumour groups to plan and provide appropriate capacity |
| **Cancer: 28-Day Faster Diagnosis Standard (FDS) - *Target >75%***<br>*% Pathways Received a Diagnosis within 28 Days of Referral.*<br>**November Performance – 66.3%**<br>This is an improvement of 4% compared to 62.3%.in October 2023 | • Breast performance improved to 65.8% in November from 40.1% in October<br>• Gynaecology performance decreased to 26.7% in November from 38.6% in October<br>• Upper GI performance decreased to 33.3% in November from 77.8% in October<br>• Urology performance decreased to 29.9% in November from 37.2% in October | • To further improve the effectiveness and consistency in our tracking and co-ordination for outpatients, diagnostics, histology, an MDT coordinator tracker has been funded by NCL cancer Alliance until March 24 enabling improved Data quality and PTL management.<br>• Action plan for Breast and Gynaecology will improve 14 days/ 28-day FDS performance<br>• Urology performance continued to be challenged due to workforce vacancies within the registrar establishment. Successful recruitment took place in November and the urology department planned to be at full registrar establishment by March 2024. Locum support in place for the interim.<br>• Gynaecology continuing with business case and planning to address short-term issues and longer-term robustness of service including: sonography/admin/CNS/consultant staffing. Annual leave and IA impacted November's performance |
| **Cancer: 62-Day Performance - *Target >85%***<br>*No. of pts receiving their first treatment for cancer within 62 days of GP referral.*<br>**November Performance – 48.8%**<br>This is a worsening of 2.2% compared to 51% in October 2023 | • Breast performance was 0% for November, with all patients treated over 62 days<br>• Both Gynaecology and Lung performance was at 25% for November<br>• Urology performance was at 21.4% for November | • 62-day performance impacted by industrial action in September and October with all theatre activity cancelled throughout the strike days<br>• Breast service additional outpatient and theatres capacity planned to start in December and January respectively and will remain until Year end. This will start to improve 62-day performance<br>• Urology surgical and prostate oncology pathway in planning for a joint pathway with UCLH. Planned to commence January 24<br>• Lung pathway challenged due to PET scan & Ebus capacity challenges at UCLH<br>• Gynaecology performance challenged due to workforce challenges with annual leave and the impact of previous months IA. Business planning under way to provide longer term stability |

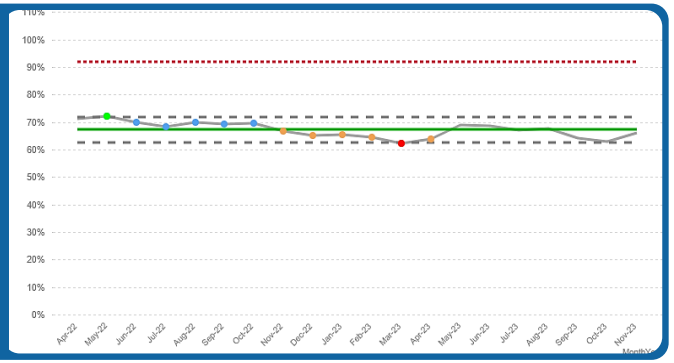
ICARE EQUITY

# Responsive - Access

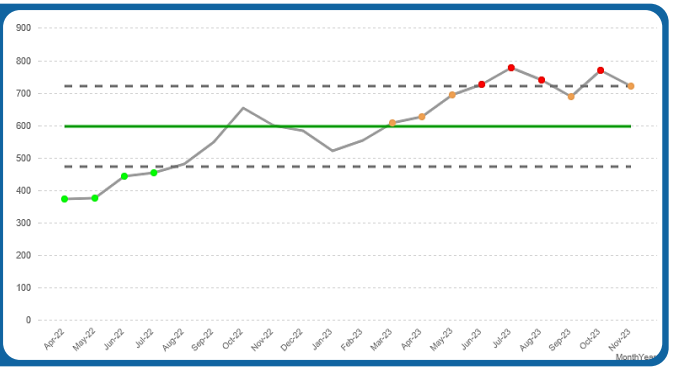
Whittington Health NHS Trust

| What the Data Tells Us | Issues | Actions and Mitigations |
|---|---|---|
| **Referral to Treatment Incomplete % Waiting <18 Week** – ***Target 92%***<br><br>**December Performance – 66.46%**<br>This is an improvement of 0.45% from November's performance of 66.1%. | • The Trust was 36 patients away from hitting the 78-week target<br>• The overall 52-week position has not worsened despite industrial action in December. | • Ongoing review to ensure the Trust is compliant against the 65-week target by the end of 2023/24.<br>• Additional sessions to mitigate backlog increase took place throughout November and December 2023.<br>• Ongoing review to check the Trust is compliant against the new national requirement of having no over 78-week waiters by the end of March 2024. |
| **Referral to Treatment 18 Weeks - 52 Week Waits** – ***Target 0***<br><br>**December Performance – 659**<br>This is a worsening of 61 from November's performance of 720<br>There were 36 Patients waiting over 78 weeks. | | |
| **DM01: Diagnostic Waits <6 Weeks – Target 99%**<br>*Percentage of patients waiting less than 6 weeks for 15 key diagnostic tests and procedures.*<br><br>**December Performance –89.24%**<br>This is a worsening of 2.76% from November's performance of 92%. | • Overall improvement in the backlog continues, with a noticeable improvement in audiology assessments, however it remains behind target.<br>• The areas of concern remain around neurophysiology tests, and sleep studies which relate to capacity constraints.<br>• Significant improvement with echocardiograms who achieved 100% compliance against the standard. | • Audiology continue to implement extra clinics to support recovery plan.<br>• The Clinical Diagnostic Centre in Wood Green will support MRI capacity and opened in December 2023. Due to industrial action improvements are expected to be seen through quarter 4 2023/24.<br>• Service reviewing capacity for neurophysiology and sleep studies as part of business planning for 2024/25 |

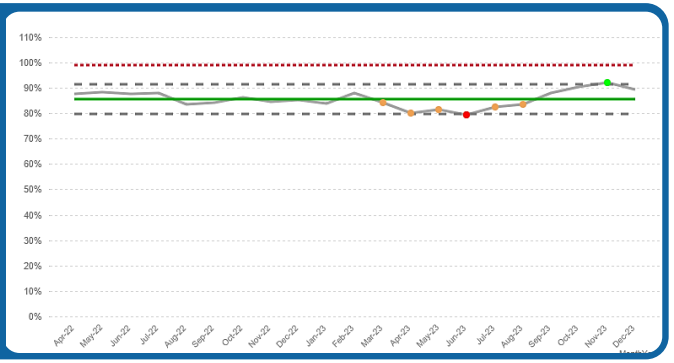
18 Weeks RTT



52-Week Waiters



DM01



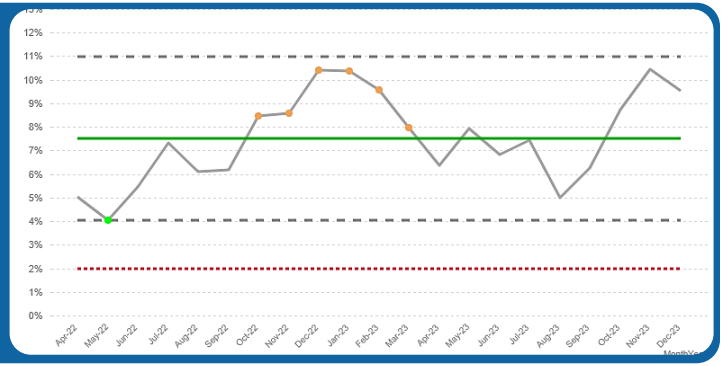
ICARE EQUITY

# Responsive - Emergency Care

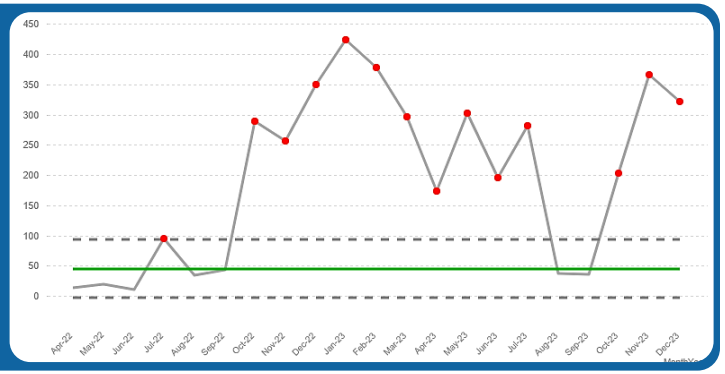
Whittington Health NHS Trust

| Indicator | Target | Current Month | | Previous Month | 2023-2024 | Variation | Assurance |
|---|---|---|---|---|---|---|---|
| Las Patient Handover Times - 30 Mins | 0 | Dec | 86 | 94 | 633 | | F |
| Las Patient Handover Times - 60 Mins | 0 | Dec | 16 | 9 | 172 | | F |
| % Streamed to an Onsite Service | >7.5% | Dec | 2.0% | 1.6% | 2.0% | | F |
| Median Wait for Treatment (Minutes) | < 60 min | Dec | 124 Mins | 122 Mins | 106 Mins | | F |
| % Of ED Attendance Seen by Clinician Within 60 Mins of Arrival | | Dec | 29.4% | 29.1% | 35.9% | | |
| Median Time From Arrival to Decision to Admit | | Dec | 05:10 | 05:26 | 04:53 | | |
| 12 Hour Trolley Waits in ED | 0 | Dec | 322 | 366 | 1915 | | F |
| Total ED Attendances in Dept for More Than 12 Hours (Arrival to Dept) | | Dec | 848 | 767 | 5904 | | |
| % Of ED Attendances Over 12 Hours From Arrival to Departure | <2% | Dec | 9.5% | 10.4% | 7.6% | | F |
| ED Waits (4 Hrs Wait) | >95% | Dec | 57.8% | 58.5% | 63.9% | | F |
| % Left ED Before Being Seen | | Dec | 12.8% | 12.6% | 11.9% | | |
| % ED Re-Attendance Within 7 Days | | Dec | 9.9% | 9.3% | 10.2% | | |

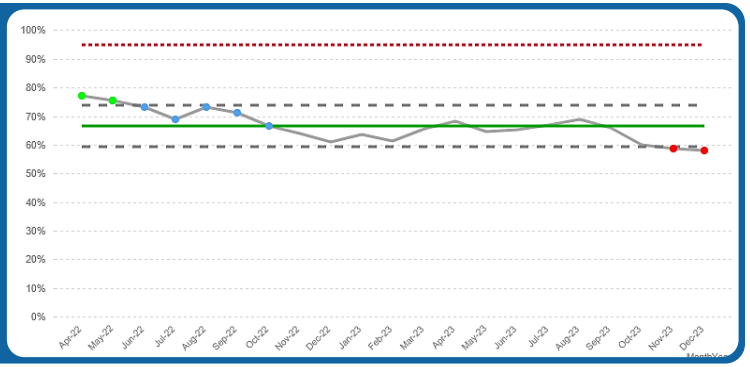
ED Attendances Over 12 Hours



12-Hour Trolley Waits in ED



ED 4-hour Waits



ICARE EQUITY

# Responsive - Emergency Care

NHS Whittington Health NHS Trust

| What the Data Tells Us | Issues | Actions and Mitigations |
|---|---|---|
| **% Of ED Attendances Over 12 Hours - *Target <2%***<br>*Percentage of patients in ED for more than 12 hour.*<br>**December Performance – 9.5%**<br>This is an improvement of 0.9% from November's performance of 10.4%.<br><br>**12-Hour Trolley Waits in ED - *Target 0***<br>*No. of patients who waited longer than 12 hours to be admitted to the ward following decision to admit.*<br>**December Performance – 322**<br>**(Average 10 per day)**<br>This is an improvement of 44 from November's performance of 366.<br><br>**Emergency Department Waits (4 hrs wait) - *Target >95%***<br>*No. of patients treated within 4 hours of arrival in ED.*<br>**December Performance – 57.8%**<br>This is a worsening of 0.7% from November's performance of 58.5%.<br><br>**LAS Handovers - *Target 0***<br>*Number of Ambulance Handover delays of greater than 30 minutes and 60 minutes.*<br>**December Performance (30 mins) – 86**<br>This is an improvement of 8 from 94 in November 2023.<br>**December Performance (60 mins) – 16**<br>This is a worsening of 7 from 9 in November 2023.<br><br>***Median Wait for Treatment - Target <60***<br>*Time from arrival to seeing a doctor or nurse practitioner.*<br>**December Performance – 124 minutes**<br>This is a worsening of 2 minutes from 122 in November 202 | **Sector Challenges**<br>Pressures across NCL continued in December with NMUH requesting regular diverts<br><br>**Whittington position and impact**<br>• Emergency Department on OPEL 4 70% of days in December<br>• Increased attendances from 8592 in November to 8911 in December which is a 3.7% increase<br>• Increase in 45 min LAS offload protocol<br>• Higher acuity of patients requiring prolonged senior resource<br>• Industrial action 21st, 22nd and 23rd of December<br>• Approximately 20% of complex and acute patients being streamed to UTC making it challenging to treat patients within 4hrs<br>• Workforce challenges with sickness and vacancies<br>• High number of MH patients spending an average of 640 mins in the department | **UEC improvement plan developed which focusses on Inflow, ED assessment and Outflow**<br>Focus on streaming:<br>• Improving streaming pathways to Urgent Treatment Centre (UTC) and Primary Care and working with GP liaison to engage with Primary Care partners<br>• Increased collaboration with Ambulatory Emergency Care (AEC) to improve pathways and increase streaming<br>• Embedding senior decision makers in Rapid Assessment Triage (RAT)<br>ED assessment and Management:<br>• Implemented huddles in majors to focus on breach prevention, resource redirection and escalations<br>• Finalised GP tendering specification to provide increased GP provision in the UTC<br>Specialty review, discharge and admission:<br>• Focus on UTC performance with daily huddles to review wait times, breach preventions and resource allocation<br>• 6-week pilot in UTC to ensure appropriate patients streamed to UTC<br>• Embedding senior decision maker presence in UTC<br>• Improve specialty response times and escalations<br>• Embedding criteria led discharge<br>• Early system escalation for discharges working with community partners, social care, mental health providers and councils<br>• Focus on criteria not met to reside and reducing long LOS<br>• Increased virtual ward capacity<br>• Improvement weeks to support flow undertaken prior to Christmas and in January |

ICARE EQUITY

# Activity

Whittington Health NHS Trust

| Indicator | Target | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Activity |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ED Attendances | | 8309 | 7891 | 8762 | 7988 | 8823 | 9098 | 8609 | 8042 | 8426 | 8772 | 8592 | 8911 | |
| ED Admission Rate % | | 10.9% | 9.9% | 10.4% | 10.6% | 9.6% | 9.3% | 9.7% | 10.0% | 10.3% | 10.2% | 10.8% | 11.4% | |
| Elective and Daycase | | 2233 | 2012 | 2152 | 1877 | 2221 | 2418 | 1910 | 2167 | 2150 | 2317 | 2402 | 1895 | |
| Emergency Inpatients | | 1605 | 1468 | 1619 | 1395 | 1551 | 1588 | 1576 | 1589 | 1622 | 1638 | 1672 | 1768 | |
| GP Referrals to an Acute Service | | 8140 | 7410 | 8489 | 6672 | 10025 | 8067 | 7101 | 7861 | 7717 | 8628 | 8183 | 6312 | |
| % Of GP Referrals Completed via eRS | | 72.8% | 68.7% | 69.5% | 61.9% | 58.7% | 52.7% | 44.0% | 44.9% | 50.4% | 53.2% | 67.4% | 71.9% | |
| % e-Referral Service (e-RS) Slot Issues | <4% | 34.3% | 35.3% | 38.5% | 48.0% | 48.2% | 56.5% | 69.6% | 65.8% | 60.3% | 61.2% | 69.6% | 71.9% | |
| Maternity Births | 320 | 248 | 221 | 227 | 192 | 226 | 228 | 237 | 263 | 245 | 266 | 251 | 234 | |
| Maternity Bookings | 377 | 293 | 327 | 356 | 313 | 263 | 291 | 302 | 274 | 271 | 300 | 332 | 310 | |
| Outpatient DNA Rate % - New | <10% | 11.2% | 11.4% | 11.7% | 11.8% | 11.5% | 11.8% | 11.7% | 11.3% | 12.2% | 12.8% | 12.8% | 11.7% | |
| Outpatient DNA Rate % - FUp | <10% | 9.8% | 10.5% | 10.2% | 9.8% | 10.2% | 10.5% | 9.9% | 10.3% | 10.2% | 11.0% | 10.4% | 10.9% | |
| Outpatient New Attendances | | 12389 | 11587 | 12260 | 10657 | 12186 | 13215 | 12554 | 12742 | 11670 | 12402 | 10781 | 8741 | |
| Outpatient FUp Attendances | | 17893 | 16437 | 17845 | 14794 | 17699 | 18550 | 16959 | 17930 | 17165 | 17382 | 18559 | 15519 | |
| Outpatient Procedures | | 6455 | 5789 | 6561 | 5416 | 5734 | 6420 | 6313 | 5977 | 6171 | 6304 | 6242 | 5405 | |

## GP Referrals

### December Performance – 6,312

This is a worsening of 1,871 compared to 8,183 November 2023.

It is a worsening of 163 compared to 6475 in December 2022.

## % e-Referrals Appointment Slot Issues (ASI) - *Target <4%*

### December Performance – 71.9%%

This is a worsening of 4.5% from November's performance of 67.4%

Due to an ongoing increase in 2WW referrals for Dermatology, general dermatology capacity has been moved to accommodate this demand, this has subsequently contributed to an increase in ASIs.

Plans are in place to implement Robotic Process Automation for the management of referrals. Delivery is now expected to start in February 2024. This will negate ASI's as an issue going forward.

ICARE EQUITY

# Activity - Highlights

Whittington Health NHS Trust

## Activity Highlights

**Maternity Births December Performance - 234**

This is a worsening of 17 from November's performance of 251. It is an increase of 3 from 231 in December 2022

**ED Attendances December Performance - 8,911**

This is an increase of 319 compared to 8,592 in November 2023, and a decrease of 376 Compared to 9287 in December 2022

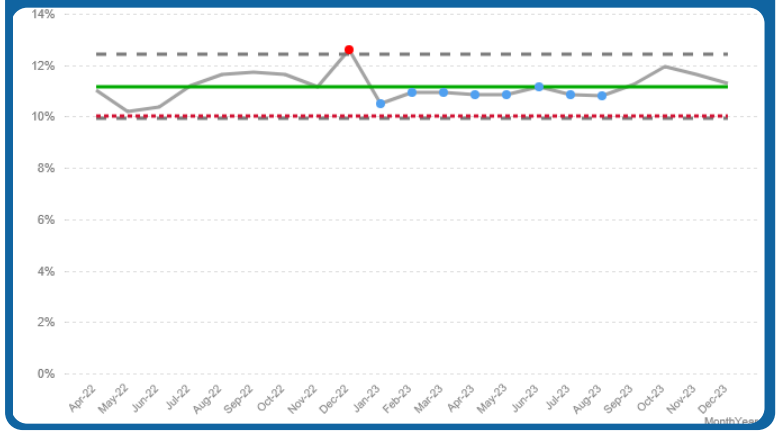
**DNA Rates December 2023:**

Acute DNA rate for December was 11.3% this is an improvement of 0.3% from November's performance of 11.6%.

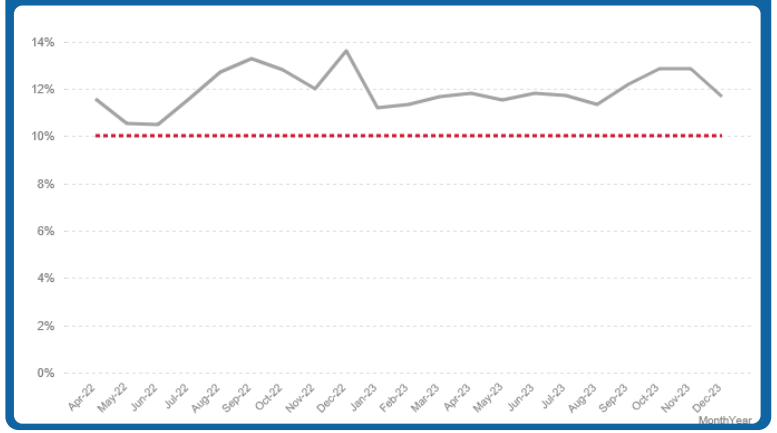
Outpatient DNA rate for new appointments was 11.7% for December. This is an improvement of 1.2% from November's performance of 12.9%

Outpatient DNA rates for follow-up appointments was 10.9% for December. This is a worsening of 0.4% from November's performance of 10.5%

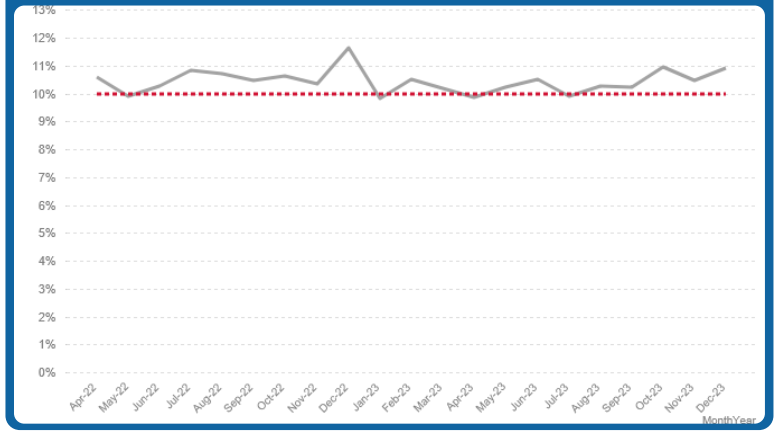
## Acute DNA % Rate




## Outpatient DNA % Rate - New




## Outpatient DNA % Rate – Follow-Up




ICARE EQUITY

# Activity – Activity and Forecasts

NHS Whittington Health NHS Trust

## Activity Highlights

**Outpatient First Appointments:**
There were 13,547 first appointments in the last 4 weeks of December, this is 157% of 19/20 levels.

**Outpatient Follow-up Appointments:**
There were 10,501 follow-up appointments in the last 4 weeks of December, this is 133% of 19/20 levels. Follow-up activity is in line with productivity improvements.

**Elective Activity:**
There were 1,849 cases in the last 4 weeks of December, this is 171% of 19/20 levels. However, there is a variation in case mix where we have seen less inpatient activity and increased day cases.

## Weekly Outpatient First Attendances


## Weekly Outpatient Follow-up Attendances

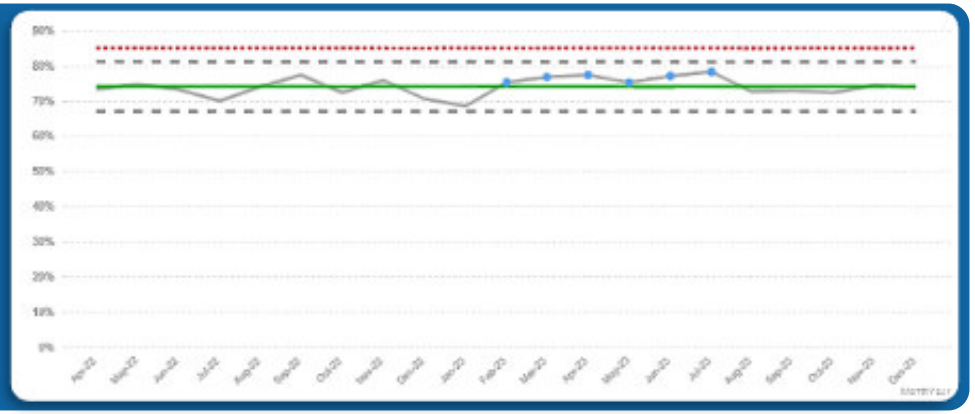

## Weekly Elective Activity


ICARE EQUITY

# Effective

| Indicator | Target | Current Month | | Previous Month | 2023-2024 | Variation | Assurance |
|---|---|---|---|---|---|---|---|
| Cancelled Ops Not Rebooked <28 Days | 0 | Nov | 5 | 0 | 15 | H | |
| Hospital Cancelled Operations | 0 | Nov | 13 | 6 | 47 | H | F |
| Theatre Utilisation | >85% | Dec | 73.8% | 74.4% | 74.7% | | F |
| Community DNA % Rate | <10% | Dec | 7.0% | 7.3% | 7.5% | | P |
| Acute DNA % Rate | <10% | Dec | 11.3% | 11.6% | 11.2% | | F |
| Outpatients New:Follow Up Ratio | 2.3 | Dec | 1.78 | 1.72 | 1.47 | | P |
| Non Elective Re-Admissions Within 30 Days | <5.5% | Dec | 4.1% | 3.1% | 3.8% | | P |
| Rapid Response - % Of Referrals With an Improvement in Care | | Dec | 69.6% | 66.7% | 71.6% | | |

Theatre Utilisation



## Theatre Utilisation - Target 85%

*Percentage of available Theatre time used for elective procedure.*

**December Performance – 73.8%**

This is a worsening of 0.6% from November's performance of 74.4%.

**Issues:**

- Short notice patient-initiated cancellations due to respiratory illness during winter month paired with booking team focus on supporting cancellation/ rebooking with periods of industrial action.
- Average utilisation distorted by outliers, paediatric dental 68%, all other specialities range from 80-89%
- Challenge of driving utilisation and efficiency for paediatric dental lists with patient cohort with learning difficulties.

**Actions:**

- Service to establish Standardised Operating Procedures to facilitate rapid backfill of vacated appointment slots.
- Focussed support for paediatric dental speciality to boost efficiency

## Hospital Cancelled Operations - Target 0

**November Performance – 13**

This is a worsening of 7 from October's performance of 6.

**Issues:**

- Three were initiated by the Trust and were non-clinical cause and related to bed availability for in patient stay in the background of significant winter Emergency Dept attendance.
- Use of recovery area in theatres mitigates this by accommodating overnight stay and maintain safe post operative monitoring.

# Caring



| Indicator | Target | Current Month | | Previous Month | 2023-2024 | Variation | Assurance |
|---|---|---|---|---|---|---|---|
| ED - FFT % Positive | >90% | Dec | 69.8% | 73.2% | 77.8% | | |
| ED - FFT Response Rate | >15% | Dec | 9.3% | 9.8% | 11.3% | | |
| Inpatients - FFT % Positive | >90% | Dec | 96.3% | 91.2% | 93.7% | | |
| Inpatients - FFT Response Rate | >25% | Dec | 13.9% | 19.7% | 15.7% | | |
| Maternity - FFT % Positive | >90% | Dec | 98.1% | 98.8% | 97.3% | | |
| Maternity - FFT Response Rate | >15% | Dec | 11.5% | 16.3% | 8.9% | | |
| Outpatients - FFT % Positive | >90% | Dec | 86.3% | 86.0% | 91.4% | | |
| Outpatients - FFT Response Rate | 400 | Dec | 466 | 279 | 2865 | | |
| Community - FFT % Positive | >90% | Dec | 95.6% | 96.9% | 95.9% | | |
| Community - FFT Response Rate | 1500 | Dec | 547 | 783 | 7055 | | |
| Complaints Responded to Within 25 or 40 Working Days | >80% | Dec | 26.1% | 45.0% | 50.9% | | |
| Complaints (Including Complaints Against Corporate Division) | | Dec | 23 | 20 | 224 | | |

**December Performance – 26.1%**

This is a worsening of 18.9% from November's performance of 45%.

There were 26 complaints received where a response was required in December 2023. Three of these were de-escalated leaving 23 responses due for December 2023. The performance was 30% (7/23).

The Complaints Team continue to work closely with the ICSUs to support with the completion of these and all complaint investigations. In the meantime, all urgent issues have been actioned.

**Severity of complaints**: 74% (17) were designated 'low' risk, 22% (5) were designated as 'moderate' risk & 4% (1) was designated as 'high' risk.

**Themes:** A review of the complaints due a response in December 2023 shows that 'Medical Care' Attitude' 35% (8), 'Attitude' 26% (6), 'Communication' 17% (4), 'Delay' 17% (4) were the main issues for complainants.

Of the 7 complaints that have closed, 1 (14%) was 'upheld', 4 (58%) were 'partially upheld', and 2 (28%) were 'not upheld', meaning that 72% of the closed complaints in December 2023 were upheld in one form or another.

# Well Led

| Indicator | Target | Current Month | | Previous Month | 2023-2024 | Variation | Assurance |
|---|---|---|---|---|---|---|---|
| Appraisals % Rate | >85% | Dec | 79.4% | 78.9% | 77.4% | | F |
| Mandatory Training % Rate | >85% | Dec | | 88.6% | 87.1% | | P |
| Permanent Staffing WTEs Utilised | >90% | Dec | 90.0% | 90.6% | 89.5% | | P |
| Staff Sickness Abscence % | <3.5% | Nov | 4.2% | 4.4% | 3.7% | | F |
| Staff Turnover % | <13% | Dec | 11.7% | 12.2% | 12.9% | | P |
| Vacancy % Rate Against Establishment | <10% | Dec | 10.0% | 9.4% | 10.5% | | P |
| Average Time to Hire | <=63 | Dec | 61 | 54 | 59 | | P |
| Safe Staffing Alerts - Number of Red Shifts | | Dec | 7 | 4 | 33 | | |
| Safe Staffing - Overall Care Hours Per Patient Day (CHPPD) | | Dec | 10.4 | 9.9 | 9.7 | | |

## Appraisals % Rate - *Target >85%*

**December Performance –79.4%**
This is an improvement of 0.5% from November's performance of 78.9%.

**Issue:** Winter pressures, festive season as well as continued disruption through strike action have not been conducive to a larger increase in appraisal compliance.

**Actions:** The trust will continue to remind and encourage managers and staff to set and appraisal dates and hold discussions.

## Staff Turnover % - *Target <13%*

**December Performance – 11.7%**
This is an improvement of 0.5% from November's performance of 12.2%.

**Issue:** Turnover rate continues to improve month on month and is now remaining under the Trust target.

**Actions:** To continue to identify the reasons for staff leaving the Trust in order to positively respond and reduce the turnover rate further.

## Vacancy % Rate - *Target <10%*

**December Performance – 10%**
This is a worsening of 0.6% from November's performance of 9.4%, however, it is compliant against the target of 10% or less.

**Issue:** Although a slight increase in the vacancy rate from the previous month, it remains within the Trust target. There are still a number of hard to recruit roles across the Trust due to skills shortages.

**Actions:** Continue to review roles and skill mixes and look at alternatives that are open to a wider pool of people. Targeted recruitment on hard to recruit posts. Targeted recruitment within the local community.

| | | |
|---|---|---|
| **Meeting title** | **Trust Board – public meeting** | **Date: 26.01.2024** |
| **Report title** | **2023/24 Quarter three delivery of Corporate Objectives** | **Agenda item: 11** |
| **Director leads** | Sarah Wilding, Chief Nurse & Director of Allied Health Professionals, Clare Dollery, Medical Director, Chinyama Okonuga, Chief Operating Officer (Quality entries); Norma French, Director of Workforce, (People entries); Jonathan Gardner, Chief Strategy, Digital and Improvement Officer (integration and Sustainable 3 entries); and Terry Whittle, Chief Finance Officer (Sustainable 1 and 2 entries), | |
| **Report author** | Jonathan Gardner | |
| **Executive summary** | Board members are presented with the quarter three outcomes for performance indicators linked to the delivery of Whittington Health's annual corporate objectives (see appendix 1).<br><br>The Board is asked to note the report. | |
| **Purpose** | Note | |
| **Recommendation** | Trust Board members are asked to receive and note the outcomes against performance indicators for delivery of Whittington Health's corporate objectives in quarter one 2023/24. | |
| **BAF** | All entries | |
| **Report history** | Trust Management Group, Executive team | |
| **Appendices** | 1: Q3 delivery of corporate objectives | |

# 2023/24 objectives
# QUARTER THREE
# UPDATE
# V3

# Deliver outstanding safe and compassionate care in partnership with patients

Exec: Chief Nurse / MD

Committee: Quality

worse
better
Same

| Key metrics | Target | Score | RAG |
|---|---|---|---|
| SHMI score | | 0.94 July 2022-June2023 | |
| Readmission rate | 5.5% | 3.27% | |
| Pressure ulcers grd. 4 and 3 | Reduce | Average 11 in q3 | |
| FFT % satisfaction | 90% | IP Average q 3 89.3% | |

| Key metrics | Target | Score | RAG |
|---|---|---|---|
| RTT | 92% | 66.1% | |
| ED 4hr | 95% | 57.8% | |

| Key metrics | Target | Score | Direction and RAG |
|---|---|---|---|
| PALS response time | 80% | 26.1% | |
| 48hrs DN referral | 95% | 89.9% | |
| 2hr referral | N/A | 71.1% | |

## Objective

**Deliver Safe & Effective Care – continuous improvement in safety culture & delivery of best practice care**

- Implementation of the new NHS Patient Safety Incident Response Framework (PSIRF), with a focus on learning and human factors*
- Develop and implement a quality governance recovery plan (including complaints, incidents, duty of candour, policies)
- Embed back to the floor programme, and improve medicines management to support delivery of harm free care
- Develop a plan that focuses on our most vulnerable adult patients with learning disabilities, and Mental health needs
- Implement national maternity services recommendations and local priorities
- Reduce harm from hospital acquired deconditioning*
- Improving care and treatment related to blood transfusion*
- Continue to build our research portfolio research and make the most of our participation in the BRC

## Progress in last quarter (Q2)

- December 2023 we held a celebration event to thank the staff from across the organisation and acknowledge the positive impact of back to the floor.
- Head of vulnerable adults post successfully appointed to. Planning commenced for the introduction in March of MH training for ED which is focusing on communication and de-escalation
- CQC preparation ( previously Better Never Stops) meetings introduced in December to ensure staff from across organisation are prepared for a visit,
- Implementation of Flow Programme aiming to reduce medically optimised patients – A 'home for the holidays' flow programme took place in December prior to the Christmas break. The Same Day Emergency Care (SDEC) saw over 100 patients each day which avoided admissions and attendances to the Emergency department. Islington Rapid Access & Haringey Urgent Response teams have now merged and work together to enable patients to be seen within the national guidance times.
- Governance recovery plan:
    - Since changing to LFPSE under PSIRF, incidents and DOC reporting requirements have changed. As levels of Harm are no longer captured, any incident that caused physical or psychological harm requires a DOC (As opposed to moderate or above previously). As such numbers have risen with 167 outstanding DOC, compared to 73 pre LFPSE.
    - Progress has been made with reviewing and updating policies in Q3. Total Policies due for review 40% a reduction from 50 % in Q2 of which 4% operational (4% in Q2), 11% clinical (14% Q2), 25% non-clinical (30% Q2)
- Complaints: Performance against responding to complaints within the agreed timeframe remains below the 80% target at 47%. Between Oct – Dec we saw a decline in performance from 63% to 30% in Dec, performance was affected by winter pressures.
- PSIRF: Implementation and T&F groups in progress. Funding for first cohort of training approved. Policy and plan approved by QAC and TMG.
- Pressure ulcers: the Trust continues to work through the actions in a comprehensive overarching plan and community has a more bespoke plan. The TVN team are working closely with the community nursing teams to support with the early intervention and prevention of patients with complex health needs and higher risk of PU damage.
- FFT – The Patient experience team have introduced a dashboard monitoring FFT performance and bottom three areas. Maternity - The patient experience team met with the Head of Maternity regarding the implementation of SMS for community postnatal. In addition to the FFT question the survey will include a question "were you provided with enough information about feeding your baby?" following the National Maternity Survey 2023 results (currently embargoed until 31st January 2024), where areas of improvement centred on providing enough support and advice with feeding your baby.
- MIS Year 5 declaration of compliance on tract for submission of 1st February 2024
- SHMI is within the expected range but has risen this is under review by the mortality review group and coding of palliative care is being considered. To note there is no difference between weekday and weekend mortality

| Objective 1 | Progress in last quarter |
|---|---|
| **Deliver Caring and Responsive services**<br>• Improve performance - emergency care standards & reduced overcrowding in ED<br>• Improve performance - planned care standards (RTT and Cancer waiting times)<br>• Improve communication between clinicians and patients*<br>• Implementation of our Patient Experience strategy year 1 | • The Trust continues to experience demand and flow challenges in the Urgent Emergency Care pathway. The anticipated Winter Surge increase occurred much earlier than the official winter period. As a result, the Operational team led the development of a robust Winter plan. In addition, the trust was successful in obtaining funding to support additional capacity and initiatives for the winter period. Some of the initiatives are a result of the work undertaken with the support of ECIST and PA Consulting, who were in the Trust over the Summer period. On going improvement plans are managed through the workstreams in the Patient Flow Programme that is co chaired by the Chief Operating Officer and Chief AHP.<br>• Recovery plans have been developed to improve access for Elective patients including a<br>• Current Improvement project focussing on Outpatients Access, productivity and efficiency led by the COO office.<br>• With the recently started Cancer Manager plans are underway to improve pathways. Funding Investment was agreed in the 2023/24 budget to increase pathway coordinators and MDT Trackers. |
| **Improve population health & addressing health inequalities**<br>• Work to reduce health inequalities in our local population*<br>• Undertake an assessment against the NHS EDS<br>• Develop the use of the CORE20PLUS5 metrics for adults and children to evidence improved outcomes | • Population health report has been updated and some fascinating data has been gathered on our current DNA rates etc which we will present at a future committee. Also ACS have a number of health inequalities projects such as the VCS forum and the community heart service which are having measurable impacts on ED attendances for deprived communities. The EDS assessment is scheduled for Q4. |
| **Ensure Board Governance is fit for purpose**<br>• Commission an external well-led review and associated action plan development / delivery<br>• Strengthen estates governance & implementation of the premises assurance model | • Well-led review has been completed and a board seminar was held in October to discuss the outcomes.<br>• Premises assurance model was submitted on time.<br>• 6 facet survey completed and key outcomes were presented at November's seminar<br>• The IPDC reviewed elective metrics last month. |

# Empower support and develop engaged staff

Exec: Workforce Director / COO

Committee: WAC

worse
better
Same

| Key metrics | Target | Score | Direction and RAG |
|---|---|---|---|
| Turnover rate | 13% | 12.2% | |
| Vacancy rate | 10% | 9.4% | |
| Appraisal rate | 90% | 78.9% | |
| Mandatory training | 90% | 88.6% | |

| Key metrics | Target | Score | Direction and RAG |
|---|---|---|---|
| Staff Sickness | 3.5% | 4.4% | |
| *Likelihood BAME candidate being appointed* | *1* | *1.52* | |
| *Staff Survey /People Pulse Response rate* | *20%* | *44%* | |

| Key metrics | Target | Score | Direction and RAG |
|---|---|---|---|
| *Relative likelihood of disciplinary for BAME* | *1* | *0.68* | |
| % staff recommending WH as place to work | 65% | *59.2%* | |

| Objective | Progress last quarter |
|---|---|
| **Improve Staff Engagement & Wellbeing**<br>• Develop a local listening strategy & improvement plan that responds to priorities identified by staff to improve their working lives<br>• Deliver equalities & inclusion programmes to actively tackle disparities in staff experience<br>• Complete an assessment against the NHS Equality Delivery System 2022 workforce domain outcomes in partnership with local stakeholders | • New Head of Staff Wellbeing and Engagement commenced October 2023 and reporting her recommendations to WAC in Jan 2024<br>• Staff Survey 5 Key Actions Listening Events completed and reported to WAC, TMG and Partnership Group – action plan developed and being taken forward<br>• Improvement to WRES indicators<br>• Building on the success of the Successful Menopause Café monthly events now scheduled<br>• 2022/23 PSED approved at WAC in October 2023 |
| **Recruit, develop and retain talent**<br>• Through the updated People Strategy, deliver recruitment and retentions strategies for our hard to recruit clinical workforce;<br>• Medical education & workforce planning – develop strategies to mitigate risk from reductions in training grade posts within London.<br>• Identify non-clinical workforce development priorities and work programme through comprehensive leadership development programmes and support<br>• Improve the diversity of our senior workforce in line with our Model Employer targets | • Strong recruitment pipeline continues comprising: graduate nurses, international nurses, international midwives AHPs and HCSWs – vacancy rate down to 8% for AfC Band 5 nurses<br>• Future Leaders programme for consultant medical staff new cohort underway<br>• Bands 2 – 7 programme for staff from a black, Asian or minority ethnic background - third programme commenced<br>• Admin Forum led by COO and a member of the Admin team is a regular occurrence<br>• Reciprocal mentoring programme underway with executive sponsorship |

# Actively collaborate to deliver integrated, joined up care for our communities

↔

Exec: Director of Strategy / COO

Committee: Board

worse
better
Same

| Objective | Progress last quarter |
|---|---|
| **Transform community services & place-based care**<br>• Actively participate in borough-based partnership forums & proactively seek opportunities to integrate care to maximise benefit for our communities<br>• Expand and improve the new model of care in localities with our primary care, PCN, council and voluntary sector partners – focus on long term conditions and proactive, preventative care models<br>• Lead NCL virtual ward and remote monitoring programme<br>• Lead NCL community children's transformation programme<br>• Expand CDC at Wood Green and promote direct access pathways for primary care | • Borough partnership attendance continues as do the CIG meetings with primary care<br>• Integrated health hub not approved at the last board meeting, uncertain if central approval will be forthcoming<br>• Transformation Programme for Children's services continues<br>• MRI and CT opened in December on time and on budget. Formal opening on the 23rd February.<br>• The current capacity of Adult and CYP Virtual Ward Beds across NCL, led by us, stands at 175 beds, intending to reach 193 beds by March 2024. Whittington Health currently stands at 28 Adult Virtual Ward beds (with 8 of those allocated to virtual monitoring) with a view to expanding to 45 beds through the introduction of additional consultant cover to the Acute Virtual Ward by March 2023 and the launch of the eight Islington Community-Based Virtual Ward Beds supported by UCLH and CNWL by end January 2023. |
| **Collaborate with providers and system**<br>• Establish joint board committee to support collaborative care delivery with UCLH<br>• Establish a joint 'case for collaboration' with UCLH & clearly set out current and future areas for collaboration to support delivery of excellent local secondary care for our residents.<br>• Actively participate in the Integrated Care System & UCL Health Alliance to support delivery of agreed system priorities | • Joint board committee has been set up and has met regularly.<br>• The final report on the collaboration was received by both boards and will be ratified at a future public board.<br>• Continued strong participation in the system and UCL health alliance<br>• We continue to actively participate in the sharing of elective resources and present at the ICB on issues such as the Integrated Health Hub. |

# Transform and develop sustainable and innovative services

Exec: Finance Director / COO

Committee: TMG

worse
better
Same

| Key metrics | Target | Score | RAG |
|---|---|---|---|
| % CIP delivery against target | Annual Target 100% (£17.98m)<br>Target at end of Q1 15% (£2.70m) | Actual delivery of £5m and slippage of £6.5m against target | |
| Average beds used | 197 | 231 | |
| Financial position | Annual Plan (£2.0m surplus)<br>Plan to end of Q2 (£11.8m deficit) | Actual deficit of £16.1m and £3.5m worse than plan. Forecast is £1.1m surplus | |
| Capital spend against plan | Annual Plan is £24.9m (£12.2m internally funded and £12.7m PDC). | Capital expenditure at end of Q3 was £17.6m, of which £7.5m related to external funded, £9.5m to internally-funded projects and £0.6m to IFRS16 leases. | |

| Key metrics | Target | Score | RAG |
|---|---|---|---|
| Average LOS Non-elective | 5.5 | 5.2 | |
| % super stranded pts | 18% | 20.2% | |
| Elective activity against recovery plan | 104% of 2019/20 | 113% (Volume)<br>TBC% (value) | |
| Theatre utilisation | >85% | 73.54% | |
| Virtual vs face to face outpatients | 25% | 17.5% | |

| Objective | Progress since last quarter |
|---|---|
| **Deliver best value care**<br>• Develop & deliver a robust multi-year productivity & cost improvement plan<br>• Strengthen transformation and delivery capability and capacity<br>• Deliver in year financial targets | • 2023-24 financial plan is to breakeven as a system and a surplus of £2m for the Trust. The Trust is forecasting a year end surplus of £1.1m which £0.9m worse than plan.<br>• The Trust is reporting a deficit of £16.1m at the end of Q3 which is £3.5m worse than plan. The planned deficit to end of Q3 was £12.6m. |
| **Net Zero NHS**<br>• Finalise Greener WhitHealth plan & deliver year one priorities | • The Trust has concluded consultancy support from NCL Transformation Partners and is establishing a 'Green Group' to coordinate the green agenda. Specific progress has been made in pharmacy prescribing and improving the $CO_2$ footprint of the estate. |
| **Deliver hospital and community estate transformation plans**<br>• Finalise capital programme & maximise delivery<br>• Progress key strategic capital investment priorities<br>• PFI rectification ~ finalise fire remediation business case & explore / secure funding<br>• Maternity and Neonates redevelopment: secure system support & agree funding strategy ~ phase 1 delivery & phase 2 planning<br>• Wood Green Integrated Health Hub: secure system support & agree funding strategy ~ delivery timeline TBC<br>• Power improvement programme: phase 1 delivery, phase 2 planning (internally funded subject to confirmation of capital allocation) | • Capital programme of £39.4m for 2023/24, including additional £5m fire investment from NHS England. Robust internal forecasting exercise completed to reallocate expected capital underspends to other priorities.<br>• Capital investment of £9m for fire remediation, maternity and power infrastructure agreed with ICB.<br>• Wood Green health hub business case was not approved at board due to capital and revenue affordability, discussion with partners to secure support.<br>• Power improvement programme approved, with £5+m expenditure planned this year. |
| **Digital transformation & data driven decision making**<br>• Progress FBC for new EPR<br>• Strengthening BI<br>• Real time data to support operational delivery<br>• Data driven planning and decision making<br>• Implementation of digital strategy year 2 priorities | • IM&T successfully carried the migration of EPR onto a new cluster to ensure compliance with OS support and cybersecurity standards, therefore achieving a successful system upgrade. Additionally, Wayfinder (NHS app) is now enabling service users to receive in-app notifications and messages.<br>• The department also went live with three new dashboards on Power BI (Inpatients, Outpatients and ED) which places the Trust in a healthy position to complete a full move to Power BI in the upcoming months, leading to an expected improved user experience. |