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, 30 January 2026** from **9.10am to 10.35am** held at rooms A1 and A2 of the Whittington Education Centre, Highgate Hill, London N19 5NF

Item	Time	Title	Action
		Standing agenda items	
1.	*0910*	**Welcome, apologies, declarations of interest** *Julia Neuberger, Trust Chair*	Note
2.	*0911*	**Patient Story** *Sarah Wilding, Chief Nurse & Director of Allied Health Professionals*	Note
3.	*0925*	**Draft minutes 26 November 2025 meeting** *Julia Neuberger, Trust Chair*	Approve
4.	*0930*	**Chair's report** *Julia Neuberger, Trust Chair*	Note
5.	*0940*	**Chief Executive Officer's report** *Selina Douglas, Chief Executive Officer*	Note
		Quality and safety	
6.	*0945*	**Quality Assurance Committee Chair's report** *Mark Emberton, Committee Chair*	Note
		Governance	
7.	*0955*	**Maternity Incentive Scheme submission** *Sarah Wilding, Chief Nurse & Director of Allied Health Professionals*	Approve
8.	*1005*	**Audit and Risk Committee verbal report** *Rob Vincent, Committee Chair*	Note
		Finance & Performance	
9.	*1010*	**Integrated performance report** *Chinyama Okunuga, Chief Operating Officer*	Note
10.	*1020*	**Finance and capital expenditure report** *Terry Whittle, Chief Finance Officer*	Note
11.	*1027*	**Questions to the Board on agenda items** *Julia Neuberger, Trust Chair*	Note
12.	*1030*	**Any other urgent business** *Julia Neuberger, Trust Chair*	Note

Minutes of the meeting held in public by the Board of Whittington Health NHS Trust on 26 November 2025

Present:	
Baroness Julia Neuberger	Non-Executive Director & Trust Chair
Selina Douglas	Chief Executive
Dr Junaid Bajwa	Non-Executive Director (via MS Teams)
Dr Clare Dollery	Deputy Chief Executive and Chief Medical Officer
Professor Mark Emberton	Non-Executive Director
Amanda Gibbon	Non-Executive Director
Chinyama Okunuga	Chief Operating Officer
Baroness Glenys Thornton	Non-Executive Director
Nailesh Rambhai	Non-Executive Director (for item 2)
Rob Vincent CBE	Non-Executive Director
Terry Whittle	Deputy Chief Executive and Chief Finance Officer
Sarah Wilding	Chief Nurse & Director of Allied Health Professionals
In attendance:	
Dr Karen D'Souza	Consultant Breast Oncologist (item 2)
Ruben Ferreira	Freedom to Speak Up Guardian (item 10)
Liz O'Hara	Chief People Officer
Gemma Ingram-Adams	Lead Cancer Nurse (item 2)
Tina Jegede MBE	Joint Director of Inclusion & Nurse Lead, Islington Care Homes
Marcia Marrast-Lewis	Assistant Trust Secretary (via MS Teams)
Sharon Pilditch	Associate Director of Nursing, Surgery & Cancer Clinical Division (item 2)
Andrew Sharratt	Director of Communication and Engagement
Swarnjit Singh	Joint Director of Inclusion & Trust Company Secretary

The minutes of the meeting should be read in conjunction with the agenda and papers

No.	Item
1.	**Welcome, apologies and declarations of interest**
1.1	The Chair welcomed everyone to the meeting.
1.2	The Chair restated the declared interests for herself, Junaid Bajwa, Mark Emberton, Nailesh Rambhai, and Rob Vincent who were all Non-Executive Directors at University College London Hospitals NHS Foundation Trust (UCLH) and for Liz O'Hara, who was Chief People Officer for both UCLH and Whittington Health NHS Trust. There were no new declarations of interest reported.

2.	Patient Story
2.1	Sarah Wilding introduced a breast cancer service user, together with Gemma Ingram-Adams and Dr Karen D'Souza, who attended the meeting to share learning from a recent Breast Cancer Patient Information Day and the service user's personal experience of care.
2.2	Gemma Ingram-Adams advised that the event held in October was a collaborative initiative between the Trust and University College London Hospitals NHS Foundation Trust (UCLH), held in October, and designed in direct response to feedback from the National Cancer Patient Experience Survey and the Breast Cancer Now Survey. The agenda focused on areas identified by patients as priorities, which included the management of menopausal symptoms, sexual health, exercise, diet and nutrition, care pathways, research opportunities and access to local support groups. The event was supported by a Cancer Alliance grant and involved a range of charities, clinicians, researchers, specialist nurses and patient experience teams from both organisations. Feedback from attendees had been highly positive, with requests for future events to be held on a more regular basis. Work was now underway to explore future patient conferences, including a potential cancer event across North Central London.
2.3	The Trust Board heard directly from the service user, who described her experience of being diagnosed with breast cancer at the age of 36 and the subsequent treatment she received which included surgery, chemotherapy, radiotherapy and ongoing hormonal therapy. The service user fed back positively about the quality of care at the Trust, highlighting the importance of feeling listened to, being well informed and being able to build trust with her clinical team. She emphasised the value of clear communication and opportunities to ask questions, which built her confidence and reduced anxiety throughout her treatment. She also praised the care and support provided by staff in the chemotherapy unit and described feeling safe and well supported when attending appointments independently.
2.4	The service user reflected that the Information Day, had been extremely beneficial, as it enabled patients to access a wide range of information and support in a single setting. Attendees were provided with direct contacts for charities and opportunities to engage directly with clinicians from different specialties through question-and-answer sessions. She welcomed the Trust's responsiveness to patient feedback, which included follow-up sessions, and encouraged the continuation and expansion of similar events. She also highlighted areas for further consideration, covering additional support for mental health and wellbeing following a cancer diagnosis, reducing uncertainty during lengthy waiting times for appointments, and minimising delays in receiving scan results to reduce patient anxiety.
2.5	In discussion, Board members raised the following points: • Amanda Gibbon welcomed the feedback on the importance of trust and continuity in clinical relationships, as it had a positive impact on patient experience. She raised the need to improve patient experience while they were waiting for appointments and asked whether practical steps could be

	taken to help, as had been the case in the emergency department. The Chair agreed that this was an priority area for improvement. • Clare Dollery acknowledged the leadership and contribution of the cancer team. She advised that the Trust had made significant improvements in cancer service performance and was now recognised as the most improved Trust in England for one of the cancer performance indicators. She acknowledged that, while challenges remained in some specialties, the overall direction of travel was positive and reflected strong clinical and nursing leadership across cancer services. • Selina Douglas echoed the comments made in relation to the leadership and delivery of the Breast Cancer Information Day which had been well organised in partnership with voluntary, community and social enterprise organisations. She emphasised the importance of events being patient-led, shaped by what service users identified as most important issues, and suggested that mental health and wellbeing might be considered as a topic for a future Information Day event. Selina Douglas sought assurance on the capacity to run future events and whether additional support might be required. • Gemma Ingram-Adams confirmed that there was strong motivation and capacity within the multidisciplinary team to continue this work, supported by nursing, medical, research and communications colleagues. She advised that future events were likely to be held outside the hospital setting, as this would be more accessible and appropriate for patients, and that discussions on suitable venue were underway with the Cancer Alliance. Dr Karen D'Souza highlighted the gap in accessible, trusted information for patients outside clinic appointments and welcomed plans to expand delivery through a combination of in-person events and webinars, providing multiple touchpoints throughout the year • The service user strongly endorsed the Information Day, describing it as well organised, informative and highly valuable. She emphasised the importance of holding such events more frequently, particularly to help counter the volume of misinformation that was circulated through social media, especially in relation to nutrition and lifestyle. She highlighted the value of receiving evidence-based, clinically endorsed information directly from specialists, to help patients make informed decisions and to support them in living well with a cancer diagnosis. • Rob Vincent reflected on the service user's observation that access to information increased confidence and resilience. He felt that this was closely linked to emotional engagement, trust and the warmth of relationships with clinical teams. **The Trust Board thanked the service user and members of the breast cancer team for their attendance at the meeting to share their experience.**
3.	**Minutes of the previous meeting**
3.1	The Board approved the draft minutes of the meeting held on 25 September 2025 as a correct record and noted the updated action log item to confirm the performance metrics for delivery of the Clinical Strategy would be completed

	by the end of quarter three. There were no matters arising which were not covered by an item on the agenda.
4.	**Chair's report**
4.1	The Chair took the report as read and added the following points: • As part of visits to different services, she had recently, with the Chief Executive Officer, visited to Cellier Ward and maternity services. • This was Clare Dollery's final public Board meeting and her exceptional contribution to the organisation was appreciated. • The Chair thanked Sarah Wilding for her involvement during recent inquests. • On 20 November, there had been a constructive and energised meeting of the Partnership Development Committee-in-Common between UCLH and Whittington Health, which demonstrated the shared commitment to collaborative working, to support greater joint working and efficiencies, particularly on patient pathways. **The Trust Board received and noted the Chair's report.**
5.	**Chief Executive Officer's report**
5.1	Selina Douglas summarised her report and drew Board members' attention to the following issues: • The Trust was entering a challenging 2026/27 planning round, with the first draft of activity, financial and workforce plans required by 17 December, against a backdrop of continued uncertainty regarding the Chancellor's budget announcements, also due later today. • The merger of the North West and North Central London Integrated Care Boards would impact with increase scale and complexity, introducing additional risk to collaborative arrangements. • NHS England (NHSE) had confirmed that the Lower Urinary Tract Service, a multi-site research programme, would be removed from national performance reporting, until 1 April 2028, as it was a unique service and delivery model. • Early verbal feedback had been received from the recent Care Quality Commission's (CQC) inspection of the urgent and emergency care pathway, which highlighted the caring and supportive approach of staff, particularly towards elderly patients. • Significant improvement had been made in cancer performance, and it was now important to maintain this progress. • During the Resident Doctors' industrial action from 14 to 19 November, approximately 57% of Resident Doctors at the Trust had participated. Despite this, the Trust was able to deliver a higher level of elective activity, than initially anticipated. • A significant capital allocation had been received and would be used to support fire safety, cyber security and the new energy centre required for the Start Well programme to progress. • Vaccination uptake among frontline staff continued to be actively promoted by the vaccination team.

	• On 11 November, Trust staff held a Remembrance Day event. In addition, she had enjoyed and an exhibition celebrating the contribution of people of Irish heritage to the NHS would take place from 3-18 December at the Trust. • The Trust and the North Central London (NCL) Integrated Care Board had received the Health Service Journal award for reducing inequalities and improving outcomes for children and young people for the NCL Dental Transformation Programme. • As the Trust headed into the Christmas period, staff were working hard to keep services safe. • In addition, she had enjoyed a wonderful event celebrating the contribution of Irish nurses to the NHS, and an exhibition
5.2	During discussion, Board members raised the following points: • In reply to a question from the Chair on ambulance diverts, Chinyama Okunuga reported that North Middlesex University Hospital was under significant pressure on 16 December and, following calls for help, ambulance diverts were sent to Whittington Health and to UCLH. Chinyama Okunuga also emphasised the importance of recognising the impact of emergency care diverts alongside ongoing financial negotiations. • Glenys Thornton reflected on the benefits of robotic-assisted surgery which could significantly reduce length of stay, improve recovery outcomes, and reduced bed utilisation. Board members acknowledged that while the technology carried cost implications, the wider system and patient benefits were clear. • Rob Vincent asked for an update on neighbourhood working to be brought to a future meeting. **The Trust Board noted the Chief Executive Officer's report and agreed that progress on neighbourhood work would be reported on a regular basis.**
6.	**Quality Assurance Committee**
6.1	Mark Emberton presented the Committee Chair's assurance report for the meeting held on 12 November 2025 and highlighted the following issues: • He thanked Amanda Gibbon and other Committee members for their help while he chaired his first meeting. • A presentation on the implementation of the hot cholecystectomy pathway to treat patients with gallstone disease. within seven days of presentation, and provided a positive example of an evidence-based approach, which demonstrated benefits including shorter length of stay, fewer side effects and improved value for money through reduced overall cost. • The Committee discussed a wrong-sided regional block incident and welcomed the detailed investigation which drew attention to the contributory factors which included emergency context, staff changes, unfamiliar environments and reduced adherence to standard safety protocols. • The Committee reviewed the 45 risk entries on the Trust Risk Register rated at 15 or above, which requiring oversight and monitoring.

	• Ongoing concerns were highlighted for information systems in maternity services, and for pressure ulcers, where hospital performance was positive, but limitations in community technology were identified as a risk. • The Committee agreed to escalate concerns regarding the impact of Integrated Care Board changes on safeguarding arrangements and risks to the delivery of safety actions 4, 7 and 8 needed for the maternity incentive scheme • A recurring theme throughout the Committee's discussions was the lack of interoperability between clinical information systems, which was identified as a contributory factor to sub-optimal care across several areas, including maternity services. • The Committee approved the quarter three Board Assurance Framework for the Quality and Integration 2 entries and agreed that the risk descriptor for the Quality 2 entry be amended to reflect the impact of industrial action by resident doctors. **The Board noted the Chair's assurance report for the Quality Assurance Committee meeting held on 12 November 2025 and approved the amendment to the risk descriptor for the Quality 2 entry to reflect the impact of industrial action by resident doctors**
7.	**Audit and Risk Committee**
7.1	Rob Vincent presented the Committee Chair's Assurance report for the meeting held on 20 October 2025 and highlighted the following areas: • Three internal audit reports were received, all of which achieved a reasonable assurance rating: ○ Virtual Wards and data management, where systems were found to be sound, with some follow-up actions identified to strengthen the governance of discharge processes, refining reporting for key performance indicators, and ensuring trackers captured the right data to monitor delivery. ○ The Annual Cyber Assurance Framework, which continued to evolve and become more demanding. The internal audit team was satisfied with the Trust's approach and self-assessment. ○ Data quality in relation to theatre utilisation, with findings providing assurance on underpinning systems. The Committee had been informed that the recommendations would focus on ensuring the consistent monitoring of performance indicators and timely interventions, where required. • Cyber Security discussions highlighted the increasing complexity of cyber threats, including risks associated with third-party suppliers, where assurance was provided to the Committee that the Trust was doing all that it could on cyber resilience and would continue to strengthen the contractual oversight and assurance mechanisms available. The Committee discussed the importance of robust contingency arrangements, including the availability of basic manual systems, should digital systems be compromised, as part of business continuity arrangements. • An internal audit benchmarking report against other Trusts placed Whittington Health mid-table.

	• The Committee received and reviewed an annual counter-fraud report and Committee members agreed that the change in provider to RSM had delivered increased confidence and this was supported by a gradual rise in reported activity, with a specific example provided where an attempted mandate fraud was prevented, avoiding a significant financial loss. • The Committee received a report from KPMG, the external auditors, on the year-end process. It was also confirmed that the Trust was taking forward a tender exercise for the new external audit contract. **The Board noted the Chair's assurance report for the Audit and Risk Committee meeting held on 20 October 2025.**
8.	**Integrated Performance Report**
8.1	Chinyama Okunuga presented the report for October 2025 and highlighted the following areas: • Urgent and Emergency Care performance against the four-hour access standard declined slightly in October to 69.8%. This was below the national average of 74.1% and was driven by an increase overall in patient attendances, despite a reduction in ambulance conveyances. Some of the increase in attendance was the result of a lack of access to primary care services, on whom there was significant pressure in London. Primary care colleagues had been encouraged to engaged in an on-site audit with Whittington Health. • The Emergency Department's Same Day Emergency Care (SDEC) model had been developed, with the aim was to have this in place from 26 January. It was anticipated that this initiative would help to deliver a 7%–9% improvement in performance through improved patient flow across the organisation. • Performance against the 18-week referral to treatment indicator was reported at 60.44%, and was mid-range compared with NCL providers. The Trust remained focused on eliminating 65-week waiters by 31 December; numbers had reduced to 38 at the end of October, largely within vascular services. The waiting list initiatives would also help to reduce the numbers waiting for an appointment. • Work would continue to address patients waiting over 52 weeks, particularly within dermatology, general surgery and orthopaedic services, alongside a strengthened validation process to ensure the accuracy of waiting list data. • Diagnostics (DM01) had dipped following the reduction in the use of temporary staff, as part of financial controls. Diagnostic performance was at 81.24%. • Strong performance continued in endoscopy, and scanning. • Audiology services had been identified as an area requiring improvement, with work underway to address access, particularly for older patients. • Cancer performance showed sustained improvement, with the Trust recognised as one of the most improved nationally. • Community services continued to experience challenges in district nursing capacity, requiring continued reliance on temporary staffing. Work would continue to right-size the service offer, with early progress in reducing

	inappropriate caseloads and enabling greater focus on complex care, including pressure ulcer management. • Occupancy on the virtual ward had reduced over the summer due to workforce and engagement challenges, and a recovery plan was in place and early improvement had been reported. • The number of patients not meeting the criteria to reside has reduced from levels seen in the previous winter, but remained above target. Daily escalation meetings with system partners, including local authorities, had been used to drive improvement.
8.2	Sarah Wilding reported on the following quality and safety metrics: • Two additional cases of clostridium difficile occurred in October, bringing the total to 13, against a 12-month trajectory of 22. She highlighted a letter from NHSE on antimicrobial stewardship, with a commitment to return to the Board with benchmarking data. • Complaints volumes remained highest in major surgery and cancer, reflecting complexity and volume.
8.3	In terms of workforce metrics, Liz O'Hara confirmed that appraisal compliance had reduced slightly in October to 78% and the sickness absence rate was 4.8%.
8.4	In discussion, Board members raised the following points: • Glenys Thornton highlighted the increasing pressure faced by the district nursing workforce and raised the need for a strategy for this group of staff which included a strong workforce element. The Chair concurred and supported the need for national and local work for district nurses. • Mark Emberton raised a concern that teams were operating under unsustainable pressure and stressed the need for escalation to the Board, when needed. • Chinyama Okunuga added that that workforce pressure was felt across the organisation, with a recent increase in sickness absence affecting multiple staff groups, including nurses, healthcare assistants and doctors, with a particular hotspot identified in anaesthetics. • Amanda Gibbon welcomed the analysis on did not attend rates (DNA) queried the higher DNA rates in some services and asked whether they reflected patients who no longer required appointments, following long waits and for a plan to be brought back to the Board. In response, Chinyama Okunuga explained that factors that contributed to increased DNA rates included long intervals between booking and appointment dates with insufficient reminders and patients experiencing difficulties in changing appointments by contacting services. She added that DNA rates were recognised as an opportunity for improvement and would be addressed through next-year's planning round. • Tina Jegede advised that district nursing teams were increasingly carrying out social care elements of care due to capacity pressures within local authorities. She reported that she had met with the Adult Community Services' team who had highlighted concerns at local authority capacity and the impact on their own workload and performance.

	• Clare Dollery emphasised the importance of communication with patients to help reduce DNA rates. and highlighted the importance of reviewing clinic start and finish times of clinical administrative staff to help. • Rob Vincent felt that the issue extended beyond DNA rates to the wider administrative experience for patients, particularly communication and access. He advised that this concern has been raised previously at Board level but had not yet been considered through a formal governance route and suggested that there was a need to identify the most appropriate Board Committee to undertake detailed scrutiny of administrative processes, workforce implications and system enablers. **The Board noted the integrated performance report and agreed:** • **an update would be reported to the Board on progress on actions taken to reduce DNA rates, including improvements in patient communication and appointment management; and** • **the appropriate board committee route should be identified to oversee improvements in administrative processes and patient communications.**
9.	**Finance report**
9.1	Terry Whittle presented the finance report for October and highlighted the following points: • The Trust reported a £12.1m year-to-date deficit, which was £6.9m adverse to plan. • The deficit reflected front-loaded pressures in the first half of the year, with recovery expected in the second half, as savings schemes and financial interventions took effect. • Several organisations across NCL remained under significant financial pressure, including Whittington Health, North London NHS Foundation Trust, Great Ormond Street Hospital for Children NHS Foundation Trust and the Royal Free London NHS Foundation Trust. • Expenditure on agency staff reduced to £358k in October, compared with over £1m per month at the start of the financial year. Bank staffing costs had plateaued at c. £1.7m-£1.8m per month. • The year-to-date position included approximately £10m of non-recurrent interventions. • The Trust's delivery of cost improvement programme savings was slightly ahead of other NCL organisations. • Key financial risks and overspends included: o The impact of industrial action, with costs already exceeding £0.4m and potentially rising towards £1.0m. o Additional unplanned costs arising from equipment provider, NRS, going into administration. o Ongoing costs associated with system support services, including the Minerva Airmid bridging service to help relieve pressures in the urgent and emergency care ;pathway.

9.2	• Discussions were ongoing with the NCL Integrated Care Board regarding potential additional funding, although this was unlikely to be at the scale seen in previous years. • The Trust continued to forecast a £1.6m year-end deficit, in line with its agreed plan. • At the end of October, the Trust held £37.51 million in cash, £8.74m favourable to plan. • The capital position remained strong, supported by additional funding secured through national safety funding allocations. Excluding Start Well and the energy centre programme, the Trust's capital programme for the year was £46.9m. Capital investment had been directed primarily towards the mitigation of risk register entries. During discussion, the following issues were raised: • Amanda Gibbon commented on the graph which showed that, during October, the number of open beds had dipped below our funded bed base and wondered how the graph might look in three months' time. • Chinyama Okunuga referred to the NCL ICB's bed productivity work which encouraged providers to reduce their bed base. While 46 bed closures had been mooted for Whittington Health, it had managed to close 20 beds and utilised the Minerva Airmid bridging service to also help. She envisaged that some beds would be re-opened in response to winter pressures. • Terry Whittle reported that Selina Douglas had written to the NCL ICB and local authorities regarding the cost of Minerva and that in the North East London Integrated Care System, the costs of a bridging service had been recovered from Better Care Fund monies, and was an approach to emulate. • Selina Douglas added that work was taking place to benchmark against how other providers were managing quality and safety risks, particularly with further reductions in bank staffing expenditure. **The Trust Board noted the month seven finance report.**
10.	**Freedom to speak up (FTSU) report**
10.1	Ruben Ferreira presented the quarter 1 and 2 report and highlighted the following issues: • He started the FTSU Guardian role seven years ago and was grateful to the executive team and to Rob Vincent, as lead Non-Executive Director for speaking up, for their help, advice and support. • A total of 58 concerns requiring action were received, representing an increase compared with the 44 concerns received in the same period last year. This reflected a return to pre-pandemic reporting levels and was viewed as a positive indicator of confidence in raising concerns. There had been a significant increase in the number of concerns raised in the Adult Community Services Clinical Division and by estates and facilities staff. • Only two concerns were raised anonymously, and reflected a positive speaking up culture at Whittington Health. • The number of bullying and harassment concerns raised had reduced from 34 to 25 compared with the same period last year, and mirrored a national trend.

	• Concerns relating to inappropriate attitudes and behaviours and staff safety and wellbeing remained prominent themes. • For the first time, quality and safety represented the largest category of concerns (26%), reflecting staff perceptions. • 42% of staff raising concerns identified as from an ethnic minority background, 37% were White British and 18% as other White backgrounds. • There was increased reporting from allied health professionals. Concerns raised by medical and dental staff had doubled year-on-year. Nurses and midwives continued to represent the largest professional group raising concerns. • Proactive work was underway with Clinical Divisions' leadership teams and the organisational development team to address concerns and support staff. • Closer joint working with senior quality leads would be undertaken in response to the increase in quality and safety-related concerns. • Increased Freedom to Speak Up training and awareness would include greater use of corporate induction, communications and e-learning, with a particular focus on managers. • Recruitment and deployment of FTSU champions would continue to support the current network of 44 champions with a focus on areas of limited coverage.
10.2	In discussion, Board members raised the following points: • Selina Douglas acknowledged the significant work undertaken by the Freedom to Speak Up Guardian and Serena Wilshire during meetings held with domestic and portering staff. She explained that well-attended listening sessions had enabled staff to openly share their experiences, contributing to a reduction in anonymous correspondence and increased confidence in speaking up. • Tina Jegede reflected on the huge amount of work undertaken by the Guardian and encouraged support for the expansion of the FTSU Champions' network. She added that the launch of the sexual safety charter would help too. • Junaid Bajwa invited Ruben Ferreira to share a few reflections on how the role had evolved over seven years and its future evolution. In response, Ruben Ferreira explained that patterns and volumes of concerns were closely linked to the wider social, cultural and political context, including the pandemic, the Black Lives Matter social justice movement and now, rising nationalism and increased tension, all of which influenced staff experience and behaviour in the workplace. In addition, there was also a need to understand the individual context and lived experience of staff raising concerns. • Ruben Ferreira advised that impartiality and independence remained central to the effectiveness of the role, which required ongoing self-reflection to ensure appropriate professional distance from organisational structures while continuing to provide meaningful support.

	The Trust Board noted the Freedom to Speak Up Guardian's quarter one and two report.
11.	**Questions from the public**
11.1	There were no questions received.
12.	**Any other business**
12.1	Selina Douglas thanked Swarnjit Singh for his response to a request from Islington Council for male allyship in support of the United Nations' 16 Days of Activism against gender-based violence initiative. Swarnjit Singh added that senior male leaders across the Trust had engaged enthusiastically, many of whom signed pledges and participated visibly in the campaign. The Board welcomed the positive response and the Trust's contribution, which was well received by local authority partners.

26 November Public meeting action log:

Agenda item	Action	Lead(s)	Progress
Chief Executive's report	Bring an update to the Board on neighbourhood working	David Cheesman	Completed at the December 2025 Board meeting
Integrated performance report	Provide an update to the Board on progress on actions taken to reduce DNA rates, including improvements in patient communication and appointment management;	Chinyama Okunuga	Completed as part of the Integrated Performance Report brought to the private Board meeting in December 2025
	Identify the most appropriate committee route to oversee improvements in administrative processes and patient communications.	Chinyama Okunuga	This will be reported through the Quality Assurance Committee

Actions carried forward

Agenda item	Action	Lead(s)	Progress
Nursing, midwifery and allied health professionals' strategy	Confirm in Q3 the success measures for delivery of the strategy which can be included in quarterly reporting to the Board alongside other corporate objectives	Sarah Wilding	A separate paper has been emailed to Board members regarding the metrics to measure the delivery of this strategy
Clinical strategy	Confirm the success measures for delivery of the strategy by the end of quarter three	Clare Dollery, Helen Taylor, Clarissa Murdoch	A verbal update will be provided at the Board meeting for this action

Meeting title	**Trust Board – public meeting**	**Date: 30.01.2026**
Report title	**Chair's report**	**Agenda item: 4**
Non-Executive Director lead	Baroness Julia Neuberger, Trust Chair	
Report authors	Swarnjit Singh, Trust Company 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 26 November 2025.	
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 undertaken since the last Board meeting held in public on 26 November 2025.

First, on behalf of the Board, I would like to thank all of our staff and volunteers for their continued hard work over the holiday period in providing quality services and a good experience for our patients during a time of high demand and industrial action by resident doctors in December. Along with Terry Whittle and Tina Jegede, I had the privilege of visiting our hospital wards on Boxing Day to talk with both patients and staff, and to wish them all a Happy Christmas and New Year.

Private Board meeting and seminar, December 2025
The Board of Whittington Health held a private meeting on 17 December. The main items discussed at the meeting included a report from the Chief Executive Officer; the first draft of our 2026/27 planning submission to NHS England covering activity, finances and workforce projections; updates on the programme of ligature risk assessment works, neighbourhood working, fire safety and the collaboration with University College London Hospitals NHS Foundation Trust (UCLH). In addition, there were reports from the Chairs of the Finance and Business Development Committee and the Charitable Funds Committee, and a report detailing an annual well-led self-assessment. The Board also reviewed regular items which included a finance report and our integrated performance report. Board members also took part in a seminar after the private meeting which discussed key organisational priorities for 2026 and the local, regional and national; drivers behind them and our risk appetite

Chair recruitment
In line with NHS England's guidance, my term as Chair of both Whittington Health and UCLH will end on 30 September 2026. It has been an immense honour to serve two wonderful organisations. I joined Whittington Health on 1 April 2020 and have witnessed a period of extraordinary change during this time. A week after I was appointed, the then Prime Minister announced the first COVID-19 lockdown. My personal highlights have included a visit by the Queen in 2021 to mark the international day of the nurse; and the opening of our brand-new Community Diagnostic Centre in Wood Green in 2022, and its expansion in 2023 (this centre has helped to improve access to diagnostic tests for our community, particularly those from more deprived backgrounds); securing the future of our maternity and neonatal services as a result of the Start Well review led by the North Central London Integrated Care Board. As a result, we will see the start of works to transform our maternity estate commencing later this year. In addition, I was delighted during my term as Chair that the Barnet Children's Integrated Therapy and Universal Services teams were incorporated into Whittington Health, expanding the reach of our services into the borough; and for Whittington Health being chosen as a site to host a statue commemorating the vital contribution of the Windrush generation to our NHS. Whittington Health has been a part of my life long before I had the honour of becoming its Chair and I will continue to be a huge supporter of the trust long after the end of my term. It has been my pleasure to work alongside such an amazing team of caring, skilled and utterly committed people who I will miss terribly. I am

proud of what we have achieved, together, over the past six years. I am more confident than ever that Whittington Health will continue to go from strength to strength, caring and supporting the local community for whom it has such a special place in their hearts.

Partnership Development Committee-in-Common
On 19 January, I chaired the quarterly meeting of the partnership development committee-in-common between UCLH and Whittington Health NHS Trust. Items included on the meeting's agenda were an update on the UCLH at Home (virtual ward initiative) and a Programme Director's report. The next partnership development committee-in-common meeting is scheduled for 2 March. I would also like to emphasise that, while UCLH and Whittington Health may not have a joint Chair from October of this year, they will continue to collaborate on clinical pathways where this makes clear sense for local patients.

Board development
A specific Board development session will take place at the seminar scheduled on 21 May, before a focussed development programme starts in quarter three.

Integrated Care Board consultation
As part of the ongoing change programme within Integrated Care Boards (ICBs), the North Central London and North West London ICBs have now begun consulting with staff on:

- the transfer of staff from NC London and NW London ICBs to the West and North London ICB on 1 April 2026
- the proposed future single structure (proposed directorate and team structures and roles), including accommodation arrangements
- functions that may transfer out from the ICBs on 1 April 2026 or later in 2026/27.

In keeping with standard procedure, the consultations are only open to North Central London and North West London ICB staff. The outcome will inform the future target operating model for the new West and North London ICB from its creation in April 2026. The consultations ran from 8 December 2025 to 25 January 2026, with a voluntary redundancy scheme also running concurrently. Following the consultation, the consideration of the feedback and the confirmation of a final structure, work will take place on selection and exit processes that will run throughout March and into the next financial year.

The changes to ICBs follow a national announcement earlier this year, in which all ICBs were asked to reduce running costs by approximately 50% in 2025/26 and to take on a new role as a strategic commissioner. Our two ICBs, which are responsible for planning and paying for local NHS and care services, will legally merge on 1 April 2026 – becoming a new organisation called West and North London ICB, serving 13 boroughs and circa 4.5m residents and service users. Along with driving financial efficiencies, the merger will help create a resilient ICB that can continue to focus on improving access to health, reducing inequalities, moving services closer to the community through neighbourhood delivery, and ensuring the health system works better for residents.

Consultant recruitment
I am grateful to non-executive director colleagues, Amanda Gibbon and Glenys Thornton for participating in recruitment and selection panels for consultant posts. The table below shows the four panels that were held in December 2025 and January 2026.

Post title	Non-Executive Director	Selection panel date
Neonatal Consultant	Amanda Gibbon	2/12/2025
Haematology Red Cell & Haematology Thrombosis (two posts)	Glenys Thornton	11/12/2025
Consultant Community Paediatrics	Julia Neuberger	17/12/2025
Obstetrics & Gynaecology – Benign Gynaecology	Amanda Gibbon	20/1/2026

From Ireland to the NHS
On 3 December, I was delighted to attend a new exhibition at Whittington Hospital celebrating the vital contribution of people of Irish heritage to the National Health Service. The exhibition featured powerful photographs by Fiona Freund and first-hand testimonies gathered by Professor Louise Ryan, Gráinne McPolin and Neha Doshi, authors of Irish Nurses in the NHS: An Oral History, which highlights the stories of Irish nurses who helped shape the NHS from its earliest years to today.

Other meetings
In addition to the meetings already outlined in this report, I have also participated in the following:

- Weekly North Central London Health Alliance calls
- A committee-in-common meeting held on 12 January between the NCL and NWL ICBs
- Regular one -to-one meetings with the Chief Executive Officer, other members of the executive team, non-executive directors, and the Programme Director for the collaboration with UCLH
- Meetings of the Trust Board and Charitable Funds Committee
- A meeting with the company taking forward the recruitment and selection exercise for a new Chief Medical Officer and also the selection panel itself
- I attended and presented at corporate induction for new starters
- I have also taken part in weekly calls for the North Central London Integrated Care Board

I have also continued my informal walk abouts across the Whittington Health estate, meeting individual staff, patients and visitors.

Meeting title	**Trust Board – public meeting**	**Date: 30.01.2026**
Report title	**Chief Executive Officer's report**	**Agenda item 5**
Executive lead	Selina Douglas, Chief Executive Officer	
Report authors	Swarnjit Singh, Trust Company Secretary, and Selina Douglas	
Executive summary	This report provides Board members with an update on key developments nationally, regionally and locally since the last the Board meeting held in public on 26 November.	
Purpose	Noting	
Recommendation	Board members are invited to note the report and to endorse the approach being taken on the new car parking policy.	
BAF	All Board Assurance Framework entries	
Appendices	None	

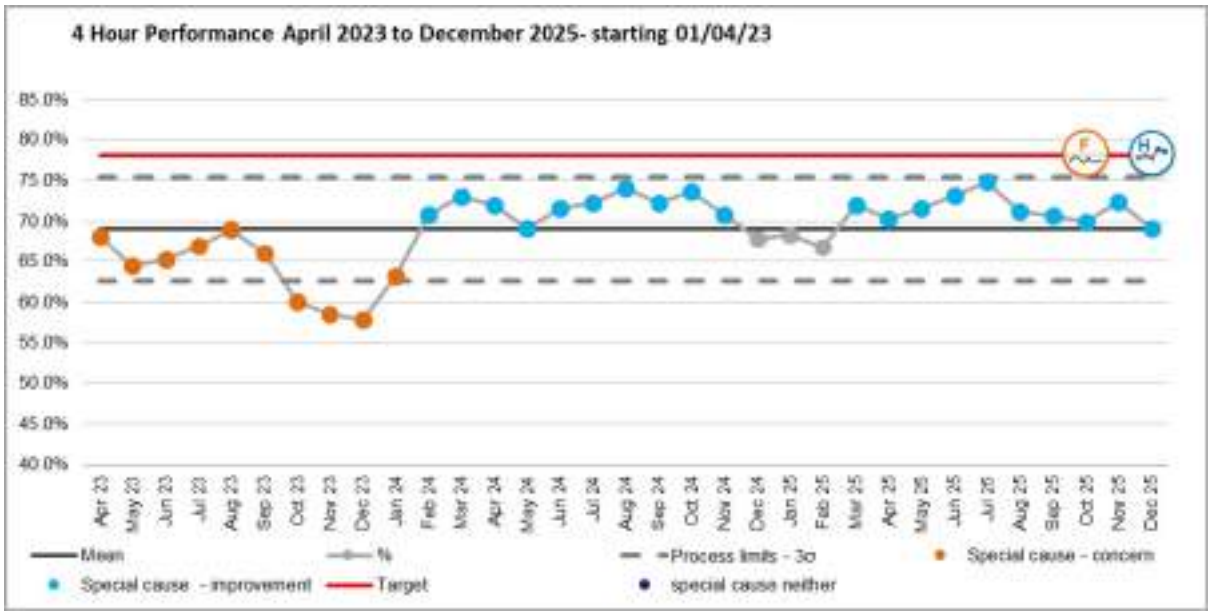
Chief Executive Officer's report

Medium Term Planning Framework - delivering change together 2026/27 to 2028/29

On 24 October, NHS England published the Medium-Term Planning Framework. It includes the following commitments for the next three financial years: by 2029 expanding mental health support teams to have blanket coverage of all schools and colleges, ensuring young people get help early; scaling up NHS Talking Therapies and providing individual placement and support to assist people getting back into work; mental health emergency centres being co-located with emergency departments, providing appropriate support in crisis. The framework provides a direction of travel for the next three years for NHS organisations and our voluntary, community and social care and wider partners. The aim of this guidance is to return the NHS to much better health over the next three years, with a reduction in waiting times, increased access to local care and a removal of unnecessary bureaucracy and the reinvestment of savings into frontline services and staff.

Urgent and Emergency Care

In December 2025, our urgent and emergency care pathway's performance on the four-hour access target declined to 69.1%, from 72.4% in November. This drop occurred despite a decrease in attendances to 9,135 from 9,340 in November 2025. Ambulance conveyances remained stable at 1,583 for both months.



There are several factors behind our four-hour access performance challenge including out-of-hours variability which results in fluctuations in performance, particularly during evenings and weekends; workforce pressures from increased sickness levels among medical and nursing staff; a sustained impact from London Ambulance Service diverts from North Middlesex University Hospital which have impacted on flow and performance; increased presentations by patients who need specialist mental health care; and the impact of estate work on flow within the Accident & Emergency department.

The number of 12-hour emergency department trolley breaches decreased to 260 in December from 317 in November, however, the mental health related breaches increased to 26 from 24 in November 2025. The Trust is actively collaborating with system partners, including the North London NHS Foundation Trust, to reduce delays for mental health patients, and there has been some positive impact but more is needed to help manage increases the position.

In 2026, our strategic priorities will be to have an early system-wide discharge escalation in place, engaging community services, social care, mental health providers, and local councils; the full implementation of actions from the flow improvement programme; and reducing the criteria to reside and long length of stay.

Our operational performance goals this year will be to optimise out-of-hours care to reduce variation in waiting time through better use of pathways and streaming; an increased use of the clinical decision unit; enhanced admission avoidance pathways to support flow and patient care; and an expanded emergency departments same day emergency care footprint to deliver better treatment times.

Home for the Holidays
During the weeks of the 15-19 December 2025 and 9-10 January 2026, the Trust ran two discharge focussed weeks, called Home of the Holidays. During these weeks, various initiatives were trialled such as the piloting a new risk of length of staff screening tool in our acute medical unit; colleagues from Haringey and Islington social care teams attended various wards to support discharges for long length of stay patients; the launch of our partnership with the Juliet O Foundation, who have donated care packages for vulnerable and homeless patients; the trialling of a new discharge checklist on Thorogood and Cloudesley wards; and the trialling of afternoon discharge huddles on our Care of the Elderly wards.

Both weeks were successful in facilitating increased numbers of discharges and implementing new learning and initiatives to support future improvements which can be integrated as part of business-as-usual practice going forward. The week starting on Monday, 15 December was particularly successful, with a significantly increased discharge profile compared to the average for the year.

Referral to Treatment (RTT)
RTT performance has seen a slight decline against the 18-week standard, with achievement of 59.12% in December 2025, compared to 60.08% in November 2025. The Trust's recovery plan remains focused on delivering sustained improvement, with a target of achieving 71% compliance by the end of March 2026. In line with NHS England's requirement that no patients should be waiting longer than 65 weeks for treatment by 31 December 2025, a full validation and clinical review was undertaken. As a result, seven patients remained above the 65-week threshold by the end of the last calendar year. Each of these patients has been individually reviewed and clinically prioritised, with definitive management and treatment plans in place for January 2026. In recognition of this work, the Trust received a formal letter of thanks from Dame Caroline Clark, Regional Director for NHS England (London region), acknowledging the actions taken to eliminate the remaining long waits. She

commended the clarity of the Trust's commitment and thanked the organisation for its continued efforts.

Operational teams are now actively engaged in the Quarter 4 Performance Sprint. This initiative is focused on accelerating recovery by delivering improvements over and above the original activity plans, with particular emphasis on reducing the number of patients waiting over 52 weeks, improving performance against the 18-week RTT standard, and supporting delivery of the wider RTT recovery plan.

DNA rates
A recent review of "Did Not Attend" (DNA) appointments, shared in the Trust Board papers for November 2025, showed a small improvement in attendance. However, some services are still seeing DNA rates above the Trust target of 9%. This includes areas such as nephrology, occupational therapy, physiotherapy, the tuberculosis service, and several surgical specialties, including ear, nose and throat, ophthalmology and vascular surgery. To improve access to care and reduce delays for patients, the Trust will now monitor DNA rates more closely across all services. This will help ensure we make the best use of appointment slots, support our activity plans, and reduce waiting times for treatment.

Skin Cancer
Along with other NCL providers, Whittington Health had been commended for its work to reduce the 62-day skin cancer backlog. As at 10 January, NCL was recognised nationally as having the lowest skin backlog in the country. On behalf of the Board, I would like to thank colleagues in the Surgery and Cancer Clinical Divisions for this achievement.

Senior staffing changes
Dr Clare Dollery, our Chief Medical Officer and Deputy Chief Executive will be stepping down on 31 January after six and a half years at Whittington Health. Clare has been a valued colleague in her current role and as our Acting Chief Executive, prior to my arrival. On behalf of all Board members, I would like to thank Clare for her leadership, kindness, professionalism and support. Clarissa Murodch will be our Interim Chief Medical Officer from 5 January, until a permanent Chief Medical Officer is recruited. In addition, Jonathan Gardner, our Chief Strategy, Digital and Improvement Officer, has been appointed as the Executive Managing Director at the James Paget University Hospital which is part of Norfolk and Norwich University Hospitals NHS Foundation Trust. Jonathan's last day of service with Whittington Health was 9 January 2026 and, on behalf of the Board, I thank him for his service with us since he joined in May 2018. In addition, I would like to thank Liz O'Hara for her contribution as our Chief People Officer. Liz will be returning to her substantive post at UCLH. Recruitment and selection exercises for these two latter executive director roles will take place in quarter four.

Start Well Programme
I am pleased to report that, following an open recruitment and selection exercise, Sarah Mansuralli was appointed as the Start Well Programme Director. Sarah brings a wealth of experience to Whittington Health having formerly been the North Central London Integrated Care Board's Deputy Chief Executive and Chief Strategy and Population Health Officer. I chair the NCL Start Well chief executive officers' group

which will provide strategic oversight of the service reconfiguration programme to improve maternity, neonatal, and paediatric services across North Central London.

Neighbourhoods
The NHS's 10-year plan includes a significant focus on neighbourhood health and changing from 'you come to care' to 'care comes to you' through the development of new neighbourhood models. In London a new Integrator function has been established to provide responsibility for operational leadership and delivery of the neighbourhood model and its functions, including hosting the neighbourhood leadership teams. Reporting into the place-based partnerships the integrators will be required to have close and integrated working relationships with all partners locally – NHS, local authority and voluntary, community and social enterprise organisations – so they can help fulfil each of the four neighbourhood pillars: creating community assets for health and well-being; outreach & early identification; targeted interventions and secondary prevention; and prompt action on rising risk. Whittington Health will be represented in the borough arrangements shown in the table below.

Borough	Integrator arrangements
Haringey	Whittington Health will form an Alliance with Haringey Council and the local GP federation
Islington	Whittington Health and UCLH will form an Alliance with Islington Council and the local GP federation

The challenge for Whittington Health is to see how we can really make the left shift happen, through better co-ordination of the long-term conditions service already in place, but by also exploring whether an acute physician linked to each neighbourhood is something that could be possible to support efforts keeping people out of hospital. New governance arrangements to ensure that there are appropriate assurance and scrutiny systems in place are being developed.

Cyber security
I am also pleased to report that Whittington Health has been awarded £391k from NHS England's Cyber Risk Reduction Funding to improve our cyber security resilience. The funding includes added security inside our network, and a new secure cloud-based backup which will ensure the recoverability of critical systems and data in the event of a cyber incident, including 'ransomware' attacks.

Winter flu vaccination
All staff have been able to receive the flu vaccination at the Vaccination Centre located at the hospital site and open from 0900 to 1700, Monday to Friday. Since the start of September, vaccination teams have been rolling out flu vaccines to pregnant women and children through GP practices, maternity services and via schools. As of 19 January, our staff flu vaccination programme has now vaccinated over 2,000 colleagues, of which 39.2% were frontline staff.

Power Infrastructure Project

I am to confirm that planning permission has been granted for the next phase of our hospital site's power infrastructure project. This stage of the project will deliver a new building on the hospital site to house a replacement energy centre, bulk stores and ancillary office accommodation. The development will replace the Old Boiler House on the south side of the site and represents a major step forward for the Trust's estate. Securing planning permission is a significant milestone in Whittington Health's estate strategy. The application followed detailed engagement with Islington Council planning officers, whose input helped shape a design that is practical, resilient and appropriate for the site.

The scheme will provide modern and reliable power infrastructure, alongside much-needed additional storage and office space to support the day-to-day running of the hospital. Upgrading the hospital's power systems is essential to ensure clinical services and patient care are protected, particularly during emergency situations. The project will also support wider clinical improvements, including the approved Maternity and Neonatal transformation programme and the delivery of the Start Well programme at the Trust.

Importantly, the new energy centre will significantly reduce the hospital's reliance on fossil fuels. Heating will move towards electric heat pumps powered by green electricity, with the project expected to deliver an estimated 80% reduction in carbon emissions on completion. This is a major step towards the Trust's ambition for a net zero carbon estate. I would like to thank colleagues across the estates & facilities team, including Nick Woellwarth, Estate Development Lead, and Ahmed Hassan, Power Infrastructure Project Director, as well as Islington Council's Planning Team and our wider consultant teams, for their work in bringing this project forward.

First images of our future maternity services

On 21 January, Whittington Health released on its webpages, the first images of its future maternity and neonatal unit, offering a clear look at a major redevelopment now moving towards construction. Following the first phase of the project, every room on Labour Ward will have its own en-suite bathroom, improving privacy and comfort during labour and birth.

The images reveal calm, modern and light-filled spaces, designed to provide a relaxing environment with purpose-built facilities specific for labour and birth. Building work is expected to begin this year, following several years of detailed planning with staff and local people. The redevelopment is underpinned by £60milion of capital investment in maternity and neonatal services at the Whittington - the most significant improvements to local birth facilities in a generation.

This phase also include a larger neonatal unit which will bring the currently separate neonatal intensive care unit and special care unit together in one modern environment. The new unit is designed to support the most vulnerable babies as work is being completed on a new purpose built neonatal intensive care unit. Families will also benefit from a brighter maternity entrance and a redesigned triage area at the front of the hospital. These changes aim to create a smoother arrival and simpler access to care.

Despite the scale of the redevelopment, maternity and neonatal services will remain open throughout the works. Construction phases have been carefully planned to protect safety and a positive experience for those giving birth and using the Trust's other maternity services. One of the first stages will be the new combined neonatal unit, built away from later construction activity. The hospital's tiniest patients will only move once the new space is fully ready. Pregnant women, people, and families are being reassured that they can continue to plan their birth with confidence. Care will remain personalised and centred on individual birth plans.

Emma Prescott MBE
On behalf of everyone at Whittington Health, I want to say a huge congratulations to Emma Prescott, Thalassaemia Nurse Specialist, for her service to people living with Thalassemia Syndrome. I am so pleased that her many years of dedicated service to her patients and the community of people living with Thalassaemia has been recognised and rewarded with an MBE in the King's New Year's Honours. Moreover, this is not the first time Emma's hard work has been recognised as in 2018, she received the Patient Choice Award at the Trust's annual staff awards,

Ask Aunty
Whittington Health will be an early implementer of the NHS England London region's Ask Aunty reciprocal mentoring programme for internationally trained professionals, aimed at helping them adapt to working and living in the UK and advance their careers. All staff are invited to join. International staff can pair with experienced mentors, called Aunty or Uncle, for six months of online support, including training, mentoring, peer support, and reflection. The mentors will share experiences on integration, culture, and inclusion and the programme starts in February 2026.

Sexual safety
Sexual safety is everyone's responsibility, and every member of staff deserves to feel safe, respected and protected at work. Following NHS England's national drive, in common with many NHS organisations, we have signed the national sexual safety charter and launched a new sexual safety policy. The policy provides a new framework which sets out what sexual misconduct looks like, with examples and expectations that are easy to understand. It also outlines the pathway following reporting an incident.

Service visits
Since the last Board meeting, I have had the privilege of visiting the following service teams and colleagues:

2 December, paediatric audiology departmental meeting at St Michael's Primary Care Centre, Enfield
I spent time with the team talking about how they have developed a comprehensive wellbeing approach which has worked to bring the team together. This initiative has meant that a dispersed team has a real anchor and support mechanism for their day-to-day work.

3 December, Long Service Awards & Staff Appreciation Day at the Triangle Family Hub
This was a brilliant event with the team talking about their achievements and best practice they are involved in. The impact that teams have on families in Haringey was evident and the passion they have for supporting their community was part of every discussion. They even had their own bake-off competition.

11 December, Northway School and Edgware Community Hospital
I spent team with a class in the school and two individual children's sessions thinking about how physiotherapy interventions can support speech and language therapy. These sessions are designed to support and enable learning assistants in their day-

to-day practice. I then met the wider Barnet team, and they explained how they had transferred into Whittington and firmly part of the organisation.

15 December, Bounds Green Health Centre
At Bounds Green, I was delighted to present Munira Mohammed, an administrator in our Improving Access to Psychological Therapies service, with an Extra Mile Award. Munira was nominated for demonstrating considerable compassion and care to a colleague who turned up to work on a Monday morning extremely unwell and in a considerable amount of distress, so much so that such concerns resulted in an ambulance a rapid response vehicle being dispatched to the scene. Munira went the extra mile because she constantly reassured the colleague that everything was going to be ok, and that the ambulance was on its way. She supported the colleague by holding her hand until the ambulance arrived and calmed down the colleague to regulate her breathing, as this was extremely erratic, and she supported the colleague by manoeuvring them into a more comfortable position, and did not leave her side until the ambulance arrived.

Proposed car parking changes
The Trust has had to review its current carparking arrangements as the leased space across the road from the hospital site is no longer be available. Following a full review, the revised car parking policy seeks to introduce a sustainable and transparent model for managing limited staff parking capacity, ensuring compliance with Department of Health & Social Care guidance, supporting the Trust's Green Travel Plan, and aligning with the NHS's net zero agenda. The key changes are:

- The introduction of a paid permit system with tiered charges based on days worked per week.
- A permit allocation ratio reduced to 1.25 per bay to prevent oversubscription.
- The removal of patient/visitor parking after 5pm and at weekends, freeing capacity for staff. Patient drop-off & collection will remain the same with access to the main entrance of the hospital.
- Designated parking will be reserved within the Whittington Education Centre (WEC) for emergency on-call medical staff, who are required to attend site urgently. Access will be limited to staff listed on the official on-call rota.
- Emergency on-call medical staff may access the Trust approved taxi service for travel to and from site during emergency callouts, supporting staff safety and out-of-hours response.
- Implementing six guaranteed, allocated permits for emergency on-call medical staff, for day (of) parking prior to emergency night on-call shifts. The allocated will be managed by very senior medical leadership (named director) and logistically supported by the Head of Security.
- Special parking arrangement for important colleagues & guests (CQC, Ministers etc.) will be coordinate by the Head of Security and allocated within the WEC car park as required with 48hrs notice.

All staff briefings

Since the November Board meeting, there have been three all staff briefings at Whittington Health. The topics covered at the most recent one held on 15 January included a review of performance in 2025 which highlighted our ranking under the NHS Oversight Framework, our improved cancer where Whittington Health was named as England's most improved cancer service performance against the 62-day target, the 18% increase in diagnostic appointments provided at the Wood Green Community Diagnostic Centre' and the elimination of waits for planned care for people who have waited over 65 weeks. We also highlighted sustainability as a key area to continue progressing in 2026 through our Improvement programme's four workstreams and the delivery of recurrent savings.

Meeting title	**Trust Board – public meeting**	**Date: 30 January 2026**
Report title	**Quality Assurance Committee Chair's report**	**Agenda item: 6**
Committee Chair	Professor Mark Emberton, Non-Executive Director	
Executive leads	Sarah Wilding, Chief Nurse & Director of Allied Health Professionals, Dr Clarissa Murdoch Acting Chief Medical Officer	
Report author	Marcia Marrast-Lewis, Assistant Trust Secretary	
Executive summary	The Quality Assurance Committee met on 14 January 2026 and was able to take good assurance from the following agenda items considered: • Board Assurance Framework - Quality and Integration 2 entries • Reduction of Viral PCR Testing Project - Quality Improvement project • Q2 Patient Safety Investigation Framework update • Patient Safety Incident Investigation report (PSII) reports • Q3 2025/26 Maternity Board report • Maternity Incentive Scheme Year 7 submission • Learning from Deaths report • Mental Health Update • Ligature Risk assessment report • Biannual Health & Safety Report • Nursing and Midwifery 6 monthly safer staffing review The Committee took partial assurance from the following agenda items: • Risk register report • Fire safety report The Committee also received the minutes of the meeting of the Quality Governance Committee that took place on 9 December 2025. The Committee agreed that the nursing establishment review was escalated to the Quality Assurance Committee together with infection prevention control in the context of winter pressures and winter infections. The Committee agreed that the following areas be brought to the Board's attention: 1. The need for members to review unredacted Patient Safety Incident Investigation (PSII) reports to ensure a full understanding of the issues and context.	

	2. The compliance achieved so far, against the ten safety actions for year seven of the Maternity Incentive Scheme (MIS) and the remaining areas of risk. 3. Safer staffing submission with an emphasis on workforce sustainability and the reduction of bank and agency 4. Mental health and the impact on patients when their needs are not met in the right setting. 5. The need to develop a more quantified approach to scoring risks against the BAF to strengthen consistency and transparency.
Purpose	Approval
Recommendation	Board members are asked to note the Chair's assurance report for the Quality Assurance Committee meeting held on 14 January 2026.
BAF	Quality 1 and 2 entries and Integration 2 entry
Appendices	1. Six Patient safety incident investigation reports: • A118499 - Went to QAC 2/11/25 (held back due to Inquest on 16/01/26) • A122107 - Went to QAC 10/09/25 (held back due to Inquest on 23/12/25) • A124352 went to QAC 14/01/26 • A124977 - Went to QAC 14/01/26 • A131504 - Went to QAC 14/01/26 • A116750 - Went to QAC 14/01/26 2. Q2 Learning from deaths report 3. Nursing and Midwifery 6 monthly Safer Staffing Review Report

Committee Chair's Assurance report

Committee name	Quality Assurance Committee
Date of meeting	14 January 2026
Summary of assurance:	

1. Emerging issues

The Committee noted the following updates:

a) **Care Quality Commission inspection report**

The draft report on the outcome of the inspection of urgent and emergency care (UEC) has been received and would be reviewed for factual accuracy. A response was due by 23 January. The CQC had given the UEC a rating of requires improvement which does not alter the Trust's overall position of good.

b) **Simmons House**

Notification has been received from the CQC of their intention to reopen the formal investigation into the tragic death by suicide at Simmonds House in October 2023.

c) **Never Event**

The Committee was informed that of a never event related to the misplacement of a nasogastric tube in an elderly patient. An investigation has commenced and the findings would be reported to the Committee upon completion.

2. The Committee confirms to the Trust Board that it took good assurance from the following agenda items:

Q3 Board Assurance Framework (BAF) – Quality 1 and 2 and Integration 2 entries

The Committee reviewed risks relating to the delivery of the Trust's Quality and Integration strategic objectives and agreed that no changes should be made to the total risk scores for the three relevant entries at this time.

Committee Members discussed the broader issue of quantifying risk indicators and their influence on risk scores. It was agreed that a quality dashboard, reporting on a comprehensive set of metrics would strengthen the risk scoring process and enable more accurate reporting.

The Committee approved the Q3 BAF for the Quality and Integration 2 entries.

Q3 Patient Safety Investigations Framework (PSIRF) update

The Committee reviewed the Q3 PSIRF update. The top ten reported categories continued to relate primarily to discharge and transfer, reflecting sustained winter pressures, alongside pressure ulcers and other skin damage, which remain priority areas for improvement. The Committee received assurance that that these themes were being addressed through established improvement groups, with assurance provided through the implementation of agreed improvement and safety actions. In addition, the range of learning responses across clinical divisions, were demonstrably linked to improvement activity.

The Committee learned that five Patient Safety Incidents (PSIs) were declared during the reporting period. All five PSIs are currently subject to formal investigation, with weekly progress updates reported to the Whittington Improvement Safety Huddle to ensure actions were tracked and delivered. All completed investigations will be escalated to the Trust Board in line with agreed governance arrangements.

Overall, the Committee was assured that good progress is being made. While recently declared PSIs are progressing through the investigation process, the majority of legacy cases have now been concluded, providing improved assurance around timeliness and organisational grip.

The Committee noted the report

Patient Safety Incident Investigation reports

The Committee received the findings from the following four investigations

- The first patient safety incident involved a patient who presented to the ED following a seizure and was subsequently found to have a cervical spinal cord injury. While initial CT imaging did not identify a fracture, a radiology addendum indicating potential cervical spine instability was not directly communicated to clinicians. The patient later developed neurological symptoms, with MRI confirming a soft-tissue spinal injury resulting in tetraplegia. The Committee was informed that the incident had been reviewed through established governance processes, including a radiology discrepancy review, and that learning had resulted in strengthened arrangements for the direct notification of radiology addenda, reinforced expectations for neurological assessment prior to removal of cervical spine immobilisation, and clearer guidance on the early use of MRI where ligamentous injury is suspected.
- The second incident involved a patient with complex needs, known to community nursing services, who died following a cardiac arrest in the community. The patient had repeatedly declined care, hospital admission and transport, raising initial safeguarding concerns. The Committee was informed that a review of the incident identified inconsistent documentation and assessment of mental capacity in community settings, alongside challenges in coordinating care across services. Learning actions included strengthening the use of complex solutions teams, improving the visibility of patients with learning disabilities and complex needs through enhanced alerts on community systems, and reinforcing joint working between learning disability services, community nursing and social care.
- The third incident involved a retained swab following a vaginal delivery on the maternity unit. The retained swab was identified postnatally and removed under general anaesthetic, with the patient making a full recovery. The Committee was advised that the review identified non-adherence to established swab counting processes, rather than absence of controls, and that learning has been reviewed using a systems-based approach. Actions included clarified guidance on swab counting and escalation, revision of perineal tear documentation and Local Safety Standards for Invasive Procedures, strengthened use of post-delivery workflow checks, and additional training and role clarity for maternity staff. The Committee took assurance that improvement actions were in place to reinforce compliance

with swab counting processes and reduce the risk of recurrence. Committee members also agreed that the incident provided an opportunity to undertake a quality improvement project expanded across all clinical divisions.

- The Committee considered a report on a serious incident involving a patient on a care of older people ward who sustained a fall in a recognised high-risk bathroom area and was subsequently found to have a fractured neck of femur. The patient underwent surgical repair but later developed aspiration pneumonia and sadly died. A review identified gaps in falls risk assessment and post-fall management, including failure to update risk assessments following an earlier fall, lapses in bay observation arrangements, and deviation from agreed post-fall procedures, including the use of appropriate manual-handling equipment. Actions included strengthened controls around falls risk assessment and documentation, reinforcement of post-fall and manual-handling procedures, review of bathroom risk controls on care of older people wards, and refresher training to support safe supervision and escalation.

The Committee noted the PSII reports which would be appended to the Chair's report to the Board

Q3 2025/26 Maternity Services Quarterly report

The Committee received a summary of the work undertaken in the maternity department for quarter 3. The following points were highlighted:

- The 2025 CQC Maternity Patient Survey has been published, and work would continue through monthly meetings with the Maternity and Neonatal Voices Partnership to co-produce an action plan, with particular focus on addressing the lowest-scoring survey domains.
- There was one ongoing MNSI investigation, with a response awaited, and one coroner's case, for which the PSII has been finalised and an inquest is scheduled. No new PSII incidents were reported in Quarter 3 beyond those already under investigation.
- Key learning themes from Quarter 2 incidents included NICU admissions and respiratory distress, major obstetric haemorrhage, and a cluster of safeguarding cases. The Board noted ongoing audit activity and the need to maintain compliance with mandatory safeguarding training, recognising the risk of reduced compliance if uptake is not maintained ahead of the next training cycle.
- There was 100% compliance with supernumerary labour coordinator arrangements, delivery of one-to-one care in labour, and ongoing monitoring of midwife-to-birth ratios and planned versus actual staffing levels.
- A review of home birth services was undertaken following a Prevention of Future Deaths report in greater Manchester. Areas for improvement were identified relating to on-call arrangements, staffing and experience, with an action plan in place, the introduction of skills-in-real training, completion of staff listening events, and a review of the service model was underway, with proposed changes expected by July 2026.
- For MIS year 7, the Trust was compliant with 9 of the 10 safety actions, with actions in place to address the remaining requirement. The Trust was not compliant with Safety Action 4 relating to elements of the obstetric medical workforce at the point of submission. However, assurance was provided that compliance has been achieved since April, supported by audit, and that

an agreed action plan will be submitted to NHS Resolution alongside the declaration. The Committee was assured that the Trust is on track to achieve compliance with Safety Action 10 within the required timeframe for the next MIS submission.

The Committee noted the Q3 maternity report.

Learning from deaths report

The Committee received an update on mortality, learning and prevention of future deaths. The following key issues were highlighted:

- 102 inpatient deaths were recorded during the period, with a further 14 deaths in non-inpatient cohorts.
- The Standard Hospital Mortality Indicator (SHMI) remained within expected limits (0.94), providing assurance. A review of SHMI data highlighted improved elective coding quality, with ongoing challenges in non-elective coding, impacting the capture of comorbidities and overall mortality metrics.
- Learning from Prevention of Future Deaths (PFD) reports, included the need for strengthened preparation and support for community teams involved in inquests, and continued improvement work relating to pressure ulcer prevention in the Emergency Department (ED). A further PFD related to crowding in the ED was noted, recognising this as a significant and ongoing pressure locally and nationally.
- Learning from Structured Judgement Reviews (SJR) identified themes around complexity of mental health assessment, fluctuating capacity, and radiology learning, with assurance provided regarding proactive review and dissemination of learning through established governance routes. Good practice was noted in relation to end-of-life care, alongside targeted improvement work to strengthen treatment escalation planning in clinical areas with smaller cohorts of patients at risk of deterioration.
- The Committee received assurance from a detailed review of a temporary signal in lung cancer mortality, where numbers had returned to expected levels and that case review identified late presentation and advanced disease as contributory factors. The Committee requested that avoidability scores would be included in future reports to strengthen assurance.

The Committee noted the report.

Reduction of Viral PCR Testing Project

The Committee welcomed Neil Jones, Pathology Operations Manager, who delivered a presentation on a demand optimisation project for pathology services. The project, implemented under the outsourced model with HSL, has achieved significant improvements in controlling pathology testing and reducing unnecessary tests, which carry both financial and clinical implications.

The following key points were noted:

- Project Approach: Adopted a quality improvement methodology focusing on high-cost, high-volume tests. Initial target was the Quad PCR test (COVID, RSV, Influenza A & B), costing approximately £75 per test, with annual volumes around 10,000.
- Audit Findings: Initial audit identified approximately 500 unnecessary tests for adult admissions, with potential savings estimated at £450k per year if compliance was achieved.

- Interventions: Education programme, clinician engagement, and clear guidance via screensavers on appropriate testing criteria.
- Impact: Re-audit showed a reduction in asymptomatic testing from 60% to 11%, delivering estimated savings of £150k–£200k to date, with potential for further savings.
- Next Steps: Expansion of the demand optimisation model to other high-cost tests.

The Committee thanked Neil Jones for his presentation and commended the success of this initiative and its contribution to cost control and clinical quality.

Nursing and Midwifery 6 monthly Safer Staffing Review Report
The Committee received an assurance update on the Trust's compliance with statutory requirements for safe nursing and midwifery staffing. Focus was given on the following:

- Proposals to strengthen nursing staffing in the Paediatric ED,
- Staffing on Ifor Ward had been permanently increased, with over-recruitment and additional healthcare support workers in place to strengthen enhanced care provision.
- A focus on enhanced therapeutic care, strengthened training for staff supporting patients with mental health needs, review of ward manager supervisory time, and progress with team-based rostering. Ward managers at the Trust were not fully supernumerary, and a benchmarking exercise has been commissioned to inform future options within the current financial context.
- Progress on resetting net nursing hours, would be considered through Audit Committee.

The Board took assurance that appropriate governance and review arrangements were in place to support safe staffing across nursing and midwifery services.

Mental Health Update Report
The Committee was informed of concerns regarding the number of inpatients awaiting psychiatric assessment, treatment or transfer, including patients detained under the Mental Health Act, and the associated impact on patients with co-existing physical health needs.

The Committee received an update on progress against the six priority areas which included ongoing work to strengthen arrangements in the ED for the review and use of restraint and seclusion, supported by monthly audit and the continued embedding of Code 10, a multidisciplinary response for patients requiring enhanced support. A a multidisciplinary review of the ED environment was scheduled for completion by the end of January. Progress was also noted in relation to mental health training for staff in the ED, Ifor and Emergency and Integrated Medicine wards, with training delivered between August and December 2025. Further sessions were planned which would focus on de-escalation and safe, compliant use of restraint.
The Committee received assurance that work would continue to improve the interface between physical and mental health care, including practical measures

such as access to nicotine replacement therapy, and ongoing oversight of Mental Health Act compliance.

In addition, the Committee took assurance from audit findings that rooms 12 and 12A had not been used for patients under the age of 18 during the past year, The Committee welcomed evidence that staff training had strengthened confidence in using alternative de-escalation approaches, reducing reliance on restrictive practices.

Committee members acknowledged concerns regarding a small number of children and young people on Ifor Ward that had experienced delayed discharge due to limited availability of suitable social care placements. The Committee received assurance that work was underway with system partners across North Central London to develop a collaborative escalation protocol to expedite access to appropriate placements, led by the Head of Safeguarding Children and the Trust's Children's Mental Health Champion.

The Committee noted the report

Ligature risk update

The Committee considered the report on the Trust's management of ligature risks. It was acknowledged that during 2025, risk assessments were completed in 16 high-risk areas, alongside delivery of associated estates works. This has reduced the overall ligature risk score from 20 to 15, with a further aspiration to reduce this to 12 through continued mitigation, completion of estates works, strengthened training assurance, and review of the Ligature Risk Assessment Policy, scheduled for February and March.

Committee members welcomed strengthened governance and joint working with security, estates and clinical teams, including learning from a recent coroner's inquest, improved clarity of roles and responsibilities, and embedded ownership at clinical and divisional level. Progress on estates works was noted, including access control and window replacements on Ifor Ward, supported by an increased £700k capital budget. The Committee took assurance that next steps, included policy and process review and escalation through established governance routes.

The Committee noted the report

Bi – Annual Health and Safety Report

The Committee considered a report on the Trust's health and safety governance arrangements and health and safety metrics. The following key themes were highlighted:

- Incident reporting performance met the Trust KPI, with 25% of incidents reported within seven days. The most frequently reported incident categories related to security and violence and aggression in the ED and maternity departments
- Overall health and safety policy compliance was at 76%, with an action plan in place through the Health and Safety Committee to achieve near-full compliance by the end of Quarter 4.

	• Ongoing actions in response to a food allergen alert, included strengthened ward-level food safety training and planned review of patient catering arrangements. • Mandatory health and safety training compliance remains around 90%, with fire safety training temporarily reduced to 84% due to staff turnover; additional external support has been secured to restore compliance. • The completion of fire risk assessments had reduced to 56% on the acute site and 47% in community services due to staffing changes. Assurance was provided that external specialist support has been appointed and recovery work is underway. • Four Reporting of Injuries, Diseases and Dangerous Occurrences Regulations incidents were reported, all were appropriately managed with staff supported and no critical systemic issues identified. Committee members sought assurance in relation to the significant increase in reported incidents over the six-month period (1,241 compared to 521), and whether this reflected an increase in incidents or improved reporting. The Committee was advised that the increase was attributable to improved reporting (approximately 90%), rather than a deterioration in safety. This reflected targeted work to strengthen reporting culture, particularly in the ED and mental health related activity, alongside efforts to clarify roles, responsibilities and service scope. Work is also underway with the Datix System and risk teams to streamline reporting processes. **The Committee approved the report.**
e3.	**Committee members took moderate assurance from the following agenda items:** **Risk Register report** The Committee reviewed the risk register report which showed 49 risks scored at 15 or more on the risk register. The Committee reviewed the following added high risks: • 1675 - Inadequate Staff Resource for Women's Health Clinical Governance Activities and Oversight • 1681 - Health Visiting Service – Barnet • 1684 - Safeguarding Training Compliance for Midwives and Obstetricians • 1678 - Over 15000 Patients Lost to Follow Up The Committee discussed the plans to address the patients lost to follow-up and was assured that harm reviews were ongoing and a working group had been established to complete the investigation. The Committee would be informed of clinical risk assessments in due course. **The Committee noted the Risk Register report.** **Fire safety action plan update** The Committee received an update on progress of fire safety remediation works across the Trust. It was reported that significant capital works were underway, with a particular focus on A, L and K blocks, and that engagement with the London Fire Brigade continued on a quarterly basis. The Committee welcomed

	the strengthening of the relationship with the London Fire Brigade, with further site engagement anticipated later in the year. The Committee received assurance regarding delivery of the fire remediation programme, including decant arrangements to enable works in clinical areas, a review and upgrade of the Trust's fire strategy, and phased remediation across the acute and community estate. It was noted that compliant L1 fire alarm systems and fire doors would be in place in priority blocks by Q1 of the next financial year, materially reducing risk. Progress on works at Stuart Crescent was noted, with mitigations in place where access challenges remained. The Committee took assurance that risks are recognised, funding arrangements were being actively managed, and the programme was progressing in line with plan. **The Committee noted the report**
4.	**Present:** Mark Emberton, Non-Executive Director (Chair) Amanda Gibbon, Non-Executive Director Baroness Glenys Thornton, Non-Executive Director Sarah Wilding, Chief Nurse & Director of Allied Health Professionals Clarissa Murdoch. Deputy Chief Medical Officer Tina Jegede, Joint Director of Inclusion and Islington Care Homes Lead Swarnjit Singh, Joint Director of Inclusion and Trust Company Secretary **In attendance:** Isabelle Cornet, Director of Midwifery Selina Douglas, Chief Executive Dr Phillip Lee, Associate Medical Director, Patient Safety Marcia Marrast-Lewis, Assistant Trust Secretary Matthew Minter, Associate Director of Clinical Governance Theresa Renwick, Safeguarding Adults Lead Liam Triggs, Director of Estates & Facilities Ruth Woolhouse, Senior nurse & Manager Paediatric Mental Health Team, Carolyn Stewart, Executive Assistant Chief Nurse & Director of Allied Health Professional Ruth Law, Assistant Medical Director, Quality Improvement & Clinical Excellence Mike Cooshneea, Deputy Chief Operating Officer/Director of Operations EIM Neil Jones, Pathology Operational Manager **Apologies** Chinyama Okunuga, Chief Operating Officer

Whittington Health NHS Trust

Learning from a patient safety incident involving a person with learning disabilities and complex needs who declined care.

V2.1

Distribution list List who will receive the final draft and the final report (e.g. patients/relatives/staff involved, board)	
Name	**Position**
[redacted]	Tissue Viability CNS
[redacted]	Learning Disability Nurse
[redacted]	Lead Learning Disability Nurse
[redacted]	Registered Nursing Associate
[redacted]	DN Team Manager
[redacted]	Care Manager
[redacted]	Social Worker
[redacted]	Community staff nurse
[redacted]	Head of Vulnerable Adults
[redacted]	Adult Safeguarding Lead

Date of incident	[redacted]
Incident ID number	A124352
PSII Approved by	
Job Title	
Signature	
Date Approved at Quality Assurance Committee	

Participants of the PSII	
Name	Role
[redacted]	Lead District Nurse
[redacted]	Lead District Nurse

1. About patient safety incident investigations

Patient safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers and staff.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Duty of Candour and the Engaging and involving patients, families and staff after a patient safety guidance in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the Just Culture guide in the minority of cases when staff may be referred to them.

PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

2. A note of acknowledgement

We would like to thank all staff who contributed to review of the patient safety incident summarised in this report.

Your support, openness and transparency have been invaluable. Your insights into how care is delivered across teams have helped us to understand what happened and to identify areas for improvement.

Our role as Learning Response Leads is to gather insights into the healthcare setting and systems in which you work. Our focus has been on understanding how teams work together to deliver patient care, the challenges you face, and how system factors can influence the safety and quality of that care. We are not here to judge or criticise, but to facilitate learning in supportive, caring and collegiate way.

Without the insights and contributions of the staff who participated in this review, this report would not have been possible.

Thank you for your continued dedication to safe and compassion care!

3. Contents

4. Executive summary

4.1. Incident overview

On [redacted], a clinical incident was reported by the Tissue Viability Nurse following the death of [redacted], who suffered a cardiac arrest shortly after a nursing visit and sadly died the same day.

Concerns had been raised since [redacted] that [redacted] had not been eating, drinking, or taking [redacted] prescribed medications, and that [redacted] four-times-daily care package appeared insufficient to meet [redacted] needs. However, the care agency's statement did not indicate how these concerns were escalated. (care packages are commissioned by the Local Authority)

[redacted] had also been found lying on a deflated pressure-relieving mattress, which had been unplugged from the pump. The exact date of the power loss remains unclear, but RiO entries confirm that the property was without power from at least [redacted]

Between [redacted] and [redacted], there had been seven 999 calls to the London Ambulance Service (LAS), during which [redacted] repeatedly refused hospital admission after clinical review. Although the initial incident report suggested that no Mental Capacity Assessments (MCAs) had been completed, this investigation confirmed that LAS undertook an MCA on [redacted], concluding that [redacted] had capacity to refuse hospital attendance.

[redacted] was under the District Nursing (DN) caseload, but the investigation found limited evidence of senior oversight or timely escalation of concerns. Escalation to the GP reportedly occurred around [redacted], though communication challenges were noted due to data protection restrictions on email correspondence. GP records confirm ongoing concerns regarding chest pain, leg pain, and repeated refusals of ambulance assistance.

4.2. Summary of key findings

Carers identified that the accommodation where [redacted] was living had no running water, electricity or heating, but this was not isolated to [redacted] accommodation and the whole street was affected. The carers escalated these concerns to Social Services. This escalation led to all other residents being relocated to a suitable accommodation, although no definitive date was identified during the investigation but would have been around [redacted]. [redacted] was offered a nursing home placement, but [redacted] declined. Several attempts were made to discuss alternative accommodation with [redacted]. However[redacted] continued to refuse and chose to remain in the property where everyone else had vacated.

Upon further review, there is no evidence of safeguarding concern being raised when housing concerns were identified by carers, as a result, [redacted] was the only resident remaining in the property. According to the care manager, during this period, [redacted] mobility deteriorated, and carers reported increasing difficulty in providing care and support safely and effectively and reported concerns to social worker who in turn contacted the Learning Disability (LD) nurse.

Initially, neither the District Nursing (DN) service nor the Learning Disabilities (LD) team were informed of [redacted] unhabitable home environment or [redacted] wish to remain at home. Expectation would have been to raise safeguarding concern and inform Whittington Health NHS Trust's safeguarding team. From the investigation, no correlation has been established between home environment and mobility.

The LD team became aware of concerns related to [redacted] on [redacted], including that [redacted] was in pain, unable to mobilise, and hoarding personal belongings around [redacted] bed, preventing carers from moving items to enable care. Prior to this, on [redacted], SSKIN Bundle home visit was undertaken by the DN team, but the patient declined treatment. The plan was for DNs to continue visits for SSKIN Bundle twice a week. Lack of patient's concordance was noted and escalated during handover to the team coordinator. Expectation would have been to raise safeguarding concern and inform Whittington health safeguarding team.

On [redacted], [redacted] support worker requested a DN visit for possible pressure ulcer damage.

On [redacted], carers contacted London Ambulance Services (LAS) as [redacted] was complaining of chest pains and feeling unwell. The LAS attended and confirmed that [redacted] had developed a pressure ulcer, but location was not specified. This was later established and documented by DN team to be a moisture associated skin damage (MASD) on the sacrum. [redacted] declined hospital admission. The LAS completed a Mental Capacity Assessment (MCA) and concluded that [redacted] had capacity to refuse hospital admission. According to the LAS report (obtained from LCR), [redacted] was self-neglecting and acknowledged that [redacted] accommodation lacked running water. This investigation has found no evidence that safeguarding concerns were considered. There were also no welfare referral completion and no safeguarding referral completed.

[redacted] was visited by DN team on [redacted] for pressure ulcer risk assessment, but [redacted] declined care from the visiting nurse. [redacted] started to get agitated after several attempts of trying to persuade [redacted] to accept care. Carers attempted to persuade patient as well, but [redacted] declined. From LD nurse's statement, it was established that the visiting LD nurse had requested carers to send an image of [redacted] pressure ulcer and they in turn escalated concerns to their care manager around refusing personal care, pressure ulcer care and refusal to attend hospital for appropriate care. A Social worker contacted LD nurse regarding concerns and agreed a plan to discuss concerns with [redacted] GP.

The DN team became aware of the home environment (no running water and no electricity) on [redacted]. Prior to this date the DN team visited [redacted] for once weekly SSKIN bundle reviews, and there were no recorded concerns to be escalated prior to [redacted] about the home environment. However, according to RiO progress notes, there is evidence that [redacted] had a history of refusing treatment, medications and safeguarding concern. Although no formal safeguarding referral was raised, safeguarding concerns were discussed by email. Sent on sent on [redacted] by care manager. It was established that, although no MDT meeting held to review concerns, there were emails circulating between the LD team, social services, the GP regarding refusal to take medications.

On[redacted], the DN team assessed [redacted] wound and identified Moisture Associated Skin Damage to [redacted] sacrum. [redacted] living conditions were escalated to the DN team manager, the Head of Safeguarding Vulnerable Adults via phone call and email. HLDP nursing team was contacted by the Head of Safeguarding Vulnerable Adults to request an urgent response.

The carers reported that [redacted] frequently declined their care, including assistance with personal hygiene, and was sometimes found in soiled incontinent pads. [redacted] had a hybrid mattress for pressure relieve to prevent the development of skin damage that required electricity to operate effectively, but as the electricity was off, the air the mattress was not functioning as intended.

On [redacted], [redacted] was referred to the Multi – Agency Care and Coordination Team (MACCT) for an urgent review on the same day. The earliest slot for an MDT discussion was the following Tuesday [redacted]. However, this review did not take place as [redacted] died on [redacted]. [redacted] was visited by Learning Disability nurse (LD) nurse who reported that [redacted] did not wish to engage in assessments or discussions. The LD nurse asked [redacted] if [redacted] could call the ambulance as [redacted] was worried about [redacted] presentation, but [redacted] declined. [redacted] explained that [redacted] knew and did not want to go to hospital but agreed for [redacted] GP to be contacted for a blood test. The LD nurse contacted the GP to request for urgent blood test.

Based on LD nurse's statement, there is no mention of home environment LD nurse, however, there is an email correspondence from [redacted] 'care manager escalating the unsuitable home environment and pain to the GP on [redacted]. The carer also reported that [redacted] had been refusing food, fluids, and medication since [redacted]., [redacted] continued to decline personal care but agreed to have blood test taken on [redacted].

On [redacted], a joint welfare visit was carried out by LD nurse, TVN and Social Worker. During the visit, it was documented that [redacted] was awake and mumbling. [redacted] foot was swollen and painful. The TVN completed an MCA, concluded that [redacted] lacked capacity to decide about going to hospital. The TVN called the LAS for urgent transfer to an acute setting. At the time of assessment, no immediate life-threatening conditions were identified that required category 1 or 2 response., Approximately one hour later, the TVN contacted the LD team, who advised that [redacted] had gone into cardiac arrest. The LD Nurse called an ambulance at approximately 12:43, and the crew arrived at 12:45 and commenced CPR. As the attending crew were not paramedics, they requested additional emergency support. The paramedic team arrived at approximately 13:00 and took over resuscitation efforts. Despite attempts at CPR, they were unsuccessful, and [redacted] was pronounced deceased at 14:09.

On [redacted], MDT teleconference was held to discuss [redacted] death. The GP advised the team that the case would not be investigated by the coroner. Whittington Health NHS Trust's Safeguarding Lead raised safeguarding adults concern with coroner who reported that circumstances connected with [redacted] death had already been reported to the coroner and did not consider that there was a duty to investigate the death under Section 1 of Coroner and Justice Act 2009. It was concluded that medical cause of death provided by attending practitioner and scrutinised by Medical Examiner raised no concerns and medical cause of death was natural and did not appear to be related to the care [redacted] was receiving.

4.3. Summary of areas for improvement and associated safety actions

i. This investigation has identified several areas where system learning, and service improvements can be strengthened safety and quality of care for patients with complex needs who are at risk of self- neglect.

ii. Improvements are required in early identification and escalation of risk, (patient to be added to the patient of concern list within DN service with an oversight of the Team manager), ensuring that concerns about unsafe living conditions or refusal of care are promptly recognized as potential safeguarding issue and jointly managed across health and social care teams.

iii. District Nurses will pick up patients with learning disability from when they are referred onto the service during triage. Triage nurse will then enquire whether there are any reasonable adjustments in place for the patients. This will need to be added by the referrer. The referrer will also mention whether the patient is known to the LD team in the borough with contacts provided were possible. This information should be cascaded to the DN team the patient falls under. DN to contact LD nurse prior to assessment. Prior to the initial assessment, the DNs should liaise with the LD nurse to find out more about the patient prior to visit, with the view to carry out a joint visit with the LD nurse for the initial assessment were possible.

iv. Patients with learning disability requiring reasonable adjustment should have an alert on our Rio system, prompting clinicians as soon as they open their records on Rio (prompt added via case record prompt). In addition, reasonable adjustment notice needs to be added on daily team planner section as was done in this case.

v. Enhanced information sharing and multidisciplinary coordination will help ensure that all professionals involved have a shared understanding of the patient's situation, capacity status, and level of risk. This included clear pathways for communication between the District Nursing, Learning Disability, Social Care, and Ambulance Services.

vi. Patients with mild/complex learning disabilities could also benefit from having their care plan on UCP to ensure clinicians to see what their support needs are as well as aid adequate management of their care needs ensuring that these patients receive best care across all services.

vii. Any healthcare facing potentially a safeguarding concern should raise safeguarding alert as soon as possible and escalate concerns to senior management team. Raise awareness within district nursing of the importance of prompt escalation of issues concerning learning disability patients concerns.

viii. Consistency in capacity assessment and documentation is also key area for improvement. Staff should be supported to apply the Mental Capacity Assessment confidently, including when reassessment is required and recorded.

ix. Oversight and clinical leadership should be strengthened for high – risk patients. The patient should also be added unto the patient of concern list with an oversight from the team manager. In addition, service to utilise non concordance flow chart.

5. Duty of candour

Different elements	Yes	No	Date	By whom?
Was the patient / NoK contacted and apologised to?	☐	☒	Click or tap to enter a date.	N/A due to no identifiable NOK
Was this followed up in writing?	☐	☒	Click or tap to enter a date.	
Has the family agreed to receive the final report?	☐	☒	Click or tap to enter a date.	
Has the duty of candour been complied with?	☐	☒	Click or tap to enter a date.	

Background and context of the patient safety incident

A124352 Learning from a patient safety incident involving a person with learning disabilities and complex needs who declined care.

[redacted] was an adult with learning disabilities and significant physical health needs. [redacted] lived in supported accommodation shared with other residents and received a four -time a day package of care. [redacted] was transferred to a temporary accommodation ([redacted]) due to works being carried out to the building of his permanent accommodation ([redacted]). [redacted] had a history of complex health conditions and disabilities, including amputation of [redacted] leg and loss of one eye following a previous hospital admission two years ago. That admission had followed a similar pattern of non-concordance and delayed hospital attendance despite prior completion of an MCA. When [redacted] finally accepted admission on [redacted], it was too late to effectively treat [redacted] wound infection, resulting in amputation.

[redacted] required ongoing support with mobility, personal care and medication administration Despite this, [redacted] often expressed a strong wish to remain independent and was known to decline aspects of care or professional input. While at the temporary accommodation, it was noticed by carer that [redacted] mobility was deteriorating, and [redacted] carers were finding it increasingly challenging to provide the necessary support in a safe and effective way as [redacted] seemed to be in pain and could barely move. According to Rio notes, referral for physiotherapy input was sent to HURT but this was rejected due to "long history of compliance and behavioural issues to which the learning disability physiotherapist will be able to address given their speciality training in behavioural and complex disability management.".

In early [redacted], concerns began to escalate about [redacted] living conditions, physical deterioration, and refusal of care. These concerns ultimately led to multiple professional contacts and emergency service involvement prior to [redacted] death on [redacted].

6. Investigation approach

6.1. Investigation Team

Role	Initials	Job title	Department	Other
[redacted]	[redacted]	Lead District Nurse	District Nursing Service	
[redacted]	[redacted]	Lead District Nurse	District Nursing Service	

6.2. Summary of investigation process

A124352 Learning from a patient safety incident involving a person with learning disabilities and complex needs who declined care.

[redacted] was patient with Learning disabilities and Safeguarding needs who had a sudden cardiac arrest and died on the [redacted]. Following [redacted] death an incident was raised via Datix, highlighting concerns with the multidisciplinary teams/services (DNs, TV, LAS, Social Services, GP) co-ordination of care with handover between services and alleged delayed escalation to Learning disabilities and safeguarding teams. A Rapid action review investigation was instigated and was presented at WISH panel on [redacted] for review. The panel agreed that the circumstances met the criteria for a PSII (Patient Safety Incident Investigation) under PSIRF (Patient Safety Incident Response Framework). The purpose of the investigation was to examine the events leading up to the incident, identifying contributory factors, and develop system – level learning to prevent recurrence

An immediate discussion took place on [redacted] between the DN service, the ACS Risk and Quality Manager, the Adult Safeguarding Lead and the ACS Associate Director of Nursing to review the circumstances of the incident and agree next steps.

Key staff involved in [redacted] care were subsequently asked to provide written statements covering the period between [redacted] and [redacted]. These statements were requested to outline the chronology of care delivered and the communication that took place between services.

There was a delay in completing the investigation report due to late submission of some staff statements.

The TOR were finalised and approved on [redacted]

6.3. Terms or reference summary	
Incident/incident reference	A124352 Patient with LD needs and SG concerns had a sudden cardiac arrest whilst awaiting LAS to attend for transfer to acute care.
Date agreed/version no.	
Date investigation is to be completed by	
Learning response lead	[redacted]- Haringey Acting Locality Service Manager District Nursing & Community Rehab

	[redacted] – Lead District Nurse for Haringey District Nursing Teams
Staff engaged in the development of ToRs (names/roles)	[redacted] – Haringey Acting Locality Service Manager District Nursing & Community Rehab [redacted] – Lead District Nurse for Haringey District Nursing Teams [redacted] – ACS Risk and Quality Lead
Patient/family/carers engaged in the development of ToRs (names/relationship)	

Name	**Relationship**
The patient does not have any family or relatives	

ToR 1	To understand how the health and Social Care settings – including the care package, communication between services, staffing structures, and the living environment – influenced the management and outcome for this patient
Key questions	1. Was the package of care sufficient, appropriate and regularly reviewed? 2. How was the decision made to allow the patient to remain in unsuitable accommodation? 3. What is the process of escalating concerns about vulnerable patients within and across teams? 4. Was there appropriate clinical oversight or case management when the patient was deteriorating? 5. Were there any factors either Health or social care that should have been considered to change the patient's outcome?

	6. Do the managers of the teams involved in the patient's care understand 'work as done' in the community settings
Healthcare settings	• Internal: LD team • Internal: Safeguarding • External: Social care service • Internal: District nursing • External: LAS
Healthcare processes	• Escalation • Communication • Patient's pathway

ToR 2	To explore the care processes, decision – making pathways, clinical oversight, and adherence to policies and best practice guideline in response to the patient's ongoing refusal of care.
Key questions	1. Was a Mental capacity act (MCA) assessment completed when the patient refused to go to Hospital? 2. What is the process for reviewing patients who refuse or disengage from their care package? 3. Were reported refusal of care assessed in line with best practice in supporting patients with LD? 4. What protocols exist for patients refusing essential care, and how are they applied? 5. Were the staff involved aware of their roles and responsibilities including escalation of risks identified? 6. Is it clear across the system regarding risks identification, management and escalation
Healthcare settings	• All relevant MDT involved: Internal and External
Healthcare processes	• Policies and guidelines • Escalation processes • Decision making pathways

6.4. Information gathering

The methodology for information gathering included requesting staff for written statements and where additional questions arose, discussions were had within each of the identified work streams. The meeting included comprised of clinical staff that had provided care for the patient.

Throughout the investigation the SEIPS (Safety Engineering Initiative for Patient Safety) model was used as a lens to understand the events and draw conclusions. SEIPS model describes how a work system can influence process, which in turn shapes outcomes. The key headings are **tools and technology, tasks, environment**, people and organisation.

Some of the Information was gathered from the people involved through meetings, written statements, timeline, information from Datix (rapid action review), feedback from WISH, information held on our electronic system (Rio). Staff Interviews.

7. Findings

7.1. All Findings

Organisational Factors

- The process of escalating environment or safeguarding concerns across community was not followed. Promptly.
- Limited senior oversight or review of the patient's complex case (the patient was not on the patient of concerns list until around [redacted] Although [redacted] was on the patient of concern list while in Haringey East Team. It was not explicitly handed over to Haringey Central as a patient of concern list.
- Lack of established MDT forum or case management pathway for individuals at high risk of self- neglect or repeated refusal of care.
- Delay in communication and lack of coordination between services contributed to fragmented care.

Task Factors-

- Absence of structured process to manage and document repeated care refusal, including escalation triggers and best – interest decision – making.
- Inconsistent application of the Mental capacity Act – capacity was assessed by different services with different conclusion within short timeframe. From the investigation, no formal capacity assessment was identified as being completed by DN service. From the progress notes, we have not established that the patient lacked capacity.
- According to correspondences received from LD nurse, Carers reported increasing difficulty to carry out personal care safely due to [redacted] inability to move secondary to pain and hoarding of personal belongings around [redacted] Plan was for the project manager to discuss with [redacted] to move [redacted] personal belongings and if required consider use of a hoist. A joint visit was planned to be had in a week's time. From the investigation this would have been a delayed intervention considering carers were struggling with moving and handling [redacted] and GP review of medication. There was no record of moving and handling challenges reported by DN team.

Tools and Equipment Factors

Bariatric Stretcher

- To enable transfers, [redacted] would have required a bariatric stretcher, a carrying board and a four-man crew. This would have required coordination with key people that [redacted] had rapport with.

People Factors

- There were several staff involved in [redacted] 's care on [redacted], including social services, carers, ambulance crew also attended, contact from GP. On this day, [redacted] was offered to go into a nursing home, alternative accommodation and [redacted] refused hospital admission. It has been established that multiple sources of information would have been overwhelming for [redacted] to process, and this would have impacted on his decision-making ability of refusing options offered. There were no communication aids in place within district nursing to aid [redacted] [redacted] understanding information regarding his wound care. Ideally, this could have been facilitated jointly with LD team.

- Following interview with LD team, it was established that [redacted]-did not trust healthcare professionals and hospital admission due to a history of [redacted] family being admitted and dying in hospital.
- Health Care Professionals: [redacted] did not have a good working relationship with [redacted] GP. When the practice called, [redacted] swore at them, got a warning letter and de-registered with [redacted] GP and reverted to [redacted] former GP. In addition, the former practice [redacted] reverted to was now outside [redacted] catchment area.
- Personality- [redacted] had a mixed personality and depending on how [redacted] felt [redacted] would not engage with staff. For example, [redacted] would not eat or drink, take [redacted] medication, although staff have reported finding sweet paper wrappings in the bin on days that [redacted] would refuse to eat or drink. When [redacted] was in a good mood, [redacted] would be more talkative and more receptive of care.

External Factors:

- Multiple agencies were involved without a unified escalation pathway or shared governance structure.
- [redacted] right to refuse care was appropriately respected under MCA, but system – level processes for managing self- neglect cases were unclear.
- Limited coordination between local safeguarding and healthcare process led to delay recognitions of cumulative risk. It is not clear if other services raised safeguarding, but it confirms by the safeguarding team that LAS did not raise any safeguarding concerns in the period of this investigation. It has been established that DN service raised safeguarding dated [redacted]

Technology:

- There is no shared electronic record system across involved agencies.

7.2. Areas for improvement and associated safety actions

Sharing of patient information

- [redacted] had a care plan drawn by the LD teams, but this was not shared with other services. Perhaps sharing of care plans would have helped to implement reasonable

adjustments for [redacted] to help improve care that [redacted] received. Urgent Care Plan was explored with the LD team, and it was reported that attempts were made to record care plan on London Care Record but due to editing issues this was not possible.

- The DN and the MACCT team to share reasonable adjustment plans using Rio Case Record Prompt instead of only daily visiting planner comment which is not accessible to other services.

Recommendation

- Explore access to UCP on London Care record and ensure LD team can populate patient care plans and where this is not possible, care plan should be emailed to respective services involved in looking after a patient with LD.
- Ensure nurses receives training on when and how to use the mental capacity act to convey a person to hospital for physical health treatment.

Patient Referrals

- All patients' referrals that indicate patient has LD but there is no associated care plan with the referral. Triage nurse should review London Care record to ascertain existence or lack of UCP and if there is no UCP, to request referrer to send patient Care Plan.
- Triage nurse to add an alert on Rio alerting staff that patient has LD and requires reasonable adjustments to be implemented using Case Record Prompt. The responsibility of alerts also sits with DN caseload holder to ensure appropriate alerts are in place to safeguard patients.
- For LD patients, as part of triage, contact is made by DN team with LD team and discussions around whether joint visit required or any other forms of communication. DNs to upload hospital passport upon receipt from referrer.

Early escalation with the LD teams for patients with learning disability

- Teams should actively reach out to LD teams for any patients known to their teams who have LD to ensure there is MTD approach in delivering patient care. Where patients are not known to LD team, referrals should be made and multidisciplinary support obtained from safeguarding team should there be safeguarding issues arising that have been raised with the local authority to safely manage the patients in the community.

Patient of concern list

- All patients with LD should be recorded on patient of concern list with a comprehensive plan of care and mitigation of any patient risk. It is expected that DN team manager reviews and updates the list with appropriate actions that aims to safeguard patient care. DN team manager as caseload holder is expected to visit patient of concern and update care plans in conjunction with patient, family, MDT and DN team.

Capacity Assessment Training

- There were some opportunities to complete mental capacity assessment training throughout [redacted] care, and this were not always completed. Staff are recommended to complete Oliver McGowan course and mental capacity assessment training to help equip them with better skills to manage complex care patients and initiate best interest meeting where appropriate.

Communication with external services

- There is a need for better communication with social services around information sharing. In Haringey there are some workshops under way in exploring how communication can be improved as services are now aligned with neighbourhoods. Haringey social services are now aligned in neighbourhoods and having key neighbourhood leads would help improve information sharing and any patient follow ups.
- Patients who have been referred to MACCT and have been discussed but there remain concerns should be escalated to multi-Agency solution panel (MASP).

Improve handovers and documentations between DN teams

- When patients from one catchment area to the next, it is best practice for staff to handover patient care to the next team. If an alert had been in place after initial incident (case record prompt alert) this would have triggered reasonable adjustments needed for the patient and improve outcomes of patient care.

DN service to consider implementing patient transfer form from one team to the other.

7.3. Learning Response Tool Analysis [Name of tool used]	
Select as applicable	Further Details

A124352 Learning from a patient safety incident involving a person with learning disabilities and complex needs who declined care.

Tasks	Used SIEPS Model
Tasks	MDT Meetings
Choose an item.	Staff interviews
Choose an item.	Staff statements

8. Patient/Next of Kin questions (if applicable)

- [redacted] had no known next of kin. According to [redacted] LD nurse, most of [redacted] family members are deceased.
- Attempts made to contact NOK but there was none identified.

9. Appendices

9.1. Appendix 1 – Terms of Reference

TOR A124352
Patient with LD neec

9.2. Appendix 2 - Timeline / patient journey map

[redacted] [redacted] was visited by DN service for SSKIN (**SSKIN- S**-Surface, **S**-Skin Inspection, **K-** Keep Moving, **I-** Incontinence /Moisture, **N-** Nutrition) but [redacted] declined all treatment. Upon investigating this incident and interviewing staff who visited, it has not been established the status of [redacted] home environment during the visit. In addition, upon reviewing RiO progress notes visits prior to [redacted] there is no record of home environment or home living concerns.

[redacted] - The carers find the accommodation had no running water, electricity or heating.

- [redacted] - The carers escalate this to social services. All other residents were relocated to suitable accommodation; [redacted] was offered a placement in a nursing home which [redacted] declined. It is not known if any further attempts were made to discuss relation of [redacted].

No contact was made with the DN service or the LD team regarding [redacted] uninhabitable accommodation or [redacted] not wishing to be relocated. It is not known if a capacity assessment was completed by social services.

- [redacted] – [redacted] - The carers continued to visit [redacted] and carried water from the property next door during their visits; no gas or electricity was available.
- [redacted] – The carers contact the DN service requesting a visit for possible pressure ulcer/damage.
- [redacted] - The carers contacted LAS following [redacted] reporting chest pains and seeming unwell. LAS attended, the carers reported concerns [redacted] had developed a pressure ulcer, [redacted] declined admission to hospital and a mental capacity assessment by LAS concluded [redacted] had capacity.
- [redacted] - LAS report [redacted] was self-neglecting. The LAS report acknowledged the accommodation had no water, LAS may have contacted CHUB, and QDS package of care is acknowledged by the LAS crew, but no escalation was made to the LD Team, Safeguarding Team or Social Services regarding the unsafe living environment for [redacted].
- [redacted] – LAS contacted [redacted] GP was referred to the DN service and TVN service for possible pressure ulcer damage or MASD.
- [redacted] –[redacted] was visited by the DN service, [redacted] declined care from the visiting practitioner, there is no further actions recorded by the DN Team.
- [redacted] – Referral to the DN service, it is recorded as a duplicate referral from [redacted].

[redacted] – A joint visit planned with TVN nurse and DN service – the TVN nurse was unable to attend. The visit was rebooked for [redacted]

- [redacted] – [redacted] was visited by DN practitioner. MASD was identified and the carers informed the practitioner there was no heating, water or electricity. The bariatric profiling bed was at floor level, and the mattress was deflated. The carer reported RF was not taking [redacted] medication. It was also reported by the carer that the GP contacted [redacted] on the [redacted] and advised [redacted] to attend A&E, but [redacted] declined. Barrier products were ordered and photos of the MASD were sent to the TVN nurse.
- [redacted] – The living conditions of [redacted] were immediately escalated to the Senior DN Team, contact was made with the Safeguarding Lead at the Whittington, email and phone communication was used quicker than a formal SGA therefore an SG was not raised at that time. Communication is made between the SGA Lead and LD Team in the community; an urgent visit from the LD team was arranged for the [redacted] to assess [redacted] needs.
- [redacted] – [redacted] was referred to the MDT teleconference for an urgent review.

- [redacted] – [redacted] was visited by the LD Team; the nurse found [redacted] did not wish to engage in an assessment or discussion, this was an abnormal response from [redacted]. It was reported by the carer to the LD nurse that [redacted] was declining food, water and medication from the [redacted]. [redacted] declined personal care from the carers; [redacted] agreed to bloods being taken on the [redacted].
- [redacted] right leg was observed as being swollen, and [redacted] was shouting in pain when it was moved. The LD Team requested a Safeguarding Alert to be raised by the care agency and DN service. The LD nurse requested a referral for bloods was made to the DN service from the GP.
- [redacted] – A joint visit with the LD Nurse, TVN nurse, social worker and carers. Contact was made with the SG Team regarding a management plan for [redacted] and if [redacted] required a transfer to acute care following initial assessment. During the visit [redacted] was deemed not to have capacity, had a possible infection in the right leg due to evidence of large swellings with puss present and severe pain in the leg. LAS was contacted for an urgent transfer to acute care at RFH. The bed and mattress were not connected to an electric supply or connected to each other, and the mattress was partially deflated. The TVN nurse reports it was difficult to assess [redacted] due to clutter and [redacted] size (as [redacted] was obese). The LAS provided a response time of four hours. At the time of the assessment the TVN nurse did not find any life-threatening conditions requiring the LAS referral being graded as a Cat 1 or Cat 2 response.
- [redacted] – The TVN nurse contacted the LD Team an hour after calling the LAS, they advised whilst waiting for LAS [redacted] went into cardiac arrest. Once the LAS team arrived, CRP was commenced for one hour, but [redacted] died. Police attended the address as it was an unexpected death
- [redacted] – The MDT teleconference discussed [redacted] and [redacted] death; GP advised the case will not be investigated by the coroner.

10. References

State where we received statements from (services)

Learning Disabilities Team

Social Services

Care Agency

District Nursing

Tissue Viability Team

Patient's GP

There are no sources in the current document.

NHS Whittington Health NHS Trust

11. Safety Action Summary Table:

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
1	Alerts on Rio and appointment allocation	Implement an automatic alert on Rio that appears immediately (without needing to manually open alerts). Ensure additional appointment time is automatically allocated for patients with complex needs.	[redacted] Lead District Nurse to explore visibility with Rio Team	31.12.2025			Monthly audit of Rio alerts and appointment booking accuracy	IT/ Service Manager	31.03.26	
2	Escalation protocol for patients refusing care	Develop and implement a clear protocol outlining escalation steps and responsibilities when a patient refuses care, including consideration of capacity and safeguarding.	Clinical Governance / Safeguarding Lead [redacted] Lead District Nurse	31.12.2025			Quarterly review of incident reports and escalation cases		01.04.26	
3	Raise Staff awareness of MAC, INC and MASP	Assess current staff awareness of the MACC team and the Multi-Agency Solutions Panel (MASP) through survey or team meetings. Provide information and	Team Manager [redacted] Lead District Nurse	02.01.2026			Quarterly staff survey / supervision discussions		02.08.26	

NHS Whittington Health NHS Trust

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
		guidance via intranet, newsletters, and training sessions.	[redacted] Lead District Nurse [redacted] Lead District Nurse							
4	Escalation pathways within HLDP	Map and clarify escalation pathways within the Health Learning Disability Pathway (HLDP). Share updated pathways with all relevant teams.	[redacted] LD Team Manager / [redacted]	31.01.2026			Bi-annual review of pathway uses and feedback from MDT meetings		31.08.26	
5	Communication between LD and DN teams	Strengthen communication between Learning Disability (LD) and District Nursing (DN) teams. Explore access to UCP via London Care Record; ensure LD team can populate care plans or, if not possible, that care plans are securely emailed to responsible services.	LD Team Manager / [redacted] Lead District Nurse [redacted] Lead District Nurse [redacted] Lead District Nurse	31.01.2026			Monthly case audit and review of care plan sharing		31.08.26	

NHS Whittington Health NHS Trust

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
6	Training on Mental Capacity Act and conveyance	Ensure all nurses receive training on applying the Mental Capacity Act (MCA) when conveying a person to hospital for physical health treatment. Include practical case examples and escalation guidance.	[redacted] Lead District Nurse for Professional Development and Quality Improvement PDN Service Manager	01.02.2026			Training compliance reports every 6 months		01.09.26	

Patient Safety Incident Investigation (PSII) Report

Date of Incident	[redacted]
Incident ID Number	A124977
PSII Approved By	[redacted]
Job Title	Clinical Director for ACW – Women's Health
Signature	 [redacted]
Date Approved by Quality Assurance Committee	

Participants of the PSII	
Name	Role
[redacted]	Midwife
[redacted]	Midwife
[redacted]	Midwife
[redacted]	Midwife
[redacted]	Midwife

1. About Patient Safety Incident Investigations

Patient safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers and staff.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Duty of Candour and the Engaging and involving patients, families and staff after a patient safety guidance in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the Just Culture guide in the minority of cases when staff may be referred to them.

PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

2. A Note of Acknowledgement

A message to the mother and the family

We are conscious that you have endured the distress of the event described in this report. We would like to convey our sincere apologies for this and for the shortcomings in your care that have been identified through this investigation.

We have sought to understand what happened at the time of the incident, so that the services involved can learn for the future. We have sought to carry out and present the findings of an open and transparent systems-based investigation. In reporting the findings of our investigation, the investigation team has had to remain detached and analytical. As a result, the language we have used in the report may appear cold and technical. Despite our necessary detachment, you have been at the forefront of our minds as the investigation has progressed.

Where learning and safety actions have been identified, a plan to address these as a matter of priority is the responsibility of the Maternity Service.

A message to staff

Thank you to all the staff who engaged with the investigation and for their openness and willingness to support improvements in service delivery and safety. Our role as learning response leads is to gather insight into the healthcare settings and systems in which we work. This report does not wish to judge or criticise; we are here to facilitate learning in a caring and supportive way.

3. Contents

4. Executive Summary

4.1. Incident Overview

4.1.1. On the [redacted] a vaginal swab was unintentionally retained following a spontaneous vaginal birth on a Labour Ward delivery room.

4.1.2. On the [redacted] postnatal day 2, the patient attended Maternity Triage with 'something coming out of the vagina'. The patient was reviewed by the Resident Doctor (SHO), and a retained swab was noted.

4.1.3. The Consultant Obstetrician was asked to review the patient. The retained swab was noted to be malodorous and sutured into the knot of the apex of the perineal tear. The suture line was intact.

4.1.4. Following these findings the plan was for the swab to be removed in theatre under anaesthesia. A microbiology swab was taken from the perineal wound, and antibiotics were prescribed to reduce the risk of infection.

4.1.5. The surgical procedure was performed under spinal anaesthesia and took place in Cearns Theatre. The procedure was performed by a Consultant Obstetrician, and it was uneventful and documented as 'Cleaned and draped. 22x22 cm swab hanging from the vagina, Apex stitch has gone through one thread in the swab. Identified and cut. No swab remnants left behind. Sutures intact. Examination of vagina - NAD/ cervix-NAD / minimal bleeding / PR -done with permission -no buttonhole.'

4.1.6. Following the procedure, the patient was transferred to Labour Ward Recovery and later discharged home on the same day with oral antibiotics and tinzaparin prescribed. The patient was advised and follow up care was arranged with Community Midwifery services and contact details provided.

4.1.7. It is noted that that as a hospital admission was necessary due to the retained swab, this meant the mother and her baby were separated. This has the potential to negatively impact on both mother and baby's emotional and mental health. The newborn was cared for at home by grandparents during this time.

4.2. Summary of Key Findings

4.2.1. A spontaneous unassisted vaginal birth was carried out in a Labour Ward delivery room. A delivery pack of swabs was opened but the formal counting process did not occur as only one member of staff carried out the count.

4.2.2. Following delivery, a perineal examination took place and a first-degree tear to posterior vaginal mucosa was identified and required suturing to repair.

4.2.3. A swab pack from the cupboard was sourced and opened to complete the repair. This pack was also not subject to a formal count with another member of staff and was not documented.

4.2.4. A swab was inserted in the vaginal fornix for a better view of the perineal tear. This swab was not clipped, documented nor was another member of staff informed.

4.2.5. As the formal counting process was not followed or documented from the beginning of the procedure, it was not identified that there was a retained swab.

4.2.6. Throughout the procedure the white board in the delivery room was not utilised to document the counting process and staff were unfamiliar with the purpose of the white board.

4.2.7. The counting process was not documented contemporaneously on the patient's paper records or digitally on Careflow Maternity, leading to errors in documentation of the count on the 'Post Delivery Checks' workflow.

4.2.8. The Maternity Services Guidelines regarding the swab counting process do not:

- clarify whether the formal count should be recorded in paper records and/or electronically and what level of detail is required as each method has different fields to complete.
- Provide explicit guidance on who is responsible for completing the counts and how often this should occur.

- Provide explicit guidance on the counting process in a delivery room but provides specifics for surgical environments.

4.3. Summary of Areas for Improvement and Associated Safety Actions

4.3.1. **Area for Improvement 1**: Standardise the process of swab counts to enable documentation to be completed contemporaneously in delivery rooms.

- Whiteboards to be updated with template to capture when the checks should occur, how often and by whom.
- Update 'Post Delivery Checks' workflow on Careflow Maternity to capture same information and consider whether the field becomes user credential signed as a requirement.
- If Action 2 is not possible due to limits with Careflow Maternity, reinstate completion of proforma in paper records or implement sticker label to be attached to paper records to capture required information.
- Training Midwives on use of digital systems to support with accurate and timely documentation for recording care activities.

4.3.2. **Area for Improvement 2**: Ensure there is clear and consistent guidance across relevant Maternity policies to clarify roles, responsibilities and processes to follow when completing swab counts in delivery rooms.

- Update Swab, Instrument and Needle Count within Maternity Care Settings MEDL (January 2024).
- Update Perineal Tear Proforma / LocSSIP (October 2019) to align with National Safety Standards for Invasive Procedures (NatSSIPs).
- Postnatal Care Guideline to be developed and aligned with NICE guidance. To include how often observations must be completed and documented on patient records.

4.3.3. **Area for Improvement 3**: The number of trained staff present in delivery rooms.

- Explore having a Maternity Support Worker present in the delivery room to support the Case Midwife with tasks that need to be completed in the immediate postpartum period.

4.3.4.	**Area for Improvement 4**: Information included in Education, Training and Induction regarding swab count processes and documentation. • Incorporate swab count process (including documentation, communication and cross checking) in live skills and drills scenarios in the clinical area. • Incorporate swab count process (including documentation, communication and cross checking) in perineal repair and third- and fourth-degree repair workshops. • Integrate swab count process (including documentation, communication and cross checking) into Induction for new staff members and as part of Annual Mandatory Training. • Present case and identified learning at Learning from Risk meeting for Obstetric and Gynaecology staff.
4.3.5.	**Area for Improvement 5**: The equipment used to support with accurate swab counting to prevent retained foreign objects. • Contact iCount representative to explore use of equipment specific to support with counting of swabs to prevent retained foreign objects.

5. Duty of Candour

Different Elements	Yes	No	Date	By whom?
Was the patient / NoK contacted and apologised to?	☒	☐	[redacted]	[redacted] Consultant Obstetrician
Was this followed up in writing?	☒	☐	[redacted]	[redacted] Consultant Obstetrician
Has the family agreed to receive the final report?	☒	☐	[redacted]	[redacted] ntrapartum Matron
Has the duty of candour been complied with?	☒	☐	[redacted]	[redacted] Consultant Obstetrician

6. Background and Context of the Patient Safety Incident

6.1. Never Event Framework – Retained Foreign Object

6.1.1. The NHS Improvement Never Events Policy and Framework (revised January 2018) supports learning from what goes wrong in healthcare, as this is crucial to preventing future harm. Never Events are defined as serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

6.1.2. The Never Events list consists of 15 categories, one of which is Retained Foreign Object Post Procedure.

6.1.3. The retained swab in this event is considered a 'foreign object' as it is subject to the formal counting and checking process at the start of the procedure and before completion of a procedure.

6.1.4. Swabs are routinely used during and following vaginal birth by midwives to control and absorb bleeding. Swabs are found in bundles of 5 in the delivery and suture packs that are used at the time of a vaginal birth, and additional swabs are available separately.

6.1.5. Maternity services are required to have written procedures in place to support the counting and checking of swabs used at all births in all settings following a Patient Safety Alert by the National Patient Safety Agency (National Patient Safety Agency, 2010).

6.2. National Safety Standards for Invasive Procedures (NatSSIPs)

6.2.1. The introduction of National Safety Standards for Invasive Procedures (NatSSIPs) by NHS England in 2015, provided a framework for producing Local Safety Standards for Invasive Procedures (LocSSIPs). All Trusts in England were required to identify relevant clinical procedures in their organisation, including those undertaken outside of theatre settings, and produce LocSSIPs created by cross-professional clinical teams to standardise key elements of procedural care across all clinical environments where invasive procedures occur.

6.2.2. In 2023, the Centre for Perioperative Care published revised NatSSIPs to NatSSIPs2. This was designed to reduce errors and misunderstandings and to improve team cohesion. It mandates key stop moments for standardisation, harmonisation and education, when the standard pathway is confirmed, and patient specific details have been clarified. This helps to prioritise both patient safety and team working.

6.2.3. The national standards cover all invasive procedures including those performed outside of the operating department. The standards of counting, equipment reconciliation, training in the count and count handover apply in full to birthing and delivery rooms.

6.2.4. The Safety Standard for 'Reconciliation of Items in the Prevention of Retained Foreign Objects' supports safe, consistent and efficient practice in accounting for all items used during invasive procedures and in minimising the risk of them being retained unintentionally.

6.2.5. The prevention of retained foreign objects is a shared responsibility, and the risk of occurrence is reduced through education, effective teamwork and processes.

7. Investigation Approach

7.1. Investigation Team

Role	Initials	Job Title	Department
Learning Response Lead	[redacted]	Intrapartum Matron for Labour Ward	Maternity Department, Whittington Health NHS Trust
Investigator and Author	[redacted]	Women's Health Clinical Governance Manager	Maternity Department, Whittington Health NHS Trust
Investigator and Author	[redacted]	ACW Divisional Quality and Risk Manager	Acute Patient Access, Clinical Support Services and Women's Health Division, Whittington Health NHS Trust

7.2. Summary of Investigation Process

7.2.1. **Incident Reporting**

7.2.2. The incident was reported on the Trust's incident reporting system, Datix (A124977), on [redacted] A Rapid Action Review was completed outlining the key facts of the case and immediate actions taken. It was determined that the Never Event criteria had been met in relation to a 'retained foreign object'.

7.2.3. The Rapid Action Review was presented at the Whittington Improvement and Safety Huddle (WISH) on [redacted] In line with national guidance and the Whittington Health NHS Trust's PSIRF Plan, a Never Event requires a Patient Safety Incident Investigation (PSII).

7.2.4. The incident was reported on StEIS on [redacted] and assigned the reference number 2025.2174.

7.2.5. The Never Event was reported to the Care Quality Commission (CQC) on [redacted]

7.2.6. **Learning Response**

7.2.7. The investigation was conducted under the PSIRF framework, with a system-based, human factors-informed methodology.

7.2.8. Once the PSII is completed, it will be shared with the staff involved for factual accuracy and with the patient for comment. The final report will be approved by the WISH panel and shared with the patient, the Whittington Health NHS Trust Board and CQC.

7.2.9. Actions identified from the investigation and recorded in this report will be monitored through the Acute Patient Access, Clinical Support Services & Women's Health Division and via Divisional reports to the Whittington Health NHS Trust's Quality Governance Committee.

7.3. Terms of Reference Summary

7.3.1. This investigation will review and explore the care delivered on [redacted] during the immediate postpartum period that led to the retention of the swab.

7.3.2. The checks and guidance in place as well as the documentation made regarding the suturing will be reviewed.

7.3.3. The contributory human, system and environmental factors will be explored to identify the process of suturing as it is imagined and what was done.

7.3.4. The healthcare setting of the Labour Ward delivery room will also be reviewed to consider if this was a contributory factor which led to the retention of the swab.

7.3.5. Please refer to Appendix 1 for the full Terms of Reference for this investigation.

7.4. Information Gathering

7.4.1. The investigation considered how factors such as environment, equipment, task and policies influenced the decisions and actions of staff. The investigation sought to gain insight into 'work as done' in a health and social care system. By 'work as done' we mean how care is delivered in the real world, not how it is envisaged in policies and procedures (work as imagined). This methodology adopts the Systems Engineering Initiative for Patient Safety (SEIPS) model (NHS England, 2022) to understand how the incident occurred.

7.4.2. The Learning Response Leads gathered information by using a range of methodologies to gather evidence and verify findings including:

- Interviews with clinical staff involved in the incident.
- Review of relevant Whittington Health NHS Trust's Maternity Services Guidelines.
- Review of previous incidents and investigations relating to retained swabs.
- Review of patient's medical records, paper and electronic.

8. Findings

8.1. Procedure

8.1.1. In preparation for the birth, the Case Midwife (Midwife 1) opened a delivery pack of swabs, which contains 5 swabs. Delivery packs are kept in a cupboard in each Labour Ward delivery room.

8.1.2. The expectation is that when opening a delivery pack a swab count is undertaken by two staff members. This is to confirm the number of swabs within the pack at the time of opening. On interview, Midwife 1 disclosed that she counted the 5 delivery pack swabs upon opening. However, this was not done with another staff member, as per guideline.

8.1.3. The baby was born at 14:11. At 14:28 the placenta was delivered by Midwife 1.

8.1.4. On interview Midwife 1 disclosed that [redacted] sourced a swab pack (not delivery or suturing pack) from the cupboard in the Labour Ward delivery room. Swab packs have 5 swabs. [redacted] opened the swab pack. This pack was also not subjected to a formal counting process by two staff members. This was not documented as per guideline.

8.1.5. The patient consented for perineal examination. This was done by Midwife 1 under supervision of Midwife 2. A first-degree tear to posterior vaginal mucosa was identified. The patient was informed and gave her informed consented for suturing.

8.1.6. At 14:45 Midwife 1 commenced perineal suturing. Midwife 1 informed the investigation team that as the bleeding was ongoing, [redacted] inserted a swab in the vaginal fornix so that [redacted] could have a better view of the perineal tear. Midwife 1 confirmed that [redacted] did not clip the swab, did not document this nor informed another member of staff. The MEDL Guideline states that any swabs inserted in the vagina during perineal repair must be clipped, documented and both staff informed.

8.1.7. It is unclear when Midwife 2 was no longer present in the delivery room, leaving Midwife 1 to complete the procedure. This is normal practice, however, leaves room for error as the individual midwife is responsible for completing the suturing (sterile procedure), documenting notes, monitoring the mother and baby's vitals, baby's adaptation to life outside the womb, support with skin-to-skin contact and early breastfeeding.

8.1.8. At 15.00, Midwife 1 completed suturing and inserted an indwelling catheter. Midwife 1 called another midwife on duty on Labour Ward, Midwife 3, to witness the counting of swabs following completion of suturing. Midwife 3 was providing 1:1 care to a labouring woman in another room on the Labour Ward.

8.1.9. Midwife 1 and Midwife 3 counted 5 swabs at the end of the procedure.

8.2. Documentation

8.2.1. **Digital Documentation**

8.2.2. The swab count was documented in retrospect on the Careflow Maternity patient system at 16:29 when Midwife 1 was completing the 'Delivery Workflow' under 'Post Delivery Checks'.

Figure 1 'Post Delivery Checks' workflow on Careflow Maternity.

8.2.3. The 'Number of swabs post-procedure' was documented as '10'. Upon interview, Midwife 1 and Midwife 3 were each asked to describe the process of counting the swabs. Midwife 3 confirmed [redacted] only counted 5 swabs at the end of the procedure, which were from the delivery pack.

8.2.4. The 'Delivery swab count correct' was documented as 'Yes'. However, this is incorrect, as the retained swab was part of the delivery pack and therefore the count should have been 4 at the end of the procedure. This was not noted at the time of the procedure as the correct processes were not followed throughout when opening and counting the swabs.

8.2.5. When documenting the primary and secondary person responsible for the delivery count on CareFlow Maternity, names are selected from a dropdown list meaning there is no user credential signature.

8.2.6. **Paper Documentation**

8.2.7. Upon investigation, it is noted that in each patient's paper records, often referred to as the 'Yellow Book', there is a 'Swab, Needle and Sutures Counting Proforma'. Please refer to Appendix 3 for the proforma template.

8.2.8. There are no paper records of the swab count, and minimal description of suturing procedure as it is expected to complete the 'Delivery Workflow' in detail digitally on Careflow Maternity.

8.2.9. **White Boards**

8.2.10. The MEDL Guideline states, 'Standardised white count board in delivery rooms & operative theatres must be used to record count.' This is to ensure there is good communication and accountability for safe practice to ensure that all swabs, needles and instruments are always accounted for throughout the procedure.

8.2.11. Upon interview with Midwife 1 and Midwife 3, they were not aware of the rationale for the white boards in the Labour Ward delivery rooms. There was an assumption the white boards were to be used for post-partum haemorrhages (PPH) in the event of a Code Red. They informed the investigation team that they had never used the white boards for swab counts.

8.2.12. For context, Midwife 1 is a Band 6 and has been on the Labour Ward rota since [redacted]. Midwife 3 is a Band 5 and started their role at in [redacted]

Figure 2 Photo of updated white boards in Labour Ward delivery rooms.

This was Midwife 3's sixth shift on the Labour Ward and the second shift where [redacted] was not supernumerary. Supernumerary is when a newly qualified Midwife rotates to a new area and works alongside a Senior Midwife for a certain number of shifts.

8.2.13. At the time of the incident, the white boards were blank with no headings to aid staff in understanding the expectations for use. Since this incident the boards have been updated to include headings, as shown in the image below, to provide guidance on what is expected to be documented.

8.2.14. Although the additional information added to the white boards provide some context on what is expected, it does not provide enough detail on when the checks should occur, how often and by whom.

8.3. Postnatal Care and Discharge

8.3.1. The patient was transferred to [redacted] Ward (Postnatal Ward) at around 17:05 by Midwife 1 and care was handed over to Postnatal Midwife 1.

8.3.2. All postnatal care activities are recorded digitally on Careflow Maternity. There is no documentation on the patient's paper or digital record until 1:40 on the [redacted]

8.3.3. The expectation is that on transfer and handover between clinical areas, the patient's perineum is inspected as part of the postnatal assessment. As there is no documentation, the investigation team are unable to determine if this assessment took place.

8.3.4. The postnatal assessment would have been an early opportunity to identify the retained swab immediately following the procedure.

8.3.5. Postnatal Midwife 2 documented on 'Sutures are intact, no signs of infection or primal symptoms' on Careflow Maternity at 1:56 on the [redacted]

8.3.6. There is no further documentation of the care provided to the patient. It is documented that the patient was transferred home at 19:00 on the [redacted] There is no record of information or advice provided upon discharge.

8.4. Maternity Services Guidelines

8.4.1. Whittington Health NHS Trust Maternity Services have three documents which provide guidance to clinicians regarding the use, count, checking and documentation processes of swabs used for birth and for perineal suturing.

8.4.2. **Perineal Trauma Guideline (February 2024)**

8.4.3. The purpose of the Perineal Trauma Guideline is 'to ensure that perineal trauma including episiotomies and anal sphincter trauma are correctly diagnosed and the appropriate repair carried out by an appropriately trained midwife or doctor.'

8.4.4. Within the 'Suturing Technique for Repair' sections, specific guidance is provided on the tasks to be carried out to complete the repair. There is a link to the Swab Instrument and Needle Count Within Maternity Care Settings MEDL

Guideline and a mention of 'Equipment should be checked, and swabs and needles counted before and after the procedure.'

8.4.5. The Guideline states 'The proforma for assessment & suturing of perineum/vagina post-delivery must be used.' and a copy of the Perineal Tear Proforma / LocSSIP (October 2019) is included in the Appendix of the Guideline.

8.4.6. **Swab Instrument and Needle Count Within Maternity Care Settings MEDL Guideline (January 2024)**

8.4.7. Please refer to Appendix 2 for the full Swab Instrument and Needle Count Within Maternity Care Settings MEDL Guideline.

8.4.8. The MEDL Guideline (Medical Emergencies Document Library Guidelines) is applicable in 'ALL maternity settings where swabs, needles and instrument are used.'

8.4.9. The Guideline provides clear direction on how countable items should be packaged and what to do when an item is missing from the count.

8.4.10. However, the Guideline does not explicitly provide:

- a clear step-by-step guide on how the process counting of items occurs.
- which two members of staff are responsible for completing the counts. There is mention of 'two members of staff', 'both staff informed' and 'two perioperative staff'.
- Where and at what point in the procedure the counts are expected to be documented. There is mention of a 'white count board', 'operative notes', 'patient notes' and 'digital records'.
- The different types of swab packs available for use and when to use them.

8.4.11. The Guideline provides more detail for the counting process in a surgical environment rather than a delivery room, which can lead to uncertainty of the responsibilities of tasks for staff.

8.4.12.	**Perineal Tear Proforma / LocSSIP (October 2019)**
8.4.13.	Please refer to Appendix 4 for the full Perineal Tear Proforma / LocSSIP.
8.4.14.	The Proforma / LocSSIP provides clear expectations of what steps to take and what needs to be documented where a patient has sustained a perineal tear following delivery.
8.4.15.	Within the Proforma is the 'Counts and Post Repair Checks' section which provides a detailed breakdown of the expected counts at each stage of the procedure and enables the primary and secondary person completing the counts to sign at each step.
8.4.16.	Although this Proforma is referenced in the 'Perineal Trauma Guideline' and the 'Counts and Post Repair Checks' section is included in the patient's paper records, it is unclear whether the Proforma is utilised.
8.4.17.	Maternity staff are expected to use both digital and paper systems to record care activities, which leads to the fragmentation of patient records and lack of clarity for staff to understand what type of care activities are recorded on paper or digitally.

8.5. Learning Response Tool Analysis – Systems Engineering Initiative for Patient Safety (SEIPS)	
System Factor	**Detail**
Tools and Technology	• The Maternity services at Whittington Health have a known risk recorded titled 'Hybrid Maternity Clinical Records and Multiple Clinical and Non-Clinical IT Systems'. Part of this risk acknowledges the challenges with the existing Careflow Maternity system which is being phased out and has limited scope to update workflows to better suit data collection requirements. • Computers are available in every Labour Ward delivery room however not utilised to document contemporaneously.

	• As a delivery pack had already been opened prior to delivery, the midwife performing the unassisted vaginal is expected to continue to use this pack. In this case another swab pack was opened
Person	• Limitations in staff members' perception of responsibility for managing risks to patient safety could result in a lack of oversight and supervision of the procedure, or issues associated with distribution of responsibility. • The number of staff present in the delivery room differs depending on the type of delivery. In this case it was a spontaneous unassisted birth and at times there was only one Midwife in the room carrying out all the tasks.
Tasks	• The Trust's process for swab insertion and mitigations against retention of swabs relies on staff performing many processes and procedures correctly. There were numerous opportunities for error, especially considering that staff may be distracted by other tasks in the immediate postpartum period. • Poor completion of documenting regular observations postnatally on Cellier Ward.
Internal Environment	• Procedure was carried out in a Labour Ward delivery room and relies on the midwives in the room to facilitate the counts, whose role is not solely on the counts and who have other tasks in the immediate postpartum period they are responsible for. If it took place in a surgical environment the checking process would be more robust as there are designated staff to complete the counts.
Organisation	• Existing guidelines do not specify the roles responsible for the counts in a delivery room and is vague. • Existing guidelines does not clarify steps for completing the count when the procedure is carried out in a delivery room as wording is specific to a surgical environment.

9. Appendices

9.1. Appendix 1 – Terms of Reference	
ToR 1	Explore the immediate postpartum care related to the unintentional retention of a vaginal swab following spontaneous vaginal birth.
Key Questions	• What happened during the immediate postpartum period that led to the retention of the swab? • What were the contributory human, system, or environmental factors? • Were appropriate checks and documentation completed? • Was existing guidance followed or were there barriers to compliance? • What can be learned, and what safety actions are needed? • What was the work as imagined, and the work as done? What were the contributory factors?
Healthcare Settings	Labour Ward Labour Ward Theatre Cearns Theatre
Healthcare Processes	Swab, Instrument and Needle Count Within Maternity Care Settings MEDL Guideline

9.2. Appendix 2 – Swab, Instrument and Needle Count within Maternity Care Settings MEDL Guideline

Whittington Health NHS

Swab, Instrument and Needle count within Maternity Care Settings

The Association for Perioperative Practice AFPP Website

Introduction

This MEDL is to be used in **ALL** maternity settings where swabs, needles and instrument are used.

Non –adherence can lead to retention of swabs. Retention of swabs can be a potential source of maternal morbidity including pyrexia, infection, pain and secondary haemorrhage.

In extreme cases it can lead to maternal death.

Checking Procedure

Packaging

- A count must be undertaken for all procedures where countable objects (e.g., swabs , instruments, needles, sharps) which are used in vaginal birth, instrumental birth, caesarean birth, perineal repair and evacuation of retained products of conception.
- All swabs should have Raytec tape(x -ray detectable).
- All swabs must be packed in bundles of 5 and be of uniform size & weight.

Responsibility of counts

- The count must be audible to those present and must be conducted by two members of staff.
- If a change of operator occurs at any stage of the procedure, a re-count must take place and be recorded.
- Swabs and instruments must be accounted for if they leave the room.
- Standardised white count board in delivery rooms & operative theatres must be used to record count.

References

- WHO check list 2009 Implementation manual WHO surgical safety checklist 2009
- The Association for Perioperative Practice 2017 AFPP Website

- The initial count must be performed immediately prior to the procedure. In theatres the WHO surgical safety checklist must be completed.
- Red strings must remain on the trolley.
- During a surgical procedure, the same two perioperative personnel should perform all counts.
- If there is a change in scrub practitioner a complete count must be performed and recorded by the incoming and outgoing practitioner.
- A 2nd count must be carried out prior to closure of the abdomen or completion of repair.
- If a vaginal or abdominal pack, or Bakri balloon is to remain in situ this must be recorded in the operative notes (including time and expected date of removal).
- Any swabs inserted in the vagina during perineal repair must be clipped, documented and both staff informed.
- If vaginal swabs are left in situ an additional wristband must be attached to the patient's wrist.

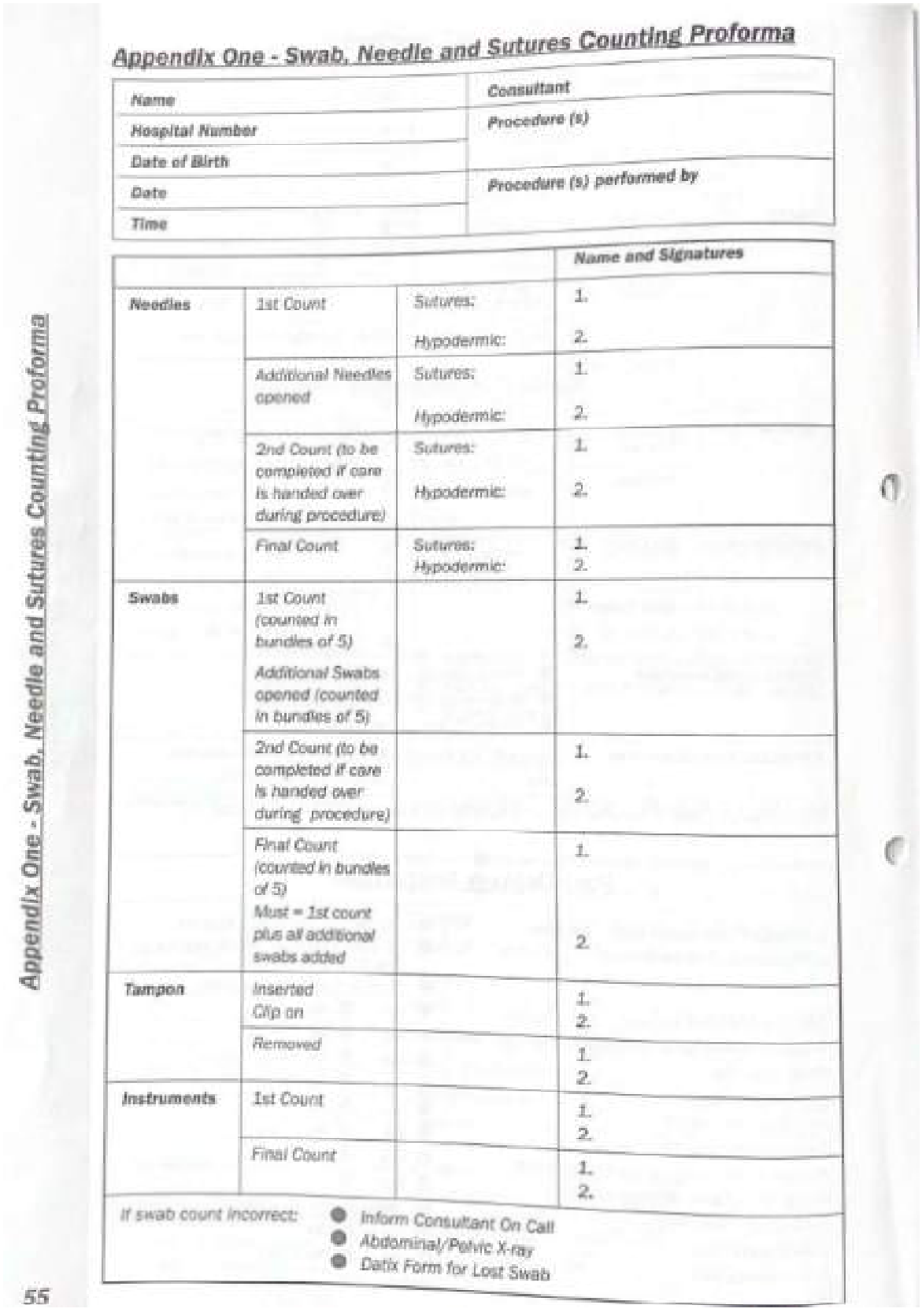
What to do if a swab/ needle/instrument is missing

- Re-count the swabs.
- Try to find the swab
- Remember to check rubbish bins bags and bedding.
- Inform the Surgeon and Assistant that a swab is missing
- Escalate to the Obstetric Consultant and Labour ward coordinator
- Organise for an abdominal/pelvic x-ray to be performed
- Report on Datix
- Inform the patient – duty of candour

A copy of the count should be retained in the patient notes and digital record.

MEDL GUIDELINE DETAILS
Authors: Nosheen Rafaqa, Alicia Stlouis
Specialist: Pharmacists:
CGC approval: January 2024 Review date: January 2027

9.3. Appendix 3 – Swab, Needle and Sutures Counting Proforma in Paper Records



Appendix One - Swab, Needle and Sutures Counting Proforma

Name	Consultant
Hospital Number	Procedure (s)
Date of Birth	
Date	Procedure (s) performed by
Time	

			Name and Signatures
Needles	1st Count	Sutures: Hypodermic:	1. 2.
	Additional Needles opened	Sutures: Hypodermic:	1. 2.
	2nd Count (to be completed if care is handed over during procedure)	Sutures: Hypodermic:	1. 2.
	Final Count	Sutures: Hypodermic:	1. 2.
Swabs	1st Count (counted in bundles of 5) Additional Swabs opened (counted in bundles of 5)		1. 2.
	2nd Count (to be completed if care is handed over during procedure)		1. 2.
	Final Count (counted in bundles of 5) Must = 1st count plus all additional swabs added		1. 2.
Tampon	Inserted Clip on		1. 2.
	Removed		1. 2.
Instruments	1st Count		1. 2.
	Final Count		1. 2.

If swab count incorrect:
- Inform Consultant On Call
- Abdominal/Pelvic X-ray
- Datix Form for Lost Swab

Appendix One - Swab, Needle and Sutures Counting Proforma

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9.4. Appendix 4 – Perineal Tear Proforma / LocSSIP

NHS
Whittington Health
NHS Trust

Perineal Tear Proforma / LocSIPP (October 2019. V7)

SIGN IN

Date	Consultant
Time	Surgeon
Name	Assistant
Hospital Number	Anaesthetist
Date of Birth	Allergies Y/N
Type of Delivery Spontaneous Instrumental	Place of Repair Obstetric theatre Delivery Room (reason.....)
Analgesia: General/Epidural / Spinal / CSE/ other (state.....)	

Time Out EXAMINATION FINDINGS

Consent	Has the women confirmed her identity, procedure and consent? Yes No Verbal Written
PR examination prior to repair	☐ Yes ☐ No
Classification of tear confirmed by 2nd practitioner	☐ Yes ☐ No Name:
Classification of tear (tick as appropriate) Epi-scissors used YES / NO	Episiotomy ☐ 1st degree ☐ 2nd degree 3rd Degree ☐ 3a- < 50% EAS injured ☐ 3b- > 50% EAS injured ☐ 3c- EAS and IAS injured 4th Degree EAS, IAS and anal epithelium injured Anal mucosa with intact sphincter (buttonhole tear) Vaginal Wall tear

9.4. Appendix 4 – Perineal Tear Proforma / LocSSIP

METHOD OF REPAIR

Sutures and techniques used (tick as appropriate)	Anal epithelium	☐ N/A ☐ Vicryl 2/0 ☐ other Knot: ☐ Inside canal ☐ outside canal
	IAS	☐ N/A ☐ 3/0 PDS ☐ Vicryl 2/0 ☐ other
	EAS	☐ N/A ☐ 3/0 PDS ☐ Vicryl 2/0 ☐ other Technique: ☐ Overlapping ☐ End to end
	Perineal muscle	☐ N/A ☐ Vicryl 2/0 ☐ other Technique: ☐ Continuous ☐ Interrupted
	Vaginal mucosa	☐ N/A ☐ Vicryl 2/0 ☐ other Technique: Continuous Non-locking: ☐ Yes ☐ No If no, which technique and reason .....
	Perineal Skin	☐ N/A ☐ Vicryl 2/0 ☐ other Technique: ☐ Subcuticular ☐ Interrupted
Post-Repair	PV performed: ☐ Yes ☐ No PR performed: ☐ Yes ☐ No Suturing checked by a second practitioner: ☐ Yes ☐ No Name:	

Counts and Post-Repair Checks			Name and Signatures
Needles	1st Count	Sutures: Hypodermic:	1. 2.
	Final Count	Sutures: Hypodermic:	1. 2.
Swabs	1st Count		1. 2.
	2nd Count	(to be completed if care is handed over during procedure)	1. 2.
	Final Count		1. 2.

Local Safety Standards for Invasive Procedures – Perineal Trauma v7, Oct 2019, Review Oct 2020

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9.4. Appendix 4 – Perineal Tear Proforma / LocSSIP

Tampon	Inserted and clip on		1. 2.
	Removed		1. 2.
Instruments	1st Count		1. 2.
	Final Count		1. 2.
If swab count incorrect:		☐ Inform Consultant on call ☐ Abdominal/ Pelvic Xray ☐ Incident Form for lost swab	
Estimated Total Blood Loss		mls	Analgesia ☐ Paracetamol ☐ NSAID
Further Description of Perineal Repair (please write more in the notes if required)			

SIGN OUT POST DELIVERY INSTRUCTIONS

Discussion and leaflet regarding care and support given to woman	☐ Discussion regarding aftercare ☐ Perineal trauma following vaginal birth (tear/episiotomy) ☐ Third or fourth degree tear
Incident form completed (3rd/4th degree tear)	Yes / No
Woman's Consultant informed (3rd/4th degree tear)	Yes / No
Foley Catheter	Yes / No Remove when
Antibiotics Prescribed	Yes / No
Laxatives Prescribed	Yes / No

9.4. Appendix 4 – Perineal Tear Proforma / LocSSIP

Further analgesia prescribed	Yes/ No
Bowels to be opened prior to discharge	Yes/ No
Pelvic Floor Clinic referral at 6/52	Yes / No
Thrombo-embolic Risk	□ Anglia Ice Thromboprophylaxis complete
LMWH prescribed	Yes/ No
Post Delivery FBC	Yes / No When

Name Designation

9.1. Appendix 5 – Suggested White Board Count Template

Item	Before Procedure			After Procedure		
	First Count	Checked By	Witnessed By	Final Count	Checked By	Witnessed By
Swab						
Needle						
Instrument						

Intentionally retained item?	Yes / No
Reason:	
Planned Removal Time:	

10. References

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11. Safety Action Summary Table

No.	Action Description	Action Owner	Target Date for Implementation	Date Implemented	Tool / Measure	Measurement Frequency	Responsibility For Monitoring/ Oversight	Planned Review Date	RAG
Area for Improvement 1: Standardise the process of swab counts to enable documentation to be completed contemporaneously in delivery rooms.									
1	White boards to be updated with template to capture the following information for swabs, needles and instruments: • First count • Final count • Person checked by • Person witnessed by	[redacted] Intrapartum Matron [redacted] Birth Centre Matron	December 2025		Delivery Room Checklist – Ensure white boards have working pens and clear labels. Spot Check Audit – Use of whiteboards during procedures in delivery rooms	Start of each shift Monthly	Maternity Clinical Governance and Safety Champions Meeting	Quarterly	
2	Explore updating 'Post Delivery Checks' workflow on Careflow Maternity to capture same information. To consider whether the field becomes user credential signed as a requirement, to support accurate recording of who completes the counts as opposed to selecting names from a pre-set dropdown list.	Maternity Digital Team [redacted] Director of Midwifery	December 2025		Audit – Export 'Post Delivery Checks' report to monitor compliance	Monthly	Maternity Clinical Governance and Safety Champions Meeting	Quarterly	
3	If Action 2 is not possible, reinstate completion of proforma in paper records or implement sticker label to be attached to paper records which capture the: • First count • Final count • Person checked by • Person witnessed by	[redacted] Intrapartum Matron [redacted], Birth Centre Matron	January 2026		Audit – 10% of total deliveries paper records reviewed for compliance	Monthly	Maternity Clinical Governance and Safety Champions Meeting	Quarterly	
4	Develop sticker with prompt to complete counting process to be placed on delivery swab packs to act as visual reminder. **SWAB COUNT REQUIRED** **Before you start:** ☐ Confirm number of swabs in the pack	[redacted] Consultant Lead for Labour Ward	January 2026		Spot Check Audit – Sticker placed on delivery swab packs	Monthly	Maternity Clinical Governance and Safety Champions Meeting	Quarterly	

No.	Action Description	Action Owner	Target Date for Implementation	Date Implemented	Tool / Measure	Measurement Frequency	Responsibility For Monitoring/ Oversight	Planned Review Date	RAG
	☐ Record the count with your colleague on the whiteboard **Before leaving the room:** ☐ Final swab count completed ☐ All swabs **accounted for** ☐ Documented in notes **If counts don't match: STOP. SEARCH. ESCALATE (incl. X-ray).** **No exceptions. No shortcuts. Patient safety first.**	[redacted] Intrapartum Matron							
4	Training Midwives on use of digital systems to support with accurate and timely documentation for recording care activities.	Maternity Digital Team	May 2025	Ongoing	Training Logs	Monthly	Professional Development Midwives	Quarterly	
Area for Improvement 2: Ensure there are clear and consistent guidance across relevant Maternity policies to clarify roles, responsibilities and processes to follow when completing swab counts in delivery rooms.									
5	Update Swab, Instrument and Needle Count within Maternity Care Settings MEDL (Jan 2024) to clarify: • Clarify which roles are responsible for swab count. • Clarify where swab counts should be documented. • Clarify process for delivery rooms (currently only mentions surgical environment)	[redacted] Consultant Lead for Labour Ward [redacted] Intrapartum Matron	January 2026		Review as per Trust Policy	3 years	Maternity Guidelines and Audit Group	3 years	
6	Update 'Perineal Trauma Guideline' (Feb 2024) to link to Swab, Instrument and Needle Count within Maternity Care Settings MEDL Guideline.	[redacted] Consultant Obstetrician	January 2026		Review as per Trust Policy	3 years	Maternity Guidelines and Audit Group	3 years	
7	Update Perineal Tear Proforma / LocSSIP (Oct 2019) to align with National Safety	[redacted] Consultant Obstetrician	January 2026		Review as per Trust Policy	3 years	Maternity Guidelines and Audit Group	3 years	

No.	Action Description	Action Owner	Target Date for Implementation	Date Implemented	Tool / Measure	Measurement Frequency	Responsibility For Monitoring/ Oversight	Planned Review Date	RAG
	Standards for Invasive Procedures (NatSSIPs).								
8	Postnatal Care Guideline to be developed and aligned with NICE guidance. To include how often observations must be completed and documented on patient records.	[redacted] Inpatient Matron [redacted] Consultant Lead for Inpatients [redacted] Consultant Midwife for Public Health and Education	March 2026		Review as per Trust Policy	3 years	Maternity Guidelines and Audit Group	3 years	
Area for Improvement 3: The number of trained staff present in delivery rooms.									
9	Explore having a Maternity Support Worker present in the delivery room to support the Case Midwife with tasks that need to be completed in the immediate postpartum period.	[redacted] Head of Midwifery [redacted] Director of Midwifery	January 2026		Staff Establishment Review Meeting	Monthly	Head of Midwifery Director of Midwifery	Quarterly	
Area for Improvement 4: Information included in Education, Training and Induction regarding swab count processes and documentation.									
10	Incorporate swab count process (including documentation, communication and cross checking) in **live skills and drills scenarios** in the clinical area.	[redacted] Intrapartum Matron Professional Development Midwives	January 2026		Training Logs	Monthly	Professional Development Midwives	Annually	
11	Incorporate swab count process (including documentation, communication and cross checking) in perineal repair and third- and fourth-degree repair **workshops.**	Professional Development Midwives	November 2025	November 2025	Training Logs	Monthly	Professional Development Midwives	Annually	

No.	Action Description	Action Owner	Target Date for Implementation	Date Implemented	Tool / Measure	Measurement Frequency	Responsibility For Monitoring/ Oversight	Planned Review Date	RAG
12	Integrate swab count process (including documentation, communication and cross checking) into **Induction** for new staff members and as part of **Annual Mandatory Training.** Such as a video demonstrating correct process and include learning from previous incidents.	Professional Development Midwives Educational Supervisors	November 2025	November 2025	Training Logs	Quarterly	Professional Development Midwives	Annually	
13	Present case and identified learning at Learning from Risk meeting for Obstetric and Gynaecology staff.	[redacted] Intrapartum Matron	January 2026		Learning from Risk Meeting	Once	Maternity Clinical Governance and Safety Champions Meeting	N/A	
Area for Improvement 5: The equipment used to support with accurate swab counting to prevent retained foreign objects.									
14	Contact iCount representative to explore use of equipment specific to support with counting of swabs to prevent retained foreign objects.	[redacted] Consultant Lead for Labour Ward [redacted] Intrapartum Matron	October 2025	Awaiting Company Representative to attend Maternity Department	Feedback outcome of discussion at Governance Meeting.	None	Maternity Clinical Governance and Safety Champions Meeting	N/A	

Patient Safety Incident Investigation (PSII) Report

Date of incident	[redacted]
Incident ID number	A131504
PSII Approved by Division	[redacted]
Job Title	Associate Director of Nursing EIM Division
Signature	[redacted]
Date Approved at WISH	[redacted]
Date Presented at Quality Assurance Committee	[redacted]
Date Noted in Chairs Report at Trust Board	[redacted]

Participants of the PSII	
Name	Role
[redacted]	Falls Lead WH
[redacted]	Ward Manager [redacted]
[redacted]	HCA
[redacted]	RN
[redacted]	Doctor
[redacted]	COOP Therapy Lead, Occupational Therapy
[redacted]	Speech and Language Therapists

Distribution list	
Name	Position
[redacted]	Falls Lead WH
[redacted]	Ward Manager [redacted]
[redacted]	RN
[redacted]	Doctor
[redacted]	HCA
[redacted]	COOP Therapy Lead, Occupational Therapy
[redacted]	Speech and Language Therapists

1. About patient safety incident investigations

Patient safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers and staff.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Duty of Candour and the Engaging and involving patients, families and staff after a patient safety guidance in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the Just Culture guide in the minority of cases when staff may be referred to them.

PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

2. A note of acknowledgement

The Learning Response Leads ([redacted], [redacted] and [redacted]) would like to thank the staff who contributed to reviewing the patient safety incident summarised in this report. Thank-you for your support, your openness, and your transparency. Your insights into how care is delivered in the Whittington Hospital have helped us to understand what happened. Each of you has helped us better understand how the technology and tools, organisation, task, person, internal environment, and external influences impact on the performance of staff working on the ward.

We know we have committed, professional and caring staff working in the Whittington Hospital. We know you go to work every day aiming to deliver safe patient care.

Our role as Learning Response Leads is to gather insight into the healthcare settings and systems in which you work: Our focus has been on learning how teams working in the Whittington Hospital deliver patient care, the challenges, constraints and demands you work with, and how systems factors impact on safe patient care. We are not here to judge or criticise: We are here to facilitate learning in a supportive, caring, and collegiate way. Without the insights and contributions made by the staff who participated in the review, the report would not have been possible. So, thank-you.

3. Contents

4. Executive summary

4.1. Incident overview

4.1.1. [redacted]: The patient was deemed medically fit for discharge after medical ward rounds that morning. The patient was awaiting confirmation for a package of care to be implemented, as well as patient transport.

4.1.2. At approximately 12:00pm, the patient was found sitting on the bathroom floor.

4.1.3. The RN allocated to the bay had left to get medication from a trolley in another bay, causing a lapse in Baywatch maintenance.

4.1.4. The patient recounted that they went to the toilet by themself, without a walking aid. The patient went to wash their hands at the sink but unfortunately lost their balance and fell backwards onto their right elbow and right leg. The patient had capacity and did not show signs of confusion or delirium throughout admission.

4.1.5. The patient was assisted off the floor into standing by the Registered Nurse (RN) and Health Care Assistant (HCA). With assistance, the patient stood and sat on the toilet. The patient was then assisted to step transfer onto a wheeled shower chair, where patient was then wheeled to their bed side chair. The patient was again assisted to step transfer from shower chair to the bed side chair.

4.1.6. The patient complained of pain in their right hip.

4.1.7. The RN and HCA notified the medical team to review the patients post fall.

4.1.8. The medical team then immediately assessed the patient on the chair. The patient was found to have significant pain and limited movement through their right hip. A hip and pelvis Xray was ordered and the patient was prescribed analgesia for pain.

4.1.9. The patient was assisted back to bed with assistance and was instructed to remain non-weight bearing through their right lower limb for the transfer. In total, the patient step transferred four times after the fall.

4.1.10. The X-ray was completed at 14:55 confirming a right intracapsular neck of femur fracture. At 16:15, the medical team informed the orthopaedic specialist team to review the patient for surgery the next day.

4.1.11. [redacted] The patient underwent successful right hemiarthroplasty.

4.1.12. Post-operatively, complications included oxygen desaturation and increasing supplemental oxygen requirements likely due to aspiration pneumonia, possibly linked to pre-existing swallowing difficulties (patient had commenced eating and drinking with acknowledged risk pathway on [redacted]).

4.1.13. A decision was made to implement short term nasogastric tube feeding, alongside already agreed oral intake with accepted risk of aspiration, to boost nutritional intake to support post-operative recovery.

4.1.14. Despite treatment and supplemental feeding, the patient's condition deteriorated. The family were kept informed throughout the patient's clinical decline.

4.1.15. [redacted] The patient sadly passed away at midday.

4.2. Summary of key findings

4.2.1. The falls risk assessment was not updated after the first fall

- The falls risk assessment was not re-evaluated following the first inpatient fall, as required by Trust Protocol, creating a gap in care planning
- Physiotherapy and Occupational Therapy teams did not reassess the patient's mobility and functional ability after the first fall, missing an opportunity for multidisciplinary input for care planning

4.2.2. Lapse in patient monitoring (Baywatch)

- Baywatch was interrupted for medication rounds due to the current staffing model, leaving one bay unsupervised for 10-15 minutes

4.2.3. The post fall protocol was not followed, including an escalation delay

- There was no on-the-floor assessment completed before retrieval off the ground
- The medical team were informed only after the patient was assisted off the floor and transferred multiple times onto a chair
- The Ward Manager and Falls Lead were not promptly notified, reducing leadership oversight
- The post-fall protocol and policy need to be revised to meet the Royal College of Physicians, National Audit of Inpatient Falls Standards.

4.3. Summary of areas for improvement and associated safety actions
4.3.1. To strengthen documentation and handover processes within the multidisciplinary team
4.3.2. To redesign and strengthen Baywatch responsibilities
4.3.3. Revise the post-fall protocol and enforce regular training sessions to build confidence in safe retrieval methods
4.3.4. To improve therapy prioritisation and multidisciplinary review

5. Duty of candour

Different elements	Yes	No	Date	By whom?
Was the patient / NoK contacted and apologised to?	☒	☐	28/08/2025	[redacted], Ward Manager
Was this followed up in writing?	☒	☐	02/12/2025	[redacted], Ward Manager There was telephone contact with [redacted], who initially did not want a letter causing the delay in sending.

Has the family agreed to receive the final report?	☐	☐	Click or tap to enter a date.	
Has the duty of candour been complied with?	☐	☐	Click or tap to enter a date.	

6. Background and context of the patient safety incident

6.1.1. [redacted] Ward is a 25-bed acute care ward for older people, admitting patients with varying medical needs and levels of dependency, ranging from moderate to high. The ward often cares for patients with delirium and cognitive impairment.

6.1.2. Standard daily staffing includes four registered nurses, three healthcare assistants, and one senior nurse (Band 6 or 7). Staffing levels are continuously reviewed by the ward manager or nurse in charge, with risk assessments determining if extra staff are required to provide enhanced care (1:1 support).

6.1.3. [redacted] ward is based on level 6 of the Whittington Hospital and is part of the Care of the Older People Unit. The ward provides care for the older adult patients through multi-disciplinary comprehensive geriatric assessment. The ward comprises four bays (5-6 patients each) and four individual side rooms.

6.1.4. On the day of the incident, the registered nurse allocated to the bay was relatively new to the ward, and this incident was their first time managing and responding to a patient fall.

6.1.5. During medication rounds, Baywatch monitoring was affected by staffing constraints. There were only three healthcare assistants available to cover four bays, there was no HCA present to monitor the bay when the patient left to go to the bathroom, where the incident occurred.

7. Investigation approach

7.1. Investigation Team			
Role	Initials	Job title	Department

[redacted]	[redacted]	Falls Lead WH	Whittington Health NHS Trust
[redacted]	[redacted]	Quality and Risk Manager EIM	EIM
[redacted]	[redacted]	Ward Manager [redacted]	EIM

7.2. Summary of investigation process

7.2.1. The incident report was raised on the trust Datix system which due to the serious nature, ensured an alert was raised with the trusts senior leaders.

7.2.2. This resulted in a Rapid Action Review (RAR) being written to gather information and an initial investigation into the incident.

7.2.3. This report was then presented to the senior leadership team and trusts patient safety leads via the Whittington Improvement Huddle (WISH) panel. This panel was led by the Associate Medical Director for Patient Safety and panel members of the executive team including the Chief Nurse and Chief Medical Officer. At this panel a decision was made to investigate this incident further and that a deeper more thorough and detailed report was required due to the seriousness of the patients' outcomes resulting in the requirement for this PSII report.

7.2.4. On completion of this report, a copy will be sent to members of staff involved and the patient's family for accuracy checking.

7.2.5. The WISH panel members will then review the report and sign it off.

7.2.6. Actions will be monitored by Emergency and Integrated Medicine Unit Quality Committee.

7.3. Terms or reference summary

7.3.1. **Was a falls assessment completed, and were all required actions taken in line with the STOP falls plan? (i.e. no use of side-rooms, high risk falls poster on bed space). If appropriate was 1:1, or Baywatch in place?**

- An initial falls risk assessment was completed on admission; however, it was not fully comprehensive. Only poor nutritional intake was identified, while other significant risk factors, such as Parkinson's disease, recent decline in

mobility, and polypharmacy were not captured. A lying/standing blood pressure was also not undertaken.

- A repeat falls risk assessment was completed two days later. This assessment action plan was accurate and included appropriate actions in line with the STOP falls plan.
- Baywatch was in place, but staffing limitations impacted its effectiveness. With four bays and only three HCAs, one bay was left without observation during medication rounds. A review of the Baywatch initiative is required to strengthen the multidisciplinary team (MDT) involvement and ensure continuous monitoring, even during periods of reduced staffing.

7.3.2. **What monitoring mechanisms for falls risks are there in place on the ward when a patient is awaiting discharge?**

- No changes were made to the patient's care plan while awaiting discharge. Baywatch remained in place, but there was a lapse in observation during medication rounds.

7.3.3. **Were staffing levels safe as per safer staffing?**

- Yes, staffing levels met standard safe staffing requirements at the time of the incident.
- However, observation was compromised during medication rounds due to the Baywatch gap described above.

7.3.4. **Was the patient's mobility assessed before discharge and was the right mobility support put in place?**

- The patient's mobility was last assessed by Occupational Therapy on [redacted] August, the day before their first inpatient fall.
- The patient's mobility was not reassessed after the first inpatient fall. Physiotherapy saw the patient on [redacted]; however, their priorities shifted to chest assessment following Videofluroscopic Swallow Study (VFSS) due to aspiration. The patient's fall was not acknowledged in the therapy CareFlow notes.
- On the day of the second fall, the patient was awaiting discharge with care package and transport confirmed, but a post-fall mobility reassessment had

still not taken place. This highlights the importance of prioritising mobility reassessment after any fall, particularly for patients with a history of recurrent falls.

- Communication within the MDT could have been stronger to ensure consistent mobility recommendations and reinforce guidance for the patient.
- After the incident, the patient was reviewed daily by the therapy team until their passing.

7.3.5. **Once the fall was identified was the right assessment completed? And was this done in a timely manner?**

- The correct assessment was not completed.
- The patient was attended to immediately after a noise was heard in the bathroom; however, the patient was assisted up from the floor before an 'on-the-floor' assessment was carried out.
- This omission delayed identification of hip pain and prevented appropriate manual handling decisions as per protocol. Hip assessment occurred later when doctors reviewed the patient in a chair next to their bed.

7.3.6. **When the patient was retrieved from the bathroom floor, was the correct equipment used, i.e. Hoverjack?**

- The correct equipment was not utilised. The patient was manually assisted to stand by two staff members, which required weight-bearing through the affected hip.
- If an assessment had been completed prior to retrieval and senior support notified earlier, HoverJack use would have been identified as the appropriate method in line with protocol.

7.3.7. **Was the patient's capacity assessed and actioned appropriately?**

- The patient's capacity was not formally assessed during admission; however, there were no concerns regarding cognition.
- The patient completed a 4AT delirium screen on [redacted] where the patient scored 0, indicating no delirium or cognitive impairment. A cognitive management plan was not required.

7.3.8. **Were appropriate measures taken on the ward to reduce the risk of hospital related deconditioning e.g. being assisted to get out of bed when well enough?**

- The patient was assisted and encouraged to mobilise on the ward daily to meet their basic needs, such as toileting.
- The patient received one Occupational Therapy mobility assessment prior to their inpatient falls, during which the patient was advised to walk with supervision and a Zimmer frame. An individualised exercise programme may have further reduced the risk of hospital-related deconditioning.
- There was a missed opportunity for physiotherapy input to assess the patient's gait and Parkinson's disease related mobility symptoms. A more detailed review of the patient's falls history and mechanisms could have informed targeted interventions to support their movement disorder and prevent future falls.
- While these additional measures may have reduced the patient's overall risk, they would not have guaranteed prevention of a fall.

7.4. Information gathering

7.4.1. Individual discussions were held with staff involved in the incident, to understand the different elements involved.

7.4.2. The patient electronic record notes have been consulted.

7.4.3. A Structured Judgment Review (SJR) has been completed, see appendix 3.

7.4.4. Guidelines and policies have been reviewed in terms of processes around falls.

7.4.5. Training records relating to falls have been reviewed.

7.4.6. Nursing staffing rosters have been reviewed to review staffing levels and skill mix along with reports on the situation of acuity on the ward at the time of the incident.

8. Findings

8.1. All Findings

8.1.1. A Falls risk assessment was not re-evaluated following the patient's first inpatient fall. Although Trust protocol requires nursing staff to update the assessment after such an event, this step was not completed. This oversight represented a missed opportunity to review the care plan and reinforce safe activity guidance

8.1.2. After the first fall, the Physiotherapy and Occupational Therapy team did not reassess the patient's mobility and functional ability, contrary to Trust policy. This was a missed opportunity for multidisciplinary input to optimise safe activity and provide re-education.

8.1.3. Communication between therapists and nursing staff regarding mobility recommendations was inconsistent throughout the patient's admission. Similarly, key information about the patient's falls risk factors and recommended mobility status was not reliably shared, leading to gaps in understanding and care coordination.

- Written handovers were inconsistent across the multidisciplinary team; therapy teams assessed and recommended mobility, but this was not documented in nursing handovers.
- The mobility status on the board by the patient's bedside was not used consistently and is often unreliable, limiting its effectiveness as a communication tool.
- At times, the patient was assisted to the bathroom without their recommended gait aid, using hand-hold assistance instead of a Zimmer frame. This inconsistency in facilitation across disciplines and throughout the day could have caused confusion for the patient about what was safe and recommended, potentially contributing to the patients falls risk.

8.1.4. There was a temporary lapse in patient monitoring (Baywatch) during a medication round. Under the current safer staffing model, there are routine periods during medication rounds where one bay is left without an RN or HCA completing Baywatch observations. This highlights a flaw in this initiative.

8.1.5. The patient mobilised independently to the bathroom without assistance or a Zimmer frame, contrary to the therapist's recommendation for supervised mobilisation with a Zimmer frame. The patient had capacity to make this decision.

8.1.6. The required post-fall procedure was not fully followed. Specifically:

- An on-the-floor assessment was not completed to guide safe retrieval (e.g., use of flat-lifting equipment/HoverJack).
- The medical team was informed only after the patient had been assisted into standing.

8.1.7. The incident was not promptly escalated to the Ward Manager or Falls Lead, resulting in a missed opportunity for leadership intervention and oversight.

8.1.8. Nursing documentation on CareFlow lacked consistency and accuracy across shifts. For example:

- Mobility status varied between entries, creating uncertainty about whether this reflected patient choice or staff misunderstanding of recommended mobility status.
- Incontinence status was inconsistently recorded, although the patient was mostly continent.

8.1.9. Post fall documentation within the electronic patient record (CareFlow) was incomplete and lacked key details about the incident, which required additional investigation. The existing post-fall template did not prompt staff to capture all essential information needed for the National Inpatient Falls Audit, limiting the quality of data for audit and learning purposes.

8.2. Areas for improvement and associated safety actions

8.2.1. To enhance communication with patients and families regarding mobility recommendations, falls risk factors, and monitoring requirements and strengthen the use of education leaflets and verbal reinforcement to promote safe activity awareness.

8.2.2.	To clarify and reinforce Baywatch responsibilities within teams to ensure consistent observation, interaction, response, and communication with patients in bays. A review of the Baywatch initiative is underway to enhance role definition, address current monitoring gaps, and establish an effective multidisciplinary approach.
8.2.3.	To improve physiotherapy and occupational therapy prioritisation tools to ensure patients who fall are reviewed promptly for mobility and functional reassessment.
8.2.4.	To improve awareness and procedures for all falls, including low or no-harm events, to encourage early multidisciplinary discussions and timely therapist review to optimise patient care plans.
8.2.5.	To strengthen staff education and awareness of post-fall protocols to ensure safe retrieval methods are consistently applied, including correct use of HoverJack or other flat-lifting equipment.
8.2.6.	To reinforce escalation pathways following a fall to ensure timely communication with the Trauma Team, Ward Medical Team, Ward Manager, and/or Falls Lead, enabling prompt leadership oversight and multidisciplinary input.
8.2.7.	To strengthen documentation practices to ensure accurate records of risk reassessment, interventions, and escalation steps, supporting transparency and shared learning.
8.2.8.	To improve post-fall documentation templates within CareFlow to capture all essential details required for the National Inpatient Falls Audit, ensuring completeness, audit compliance, and better learning from incidents.

8.3. Learning Response Tool Analysis [Name of tool used]	
	Further Details
Person	Interviews with individuals involved in the incident
Organisation	Review of Policies and Procedures, see attached in appendix
Tools and Technology	Review of electronic case notes

9. Patient/Next of Kin questions (if applicable)

9.1.1.	The family did not forward any questions.

10. Appendices

10.1.	Appendix 1 – Terms of Reference
10.1.1.	Was a falls assessment completed, and were all required actions taken in line with the STOP falls plan? (i.e. no use of side-rooms, high risk falls poster on bed space). If appropriate was 1:1, or Baywatch in place?
10.1.2.	What monitoring mechanisms for falls risks are there in place on the ward when a patient is awaiting discharge?
10.1.3.	Were staffing levels safe as per safer staffing?
10.1.4.	Was the patient's mobility assessed before discharge and was the right mobility support put in place?
10.1.5.	When the patient was retrieved from the bathroom floor appropriately, was the correct equipment used, i.e. Hoverjack?
10.1.6.	Once the fall was identified was the right assessment completed? And was this done in a timely manner?
10.1.7.	Was the patient's capacity assessed and actioned appropriately?
10.1.8.	Were appropriate measures taken on the ward to reduce the risk of hospital related deconditioning e.g. being assisted to get out of bed when well enough?

10.2.	Appendix 2 - Timeline / patient journey map
10.2.1.	[redacted] 16:20 Arrived and assessed in ED with presenting complaint of a cough and general decline over 2 weeks
10.2.2.	[redacted] 02:20 Admitted on to [redacted] ward. A falls risk assessment was completed but only identified nutritional intake as a risk factor. Medical Daily Review Diagnosed with: Community Acquired Pneumonia
10.2.3.	[redacted] 00:20 Documentation of transfer onto Care of the Elderly Ward – [redacted] Ward.
10.2.4.	[redacted] 19:15 Falls Risk Assessment completed, but incomplete.
10.2.5.	[redacted] 00:30 Falls risk assessment done again, further completed.
10.2.6.	[redacted] 11:00 Medical Daily Review, Ward Therapy Review [redacted] present for functional review and discharge planning
10.2.7.	[redacted] 01:30 **First inpatient fall – unwitnessed** Patient had a fall overnight at the bed side as the patient tried to stand up on their own to go to the toilet. 02:15 Medical assessed post fall.
10.2.8.	[redacted] 09:30 Medical Daily Review, plan for discharge today. 12:00 **Second inpatient Fall – unwitnessed**

10.3.	Appendix 3 Serious Judgement Review (SJR)

National Mortality Case Record Review Programme: Comprehensive Mortality Structured Judgement Review Form

Hospital number:	[redacted]
Date of Birth:	[redacted]
Age at death (years):	[redacted]
Gender:	[redacted]

Ethnicity:	
Day of admission/attendance:	[redacted]
Time of arrival:	18:50
Day of death (Date of incident) :	[redacted]
Time of death	12:10
Number of days between arrival and death:	17
Month cluster during which the patient died:	
Specialty team at time of death:	Orthopaedics
ICSU:	EIM and Surgery
Specific location of death:	[redacted] Ward
Type of admission:	Medical originally
The certified cause of death (if known):	With coroner
REVIEWER 1	
The Patient	
Main diagnosis on admission	1. Pneumonia
Significant co-morbidities	Parkinsons Disease Spinal Stenosis Previous Fractured NOF
Certified Cause of Death	1) To be confirmed

Was there a hospital post mortem?	Y/N	
Was the Coroner informed/consulted?	Y/N	*Yes - death following fall in hospital*
Was there a Coroner's Post mortem?	Y/N	*No*

Structured case note review data collection

1 Phase of care: **Admission and initial management (approx. first 24 hours)**
Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant

that you wish to comment on, then please do so.

IMPRESSION:
Clerked by medical SHO shortly after arrival around 6pm. Suspected pneumonia diagnosed, and antibiotics started. Seen by an acute medical consultant within 2 hours of initial medical clerking. Thorough post take assessment which confirmed the suspected diagnosis of pneumonia, set in the context of severe frailty and Parkinson's Disease (PD). Need to receive timely Parkinson's meds noted and plans in place for this. NOK ([redacted]) updated by consultant as part of this review.

Admitted to acute medical ward by 02:20 on [redacted] Appropriate nursing admission documentation completed- very high falls risk noted, and plans put in place to reduce risk. Pressure areas assessed. Medicine reconciliation completed the following morning (within 24 hours of admission), Speech and language and physiotherapy teams involved following consultant review that morning.

Please rate the care received by the patient during this phase.

5 = excellent care

2 Phase of care: **Ongoing care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

IMPRESSION:

Transferred to Care of Older People (COOP) ward the following day ([redacted]). Nursing note records redness to heels and sacrum. Consultant review that morning with appropriate ongoing management of pneumonia, PD and frailty. Whole MDT involvement including Speech and Language Therapy (SALT), dietician, therapies. Initial nursing focus in care plans is on pressure ulcer prevention rather than falls prevention. Falls risk assessment appropriately completed the following day and recommended assistance of 1 for safe mobilisation plus 'Baywatch' at all times. Received daily medical review and by [redacted] was recovering well enough to be listed as fit for discharge from a medical perspective but required ongoing input around mobility due to deconditioning. An NCL form was sent for community therapy input and a package of care (POC) to support discharge.

The patient had capacity to make decisions about their care, including whether to follow the recommended guidance around mobility. That night, the patient attempted to mobilise to the bathroom without assistance and fell. The patient was found on [redacted] around 02:00 sitting on the floor by nursing staff. The patient was reviewed by the night doctor at 02:30 having been helped back to bed. This was a good medical assessment and checked for injury appropriately. There is appropriate documentation and checks by both medical and nursing staff documented using the correct proformas overnight. The patient's next of kin was also informed.

Later the same day ([redacted]) the patient attended a videofluoroscopy assessment of their swallow. This diagnosed severe oropharyngeal dysphagia, most likely related to progression of their Parkinson's Disease. The patient was appropriately reviewed with 48 hours with chest physiotherapy input as a precaution following this. The same day the specialty registrar had a detailed discussion with the patient and family about options for feeding given the dysphagia diagnosis. This is well documented and appears to have been a detailed and compassionate review. The patient opted to 'eat and drink with acknowledged risk.' The decision and parallel discussions with SALT, pharmacy, nursing are well documented using the correct proformas. Discharge planning continued with the support of the whole MDT. This was obviously an unexpectedly busy day in terms of the patient's management, and I suspect as a result, further assessment of falls risk in relation to the fall that had happened at 02:00 such as lying and standing BPs suggested in the medical plan overnight, were not addressed. This represents appropriate prioritisation of a new acute issue (severe dysphagia and potentially NBM status) but is a gap in care.

The following day ([redacted]) the patient again mobilised independently around midday and fell in the bathroom. There is very limited documentation around the circumstances of this fall in the nursing and medical notes. This is not adequate. For example, it is not clear who found the patient, what condition the patient was in or how the patient was moved from the bathroom to their bed. Although it is documented that the fall was at midday, the nursing note is 13:45 and the doctor note around 16:00. The assessment of the reviewing doctor does not include the level of detail I would expect, possibly due to time pressure as the correct investigations were ordered and a hip fracture was diagnosed. All the correct specialty advice was sought, and the consultant was informed. The patient was reviewed that evening by a consultant in orthogeriatric. Orthopaedics team reviewed and the patient was listed for theatre the following day.

I have asked the attending doctor to document their recollection of the event to assist this review. The doctor attended the patient promptly who had already been moved back to a chair having fallen in the bathroom. The patient reported falling in the bathroom where they had mobilised unaided, when the patient had turned to wash their hands. The patient was then assisted back into their bedside chair prior to clinical review. The doctor performed an appropriate examination and ordered the necessary examinations before seeking specialist input. The doctor also prescribed analgesia.

In addition to the clinical record, I have reviewed the subsequent notes made by the ward matron who investigated the fall with the 'SWARM' approach within 48hours of the incident. The following narrative was documented:

- At approximately 12:10, RN noted the patient was not at their bedside and went to look for the patient. Patient was found sitting on the bathroom floor. Fall was unwitnessed. Patient had mobilised independently without assistance and without their Zimmer frame. Patient was high risk of falls as had a fall on [redacted] and sustained a graze on their right elbow. Son was with patient awaiting discharge when he left for a moment. Patient was not observed leaving the bay to go to the toilet from bed 13 to bay C bathroom. RN left the bay unattended to go and get medication from another trolley in another bay on their return patient was not there. RN proceeded to go and look for patient and found the patient on the floor in the bathroom near toilet. Patient was assisted off the floor by RN and HCA and was sat on the toilet before nurse in charge or medical team attended. Medical team attended at this point. There was a missed opportunity to retrieve the patient correctly using the HoverJack device, and the Trauma Team was not called. The

incident was not escalated to the Ward Manager at the time, representing a further missed opportunity for leadership and oversight.

The following learning was identified and appropriate action plans created to address improvements have been made:

- Falls in high-risk patients require close monitoring, especially following a recent fall.
- Retrieval should follow protocol, using HoverJack or appropriate equipment, and involve the Trauma Team.
- Inform Falls Lead as soon as possible
- Escalation to the Ward Manager should occur immediately after a significant fall for oversight and leadership.
- Staffing challenges and redeployment can compromise observation and supervision, increasing falls risk.
- Lack of falls training among staff contributed to uncertainty in managing the event appropriately.

Please rate the care received by the patient during this phase.

Although there are examples of excellent care during the inpatient stay, I have judged this episode of care in relation to management around the second fall:

2 = poor care

3 Phase of care: **Care during a procedure (excluding IV)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

NR

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = excellent care**

Please circle only one score.

4 Phase of care: **Perioperative care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

The patient received timely orthogeriatric, anaesthetic and orthopaedic review and was operated on within 24 hours of their injury. Post operatively clear plans are documented using appropriate proformas. There is documentation of communication with the NOK.

Postoperatively the critical care outreach team reviewed the patient as the patient was deteriorating from a respiratory perspective with desaturations. Given the patients known dysphagia, concerns were raised about possible aspiration pneumonia. Antibiotics were started and chest physiotherapy given. The patient remained very fatigued with an oxygen requirement. The patient continued to receive regular input from the orthogeriatrician with appropriate screening for delirium. Ongoing concerns about their nutrition were addressed by SALT, dietician and the orthogeriatric consultant in liaison with the patient and their NOK. A decision was made for short term nasogastric (NG) feeding. Given their infection, ongoing oxygen requirement and poor nutritional reserve, on [redacted] the orthogeriatrician spoke with the patient's family to explain that the patient was ill enough to die. This was a timely and appropriate conversation. The consultant explained that this may mean a move to palliative care was in the patients' best interests in the coming days. Unfortunately, despite appropriate management of their perioperative complications, the patient continued to deteriorate and was therefore referred to palliative care on [redacted]. A deep tissue injury was noted on the patient's sacrum the same day during daily skin care; likely indicative of their terminal condition and an appropriate mattress was requested.

Please rate the care received by the patient during this phase.

5 = excellent care

5 Phase of care: **End of life care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

IMPRESSION:

The patient received palliative care assessment on the day of referral. Appropriate medications were prescribed and needs assessed as I would expect. The correct documentation is filled out and there are documented conversations with the NOK.

The patient died on [redacted] around 11:00 with their family present. The confirmed time of death was 12:10

Please rate the care received by the patient during this phase.

5 = excellent care

6 Phase of care: **Overall care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

IMPRESSION:

There are several parallel and important points to be drawn from this review. It is an unavoidable fact that

-the patient died of a perioperative complication

-the operation was only necessary due to the fracture sustained during their inpatient fall.

-if the patient had not sustained this fracture, the patient would not have had the operation and would not have died in this way.

However- this must be seen in the context of their dysphagia and risk of aspiration pneumonia, the patient's severe frailty and their progressive Parkinson's Disease which all put the patient at risk of hospital acquired complications and death. In addition, the clinical notes illustrate some examples of excellent care. In particular, the MDT management of the patients swallowing difficulties led by SALT and the documentation of this, the perioperative care with the support of orthogeriatrics and the ultimate involvement of the palliative care team. All of these specialists demonstrated what I would consider to be best practice in their management of the case and communication with the NOK and patient.

Nevertheless, the management immediately before during and after the fall on [redacted] does not meet the standard of care we aspire to and expect to deliver. I have therefore rated this overall as poor

Please rate the care received by the patient during this phase.

OVERALL: 2- poor care

1 Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick) ☒ Yes ☐ No

☐(please stop here) ☐(please continue below)

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case.

Problem types

1	**Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)*				☒ Yes
	Did the problem lead to harm?	No ☒	Probably ☐	Yes ☐	
2	**Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)*				☐ Yes
	Did the problem lead to harm?	No ☒	Probably ☐	Yes ☐	
3	**Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE)*				☒ Yes
	Did the problem lead to harm?	No ☒	Probably ☐	Yes ☐	
4	**Problem with infection management**				☒ Yes
	Did the problem lead to harm?	No ☒	Probably ☐	Yes ☐	
5	**Problem related to operation / invasive procedure** *(other than infection control)*				☐ Yes
	Did the problem lead to harm?	No ☒	Probably ☐	Yes ☐	
6	**Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise and respond to changes)*				☐ Yes
	Did the problem lead to harm?	No ☐	Probably ☐	Yes ☒	
7	**Problem in resuscitation following a cardiac or respiratory arrest** *(including cardiopulmonary resuscitation (CPR))*				☐ Yes
	Did the problem lead to harm?	No ☒	Probably ☐	Yes ☐	
8	**Problem of any other type not fitting the categories above**				☐ Yes
	Did the problem lead to harm?	No ☒	Probably ☐	Yes ☐	

Adapted from Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. *BMJ* 2015;351:h3239. DOI: 10.1136/bmj.h3239

7 Avoidability of death judgement score (most appropriately used at second stage review, if required)

We are interested in your view on the avoidability of death in this case. Please choose from the following scale.

Score 1	Definitely avoidable
Score 2	Strong evidence of avoidability
Score 3	Probably avoidable (more than 50:50)
Score 4	Possibly avoidable but not very likely (less than 50:50)
Score 5	Slight evidence of avoidability
Score 6	Definitely not avoidable

Please explain your reasons for your judgement of the level of avoidability of death in this case, including anything particular that you have identified.

As detailed in my 'overall judgement' score, this patient died from an aspiration pneumonia which was made more likely due to their vulnerable post operative condition. The operation was only necessary due to a fall and fracture sustained in hospital. In this sense it was an avoidable death. However, taken in the context of the patient's underlying frailty, dysphagia and Parkinson's Disease I have scored this as avoidability of 3.

Score 3: Probably avoidable (more than 50:50)

11. References

- Adult Inpatient Falls Prevention and Management Policy

  https://whittnet.whittington.nhs.uk/document.ashx?id=5874

- Supporting best and safe practice in post-fall management in inpatient settings

  National Audit of Inpatient Falls (NAIF) | RCP

12. Safety Action Summary Table:

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
1	Post Fall documentation on CareFlow	Update CareFlow templates to include all essential post-fall details required for the National Inpatient Falls Audit.	Falls Lead	Nov 2025	Nov 2025	Manual audits for accuracy	Monthly	Falls Lead, Ward Managers for local compliance	March 2026	
2	Communication within disciplines and across MDT	Streamline and standardise the mobility recommendation process on Careflow handovers for consistent practice	Therapists & Ward Managers	Feb 2026		Manual audits for accuracy and consistency	Monthly	MDT		
3	Post Fall Procedure	Update post-fall algorithm to align with the Royal College of Physicians, National Audit of Inpatient Falls program	Falls Lead	Feb 2026		Document sign-off from governance	Yearly	Falls Lead		
		Review and update the post-falls management policy to be in line with the Royal College	Falls Lead	March 2026		Policy approval and publication	Yearly	Falls Lead		

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
		of Physicians, National Audit of Inpatient Falls program								
		Deliver structured education and hands-on simulations to embed best-practice post-fall management, emphasising on-the-floor assessment and safe retrieval using appropriate equipment.	Falls Lead & Ward Managers	Sept 2025	Sept 2025	Training attendance records, observed practice audits following falls	Quarterly	Falls Lead	March 2026	
4	Baywatch	Redesign and relaunch the Baywatch initiative to establish clear accountability and integrate MDT coverage during medication rounds to avoid supervision gaps.	Falls Lead, Falls Group	Feb 2026		Approval from Falls Group members, compliance audits		Falls Lead, Ward Managers, Matrons		
5	PT/OT prioritisation tool	Update the PT/OT prioritisation tool to enforce the	COOP Therapy lead	Sept 2025	Sept 2025	Manual audits	Quarterly	COOP Therapy lead	March 2026	

Number	Area of improvement	Action description	Action owner	Target date for implementation	Date implemented	Tool / measure	Measurement frequency	Responsibility for monitoring/ oversight	Planned review date	RAG
		importance of post inpatient falls Ax								

Whittington Health NHS Trust

Patient safety incident investigation

Incident ID number:	A116750
Date incident occurred:	[redacted]
Report approved date:	[redacted]
Approved by:	WISH

Distribution list

List who will receive the final draft and the final report (e.g. patients/relatives/staff involved¸ board). Remove names prior to distribution.

Name	
[redacted]	ED Consultant and Patient Safety Lead
[redacted]	EIM Clinical Lead and ED consultant
[redacted]	Risk Manager for EIM
[redacted]	ED SHO Doctor 1
[redacted]	ED SPR Doctor 2
[redacted]	ED Consultant 2 Doctor
[redacted]	Medical Registrar 1
[redacted]	ED Consultant 1
[redacted]	ED doctor 4
[redacted]	Radiology SpR 1
[redacted]	Radiology Consultant 1
[redacted]	Radiology Consultant 2
[redacted]	Radiology Consultant 3
[redacted])	CT radiographer evening / night of 7/8/24
[redacted])	MRI radiographers

[redacted])	MRI radiographer 2
[redacted]	EDA 1 (Emergency Department Assistant)
[redacted]	RLH NS SpR 1
[redacted]	RLH NS SHO 1
[redacted]	RLH NS Cons
[redacted]	Nurse 1
[redacted]	Nurse 2
[redacted]	Nurse 3
[redacted]	Nurse 4
[redacted]	Nurse 5
[redacted]	NIC 1
[redacted]	Consultant MSK and Breast Radiologist Clinical Lead Imaging REALM meeting notes

About patient safety incident investigations

Patient safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers and staff.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Duty of Candour and the Engaging and involving patients, families and staff after a patient safety guidance in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the Just Culture guide in the minority of cases when staff may be referred to them.

PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

A note of acknowledgement

The Learning Response Leads [redacted] and [redacted]) would like to thank the staff who contributed to reviewing the patient safety incident summarised in this report. Thank-you for your support, your openness, and your transparency. Your insights into how care is delivered in the adult section of the Whittington Hospital Emergency Department have helped us to understand what happened. Each of you has helped us better understand how the technology and tools, organisation, task, person, internal environment, and external influences impact on the performance of staff working in the adult section of the Emergency Department.

We know we have committed, professional and caring staff working in the Whittington Hospital Emergency Department. We know you go to work every day aiming to deliver safe patient care.

Our role as Learning Response Leads is to gather insight into the healthcare settings and systems in which you work: Our focus has been on learning how teams working in the adult section of the Whittington Hospital ED deliver patient care, the challenges, constraints and demands you work with, and how systems factors impact on safe patient care. We are not here to judge or criticise: We are here to facilitate learning in a supportive, caring, and collegiate way. Without the insights and contributions made by the staff who participated in the review, the report would not have been possible. So thank-you.

Executive summary

Incident overview

[redacted] was brought into ED by ambulance on after being found unconscious on the street. [redacted] had a history of epilepsy and had had an epileptic seizure. The doctor examined [redacted] and this was reported as normal (no injuries) with no cervical spine tenderness. [redacted] expressed a wish to self-discharge. [redacted] was assessed by the doctor and nurse and deemed to have capacity to make this decision and self-discharged.

After discharge [redacted] had collapsed in the ambulance bay. The team was suspicious that [redacted] might have sustained significant trauma during the fall as [redacted] was complaining of neck pain. The CT scans were verbally and electronically reported as normal. Cervical spine immobilisation was removed, and it was noted that [redacted] was freely moving [redacted] neck and able to move all four limbs. There is no documentation of neurological examination following the seizure except GCS 15/15; Bilateral pupils-4+ equally reacting.

There was an addendum added to the radiology report, noting if there are neurological signs an MRI should be considered. This addendum was not verbally communicated to the ED or Medical teams. The patient began to complain of neck pain. The Medical team was informed. An urgent MRI was booked and [redacted] was re-immobilised. Significant changes were seen on the MRI. [redacted] was transferred to RLH for surgery, he was re-patriated back to the Whittington Hospital ITU and after this transferred to a rehabilitation facility.

Summary of key findings

The investigation found that the CT addendum with significant finding not verbally communicated to ED. This resulted in the addendum not being reviewed before the patient was discharged. It is possible that, had the ED team had been verbally informed of the amended report, [redacted] might not have had [redacted] spinal immobilisation removed. It is also possible that, in that case, an MRI might have been arranged prior to [redacted] developing neurological symptoms.

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Background and context

The Whittington Emergency Department (ED) sees approximately 110,000 patients per year. Patients attend by ambulance or walk in. Of those 110,000 patients per year approximately 17000[1] attend after having had a fit.

Patients arriving to the ED via ambulance are brought into the rapid assessment (RAT) area and are triaged. A handover is given by ambulance staff to hospital staff. A category is assigned demonstrating the seriousness of the patient's condition and urgency in which a clinician should assess them. In the Whittington ED the Manchester triage[2] tool is used to categorise patients. This is a common, well established, national tool used in many EDs within the NHS.

The rapid assessment area is staffed by a senior nurse overnight who receives handover, assesses and initiates initial investigations and referrals for patients arriving via ambulance. From 09:00-20:00hrs this area is also staffed by a senior doctor (ED Consultant or Registrar).

Once assessment, investigations and referrals are completed the patient is transferred to a different area of the department. The rapid assessment area is often busy, particularly when high numbers of ambulance arrivals occur, with a high patient turnover, a fast pace and a high workload for staff working there. NHS national standards around ambulance handover (offload) times state that all handovers should take place within 60 minutes, with 95 % being completed in under 30 minutes and 65% being completed in under 15 minutes.

Trauma patients who present to ED and meet certain criteria have a 2222 'trauma call' activated. This ensures prompt and timely care by the multidisciplinary trauma team which includes the ED team and Anaesthetic, Orthopaedic and General Surgery teams.

Certain patients, on arrival or after being seen by a health professional, wish to discharge themselves against medical advice. There is a trust policy[3] regarding this decision which must be discussed with a senior doctor or nurse. The patient must have a capacity assessment performed and documented in the notes. If the patient is deemed to have capacity, then they are able to make their own decision regarding further medical treatment.

Any imaging performed on a patient is reviewed by a radiologist and the report can be verbal or formally recorded on Careflow. Initial reports can be done by a radiology registrar in which case the imaging is reviewed by a radiology consultant. As a result, there can be a significant addendum added to the report that might change further management of the patient. It is important that there is good communication between the ED and Radiology team to ensure that any new finding is communicated and acted on appropriately.

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[1] Data provided by the Whittington Health Information Team

[2] Manchester Triage; https://www.pslhub.org/learn/patient-safety-in-health-and-care/care-settings/emergency-medicine/manchester-triage-system-updated-24-february-2021-r4320/

[3] Discharge planning policy; https://whittnet.whittington.nhs.uk/document.ashx?id=1512 and *Self-discharge quick guide for health professionals v3.pdf*

Description of the patient safety incident

Summary of Incident A116760

[redacted] was brought into ED at 12:03hrs by ambulance on [redacted] after being found unconscious on the street. [redacted] reported that [redacted] had had a seizure and was known to suffer from epilepsy. [redacted] had recovered by the time London Ambulance (LAS) arrived but was witnessed to have a second seizure lasting 40 seconds that self-terminated. [redacted] was still drowsy. [redacted] observations by the LAS crew were normal and [redacted] had no allergies.

Soon after [redacted] arrival, at 12:18 [redacted] was seen by the RAT doctor and nurse. By this time [redacted] was alert and able to give a full history to the doctor. [redacted] remembered walking back home after a couple of drinks with friends and then waking up on the street near [redacted] home. [redacted] reported taking all [redacted] medications regularly including [redacted] epilepsy medications, three times daily, last taken at 4pm yesterday. [redacted] denied all other symptoms and reported that [redacted] 'felt fine'.

The doctor examined [redacted] and this was reported as normal. There was no cervical spine tenderness.

At approx. 12:47 hrs [redacted] expressed a wish to self-discharge. [redacted] stated that [redacted] seizures were triggered by staying in hospital and that [redacted] felt like [redacted] should be at home. [redacted] was made aware by the doctor that [redacted] might have a further fit, and [redacted] might be at risk of more serious injuries or death. [redacted] replied that "everybody has to die one day", and [redacted] is also a doctor, [redacted] had PhD in Anthropology and was fully aware and taking responsibility of anything forthcoming as a result of discharging [redacted] was assessed by the doctor and nurse and deemed to have capacity to make this decision and self-discharged.

At 13:20 hrs a 2222 trauma call was put out as [redacted] had collapsed in the ambulance bay. The team was suspicious that [redacted] might have sustained significant trauma during the fall as [redacted] was complaining of neck pain. [redacted] cervical spine was immobilised as a precaution and, after a primary survey, a CT head and CT cervical spine were arranged. The scans were performed at 14:18hrs and 14:10 hrs respectively. Noted to be hypotensive in the primary survey.

There was a delay in the CT scan being reported so the ED registrar contacted the radiology hot seat registrar directly for an update. The CT scans were both verbally reported at 15:07hrs as normal and the formal written report was also reported as normal.

The doctor went to re-examine [redacted] [redacted] removed [redacted] cervical spine immobilisation and noted that [redacted] was freely moving [redacted] neck and able to move all four limbs. There is no documentation of neurological examination following the seizure except GCS 15/15; Bilateral pupils-4+ equally reacting.

As [redacted] had had three collapse episodes, possibly to be seizures, [redacted] was referred to the medical team for observation at 15:35hrs. The ED doctor then finished their shift.

At 15:52 hrs (approx.) There was an addendum added electronically to the radiology report. The addendum stated:

On further review, the facet joints of C4/5 bilaterally appear sub-luxed and there is widening of the interspinous space at this level. These findings are almost certainly related to chronic degenerative

changes but correlation with any neurological signs is recommended and if any such signs are present on examination, an MRI should be considered.

This addendum was not verbally communicated to the ED or Medical team

At 16:00hrs the patient began to complain of neck pain. The Medical team was informed.

The patient was seen soon after at 16:24hrs by the Medical Registrar. Despite having been mobilising independently earlier, the patient was now complaining of severe neck pain and was unable to move or feel their lower limbs. The case was rediscussed with the ED team and the imaging reports reviewed. At this point the addendum was noted: 'query chronic subluxation in c-spine and advised to correlate with clinical findings and consider MRI'

Given the new symptoms and radiology addendum an urgent MRI was booked at 17:35hrs. [redacted] was strictly immobilised with a hard collar, blocks and tape. MRI was performed at 18:24hrs.

MRI images were reviewed by the ED team and possible C4/5 Injury was noted. [redacted] was holding both arms in fixed flexion with 0/5 power both lower limbs bilaterally and sensory level at T10.

The MRI was reported by the Radiology Consultant at 20:38hrs:

No acute fractures demonstrated. Features of prominent interspinous ligamentous tearing and prominent anterior longitudinal ligament tearing at C4-5. Features suggestive of traumatic C4-5 spondylolisthesis with an associated small epidural haematoma with maximum depth of 3 mm. The spondylolisthesis and haematoma cause moderate to severe canal stenosis. There is myelopathy at C4 and C5 levels, which may be traumatic or compressive in nature. Prompt neurosurgical review could be considered. Background moderate cervical spine osteoarthritis

An emergency referral to neurosurgeons at Royal London Hospital (RLH) was made at 19:47hrs and ED radiographers sent images via IEP. There was a delay in images being received by RLH and reviewed by neurosurgeons.

LAS transport booked and patient departed for RLH at 21:20hrs
[redacted] was transferred to RLH for surgery on [redacted]. [redacted] underwent a C4-5 anterior cervical discectomy and fusion, C3-5 posterior decompression and C4/5 posterior fixation. After [redacted] surgery [redacted] was re-patriated back to the Whittington Hospital ITU on [redacted] Although awake required ventilation through a tracheostomy. [redacted] remained in ITU awaiting a rehab bed at Stanmore.

During [redacted] stay on ITU [redacted] struggled with pain and difficulty sleeping although these improved during [redacted] stay and [redacted] was reviewed regularly by the pain team. [redacted] was able to communicate however remained partially dependent on the ventilator via his tracheostomy. Prior to [redacted] transfer for rehab, [redacted] expressed ongoing frustration with pain management but also concerns re [redacted] living arrangements after rehab. A duty of candour conversation was started re [redacted] experience in ED, and [redacted] explained that [redacted] had wished to self-discharge due to long waits. It was also explained to [redacted] that due to the severity of this outcome a full investigation would be carried out by the trust

[redacted] was transferred to rehab on [redacted]
Update on [redacted] [redacted] is in a care home called [redacted] [redacted] is quadriplegic and bedbound with a tracheostomy, urinary catheter and is peg fed. [redacted] is

Glasgow Coma Scale 15 and able to communicate. (GCS, is a tool that healthcare providers use to measure decreases in consciousness, range from 0-15)

Investigation approach

Investigation team

Role	Initials	Job title	Dept/directorate and organisation
Investigation commissioner/convenor:	Whittington Health		
Investigation lead:	[redacted]	ED Consultant	EIM

Summary of investigation process

This incident happened on the Trust premises, just outside the Emergency Department. An incident report was raised on the trust Datix system which, due to the serious nature, ensured an alert was raised with the trusts senior leaders. This resulted in a Rapid Action Review (RAR) being written to gather information and an initial investigation into the incident. This report was then presented to the senior leadership team and trusts patient safety leads via the Whittington Investigation Safety Huddle (WISH) panel. This panel was led by [redacted] and panel members of the executive team including the chief nurse and medical director. At this panel a decision was made to investigate this incident further and that a deeper more thorough and detailed report was required due to the seriousness of the patients' outcomes resulting in the requirement for this PSII report.

On completion of this report, a copy will be sent to members of staff involved and the patient's family for accuracy checking. The WISH panel members will then review the report and sign it off. Actions will be monitored by Emergency and Integrated Medicine Division Quality Committee.

The Learning Response Leads gathered information by carrying out a multi-disciplinary team review workshops and individual discussions with some of the staff involved.

Terms or reference

Incident/incident reference	2024.7379/ A116750
Date agreed/version no.	[redacted]
Date investigation is to be completed by	Reported on StEIS on [redacted]
Learning response lead	[redacted] ED Consultant &Patient Safety Lead
Staff engaged in the development of ToRs (names/roles)	[redacted]- EIM Patient Safety Lead [redacted]- EIM Risk manager [redacted]- EIM AdoN

Patient/family/carers engaged in the development of ToRs (names/relationship)	**Name**	**Relationship**
	The incident was discussed with the patient in person whilst the patient was in the hospital. The patient did not have any questions at the time. It was discussed if we had any questions in the future, [redacted] would be able to contact us again. This was followed up with a DoC letter. The patient has since moved to rehab accommodation.	

ToR	Explore patients' clinical presentation to the Emergency department
Key questions	1. What clinical pathways are used in ED for patients presenting with seizures and are there any barriers and facilitators that impact on the care they patient received on this pathway? a. Was there evidence of serious injury prior to [redacted] leaving ED/should [redacted] have been trauma called/should imaging have been done? b. Were guidelines for the management of suspected spinal injury followed and what might the barriers to this have been? (ongoing neck pain post normal CT ??needed MRI but challenging patient who was keen to go home). 2. What pathways are there in ED to assess capacity in ED and are there any barriers and facilitators that impact on the care they patient received on this pathway? a. Did the patient have capacity to discharge [redacted] against medical advice on his initial attendance? (full capacity assessment done/documented/escalated) b. What legal frame work is available in cases like this 3. Once the patient had collapsed outside ED was the trauma managed effectively? Was everything done that could have been done?

	4. What pathways are there in place in ED when a decision has been made to refer to imaging a. Was the significant late addendum to the CT report communicated by radiology to the ED team? Is there a robust system in place for this? b. Delay in MRI scan which showed significant ligamentous injury. Might this delay have been avoided at any point? Could/Should the patient have had an earlier MRI c. Was the correct imaging according to the NICE guideline requested in a timely fashion at all points in the management of this patient? d. Was the CT scan reported correctly by a radiologist with appropriate competencies or supervision? e. Did the EM doctor treating the patient respond to the report findings in line with NICE guidance? 5. How did the internal environment, technology & tools, organisation of work (i.e. staffing, resource allocation culture etc person (i.e. leadership teamwork roles and responsibilities) tasks and external influences impact on clinical decision making
Healthcare settings	• Emergency Department • Emergency Medicine • Internal: policies/guidelines within Whittington health
Healthcare processes	• Clinical Pathway for adults presenting to the Whittington ED with seizures • Referral process to the Whittington Imaging team • Triage process in ED • Discharge planning ED related to self-discharge against medical advice • Adult major trauma guidelines • Indications for CT head/CT c spine • Indications for cervical spinal immobilisation • Capacity assessment in ED • Requirements for 1 to 1 nurse

Information gathering

A Multi-Disciplinary Meeting was completed on [redacted] using a System Engineering Initiative for Patient Safety (SEIPS) model to understand the different elements involved in this incident. The meeting included ED nursing and medical staffing and radiology staffing.

The multi-disciplinary team (MDT) approach, includes an analysis of what happened vs what was expected, to identify the differences between expectation and event and to identify appropriate learning for the department.

Where ED staff were unable to attend the MDT reflective discussions were organised to allow their perspectives and voices to be heard in this report. These discussions were carried out by the main investigator in order to offer a subjective view and to allow staff to express their opinions openly and honestly.

A timeline was created from the electronic patient record CareFlow and which has been thoroughly reviewed in the process of this investigation.

Guidelines and policies have been reviewed in terms of processes around seizure related clinical conditions, trauma calls, imaging, capacity assessment and guidelines around assessing patients who wish to self-discharge against medical advice have been reviewed.

Nursing and medical staffing rosters have been reviewed to review staffing levels and skill mix along with reports on the situation on capacity in the ED at the time of the incident.

Findings

The purpose of this section is to share our findings. PSIRF learning responses focus on the broader work system in which patients' safety incidents occur. The investigation used a multi-disciplinary review. This has enabled us to review and understand how the technology and tools, organisation, person, internal environment, task and external influences impact on patient care.

The themes discussed below are based on questions posed in Terms of Reference

1. Management of the patient post seizure

This patient's seizure had resolved by the time [redacted] had arrived in ED. [redacted] was assessed in a timely manner and was managed as per the Whittington Seizure Pathway[4]. A clear history was taken, a cause was determined, blood tests were taken.

2. Capacity and safe discharge

The patient wanted to discharge [redacted] and was deemed to have capacity by the senior ED doctor and nurse. The capacity assessment was fully documented in the notes. In terms of safe discharge from ED post fit [redacted] met the criteria as per fit guideline in addition [redacted] did not on presentation have any evidence of any serious traumatic injury that might have warranted further investigations.

[44] Whittington Seizure Pathway; https://whittnet.whittington.nhs.uk/document.ashx?id=18012

3. Management of trauma after patient self-discharged

After the patient collapsed a full trauma call was put out and the trauma team were in attendance. There is no documentation of neurological examination following the seizure except GCS 15/15; Bilateral pupils-4+ equally reacting. [redacted] neck (c spine) was immobilised, and [redacted] was safely managed as per ATLS guidelines[5]. This included full investigation and management of suspected traumatic injuries including spinal injury. CT head and CT neck performed.

4. Initial radiology report

The initial reports (verbal and electronic) were normal. All subsequent actions were based on the normal CT report.

The ED doctor went back to the patient who was fully moving their neck and had no abnormal neurology, however this is not documented. As the patient had had a further fit, they were referred to the medical team as they were no longer a safe discharge as per the trust seizure guideline.

The doctor documented their findings and finished their shift.

The CT scan was subsequently reviewed in the Radiology Events and Learning Meeting (REALM) with the outcome:

Patient [redacted] has been discussed in the REALM meeting on [redacted]
The CT of the spine was reviewed and the present Radiologists at the meeting agreed with the report. No discrepancy was identified. There was no indication of an acute bony injury. There was some spondylolistheses most likely attributed to degenerative changes. The CT suggested MRI if clinically appropriate.

It has been highlighted in the meeting that ligamentous injuries cannot be identified on the CT and they would require MRI. There was broad agreement with the diagnosis made in the amended report and the suggested management (to seek MRI if neurological signs present)

Learning was taken that, in describing the widened interspinous , the phrase "almost certainly" could have been replaced with "likely" given the context of recent trauma. There was an assumption that the findings were chronic despite the context of trauma and as well as suggesting an MRI if neurological findings, an MRI should have been suggested if there was clinical suspicion or ongoing concerns[6] "MRI is indicated if there is any neurology referable from the cervical spine, or if there is severe pain, despite a normal CT scan as some unstable ligamentous injuries may only be seen on MRI."

The body of radiologists were keen to stress that the cervical spine cannot be cleared based on radiological findings alone. Cases of spinal cord injury without radiographic abnormality (SCIWORA) were highlighted to illustrate this point.

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[5] ATLS guidelines; https://www.resus.org.uk/library/2021-resuscitation-guidelines/adult-advanced-life-support-guidelines

[6] https://www.rcemlearning.co.uk/modules/cervical-spine-injury/lessons/investigation-2/

5. Addendum added to initial report

While the patient was waiting to be seen by the medical team an electronic addendum was added to the original report by the radiologist and the patient developed new neurological symptoms. There was no verbal handover to the ED or medical team regarding the addendum.

These new symptoms and the amended radiology report were noted by the medical team, the patient was re-immobilised, and an MRI was requested.

6. Care post MRI

Post MRI patient had appropriate ongoing care.

This was a complex and challenging case for all the issues outlined above. If the patient had agreed to stay in hospital on initial attendance, they might not have sustained further trauma.

If the CT addendum had been verbally handed over to the ED and Medical teams the patient might have been reassessed earlier, had spinal immobilisation and their MRI earlier. It seems to be that the change in neurology and the change in the report might have happened within a very close time frame.

7. How did the internal environment, technology & tools, organisation of work (i.e. staffing, resource allocation culture etc person (i.e. leadership teamwork roles and responsibilities) tasks and external influences impact on clinical decision making?

The environment, technology and tools did not directly impact clinical decision making. In terms of deciding to 'clear' [redacted] cervical spine this was based on the best information that the treating doctor had coupled with clinical findings i.e. the patient had no neurological symptoms and was moving their neck.

Unfortunately, the change in information (addendum to report) was not communicated with either the medical or ED team prior to the patient developing new symptoms. Had this information been conveyed verbally the patient might have remained immobilised and had an MRI prior to developing symptoms.

In addition, both the change in symptoms and addendum happened during the handover time between the ED and medical teams. The handover was safe and thorough and did not impact clinical decision making or compromise care of the patient.

Summary of findings, areas for improvement and safety actions

Initial documentation in the Emergency Department was poor, there is no documented neurological examination or assessment of pain, tenderness and movement in the cervical spine after the CT report.

[redacted] was reviewed by the medical team and found to have neck pain and new neurology. [redacted] was immobilised as a precaution. It was at this time that the radiology addendum was noted on the system and consequently an urgent MRI arranged.

- There is currently no safety net mechanism where the ED are directly informed of significant radiology addenda. The current system is electronic and reliant on the clinicians going back to re-check the initial report for any change. This only happens in certain circumstances e.g. if informed verbally by radiology, if there is a clinical change or when the patient has been taken over by another team. The addendum was added six minutes after the first report. It is possible that, had the ED team had been verbally informed of the amended report, [redacted] might not have had [redacted] spinal immobilisation removed. It is also possible that an MRI might have been arranged prior to [redacted] developing neurological symptoms.

Safety Action:

- Review communication between ED and radiology in terms of significant addenda to reporting[7]
- Neurological assessment to be completed and documented prior to removing neck collar.
- Check if an addendum is available when an image is requested prior to discharge form ED.
- Presentation this case to Trauma Group.

[7] Add a link to the SOP regarding communication between Imaging and ED.

Safety action summary table

	Safety action description *(SMART)*	Safety action owner *(role, team directorate)*	Target date for implementation	Date Implemented	Tool/measure	Measurement frequency *(eg daily, monthly)*	Responsibility for monitoring/ oversight *(eg specific group/ individual, etc)*	Planned review date *(eg annually)*
1.	Meet with radiology team to discuss notification of addenda.	[redacted] ED Consultant Patient Safety Lead ED	01.12.2025		Meeting with ED and Imaging Clinical Leads	N/A	N/A	Change of process to be updated in the SOP, then part of SOP review process.
2.	Education: Review patient neurology prior to removing c spine collar	[redacted] PDN Trauma [redacted] ED Consultant Trauma Lead	01.12.2025		Through 10:10	Part of the 10:10 programme	ED Patient Safety meeting	N/A
3.	Education: Final review of radiology report prior to patient being discharged	[redacted] ED Consultant Patient Safety Lead ED	01.12.2025		Through 10:10	Part of the 10:10 programme	ED Patient Safety meeting	N/A
4.	**Radiology review the guidance regarding:**	[redacted] Clinical Lead Imaging	01.12.2025		tbc	tbc	tbc	Change of process to be updated in the SOP, then part

	Safety action description *(SMART)*	Safety action owner *(role, team directorate)*	Target date for implementation	Date Implemented	Tool/measure	Measurement frequency *(eg daily, monthly)*	Responsibility for monitoring/ oversight *(eg specific group/ individual, etc)*	Planned review date *(eg annually)*
	"MRI is indicated if there is any neurology referable from the cervical spine, or if there is severe pain, despite a normal CT scan as some unstable ligamentous injuries may only be seen on MRI."							of SOP review process.

Appendices

1. Adult major trauma guidelines
   Adult advanced life support Guidelines | Resuscitation Council UK

2. Indications for CT head/CT c spine
   Overview | Head injury: assessment and early management | Guidance | NICE

Patient Safety Incident Investigation (PSII) Report

Preterm neonatal death at 33 weeks and 4 days after premature rupture of the membranes

Incident ID Number	A118499 / 2024.10305	
Date Incident Occurred	[redacted]	
Report Approved Date	[redacted]	
Approved By	Whittington Improvement and Safety Huddle (WISH)	[redacted]
	Quality Assurance Committee	

About Patient Safety Incident Investigations

Patient safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers and staff.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Duty of Candour and the Engaging and involving patients, families and staff after a patient safety guidance in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the Just Culture guide in the minority of cases when staff may be referred to them.

PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

Notes of Acknowledgment

A message to [redacted] and [redacted]

The Whittington Health Maternity and Neonatal Departments wish to give you our deepest condolences for your loss. We are conscious that you have endured the distress of the death of your baby [redacted] described in this report and experienced loss of trust in the care provided to you. The investigation team members know that we could never understand what you have been through. We would like to convey our sincere apologies for any distress this report might cause. We have sought to understand what happened at the time of the incident, so that the services involved can learn for the future. We have sought to carry out and present the findings of an open and transparent systems-based investigation. In reporting the findings of our investigation, the investigation team has had to remain detached and analytical. As a result, the language we have used in the report may appear cold and technical. Despite our necessary detachment, we have not lost sight of your suffering. You have been at the forefront of our minds as the investigation has progressed. Where learning and safety actions have been identified, a plan to address these as a matter of priority is the responsibility of the Maternity and Neonatal Departments.

Thank you to [redacted], [redacted] mother, who shared her questions with the Coroner's Team, which built the basis of this investigation.

A message to staff

Thank you to all the staff who engaged with the investigation and for their openness and willingness to support improvements in service delivery and safety. Our role as learning response leads is to gather insight into the healthcare settings and systems in which we work. This report does not wish to judge or criticise; we are here to facilitate learning in a caring and supportive way.

A message to external reviewers

Thank you very much to our dedicated external reviewers for sharing their expertise, experience and objective judgement for this case.

Executive Summary

This review, PSIRF-aligned Patient Safety Incident Investigation (PSII) was undertaken following the death of baby [redacted], a preterm baby [redacted] born by emergency caesarean section at 33 weeks and 4 days gestation. [redacted] mother had a complex antenatal journey marked by multiple risk factors, including a history of previous preterm births and recurrent non-engagement with antenatal care offers.

Throughout this investigation, the care planning followed national guidance and was found to be personalised and patient-centred during the antenatal period to balance clinical safety with respect for the mother's autonomy and informed decisions. We acknowledge and accept that[redacted] mother's view might be different. Patient-centred and personalised care examples included opportunistic booking for antenatal care, arranging for an elective cerclage on the weekend to adjust to the mother's childcare needs, streamlining her appointments in time and place, as well as an agreement to 'day leave' while admitted for inpatient care.

The purpose of antenatal care is to monitor the health of the mother and baby, identify and manage potential complications aiming to reduce pregnancy related risks and poor outcomes. In this case the baby, sadly, died from sepsis secondary to chorioamnionitis.

This review has identified several learning points, including the need for a formalised inpatient 'day leave' policy, improved microbiology handover, and standardisation of cardiotocography (CTG) interpretation. These are areas for learning, and on review did not contribute to the death of the baby.

Following the death of the baby, the care relationship between the mother, her family, and the Maternity Team became strained. The staff felt conflicted, they aimed to best support a grieving mother and family, but they also experienced incivility. On many occasions these episodes were not reported on Datix in a timely way or escalated via the correct route when staff felt threatened.

Incident Overview

The mother was a [redacted] woman from a [redacted] background, in her [redacted] pregnancy, with no language barrier. Her medical history included asthma, pregnancy-induced hypertension, and a high-risk obstetric background. She booked late for antenatal care at 19 weeks and 2 days gestation, the mother explained that childcare issues were the reason for her booking the pregnancy late. She had a history of recurrent premature labour and births, including a [redacted] born at 32 weeks in [redacted] and a [redacted] born at 24 weeks in [redacted], the latter requiring a 20-month hospital stay due to complex health needs arising from [redacted] prematurity.

She had one previous caesarean section and five vaginal births after caesarean (VBAC). A Group B Streptococcus (GBS) infection occurred during a pregnancy in [redacted]. A cervical cerclage was inserted for her pregnancy in [redacted], based on previous history to prevent preterm birth.

During this pregnancy, there were 9 missed care opportunities from non-attendance (Did Not Attend, DNA) at antenatal appointments. A high-chance result for Trisomy 21 (1 in 7) was identified through quadruple test screening; no further testing was pursued following counselling according to the mother's wishes.

The mother reported distress and anxiety at times in this pregnancy and support from the Perinatal Mental Health Team was offered. The mother's capacity was assessed and confirmed. Childcare challenges impacted on the mother's antenatal care journey, but no social support options were explored jointly.

The pregnancy was complicated by preterm premature rupture of membranes (PPROM). The mother was admitted for conservative management at 32 weeks and 4 days in line with national and local guidance. During admission, the mother exercised her right to make informed decisions regarding elements of her care, including declining corticosteroids administration and leaving the hospital for 'day leave'.

When the mother experienced contractions at 33 weeks and 4 days gestation she was transferred to Labour Ward. Changes in the baby's heartbeat pattern with deceleration on the CTG were noted and infection from chorioamnionitis was suspected. When chorioamnionitis was suspected the decision to expedite birth by Emergency Caesarean Section (EMCS) was made.

The baby was born in poor condition and required immediate resuscitation by the Neonatal Team before admission to the Neonatal Unit for ongoing care. Intensive care management included antibiotics, intravenous fluids, mechanical ventilation, blood pressure support and blood transfusion.

Advice was sought from [redacted] Hospital, the local Neonatal Tertiary Care Unit, and the [redacted] Transport service and arrangements made for transfer. Despite initial stabilisation, the baby's condition deteriorated and at the age of almost 11 hours, despite intensive efforts, [redacted] sadly passed away.

Postmortem examination concluded, on the balance of probability the cause of death was due to "an ascending intra-uterine infection, resulting in hypoxic-ischaemic encephalopathy which led to multi-organ failure. The severity of the infection was likely to have evoked a severe systemic inflammatory response which hindered normal tissue perfusion, leading to widespread hypoxia which, when sustained, led to catastrophic, irreversible injury to the brain and other organs."

This means, that the postmortem examination had found the baby had died because of an infection that spread into the womb. This infection affected the blood flow and oxygen supply to the baby's body, leading to multiple organs to stop working.

The case triggered a PSII due to the unexpected neonatal death and the complex care dynamics involved.

Summary of Key Findings

1. The care provided during the antenatal period was mostly aligned with national and local guidance, with evidence of personalised and patient-centred care, and efforts to adapt to maternal individual.
2. The key areas for service improvement were to improve follow-up on raised Carbon Monoxide (CO) levels, improve adherence to guidance on recurrent DNAs and building a framework for inpatient 'day leave'. These are areas of learning but did not contribute to the death of the baby.
3. Missed care opportunities by the mother impacted on the timing of care provision.
4. Decision-making around preterm birth prevention, preterm premature rupture of membranes, cerclage, antenatal surveillance, diagnosis of chorioamnionitis, and emergency birth were clinically appropriate with no avoidable delay in birth.
5. This case showed good examples of consultant presence and involvement in care planning and decision making.
6. Prior to birth it was recognised that the expected newborn could have difficulties and the Neonatal Team were present at the delivery. The baby's resuscitation and management by the Neonatal Team have been externally reviewed and are in keeping with national standards.
7. The baby's ability to respond to [redacted] illness was compromised by [redacted] prematurity and the extent of [redacted] illness.
8. Bereavement and postnatal care were delivered according to guidance and with best interest but challenged by environmental limitations and complex care needs of the mother.

Summary of Areas for Improvement and Safety Actions

The Areas for Improvement identified following this review have been categorised in two ways:

- Safety Action – an action to be completed where the investigation and evidence has identified potential safety issues that need to be addressed.
- Learning and Safety Prompt – a prompt to help to improve safety at a local level which the investigation and evidence highlighted as a learning opportunity.

1. **Elevated maternal Carbon monoxide (CO) levels** were identified in the mother. The mother stated she was a non-smoker, but her partner was a smoker. Follow-up checks of CO levels, safety advice, and partner referral for smoking cessation were not documented or actioned, contrary to guidance. When this mother booked for antenatal care no definite support structures were in place. Mothers booked from [redacted] with high CO levels are offered care along a clear pathway. This pathway is in line with 'Saving Babies Lives Care Bundle Version 3', for maternity services. There is a dedicated, inhouse smoking cessation service. This includes following up service users with high CO readings and checking levels at each appointment.

   Learning and Safety Prompt: Continue mandatory staff training on the risk of carbon monoxide (CO) exposure during pregnancy. In addition to training, this will include providing the appropriate advice and referring patients via support service pathways.

2. **Inconsistent engagement with care offers and recurrent non-attendance** (DNAs) has an impact on timing of care provision and needs to be further explored. Recurrent non-attendance should trigger concern about the wellbeing of the mother, and further exploration of reasons if wished by the mother. Recurrent DNAs should trigger assurance of capacity and liaison with other professionals involved in the family (GP/Health Visitors/Mental Health Teams & Social Care where appropriate) while respecting the mother's autonomy. We will highlight awareness among staff and remind of the existing recurrent DNA guideline, ensuring tactful exploration of reasons for DNAs, assessment of social or safeguarding concerns or barriers, and consideration of wider information-sharing with all community care providers. A discussion about possible supportive structures on offer should be considered. Flexibility in care delivery to accommodate personal maternal circumstances, within national and local guidance, should be offered.

   Learning and Safety Prompt: All staff involved in patient care must adhere to the Did Not Attend (DNA) guideline, ensuring that:

   - Every non-attendance is followed up with a tactful exploration of the reason.
   - Any potential, social, safeguarding or access-related barriers are assessed and documented.

- Appropriate information sharing is considered where necessary with the relevant community care providers.

The DNA guideline to be incorporated into mandatory study days to ensure understanding of the guideline.

3. **Informing and supporting decision making.** Handing out the Royal College of Obstetricians and Gynaecologists (RCOG) patient information leaflet 'Preterm Prelabour Rupture of Membranes >24 weeks' should be documented.

   Learning and Safety Prompt: Reinforce staff compliance in providing relevant clinical information leaflets during appropriate clinical encounters and ensuring that this is clearly documented in the patient's clinical record. Where possible, information should be given via text message or email as well.

4. **Building a structured framework for 'day leave'.** The absence of a structured framework for 'day leave' meant for both, the mother and the healthcare professionals that time boundaries and expectations of 'day leave' were not clear. This mother's journey highlighted the need for a formalised Standard Operating Procedure (SOP) on inpatient 'day leave' in Maternity.

   Safety Action: Develop and implement Standard Operating Procedure (SOP) on inpatient 'day leave' in maternity services, which will set clear expectations for staff and patients, support safer decision-making and strengthen governance assurance.

5. **Remind Maternity staff of existing communication pathways with Microbiology.** Communication with Microbiology Department experienced some delay as the Obstetric Resident Doctor (SHO) was not able to get through to the Resident Doctor in Microbiology promptly. The escalation process via switchboard was not followed immediately.

Learning and Safety Prompt: Disseminate the communication pathway for contacting the Microbiology Department when seeking advice on urgent results within the Maternity Department. This includes the out-of-hours and escalation processes.

6. **Remind Maternity staff to ensure samples are sent with the appropriate request form,** so tests can be processed accordingly. Upon admission on [redacted], a urine sample was taken but no corresponding request form for testing was made on the ICE system, which meant the sample was not processed.

   Learning and Safety Prompt: Remind staff to ensure all appropriate requests are entered on the ICE system prior to sending samples to the laboratory for testing.

7. **Seniority guidance with antenatal cardiotocography (CTG) interpretation.** RCOG intrapartum care standards and CTG interpretation guidance recommend that CTG interpretation and management decisions for complex or high-risk cases should be performed by Registrar level doctors or above. This is highlighted at Maternity in-house study days and at induction of Resident Doctors. Here, on one occasion, a CTG was reviewed by a Resident Doctor (SHO). On review, the Resident Doctor (SHO) discussed the CTG with a Resident Doctor (Registrar) who agreed with the original interpretation, but it was not formally reviewed at the time.

   Learning and Safety Prompt: Antenatal CTG Guideline must be reviewed and updated to fully align with RCOG standards to formalise that an Obstetric Doctor of at least Registrar level must complete the interpretation of an antenatal CTG.

8. **Consideration for additional antibiotics for neonate in addition to standard first line treatment.** This case showed the baby's resuscitation and management in keeping with national standards.

Learning and Safety Prompt: Staff to consider prescribing additional antibiotics in the context of suspected severe neonatal infection in addition to standard first line treatment.

These actions above are areas for learning, and on review did not contribute to the death of the baby.

Contents

Background and Context

This investigation explores the circumstances of the early birth, neonatal care and sad death of baby [redacted] and reviews the care provided. Baby [redacted] was born early (preterm), at 33 weeks and 4 days gestation, following preterm premature rupture of membranes (PPROM) at 32 weeks and 4 days gestation.

PPROM happens when the waters around the baby break before 37 weeks of pregnancy and before labour starts. It affects about 3 in every 100 pregnancies (RCOG Green Top Guideline No. 73). It is recognised that PPROM can complicate pregnancies and can affect both mothers and babies. PPROM can cause preterm labour, placental abruption and infection of mother and baby, including chorioamnionitis and sepsis. With PPROM the umbilical cord can slip into the vagina (cord prolapse). PPROM is associated with a higher risk of stillbirth and neonatal death.

National guidance (NICE Guideline NG25 *Preterm Labour and Birth*; RCOG Green-top Guideline No. 73 *Care of Women Presenting with Suspected Preterm Prelabour Rupture of Membranes*) recommends that women whose pregnancy is complicated by PPROM, who have no contraindications to continuing pregnancy should be offered expectant management until 37 weeks gestation, as this is associated with better outcomes compared with early birth. Women with a history of GBS colonisation, infection or a previously affected baby with early onset GBS sepsis should be individually assessed and an induction of labour at 34 weeks gestation should be considered. The timing of birth should be discussed with each woman on an individual basis.

Women with PPROM should be admitted to hospital for initial management of PPROM. While in hospital, care usually includes:

- Daily fetal heart rate monitoring using cardiotocography (CTG),
- Regular maternal observations (temperature, pulse, blood pressure, respiratory rate),
- Blood tests (Full Blood Count and C-reactive protein (CRP)),
- Administration of antibiotics to help reduce the risk of infection,
- Consideration of antenatal corticosteroids to help prepare the baby's lungs for breathing,

- Administration of magnesium sulphate to protect the baby's brain if birth is likely before 30 weeks gestation,
- Planning the birth of the baby, at 37- or 34-weeks gestation (as explained above) unless there are earlier concerns.

NHS England's Saving Babies' Lives Care Bundle (Version 3) and the National Preterm Optimisation Framework emphasise the importance of early identification of women at risk of preterm birth, timely interventions to prolong pregnancy, and optimising outcomes if early birth cannot be prevented.

Prevention strategies include cervical length surveillance, vaginal progesterone, and cerclage placement where indicated.

Optimisation strategies in the event of imminent preterm birth include administration of antenatal corticosteroids for fetal lung maturity, magnesium sulphate for neuroprotection, in-utero transfer to an appropriate level Neonatal Intensive Care Unit where appropriate, and delayed cord clamping at birth.

Whittington Health Maternity Department have a guideline titled *Preterm Prelabour Rupture of Membranes* which reflects national guidance, setting out the recommended management pathway for women with PPROM, including surveillance, infection prevention, preterm birth prevention interventions, and criteria for birth.

On [redacted], at 33 weeks and 4 days gestation, the mother reported contractions and subsequently developed an abnormal CTG. She was transferred to Labour Ward, where an urgent Consultant Obstetrician review led to a decision for emergency caesarean section. The caesarean section was escalated from Category 2 to Category 1 at theatre sign-in due to evolving fetal heart rate abnormalities. The baby was delivered within the RCOG decision-to-delivery timeframe of 30 minutes. However, the baby was born in poor condition.

Premature infants are more vulnerable because their organ systems are incompletely developed. Although safe in the womb, once their protective barriers are breached, they

are at risk of significant illness as the ability of their immature organs to adapt successfully to the external environment is limited and might be compromised.

Colonisation of the genital tract by certain bacteria can cause rupture of the amniotic membranes and gain entry to the fetus via the lungs, from where infection spreads into the body. Infection can become widespread affecting multiple organs.

Lung function is compromised by persisting pulmonary vascular resistance causing poor gas exchange (Persistent Pulmonary Hypertension of the Newborn - PPHN) and premature lungs may have insufficient surfactant to keep the air spaces open.

Poor cardiac function results in decreased tissue organ perfusion including the heart itself, the brain, kidneys and muscles and results in lactic acidosis.

Overwhelming infection may also hinder the immune response and cause depletion or absence of white blood cells (in this case neutropenia). The infection coupled with prematurity prevented the baby's ability to make a successful cardiovascular and respiratory transition to infant life and [redacted] immune system was unable to respond effectively.

The baby received the necessary and well described management for respiratory support which was adjusted according for [redacted] condition. [redacted] was treated for infection; low blood pressure and management advice was sought from the local Neonatal Tertiary Care Unit with plans for transfer of [redacted] care.

Placental histology confirmed chorioamnionitis, and the cause of death according to the postmortem was neonatal sepsis.

Description of the Patient Safety Incident

The incident involves the death of a baby born at 33 weeks and 4 days gestation by emergency caesarean section on [redacted]. The mother had presented one week earlier on [redacted] with PPROM and was admitted for inpatient care. Conservative management of the pregnancy with hospital admission, increased fetal and

maternal surveillance were offered according to national guidance. The intended care plan as per guidance included: antenatal corticosteroids, magnesium sulphate, antibiotics, twice daily CTG, twice daily maternal observations, alternate days blood tests and an induction of labour at 34 weeks gestation. This was unless any signs and or symptoms of maternal or fetal infection arose which would indicate the need to expedite birth.

Throughout her antenatal admission, the mother expressed a wish to be discharged home. It was explained that if discharged, regular daytime appointments for monitoring of the mother and baby in the Maternity Assessment Unit would be indicated. The mother preferred inpatient care and asked for 'day leave' while an inpatient. On [redacted], planned 'day leave' as an inpatient was agreed to by the clinical team. The mother went on 'day leave' for prolonged periods, lasting from 11 hours to beyond 16 hours. The mother missed care episodes and timely observations.

Three days later, when returning to the antenatal ward, on [redacted], a CTG did not meet Dawes-Redman criteria (DRC). These interpretation criteria are applied for antenatal CTGs only, not when a mother is contracting and not when a mother is in labour. When the DRC are not met, further review is indicated. The mother was transferred to Labour Ward and reviewed by the on-call Obstetric Team. The review was found to be reassuring, and the mother was transferred back to the Antenatal Ward.

The next day, [redacted], the mother complained of contractions and rectal pressure, these occurred at the same time as CTG changes, and the mother was promptly transferred from the Antenatal Ward to the Labour Ward for review by the on-call Obstetric Team.

Initially, the team expected rapid establishment of preterm birth, however despite contractions, labour was not established.

CTG changes were identified that were suggestive of chorioamnionitis and a consultant led decision to expedite the birth was made.

Following birth, the baby required immediate resuscitation and died shortly afterward from sepsis secondary to chorioamnionitis. There were no overt clinical signs of maternal infection prior to birth.

Investigation Approach

Investigation Team

Role	Initials	Job Title	Department/Directorate and Organisation
Investigation Commissioner / Convenor	WISH	Whittington Improvement and Safety Huddle	Quality Governance, Whittington Health NHS Trust
Investigation Lead(s)	[redacted]	Consultant in Obstetrics and Fetal Medicine	Maternity Department, ACW, Whittington Health NHS Trust
	[redacted]	Women's Health Clinical Governance Manager	
	[redacted]	Consultant Paediatrician	Neonatal Intensive Care Unit, CYP, Whittington Health NHS Trust
	[redacted]	Senior Neonatal Nurse	
External Reviewer(s)	[redacted]	Group Director of Midwifery	Royal Free London
	[redacted]	Consultant Obstetrician and Chief Obstetrician of London	University College London Hospital
	[redacted]	Neonatal Consultant and Medical Clinical Lead for Risk in Starlight Neonatal Unit	Barnet Hospital

Summary of Investigation Process

Incident Reporting

The incident was reported on the Trust's incident reporting system, Datix (A118499) on [redacted]. The incident was reported to MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) as per national requirements and the plan was for a Rapid Action Review to be completed on the next working day on [redacted].

The clinical records were not made available for review, as the mother wished to keep the maternity paper notes with her in her room. Therefore, the Maternity Team were unable to formally complete a Rapid Action Review. A verbal update outlining the key facts was presented at the Whittington Improvement and Safety Huddle (WISH) on [redacted] by the Maternity Clinical Governance Leads.

At this panel a decision was made to investigate this incident by way of a Patient Safety Incident Investigation (PSII) with the support of external reviewers and a Perinatal Mortality Tool Review (PMRT) to be completed.

The incident was reported on StEIS on [redacted] and assigned reference number 2024.10305.

Learning Response

The investigation was conducted under the PSIRF framework, with a system-based, human factors-informed methodology.

A multidisciplinary investigation panel was convened and included senior representatives from Obstetrics, Neonatology, Midwifery, and Clinical Governance as well as an external Consultant Obstetrician.

Once the PSII is completed, it will be shared with the staff involved for factual accuracy and with [redacted] parents for comment. The final report will be approved by the WISH panel and shared with [redacted] parents and the Trust Board. It will also be shared with the Integrated Care Board (ICB) and the coroner.

Actions identified from the investigation will be monitored through the Acute Patient Access, Clinical Support Services & Women's Health Division and Children and Young People Division, and via Divisional reports to the Trust's Quality Governance Committee.

Family Engagement

In accordance with PSIRF principles, the Maternity Senior Leadership Team made concerted efforts to involve the family in the investigation process, including in the development of the investigation Terms of Reference (ToR). The family was offered two

appointments for a Multidisciplinary Team meeting and a structured opportunity to contribute their account.

These invitations were communicated via both email and formal letter. Follow-up contact attempts were also made via telephone. Unfortunately, despite these efforts, no response was received, and the family did not engage with the investigation.

However, the mother did share her concerns about aspects of her and the baby's care to the Coroner's Team in an email on [redacted]. These were included in ToR to support with the investigation.

The Trust remains open to engaging with the family at any time in the future and is committed to ensuring they can review the investigation findings and share their perspective, should they wish.

Terms of Reference

ToR 1	***Explore patients clinical care from booking to the death of the preterm neonate*** The investigation will review all aspects of care from the pregnancy booking appointment up to the death of the preterm neonate. This will enable the investigation to understand the context and situational factors and how these influenced the care given to the mother and baby. We will aim to ensure the perception of events is captured from the family and the clinical staff involved in the care.
Key Questions	1. Were all relevant risk factors appropriately identified in a timely manner? Were there appropriate management plans in place to monitor and mitigate the risks? 2. Were the risk assessments contextual? Were all available support structures, including safeguarding team, explored to ensure optimal personalised care?

	3. Following attendance on the [redacted] with history of premature pre rupture of membranes (PPROM) was the decision for hospital admission and stay personalised and appropriate? 4. During the hospital admission have the risk factors changed or new risks developed? Was this recognised and acted upon appropriately? 5. During the hospital admission were there any indications to plan for an earlier birth? 6. Were the signs of established labour identified and was the mother's perception considered? 7. Was the timing of the birth appropriate? If not, why not? 8. Following birth, was the care given to the baby timely and appropriate? 9. Was the woman's clinical postnatal bereavement care in line with current guidance? If not, why not?
Healthcare Settings	• Pre-term Birth Prevention Clinic • Antenatal Ward • Maternity Triage • Labour Ward
Healthcare Processes	• Antenatal appointments – Procedure for women who do not attend (DNA) • Antenatal fetal monitoring guideline • Care of Women in Labour Guideline • Counselling women at risk of preterm delivery • Intrapartum fetal monitoring guideline • Maternity Triage (traffic light system) guideline • Perinatal mental health guideline • Pre-term labour and pre-term birth – prevention, diagnosis and Management guideline • Pre-term pre labour rupture of membranes (PPROM) guideline

	• Reduced or altered fetal movements guideline • Sepsis – Obstetric sepsis/ sever sepsis care pathway • Sepsis – pregnancy related sepsis management • Unscheduled attenders and late engagement with maternity care guideline • Women who do not attend (DNA) for scheduled antenatal postnatal appointments guideline • Pregnancy loss management guideline

ToR 2	***Parental Concerns and Questions***
Key Questions	"I would like to mention my serious concerns regarding my hospital notes. On [redacted] at approx 08.30 I caught my midwife amending the notes. I noticed she had the notes open near the front/middle of my book and she was writing on pages and sticking my name label stickers also. I did not see what she was writing however this was very disturbing considering they are legal documents and should not be amended. I would like to think the hospital would not authorise such an act however it is extremely difficult to have the worry of the hospital possibly amended the notes in my absence after witnessing it occurring in my presence. I am concerned that the notes are handwritten and have many continuation pages that have been stuck in with cellotape." Were my risk factors recognised and taken into account during my antenatal care? "My waters had broken [redacted] was 32+5 weeks gestation I have tested positive for GBS in this pregnancy

	I had a previous birth which resulted in baby contracting GBS. The baby had pneumonia 2 previous preterm pregnancies (32 weeks & 24 weeks gestation) My CRP when arriving in hospital was 6 with broken waters I had a cervical suture in place Previous C-Section [redacted] baby 2 previous postpartum haemorrhage" From summary of Coroner's office: "During [redacted] pregnancy your waters broke the week before, however it wasn't planned to remove [redacted] until Sunday. An emergency C-section was done before that, however, as concerns were raised regarding [redacted] condition. You believe that given that your waters had broken, making an infection a danger, [redacted] ought to have been removed before [redacted] actually was." Question: Why was [redacted] not delivered earlier? From summary of Coroner's office: "In addition, you said you were in labour - you know the signs as you have given birth to [redacted] children, however you don't feel medical staff at the hospital took you seriously enough." Question: Why did hospital staff not take me seriously when I said I was in labour? From summary of Coroner's office: "You also believe that your previous medical history wasn't taken into consideration enough when deciding when to elect for the C-section."

	Question: Why was my previous medical history not taken into consideration enough when deciding to elect for the Caesarean Section? "After [redacted] delivery we are not happy with the care I have been receiving, and we are now questioning if the care [redacted] received was carried out with due care?"

Information Gathering

The following methods were utilised in the investigation to gather information and verify findings:

- An After-Action Review (AAR) was completed. The AAR is a Multidisciplinary Team (MDT) approach and includes an analysis of what happened versus what was expected, to identify the differences between expectation and event and to identify appropriate learning for the Maternity Department.
    - The AAR was held on the [redacted] and attended by Obstetric Lead for London (external), WH Consultant Obstetrician and Clinical Governance Lead, WH Head of Midwifery, WH Consultant Gynaecologist and Obstetrician (x3), Labour Ward Coordinator and Bereavement Specialist Midwife, Perinatal Mental Health Specialist Midwife, ACW Clinical Director and Assistant Service Manager for Women's Health.
    - Unfortunately, some of the staff involved were unable to attend the AAR, they were offered the opportunity for a 1:1 conversation at another date, and/or to complete a statement to allow their perspectives and voices to be heard in this report.
- The mother and baby's medical records, on paper and electronically, have been thoroughly reviewed in the process of this investigation including CTG traces, microbiology, blood and specimens' results.
- Relevant policies, national guidance (e.g. RCOG, NICE, BAPM), scientific papers, alongside local guidelines and policies were reviewed, as outlined in ToR, health processes and through this report.

- The postmortem report by the Histopathology Department at Great Ormond Street Hospital (GOSH).
- The investigation considered how factors such as the environment, equipment, tasks, and policies influenced decisions and actions of staff. This methodology adopts the Systems Engineering Initiative for Patient Safety (SEIPS) model (*NHS England, 2022*) to understand how the incident occurred.
    - It is important to highlight that the SEIPS model is dynamic, with interdependent elements in the work system and external factors that often lie beyond the organisation's control.

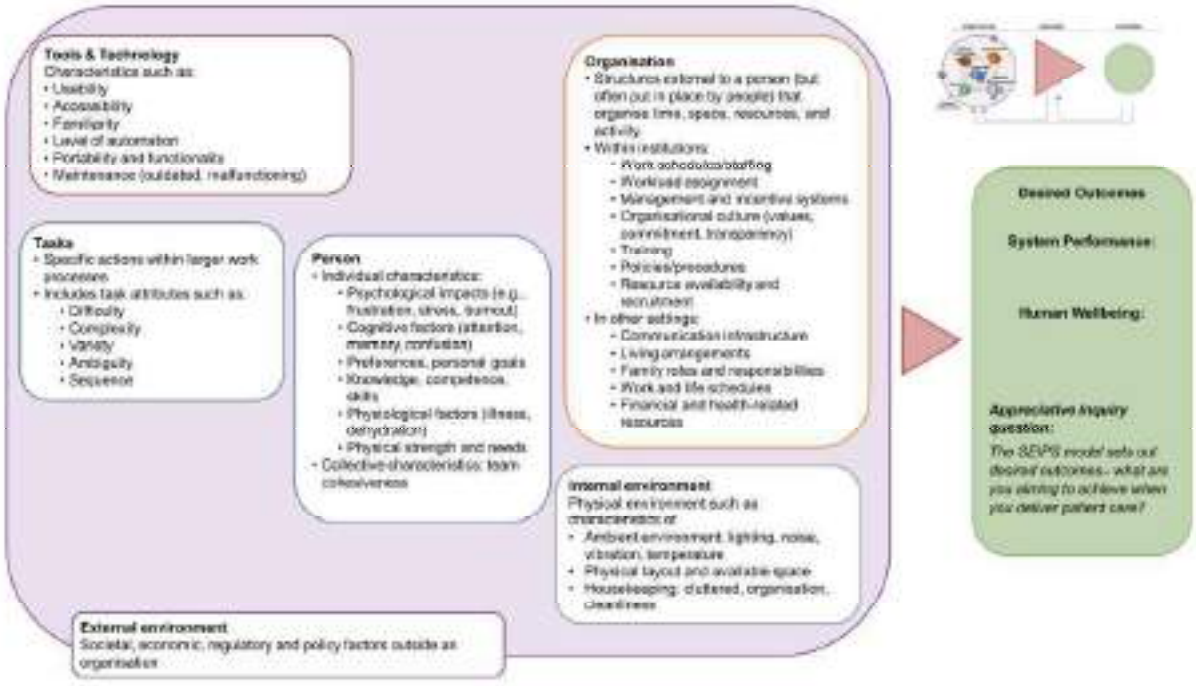

Figure 1 Systems Engineering Initiative for Patient Safety (SEIPS) Model

Investigation Analysis and Findings

In this section of the report, findings from the investigation will be set out from the time the mother referred to maternity services up to the sad death of baby [redacted] The key questions within the lines of enquiry included in the ToR will be addressed along with the questions from [redacted] parents.

Triangulation and thematic analysis of the information that was gathered for this investigation (using the methods listed above) has been completed. The themes identified will be outlined and are discussed below.

1. The Mother's Journey Prior to Booking of the Pregnancy

Date	Event	Gestation
[redacted]	Last Menstrual Period (LMP)	-
[redacted]	Positive pregnancy test at home	Approx. 15 weeks
[redacted]	Ultrasound scan at Women's Diagnostic Unit	15 weeks and 4 days (by scan)
[redacted]	Self-referral to maternity services	15 weeks and 6 days
[redacted]	Opportunistic booking appointment	19 weeks and 2 days
[redacted]	Dating scan and anatomy scan completed	19 weeks and 3 days

Table 1 Key Dates Prior to Booking Appointment

The mother's first contact with maternity services at the Whittington Health Hospital was on [redacted]. She attended the Women's Diagnostic Unit with bleeding from the vagina and a cramping lower abdominal pain. She had found out about the pregnancy two days earlier and had stopped her contraception with the mini pill at that time. Her Last Menstrual Period date (LMP) was [redacted], which made her approximately 15 weeks pregnant by date. An ultrasound scan was offered to assess viability of the pregnancy. The ultrasound confirmed a viable intrauterine singleton pregnancy with a gestational age consistent with dates.

The fetal crown rump length (CRL) was 99mm, estimated as a pregnancy of 15 weeks and 4 days gestation. The CRL allowed calculation of an Estimated Date of Delivery (EDD) by scan of [redacted].

The cervical length was measured in view of the mother's history of preterm birth. The cervical length was normal (30mm), and the cervical canal was closed. Such cervical length scan is not routinely offered to women attending the Women's Diagnostic Unit. As her history of preterm birth was recognised as a risk factor for a shorter cervical length, an early assessment was offered at the time and a transvaginal scan (TVS) completed with consent.

2. Risk Factors Identified and Managed at Booking

A comprehensive risk assessment was carried out at the mother's booking appointment. The mother's previous medical and obstetric history were taken into consideration when planning the antenatal care.

The mother was a [redacted] gravida 6, para 5, with previous preterm births at 24- and 32-weeks' gestation. She self-referred on [redacted] at 15 weeks and 6 days gestation. In line with local guidance, an urgent booking appointment was arranged for [redacted] at 17 weeks gestation, however the mother did not attend. A further three appointments were made on [redacted], [redacted] and [redacted], and the mother did not attend. The booking appointment was completed on [redacted] at 19 weeks and 2 days gestation when the mother attended the Antenatal Clinic unannounced and the Midwife opportunistically completed the booking.

Key risk factors identified at booking included:

- Maternal age above [redacted]
- Late booker.
- The mother found out about her pregnancy at approximately 15 weeks gestation of pregnancy and stopped contraception with the mini pill (Progesterone only pill) at the same time.
- History of premature labour and birth (PTB) in previous pregnancies at 24- and 32-weeks' gestation.

- Cervical cerclage in previous pregnancy.
- History of post-partum haemorrhage (PPH).
- History of previous birth by caesarean section (CS).
- Group B streptococcus (GBS) infection in previous pregnancy.
- Asthma.
- History of gestational hypertension (high blood pressure in pregnancy).
- History of urinary tract infections (UTI).
- Elevated body mass index (BMI of 30).
- High CO level of 7 at booking. Ex-smoker stopped smoking after conception according to the mother. Her partner was a current smoker.

Her antenatal care was complicated by recurrent non-attendance at antenatal appointments (9 DNAs). The mother cited childcare difficulties as a reason for booking late for her antenatal care and difficulties in attending appointments.

Several risk factors were recognised, documented and discussed with the mother at the booking appointment. As explored below, some risk factors were acted upon; some risk factors were identified but not acted upon. The risk factors that were not acted upon did not contribute to the death of the baby, and on review has provided learning opportunities for the Maternity Department.

Referrals from booking appointment

The risk factors identified led to a recommendation of Consultant Obstetrician led care. Referrals to the Preterm Birth Prevention Clinic (PTBPC), for an oral glucose tolerance test (OGTT) and for serial growth scans were completed according to national and local guidance.

High carbon monoxide level (CO) levels identified

The mother's CO at 19 weeks and 2 days gestation was high (CO 7ppm) and above the normal cut off CO level of 4ppm. This observation was noted by the midwife during the booking appointment. The midwife set an alert flag on the mother's Careflow Maternity record. It is the midwife's usual practice to have a discussion about the finding; however, there is no documentation to confirm that such a discussion took place.

Information that could have been shared includes:

- As the mother was an ex-smoker, a high CO reading could be due to a faulty gas appliance or home heating appliance or a faulty car exhaust.
- It could also be due to environmental issues, such as burning incense and shisha use.
- Advice to call the Gas Emergency Line for expert help and to check that all cooking and heating appliances are safely installed; and to purchase a CO alarm.
- Signposting to support services so that her partner's tobacco dependence could be addressed through [redacted] GP.

Serial CO assessments at each antenatal visit were also indicated. The mother had no further CO assessment during the pregnancy.

Inconsistent engagement with maternity services

The mother's antenatal care was complicated by recurrent non-attendance at antenatal appointments (9 DNAs).

She also attended unplanned on three occasions, without an appointment on the day or at a different time than planned. At these occasions she was seen and the Maternity Team demonstrated flexibility and care focused on the mother's needs.

After non-attendance at appointments, the following were provided ad-hoc when the mother presented:

- Attended without appointment at 19 weeks and 2 days gestation and her Midwife completed the booking appointment.
- Attended Fetal Medicine Unit without appointment at 22 weeks and 2 days gestation and an ultrasound scan was done.
- Attended Labour Ward for her booked emergency cerclage, which had been arranged for Sunday at 8:00 hours, the mother attended several hours after the appointment time, but the procedure was still completed that day.

The mother cited childcare difficulties as a reason to not attend her antenatal care appointments. She shared her complex family duties with the team.

The mother was seen in the Preterm Birth Prevention Clinic at 20 weeks and 4 days gestation. The Preterm Birth Prevention Consultant in charge of her care is also the Departmental Lead for Perinatal Mental Health. The mother demonstrated full capacity and declined referral to Perinatal Mental Health. The streamlining of appointments geographically and in timing were offered to the mother.

National and local guidance emphasises that it is important for health care professionals to seek to understand why service users do not attend appointments with maternity services or disengage from services. Health care professionals should seek to obtain information from other professionals involved in the family (GP/Health Visitors/Mental Health Teams and Social Care where appropriate) and review any previous records to inform their assessment. Guidance reminds professionals of the importance of identifying underlying factors that may have led to the altered engagement with maternity services so that the woman's needs can be considered and additional care or support put in place. The clinical team did not explore further options of support.

Clinical documentation demonstrates that the Multidisciplinary Team of Midwives and Doctors worked to tailor her care to address the mother's difficulties of attending appointments due to childcare issues. For example, her cervical cerclage was scheduled out of hours, at the weekend, to accommodate her childcare needs. Multidisciplinary efforts were made to engage with her, provide care opportunistically, and to streamline her appointments in the Fetal Medicine Unit to maintain continuity of care.

Although the mother's engagement with antenatal care appointments was irregular, this had no immediate effect on the baby's death.

3. Risk Factors Identified and Managed During her Pregnancy

The mother's risk factors were revisited regularly throughout the pregnancy. As explored below, some risk factors were acted upon, and some were not acted upon. The risk factors

that were not acted upon did not contribute to the death of the baby, and on review has provided learning opportunities for the Maternity Department.

Quadruple screening test result – High chance of 1:7 for Down's Syndrome (Trisomy 21)

On [redacted], the mother had her dating scan at 19 weeks and 3 days gestation. As she was over 19 weeks, the anomaly scan was also performed at the same visit. The ultrasound did not reveal any obvious fetal structural abnormalities or variations from normal.

As the mother missed the time window for the first trimester, combined screening test (CST), a quadruple test (QT) to assess the chance of the baby being affected by Down's syndrome was offered to the mother. She consented to the screening test. The blood sample was taken for the quadruple test.

At 20 weeks and 1 day gestation, the mother was counselled by a Fetal Medicine Unit Midwife via telephone regarding a high-chance quadruple test result for Trisomy 21, with a calculated chance of 1 in 7. The available options were discussed, such as invasive diagnostic testing by amniocentesis or a more sensitive further screening test, called non-invasive prenatal testing (NIPT), or no further testing. It was agreed that the Fetal Medicine Unit Midwife would call the mother the following day to ascertain her decision.

At 20 weeks and 2 days gestation, the mother attended the Fetal Medicine Unit for an ultrasound scan due to the increased chance of Trisomy 21 based on the quadruple test screening result. She was further counselled by the Fetal Medicine Unit Consultant regarding the high-chance result. The mother declined diagnostic invasive genetic testing by amniocentesis but stated she would consider NIPT.

She was due to attend the Preterm Birth Prevention Clinic (located in the Fetal Medicine Unit) in two days' time for a further cervical length scan. The Fetal Medicine Unit Consultant Obstetrician offered to perform the cervical length scan during this visit to avoid the need for the mother to return for a further appointment in two days, and in view of the mother's higher risk for preterm birth.

However, on further review, her first visit in the Preterm Birth Prevention Clinic with full preterm birth risk assessment was scheduled in two days' time to see the Preterm Birth Prevention Consultant. It was agreed that the cervical length scan could be performed in two days' time at the original Preterm Birth Prevention Clinic appointment as the mother was still considering returning for a possible NIPT. Streamlining the mother's appointments was hence discussed and offered but priority was given to provide full MDT clinical care by the different specialists and was agreed to by the mother.

At 24 weeks and 2 days gestation, the mother decided against both NIPT and invasive testing, explaining that she felt fully committed to the pregnancy regardless of the genetic result. A fetal echocardiogram (ECHO) was offered for additional reassurance in view of the higher chance of Trisomy 21 from the screening test.

At 25 weeks and 3 days gestation, a fetal heart ECHO was completed at [redacted] Hospital ([redacted]), and it did not reveal any abnormalities.

The Fetal Medicine Unit Team offered fetal growth surveillance with serial scans in view of maternal age, higher chance screening test result and complex obstetric history. This was accepted by the mother and arranged according to the local guideline schedule.

Preterm Birth risk recognised, and elective preventative cerclage offered

Date	Planned Appointment	Details
Sunday [redacted]	Elective Cerclage	Booked on a Sunday, to accommodate mother's childcare needs. DNA.
Thursday [redacted]	Preterm Birth Clinic	Cervix short at 23mm. Emergency Cerclage booked for Saturday, to accommodate mother's childcare needs.
Saturday [redacted]	Emergency Cerclage	Mother attended 4 hours later than scheduled, but the procedure was still completed that day.

Table 2 Key Dates for Cervical Cerclage

The mother's increased risk of preterm birth due to her history of previous preterm births was recognised and acted upon. At her first encounter with maternity services at approximately 15 weeks and 4 days gestation, in the Women's Diagnostic Unit for early pregnancy care, her cervical length was measured. The cervix was long and closed (30mm).

A referral to the Preterm Birth Prevention Clinic was done and she was seen by the Preterm Birth Prevention Consultant in the clinic at 20 weeks and 4 days gestation. The cervical length was measured at 31mm.

A full preterm birth risk assessment was done, and a preterm surveillance plan was made:

1. LUTS (Lower Urinary Tract Symptoms clinic) review in view of recurrent UTI and history of prematurity.
2. Testing for UTI in case present now, before cerclage insertion.
3. High vaginal swab (HVS) today.
4. In view of PTB history of births at 24 weeks and 32 weeks the mother was counselled about the option of cervical cerclage. She agreed to insertion of a history indicated cerclage. For cervical cerclage insertion on Sunday, at 0800h. As there is no available childcare until then and the mother has multiple appointments on Monday in [redacted] Hospital.
5. Consent taken. Nil by mouth from midnight.
6. Progesterone 400mg twice daily was recommended in view of history as a preventative measure.

Elective cerclage is associated with more favourable perinatal and neonatal outcome than emergency cerclage. Research shows that, on average, women who had a planned (elective) cerclage during pregnancy stayed pregnant longer than those who had the cerclage in an emergency situation. On average, the elective cerclage group stayed pregnant about 18.6 weeks after the cerclage compared to 12.2 weeks in the emergency cerclage group. This difference is considered statistically significant.

On that basis, and if indicated on history of preterm birth, a cerclage is offered as early as possible in the pregnancy, while the cervical length is long, to allow for a likely more successful procedure.

An emergency cerclage, also called 'rescue cerclage', indicated here when the cervical length had shortened, can surgically be more difficult than an elective cerclage, and is less likely to be successful.

Elective cerclage opportunity missed, emergency cerclage as cervical length shortened

On the morning of the planned elective cervical cerclage on Sunday [redacted] at 21 weeks gestation, the mother called Labour Ward at 8:00 hours during handover. She spoke to the Preterm Birth Prevention Consultant and explained she was anxious about the procedure and busy at home. She said she would come in to discuss the procedure however the mother did not attend the planned appointment for an elective cerclage.

The Labour Ward Team called the mother twice and as there was no answer on the telephone, the Team left a message on voicemail. Numerous attempts were made to contact her to re-arrange the elective cerclage.

The Labour Ward Team were only able to contact the mother on [redacted] at 22 weeks and 4 days gestation. She had no appointment on that day but was offered to be seen at the end of that day's list. A full preterm birth prevention risk assessment was done. The cervical length had now shortened to 23mm. The cut off for a short cervical length is 25mm or below. No overt funnelling (opening) of the cervical canal was seen. The placenta was posterior not low. The fetal heartbeat was confirmed. The Preterm Birth Prevention Consultant advised an emergency cerclage is strongly recommended in view of significant shortening of the cervical length and in view of the history of PTB.

A further out of hours, weekend appointment, was arranged for 08:00 hours on Saturday [redacted] at 22 weeks and 6 days gestation according to the mother's preference, as she had no childcare during weekdays. The Labour Ward Coordinator called the mother at 11:00 hours to confirm her attendance for emergency cerclage and there was no answer on the telephone. The mother attended Labour Ward at 12:40 hours.

The mother had not collected the progesterone prescribed on the [redacted].

The Labour Ward workload was rearranged according to the mother's attendance. The emergency cerclage procedure was completed by the on-call Consultant Obstetrician under spinal anaesthesia. The post operative plan included 5 days of clindamycin (antibiotic) and to continue low dose of amoxicillin (antibiotic) until term (37 weeks gestation) in view of recurrent UTIs. Furthermore, to continue progesterone 400mg twice daily until 34 weeks. A follow up was arranged in the Preterm Birth Prevention Clinic in two weeks.

The mother had an emergency cerclage at 22 weeks and 6 days gestation with a short cervical length of 23mm, instead of the originally planned elective cerclage at 20 weeks and 4 days gestation with a long cervical length of 31mm.

Attendance with threatened preterm labour after emergency cerclage

At 01:03 hours on [redacted], the mother attended Maternity Triage reporting a feeling of pressure in the vagina that had started that evening.

She reported no abdominal pain, no contractions, fetal movements felt, no bleeding from the vagina, no spontaneous preterm premature rupture of membranes (PPROM), no urinary symptoms, no fever. She felt generally well.

On examination she was systemically stable. A speculum examination confirmed the cervical stitch was in situ, with no bleeding from the vagina and no pooling of liquor. The impression was a low likelihood of preterm labour at that time.

The mother was anxious regarding the pressure sensation and explained she had a cervical scan booked for the following day in the Preterm Birth Prevention Clinic. She asked if the scan could be expedited. She reported that labour had been quick in her previous preterm deliveries. The clinician explained that at present there was no clinical sign of preterm labour. She was not contracting, and the cervical stitch was in the correct place. A low threshold for admission was advised if any further concerns arose. She requested pain relief for the pressure, which was thought to be due to ligament pain. The case was discussed with the on-call Obstetric Resident Doctor (Registrar) who agreed with the plan.

At 12:00 hours on the same day the mother attended the Fetal Medicine Unit for a growth scan performed by the Fetal Medicine Unit Consultant Obstetrician. The scan showed normal fetal growth, with an estimated fetal weight (EFW) of 718g (38th centile), and no ultrasound concerns. A transvaginal (TVS) scan to assess the cervical length was not done, as this was not a Preterm Birth Prevention Clinic appointment. However, on a transabdominal scan an open cervix would have been visible and was hence excluded at the time.

On [redacted], at 25 weeks and 4 days gestation, the Preterm Birth Prevention Consultant Obstetrician conducted a telephone consultation, as the mother was unable to attend her scheduled appointment in the Preterm Birth Prevention Clinic in person. This meant that an assessment of the cervical cerclage by TVS could not be carried out as planned.

Oral Glucose Tolerance Test (OGTT) appointment missed

The mother was offered an OGTT to assess for diabetes in pregnancy according to national and local guidelines in view of the risk factors for maternal age and ethnicity.

The OGTT was booked early after her booking appointment and after review of her normal HbA1C (glucose memory test) test result.

Later, the Fetal Medicine Unit referral for an ECHO at [redacted] was done and was prioritised over the OGTT, which was originally booked on the same day. The mother hence missed the OGTT appointment. The mother's named Midwife followed up her non-attendance to the OGTT and realised the concurrent appointments. The named Midwife discussed best management plan with the Diabetes Team. In view of the mother's gestation and her upcoming appointment in the Preterm Birth Prevention Clinic, and respecting streamlining her appointments, a plan was made for a further HBA1C blood test on the same day as the Preterm Birth Prevention Clinic appointment.

The second HbA1C diabetes screening test was normal.

Mental Health – shared feelings of being overwhelmed and anxious

The mother shared feelings of being overwhelmed and anxious to the clinical team at different times during her pregnancy. Perinatal mental health support structures were considered and offered but declined by the mother. A second assessment with further offers for support was declined again.

On [redacted], at 25 weeks and 4 days gestation, the Preterm Birth Prevention Consultant (also the Lead for Perinatal Mental Health) telephoned the mother for follow-up as she did not attend the Preterm Birth Prevention Clinic. The mother sounded tearful when asked about her mood and explained that she could not talk openly as her children were present. She denied any thoughts of self-harm or suicidal ideation. She reported feeling overwhelmed by housing difficulties, caring for her children, and anxiety regarding preterm birth. The Preterm Birth Prevention Consultant discussed the option of referral to the Specialist Perinatal Mental Health Team (SPMHT); the mother did not feel this was required and declined the referral. The referral to the SPMHT was not done in view of the mother's preference. A face-to-face appointment was arranged for two weeks later to revisit the discussion.

On [redacted], at 27 weeks and 4 days gestation, in the Preterm Birth Prevention Clinic, the Preterm Birth Prevention Consultant reviewed the mother again. She reported finding life very busy and challenging, particularly due to caring for her children, including a son with additional health needs. She denied any thoughts of self-harm or suicide. A referral to the Women's Health Psychology Service was offered, which she said she would consider. A referral was not done according to the mother's preference. Contact details for the Crisis Team were provided to the mother.

As the mother was struggling to attend appointments and already had a follow-up growth scan arranged with the Fetal Medicine Unit Team, no further Preterm Birth Prevention Clinic reviews were scheduled, as all necessary preterm birth prevention plans were in place from a preterm birth prevention perspective.

On [redacted], at 32 weeks and 4 days gestation, at 11:30 hours the mother attended Maternity Triage with a complaint of leaking fluid from the vagina. PPROM was diagnosed. A mental health assessment was done. As documented by the attending Obstetric Doctor, the mother appeared very stressed in view of the preterm premature

rupture of her waters (PPROM) as she had her children with her in Maternity Triage. She otherwise reported feeling well. She expressed a strong desire to go home to collect her notes and drop her children off. She was advised to remain in hospital given her history of rapid labours. The attending team explained that the father could take the children home and bring her notes.

Admission to hospital was advised in view of PPROM and history of previous rapid preterm labour and birth. No further formal offer of support for childcare moving forwards was made at the time. A discussion about possible supportive structures on offer could have been considered.

Temporary housing and follow up

On [redacted], at 19 weeks and 2 days gestation, at her first booking appointment, the mother reported that she lived in temporary accommodation.

Living in temporary accommodation does not trigger an immediate safeguarding referral. The mother did not share a concern about a possible risk of homelessness with any care provider. A further explorative discussion about the mother's housing situation and whether there was a risk for homelessness would have been good care. Such discussion can provide information to inform possible further actions that could be taken to assist a mother living in temporary accommodation. There is no documentation if the mother had a housing support worker supporting this issue.

If a pregnant person is at risk of homelessness, or indeed is homeless, then NHS Maternity Services have a legal duty to refer to the local housing authority (council) for housing assistance and advice under the Homelessness Reduction Act 2018.

4. Attendance to Maternity Triage and Admission for Inpatient Care with PPROM

Preterm premature rupture of membranes (PPROM) happens in around 3 out of 100 pregnancies. PPROM is linked with 3 to 4 out of every 10 premature births (where the baby is born before 37 weeks).

The baby develops in the womb (uterus) within the amniotic sac, which contains amniotic fluid. Normally, rupture of the membranes ("waters breaking") occurs shortly before or during labour. When rupture of the membranes occurs before 37 weeks of gestation, this is termed preterm premature rupture of membranes (PPROM).

The underlying reason for PPROM is often not identified. Potential contributing factors include intrauterine infection and placental pathology such as placental insufficiency or retro-placental haematoma. Documented risk factors for PPROM include a history of preterm birth or PPROM, vaginal bleeding in pregnancy, abdominal trauma, previous cervical surgery or short cervix, poor maternal nutrition, low body mass index, history of placental abruption, polyhydramnios, and multiple pregnancy. The risk for PPROM is increased with a short cervix, as identified in this case. Importantly, PPROM is not attributable to maternal behaviour during pregnancy.

The risk of a baby dying after PPROM depends on how far along the pregnancy is when the waters break. The earlier this happens, the higher the chance of the baby not surviving during pregnancy or after birth. Waiting and closely monitoring the pregnancy (rather than delivering straight away) can improve outcomes and is called conservative management. The RCOG recommends conservative management until 37 weeks gestation in uncomplicated pregnancies with PPROM.

If a woman carries GBS in the current pregnancy or has carried it in a previous pregnancy, as in this case, the risks to the baby are different depending on how far along the pregnancy is. Before 34 weeks gestation, the risks linked to being born too early are usually greater than the risk of infection from GBS, so delaying birth is often safer. After 34 weeks gestation, it may be safer for the baby to be born. The recommendation for birth at 34 weeks gestation for the mother was based on these recommendations.

The mother presented to Maternity Triage on [redacted], at 32 weeks and 4 days gestation when she experienced clear fluid loss from the vagina. She was reviewed in triage at 13:40 hours by a Resident Doctor (SHO). There was a clear history of preterm premature rupture of membranes (PPROM) with continued leakage of clear liquor (amniotic fluid). The mother reported having experienced tightenings over the past few days, but none currently; she described only intermittent suprapubic pain. She denied

bleeding from the vagina and reported normal fetal movements. She appeared very stressed due to having her children with her but otherwise felt well. She expressed a strong desire to go home to collect her notes and drop off her children. She was advised to let her partner collect the notes and drop off the children. She was advised to remain in hospital given her history of previous rapid preterm labour. The mother agreed to stay. Maternal observations and bloods for C-reactive protein (CRP) and full blood count were taken and a mid-stream urine (MSU) sample was sent for culture and sensitivity in line with national and local PPROM protocol.

On review, the MSU sample was taken and sent but no request for analysis was made on the ICE system. This sample was not tested. A further MSU sample was sent to the Laboratory on [redacted] for microscopy and culture. The urine sample showed no infection.

While the clinician informed the Labour Ward Team of the mother's arrival, she remained in discussion with her partner about childcare arrangements. On return, the clinician was informed that after receiving antibiotics the mother had gone to the vending machine as she was hungry but had not returned to Maternity Triage. It was suspected she may have left the hospital. The Midwifery Team were made aware and planned to conduct a well-being call.

Obstetric plan in Maternity Triage for admission in line with national and local PPROM protocol:

1. Blood tests and cannula.
2. High vaginal swab (HVS), or low vaginal swab (LVS) and / or rectal swab and speculum examination to be performed when the mother returns.
3. Midstream urine (MSU) sample. *(On review, a sample was taken and sent to the Laboratory but no request for MSU analysis completed. This sample was not tested.)*
4. Steroid administration to be discussed – mother left triage before this could occur.
5. Admission to hospital recommended.
6. Neonatal Team informed.
7. Commence oral erythromycin antibiotics.

The mother returned to Maternity Triage later that afternoon. A speculum examination was completed with consent and chaperone, and a high vaginal swab was taken and sent for analysis. The cervical os (the cervical canal) was closed and clear liquor was seen pooling in the vagina. The diagnosis of PPROM was confirmed.

Reasoning behind offering a vaginal swab:
The RCOG PPROM Green-top guideline notes that it is routine practice in the UK to obtain a vaginal swab for microbiological testing while diagnosing PPROM.

The RCOG Green-top guideline for prevention of early onset neonatal Group B streptococcal (GBS) disease notes that the optimum yield (for GBS) will be obtained from swabs obtained from the lower vagina and anorectum. A single swab can be used or two swabs. The RCOG Green-top guideline about prevention of early onset GBS sepsis also recommends that women with PPROM are not tested for GBS, because they should all receive GBS prophylaxis in labour.

There is a clinical recommendation that women with PPROM and known GBS should be offered birth from 34 weeks gestation, and women with PPROM but without GBS could have expectant management until 37 weeks gestation.

The RCOG recommends handing out the patient information leaflet 'Preterm Prelabour Rupture of Membranes >24 weeks' to mothers after PPROM. It was not documented whether this leaflet was given to the mother.

Discussion about antibiotics
The mother had regular assessments for infection and was given treatment antibiotics as well as prophylactic antibiotics when indicated to reduce the risk of recurrent urinary tract infection and later to reduce the risk from infection with PPROM.

Date	Indication	Antibiotic
[redacted]	UTI	Cefalexin 500mg, BD, 7 days
[redacted]	UTI	Amoxicillin 500mg TDS
[redacted]	UTI	Clindamycin 150mg

[redacted]	UTI	Amoxicillin 500mg TDS
[redacted]	PPROM, Erythromycin Allergy	2 initial doses of IV Benzylpenicillin
[redacted]	PPROM cover, Erythromycin Allergy	Amoxicillin, 500mg TDS (three times per day) for 6 days
[redacted]	Cover for cerclage removal	Benzylpenicillin, 1.5g IV, single dose.
[redacted]	Prophylaxis for preterm early onset GBS sepsis	Benzylpenicillin 3g loading dose
[redacted]	Antibiotic cover for EMCS	Ceftriaxone, 2g IV, once daily

Table 3 Prescribed Antibiotics - Key Dates and Indication.

According to national and local guidelines, antibiotics were offered to the mother with PPROM to reduce the risk of chorioamnionitis.

Early antibiotics after PPROM

The mother is allergic to Clarithromycin. National guidance recommends Erythromycin, 10 days orally after PPROM. Given the mother's allergy and the risk of cross reaction, Erythromycin was contraindicated for the mother. She was offered two initial doses of IV Benzylpenicillin in view of PPROM and Erythromycin Allergy on [redacted]. This was to be followed by Amoxicillin, 500mg TDS (three times per day) for 6 days.

As documented on the electronic prescribing software (Careflow Medicines Management), the mother missed two doses of Amoxicillin as she was away from the ward: evening dose on [redacted] and lunch time dose on [redacted]. The mother received all other Amoxicillin doses from the evening dose on [redacted] to the morning dose on [redacted]

On [redacted], at the morning ward round the removal of the cerclage was planned. Antibiotics to cover this surgical procedure were prescribed, Benzylpenicillin, 1.5g IV, single dose. This was administered with consent on this day.

A vulval swab was taken on [redacted]. On [redacted] the vulval swab showed a microbiological result of moderate growth of candida and heavy growth of pseudomonas aeruginosa. The swab was negative for GBS.

Microbiology advice was sought by the team for appropriate management on [redacted]. The Obstetric Resident Doctor (SHO level) was not able to get through to the Resident Doctor in Microbiology promptly. The escalation process via switchboard was not followed immediately.

On [redacted], in the morning the on-call Consultant Obstetrician contacted the Consultant Microbiologist. The advice included no further antibiotic treatment.

There was no delay in reviewing the swab result. There was a delay in receiving Microbiology management advice. This did not affect the outcome in this case as the advice was not to treat. This has highlighted a need to remind Maternity staff of existing communication pathways with Microbiology, including out-of-hours and escalation processes.

Date and Test	[redacted] HVS	[redacted] Vulval swab
Findings	- GBS - Candida	- Pseudomonas aeruginosa - Candida

Table 4 Tests Taken and Diagnosis.

Intrapartum antibiotic cover

Antibiotics are offered to women during preterm labour to reduce the risk of early-onset GBS infection in the baby.

Antibiotics are also offered to women who have GBS colonisation, bacteriuria or infection during the current pregnancy or have had GBS colonisation, bacteriuria or infection in a previous pregnancy. Antibiotics in term labour are offered to women who have had a previous baby with an invasive GBS infection (like in this case) or have a clinical diagnosis of chorioamnionitis.

The first line choice of antibiotic is Benzylpenicillin 3g loading dose and subsequent 1.5g every 4 hours until delivery. The mother agreed to antibiotic administration and this was given prior to birth by emergency caesarean section.

Removal of cerclage

The decision about the timing of suture removal was influenced by the mother's decision for or against antenatal corticosteroids.

Removal of the cerclage was expected to lead to imminent start of preterm labour and delivery. Hence the timing of the cerclage removal was carefully discussed. The removal of the cerclage was offered on the night of the PPROM ([redacted]), if wished. It was explained that if the mother were to agree to corticosteroids the cerclage should stay in situ while the full course of corticosteroids would be given; this takes 24 to 48 hours. The removal of cerclage would then be planned for after corticosteroids are completed to allow the full benefits of corticosteroids for the baby's lungs. It was explained that if the mother were to decline corticosteroids, the cerclage could be removed as soon as possible. The mother declined corticosteroids and was keen on removal of cerclage.

On [redacted], at 33 weeks and 5 days gestation, the mother was transferred to Labour Ward for removal of cerclage in the afternoon.

After admission to a Labour Ward room, the mother left the ward at 15:45 hours to go towards the Emergency Department. She was upset that her partner did not bring baby clothes. A Midwife ran after her and brought her back to Labour Ward, she returned at 16:15 hours. She was put on the CTG prior to procedure. She removed the CTG herself. She was distressed and was crying. She explained that she is anxious as she had previous premature births and she feels distressed. She stated that she will not stay on the ward. The Midwife attempted to reassure the mother. The mother left the Labour Ward room and exited the Labour Ward with her partner. At 16:20 hours the Midwife spoke with the mother. She was now in the waiting area with her partner and [redacted] children. Mother agreed to return to Labour Ward room. She requested to have a shower.

At 18:00 hours the cerclage was removed easily with consent and chaperone under aseptic conditions in the Labour Ward room. The clinical findings included, clear liquor draining from the cervix and cervical dilatation of 1-2cm.

Management plan after removal of cerclage

It was anticipated, given the mother's history of rapid preterm births, that she would go into labour after PPROM and the removal of the cerclage.

The plan made after cerclage removal included to stay on the Labour Ward and be assessed for contractions. If signs of labour were to occur, antibiotics to be given to cover preterm labour. CTG monitoring was in place for fetal wellbeing assessment post procedure. The Neonatal Team were updated on removal of the suture.

Post procedure, the mother was reviewed by the on-call Consultant Obstetrician on the Labour Ward. All observations, fetal and maternal were stable after the removal of the cerclage. Good fetal movements were reported by the mother.

As there were no signs of premature labour and all maternal and fetal observations were normal, the mother was transferred to the Antenatal Ward 6 hours after cerclage removal. An ongoing care plan was discussed with the mother.

Given the stable situation, and the national guidance to aim for 34 weeks gestation after PPROM with no sign of infection, the plan was for conservative management and birth of the baby was aimed for 34 weeks gestation and the mother agreed to this plan. The Neonatal Team also met with the mother to discuss the neonatal antenatal care pathway.

On the Antenatal Ward, on [redacted], the mother complained of feeling unwell secondary to her asthma with a chesty cough. She was transferred back to Labour Ward for full assessment.

Her vital signs were all normal, her MEOWS chart score remained 0. Her bloods showed no sign of infection with normal white blood count (WBC) of 5.3, a C-reactive protein (CRP) of 4 and a Lactate of 1.5. Management of suspected exacerbation of asthma included

regular inhalers, oral antibiotics to cover a potential chest infection, a chest x-ray (which was reported as normal), regular observations every 4 hours and CTG three times per day.

Again, the birth plan was reviewed and confirmed as aiming for birth at 34 weeks gestation, if not delivered by then for other concerns.

On [redacted] at around 18:45 hours the mother was reviewed by the on-call Consultant Obstetrician on Labour Ward. This was following a request from the Labour Ward Coordinator, as the mother had expressed a wish to self-discharge. The Consultant Obstetrician discussed with the mother that the risk of preterm birth was high following the removal of the cervical stitch and strongly advised her to remain in hospital. It was explained that reassessment would be required after 72 hours of cerclage removal. The risks of GBS infection, preterm birth, and the potential for a very poor outcome if she were to go into labour while at home were outlined. Following this discussion, the mother agreed to remain in hospital.

On [redacted] the mother was reviewed by the on-call Consultant Obstetrician around 11:30 hours. The mother reported no active complaints, denied abdominal pain and bleeding from the vagina but requested discharge home. It was explained to her that it was not safe to leave hospital following the removal of the cervical cerclage, as the risk of giving preterm birth was high. She was advised that this could be re-discussed after 72 hours after the removal of the cerclage.

On examination, observations were normal, MEOWS chart score was 0. The abdomen was soft and non-tender. Fetal movements were present, and a CTG performed at 08:20 hours was normal.

The management plan was agreed to by mother and health care team:

- Conservative management with close surveillance
- Fetal wellbeing assessment twice daily (CTG)
- Blood tests every other day: full blood count, CRP
- Aim for birth at 34 weeks
- Induction of labour (IOL) was booked for [redacted] at 34 weeks

Reasoning for recommendation of Induction of Labour at 34 weeks:

The RCOG recommendation to consider birth from 34+0 weeks gestation in women with PPROM is based on secondary analysis of the PPROMEXIL trial of women who had PPROM at 34+0 -36+6 weeks of gestation. Amongst women with GBS colonisation the risk of early onset neonatal sepsis was 15.2% (7/46) in women with expectant management and 1.8% (1/57) in women with immediate delivery, odds ratio 0.10, 95% confidence interval, 0/01-0.84.22.

The role of GBS status in stratifying gestation at delivery was also assessed within the PPROM trial and the findings were not replicated, but more research, with long term follow up, is required.

5. 'Day Leave' and Engagement with Inpatient Care

The RCOG Green-top guideline advises that the decision to offer outpatient care to women with PPROM, following a period of inpatient care, should be made on an individual basis. Factors including past obstetric history, support at home and distance from the hospital should be considered in discussion with the woman about her preferences, and markers of delivery latency should be assessed (the presence of antepartum haemorrhage, amniotic fluid volume, gestational age at which PPROM occurs and clinical and laboratory markers of infection).

A Cochrane review to assess the safety, cost and women's views about planned home versus hospital care for women with PPROM identified only two relatively small trials (116 women) so that meaningful differences between the groups could not be detected.

During her antenatal admission for PPROM and a history of rapid premature labour, the mother requested to be discharged home and / or have 'day leave' on repeated occasions. It was explained that if discharged, regular daytime appointments for monitoring of the mother and baby in the Maternity Assessment Unit would be indicated. The mother preferred inpatient care and asked for 'day leave' while an inpatient.

On review, the management of the mother's requests for extended 'day leave' during her admission highlighted a significant gap in local policy. On several occasions, her 'day leave' exceeded 12 hours, during which time she missed scheduled care episodes including maternal and fetal clinical assessments, obstetric ward rounds, and medication administration. Although the clinical team attempted to maintain contact through well-being phone calls, the mother was not always contactable. At the time, the Trust did not have a guideline or Standard Operating Procedure (SOP) in place to govern inpatient 'day leave' in Maternity Department, and general principles around leave were not routinely discussed with women on admission. This created inconsistency and uncertainty for both staff and mothers, leaving care provision vulnerable to disruption.

Date	Events
[redacted]	Admission
[redacted]	Removal of cerclage
[redacted]	Mother asked for discharge
[redacted]	Mother asked for discharge
[redacted]	11 hours 'day leave'
[redacted]	>12 hours 'day leave'
[redacted]	>16 hours 'day leave'
[redacted]	Birth of baby

Table 5 Key Dates for Inpatient Care with 'Day Leave'

The situation also raises important considerations about the balance between respecting maternal autonomy and ensuring safe, effective clinical care. In line with Human Rights Law, a mother with capacity has the right to make decisions about her care, including leaving the hospital, even if this increases risk. However, the absence of a structured framework meant that risks could not be consistently managed or clearly communicated. However, it is unclear if having a SOP for 'day leave' would have changed the outcome of events in this situation.

This mother's journey has highlighted the need for a formalised SOP on inpatient 'day leave' in Maternity, which will set clear expectations for both women and healthcare professionals, support safer decision-making, and strengthen governance assurance.
The SOP has been completed and is awaiting ratification.

6. Recognition of Deterioration and Chorioamnionitis

Chorioamnionitis is characterised by infection and inflammation of the uterus, the membranes, the amniotic fluid and the fetus. It is a common pregnancy complication, especially after preterm premature rupture of membranes (PPROM) but can also affect pregnancies with intact membranes.

Diagnosis of chorioamnionitis can be challenging and is made on careful assessment of the mother and the fetus.

The National Institute for Health and Care Excellence (NICE), Preterm Labour and Birth guideline 25, recommends that a combination of maternal clinical assessment (pulse, blood pressure, temperature and symptoms), maternal blood tests (CRP and WBC) and fetal heart rate (CTG), should be used to diagnose clinical chorioamnionitis. If the results of the clinical assessment or any of the tests are not consistent with each other, it is recommended that the woman should continue to be observed, and consideration should be given to repeating the tests as per guideline.

Clinical symptoms and clinical signs remain most sensitive markers for a diagnosis of chorioamnionitis.

Typical clinical signs are:

- Maternal pyrexia (fever), hypothermia (lower body temperature), tachycardia (fast maternal heart rate) tachypnoea (fast maternal breathing rate)
- Uterine tenderness
- Offensive discharge
- Raised white blood cell count / raised CRP and the trend of the WBC and/or CRP is more important than the actual values
- Fetal tachycardia (fast fetal heart rate)
- Meconium staining - this is almost diagnostic of sepsis in a pre-term pregnancy
- Contractions and vaginal bleeding

Blood tests such as CRP, FBC and high vaginal swab tests have low sensitivities in the detection of intrauterine infection and a rising trend is considered a better diagnostic aid

then a result in isolation. A study looking at blood tests in mothers after PPROM suggested that a raised CRP was the most useful sign of chorioamnionitis. However, when the results from 13 other studies were combined, CRP was found to be only moderately accurate, correctly identifying infection in about 7 out of 10 cases. CRP has a sensitivity of only 68.7% and specificity of 77.1% in diagnosing histological chorioamnionitis.

Studies that combined results from many tests (meta-analyses) did not find strong proof that using CRP helps diagnose chorioamnionitis early in mothers whose water had broken before labour (PPROM). The studies were very different from each other, and the accuracy of CRP tests varies.

Treatment involves both antibiotic therapy and expediting birth. Despite treatment, chorioamnionitis is associated with serious maternal, fetal, and neonatal consequences.

Date / Time	[redacted]	[redacted]	[redacted]	[redacted] 02:47 am	[redacted] 16:16 pm	[redacted]
Event	PPROM				Birth at 17.24	
CRP (0-5)	6	4	1	7		61 *
WBC (3.5-12)	6.3	5.3	7.5	10.6	16.3*	21.6 *

Table 6 Trend of CRP and WBC

Date	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
MEOWS Score Chart	0	0	0	0	0	0	0	0

Table 7 Maternity Early Obstetric Warning Score Chart

Nightly episode of first abnormal CTG – chorioamnionitis was not suspected after review

On [redacted] at 06:40 hours, at 33 weeks and 4 days gestation, a CTG was commenced and discontinued at 07:15 hours when the mother requested to leave the ward

to take her children to school. At 17:57 hours, the Midwife documented that the mother had not been present on the ward throughout the entire shift and was therefore not seen or reviewed on the ward round. At 22:54 hours, the mother had still not returned to the ward. She was absent from the ward for 16 hours and 15 minutes on this day.

A Midwife telephoned her mobile phone, which went to voicemail. At 23:04 hours, the mother returned the call and reported that she was waiting for a taxi to return to hospital. She arrived back on the ward at 23:35 hours. At 23:41 hours, she complained of having back pain throughout the day and had noted to pass a large volume of clear liquor from the vagina and a CTG was commenced.

At 23:50 hours, she was given paracetamol as requested for her back pain. At 60 minutes, the CTG did not meet Dawes-Redman criteria (DRC), with a short-term variability (STV) of 5.1 (normal STV).

On [redacted] at 00:45 hours, the Midwife bleeped the Labour Ward Team and the Resident Doctor (Registrar) to review the CTG, which showed no accelerations and two unprovoked decelerations in the preceding 40 minutes. At this time the mother reported reduced fetal movements during that day, an increase in liquor loss, back pain since the evening, which was coming and going, along with a sensation of pressure and stinging. This was the first time after PPROM the baby's CTG did not meet DRC, and the Antenatal Ward Midwife escalated for review by the on-call Labour Ward Team as appropriate.

At 00:55 hours, the Midwife transferred the mother to the Labour Ward for further review.

At 01:49 hours on Labour Ward, the mother was examined by the Resident Doctor (Registrar) and her Modified Early Obstetric Warning Score (MEOWS) was recorded as 0, indicating that she was clinically well. Abdominal examination showed a soft abdomen and uterus, with no contractions palpable. A speculum examination was performed with the mother's consent and in the presence of a chaperone. This demonstrated a closed cervical os (the cervical canal) and ongoing clear, non-offensive liquor pooling in the vagina. A CTG was started on the Labour Ward and was ongoing at the time of obstetric review and no further decelerations were noted within the first 10 minutes of the trace. The DRC are used

to interpret antenatal CTGs. When a mother is contracting, these criteria cannot be applied. In this case it was not clear at the start of the CTG whether the mother was contracting. The DRC were applied to this CTG.

The impression at this time was that there was no evidence of infection, no contractions, a closed cervix, and a normal fetal heart rate tracing. Based on these findings, there was no immediate indication to expedite premature birth at 33 weeks and 4 days gestation.

According to local CTG interpretation guidance, the on-call Labour Ward Resident Doctor (SHO) and Resident Doctor (Registrar) should be informed promptly of any antepartum CTG classified as abnormal or if DRC are not met. If the mother is on the Antenatal Ward, then the on-call Labour Ward Resident Doctor (SHO) and Resident Doctor (Registrar) should be called.

It is good practice for CTG interpretation and management decisions on CTGs in complex or high-risk cases to be undertaken by a doctor of Registrar level or above. In this instance, the combination of PPROM, abnormal CTG, infection risk, previous rapid labours, and reduced fetal movements constituted a high-risk scenario. While it was appropriate for the Resident Doctor (SHO) to complete the initial assessment, final decision-making and planning should have involved a patient review by a Registrar or Consultant. It should be acknowledged that the Resident Doctor (SHO) on-call that night was an experienced Resident Doctor (SHO), who also had covered the Registrar Day shifts occasionally. The Resident Doctor (SHO) did discuss their plan with the Resident Doctor (Registrar) on-call.

The plan documented at 02:00 hours was to repeat bloods with FBC and CRP, 4-hourly CTG monitoring, an ultrasound in the morning, and escalation if further concerns arose. This was cautious and reasonable. The mother was not in labour.

The mother was transferred back to the Antenatal Ward at 03:45 hours. She was next reviewed at 07:23 hours, when the next CTG was started with DRC applied. The CTG was normal with DRC met at 36 minutes, the STV was normal at 9.9.

On review, given the clinical complexity of the case (including the first episode of reduced fetal movements, prolonged absences of the mother from the ward and multiple missed

care opportunities), the escalation to review on Labour Ward may have been better continued through the rest of the night, allowing the day on-call Obstetric Team to review the whole clinical picture.

Developments on the day of birth – leading up to transfer to the Labour Ward

The maternal blood tests on [redacted] showed WBC of 10, within normal limits, (3.5-12) and a CRP of 7, mildly raised above the cut off level of 5.

At 07:23 hours the next CTG was started, and DRC were applied. The CTG was normal at 07:45 hours with DRC, the baseline was 130bpm, the STV was 15.8ms and the DRC were met at 30 minutes.

At 07:49 hours, the mother complained of abdominal pain to the night-shift Midwife describing it as similar to the onset of her previous labours. At this time the mother was on the CTG for assessment. The Midwife stopped the CTG as the assessment was normal and completed by time. However, on review, given the mother had just started to complain of abdominal pain, it should have been considered to continue the CTG at this time and request a doctor's review.

The day-shift Midwife documented her review of the mother at 08:30 hours, during which the mother, who was known to the Midwife, reported good fetal movements this day but reduced fetal movements on the previous day. The mother informed the Midwife that she was draining clear liquor and had no bleeding from the vagina. No contractions and no abdominal pain were reported by the mother at this time. She felt physically and emotionally well, with a MEOWS of 0.

At 09:15 hours, the mother was reviewed by the Consultant Obstetrician on the ward round. Now she reported irregular tightenings. This was documented and actioned. The abdominal palpation was unremarkable, the abdomen was non tender, and the uterus was soft. The position of the baby felt cephalic, and the head was high in the abdomen, not engaged and 4/5 palpable. The cervix at a recent speculum examination (at 01:49 hours) was closed. The findings made established labour unlikely.

A plan was made by the Consultant Obstetrician for an ultrasound for fetal growth and wellbeing and review after the investigation.

As a clinical change was observed at this ward round, the Consultant Obstetrician had planned to bring the ultrasound forward by one week to the same day [redacted]. (The previous scan in Fetal Medicine Unit on [redacted], at 32 weeks and 2 days gestation, was normal. It confirmed good forward growth, an estimated fetal weight of 1946g, plotting on the 70th centile on Hadlock and 44th centile on GAP chart, with normal fetal blood flow observations. The pulsatility indexes of the umbilical artery and the middle cerebral artery (MCA) were normal. At the time a further Fetal Medicine Unit scan was offered two weeks later.)

The Consultant Obstetrician documented that the planned birth may need to be brought forward depending on possible ultrasound or clinical findings. A review of the mother after the scan by the Consultant Obstetrician was planned and documented.

The Antenatal Midwife called the main Ultrasound Department to arrange a scan and at 12:30 hours were advised that they had no capacity to accommodate this. The Fetal Medicine Unit may or may not have had capacity to accommodate an extra scan but were not contacted. On review, the plan to bring the scan forward on this morning had no clinical relevance, as the mother needed admission to the Labour Ward for obstetric care a few hours later.

The Consultant Obstetrician's plan also included to continue CTG monitoring four times daily, continuing oral antibiotics of Amoxicillin 500mg three times daily, and monitoring the mother for contractions or any other signs of preterm labour. No further encounters between the mother and the Antenatal Ward staff were documented until 14:00 hours.

At 14:00 hours, the next CTG assessment was started. The fetal heart rate baseline at the start was 160bpm. When the CTG was started by the Midwife, the mother complained of contractions, and the DRC were not applied accordingly, this was correct. The mother also reported rectal pressure and lower back pain, and the Midwife bleeped the Resident Doctor (Registrar) for review.

At 14:15 hours, the mother complained of increasing rectal pressure, and both the Resident Doctor (Registrar) and Labour Ward Coordinator were bleeped.

At 14:20 hours, two decelerations were noted on the CTG, and the Labour Ward Coordinator was again informed by the Midwife on the Antenatal Ward. The decision was made to transfer the mother to the Labour Ward immediately.

At 14:36 hours, the mother arrived on the Labour Ward and the CTG was continued.

The admission to Labour Ward had focused on the contractions and possible need to prepare for a preterm birth.

The mother did not complain of reduced fetal movements while on the Antenatal Ward on this day.

Diagnosis of chorioamnionitis

At 14:36 hours, the mother arrived on Labour Ward and was put on the CTG at 14:44 hours. The baseline was 150bpm, the variability was normal, there were accelerations and decelerations seen. The plan was to continue the CTG. A cannula was sited, and bloods were taken and sent. Maternal Observations were within normal limits; Respiration rate – 17, Blood Pressure 142/81, Pulse – 86 bpm, Temperature 36.9°C, saturation on air 96%, MEOWS score = 0.

The admission to Labour Ward had initially focused on the maternal contractions and possible need to prepare for a preterm birth and she was promptly assessed by the Obstetric Resident Doctor (Registrar).

Between 14:50 hours and 15:05 hours, the Obstetric Resident Doctor (Registrar) reviewed the mother. On speculum examination of the mother's cervix with consent and chaperone, there was no cervical dilatation, although contractions were present. Given the mother's history of rapid births following the onset of contractions, the Neonatal Team was alerted to the possibility of imminent birth. The Obstetric Resident Doctor (Registrar) discussed the CTG and management plan with the Labour Ward Coordinator in the Labour Ward office. The CTG showed a baseline of 160 bpm, considered normal for gestation, with

normal variability and two isolated decelerations that were deep but recovered to baseline. This was interpreted as consistent with cord compression after PPROM in a premature baby at the time with the mother feeling contractions.

The plan made was for continuous CTG monitoring, analgesia if required, and review in one hour unless clinical circumstances changed. The Consultant Obstetrician was on the Labour Ward and aware of the mother's transfer, and the CTG was continuously displayed on the centralised monitoring system.

The Labour Ward Coordinator noted decelerations on the central CTG monitor and asked the Consultant Obstetrician on-call to review the mother again.

At 16:00 hours, the mother was reviewed by the Consultant Obstetrician on Labour Ward and was noted to be experiencing discomfort with contractions, though she was able to speak between them.

A brief history was taken to expedite management. During this review, the mother reported reduced fetal movements throughout the day. This information was given for the first time to the Resident Doctor (Registrar) at 15:05 hours and was again communicated to the Consultant Obstetrician at 16:00 hours. The CTG at 16:05 hours demonstrated a high baseline at 160bpm with normal variability and no decelerations, and the MEOWS score was 0 at this time with no clinical signs of infection.

Considering the history of previous rapid births and ongoing contractions, there was a recognised likelihood of establishing labour and imminent vaginal birth. Based on the clinical picture, there was no immediate clinical indication to expedite the birth at this time. The plan was to change to intravenous antibiotics to cover for preterm birth as per guidance and to closely observe the CTG and, if the baby was not born shortly, there was a plan to review and discuss preparations for a caesarean section.

At 16:12 hours intravenous antibiotics were given to support imminent preterm birth as per guideline. Intravenous fluids were also given with the understanding that while these interventions were unlikely to affect the CTG immediately, they would provide appropriate supportive care while further information was gathered.

Contact was made with the Biochemistry Laboratory to obtain the CRP results from that morning, which could provide further evidence of possible infection and supported the need for expedited delivery. It is not clear at what time the results were uploaded to the ICE system. The maternal blood tests on the [redacted] showed WBC of 10, which is within normal limits, (3.5-12) and a CRP of 7, mildly raised above the cut off level of 5.

At approximately 16:35 hours, the Consultant Obstetrician reviewed the previous CTG tracings on the centralised system for comparison with the current CTG. Both the Consultant Obstetrician and the Labour Ward Coordinator noted that the fetal baseline had been significantly lower earlier that morning (130 bpm) and was now increased to 160bpm. This rise in baseline was recognised as a potential indicator of fetal infection, raising the suspicion of chorioamnionitis, not hypoxia. The team identified that the high baseline was not attributable to prematurity but was likely secondary to chorioamnionitis. The baby's heart rate variability remained normal, indicating that the baby was not hypoxic at this time. The Consultant Obstetrician discussed with the Labour Ward Coordinator that she will recommend an emergency caesarean section to the mother.

This updated plan by the Consultant Obstetrician balanced continued close surveillance against immediate surgical intervention and reflected a cautious, evidence-based approach that allowed rapid transition to an emergency caesarean section when the CTG pattern and fetal tachycardia raised suspicion of chorioamnionitis.

Evidence from current literature supports the diagnostic approach of the clinicians on the day. Data suggests that at the initial stages of chorioamnionitis the fetus activates an inflammatory response when exposed to microbial invasion or non-infection-related stimuli. The inflammatory response leads to an increase in metabolic rate which leads to an increase in fetal heart rate (FHR). Physiological guidelines have defined that this should be recognised by an increased baseline for gestational age or >10 % rise in baseline during labour. The observation of an increased baseline on the CTG lead to the suspicion of chorioamnionitis before maternal observations, blood results or swab results suggested this diagnosis.

The need for expediting birth by caesarean section was discussed with the Labour Ward Coordinator and Registrar. Given the history of grand multiparity and previous rapid vaginal births, this decision required careful consideration, as the original plan had anticipated a potential rapid vaginal birth. The team agreed with the plan to recommend expediting birth by caesarean section to the mother.

The decision was made to expedite birth by Category 2 caesarean section. The mother was informed of the concerns regarding the CTG and the suspicion of chorioamnionitis and again confirmed that she did not wish to receive corticosteroids or magnesium for her baby.

At 16:39 hours an emergency Category 2 caesarean section was recommended to the mother in view of suspected chorioamnionitis. She consented to the procedure but requested to wait for her partner's arrival. As the CTG now showed pathological changes, fetal tachycardia with decelerations, the risks of waiting, including worsening fetal infection, were explained to the mother.

The mother agreed to proceeding with emergency caesarean section and she was transferred to theatre. At this time the complete Multidisciplinary Team was present, Consultant Obstetrician, Obstetric Resident Doctor (Registrar), Obstetric Resident Doctor (SHO), Labour Ward Coordinator, Case Midwife, Consultant Anaesthetist, Anaesthetic Resident Doctor (Registrar), Anaesthetic Resident Doctor (SHO), Operating Theatre Assistant, Healthcare Professionals, Consultant Neonatologist and Scrub Team. The Consultant Obstetrician spoke directly with the Consultant Anaesthetist, and the concerns about chorioamnionitis and the urgency of proceeding with the caesarean section were discussed.

The Labour Ward Coordinator asked the Labour Ward Midwives to get the mother's partner changed and into theatre as soon as he arrived.

Classification of Urgency of Emergency Caesarean Section (EMCS):

- **Category 1** EMCS - There is immediate threat to the life of a mother or baby. Birth is performed as quickly as possible, and in most situations within 30 minutes of making the decision.

- **Category 2** EMCS - There is compromise of a mother or baby which is not immediately life-threatening. Birth should be as soon as possible and in most situations within 75 minutes of making the decision.

Were the signs of established labour identified and was the mother's perception considered?

The Coroner's Team phrased this question together with the mother. "In addition, you said you were in labour - you know the signs as you have given birth to 5 children, however you don't feel medical staff at the hospital took you seriously enough. Why did hospital staff not take me seriously when I said I was in labour?"

On careful review of the timeline of events, staff documentation and comments, it appears that staff did listen to and acted on the mother's complaints. The mother's perception was considered and acted upon.

During the day of [redacted], increased surveillance and regular observations were in the plan and completed.

At 09:15 hours, the mother was reviewed by the Consultant Obstetrician on the ward round where she reported irregular tightenings. This was documented and actioned. The abdominal palpation was unremarkable, the abdomen was non tender, and the uterus was soft. The position of the baby felt cephalic, and the head was high in the abdomen, not engaged and 4/5 palpable. The cervix at a recent speculum examination was closed (at 01:49 hours that day). The findings made established labour unlikely.

At the time of maternal complaint of worsening rectal pressure, the CTG was not normal, and the priority was immediate transfer to Labour Ward for assessment there, as well as for preparation of possible preterm labour establishing on the Labour Ward with the Multidisciplinary Team present for anticipated birth.

The admission to Labour Ward had focused on the contractions and possible need to prepare for a preterm birth.

At 15:05 hours, on Labour Ward the Resident Doctor (Registrar) completed a further cervical assessment as the mother complained of ongoing rectal pressure. The cervix was long and closed and positioned posteriorly. These findings confirm that labour was not established at this time. At this assessment the mother first disclosed reduced fetal movements.

On review the mother experienced irregular tightening, abdominal pain and rectal pressure but there was no clinical evidence that labour was established.

The baby was born by pre-labour emergency caesarean birth.

Given the mother's history of preterm and rapid vaginal births, the mother and the entire team expected labour to start rapidly and lead to a rapid birth. It was unexpected that labour was never established.

7. Timing from Decision to Birth

The mother's previous medical history was taken into consideration when planning to expedite the birth of the baby.

On admission to theatre, the CTG continued to demonstrate good variability. A repeat vaginal examination was performed, which confirmed that the cervix remained closed. Labour had not progressed to being established, no cervical changes were clinically evident from the first vaginal examination at 09.30 hours in the morning.

At this time the complete Multidisciplinary Team was present, Consultant Obstetrician, Obstetric Resident Doctor (Registrar), Obstetric Resident Doctor (SHO), Labour Ward Coordinator, Case Midwife, Consultant Anaesthetist, Anaesthetic Resident Doctor (Registrar), Anaesthetic Resident Doctor (SHO), Operating Theatre Assistant, Healthcare Professionals, Consultant Neonatologist and Scrub Team. The Consultant Obstetrician spoke directly with the Consultant Anaesthetist, and the concerns about chorioamnionitis and the urgency of proceeding with the caesarean section were discussed.

At 17:00 hours, during the surgical sign-in, the categorisation of the caesarean section was reassessed. Although initially categorised as a Category 2 emergency caesarean section, the case was verbally escalated at sign-in to Category 1 emergency caesarean section. This was to reflect the immediate need for delivery. This change was clinically appropriate, recognising the evolving urgency and the increased risk to the fetus if delivery was delayed further. The escalation from Category 2 to Category 1 was documented on the anaesthetic chart. At this point, the Obstetric Team was scrubbed and in theatre, prepared to proceed without delay.

A joint decision was made for spinal anaesthetic. For Category 1 (immediate threat to life of mother or fetus) caesarean sections, either spinal or general anaesthetic can be used. While spinal anaesthetic is generally preferred due to safety, general anaesthetic is sometimes favoured in cases where a very rapid birth is needed, as it can be quicker to establish. However, studies show that with proper technique, spinal anaesthetic can be achieved in a similar timeframe as general anaesthetic, even in urgent situations.

For two reasons the preference was to avoid general anaesthetic initially, if possible, as this may add additional complexity to the resuscitation of a preterm and potentially septic baby. In addition, the mother had also expressed a preference for spinal anaesthetic to be awake for the birth. This plan was considered appropriate given the urgent but not immediate nature of the procedure and was supported by the Multidisciplinary Team.

The three members of the Anaesthetic Team were scrubbed in theatre and ready to deliver anaesthetic care. There was an appropriate level of anaesthetic seniority present, with a Consultant Anaesthetist, Anaesthetic Resident Doctor (Registrar) and an Anaesthetic Resident Doctor (SHO) in attendance. Given this expertise, it was reasonable to anticipate that regional anaesthesia could be achieved safely; however, conversion to general anaesthesia became necessary when spinal anaesthesia was unsuccessful.

The Anaesthetic Resident Doctor (SHO) had a single attempt at performing the spinal anaesthetic at 17:09 hours, but during this time the Consultant Anaesthetist observed that the Midwifery and Obstetric Teams were having increasing difficulty with fetal monitoring. The CTG machine was not printing. The Labour Ward Coordinator left theatre to obtain an alternative CTG machine and returned to swap the machines.

The Consultant Anaesthetist instructed the Anaesthetic Resident Doctor (Registrar) to take over the procedure immediately, which they did. Whilst they attempted the spinal anaesthetic, the Consultant Anaesthetist ensured the appropriate equipment was immediately available for conversion to a general anaesthetic in case of failure of the spinal anaesthetic.

The Anaesthetic Resident Doctor (Registrar) was not able to site a spinal anaesthetic within a couple of minutes despite their very high level of experience and expertise. The Consultant Anaesthetist therefore recognised that it was now most appropriate to proceed to a general anaesthetic, especially given ongoing concerns regarding fetal monitoring.

The Consultant Anaesthetist conveyed this to the mother and the Multidisciplinary Team. It was recognised that birth was now immediately required and at this point the Obstetric Team declared the caesarean had been escalated to a Category 1. This is defined in RCOG guidelines and in the Whittington Health Trust guideline as 'must be performed within 30 minutes, immediate threat to mother and baby'. Having verbally consented to general anaesthesia at this point, the mother was laid supine with left-lateral tilt and preoxygenated by the Anaesthetic Team, whilst a urinary catheter was inserted and the mother prepped and draped by the Obstetric Team.

At 17:10 hours, the CTG showed a baseline of 99 bpm, which was considered likely to reflect the maternal heart rate rather than the fetal trace. Fetal monitoring with CTG was challenging during anaesthetic preparation, as the mother was required to sit forward for spinal insertion. The fetal heart rate was intermittently auscultated at approximately 108 beats per minute. The Consultant Obstetrician anticipated that the spinal would be sited imminently, after which the mother could be repositioned for optimal monitoring. Left lateral positioning might have facilitated fetal monitoring, but this could have compromised optimal conditions for spinal insertion. The spinal anaesthetic was attempted but proved unsuccessful. The mother was then placed supine, at which point the fetal heart rate was recorded at 90 beats per minute, consistent with bradycardia.

Following discussion between the Consultant Obstetrician and Consultant Anaesthetist, the decision was made to proceed with a Category 1 caesarean section under general

anaesthesia. General anaesthesia was induced while the Obstetric Team prepared and draped the abdomen.

At 17:16 hours, the surgical time-out was completed.

At 17:18 hours, during intravenous induction of anaesthesia, the plastic connector detached from the maternal cannula as medications were administered. This was immediately recognised, and a fresh dose of pre-prepared medication was administered without delay. The disconnection was likely caused by repositioning of the mother's arm after the Consultant Anaesthetist's initial cannula checks. Induction of general anaesthesia proceeded without delay.

At 17:19 hours, the mother was fully asleep under general anaesthesia.

A rapid birth was undertaken, with surgery commencing at 17:20 hours and the baby born at 17:24 hours.

The cord PH results of the baby at birth was within normal range. At birth, the baby was not hypoxic. One sample was insufficient; therefore, we cannot say with certainty whether the sample tested was from the cord's artery or vein.

	Result	**Normal Range**
pH	7.27	7.20 – 7.44 vein 7.10 – 7.30 artery
Base Excess	-4.7 mmol/l	-7.7 – 1.9 vein -9.0 – 1.8 artery
Lactate	4.0 mmol/l	1.5 – 4.5 mmol/l

Table 8 Cord pH Results

The caesarean section was performed without immediate complication. The estimated blood loss was 300mls.

The mother woke up without any complication.

The decision for a Category 2 caesarean section was made at 16:45 hours, with time of birth at 17:24 hours. This resulted in a decision-to-delivery interval of 39 minutes, which is well within the 75-minute standard for Category 2 procedures. The caesarean section was subsequently escalated to Category 1 at approximately 16:58 hours, with birth achieved at 17:24 hours. This represents a decision-to-delivery interval of 26 minutes, meeting the ≤30-minute target for Category 1 procedures.

Decision-to-delivery time was within national RCOG and local standards.

Was there an indication for earlier birth?

The mother's management plan after PPROM was according to national and local guidance and included surveillance for infection.

No missed clinical triggers for earlier birth were identified on multidisciplinary external review. The decision to expedite the birth was made promptly once signs of chorioamnionitis and fetal compromise emerged.

8. Neonatal Care

The ToR for the baby's neonatal medical care follows questions outlined by the Trust:

- Following birth, was the care given to the baby timely and appropriate?

And raised by [redacted] parents in discussion with the coroner:

- "After [redacted] delivery we are not happy with the care I have been receiving, and we are now questioning if the care [redacted] received was carried out with due care?"

The baby's care for the purpose of this section of the review can be divided into specific periods.

Newborn antenatal care

The Neonatal Team were aware that the mother had presented to Maternity with preterm premature rupture of membranes and were asked to speak to her regarding premature

delivery. Antenatal corticosteroids to promote lung maturation had been discussed and offered but the mother elected not to receive them.

Offering antenatal corticosteroids is standard practice before 34 weeks gestation and this advice regarding optimising lung maturation in anticipation of premature birth is in accordance with RCOG guidelines.

Resuscitation following delivery in Labour Ward Theatre

The baby was in poor condition at delivery with a heart rate of less than 100/min, blue and with poor tone. [redacted] was resuscitated according to the Neonatal Life Support algorithm (NLS) by the on-call Neonatal Team comprising of a Consultant Neonatologist, Resident Doctor (Registrar), Resident Doctor (SHO) and Neonatal Nurse. They were joined by a Senior Neonatal Nurse and a second Consultant Neonatologist.

On the Neonatal Unit

The baby received the expected and appropriate management for [redacted] condition on the Neonatal Unit. The nature and cause of [redacted] difficulties, namely severe infection and resulting poor systemic blood pressure and pulmonary hypertension were recognised and acted upon in a timely manner. The seriousness of [redacted] condition prompted the attending Consultant to discuss the baby's case with the Neonatal Tertiary Care Unit Consultant at University College Hospital (UCH) and request uplift of care and transfer by the London Neonatal Transport Service (NTS). Advice which was offered by both UCH and NTS was instituted.

The external review by the Consultant Neonatologist and Clinical Medical Lead for Risk concluded that there was both proactive identification of clinical issues and proactive management.

The external reviewer considered whether the use of additional antibiotics could have been discussed with Microbiology and administered to the baby but did not believe that this would have altered the outcome.

Care by the Neonatal Transport Service (NTS)

The NTS team arrived when the baby was just over 7 hours of age, and [redacted] was being ventilated in 100% inspired oxygen. Care manoeuvres over the subsequent almost 4 hours, including treatment of the acidosis, further augmentation of blood pressure, direct management of pulmonary hypertension and alternative ventilation were unsuccessful.

In summary, the baby's management was in keeping with the expected standards of care for a premature infant in [redacted] condition.

9. Immediate Postnatal and Bereavement Care

Following the passing of baby [redacted], the Maternity Team, including the Consultant Obstetrician and Senior Midwives, extended their sincere condolences to the family. In accordance with national and local bereavement care guidelines, an immediate debrief was offered to provide emotional support and help the family begin to process their loss. The Maternity Team ensured that communication was compassionate, respectful, and sensitive to the family's individual needs and preferences during this difficult time. Every effort was made to support the parents holistically, with appropriate signposting to bereavement services and ongoing care pathways, in line with best practice standards.

The mother received coordinated postnatal care from the Multidisciplinary Team (MDT) on the Labour Ward following the birth. Postnatal care was delivered in accordance with clinical guidelines and included regular monitoring and management of her blood pressure, appropriate pain relief, and consistent offers of psychological and bereavement support. The MDT worked collaboratively to ensure that her physical and emotional needs were met with sensitivity and respect during this difficult time.

Bereavement support in maternity care is crucial for families experiencing pregnancy loss or the death of a baby. Support was provided in line with national and local guidelines, and this was recorded. At Whittington Health, the specialised Bereavement Midwives undergo regular training according to the National Bereavement Care Pathway (NBCP) and are training in delivering trauma informed care.

Despite established guidelines and best practice standards, bereavement maternity care does not always fully align with the individual needs and expectations of mothers and families. The mother accepted initial bereavement support, and later the family chose not to receive further input from the Bereavement Team.

During the review, the antenatal care planning was found to be personalised and patient-centred by the Maternity Team. We acknowledge and accept the mother's view might be different.

Following the death of the baby, the care relationship between the mother, her family, and the Maternity Team became strained. The Maternity Staff felt conflicted, they wished to best support a grieving mother and family, but they also experienced incivility. On many occasions these episodes were not reported on Datix in a timely way or escalated via the correct route when staff felt threatened.

The mother stayed in the Lilly room, the bereavement room on the Labour Ward. Although this room is equipped to support mothers and their partner when a baby passes away, the room is not soundproof. This is a recognised shortfall of the Maternity Department and is recorded on the Risk Register.

In line with her wishes, she chose to keep baby [redacted], in a cold cot by her bedside, and this was fully supported by the clinical team to allow her time and space for bonding and grieving.

The mother decided to stay on Labour Ward for 15 days and declined the offer for care in an appropriate room away from the Labour Ward environment. The mother declined discharge from the Labour Ward and from the Whittington Health Hospital when she was medically fit for discharge,

The mother's stay on the Labour Ward for 15 days after the death of her baby was very long. During this time, the baby stayed with the mother in the Labour Ward room in a cold cot.

The mother declined further offers of bereavement care and psychological support.

The mother was grieving, and staff found the mother's behaviour challenging. Members of staff went off sick. Remaining staff felt unable to provide safe Labour Ward care to other mothers and the Labour Ward was closed for 12 hours with North Central London Integrated Care Board support for patients' safety.

The mother declined discharge home when she was medically fit for discharge. A specific discharge plan was made with support from the Trust's Chief Medical and Chief Nursing Officers. The mother exercised her right to decline clinical discharge home.

A process of facilitated discharge was initiated. The Director of Midwifery consulted with the Acting Medical Director of Whittington Health and the Regional Chief Midwife for London to agree a plan to support the mother and facilitate safe discharge home as well as ensuring safety of staff and the Maternity Department.

The facilitated discharge plan was not successful, and on [redacted] the mother was discharged from the Labour Ward and accompanied by Security Team.

A personalised plan for the mother's care upon discharge from the hospital was made prior to her discharge:

- The [redacted] Community Midwifery Team would be visiting her at home to assess her wellbeing and monitor her postnatal clinical journey.
- An ultrasound scan for review of the wound was arranged to reassess the caesarean section scar including the areas of swelling and hardness, for [redacted] at 13:00 hours at the Imaging Department at Whittington Health.
- An MDT meeting had been arranged on mother's request and was agreed to by the mother for [redacted]. The agreed date and time were confirmed, and a printed copy of the letter was given to the mother.
- A 6–8-week GP postnatal appointment should be arranged by the mother to follow up on her recovery. The GP was asked to please review her blood pressure, monitor for hypertension and adjust medication as needed; as well as to consider repeating the CRP as the mother was keen to ensure it was of normal level. Her CRP was 8 on discharge (normal CRP level is 0-5).

- For any acute problems up to 6 weeks post birth the mother was advised to contact her local Maternity Triage at Barnet Hospital.

This plan was discussed at a meeting with the presence of the mother, the Clinical Director for ACW Division and the Director of Midwifery, as well as a Senior Midwife of the mother's choice.

The Adult Criteria Led Discharge Standard Operating Procedure had been given earlier to the mother.

The mother requested to leave the hospital with a copy of her medical notes, and this was facilitated by the Head of Midwifery, who copied the notes and handed those to the mother.

After the death of the baby the care relationship between the mother, her family, and the Maternity Team was challenging. Staff experienced significant emotional impact, requiring specialised psychological support, and several team members took sick leave following the events.

While the Maternity Team are trained and experienced in supporting parents following a loss, this case presented unusual challenges for all team members. It is recognised that not every mother's needs may be fully met in every situation, and this must be acknowledged and respected within governance and patient safety considerations. The Maternity Team wished to have been able to support this mother as she expected and needed.

A second review commissioned externally is ongoing to investigate the events from baby's birth to discharge of the mother to review the Maternity Department and Trust's escalation processes to ensure staff and patient safety.

10. Health Inequalities in Maternity Care

There is solid evidence that Black women in the UK experience disproportionately poorer maternity outcomes, including maternal mortality rates up to three times higher than those

of White women (Maternal mortality 2020-2022, MBRRACE). These inequities are linked to systemic racism, unconscious bias, and broader health inequalities, manifesting in disparities across access to care, patient experience, and clinical outcomes.

Research demonstrates that Black women are less likely to feel heard, respected, and involved in decision-making, and may receive inadequate pain relief due to stereotypical assumptions about pain tolerance. Higher rates of complications, including PPROM and pre-eclampsia, delayed access to antenatal care, and gaps in culturally competent care contribute to mistrust and poorer perinatal and mental health outcomes. These systemic issues are compounded by practical barriers such as childcare, transportation, and timely access to services, further increasing risks for marginalised women.

From a PSIRF learning perspective, addressing these inequities requires robust organisational reflection and targeted improvement strategies, including enhancing cultural competence, tackling unconscious bias, ensuring equitable access to care, strengthening perinatal mental health support, and implementing mechanisms to monitor outcomes for Black women. NHS initiatives, advocacy campaigns, and ongoing research are crucial in driving systemic change, improving safety, and promoting equitable, respectful, and culturally sensitive maternity care.

At Whittington Health, our staff reflect the ethnicity of the population we serve in Haringey and Islington (as shown in Figure 2).

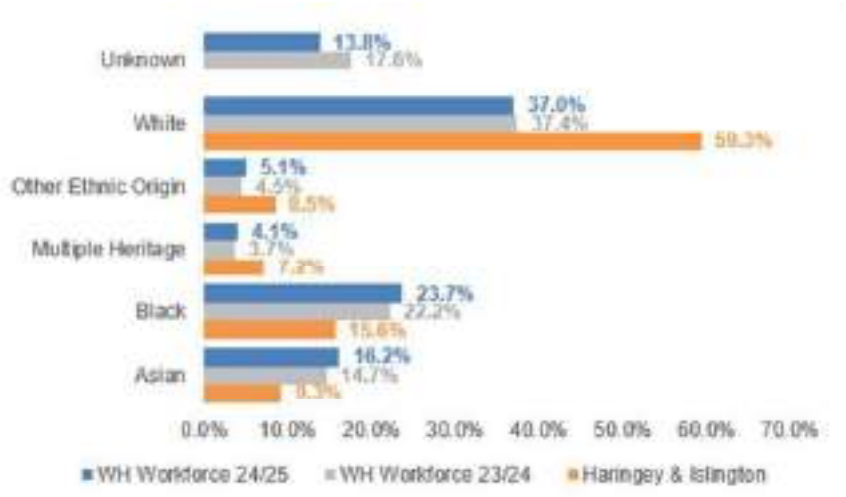

Figure 2 Whittington Health Workforce Ethnicity Data (March 2025) alongside Haringey and Islington Ethnicity Data (Census 2021)

Whittington Health fosters awareness of the ethnic and cultural diversity in maternity services to ensure that the care is sensitive and responsive to the needs of all women. Our mandatory maternity multi-disciplinary training within the framework of PROMPT (PRactical Obstetric Multi-Professional Training) and study days reflects the MBRRACE UK report and is updated regularly. All staff complete Equality, Diversity and Inclusion training as part of their annual mandatory training.

Summary of Key Findings

Risk Factors Identified and Managed at Booking

1. The mother booked late for antenatal care (19 weeks and 2 days gestation), citing childcare difficulties as the main barrier. Late booking was appropriately recognised as an additional risk factor.
2. A comprehensive risk assessment was completed at booking, with multiple significant maternal and obstetric risk factors identified according to national and local guidance and appropriate referrals were made.
3. The pregnancy was correctly identified as high risk and referred for Consultant Obstetrician led care in line with national and local guidance.
4. High maternal CO levels (7 ppm) were identified at booking; however, there was no documented discussion, advice, or follow-up. National guidance indicates this should have instigated safety advice regarding potential environmental risks, and signposting for smoking cessation support for the partner. None of these actions were documented or undertaken.
5. Engagement with Maternity services was inconsistent, with 9 DNAs and 3 unplanned attendances. The clinical team demonstrated flexibility by adapting care to her needs (e.g., opportunistic reviews, cerclage planned out of hours according to mother's needs, streamlining appointments). There is no evidence that the repeated non-attendance triggered exploration of reasons, as suggested by national and local guidance. With consent of the mother and while respecting the mother's autonomy, wider information-sharing with all care providers (e.g., GP) in and outside the community as well as an assessment of underlying social or safeguarding factors would have allowed to formally explore and address barriers of engagement.

Risk Factors Identified and Managed During Pregnancy

1. Risk factors were reviewed regularly during the pregnancy, with some acted upon appropriately and others not fully addressed. The risk factors that were not acted upon did not contribute to the death of the baby, and on review has provided learning opportunities for the Maternity Department.
2. There is evidence that the team sought to balance continuity and convenience (e.g., consideration of streamlining appointments) with the need for multidisciplinary

specialist input. The decision to prioritise comprehensive assessment in the Preterm Birth Prevention Clinic, located in Fetal Medicine Unit, was appropriate and in line with safe clinical governance.

3. **Quadruple screening test result – High chance of 1:7, Down syndrome (Trisomy 21)**
    a. The mother missed the time window for the first-trimester combined screening test and was therefore offered the quadruple test. This was performed at 19 weeks and 3 days gestation, following a dating and anomaly scan which showed no structural abnormalities.
    b. The quadruple test result indicated a high chance (1 in 7) of Trisomy 21. The mother received timely counselling by the Fetal Medicine Unit Midwife and Consultant, with options for invasive diagnostic testing (amniocentesis), non-invasive prenatal testing (NIPT), or no further testing explained. The mother declined invasive diagnostic testing but initially considered NIPT. Her decision was revisited at 24 weeks and 2 days gestation, when she declined further testing, stating commitment to continue with the pregnancy regardless of the outcome. This decision was respected, documented, and supported by the clinical team.
    c. The Fetal Medicine Unit Team appropriately offered enhanced surveillance with ECHO, serial growth scans, in view of maternal age, obstetric history (e.g., SGA), and high-chance screening result. The mother accepted this plan.
4. **Preterm Birth Risk and Cerclage Management**
    a. The mother's increased risk of preterm birth (PTB), due to previous PTBs at 24 and 32 weeks, was recognised early in pregnancy and an appropriate referral to the PTB Prevention Clinic (PTBPC) was made.
    b. A comprehensive PTB risk assessment was undertaken at 20 weeks and 4 days gestation. Preventative measures were recommended, including prophylactic progesterone (400mg BD) and elective cervical cerclage. The mother consented to elective cerclage, scheduled for 21 weeks gestation. This was arranged out of hours to accommodate her childcare needs.
5. **Elective cerclage offered but opportunity missed, therefore emergency cerclage was carried out as cervical length short**

a. Despite being prescribed progesterone at 20 weeks and 4 days gestation, the mother did not collect or commence the medication prior to emergency cerclage.
b. The mother did not attend the planned elective cerclage at 21 weeks gestation. Multiple attempts were made to contact her but were not successful.
c. The mother ultimately received an emergency cerclage at 22 weeks and 6 days gestation with a shortened cervix of 23mm, instead of the originally planned elective cerclage at 20 weeks and 4 days gestation when cervical length was long.
d. This represented a missed opportunity for optimal timing of preventative cerclage, which is recognised as the more effective intervention in preventing the risk of preterm birth.

6. **Attendance with Threatened Preterm Labour after Emergency Cerclage**
   a. On [redacted] at 01:03 hours, the mother attended Maternity Triage with symptoms of vaginal pressure. Examination confirmed the cerclage was in place, with no evidence of preterm labour.
   b. The mother's anxiety regarding the pressure symptoms and her history of rapid preterm labours was acknowledged. Pain relief was provided and safety-netting advice with a low threshold for admission was given.
   c. Later the same day, a growth scan performed in Fetal Medicine Unit demonstrated normal growth and fetal wellbeing (EFW 718g, 38th centile). A transvaginal scan was not performed as this was not a PTBPC review, but transabdominal imaging excluded obvious cervical dilatation.
   d. On [redacted], at 25 weeks and 4 days gestation, a planned PTBPC appointment was replaced with a telephone consultation due to the mother's inability to attend in person. This resulted in a missed opportunity for cervical assessment by transvaginal ultrasound as had originally been planned.
7. **OGTT Appointment Missed**
   a. The mother was appropriately identified as requiring screening for gestational diabetes due to maternal age and ethnicity. An OGTT was booked following her booking appointment and initial normal HbA1C result.
   b. The OGTT appointment was missed as it coincided with a prioritised Fetal Medicine Unit referral for fetal ECHO at [redacted].

c. The named Midwife identified the missed appointment, clarified the reason, and discussed the case with the Diabetes Team. A revised plan was agreed to streamline care, including repeat HbA1C testing at the time of a scheduled PTBPC appointment.

d. The second HbA1C result was normal, and no further diabetes-related concerns were identified during the pregnancy.

8. **Mental Health – Shared Feelings of Being Overwhelmed and Anxious**

a. The mother disclosed feelings of being overwhelmed and anxious at several points during the pregnancy. Support structures, including referral to the Specialist Perinatal Mental Health Team (SPMHT) and Women's Health Psychology Services, were considered and offered but declined by the mother on more than one occasion.

b. The mother's capacity was confirmed by the Lead Consultant for Perinatal Mental Health.

c. On [redacted] (25 weeks and 4 days gestation), during a telephone consultation, the mother was tearful and described difficulties related to housing, childcare responsibilities, and anxiety about preterm birth. She denied suicidal ideation or thoughts of self-harm. She declined referral to SPMHT. A follow-up face-to-face review was arranged.

d. On [redacted] (27 weeks and 4 days gestation), the mother again reported significant stress due to childcare pressures, including a child with additional health needs. She denied suicidal ideation. A referral to the Women's Health Psychology Service was offered, which she declined. Crisis Team contact details were provided.

e. On [redacted] (32 weeks and 4 days gestation), at the time of presentation with PPROM, a mental health assessment documented the mother as stressed and anxious in the context of childcare demands and her clinical situation. Admission was offered, but she expressed reluctance due to childcare concerns. Although reassurance was provided and immediate plans for children's care were discussed, no formal offer of ongoing support for childcare or wider psychosocial support structures was documented at this stage.

9. **Housing and Follow-Up**

a. At booking on [redacted] (19 weeks and 2 days gestation), the mother disclosed that she was living in temporary accommodation. While this did not in itself trigger an automatic safeguarding referral, good practice would have included a more detailed exploration of her housing circumstances, including whether there was risk of homelessness, and whether she had an allocated housing support worker.

Attendance to Maternity Triage and Admission for Inpatient Care with PPROM

1. The mother presented at 32 weeks and 4 days gestation with PPROM. The mother was correctly offered management of PPROM according to national and local guidelines.
2. The mother expressed her wish to leave the hospital because of childcare needs. She was advised to remain in hospital in view of recent diagnosis of PPROM and her history of rapid early labour. She initially agreed but subsequently left Maternity Triage without informing the staff. Her temporary absence from the clinical area interrupted her immediate care and prolonged the time needed to complete the PPROM protocol. A wellbeing call was done as a safety measure.
3. The RCOG recommends handing out the patient information leaflet 'Preterm Prelabour Rupture of Membranes >24 weeks' to mothers after PPROM. There is no documentation whether the leaflet was given to the mother.
4. **Discussion about antibiotics:**
    a. Antibiotic management followed national and local PPROM guidance, with appropriate adjustment made due to the mother's macrolide allergy.
    b. Microbiology results from a vaginal swab showed candida and pseudomonas aeruginosa, but no GBS.
    c. National and local guidance recommends antibiotic administration in labour for women in preterm labour to prevent early onset GBS sepsis.
    d. The mother consented to early onset GBS sepsis prophylaxis which was appropriately administered prior to delivery by emergency caesarean section.
    e. This demonstrates adherence to national guidance, with no identified gaps in antibiotic management.
5. **Removal of cerclage**
    a. The timing of cerclage removal after PPROM was discussed in relation to whether the mother wished to receive antenatal corticosteroids or not. It was

explained that corticosteroids administration would require delaying suture removal to reduce the risk of rapid onset of labour while the corticosteroids were given to optimise neonatal benefit. Whereas if corticosteroids were declined, removal could proceed without delay. The mother declined corticosteroids and requested cerclage removal on [redacted] The cerclage was removed at 18:00 hours. Findings included clear liquor draining and a cervical dilatation of 1–2 cm.

b. The procedure was planned for the afternoon of [redacted] at 33 weeks and 5 days gestation. During admission on the Labour Ward for cerclage removal, the mother demonstrated distress, left the ward on more than one occasion, and required reassurance and support from the Midwifery Team before returning.
c. The review showed that decision-making was consistent with national guidance, maternal choice was respected, and the procedure was completed safely. The mother's emotional distress highlighted the importance of providing psychological support and maintaining clear communication for interventions in stressful situations such as PPROM.

6. **Management plan following the removal of cerclage**
   a. Following removal of the cerclage, the mother was clinically stable with reassuring maternal and fetal observations.
   b. The anticipated risk was rapid progression to preterm labour, given the mother's history and PPROM. Contrary to clinical expectation, she did not go into labour after the removal of cerclage.
   c. A conservative management plan in line with national guidance was done admission to the antenatal ward, continue surveillance and plan birth at 34 weeks gestation in the absence of infection or labour. This care plan was consistent with national and local guidance, clinical reassessments were timely, maternal choice was respected, and risks were communicated clearly.
   d. The mother expressed a wish to self-discharge against medical advice on more than one occasion. Risks of preterm labour, infection (including GBS) and poor neonatal outcome were explained and the mother agreed initially to remain in hospital as a measure to reduce these risks.

'Day Leave' and Engagement with Inpatient Care

1. During her admission for PPROM, the mother made repeated requests for discharge or 'day leave'. She opted for inpatient care with 'day leave' instead of discharge with regular daytime attendance for monitoring. On several occasions, here 'day leave' exceeded 12 hours, during which scheduled assessments, ward rounds, and medication doses were missed. Attempts at contact by phone were not always successful.
2. At the time, there was no local guideline on inpatient 'day leave' in Maternity. This created inconsistency in managing requests, limited staff ability to set clear expectations, and introduced risk of inconsistent care. The absence of a structured framework reduced the effectiveness of support, risk management and communication.
3. A new SOP for inpatient 'day leave' in Maternity has been developed to provide clear guidance and is currently undergoing ratification.

Recognition of Deterioration and Chorioamnionitis

1. Chorioamnionitis is a recognised risk following PPROM, requiring surveillance, antibiotic therapy, and timely birth to manage associated risk of infection for mother and baby. Serial monitoring of inflammatory markers was undertaken:

   CRP: 6 ([redacted]), 4 ([redacted]), 1 ([redacted]), 7 ([redacted]), rising to **61** post-birth ([redacted]).

   WBC: 6.3 ([redacted]), 5.3 ([redacted]), 7.5 ([redacted]), 10.6 ([redacted] at 02:47), rising to **16.3** ([redacted] at 16:16) and **21.6** (post-birth, [redacted]).

   These results show a subtle increase of the CRP just above the normal cut-off on the day of diagnosis of chorioamnionitis. The results demonstrate that the maternal white blood cells remained within normal limits until after the caesarean birth. A raise in inflammatory markers post-surgery is expected and a normal response. The blood results did not indicate definite maternal infection prior to birth. The review of these blood results highlights the importance of a holistic approach when suspecting chorioamnionitis, as maternal inflammatory markers can lag in time.

2. At the night time episode of a first abnormal CTG, on the [redacted] at 33 weeks and 4 days gestation, the mother and fetus were fully assessed and chorioamnionitis was not suspected. On review, given the clinical complexity of the case the mother's care it would not have been unreasonable to keep her on Labour Ward through the night allowing the day on-call Obstetric Team to review the whole clinical picture again.

Developments on the Day of Birth (Leading up to Transfer to Labour Ward)

1. On [redacted], maternal observations remained normal and bloods results showed WBC within normal range and a mildly raised CRP. The subtle changes in the inflammatory marker were noted when the mother was on the Labour Ward.
2. The CTG by the night shift Midwife at 07:23 hours were normal and completed by 07:45 hours. Shortly after, the mother reported abdominal pain. The CTG was stopped as the assessment was complete, but in hindsight continuation could have been considered considering the mother's complaint of pain.
3. At 08:30 hours, the day shift Midwife documented good fetal movements on that day, and reduced FM the day before. Clear liquor, no contractions or pain, MEOWS score=0, normal.
4. The Consultant management plan at the ward round was appropriate and included escalation if findings warranted.
5. Timely recognition of maternal contractions and CTG changes led to appropriate escalation and timely transfer to Labour Ward.
6. **Diagnosis of Chorioamnionitis**
    a. On admission to Labour Ward the mother was promptly assessed by the Labour Ward Resident Doctor (Registrar) and the maternal observations were normal and she was not in established labour.
    b. The initial CTG (baseline 160 bpm, normal variability, two decelerations) was interpreted as consistent with cord compression in oligohydramnios in a preterm baby. The plan was for continuous CTG monitoring, analgesia, and review in one hour. The Consultant was on the Labour Ward and aware of the mother's transfer. CTG was visible on central monitoring.
    c. At 16:00 hours at the next review by the Consultant Obstetrician, contractions were noted and the mother now reported reduced fetal movements during the day (not previously reported by the mother). Reduced fetal movements were

only elicited late in the history, representing a missed opportunity for earlier recognition.

d. The CTG baseline remained high but with normal variability. No clinical maternal signs of infection were present. Clinical decision-making appropriately balanced maternal condition, fetal monitoring, and past obstetric history.
e. Review of earlier CTG tracings and comparison with current CTG identified a rise in baseline fetal heart rate from 130 bpm to 160 bpm. This change was recognised as a potential marker of chorioamnionitis. Diagnosis of suspected chorioamnionitis was made on fetal heart rate changes before maternal observations or blood tests indicated infection.
f. At 16:35 hours, CTG changes (tachycardia and decelerations) increased concern for fetal compromise from chorioamnionitis. The decision was made to expedite birth by emergency caesarean section.
g. The mother was counselled, informed of risks with delay, and consented. Birth by emergency caesarean section was agreed to at 16:39 hours.
h. The Multidisciplinary Team was present with consultant-to-consultant discussion ensuring awareness of suspected chorioamnionitis and urgency of delivery.

7. **Were the signs of established labour identified and was the mother's perception considered?**
    a. The mother reported abdominal pain, irregular tightenings, and rectal pressure during admission. The Midwife documented these concerns. The team responded appropriately to maternal reports, completing timely assessments and escalating care when needed.
    b. A speculum examination in the morning of the [redacted] confirmed a closed cervix. A further cervical assessment also showed a closed and posterior cervix, confirming that established labour had not begun.
    c. When the mother reported worsening rectal pressure alongside an abnormal CTG, she was promptly transferred to Labour Ward for urgent multidisciplinary assessment and preparation for potential preterm birth.
    d. Despite symptoms suggestive of labour, clinical findings did not support established labour. The baby was born by pre-labour emergency caesarean section.

e. The mother's perception of being in labour was acknowledged, taken seriously, and acted upon, but objective clinical findings demonstrated labour was not established. Maternal concerns were considered throughout.

Timing from Decision to Birth

1. The decision to expedite birth was based on suspected chorioamnionitis.
2. At transfer into theatre the CTG showed good variability.
3. CTG monitoring was challenging during anaesthetic preparation. At 17:00 hours, the emergency caesarean section was escalated from Category 2 to Category 1 to reflect the evolving urgency. At 17:10 hours, fetal bradycardia was confirmed, reinforcing the need for immediate delivery. CTG interpretation and recognition of fetal bradycardia appropriately influenced urgency of delivery during preparation for surgery. This was documented and communicated at surgical sign-in. Senior Multidisciplinary Team presence ensured escalation from Category 2 to Category 1.
4. Spinal anaesthesia was attempted twice but not successfully achieved. Conversion to general anaesthesia was promptly initiated by the Consultant Anaesthetist, with maternal consent. Anaesthetic management was appropriate, balancing maternal preference, clinical urgency, and safety.
5. General anaesthesia was induced at 17:19 hours, surgery commenced at 17:20 hours, and the baby was born at 17:24 hours.
6. The decision-to-delivery interval was:
    a. Category 2 (16:45–17:24): 39 minutes (within 75-minute standard).
    b. Category 1 (16:58–17:24): 26 minutes (within ≤30-minute standard).
7. The decision-to-delivery times were within both national (RCOG) and local standards, reflecting effective escalation and multidisciplinary teamwork.
8. **Was there an indication for earlier birth?**
    a. Following PPROM, the mother's care plan was consistent with national and local guidelines, including ongoing surveillance for infection.
    b. The external multidisciplinary review found no evidence of missed clinical triggers that would have justified earlier delivery.
    c. The decision to expedite birth was made appropriately and without delay once signs of chorioamnionitis and fetal compromise became evident.
    d. No evidence was found of avoidable delay in the timing of birth.

Neonatal Care

1. The delivery was attended by a complete on-call Neonatal Team who resuscitated the baby and transferred to the Neonatal Unit for ongoing intensive care.
2. The baby received the necessary and well described management for respiratory and cardiovascular support and was covered for infection.
3. The available clinical information, and that available subsequently from the postmortem describes a scenario of an unborn infant who was very unwell with compromised organ function and poor oxygenation prior to delivery.
4. This was recognised by the Neonatal Team, and the baby's management was discussed with the on-call Consultant at [redacted] Hospital, and plans made for transfer to the local Neonatal Tertiary Care Unit.
5. The transfer team arrived at approximately 7 hours of age. They augmented blood pressure support, administered nitric oxide to ameliorate the persisting pulmonary hypertension and escalated to High Frequency Oscillation ventilation.
6. Despite these measures and achievement of an increased blood pressure, the baby's condition continued to deteriorate, and [redacted] heart stopped. Resuscitation with multiple doses of adrenaline, ventilation and chest compressions were not successful and parents were called to be with their child.

Immediate Postnatal and Bereavement Care

1. Following the death of baby [redacted], the Maternity Team provided immediate condolences and offered debriefing in line with national and local bereavement care guidelines. Communication was compassionate, sensitive, and aimed to be tailored to the family's needs.
2. Postnatal care for the mother included monitoring of physical health, pain management, and offers of psychological and bereavement support.
3. The mother initially accepted and later declined bereavement support.
4. The mother remained on the Labour Ward for 15 days, in a room that, while designed for bereavement care, was not soundproof - a recognised departmental risk listed on the Risk Register. However, the mother declined discharge to a different room, and discharge home when medically fit.
5. Staff experienced significant emotional impact from caring for this mother. The care relationship with the mother was challenging.

6. The Labour Ward was temporarily closed to maintain safety for other patients.
7. While the Maternity Team is trained and experienced in caring for mothers after they lost a baby, this case presented unusual challenges.
8. It is recognised that not every mother's needs can be met.
9. A second externally commissioned review is ongoing to investigate the events from the birth to the discharge of the mother.

Health Inequalities in Maternity Care

1. It is recognised that Black women in the UK experience significantly poorer maternity outcomes, including maternal mortality up to three times higher than White women.
2. Nationally higher rates of complications are diagnosed in Black women including PPROM and pre-eclampsia, alongside delayed access to antenatal care and gaps in culturally competent care.

Safety Action Summary Table

Type	Safety Action Description *(SMART)*	Safety Action Owner *(Role, Team Directorate)*	Target Date for Implementation	Date Implemented	Tool / Measure	Measurement Frequency *(E.g. Daily, Monthly)*	Responsibility For Monitoring/ Oversight (E.g. specific group/ individual, etc)	Planned Review Date *(E.g. Annually)*
Area for Improvement 1: Patient information and leaflets provided at clinical encounters.								
Learning and Safety Prompt	Continue mandatory staff training on the risk of carbon monoxide (CO) exposure during pregnancy. This includes raising awareness to provide the appropriate advice and referring patients via support service pathways and document accordingly.	Smoking Cessation Midwife	July 2024	July 2024	Audits	Quarterly	Maternity Clinical Governance and Safety Champions Meeting	Every 6 months
Learning and Safety Prompt	Reinforce staff compliance in providing relevant clinical information leaflets during appropriate clinical encounters and ensuring that this is clearly documented in the patient's clinical record. For example, in this case it was not documented that a PPROM leaflet was given to the mother.	Professional Development Lead Midwife Consultant Midwife for Public Health and Education	November 2025		• Maternity Message of the Week • Staff Training incorporated into PROMPT Scenario	Monthly Review for Training Compliance	Professional Development Lead Midwife Consultant Midwife for Public Health and Education	Every 6 months
Area for Improvement 2: Development and adherence to guidelines.								
Learning and Safety Prompt	All staff involved in patient care must adhere to the Did Not Attend (DNA) guideline, ensuring that: • Every non-attendance is followed up with a tactful exploration of the reason.	Professional Development Lead Midwife Safeguarding Lead Midwife	November 2025		• Learning from Risk Meeting • Message of the Week • Incorporate into Midwifery Study Days	Monthly Review for Training Compliance	Professional Development Lead Midwife	Every 6 months

Type	Safety Action Description *(SMART)*	Safety Action Owner *(Role, Team Directorate)*	Target Date for Implementation	Date Implemented	Tool / Measure	Measurement Frequency *(E.g. Daily, Monthly)*	Responsibility For Monitoring/ Oversight (E.g. specific group/ individual, etc)	Planned Review Date *(E.g. Annually)*
	• Any potential, social, safeguarding or access-related barriers are assessed and documented. • Appropriate information sharing is considered where necessary with the relevant community care providers. The DNA guideline to be incorporated into mandatory study days to ensure understanding of the guideline.	Matron for Maternity Outpatients			• Ockenden Café • Incorporate into Resident Doctors Induction			
Safety Action	Develop and implement Standard Operating Procedure (SOP) on inpatient 'day leave' in Maternity services, which will set clear expectations for staff and patients, support safer decision-making and strengthen governance assurance.	Inpatient Matron Postnatal Obstetric Lead Antenatal Obstetric Lead Audit and Guideline Midwife	December 2025		• Message of the Week • Audit Day	Every 3 years as per Trust Policy	Maternity Audit and Guidelines Group	Every 3 years as per Trust Policy
Learning and Safety Prompt	Antenatal CTG Guideline must be reviewed and updated to fully align with RCOG standards to formalise that an Obstetric Doctor	Fetal Wellbeing Midwife	November 2025		• Message of the Week • Audit Day	Every 3 years as per Trust Policy	Maternity Audit and Guidelines Group	Every 3 years as per Trust Policy

Type	Safety Action Description *(SMART)*	Safety Action Owner *(Role, Team Directorate)*	Target Date for Implementation	Date Implemented	Tool / Measure	Measurement Frequency *(E.g. Daily, Monthly)*	Responsibility For Monitoring/ Oversight (E.g. specific group/ individual, etc)	Planned Review Date *(E.g. Annually)*
	of at least Registrar level must complete the interpretation of an antenatal CTG.	Fetal Wellbeing Consultant Audit and Guideline Midwife						
Area for Improvement 3: Communication and escalation within and outside of team.								
Learning and Safety Prompt	Disseminate the communication pathway for contacting the Microbiology Department when seeking advice on urgent results within the Maternity Department. This includes the out-of-hours and escalation processes.	Inpatient Matron Obstetric Consultant Lead	August 2025	August 2025	• Message of the Week • Ward Morning Huddle • Make available at Midwives Station • Incorporate into Resident Doctors Induction	Email confirmation	Ward Matrons Monitor via Datix Incident Reports	Every 6 months
Area for Improvement 4: Sample test requesting.								
Learning and Safety Prompt	Remind staff to ensure all appropriate requests are entered on the ICE system prior to sending samples to the laboratory for testing.	Inpatient Matron Obstetric Consultant Lead	November 2025		• Maternity Message of the Week	Email confirmation	Clinical Staff Monitor via Datix Incident Reports	Every 6 months

Type	**Safety Action Description** *(SMART)*	**Safety Action Owner** *(Role, Team Directorate)*	**Target Date for Implementation**	**Date Implemented**	**Tool / Measure**	**Measurement Frequency** *(E.g. Daily, Monthly)*	**Responsibility For Monitoring/ Oversight** (E.g. specific group/ individual, etc)	**Planned Review Date** *(E.g. Annually)*
Area for Improvement 5: Use of additional antibiotics.								
Learning and Safety Prompt	Medical staff to consider prescribing additional antibiotics in the context of suspected severe neonatal infection.	Clinical Governance Lead and Neonatal Consultant	September 2025	September 2025	To be included in new doctor induction agenda	Every 6 months	Neonatal Consultants	Every 6 months

Appendices

Glossary

AAR	After-Action Review
ACW	Acute Patient Access, Clinical Support Services and Women's Health Division
AFI	Amniotic Fluid Index
BAPM	British Association of Perinatal Medicine
BMI	Body Mass Index
CO	Carbon monoxide
CRL	Crown Rump Length
CRP	C-reactive Protein
CS	Caesarean section
CST	Combined Screening Test
CTG	Cardiotocograph
CYP	Children and Young People Division
DRC	Dawes-Redman Criteria
DNA	Did Not Attend
ECHO	Fetal Echocardiogram
EDD	Estimated Date of Delivery
EFW	Estimated Fetal Weight
EMCS	Emergency Caesarean Section
FBC	Fetal Medicine Unit
FHR	Fetal Heart Rate
GA	General Anaesthetic
GBS	Group B Streptococcus
HVS	High Vaginal Swab
ICB	Integrated Care Board
IOL	Induction of Labour
IV	Intravenous
LMP	Last Menstrual Period
LUTS	Lower Urinary Tract Symptoms
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MDT	Multidisciplinary Team

MEOWS	Maternity Early Obstetric Warning Score
MSU	Mid-Stream Sample of Urine
MW	Midwife
NICE	National Institute for Health and Care Excellence
NIPT	Non-Invasive Prenatal Test
NLS	Neonatal Life Support
NNU	Neonatal Unit
NTS	Neonatal Transport Service
OGTT	Oral Glucose Tolerance Test
PPHN	Persistent Pulmonary Hypertension of the Newborn
PPROM	Preterm Premature Rupture of Membranes
PROMPT	PRactical Obstetric Multi-Professional Training
PTBPC	Preterm Birth Prevention Clinic
PV	Per vaginam
QT	Quadruple Test
RCOG	Royal College of Obstetricians and Gynaecologists
RFM	Reduced Fetal Movements
SEIPS	Systems Engineering Initiative for Patient Safety
SOP	Standard Operating Procedure
SPMHT	Specialist Perinatal Mental Health Team
SPTB	Spontaneous Preterm Birth
STV	Short-Term Variability
ToR	Terms of Reference
TVS	Transvaginal Scan
PPH	Post-Partum Haemorrhage
PTB	Preterm Birth
UA	Umbilical Artery
UTI	Urinary Tract Infection
VBAC	Vaginal Births After Caesarean
VE	Vaginal Examination
WBC	White Blood Count
WH	Whittington Health

Dictionary

Term	Definition
Acceleration	Increase in a baby's heart rate.
Amniocentesis	A test, during which a long, thin needle is inserted through the abdominal wall, guided by an ultrasound image. The needle is passed into the amniotic sac, that surrounds a baby, and a small sample of amniotic fluid (waters) is removed for analysis.
Amniotic Fluid Index (AFI)	A measurement of the amniotic fluid (waters) around a baby.
Antenatal Corticosteroids	Corticosteroids are a medication that may be given to a mother before a baby is born to reduce the potential for breathing difficulties shortly after birth, lung disease and other associated complications for her baby.
C-reactive Protein Test	This is a blood test used to help diagnose conditions that cause inflammation or to check for the possibility of infection.
Candida albicans	Sometimes called thrush, is a common yeast infection that may affect a mother/father/baby. It is usually harmless, may be uncomfortable and may return if not treated. If one partner has thrush you may treat both to stop it being transmitted back and forth.
Carbon monoxide (CO)	A poisonous gas that reduces the amount of oxygen to both mother and baby.
Cardiotocograph	A cardiotocograph (CTG) is an electronic means of recording an unborn baby's heart rate pattern, to assess their wellbeing. This is used both during the antenatal period, and during labour. Sometimes in the antenatal period (before labour or induction of labour), this can be analysed by a computer. A CTG from a healthy baby would be expected to meet the computerised CTG analysis criteria. The antenatal use of computerised CTG analysis is recommended in national guidance due to its potential to reduce the chance of human error. Abnormal cardiotocography is when a cardiotocography (CTG) prior to labour (antenatal) is categorised as abnormal and it requires prompt senior review and action to further assess fetal wellbeing and consider if a baby needs the time of their birth brought forward.
Cerclage	A procedure where a suture is inserted into the neck of the womb (cervix) to prevent it from opening.
Cervical Length Scan	A scan to measure the length a mother's cervix.
Changed / Reduced Fetal Movements (RFM)	Most mothers are first aware of their baby moving when they are 18-20 weeks. If the pattern of movements changes, reporting is encouraged. If this occurs between 24-28 weeks, the healthcare professional will perform a full

	antenatal check-up and listen in to the unborn baby's heartbeat. After 28 weeks, in addition, a CTG should be carried out. Sometimes, a growth scan may be performed. National guidance on reduced fetal movements states that upon presenting with reduced fetal movements a history should be taken to assess a mother's risk factors for stillbirth and fetal growth restriction (NHS England, 2023).
Chorioamnionitis	Inflammation of the placental membranes.
Classification of Urgency of Caesarean Birth Category 1 (EMCS)	There is immediate threat to the life of a mother or baby. Birth is performed as quickly as possible, and in most situations within 30 minutes of making the decision.
Classification of Urgency of Caesarean Birth Category 2 (EMCS)	There is compromise of a mother or baby which is not immediately life-threatening. Birth should be as soon as possible and in most situations within 75 minutes of making the decision.
Cord compression	The cord can be compressed during labour. This can affect the blood flow through the cord. This may lead to changes in a baby's heart rate in response to the compression.
Dawes Redman Criteria not met	For a fetal heart rate tracing (CTG), it means that the baby's heart rate and pattern don't look completely normal and healthy based on a computerised analysis of the tracing. This doesn't necessarily mean the baby is in distress, but it does indicate a need for further evaluation and potential intervention. The Dawes Redman criteria act like a red flag triggering further checks and potentially leading to actions to ensure the baby is safe.
Deceleration	A temporary slowing of a baby's heart rate.
Doppler Ultrasound	A test performed during an ultrasound examination that measures blood flow in a baby and/or the placenta. It is used in a variety of situations to check on the health of a baby.
Down's syndrome (Trisomy 21)	Most people have two copies of each of their 23 chromosomes. In some people there is an extra copy of chromosome 21. This is called Down's syndrome. It occurs by chance and is not caused by anything anyone did before or during pregnancy. People with Down's syndrome have distinctive facial features, a variable level of learning disability and sometimes additional problems with their heart or eyes.
Fetal Echocardiogram (or ECHO)	An ultrasound scan which focuses specifically on a baby's heart and major blood vessels.
Fetal Heart Rate Variability	The fluctuation in a baby's heart rate from one beat to the next. Normal fetal heart rate variability is between 5 and 25 bpm. A baby with variability in this range is healthy.

Full Blood Count (FBC)	This is a blood test to check the types and numbers of cells in the blood, including red blood cells, white blood cells and platelets.
General Anaesthetic (GA)	The anaesthetist gives a mother medication to make her go to sleep and passes a tube through the mouth into her airway to allow oxygen to be delivered to the lungs. It may be needed for some emergencies, if there is a reason why a regional anaesthetic is not suitable or if a mother prefers to be asleep.
Group B Streptococcus (GBS)	One of the many bacteria that live in the body and mothers may carry it in their vagina without any problems to themselves. If a mother is known to carry GBS, or if any risk factors are identified then antibiotics would be recommended in labour, to prevent a rare and potentially serious infection in a baby. Risk factors for GBS include: • Having a previous baby affected by GBS disease • Maternal GBS carriage on a swab in current pregnancy or in urine culture • Preterm labour 24 hours • Suspected intrapartum infection • High temperature of over 38.0 on one occasion or over 37.5 on two or more occasions (30 minutes apart)
Growth Surveillance by Ultrasound Scanning	A growth scan assesses the baby's growth to ensure they are growing at the expected rate for gestation. National guidance (National Institute for Health and Care Excellence (NICE), 2019) accepts that it is difficult to accurately predict a baby's birthweight in advance of birth.
Induction of Labour (IOL)	The process of artificially starting labour.
Late Booking	First contact with, or referral to, maternity services after 9 weeks and 6 days gestation is considered a late booking according to the Key Performance Indicators. (10 weeks gestation according to NICE Guidelines)
Maternity Early Obstetric Warning Score Chart (MEOWS)	The modified early obstetric/maternity early warning score is a tool to detect and respond to mothers who are at risk of their condition worsening. Vital signs such as temperature, blood pressure, heart rate, respiration rate, are recorded and scored on an observation chart. The resulting total score indicates the appropriate action to take.
Magnesium Sulphate	A medicine given to mothers, to protect the brain of babies at risk of being born prematurely.
Non-Invasive Prenatal Test (NIPT)	A test to look for a baby's DNA (genetic material) in their mother's bloodstream.
Normal Cardiotocograph (CTG)	Categorised as normal, no escalation is required.
Oligohydramnios	Less amniotic fluid surrounding the baby than expected for gestational age.

Oral Glucose Tolerance Test (OGTT)	A medical test in which an initial fasting blood test is taken, then a glucose solution or sugary drink is given by mouth. A further blood sample is taken two hours later. The test determines how quickly the glucose is cleared from the blood in order to diagnose gestational diabetes.
Preterm Birth	Babies born before 37 weeks of pregnancy are completed.
Preterm Premature Rupture of Membranes (PPROM)	When the membranes rupture (waters breaking), before 37 weeks of pregnancy and before the onset of labour. After the waters have broken there is an increased chance of infection and that a baby will be born early.
Prolonged Rupture of Membranes (PROM)	When the waters have broken more than 24 hours before birth.
Pseudomonas	A type of bacteria which may cause an infection in a mother/ baby. Pseudomonas is often found growing on skin and in moist parts of the body.
Quadruple Test	A screening test for Down's syndrome which may be performed between 14-20 weeks of pregnancy. The quadruple test can be performed if it was not possible to obtain a nuchal translucency measurement, or a mother is more than 14 weeks into her pregnancy. It is not quite as accurate as the combined test.
Resident Doctor	Resident Doctors are qualified doctors in clinical training. They have completed a medical degree and can have up to nine years' of working experience as a hospital doctor, depending on their specialty. Senior House Officer (SHO) – Resident Doctor, at least 2 years of training Registrar – Resident Doctor, at least 6 years of training
Risk Register	A document used by a Trust to identify issues that need addressing and plan actions to reduce, mitigate or resolve the risk.
Sepsis	The body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure and death.
Speculum	Instrument to visualise a mother's cervix.
Spinal Anaesthesia	A type of regional anaesthetic used to give total numbness to the lower parts of a mother's body, for example during a caesarean birth.
White Cell Count (WCC)	A test that measures the number of white blood cells in the body. Having a higher or lower number of WCCs than normal may indicate an underlying condition or infection.

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Whittington Health NHS

Patient safety incident investigation (PSII) report

Patient Suicide Following Removal from ED A122107

Incident ID number:	A122107
Date incident occurred:	[redacted]
Approved by:	WISH
Report approved date:	[redacted]
Approved by:	Quality Assurance Committee
Report approved date:	
Approved by	[redacted]
Report approved date:	

Distribution list

List who will receive the final draft and the final report (e.g. patients/relatives/staff involved¸ board). Remove names prior to distribution.

Name	Position
[redacted]	Relative
[redacted]	Matron for ED
[redacted]	Matron for ED
[redacted]	Senior Staff Nurse for ED
[redacted]	Senior Sister for ED
[redacted]	Risk Manager for EIM
[redacted]	Head of Service Liaison, Place of Safety and MHCAS
[redacted]	Mental Health Liaison Teams (UCLH, Royal Free & Whittington Hospitals)
[redacted]	Team manager, Whittington Mental Health Liaison Team
[redacted]	Consultant Nurse for Mental Health at London Ambulance Services
[redacted]	Psychiatric Liaison Nurse
[redacted]	Head of Clinical Quality North Central Sector for London Ambulance Services
[redacted]	Clinical Nurse Specialist for Whittington Mental Health Liaison Team

About patient safety incident investigations

Patient safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers and staff.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Duty of Candour and the Engaging and involving patients, families and staff after a patient safety guidance in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the Just Culture guide in the minority of cases when staff may be referred to them.

PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

A note of acknowledgement

The Learning Response Leads ([redacted] and [redacted]) would like to thank the staff who contributed to reviewing the patient safety incident summarised in this report. Thank-you for your support, your openness, and your transparency. Your insights into how care is delivered in the Whittington Hospital Emergency Department have helped us to understand what happened. Each of you has helped us better understand how the technology and tools, organisation, task, person, internal environment, and external influences impact on the performance of staff working in the Emergency Department.

We know we have committed, professional and caring staff working in the Whittington Hospital Emergency Department. We know you go to work every day aiming to deliver safe patient care.

Our role as Learning Response Leads is to gather insight into the healthcare settings and systems in which you work: Our focus has been on learning how teams working in the Whittington Hospital ED deliver patient care, the challenges, constraints and demands you work with, and how systems factors impact on safe patient care. We are not here to judge or criticise: We are here to facilitate learning in a supportive, caring, and collegiate way. Without the insights and contributions made by the staff who participated in the review, the report would not have been possible. So thank-you.

Executive summary

Incident overview

The patient was brought to the department by ambulance at 22:27 on the [redacted]. The patient was brought in by ambulance under capacity. The patient had expressed suicidal ideation and was intoxicated. The patient's vital signs were within normal limits except for their heart rate which was 142bpm. The patient did not have bloods taken on this attendance nor did [redacted] have an ECG recorded, nor were [redacted] vital signs re-checked within the department. The patient was transferred to the majors area of the department at 23:09. No mental health referral was completed on the system. At 00:46 on the [redacted] the patient was reported to have been shouting at staff in the department using inappropriate language. The patient expressed the desire to self-discharge. The patient was given a wristband to get the bus home and was removed from the department.

On the [redacted] LAS attended to the patient at [redacted] home address who had jumped out of a window, the police were present and initiated first aid. The patient had severe trauma and a ligature around [redacted] neck that had been removed by police. The patient suffered a cardiac arrest and resuscitation was commenced. The team agreed that [redacted] injuries were incompatible with life and resuscitation was terminated by the Helicopter medical emergency Services (HEMS) at 11:11.

Summary of key findings

- The patient was brought in by the ambulance service who clearly demonstrated concerns for [redacted] mental wellbeing. This was documented on the triage notes by the nurse carrying out [redacted] initial assessments.
- The patient had no physical investigations such as bloods, vital signs and cannula despite being tachycardic with a heart rate of 142, as established by LAS.
- The mental health referral was not completed by the triage team
- A miscommunication with the mental health nurse meant that [redacted] was mistakenly believed not to have a mental health problem.
- A 1:1 healthcare assistant was not provided.
- The patient was asked to leave by the nurse in charge following an episode of abusive language.
- Hospital policies and procedures were not followed in [redacted] removal.
- The patient's abusive language was not reported as an incident despite being severe enough for [redacted] removal from the department
- The patient was not seen by a doctor and medically cleared as safe to leave.
- The patient did not have a capacity assessment completed.
- Staff were likely traumatised form a previous incident.
- The care provided to the patient during [redacted] attendance to ED was substandard.

Summary of areas for improvement and safety actions

1. **Area for improvement: Care of mental health patients within ED including policies and protocols**
    a. Introduction of CODE 10 protocol within the department (implemented May 2025)
    b. LAS handover documentation to be added to a shared drive so it is available for all to see
    c. To ensure bloods and physical checks are carried out on all MH patients who have both a physical and MH concerns (implemented May 2025)
    d. Training around capacity assessments for ED medical and nursing staff

2. **Roles of healthcare assistants and 1:1 supervision**
    a. Guidance for clinical staff on when 1:1 supervision is required
    b. Training for HCA staff around caring for MH patients
    c. Rotation of HCA mid shift while carrying out 1:1 care (implemented May 2025)

3. **Management of violence and aggression within the department**
    a. Reintroduce the staff safety meetings (implemented May 2025)
    b. Implementation of a checklist when a patient is being removed from the department for poor behaviour i.e. have all appropriate assessments been completed and recorded?
    c. Staff Listening event around violence and aggression in ED. Supported by trusts inclusion lead.
    d. 24/7 security presence in ED (implemented in January 2025)

Contents

Background and context

The Whittington Emergency Department (ED) sees approximately 110,000 patients per year. Patients attend either by ambulance or of their own accord. Of those 110,000 patients per year, 150-200 per month are referred to the Mental Health (MH) team for an acute psychiatric presentation. At times there are large numbers of MH referrals in one day, and the length of stay in ED, for those waiting for an inpatient bed, is increasing and can be 72 hours plus in ED (waiting for an acute psychiatric bed). Please see table below with numbers of referrals to the MH team from ED per month.

Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total A&E	193	193	167	202	185	157	183	137	147	192	161
No. assessed	172	177	149	183	169	147	163	131	133	169	143

The Mental Health Crisis Assessment Service (MHCAS) provides a support service to 3 local Emergency Departments, the Whittington Hospital (WH), [redacted] Hospital [redacted]) and the [redacted] Hospital [redacted]). MHCAS is based around the back of Whittington Hospital and Highgate Mental Health Centre and offers a hub and spoke service to the 3 EDs. The service ensures a senior liaison nurse is in each ED 24/7 to assess and either facilitate transfer to MHCAS, refer to a specialist registrar (SPR) for review or discharge as appropriate for each individual presentation. The aim of the service is for all acute referrals to be seen or for first contact to be made within 1 hour. The service is available for all patients attending the ED over the age of 18 and is available 24/7. Patients can be referred on arrival by either a nurse or doctor undertaking their initial assessment in the department if the patient presents with a primary Mental Health concern. The MHCAS operational policy governs this service between the acute MH trust and the 3 local EDs. It was last updated in April 2022.

Direct referrals occur when patients can be directly referred to the team if they are known to local services, under a section 136, have self-harmed, have absconded from other mental health units or if they have run out of medication. This referral is inappropriate for patients who are intoxicated, who have physical symptoms, who have overdosed or who have an acute confusional state. A parallel assessment process is in place with all 3 trusts with the expectation that a mental health assessment can take place at the same time as a medical assessment within the ED. A parallel assessment is an assessment of a patient's mental health happening alongside or at the same time as their medical assessment and treatment so as not to delay the patient's journey unnecessarily. i.e. before they are assessed as 'medically fit'. Patients fit to be referred for a parallel assessment are those whose treatment is expected to finish within the 4-hour target time, patients with a medical problem where it is believed there is also a psychiatric problem and those who have taken an overdose whose blood tests are anticipated to be normal. The patient must also be deemed to be assessable i.e. conscious and conversant for an assessment to be able to take place.

Patients arriving to the ED via ambulance are brought into the rapid assessment area and are triaged whereby a handover is given by ambulance staff to hospital staff. A category is assigned demonstrating the seriousness of the patient's condition and urgency in which they should be assessed by a clinician. In the Whittington ED the Manchester triage tool is used to categorise

patients. This is a common, well established, national tool used in many EDs within the NHS. The rapid assessment area is staffed by a senior nurse overnight who receives handover, assesses and initiates initial investigations and referrals for patients arriving via ambulance. During the hours of 10:00-20:00, this area is also staffed by a doctor of either registrar or consultant grade. Once assessment, investigations and referrals are completed the patient is transferred onto a different area of the department. The rapid assessment area is often busy, particularly when high numbers of ambulance arrivals occur, with a high patient turnover, a fast pace and a high workload for staff working there. NHS national standards around ambulance handover (offload) times state that all handovers should take place within 60 minutes, with 95 % being completed in under 30 minutes and 65% being completed in under 15 minutes.

Description of the patient safety incident

Summary of Incident A122107

The patient was brought into the Emergency Department by ambulance on the [redacted] at 06:55 with a mental health crisis. The ambulance handover stated that the patient was feeling suicidal, was intoxicated and stated [redacted] had taken an unknown amount of an overdose of [redacted] prescription medications. [redacted] had declined to have [redacted] vital signs taken by the ambulance crew. [redacted] had a blood test and an ECG taken in the rapid assessment area of the department and [redacted] was prescribed and administered 1 L of intravenous fluids. No vital signs were recorded in the department. [redacted] was referred to the mental health team at 08:57 and moved from the rapid assessment area to the majors area of the department at 10:17. [redacted] was allocated a 1:1 health care assistant during this attendance due to concerns around [redacted] mental state. The patient went outside for a cigarette and had a witnessed fall outside the department. [redacted] was seen by an ED doctor at 10:52 who cleared [redacted] of any injuries from [redacted] fall and medically cleared [redacted] in order for [redacted] to be able to be seen by the mental health team. At 10:54 the patient was reviewed by the mental health liaison nurse who was unable to engage with the patient due to [redacted] being abusive and using inappropriate language. The charge nurse assisted in de-escalating [redacted] and [redacted] cannula was removed. [redacted] capacity was assessed, and [redacted] demonstrated the ability to make decisions about [redacted] care. Due to this and [redacted] unwillingness to engage [redacted] was allowed to leave the department shortly after this.

The patient was brought back to the department by ambulance at 22:27 on the [redacted]. [redacted] was brought in by ambulance under capacity after a friend had expressed concerns around [redacted] mental state. [redacted] had been seen by a rapid response mental health ambulance who had taken a period of time to persuade the patient to attend the department as [redacted] had been reluctant to come in. [redacted] had expressed suicidal ideation and was intoxicated. LAS had stated they had completed a safeguarding referral due to [redacted] expressing [redacted] was getting kicked out of [redacted] house. The patient's vital signs were within normal limits except for [redacted] heart rate which was 142bpm. The patient did not have bloods taken on this attendance nor did [redacted] have an ECG recorded, nor were [redacted] vital signs re-checked within the department. The patient was transferred to the majors area of the department at 23:09. No mental health referral was completed on the system. At 00:46 on the [redacted] the patient was reported to have been shouting at staff in the department using inappropriate and racial language. [redacted] expressed the desire to self-discharge. A junior doctor documented that [redacted] was being verbally abusive to staff and wanted to leave and that after discussion with the nurse in charge of the department [redacted] was waiting for transport home. The nurse in charge documented [redacted] was given a wristband to get the bus home and was removed from the

department. Security were asked to assist with [redacted] removal and [redacted] walked willingly and calmly outside when asked by the security team.

On the [redacted] LAS attended to the patient at [redacted] home address who had jumped out of a window, the police were present and initiated first aid. [redacted] had severe trauma and a ligature around [redacted] neck that had been removed by police. [redacted] suffered a cardiac arrest and resuscitation was commenced. The team agreed that [redacted] injuries were incompatible with life and resuscitation was terminated by the Helicopter medical emergency Services (HEMS) at 11:11.

Investigation approach

Investigation team

Role	Initials	Job title	Dept/directorate and organisation
Investigation commissioner/convenor:			
Investigation lead:	[redacted]	ED matron	EIM

Summary of investigation process

This incident came to the attention of the trust via the MHLT service manager who informed ED managers of a patient who had attended the ED who had tragically lost [redacted] life shortly after attending the department. An incident report was raised on the trust Datix system which due to the serious nature, ensured an alert was raised with the trusts senior leaders. This resulted in a Rapid Action Review (RAR) being written to gather information and an initial investigation into the incident. This report was then presented to the senior leadership team and trusts patient safety leads via the Whittington Investigation Safety Huddle (WISH) panel. This panel was led by Dr [redacted] and panel members of the executive team including the chief nurse and medical director. At this panel a decision was made to investigate this incident further and that a deeper more thorough and detailed report was required due to the seriousness of the patients' outcomes resulting in the requirement for this PSII report.

On completion of this report, a copy will be sent to members of staff involved and the patient's family for accuracy checking. The WISH panel members will then review the report and sign it off. Actions will be monitored by Emergency and Integrated Medicine Unit Quality Committee.

Terms or reference

Incident/incident reference	**2025.426**/ A122107	
Date agreed/version no.	[redacted]	
Date investigation is to be completed by	Reported on StEIS on [redacted]	
Learning response lead	[redacted] Matron ED	
Staff engaged in the development of ToRs (names/roles)	[redacted] - EIM Risk manager [redacted] - EIM ADoN	
Patient/family/carers engaged in the development of ToRs (names/relationship)	**Name**	**Relationship**
	The incident was discussed with the patient's family. The family did not have any questions at the time. It was discussed if they had any questions in the future, they would be able to contact us again. This was followed up with a DoC letter.	

ToR 1	Explore patients' attendance to the Emergency department
Key questions	1. What clinical pathways are used in ED for patients presenting with mental health issues and are there any barriers and facilitators that impact on the care the patient receives on this pathway? a. Was the patient's capacity assessed on presentation and was this documented? b. Was a 1:1 considered? c. Was a referral to MHLT made timely? d. What legal frame work is available in cases like this 2. How are decisions communicated between teams and how are they documented? a. ED staff and MHLT staff b. ED staff and Security staff

	3. What guideline/policies are there in ED for patient who display racial abuse and are there any barriers and facilitators that impact on the care they patient receives following these guidelines/policies? 4. Was the correct procedure followed when the patient was escorted off the premisses? 5. How did the internal environment, technology & tools, organisation of work (i.e. staffing, resource allocation culture etc person (i.e. leadership teamwork roles and responsibilities) tasks and external influences impact on clinical decision making a. Exploring the acuity on the shift and other incidents that might have influenced decision making during the shift. b. Learning from previous events.
Healthcare settings	• Emergency Department • Emergency Medicine • Security team • Internal: policies/guidelines within Whittington health • Mental Health Liaison Team
Healthcare processes	• Clinical Pathway for adults presenting to the Whittington ED with Mantal Health issues • Referral process to the MHLT • Triage process in ED • Discharge planning ED related to racial abusive behaviour • Capacity assessment in ED • Requirements for 1 to 1 nurse

Information gathering

An After Action Review (AAR) was completed using a System Engineering Imitative for Patient Safety (SIEPS) model to understand the different elements involved in this incident. The AAR included the risk management team, ED matron, MHLT staff and managers and representatives from the London Ambulance Service (LAS). The AAR is a multi-disciplinary team (MDT) approach and includes an analysis of what happened vs what was expected, to identify the differences between expectation and event and to identify appropriate learning for the department.

Unfortunately the ED staff involved (triage nurse and NIC) were unable to attend the AAR therefore reflective discussions were conducted with them post AAR to allow their perspectives and voices to be heard in this report. These discussions were carried out by the risk manager in order to offer a subjective view and to allow staff to express their opinions openly and honestly.

During the AAR, documentation was reviewed including previous contact with mental health services, notes from previous ED attendances, LAS documentation and documentation from the night in question. Medical records have been thoroughly reviewed in the process of this investigation.

Guidelines and policies have been reviewed in terms of processes around referring patients to the Mental Health team in the ED. Also guidelines around assessing patients who wish to self-discharge against medical advice have been reviewed along with policies for managing episodes of aggression.

Training records relating to the mental health training received by staff in ED has been reviewed. Nursing staffing rosters have been reviewed to review staffing levels and skill mix along with reports on the situation on capacity in the ED at the time of the incident.

Data has been requested on the numbers of Mental Health patients attending the ED along with incidences of violence and aggression towards staff and other untoward incidents relating to patients with MH presentations.

Findings

The purpose of this section is to share our findings. PSIRF learning responses focus on the broader work system in which patients safety incidents occur. The investigation used an AAR review with a SEIPS model approach. This has enabled us to review and understand how the technology and tools, organisation, person, internal environment, task and external influences impact on patient care. The findings have been grouped into work system factors which contributed to the incident.

Staff recollections:

We start this section by sharing the recollection of staff involved in the incident, the assessment nurse and the nurse in charge. Staff with minimal interactions including the MH nurse and the doctor have provided statements and discussed with their respective line managers. Reflective conversations were carried out by the trusts risk manager in order to ensure staff felt safe to be open and honest.

Triage nurse recollection and reflective conversation

The senior staff nurse who received the patient's ambulance handover and completed [redacted] triage has stated that [redacted] can recall having only a brief interaction with the patient during the process. [redacted] recalls being concerned by [redacted] presenting complaint and allocated [redacted] a category 2 due to [redacted] high mental health risk. [redacted] can recall that the ambulance crew had deemed [redacted] as being under capacity and based on the story from them, [redacted] agreed so documented this on [redacted] triage notes. [redacted] says that although nurses can do capacity assessments, many nurses are not confident and try to avoid assessing capacity so refer to a senior clinician or doctor. Overnight there is no doctor in the rapid assessment area to assess and document capacity assessments. [redacted] recalls the patient sitting in a chair in the assessment area and recalls [redacted] sleeping in the wheelchair in the corridor. [redacted] can recall that [redacted] was clearly intoxicated but was able to provide responses and was able to stand and walk under supervision. [redacted] recalls giving [redacted] an ID band. [redacted] cannot recall taking [redacted] vital signs or bloods. [redacted] cannot recall completing [redacted] referral to psychiatry but remembers asking a colleague working with [redacted] in the area to assist, who [redacted] thought referred [redacted], as there was another patient requiring a referral at the same time and the area was very busy at that time. [redacted] states that normally, [redacted] would refer a mental health patient to the mental health team [redacted] and then find a space in the department for the patient. [redacted] can recall asking the ambulance crew to move [redacted] to the chairs in the majors area of the department and escalating [redacted] concerns to the nurse in charge. Following these interactions, [redacted] was not aware of the following events in ED and subsequent events until spoken to by [redacted] manager.

Nurse in charge (NIC) recollection and reflective conversation

The nurse in charge (NIC) describes how the shift would begin at 19:30, [redacted] would allocate staff and receive a handover from the day nurse in charge. [redacted] recalls a traumatic incident occurring in the department just before the patients arrival, whereby a colleague was strangled by another patient in the department. [redacted] had to provide support to the nurse, ensure [redacted] was booked in and reviewed by a doctor and send [redacted] home. [redacted] recalls the patient arriving shortly after this incident and sitting on the allocated chairs in the main department. [redacted] remembers receiving a phone call from the triage nurse about receiving a patient who was intoxicated and suicidal. [redacted] was brought

to the main department by the paramedic crew. [redacted] appeared safe to sit in a chair and was left in the corridor chairs as the department was full at the time, for the majority of the time [redacted] was sleeping. [redacted] recalls the triage nurse telling [redacted] that [redacted] would refer to the mental health team, so [redacted] believed the referral was completed.

Whilst the patient was sitting in the chairs in majors the nurse in charge can recall [redacted] saying that [redacted] didn't know why the ambulance had brought [redacted] to hospital. [redacted] was initially calm but talking loudly on the chairs in the majors area. [redacted] had a quick conversation with the MH nurse and said the ambulance had brought in a suicidal patient. The nurse in charge can recall the MH nurse approaching the patient for a conversation and recalls the mental health nurse telling [redacted] said [redacted] told the ambulance that [redacted] did not want to come to hospital to be seen by the mental health team. The nurse in charge recalls the MH nurse telling her that the patient was not there for [redacted] mental health and [redacted] had no suicidal ideation. About 45 minutes later she can recall the patient starting to shout in the department and use insulting and racially abusive words, it came out of the blue. She says she went to have a word with [redacted] to ask [redacted] not to use such language up to three times. At this point the nurse in charge called security for assistance and informed them of the language [redacted] was using in the department. She was under the impression [redacted] had been seen by the MH team as she witnessed the MH nurse speak to the patient and that [redacted] denied having suicidal ideation. She recalls [redacted] leaving the department calmly with security, no force was used. She recalls giving [redacted] an ID band to use to get the bus home. She documented there was no medical concerns. She forgot to complete an incident report on Datix in relation to the abusive language as a lot had happened so far during the shift and it slipped her mind. She had discussed with a junior doctor around completing a capacity assessment and was of the belief that if they had had concerns they would have discussed this with their senior and let her know about it.

Doctors recollection and clinical notes review

On [redacted] attendance on the [redacted], the patients medical notes include notes written by a junior doctor which stated that the patient had been verbally abusive and wanted to self-discharge. [redacted] stated this was discussed with the nurse in charge and the patient was awaiting transport. There was no documented capacity assessment in the medical notes and the patient was not documented as having had a capacity assessment on this attendance. It was not documented that [redacted] ability to understand information, retain the information, weigh the information or communicate [redacted] decision was assessed. The doctor has had a discussion with the clinical lead for ED and stated [redacted] did not actually review the patient but had put [redacted] name against the patient as [redacted] was about to review [redacted] when [redacted] was told by the nurse in charge that the patient had been removed from the department for being abusive. In the doctors statement [redacted] recalls hearing the patient shouting at the nurses and being abusive and complaining about the waiting time. [redacted] documentation does not say [redacted] reviewed the patient but that [redacted] had a discussion with the nurse in charge.

Mental Health Nurse recollection

The mental health liaison nurse on duty on the [redacted] recalls being informed of a patient in the department who would be referred to the mental health team and the patient was pointed out to her by a colleague. She was not given the patient's name nor any information in regard to [redacted] presenting complaint. As her shift was busy, she recalls introducing herself to the patient who stated [redacted] "does not know why [redacted] is in the department". She waited for a full referral to MHCAS but none came therefore [redacted] was not referred and hence not assessed. She did not interact with the patient again.

Review of CCTV

As part of the initial investigation, CCTV footage was viewed. At no point was the patient physically abusive or violent. [redacted] remained sitting on the chairs in majors the whole time but could be seen talking to other staff and patients who were seated near to [redacted] or walking past [redacted]. [redacted] was gesticulating with [redacted] arms but did not get up off the chair at any point. It was noted on CCTV that the MH nurse did go to have a very brief conversation with [redacted] and the nurse in charge also approached [redacted] to speak to [redacted]. On [redacted] removal from the department, [redacted] was asked by security to leave due to [redacted] verbal abuse of staff, [redacted] calmly asked where [redacted] should go and was escorted outside and directed to a bus stop and advised to use [redacted] hospital wrist band to get a bus. During [redacted] removal [redacted] was calm and displayed no aggression towards security staff.

Findings:

This investigation has found that there was no referral completed to the Mental Health team. There were no investigations for physical health checks completed in the rapid assessment area. [redacted] was not assessed or seen by an ED doctor. There were communication issues and misunderstandings between the triage nurse, the nurse in charge and the mental health liaison nurse. There is a lack of confidence, knowledge and understanding around completing capacity assessments on patients from ED nurses.

Procedures and Policies

Mental Health referrals in ED

Referrals to the MH team are normally completed by the triage nurse on arrival to the department after the patients initial assessment. They involve a telephone call to MHCAS hub and a detailed handover given to the senior MHCAS nurse whereby they can assess the patients risk and prioritise based on this. MHCAS would then contact the MH nurse based in the department to inform them of a referral to be seen. On the patients second attendance, the triage nurse believed [redacted] had been referred by a colleague at the same time as another patient. However, no referral was put onto the system therefore it appears as though the patient was not appropriately referred to the MH team on arrival to the department. MHCAS do not have a record of a referral of the patient to the team on the night in question. The NIC believed the patient had been referred, and believed the MH nurse had spoken to the patient and established there was no MH concern.

Capacity Assessment

Legal frameworks to be used in cases like this include the Mental Capacity Act. In this act, capacity is defined as the ability to make a decision about a particular matter at the time the decision needs to be made. The act sets out a single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time. It is therefore decision specific and time specific. An act or decision made on behalf of a person who lacks capacity must be in that persons best interests. Being under the influence of alcohol and drugs as was the case with the patient, can impair a person's decision-making skills and temporarily affect their mental capacity. The trust has a Mental Capacity Act (MCA) policy written by the trusts head of vulnerable adults which was

recently ratified on the [redacted] which details how to apply the Act and includes an MCA flowchart to guide clinical staff. Where the patient had apparently verbalised in the department that [redacted] was not here for [redacted] mental health and did not know why the ambulance had brought [redacted] in, [redacted] did not have a capacity assessment to establish if [redacted] understood what [redacted] was in hospital for and to make the decision around leaving or staying in the department.

1:1 allocation

On the patients first presentation, a 1:1 healthcare assistant was allocated to observe [redacted] in the department. A 1:1 healthcare assistant would be allocated if the triage nurse or NIC felt a patient did not have capacity and was high risk of either leaving the department before being seen by a clinician or MH team or of self-harming. If a 1:1 is allocated a capacity assessment should be undertaken and documented by a clinician and both the 1:1 staff member and security team should be informed so they are clear on actions to be taken if a patient attempts to leave the department. On [redacted] second attendance, a 1:1 was not allocated although the triage nurse expressed concerns and that she thought it necessary based on the ambulance handover. This was either not acted on by the nurse in charge or not clearly communicated by the triage nurse. There is no specific guidance on when a 1:1 should be initiated but a high-risk patient with no capacity would normally be flagged at triage. It was unclear if the patient had capacity at the time as it was not clearly assessed or documented, however at the time of the ambulance handover [redacted] did not have capacity. Once a patient has been assessed by the MH team, they will often guide staff on whether a patient requires 1:1 care in ED based on a thorough risk assessment.

As part of the AAR, there was feedback from the MHCAS matron who had provided recent training for the healthcare assistants in ED around caring for patients with mental health issues. Part of the feedback was that further training had been requested from staff around breakaway training and that staff were often providing 1:1 care in ED for a whole shift and they wished to rotate half way through.

This investigation has found there is no clear guidance on when a 1:1 is required for mental health patients attending ED. It is often based on clinical judgement. There is a requirement for further training for those staff members carrying out the 1:1 care.

In conjunction with the trusts lead for vulnerable adults, an external company has been contracted to provide 2 study days to the ED HCAs, breakaway training and verbal de-escalation which will be carried out from [redacted]

Findings:

This investigation has found that there was no referral made from ED to the MH team regarding the patient on the [redacted]. Normal processes were not followed due to busyness of the rapid assessment area of the time of arrival. There was 1 other patient with mental health concerns who arrived at the same time as the patient. There was no capacity assessment completed for the patient. [redacted] did not have a 1:1 allocated during [redacted] second attendance. Guidelines around when to allocate a 1:1 healthcare assistant for observation is unclear. There is a training requirement for further MH training to be provided to ED staff.

<u>Communication</u>

Communication between ED and the MH team

Communication between the ED team and the MH team is carried out in two ways, verbally and written. When a referral is made to the MHLT by a staff member in ED, a speciality referral is put onto the computer system CareFlow which can be seen by all staff working in the department. The referral itself is made over the phone to the MHCAS hub who then communicate with the MH navigator based in ED and ask them to review the patient. The MH navigator will communicate verbally with the nurse in charge of ED about MH patients in the department and will document their notes on the system. The MH team have access to and are able to use two systems, the community system which is RiO and the hospital system CareFlow. Hospital staff only have access to CareFlow. At times the MH navigator will communicate with the NIC, decisions made in real time such as that a patient has been reviewed and can leave the department, or that a patient requires 1:1 supervision and needs to be reviewed by the psychiatric registrar and document afterwards on the system. Verbal communication between the MH navigator and the NIC is often effective.

There are no standardised meetings or huddles between the MH team and NIC of ED. However, the MH team will attend the departmental huddles involving the wider MDT at 09:30 and 12:45 daily to discuss plans for their patients and escalate any issues. The ED huddles are brief meetings involving the wider multi-disciplinary team (MDT) to review the situation in the department and to identify and escalate any issues or safety concerns. There are regular verbal updates between the MH nurse and the nurse in charge regarding all MH patients in the department.

The patient was not officially referred to the mental health team on the night in question. Referrals are very rarely not completed by the triage team. However, if due to acuity and business in the triage area this does not happen, the nurse in charge should ensure this happens as they have overview of all patients in the department. There were misunderstandings about whether a referral had been completed or not and mis communication around [redacted] level of mental health risk between ED and the MH team.

Communication between ED and security

Between ED staff and security staff, communication is nearly always verbal. ED staff are expected to call security if they were required in the department and advise them on what they wanted assistance with, whether that be a patient assessment or assistance with escalating violence and aggression. Security staff are based in a control room off the ED waiting room and are often available fairly quickly on request of clinical staff. At the time of this incident, security were not based inside the emergency department 24/7. The department had experienced increasing episodes of violence and aggression and had written a business case for 24/7 security presence in the department. The aim of this was to act as a deterrent for violence and aggression and to support early verbal de-escalation, a support for clinical staff and for quick actions when needed.

Following a few incidents that occurred in short succession in [redacted], this was enacted by the trust and 24/7 security presence has been had in the department since both in the main waiting room and in the majors area of the department.

Communication between LAS and ED

As part of the AAR , London Ambulance Service (LAS) staff attended. They expressed the concerns they had raised in regard to the patient's mental state and felt that these concerns were not raised to the MH team. LAS described how a rapid response mental health car had attended the patient to assess [redacted] at [redacted] house. The rapid response team had felt [redacted] was unwell and required to attend hospital and had taken a significant period of time to persuade [redacted] to attend (2 hours). LAS uses

an electronic patient record system to document their patient assessments. These are available to view online on the ambulance screen when on route and on arrival to the department by hospital staff. However, once the ambulance has 'pinned off' (completed the case and signed it off on the system) and moved on to the next patient this is no longer available to hospital staff to see. These are not routinely printed off by reception staff and put in the patient notes as previously happened with the paper copies. This means that once the ambulance crew has left, their notes are no longer available. However, the aim of the rapid assessment area is to collect vital information from the paramedics in a systematic way and triage the patient based on the ambulance handover and vital signs using the Manchester triage system. This is documented on the triage notes but is significantly shorter and more condensed than the paramedics electronic records. During the AAR, it was agreed that had the MH navigator had access to the paramedics notes, they may have made a more informed decision or had more concerns around [redacted] state of mind. However, the triage nurse had documented significant risks in the triage such as that [redacted] had brought a rope and documented that the patient had no capacity based on LAS assessment.

An improvement action from the AAR for the ED service manager is to implement a system by which admin staff are responsible for downloading and adding handover sheets to a patient file or sharing them to a shared folder on the system. This will give access to all who require thorough information from the ambulance crew.

Communication between ED staff

In the patient case, there were clear concerns documented by the triage nurse that would classify the patient as high risk, such that [redacted] had brought a rope. The triage nurse documented clearly that the patient had no capacity. Normally a telephone handover is provided between the triage nurse and the nurse in charge so that the nurse in charge can allocated an appropriate space or cubicle based on the patients clinical condition and presenting complaint. [redacted] was not offloaded directly into RAT, as most ambulances are but brought into majors by the ambulance crew. This will occur at the discretion of the triage nurse and nurse in charge and can occur with MH patients at times if deemed to be high risk as it can be deemed safer to directly allocate them to majors for observation. This would have minimised the interactions between the triage nurse and patient as the patients time in the assessment area was short.

Despite the clear documentation on the triage of the concerns regarding the patient from LAS, these risks were lost on arriving in the main department.

Documentation

The triage was thorough and identified clear risks and a lack of capacity as disclosed by the ambulance crew during handover. There was basic documentation from the nurse in charge around the patient's behaviour in the department and [redacted] subsequent removal. There was documentation from a junior doctor who had not assessed the patient, nor had [redacted] assessed [redacted] capacity. There was no documentation from the MH team in relation to this attendance or any form of assessment.

Findings:

There was a lack of communication of the risks associated with the patient's attendance between the ED team and MH team. This was primarily due to no official referral to the MH team being completed. Informal communications took place instead where vital information was not

communicated or misunderstood. Although [redacted] was deemed high risk by the ambulance crew, and this was documented by the triage team, this did not filter through to the MH team. There is currently no way for the MH team to access the ambulance notes in the current admin processes and systems of work. There was a lack of acceptable documentation throughout the patient's attendance.

Security were not previously based in the ED 24/7 to support staff when situations would begin to escalate.

Management of violence and aggression in ED

The trust has a violence and aggression at work policy contains guidelines for supporting staff in managing violent and aggressive behaviour at work. This policy was written by the trusts security lead and ratified on the 7th April 2024. It contains the following paragraph in section 7.1

7.1 Where an individual is presenting with violent and aggressive behaviour from the outset of their community or hospital attendance, staff can ask them to leave the premises. In the case of patients, a patient should only be asked to leave where it has been clinically assessed that urgent healthcare is not required. If necessary, the patient/visitor can be removed from Trust premises with the assistance of the Security Services, or the police if in the community.

Urgent healthcare would include both physical and mental health care assessments, treatments and investigations. The patient was removed from the emergency department without an assessment of [redacted] physical condition. [redacted] had a heart rate recorded of 142 bpm which indicates tachycardia and should have been investigated further or treated and reassessed. [redacted] was reportedly intoxicated. [redacted] did not have an assessment of [redacted] mental health despite concerns from the ambulance crew who brought [redacted] into the department which was documented in the triage.

Four steps are advised in the policy. The first being a verbal warning, second a behaviour contract, third an orange card or formal written warning and fourth consideration of withdrawal of treatment. The verbal warning is taken from the policy below and states that a person's mental capacity should be considered when giving the verbal warning. The three steps after verbal warning are enacted by senior staff such as matrons, clinical leads and general managers following MDT discussions. A red card or withholding of treatment needs executive sign off.

8.7 The Line Manager and/or senior member of staff must explain to the patient or visitor that their behaviour is unacceptable and outline the expected standards that must be observed in the future. This should be used as an opportunity to defuse the situation and prevent escalation. Line Managers and senior members of staff should consider the individual's communication requirements e.g., is interpretation required. They should also consider their mental capacity (in accordance with the Mental Capacity Act); are they able to understand the explanation and expectations or do they require a family member or an independent advocate to be present.

As happened in this case, the patient reportedly used racially abusive language towards the nurse in charge of the emergency department when she asked [redacted] to be less abusive. As it was out of hours, there was no line manager for the NIC to turn to for support. This is an already highly pressured and stressful role with many competing demands. This demonstrates a lack of support for the charge nurses in ED out of hours particularly if they are on the receiving end of the abuse.

No colleagues stepped in to assist or support her. The policy states that if staff want a patient removed from an area of the hospital, security and the site manager should be called for support. This is not routinely carried out in ED Out of hours the ED charge nurses are often left to make clinical decisions themselves when under immense stress and pressure. There would have been a middle grade doctor in charge of the department overnight who could have offered support, or a site manager called to support as a source of escalation. Neither of these escalations were clearly enacted. Mental capacity was not assessed as being under the influence of alcohol can significantly alter a person's mental capacity.

Incident reporting

Reporting the incidence of violence and aggression on the trusts Datix system is reiterated continuously in the violence and aggression policy. Staff are advised to report all incidences of violence and aggression including those of a racial or sexual nature.

There was no incident report written or recorded on Datix for the alleged abuse given by the patient to the nursing staff despite it being severe enough for [redacted] to be removed from the department.

Staff safety meetings

For the past few years, since seeing a rise of violence and aggression during covid, the department has held staff safety meetings led by an ED consultant and attended by a senior nurse, the trusts security managers, admin support and the police liaison team. These monthly meetings discussed in detail all the incidences of violence and abuse in the department and ensured staff were contacted if support was needed, encouragement was given to report crimes the police felt could be prosecuted and feedback on ongoing cases were provided. There was regular feedback to staff on the number of incidences of violence and aggression and emails explaining what to report and how and who to go to for advice or support. Behaviour letters were often sent to patients following these meetings following an MDT discussion as to whether it is warranted, these inform patients of their negative behaviour and inform them of the expected behaviour in the future. Staff in ED regularly report incidences of aggression, verbal abuse and violence on the Datix system. Over the past few years these meetings have fallen though for a number of reasons, the ED consultants long term sickness, a lack of admin support and the police liaison service being disbanded and passed to the local constabulary. This meant that it was difficult obtaining police presence who had previously been a great source of advice. However, staff have continued to report incidences regularly and the meetings are now back up and running regularly, with limited police attendance.

These meetings have now been restarted on a monthly basis to provide support and governance around managing challenging behaviour within the department.

Findings:

The investigation has found that correct procedures were not followed when the patient was escorted off the premises for [redacted] verbal abuse. There was no assessment of whether [redacted] needed urgent health care due to either a mental or physical illness prior to [redacted] removal. No capacity assessment was undertaken prior to [redacted] removal. There was no escalation of [redacted] behaviour to the site manager. No incident report was completed

CODE 10

The ED matron and ED clinical lead in conjunction with the MH team manager have decided that due to a number of recent high-risk incidents, to introduce an action called a CODE 10. A CODE 10 is a Mental health emergency call enacted over the departmental tannoy that alerts the necessary staff of a high-risk MH patient and is designed to provide guidance to staff on how best to manage these patients. The purpose of a CODE 10 is to ensure that high risk mental health patients receive coordinated, timely and safe assessment and care which is within their best interests. A CODE 10 alert should be attended by the ED doctor in charge, the nurse in charge, the MH navigator, the security team and if available an HCA. This protocol should be enacted when a patient is brought to the department who is thought to be a serious or imminent risk of harming others, a serious or imminent risk of self-harm and trying to leave, or when a patient is displaying challenging behaviour and the patient is thought to not have capacity. It can also be utilised for patients brought in by police and detained under the Section 136 of the mental Health Act (MHA) 1983. The CODE 10 can be enacted by any staff member at any time in the patients journey if risk escalates or behaviour changes. When the CODE 10 is enacted, the team will make decisions based on the risk of the patient, where the patient should be cared for in the department, whether a 1:1 is required, a capacity assessment should be completed and whether rapid tranquilisation medication is required. A flow chart providing guidance on the process of assessing patients for rapid tranquilisation and seclusion has been developed in conjunction with this. A CODE 10 should be clearly documented in the clinical notes with the plan for the patient.

Environment and external influences

Departmental Acuity and Environment

On the night in question, at the ED situational report completed at 19:15, the department was in Operational Pressures Escalation Level 4 (OPEL4), which is the highest level and this meant the department was at full capacity. At this time there were 101 patients in the whole department, 5 of whom were under the mental health team. The hospital was in a minus 35 bed position and there were 20 patients in the ED waiting for inpatient beds within the hospital. This demonstrates significant pressures within the department in terms of both acuity, capacity and mental health. There was no further situational reports completed prior to the incident.

The Whittington ED has no separate area for treating mental health patients, who are often cared for in the majors department alongside medically unwell patients. There are two safe MH cubicles reserved specifically for high-risk mental health patients with ability to provide seclusion in a ligature free environment. Both rooms were full at the time of the patient's attendance. The patient did not require these cubicles. [redacted] was allocated to a chair in the majors corridor. This environment is not always a conducive environment for providing mental health care to patients as it can be busy and noisy, however, there is very limited space within the department.

Staffing

On the [redacted] night shift there were 21 registered nurses and 5 health care assistants on shift. Of the staff members there were 2 band 7 nurses and 6 band 6 nurses. 6 nurses were completing bank shifts and there were 2 agency nurses. 1 of the health care assistants was a bank staff

member. Normal staffing as per establishment is 17 registered nurses and 5 healthcare assistants. Four extra nursing staff were booked as part of winter pressures and for corridor care which is assessed daily at times of extreme pressure to ensure standards of care are maintained for those patients cared for in corridors and non-clinical areas. Staff are allocated to specific areas of the department based on skills and experience to ensure areas which require more independent assessment and skill such as triage and rapid assessment are staffed by more experienced staff. This represents good staffing with a good skill mix.

However, one nurse was assaulted and was unable to work a few hours into the shift which would have left the department short of 1 nurse based on acuity and capacity. This incident also very likely emotionally affected the remaining staff on shift, particularly those who witnessed the incident in the majors area where the patient was later allocated to sit.

Leadership

ED charge nurses are band 7 nurses who have a vast amount of experience in an emergency department. There are 7.62wte band 7 ED nurses in the Whittington covering nurse in charge shifts 24/7 which they self-roster themselves to cover the department. They have all worked as band 5 and band 6 nurses and completed a qualification in specialism post graduate course in emergency nursing. They have completed shift leader competencies and are capable of managing an emergency department out of hours. Part of their role includes line managing a group of ED nurses alongside leading the shifts on a daily basis. ED charge nurses learn the majority of their work through clinical experience and time on the job. This can be supported by appropriate leadership courses. The ED charge nurses are accountable to and line managed by the ED matrons. Since this incident the matrons have reviewed clinical supervision provided to the charge nurses in the department. Some nurses work more night shifts than others due to preference, flexible working and fitting in around each other's shifts. The charge nurse on duty this night worked mainly nights due to flexible working and had done for many years. However, this has resulted in difficulty in the ED matrons providing clinical supervision to those who mainly work night shifts. This is currently under review in order to ensure all charge nurses are working a variety of shift patterns in order to offer managerial support and clinical supervision to all band 7 charge nurses.

Incident that may have affected clinical decision making

Prior to the patient's attendance, there was an incident involving another patient. At 22:50 on the [redacted] a senior staff nurse was assaulted and strangled by another mental health patient. This incident was witnessed by staff within the department and was quite distressing for those involved. This incident was reported on the trusts incident reporting system, Datix number [redacted] The incident was serious enough to require a rapid action review and be reported to the trust's executives. It resulted in significant psychological harm to the staff member assaulted. Human factors were therefore likely to be affected in the clinical decision-making regarding the patient as staff were already distressed by the previous incident. This may have contributed to a lower tolerance to further incidences of aggression in the immediate aftermath.

The NIC asked for the patient to be removed from the department after verbally asking [redacted] to refrain from using abusive language and racist remarks. No colleagues stepped in to assist. This could be due to several factors including hierarchy as the NIC was overall the most senior nurse on shift or a lack of awareness of the effect of being on the receiving end of such comments from an individual. This incident has been discussed with the trusts director level lead for inclusion and

a listening event to engage staff to discuss such scenarios and their experiences of similar incidences will be explored.

The introduction of the CODE 10 will allow staff in a similar situation in the future to activate the CODE 10 to get support from colleagues. This will allow the affected staff member to remove themselves from the situation and allow colleagues who are not affected by the patients remarks to make clinical decisions in relation to the patient. This will allow a member of the mental health team in conjunction with the doctor and nurse in charge to make a clinical decision in the best interests of the patient, which would include a capacity assessment and a decision on whether medical or psychiatric care is required.

Findings:

The shift in question was particularly challenged, both in terms of capacity, acuity and numbers of mental health patients. Although a good skill mix of nurses, the department was short of 1 nurse based on the acuity and capacity. Clinical supervision and support for staff working mainly nightshifts is challenging.

There was a significant and distressing incident that occurred shortly before the patient's arrival. This very likely would have influenced staff members clinical decision making and judgement and lowered tolerance to further episodes of violence and aggression.

Summary of findings, areas for improvement and safety actions

To summarise the findings of the investigation.

- The patient was brought in by the ambulance service who clearly demonstrated concerns for [redacted] mental wellbeing. This was documented on the triage notes by the nurse carrying out [redacted] initial assessments.
- The patient had no physical investigations such as bloods, vital signs and cannula despite being tachycardic with a heart rate of 142, as established by LAS.
- The mental health referral was not completed by the triage team
- A miscommunication with the mental health nurse meant that [redacted] was mistakenly believed not to have a mental health problem.
- A 1:1 healthcare assistant was not provided.
- The patient was asked to leave by the nurse in charge following an episode of abusive language.
- Hospital policies and procedures were not followed in [redacted] removal.
- The patient's abusive language was not reported as an incident despite being severe enough for [redacted] removal from the department
- The patient was not seen by a doctor and medically cleared as safe to leave.
- The patient did not have a capacity assessment completed.
- Staff were likely traumatised form a previous incident.
- The care provided to the patient during [redacted] attendance to ED was substandard.

Safety action summary table

Area for improvement: Care of mental health patients within ED including policies and protocols								
	Safety action description *(SMART)*	**Safety action owner** *(role, team directorate)*	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** *(eg daily, monthly)*	**Responsibility for monitoring/ oversight** *(eg specific group/ individual, etc)*	**Planned review date** *(eg annually)*
1.	Introduction of CODE 10 protocol within the department	[redacted] (ED matron), [redacted] (ED Clinical lead) [redacted] (MHLT manager)	May 2025	6th May 2025	Audits of code 10 documentation	Monthly audits performed	ED matrons, [redacted] (ED charge nurse and MH link nurse)	3 monthly
2.	LAS handover documentation to be added to a shared drive so it is available for all to see	[redacted] (ED Service manager)	August 2025		Shared drive available		ED Service manager	Annually
3.	To ensure bloods and physical checks are carried out on	ED Matrons	May 2025		MH audits carried out monthly		ED Matrons, MH link nurse	Monthly

	all MH patients who have both a physical and MH concerns							
4.	Training around capacity assessments for ED medical and nursing staff	ED Matrons	Dec 2025		Training completed		ED PDNs	3 monthly

Area for Improvement: Roles of healthcare assistants and 1:1 supervision								
	Safety action description *(SMART)*	**Safety action owner** *(role, team directorate)*	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** *(eg daily, monthly)*	**Responsibility for monitoring/ oversight** *(eg specific group/ individual, etc)*	**Planned review date** *(eg annually)*
1.	Guidance for clinical staff on when 1:1 supervision is required	[redacted] (ED Matron) [redacted] (MHLT manager)	July 2025		Available guidance		ED matrons	3 months initially

2.	Training for HCA staff around caring for MH patients	[redacted] (ED Matron) [redacted] (PDN)	December 2025		Completion of training of verbal de-escalation and break away training for all HCA staff in ED.		ED matrons and ED PDNs	Annually
3.	Rotation of HCA mid shift while carrying out 1:1 care	[redacted] (ED charge nurse and MH link)	May 2025	May 2025	Staff feedback	Weekly	ED Matrons	Monthly

Area for improvement: management of violence and aggression within the department								
	Safety action description *(SMART)*	**Safety action owner** *(role, team directorate)*	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** *(eg daily, monthly)*	**Responsibility for monitoring/ oversight** *(eg specific group/ individual, etc)*	**Planned review date** *(eg annually)*

1.	Reintroduce the staff safety meetings	[redacted] (ED consultant) [redacted] (ED Service manager)	May 2025	May 2025	Minutes of the meetings held. Updated violence and aggression spreadsheet. Behaviour letters sent out.	Monthly	ED matrons	Annually
2.	Implementation of a checklist when a patient is being removed from the department for poor behaviour i.e. have all appropriate assessments been completed and recorded?	[redacted] (ED Matron)	July 2025		Documentation available		ED matrons	Annually
3.	Staff Listening event around violence and aggression in ED. Supported by trusts inclusion lead.	[redacted] (ED matron)	August 2025		Minutes of listening event meeting. Feedback from staff.		ED matrons, Trust Inclusion lead.	3 months
4.	24/7 security presence in ED	[redacted] security Lead	January 2025	January 2025	Security roster. Feedback from ED staff.		[redacted]	3 monthly

Appendices

AAR completed in March 2025

After Action Review (AAR) Report

The event	Patient Suicide Following Removal from ED
ICSU	EIM
Ref	A122107
Date of the event	[redacted]
Points to consider	
Date of the meeting	[redacted]
Sponsor *(Individual calling the AAR)*	Mental Health Crisis Assessment Service
Attendees	[redacted] Head of Service Liaison, Place of Safety and MHCAS [redacted] - Mental Health Liaison Teams (UCLH, Royal Free & Whittington Hospitals) [redacted] -Team manager, Whittington Mental Health Liaison Team [redacted] - Risk Manager for EIM [redacted] - Matron for ED [redacted], Consultant Nurse for Mental Health at London Ambulance Services [redacted] - Psychiatric Liaison Nurse [redacted] Head of Clinical Quality North Central Sector for London Ambulance Services [redacted], Clinical Nurse Specialist for Whittington Mental Health Liaison Team
Apologies	N/A

Expected Outcome *(what was expected)*:

- When a high-risk mental health patient is brought to the Emergency Department, a comprehensive handover should occur between LAS and the triage team to flag any concerns raised on their attendance.
- The triage notes should be detailed and flag any concerns raised upon initial assessment.
- The LAS handover sheet should be accessible to clinical staff throughout the patient's stay. This can be achieved through admin team downloading and saving the sheet into a shared folder; alternatively, the paperwork can be printed and placed in the patient's file.
- All medical and mental health assessments should be documented on CareFlow and a 1:1 should be implemented if guidelines suggest so.
- If a 1:1 is implemented, staff members should be regularly rotate to avoid fatigue, and to improve engagement with agitated patients.
- If a high-risk patient displays verbally aggressive behaviour, appropriate escalation processes should be in place (i.e. issuing verbal warnings, alerting security, escalating to matrons and senior clinicians.
- Should a patient need to be removed from the department, they should be assessed for any medical needs and a capacity assessment should be undertaken. The patient's history in the community and the concerns raised by LAS should also be re-evaluated.
- A capacity assessment should be performed by a senior clinician, that takes into consideration the patient's risk to self as well as their capacity to make decisions.
- This should be clearly documented before a patient is removed from the department. If a patient is deemed to be a risk to themselves, they should be placed under the MCA, and appropriate escalation processes re. their behaviour should continue to be implemented throughout their stay.

The Event/Outcome *(what happened)*:

[redacted]: The patient was admitted to ED by LAS for intoxication, an overdose and repeated suicidal ideations, triggered by accommodation issues they had been facing. Upon arrival, [redacted] was assessed by the medical team and placed on a 1:1, as [redacted] was high risk of absconding. Throughout [redacted] time in the department, [redacted] was reported as verbally abusive towards staff and non-compliant with care. MHLT assessed the patient and deemed [redacted] to have capacity, the patient subsequently self-discharged.

[redacted]: The patient presented a second time with LAS under MCA, for intoxication and repeated suicidal ideations. LAS handed over to RAT, and the patient was triaged. The triage notes clearly documented that patient's suicidal ideations, and that they were brought in under the capacity act. Unfortunately, a referral to MHLT was not made at triage, and the patient was brought to MOF with concerns escalated to the NIC. There was brief documentation describing patient as verbally abusive towards staff, non-compliant and wanting to self- discharge (denied any suicidal ideation). It was briefly documented that patient was seen by MHLT, and the patient was escorted off site by security. No formal capacity assessment, MH or medical assessment had been documented or carried out.

[redacted] LAS attended to the patient who had jumped out of a window, police were present. [redacted] had severe trauma and ligature that had been removed by police. [redacted] went into cardiac arrest and [redacted] injuries were incompatible with life. Resuscitation was terminated by HEMS at 11:11 on [redacted].

Analysis *(What was the difference in the expectation and event)*:

Following discussion, discrepancies in process were identified:

Communication and Escalation:

It was noted that limited communication regarding the patient's assessment contributed to confusion across teams. For example, the Nurse in Charge believed that the patient had been cleared by MHLT when [redacted] was removed from the department. However, this assessment had not taken place; there had only been a brief interaction between the liaison nurse and the patient, which was not documented later. It was acknowledged that increased pressures within the department have made verbal escalation a common practice, which can lead to confusion about which processes and assessments have been completed. Additionally, it was noted that a junior staff member conducted the capacity assessment before the patient's removal, and there was agreement that this should have been done by a senior clinician.

LAS highlighted that the process for managing mental health patients within the north central sector required increased promotion (the use of MHCAS). There are limitations to MHCAS as if the patient also presenting with a physical condition that requires attention, they will need to be transferred to the ED, as in this case where the Patient was suffering from severe alcohol withdrawal. There have been some issued highlighted through the Midos feedback system around the pathway which are being reviewed with the teams to ensure that eligible patients are accepted in to unit, capacity has been highlighted. The LAS team will continue to work with partners around this pathway.

To improve communication across teams and to anticipate potential risks for patients, it was proposed that MHLT and clinical staff attend regular huddles in the department. It was also proposed that an escalation system similar to a Code 10 be implemented.

Premise of a Code 10:

When a high-risk patient is brought to the department (particularly those with concerns from LAS and the police), an alert should sound requiring the nurse- in- charge, senior clinician, security lead and member of MHLT (if possible) to attend the rapid assessment area. They should perform a risk assessment and create a care plan, which should be regularly reassessed throughout the patient's stay. This had been proposed in a previous meeting held by the emergency department, where it was agreed the alert should be implemented. The ED matron also reiterated the importance of using the Code 10 when a high-risk patient is attempting to leave the department, or if a patient is being abusive and may not have capacity, to mitigate potential hazards.

Documentation:

It was acknowledged across all teams that documentation was a primary issue throughout the patient's stay in the department. A MHLT referral flagging the patient's risk to self should have been made upon initial assessment; it seems that this was not completed due to a miscommunication between the triage team.

There were also no documented assessments (from medical or MH staff) provided to clear the patient's removal from the department. Whilst it is recorded by nursing staff that the patient was assessed by MHLT, this discussion was also not documented (again due to miscommunication amongst teams), and no Datix was completed to note the abusive behaviour of the patient.

As previously mentioned, it was agreed that environmental pressures in ED have created a culture of verbal escalation as opposed to written. This subsequently places all members of staff in a vulnerable position, and there was a resolve to improve documentation processes across teams. It was also agreed that documentation needed to be added and checked before a high-risk patient can be allowed to leave the department.

Additionally, concerns regarding LAS handover documentation were raised. Whilst handovers are often clear and comprehensive, it was noted that there is difficulty accessing LAS sheets later into the patient's stay. It was suggested that a shared folder be created on the system, so that any high- risk patient's handover sheets can be downloaded and saved for staff to view later. Alternatively, it was suggested that high-risk patient's files are immediately retrieved when being registered, so that the handover sheet can be printed and attached for further review.

Environment and Training:

It was widely agreed that environmental factors contributed to lapses in process regarding this incident. The ED matron highlighted that the patient attended the department on a particularly busy night, when there were already many mental health patients within majors. An hour prior to the patient's removal, a member of staff had been physically assaulted in the major's area by another mental health patient, which greatly impacted staff involved and likely contributed to their response regarding the patient's verbally abusive behaviour. The human elements contributing to this incident were acknowledged, as well as the risks of compassion fatigue when attending to agitated patients for extended periods of time. The impact of the major's environment on the well-being of patients was also acknowledged, as the busy area can contribute to increased distress.

The strain experienced by staff during busy shifts, particularly when managing high numbers of mental health patients, was emphasised, with a request for additional mental health training and guidance to be offered. The ED Matron requested further guidance on the implementation of 1:1s (on the patient's second attendance no 1:1 was allocated despite concerns) to support the nurse-in-charge, particularly when the department is understaffed. MHLT also requested a review of the observation policy, noting concerns previously raised by 1:1 staff about insufficient support from clinical teams when managing agitated patients. The importance of 1:1 rotation was emphasised to help reduce staff fatigue during shifts.

The ED Matron noted that since September of last year, the department has been in the process of recruiting HCAs; this is now completed, making it easier to fully train staff and implement rotations on shifts. The Psychiatric Liaison Nurse reiterated a desire within the HCA team to receive further PMVA (Prevention and Management of Violence and Aggression) training, to improve their engagement with agitated patients. It was noted that the Head of Vulnerable Adults is currently organising breakaway training to be implemented trust-wide (beginning in ED), to help improve staff's engagement with these types of patients.

MHLT also highlighted the introduction of two new drug and alcohol workers, who will be able to support with vulnerable patients entering the department and further consider their risk-to-self.

Concerns were raised that the Whittington is the only North London Trust that does not have a Mental Health lead in ED; this had also been raised in a previous meeting on violence and abuse within the department, and it was agreed that it should be noted in the AAR minutes.

Learning *(what is the learning):*

- Once the patient has entered the assessment area, an alert similar to a code 10 should be sounded. This should prompt the senior clinician, nurse-in- charge and security lead (and a member of MHLT if available) to attend rapid assessment. A risk assessment should be performed, and a comprehensive care plan should be put in place to manage the patient's needs throughout their stay- this should be updated regularly.
- LAS handover sheets need to be printed and added to a patient's file once they are registered, to ensure the information is not later lost.
- A 1:1 should be allocated to the patient (if guidelines suggest so) and regularly rotated to avoid staff fatigue and improve engagement.
- All nursing, clinical and MHLT assessments should be clearly documented on the system; verbal communication is not an adequate method of escalating high-risk patients.

- If a patient is being verbally or physically abusive, a code 10 should be enacted, enabling an MDT to decide whether the patient has capacity and what the plan should be.
- All other assessments recorded on the system (including the handover sheet from LAS) should be taken into consideration and checked before the patient is allowed to leave the department.
- A patient's risk assessment should consider the patient's risk to self once they leave the department (medical history, current circumstances, previous attendances to the department, etc.).
- If a patient is verbally abusive with a history of mental health, they still must be thoroughly assessed before they are allowed to leave the emergency department.

Number	**Quality Improvement Action Plan:** **Recommendation** (please number each one)	**Specific actions** (SMART- specific, measurable, achievable/action-related, relevant, time-specific)	**Responsible person** (include job titles)	**By when**	**Evidence of implementation** (Assurance of action complete i.e. audit/spot checks, to ensure changes have been embedded)
1	Improve communication across teams	- Implementation of regular MH huddles in the department.	[redacted] for ED [redacted], Clinical Lead for ED	01.05.25	Meeting in the diary

			[redacted], Mental Health Liaison Teams Service Manager		
2	Streamline assessment processes for high-risk patients brought by LAS/ Police	- Implementation of a Code 10 system, for high-risk patients entering the department and when they are attempting to leave.	[redacted] and [redacted], Matrons for ED [redacted] Clinical Lead for ED [redacted] Security Advisor	01.04.25	Code 10 introduced
3	Improve documentation across teams.	- Implementation of a checklist when a patient is being removed from the department for poor behaviour i.e. have all appropriate assessments been completed and recorded?	[redacted], Matron for ED [redacted], Clinical Lead for ED	01.07.25	
4	Improve support given to 1:1s	- Implementation of regular rotations for 1:1s attending to agitated patients.	[redacted] and [redacted],	01.05.25	

			Matrons for ED		
5	Increase MH and PMVA training provided to ED staff.	- Implementation of breakaway training trust-wide, beginning in ED. - Implement more comprehensive PMVA and MH training for 1:1s specifically.	[redacted], Head of Vulnerable Adults [redacted], Mental Health Liaison Teams Service Manager	01.12.25	
6	Improve the handling of LAS handover documentation.	- Systems to be implemented by which admin staff are responsible for downloading and adding handover sheets to a patient's file and/ or saving them into a shared folder on the system.	[redacted] Service Manager for ED	01.08.25	

ICSU Executive approval		
Name and title	**Signature**	**Date**
[redacted] ADoN EIM		

[redacted] CD EIM		

References

1. Emergency Triage: Manchester Triage Group, 3rd ed, (Advanced Life Support Group) 2023
    - https://www.triagenet.net/classroom/

2. Management of violence and aggression at work policy.
    - https://whittnet.whittington.nhs.uk/document.ashx?id=4301

3. Mental capacity Act (MCA) policy
    - https://whittnet.whittington.nhs.uk/document.ashx?id=8906

4. Mental Health Liaison Service Operational Policy (Incorporating the mental health crisis assessment service). Camden and Islington NHS foundation trusts. April 2022.

Meeting title	QAC	Date: 14/01/2026
Report title	**Quarterly Learning from Deaths (LfD) Report** Q2, 1st July to 30th September 2025	**Agenda item: 4.6**
Executive director lead	Dr Clarissa Murdoch, Chief Medical Officer	
Report authors	Dr Sarah Gillis, Associate Medical Director Learning from Deaths Ruby Carr, Project Lead for Learning from Deaths	
Executive summary	During Q2, 1st July to 30th September 2025, there were 102 adult inpatient deaths (excluding deaths in the Emergency Department (ED), reported at Whittington Health (WH). 8 adult structured judgement reviews (SJRs) were requested for Quarter 2, and of these, 6 have been completed. 60 non-SJR mortality reviews were completed. There have been some delays in completion due to the impact on clashes with departmental morbidity and mortality meetings which were timetabled during resident doctor industrial action There were 0 maternal deaths. There were 0 neonatal deaths in Q2. There were 0 paediatric deaths. The latest published Summary Hospital-level Mortality Indicator (SHMI) is 0.895 for the Whittington and is for the data period Aug 2024 to Jul 2025.	
Purpose:	The paper summarises the key learning points and actions identified in the mortality reviews completed for Q2, 1st July to 30th September 2025.	
Recommendation(s)	Members are invited to: • Recognise the assurances highlighted for the robust process implemented to strengthen governance and improved care around inpatient deaths and performance in reviewing inpatient deaths which make a significant positive contribution to patient safety culture at the Trust. • Be aware of the areas where further action is being taken to improve compliance data and the sharing of learning.	
Risk Register or Board Assurance Framework	Captured on the Trust Quality and Safety Risk Register	
Report history	Not previously presented	
Appendices	Appendix 1: NHS England Trust Mortality Dashboard	

1. Introduction

1.1 This report summarises the key learning identified in the mortality reviews completed for Quarter 2 of 2025/26. 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/ngb-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) and autism.
- All inpatient deaths of patients with a severe mental illness (SMI) diagnosis. SMI is defined as schizophrenia, schizoaffective disorders, bipolar affective disorder, severe depression with psychosis. In addition to where these diagnoses are recorded in a patient's records, the use of Clozapine, Lithium and depot antipsychotic medication are indicative of these diagnoses.
- 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 are reviewed as per national guidance and included in this report.

3. Mortality Review Quarter 2, 2025/26

3.1 There were 102 adult inpatient deaths (excluding deaths in ED) reported at Whittington Health (WH).

3.2 There were 0 neonatal deaths in Q2 at the Whittington.

3.3 There were 0 paediatric deaths. However a 3 day old child with likely sepsis was retrieved to PICU and sadly died there. An invesigation is underway.

3.4 There were 0 maternal deaths.

3.5 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)	25
Cavell	4
Cloudesley	12
Meyrick	17
ITU (Intensive Treatment Unit)	10
Nightingale (respiratory)	16
Coronary Care Unit (Montuschi)	5
Thorogood	2
Victoria	6
Coyle	2
Mercers	0
Eddington	3
Cearns	0
Theatres Recovery	0
Child/neonatal	0
Maternal	0
Total:	**102**

3.6 Table 2a shows the total number of mortality reviews and SJRs required and how many of these reviews are outstanding. There has been some feedback that mortality reviews and departmental Morbifity and Mortality meetings have been delayed due to the pressure of resident doctor industrial action.

Table 2a: *Total number of Mortality reviews and SJRs required.*

	Number of reviews required	Completed Reviews	Outstanding reviews
Adult Mortality Reviews	94	60	34
Neonatal and Paediatric Mortality Reviews	0	0	0
SJR	8	6	2

3.7 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)	1	0
Cavell	0	0
Cloudesley	0	0
Meyrick	1	0

ITU	1	1
Nightingale	0	0
Coronary Care Unit (Montuschi)	1	1
Victoria	0	0
Coyle	1	0
Mercers	0	0
ED	2	0
Thorogood	1	0
Theatres Recovery	0	0
Other	0	0
Total:	**8**	**2**

The ITU team felt unable to review fully as they felt the review needed to be from a surgical perspective. The general surgical team is aware and the SJR has been allocated.

Table 3: *Reasons for deaths being assigned as requiring an SJR during Quarter 4, 2024/25*

Criteria for SJR	Number of SJRs identified	Completed SJRs	Comments
Staff/clinician raised concerns about care	1	1	This is also a Coroners referral
Family raised concerns about quality of care	1	1	
Death of a patient with Serious mental illness (SMI)	2	2	
Death in surgical patients	0	0	
Paediatric/maternal/neonatal/intra-uterine deaths	0	0	
Deaths referred to Coroner's office without proposed cause of death	1	1	
Deaths related to specific patient safety or QI work	0	0	
Death of a patient with a Learning disability	1	1	
Medical Examiner concern	2	0	1 of these is also a Coroners referral
Serious Incident investigations	0	0	
Unexpected Death	0	0	
Concerns raised through audit, incident reporting or other mortality indicators	0	0	
Definite COVID-19 Health Care Acquired Infection (HCAI)	0	0	
Total including Neonatal Deaths	**8**	**6**	

3.8 Deaths requiring an SJR 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.

3.9 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 process and are clearly and transparently recorded and reported.

4. Mortality Dashboard

4.1 There were 102 inpatient adult deaths recorded in Quarter 2, 2025/26 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 The number of inpatient and ED deaths in Q2 2025/26 was 116. All deaths within in ED were reviewed

4.4 There was 1 learning disability death, and 0 deaths of a patient diagnosed with Autism. 1 patient had a severe mental illness (SMI).

4.5 The radial graph below compares all crude adult mortality rates (including ED deaths) for Whittington health in 2018-19, 2019-20, 2020-21, 2021-22, 2022-23, 2024-25 and now the first data for this year.

Graph 1: Crude Adult Mortality at Whittington Health comparing previous years (April 2018 – March 2025)

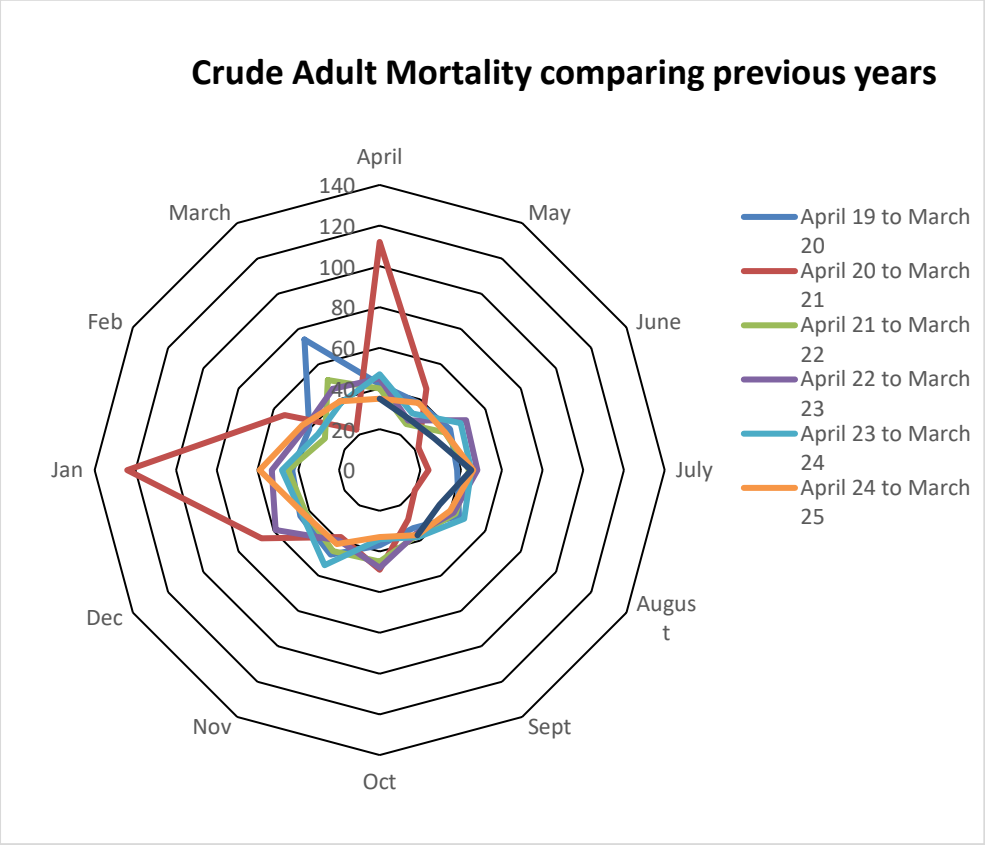

Table 4: Number of inpatient and ED deaths each month over the past 6 years

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 23	April 23 to March 24	April 24 to March 25	April 25 to March 26
April	34	42	112	40	45	47	35	35
May	37	38	46	26	28	32	38	29
June	33	40	22	37	49	46	37	31
July	25	38	24	44	48	45	46	45
August	26	45	20	43	42	48	40	34
Sept	29	33	28	37	36	38	37	37
Oct	30	37	49	45	48	34	33	
Nov	37	48	38	46	40	54	42	
Dec	44	45	67	42	59	44	43	
Jan	42	43	124	45	53	48	59	
Feb	32	40	54	31	42	35	44	
March	48	74	23	51	46	38	39	
Total	**417**	**523**	**607**	**487**	**536**	**509**	**493**	**211**

5. Summary Hospital-level Mortality Indicator (SHMI)

The latest published Summary Hospital-level Mortality Indicator (SHMI) is 0.895 for the Whittington and is for the data period Aug 2024 to Jul 2025. In hospital SHMI is 0.94 and out of hospital SHMI is 74.9. The Whittington standard HSMR (Hospital Standardised Mortality Ratio) for Oct 24 to Sep 25 is 77.6
Our average coding for elective activity has climbed, and we are now matched with our peers. Our non elective coding is more volatile, but there has been a general decline in coding, which is not seen in our peers. We are undercoded in comparison for renal, however we have a working LAS divert for patients who are on dialysis programmes to go to the Royal Free Hospital so this may reflect this.

6. Prevention of Future Deaths (PFDs)

A PFD was issued by HM Coroner in Q2 to Whittington Health. This was in regard to the care that was delivered by the Whittington Health community team to a patient who subsequently died as an inpatient at University College Hospital. A response has been submitted to HM Coroner which includes a Quality Improvement Project (QIP) in ED regarding adherence to our Pressure Ulcer (PU) Prevention and Management Policy. In the community ensuring patients have daily visits allocated individually, timely referral to TVN and that learning should be shared regarding the development of PUs. An increase in support and training for staff involved in writing statements and attending the coroner's court, and ongoing audit and training regarding Duty of Candour.
There was a PFD issued to NHSE and Dept of Health and Social Care (DHSC) regarding a frail patient who was admitted and subsequently died at the Whittington Hospital. They were admitted via ED where they remained while waiting for an inpatient bed and there were concerns regarding overcrowding in the ED. However, the coroner felt that this was a problem not just at the Whittington, but also at other acute trusts, and so the PFD was issued to NHSE and DHSC rather than the Whittington

7. Themes and learning from mortality reviews Quarter 2, 2025/2026

7.1 **Management of patients with Serious Mental Illness (SMI)**

A patient with a significant psychiatric history was appropriately flagged to the safeguarding team on admission. The patient's care was complex as they were refusing medical interventions, and their level of capacity was fluctuant. The learning was that there could have been earlier involvement of the mental health liaison team, family and potentially palliative care. Incorrect details for the family were on record, and ensuring accuracy for these for all patients is important.

Another patient was well managed as they were recognised to be dying early on in their admission and palliative care input was requested. The learning was that the patient was in distress when first seen by the palliative care team, and that both medical and nursing staff need to ensure treatment is administered promptly.

7.2 **Management of patients with Learning Difficulties or Autism**

No deaths of patients with autism were reported. Both the Medical examiner team and Morbidity and Mortality Leads need to ensure an SJR is undertaken if the patient has a diagnosis of autism
A patient with learning difficulties arrived to the hospital in periarrest. They subsequently had a cardiac arrest. The reviewer noted that ALS protocols were managed well and according to Resuscitation Council guidance, despite the patient's death

Other adult deaths

A patient presented to ED with chest pain. The learning here is that national guidance is that patients with chest pain should be triaged within 15 minutes. They were triaged at 20 minutes and had a cardiac arrest in RAT (Rapid Assessment and Treatment). They were rapidly transferred from there into the Resuscitation Room. All ALS protocols were managed appropriately and according to guidance.

A frail patient presented to ED after a fall in a Nursing Home. They had a CT head ordered. The reviewer noted that they did not meet the criteria to require a CT neck in addition to this. The CT head was reported by our out of hours reporting service. The CT was reported as no acute injuries and the patient was after review discharged to their NH. The patient reported pain and was brought back to ED where further imaging was requested including a cervical spine CT. When this was reported, the Whittington radiologist reviewed the CT head and noted there was a fracture. This case is awaiting coronial case. The patient subsequently died from an aspiration pneumonia. The case has been reviewed at REALM (Radiology Events and Learning Meetings) and also has been highlighted to the provider. This case will be reviewed in the New year in the Coroners Court.

- **Evidence of good End of life care (EOLC)**

There was evidence of good EOLC in 3 of the SJRs. There was the death of one patient with a gynaecological cancer where imminent death was not recognised. A departmental update is being organised regarding TEPs (treatment escalation plans) and ensuring good EOLC.

Feedback highlighted from adult non SJR deaths were:

None at present

8. Dissemination of Learning

8.1 This report is considered at the Mortality Review Group attended by the mortality leads from each specialty which allows them to disseminate onwards lessons.

8.2 Additionally, a PowerPoint summary of learning has been prepared and will be sent to all mortality leads to discussed at their departmental mortality meetings

8.3 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.

8.4 Teams hold mortality review meetings to discuss local cases and share wider learning between teams and jointly review cases.

9. Summary of Items at Mortality Review Group

Cancer of the Bronchus, Lung Deaths Review done by Alan Shaw, Resp Cons

In 2024, there were 26 deaths attributed to lung cancer. Lung cancer has been increasing by roughly 10% each year and of those diagnosed approximately 25% died which is in line with national cancer mortality rates. AS noted that the SHMI does not take into account comorbidities, chemotherapy performance or how long patients have had lung cancer for. On the whole, patients are dying the expected way in line with their performance and stage of cancer and there does not appear to be any cause for concern.

From HED – SHMI, HSMR and no disease specific alerts. No of actual deaths decreased. Elective coding has improved.
Discussion of discrepancies in disease specific audits for non-elective work. The view from HED and coders is that we are undercoded for non elective work. This is impacted by discharge summaries not completed, inaccurate discharge summaries. It was also noted that this was a greater problem in winter when the medical team were under greater strain. Also some poor coding.

We discussed that an audit of discharge summaries completed is distributed and I will check who that is sent to. Other hospitals have coding ambassadors who work between coding and the medical teams and this may be something that we should consider. Our Charleson scoring is decreased in comparison to peers

Appendix 1

NHS Whittington Health: Learning from Deaths Dashboard - July 2025-26

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
45	31	32	13	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
116	95	74	39	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
211	491	113	149	0	0

Time Series: Start date 2017-18 Q1 End date 2025-26 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 (QTD)	0	-	This Quarter (QTD)	0	-	This Quarter (QTD	0	-	This Quarter (QT	0	-	This Quarter (QT	0	-	This Quarter	0	-
This Year (YTD)	0	-	This Year (YTD)	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
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
0	7	0	5	0	0

Meeting title	**Quality Assurance Committee**	**14/1/25**
Report title	**Nursing and Midwifery 6 monthly Safer Staffing Review Report (November 2025)**	**Agenda item: 5.2**
Executive director lead	Sarah Wilding, Chief Nurse & Director of Allied Health Professionals	
Report authors	Marielle Perraut, Assistant Chief Nurse 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 Report outlines the Trust's response to the statutory requirements to have safe Nursing and Midwifery staffing identified across Whittington Health. • This 6-month review report includes an overview of the Nursing and Midwifery key performance indicators (KPIs) • The key findings from the 6 monthly Establishment Review of the Nursing and Midwifery workforce are based on the Safer Nursing Care Tool (SNCT) and Mental Health Optimal Staffing Tool (MHOST) audits collected in August 2025 for all inpatient areas and Emergency Department (ED). District Nursing teams were also audited against the Community Nursing Safer Staffing Tool (CNSST) • All Nursing and Midwifery Establishment reviews were undertaken from the end of October 2025 to mid-November 2025 using Summertime activity and acuity/dependency. • When funded and staffed to the recommended establishment levels, all areas meet safer staffing standards; with a few exceptions noted through specific recommendations. **(Appendix 4, Page 24-29)** • A more in-depth analysis of Enhanced Care staffing requirements in CYP is in progress outside of this process. Recommendations are included in this report. .	

<table>
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Nursing leadership is actively engaged in national and regional Enhanced Care workforce initiatives, addressing rising needs of vulnerable patients.
The committee is asked to acknowledge the recommendation to increase the establishment, noted below:

<table>
<tr><th>Service</th><th>Activity</th><th>Funded establishment
R: Registered
U: Unregistered</th><th>Recommendations</th></tr>
<tr><td>Paeds ED</td><td>67
avg/day</td><td>R: 15.78 wte
U: N/A</td><td>2.5 WTE Band 5 to cover the peak activity.
This is currently staffed as a cost pressure with temporary staff</td></tr>
<tr><th>Ward (ICSU)</th><th>Funded bed capacity</th><th>Funded establishment
R: Registered
U: Unregistered</th><th>Recommendations</th></tr>
<tr><td>IFOR (CYP)</td><td>19</td><td>39.7 wte

R: 31.41 wte
U: 8.29 wte</td><td>5.2WTE Band 3 to be included in baseline establishment to support EC</td></tr>
</table>
</td></tr>
<tr><td>Purpose:</td><td>As per the National Quality Board (2016) (NQB) ‘Expectation 1: Right Staff’ and NHS Improvement (2018), ‘The planning cycle’; this report seeks to assure Board and the public regarding the Trust’s compliance to the statutory requirements to have safe Nursing and Midwifery staffing across Whittington Health</td></tr>
<tr><td>Recommendation</td><td>The committee is asked to:
I. Review that due process was followed in line with statutory requirements to review nursing and midwifery staffing levels bi-annually.
II. Approve the recommendations made in this paper.</td></tr>
<tr><td>Risk Register or Board Assurance Framework</td><td>BAF risk Quality 1 - Failure to provide care which is ‘outstanding’ in being consistently safe, caring, responsive, effective, or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.

BAF risk People 4- Failure to recruit and keep high quality substantive staff could lead to reduced quality of care, and higher costs.</td></tr>
</table>

	Risk register: Paediatric ED staffing (reference 1564) Score 15
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 nursing recruitment team, Eroster team: End October 2025 to mid-November 2025 2. Nursing and Midwifery Leadership Group (NMLG): 22-12-25 3. COM: *TBC* 4. TMG: *TBC* 5. GGC: 9-12-25 6. QAC: 14-1-25 7. Public Board *TBC*

Nursing and Midwifery 6 monthly Safer Staffing Review Report (November 2025)

1. INTRODUCTION

- This purpose of this report is to provide assurance to the Board of Directors (BoD) and other committees (see report history section) that the Trust Nursing and Midwifery staffing levels are compliant with the Developing Workforce Safeguards NHS Improvement (2018) incorporating the National Quality Board (NQB) Standards for safe Nursing and Midwifery staffing at Whittington Health NHS Trust. (**Appendix 1**, **Page 16**)

- The guidance sets out the key principles and tools that providers should use to measure and improve their use of staffing resources to ensure safe, sustainable, and productive services, including introducing the care hours per patient day (CHPPD) metric. The three NQB's expectations that form the basis to making staffing decisions are as below:

- The Bi -Annual Nursing and Midwifery Establishment reviews were undertaken in October and November 2025 to review the Nursing and Midwifery requirements. The reviews also provide a progress overview of the outcomes from the earlier Nursing and Midwifery establishment Reviews conducted in May 2025. It also reviews progress on recruitment for all additional safe staffing posts agreed through this process in line with the Trust business planning procedures.

- Each ICSU was represented by their ADoN or nominated deputy, with Matrons and departmental leads in attendance where possible. All members of the Triumvirates and finance team are offered the opportunity to attend. At present, the attendance from the wider MDTs is variable, with continued work in progress to ensure a multi-professional approach.

- Safer staffing and skill mix reviews were undertaken the following clinical areas based on Safer Nursing Care Tool (SNCT) and Mental Health Optimal Staffing Tool (MHOST) audits undertaken across August 2025: The review process and data analysis systems provide a standardised approach to assure the Trust board that Nursing and Midwifery staffing is compliant with the required standards outlined in section 1:

  - Inpatient adult and children's wards (EIM, S&C and CYP)
  - Emergency Department (ED) (EIM)
  - Critical Care Unit (CCU) (S&C)
  - NICU (CYP)
  - Maternity services are assessed based on the Birthrate Plus report and national recommendations.

  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 Outpatients (ACW)
  - Endoscopy (EIM)
  - TB services (EIM)
  - Children Ambulatory Care/Day Care and Outpatient (CYP)

  - Community services: The community safe staffing tool, which was piloted last year, has been relaunched following a pause, with audits undertaken in district nursing teams during April and June 2025. To ensure the data reflects year-round activity and can be incorporated into establishment reviews, two further collections are required. Early findings highlight compliance discrepancies that must be addressed and validated for a 3rd data collection in January 2026 before inclusion in the review process. Oversight of this initiative is being provided by the Associate Director of Nursing, supported by the Safer Staffing Lead Nurse, ensuring accountability and alignment with safer staffing assurance.

2. ESTABLISHMENT REVIEW PROCESS AND METHODOLOGY

- As part of the bi- annual establishment review process seen in **Appendix 5, page 29,** all inpatient areas completed a Safer Nursing Care Tool (SNCT ©) audit (and Mental Health Optimal Staffing Tool- MHOST- for CYP) for 30 days during August 2025. This SNCT audit is mandated by the Developing Workforce Safeguards Improvement (2018) and is used to inform the establishment review, alongside professional judgement, to establish safe staffing in the clinical areas.

The NQB recommend the use of other quality data sets to inform professional judgement including acuity and dependency tools, review of incident data, completion of key clinical processes such as health roster management, sickness/absence, quality indicators and user feedback.

Triangulation NQB methodology 2016 and 2018:

- For this review, 6 months of key workforce data from 1st April 2025 to 31st September 2025 was collected and circulated in advance of the meetings with Locally held information to be completed by ICSUs included the following metrics:

- All Workforce data including vacancies, turnover, sickness, mandatory training, appraisal compliance, temporary staff expenditure (bank/agency)
- Establishment WTE for both funded and staff in post.
- Local budgetary data, year to date (YTD) spend.
- Roster template and budget alignment information
- Roster KPIs include Care Hours Per Patient Day (CHPPD), roster lead time compliance, annual leave percentage.
- Safer Nursing Care Tool (SNCT) inpatient validation audit data
- Red Shifts raised.
- Enhanced Care use information
- Healthcare Support Workers completion of Care Certificate
- Workforce profiles where available (including age and diversity data)
- Falls and pressure ulcer data.
- Complaints and Serious Incident data
- Staff undertaking the Professional Nurse/Midwife Advocate program.
- Advanced and specialist level practitioners and services covered.
- Local/National Guidance/recommendations
- Successes to celebrate in last 6 months period.
- Action plans to prepare further reviews.

- At the review meetings, ICSUs raised concerns and shared examples of innovation and good practice through detailed discussion of the data provided. In parallel, reviews of department roster templates, finance, and ESR alignment were undertaken to assess recent changes. These discussions

focused on ensuring that adjustments to financial and rostering templates continue to safeguard patient safety while maintaining financial alignment.

- Consideration was also given to new ways of working, opportunities, and changes in skill mix, including:
  - Nursing Associates and Student Nurse Associate (programs currently paused and impact on pipeline discussed)
  - Advanced Practitioner roles and ability to support training and fund a position when they successfully pass the program.
  - Professional Nurse/Midwife Advocates
  - Vacancies for graduates
  - Enhanced Care delivery and staffing requirements to provide safe and therapeutic support to patients requiring added support and care.

Further detailed workforce planning discussions will take place at the next Establishment Reviews in February 2026 to inform business planning and business case development.

3. WORKFORCE KEY PERFORMANCE INDICATORS (KPI) FINDINGS

- At the end of September 2025, ESR reported Whittington Health's Nursing and Midwifery funded establishment at 2095.78 WTE (1456.66 WTE Registered and 639.12 WTE Unregistered), reflecting a marginal 0.17% increase from March 2025 (2092.28 WTE).

- In September 2025, overall staff turnover improved to 8% from 10.38% in March 2025, remaining below the 13% target across all ICSUs for both Registered (7.8%) and Unregistered staff (8.2%) since November 2023 (13.68%).

Table 1- Trust Registered Turnover Sept 2024-Sept 2025

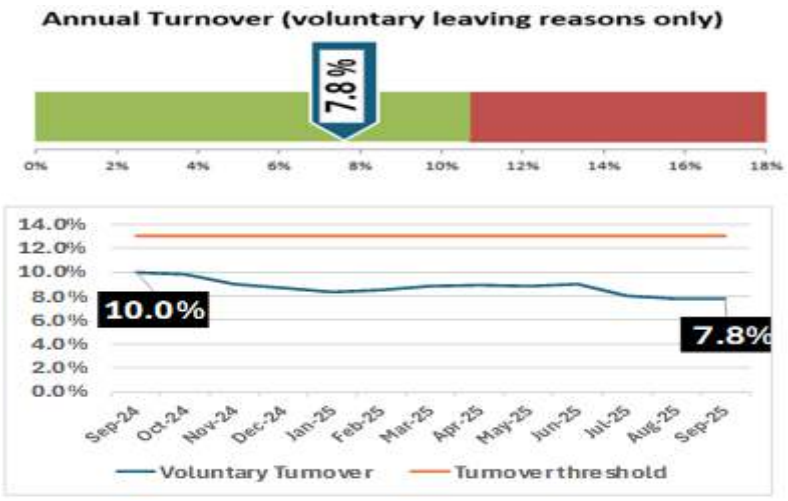
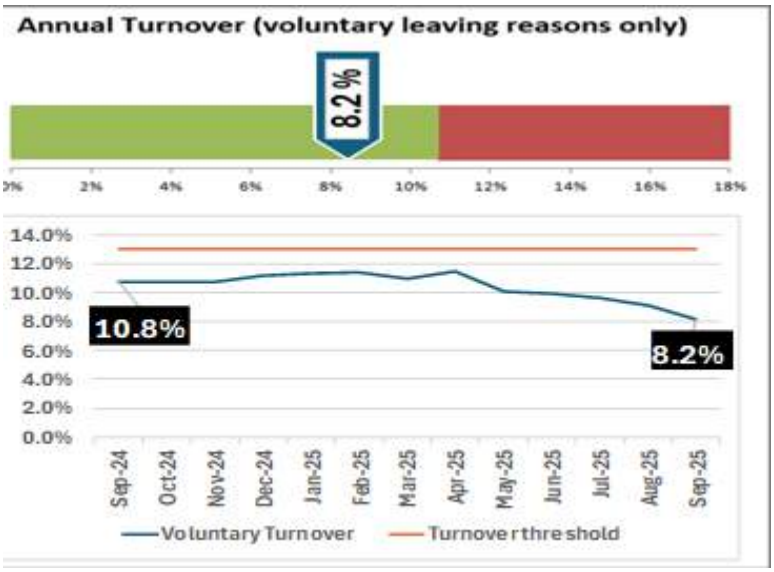


Table 2- Trust Unregistered Turnover Sept 2024-Sept 2025



- In September 2025, staff sickness-related absences averaged 7% across all ICSU (registered and unregistered), remaining above the Trust target of 3.5%. Long-term sickness themes continue to mirror previous reports, primarily mental health, stress and musculoskeletal (MSK) disorders, while short-term absences are largely respiratory and GI issues. Work is ongoing in partnership with HR and Occupational Health to support colleagues' return to work; however, ICSUs highlight challenges in managing sickness due to HR being under-resourced to provide the required support. The most impacted ICSUs remains are ACS and ACW (Midwifery)

Table 3- Trust Registered Sickness Sept 2024-Sept 2025

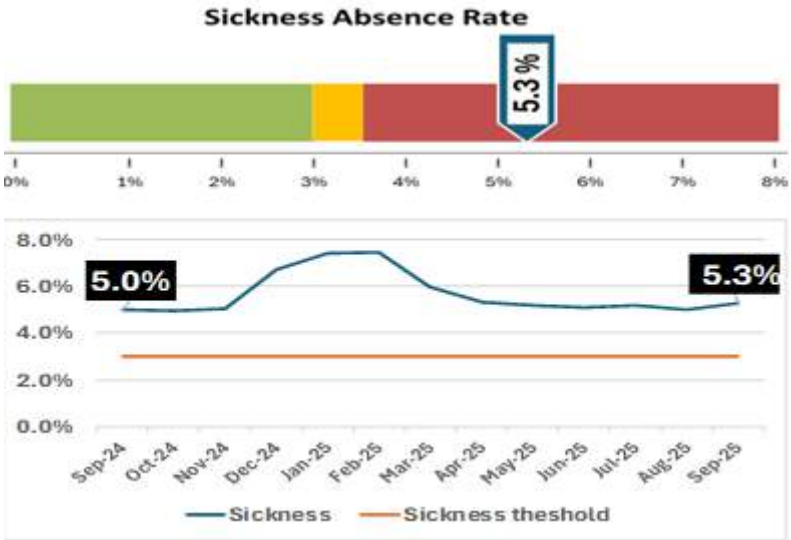
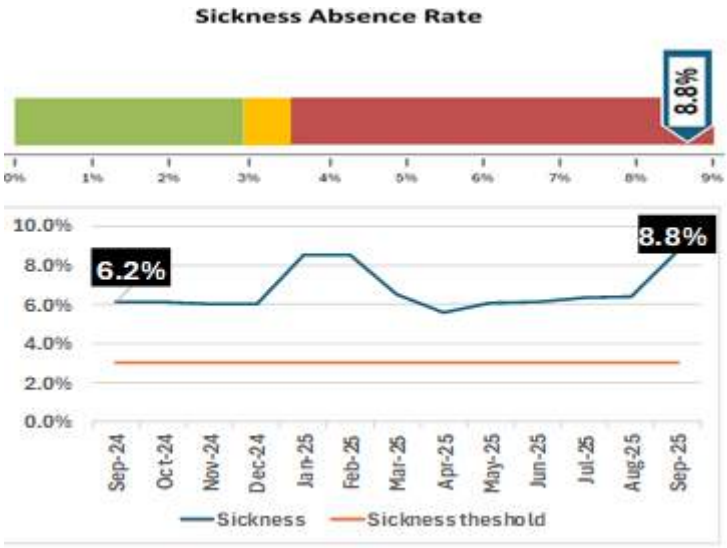


Table 4- Trust Unregistered Sickness Sept 2024-Sept 2025



- The vacancy target (below 10%) continues to show improvement, reducing from 9.1% in March 2025 to 8.3% in September 2025. This overall score is primarily driven by unregistered staff vacancies, which remain above target at 15.4%. In contrast, the registered workforce vacancy rate has remained well below target, at 1.3% in September 2025 compared to 3% in the previous period. Recruitment challenges persist for newly qualified practitioners in both nursing and midwifery, reflecting the national picture and further exacerbated in the London region. HCA vacancies also remain a concern due to increased Enhanced Care needs, with the strategic focus placed on retention.

Table 5- Trust Registered Vacancy Sept 2024-Sept 2025

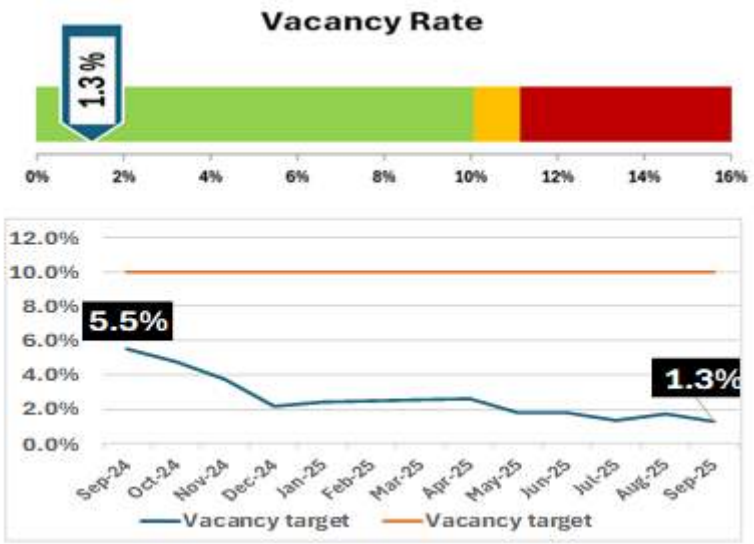
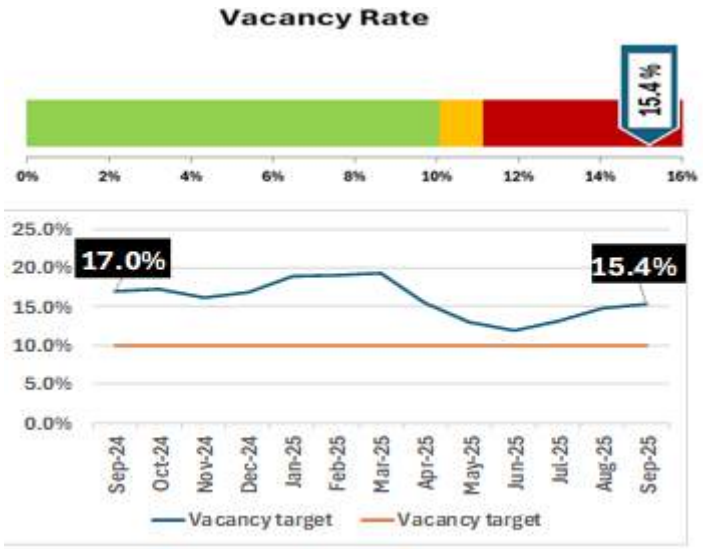
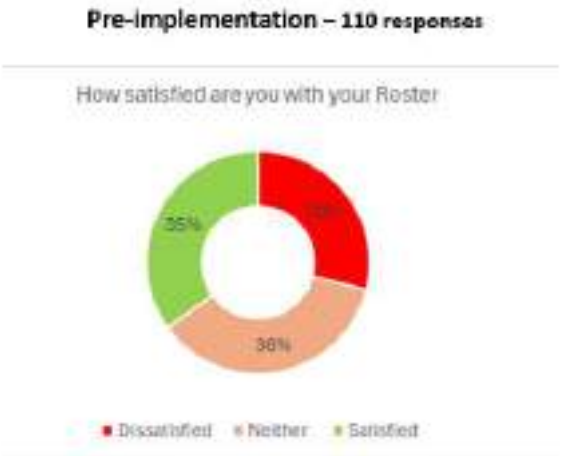


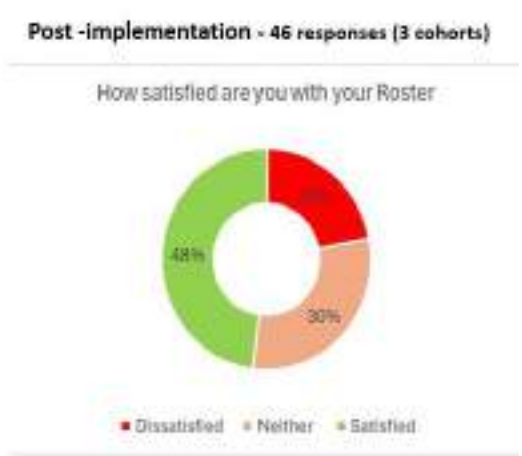
Table 6- Trust Unregistered Vacancy Sept 2024-Sept 2025



- Further in-depth discussions on workforce data and KPIs will continue at monthly Safe Staffing Governance meetings, with a focus on delivering action plans that strengthen retention and reduce reliance on temporary staffing.

- Following staff feedback on roster fairness, wellbeing, and the new flexible working policy, the Safer Staffing and Roster Utilisation team is rolling out Team-Based Rostering (self-rostering) for nurses across the organisation. To date, 27 clinical areas (9 cohorts) have enrolled, covering all inpatient services and selected outpatient areas (ACW, EIM, CYP, and S&C). A further 20 areas are scheduled for enrolment by the end of 2026. While it is too early to identify definitive trends in fully implemented areas, early indications are positive. More detailed data, including performance against KPI metrics, will be presented at the next Establishment Review.





➢ Over the past year, nursing leadership teams have actively engaged in national and regional forums on Enhanced Care, previously known as 1:1 care. This work responds to rising demand for enhanced support, particularly for patients with mental health needs.

The Trust currently provides Enhanced Care to an average of 20–25 patients every 24 hours across services including EIM, CYP, and S&C. In addition, Enhanced Care requirements are now recorded daily in ED, averaging four patients per day. To strengthen workforce planning and care insight, ETOC data has been included in all Provider Workforce Returns (PWR) since June 2025.

Extensive work over the past six months has led to a rebasing of the funded establishment to incorporate Enhanced Care provision. This has resulted in an increase of 12.5 WTE Band 3 posts across EIM, with a further recommendation for 5.2 WTE Band 3 posts in CYP. This will also result in a reduction of temporary staffing expenditure and promote continuity of care.

Alongside this, the Trust is working with NCL partners to explore training opportunities for HCSWs, ensuring they are equipped to care for our most vulnerable patients while delivering therapeutic interventions that emphasise personalised and compassionate care.

- Work to improve Net Hours (under- and over-contracted hours worked by staff) is ongoing, with the overall position showing improvement. A paper has been approved to reset hours over a two-year period, and the Trust has invested in the e-rostering team by appointing two additional members to support this work. At the time of reporting, teams are awaiting confirmation from Executive colleagues on the implementation date, and the retrospective start point. Once agreed, a tracker will be embedded into monthly Safer Staffing Governance meetings, enabling ICSU leaders to evidence their work in maintaining an accurate reflection of under- and over-hours alongside mitigation plans

4. OUTCOME

- The establishment reviews confirm that when nursing and midwifery levels are fully established with the recommended budgeted establishments, all areas meet the safer staffing standards except for the following:

- **Trust wide: Protected Management Time for Ward Managers**

Ward Managers carry responsibility for leading large teams and delivering critical functions including sickness management, clinical governance, safety and risk oversight, complaints handling, rostering, supervision, and staff development. These responsibilities are central to maintaining safe, high-quality care and compliance with Trust standards.
At present, Ward Managers are allocated an average of only 15 hours of protected management time per week. This is insufficient given the breadth of their responsibilities and the frequent requirement to cover clinical shifts due

to short staffing. The dual burden compromises their ability to provide consistent leadership, oversight, and staff support.
The Trust recognises this as a gap. While the preferred position is that Ward Managers are fully supernumerary to staffing numbers, where this is not feasible, supernumerary should be increased from 15 to 30 hours per week. As the Trust is currently an outlier in this area, this position will be reviewed at the next safer staffing establishment review, with benchmarking against national guidance and other

- **Emergency & Integrated Medicine (EIM)**

- Paediatrics ED: 2.5WTE WTE Band 5 Registered Nurse (below summary table. Also refer to Appendix 4) *This recommendation was already part of the previous establishment review, currently the ICSU uses temporary staffing to maintain safe staffing levels*

Current position	- Establishment: 15.78 WTE - Coverage: 3 Registered Nurses (RNs) per shift (day and night) - Risk: Paediatrics ED Safer Staffing on the Risk Register (Ref 1564, Score 15) - Mitigation: 4th Nurse through temporary staffing -
Recommendation	To meet national safer staffing standards and manage clinical risk, the recommendation is: • Increasing to 4 RNs on the 11:00–23:00 peak period, to cover the peak activity whilst further analysis is undertaken and reviewed. • Minimum of 2 paediatric nurses per shift (RCPCH, 2018) • Minimum of 2 paediatric nurses per shift with trauma & emergency training (RCPCH, 2018) • Triage RN (RCPCH, 2022) • Practice development & support (RCPCH, 2018) • 1:1 RN to patient ratio when resuscitation cubicles occupied (RCN) • 1:2 RN to patient ratio when HDU/Level 2 cubicles occupied (RCN)
Expected Benefits	• Enhanced patient safety and reduced clinical risk.

	• Greater resilience in the face of acuity and demand • Improved training, development, and succession planning • Compliance with national and professional standards
Next Steps	• Financial assessments complete; further audits planned to monitor demand trends. • Alignment with long-term staffing models under review

➢ **Children and Young People (CYP):**

- Ifor Ward: *5.2 WTE B3 to be included in Funded establishment baseline to include EC delivery*

Current position (for new 19 beds until March 2026)	- Establishment: 39.4 WTE (+Ward manager, Matron, PDN and Discharge coordinator) - Coverage: 6 Registered Nurses (RNs) per shift 1 HCA per shift (day and night) - Risk: 1) Average 2.6 EC care requirement per 24-hour period. Some required 2 to 1 Enhanced care. 2) Mainly patient requiring Mental health input 3) Having to flex to 23 bed capacity in times of high activity - Mitigation: average 2 WTE HCA and 0.5 WTE RMN usage daily to support EC. Mainly temporary staffing -
Recommendation	To meet national safer staffing standards and manage clinical risk, the recommendations are: **1) Enhanced care** • Increasing by 5.2 WTE HCA to enable 1 added HCA on each shift) to reduce temporary staffing expenditure • This will be achieved by using 2wte RMNs (alongside existing 2 WTE MH HCA budget) • Any added Enhanced Care temporary staffing cost due to peak demand will remain a cost pressure. **2) Bed base on Ifor.** • Beds to stay at 19 until March 2026.

	• Nursing staffing for increased bed base to be recruited as an authorised overspend, reducing temporary staffing dependency. • 1.5 WTE Band 5 budget identified to offset costs.
Expected Benefits	• Enhanced patient safety and reduced clinical risk. • Reduction in temporary staffing • Less sickness (burnout) • Better retention • Better outcome for patients
Next Steps	**1) Enhanced Care** • CYP Leads and finance to quantify the required value to cover added needs for temporary staffing related to EC. **2) Bed base on Ifor.** • CYP leads to further exploring funding options. • Bed base plan to be reviewed at end of March 2025

- Several departments and wards continue to experience staffing pressures due to sickness, vacancies, and higher patient care needs. To ensure patient safety, especially in high-pressure areas, temporary staff are deployed as needed to cover gaps and manage increased patient acuity and dependency. Red shifts/flags are monitored through the daily staffing meeting and Datix and mitigated through deployment or mitigations to reduce risk to patient and staff. A summary can be found in **Appendix 2, page 18**

- As part of the establishment review and staffing requirement assessment, there was a focus on CHPPD analysis. Care hours per patient day (CHPPD) is a metric used in inpatient settings in healthcare to measure the amount of care provided per patient in a 24-hour period. CHPPD gives a picture of how staff are deployed and facilitates benchmarking with other wards in the hospital, or with similar wards in other hospitals. CHPPD covers both temporary and permanent care staff but excludes student nurses and student midwives and staff working across more than one ward. Information for all inpatient areas are detailed in **Appendix 3, page 20**

- Any additional posts requested to provide ongoing safe staffing service expansion/increased patient acuity are reviewed as part of the business

planning, vacancy and financial review processes following agreement in principle by the Chief Nurse.

- Outcome summary tables for each clinical area are available in **Appendix 4, page 24**

5. RECOMMENDATIONS

- The Nursing and Midwifery establishments will formally be reviewed again at the bi-annual-review in spring 2026. The data collection and audits will start in January 2026. Staffing metrics will be monitored monthly through various governance and performance forums.
- 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.
- A deeper dive of enhanced care requirements will be undertaken outside of this process.

Appendix 1: Compliance with Recommendations of the Developing Workforce Safeguards (DWS)

Recommendation	Compliance	Evidence
1. "The Trust is formally using National Quality Board 2016 safer staffing guidance. Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe sustainable and productive staffing. "	Compliant	• Monthly Nursing & Midwifery Safe Staffing paper set out as per expectations of the NQB (2016) • Safer Nursing Care Tool recommendations with February and August data collection periods. • CHPPD reported monthly in comparison with peers
2.The Trust apply the principles of safer staffing – triangulation. This should include the methodology used to set staffing levels, e.g., output from staffing decision support tools (where available), review of patient quality and safety outcomes and application of professional Judgement	Compliant	• Evident within the Bi-Annual Establishment Review packs • Evidence through safecare data • Evident through daily staffing meeting
3. Evidence-based tools are used where available.	Compliant	• SNCT, MHOST and SNCT ED discussed in the biannual establishment review paper. • Detailed breakdown of SNCT recommendations per ward.
4. Trust to confirm that there is no local manipulation of identified nursing resource from approved evidence-based tools	Compliant	• Internal (within service) and external (from other services) validation take place during data collection period. • Data collection forms are signed by the nurse who carries out the validation. Available in electronic scanned copies
5. Monthly actual vs planned staffing levels are available for review	Compliant	• Monthly Actual v Planned published on trust website. • Aggregated in biannual establishment review report.
6. Director of Nursing & Medical Director must confirm safe staffing review in an annual governance statement to the Public Board	Compliant	• Statement available in annual Board report available on the trust internet page

7. A workforce plan must be in place and agreed / signed off annually by CEO & executive leaders and discussed at Public Board meeting	Partially compliant	• Challenging to identify and locate the appropriate and up to date document. • Availability of documents on the web page and local drives requires streamlining and organising.
8. Nursing and midwifery staffing establishments for all clinical areas must be reviewed twice a year and reported to the Public Board	Compliant	• Annual and Bi-annual establishment review papers, establishment review packs for challenge meetings, data collection, and analysis documents.
9. Agreed local quality dashboards on staffing & skill mix are cross-checked with comparative data each month and reported to the board.	Partially compliant	• Evidence of bi-monthly report • Workforce metrics to be added to the Board Iintegrated Board Report. • Several staffing and workforce data must be added to the existing safe staffing report. • Planning to reinstate comprehensive Safe staffing data to the Integrated Board Report and publish monthly along with other workforce metrics.
10. Quality Impact Assessment (QIA) review for service changes including skill mix changes, redesign, or introduction of new roles	Partially compliant	• Not fully embedded by clinical services • QIA forms are held by service leads And Associate Directors of Nursing. Some stored in the Safe staffing folders. • We have increased QIA panels across the ~~O~~organisation to support the QIA process regarding service changes
11. Formal risk management and escalation processes in place for all staff groups outlined within a safe staffing policy with appropriate staffing escalation process clearly identified	Compliant	• Safe staffing and escalation policy in place • Daily staffing meetings • Relaunched the SafeCare application which incorporates staffing red flags alerts
12. Boards to be made aware of continuing or increasing staffing risks	Compliant	• Regular staffing reports to the Board including biannual establishment review reporting

Appendix 2 - Red Shifts/Flags -

Table 1: All ICSUs/Divisions

Table 2**:** Maternity Services

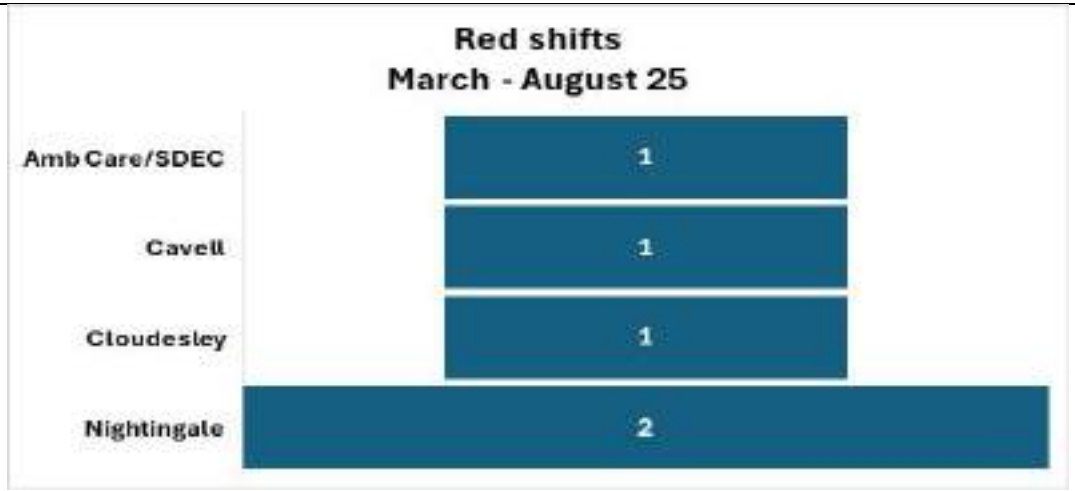
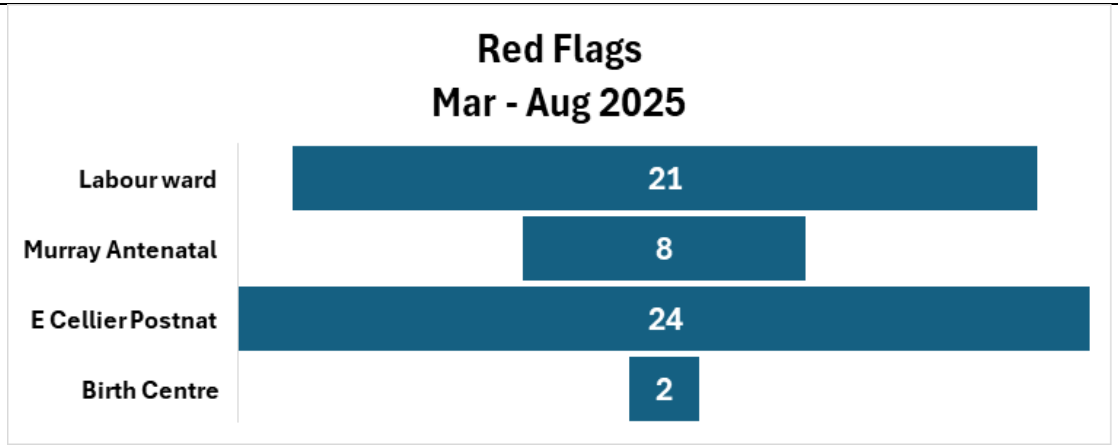
Table 1 (all ICSUs)	**Narrative**
	A total of 6 Red Shifts from March to August 2025. Several red shifts were downgraded following staff redeployment within the 1st hour of the shift and mitigation of the risk.

Table 2 – Maternity	Narrative
	Main reason for the Red Flags was delays in delivery of care or transfer of care. The Birth Centre was suspended on several occasions to redeploy staff and mitigate the risk. Reported causes of the red flags were sickness and activity.

Appendix 3- Inpatients Care hours per patient day (CHPPD)

Table 1: Surgery and Cancer

Table 2: Children and Young People

Table 3: Emergency and Integrated Medicine Table 4: Maternity Services

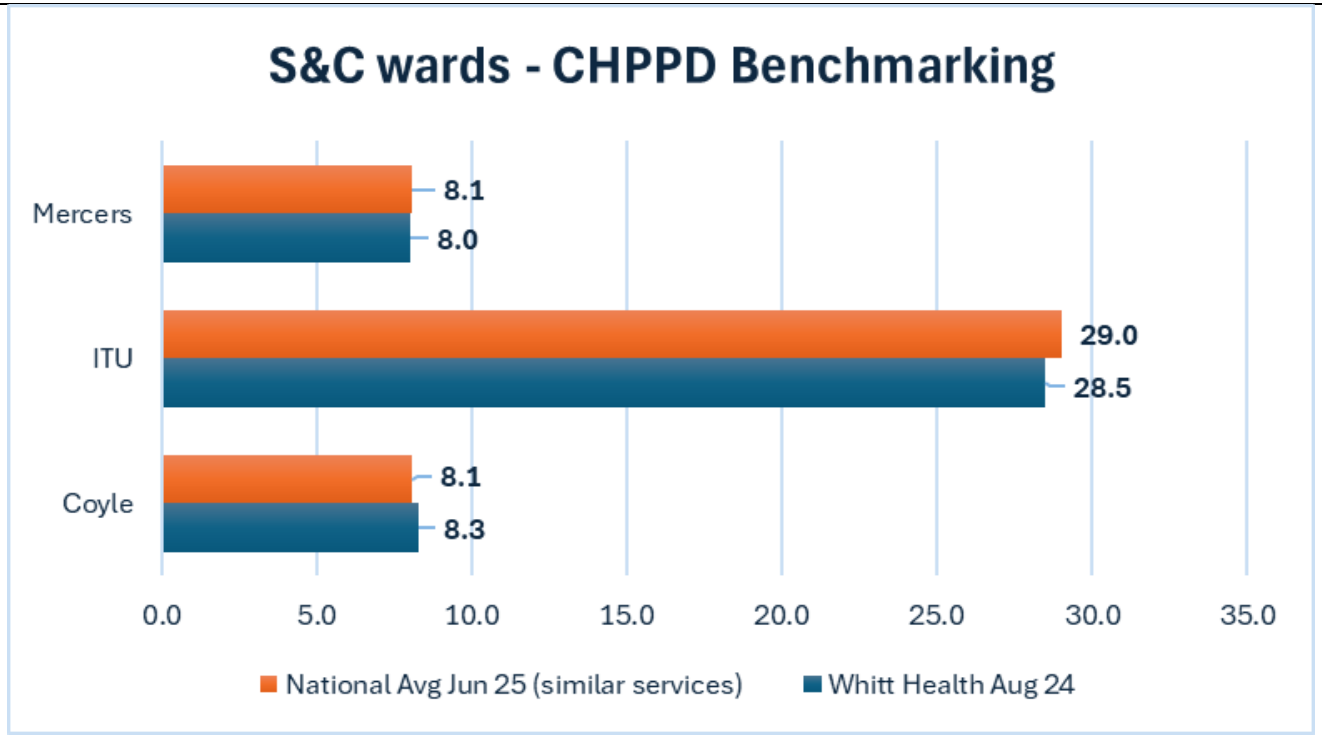
Table 1 – S&C CHPPD	**Narrative**
	CHPPD of the surgical wards was almost aligned with the national average.

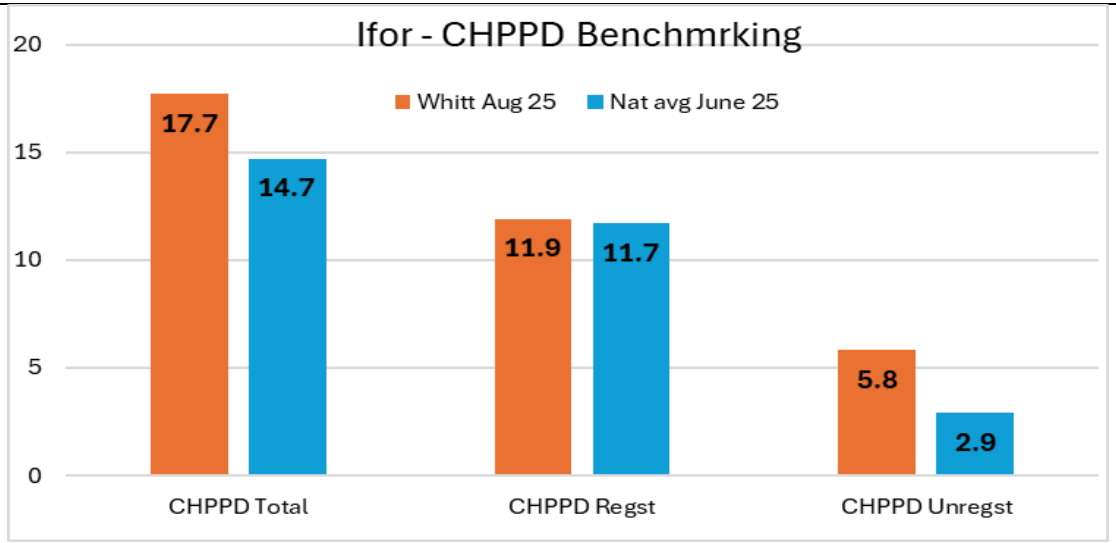
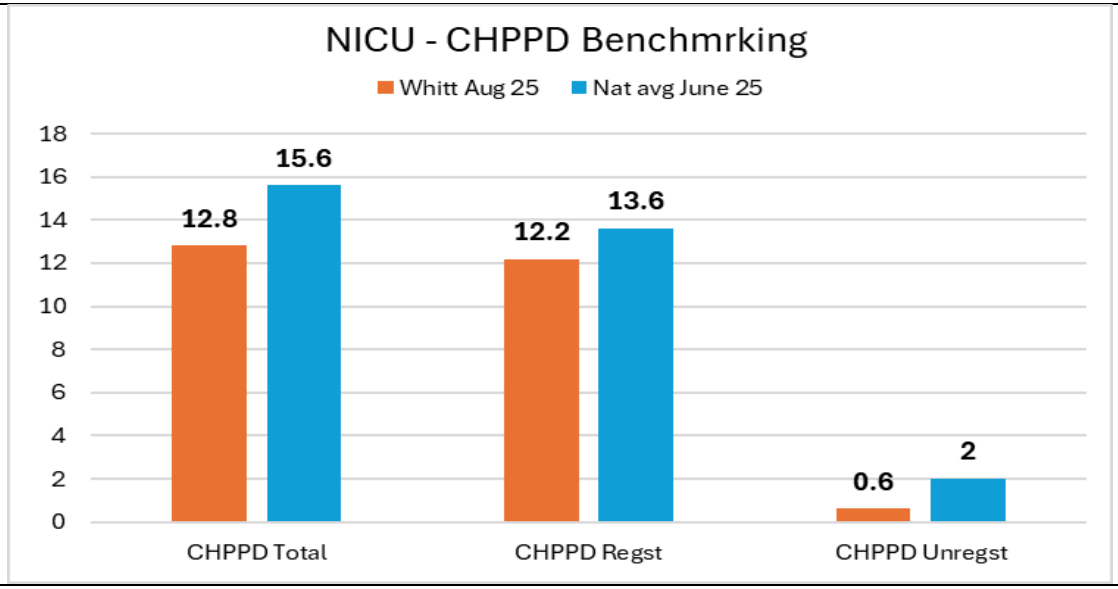
Table 2 – CYP CHPPD	Narrative
	CHPPD on Ifor ward has been consistently above the national average. The main reason has been the Enhanced Care cover with HCAs to care for CAMHS patients.
	CHPPD on NICU was below national average as a result of reduced activity/cot occupancy during March to Aug 25 overall,

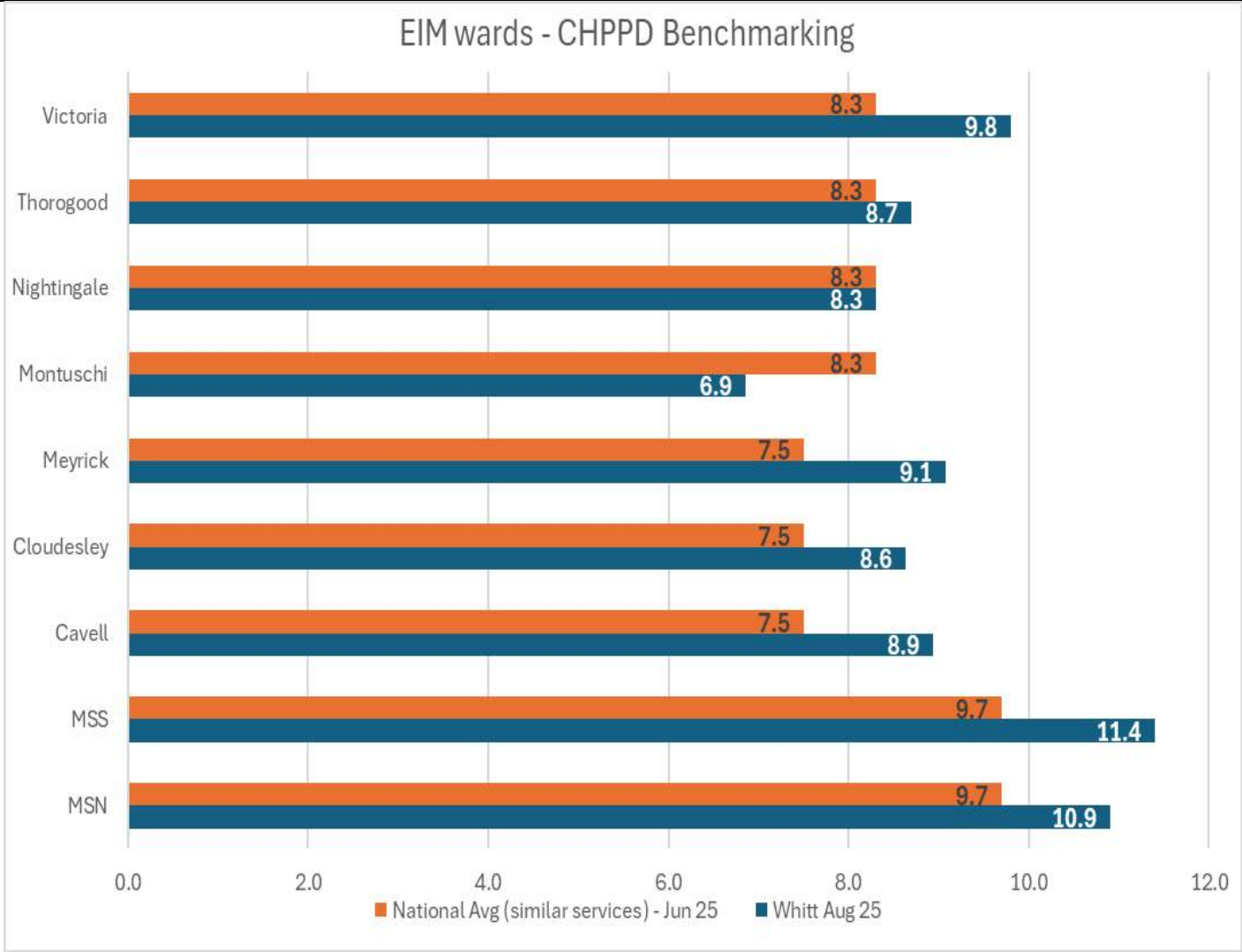
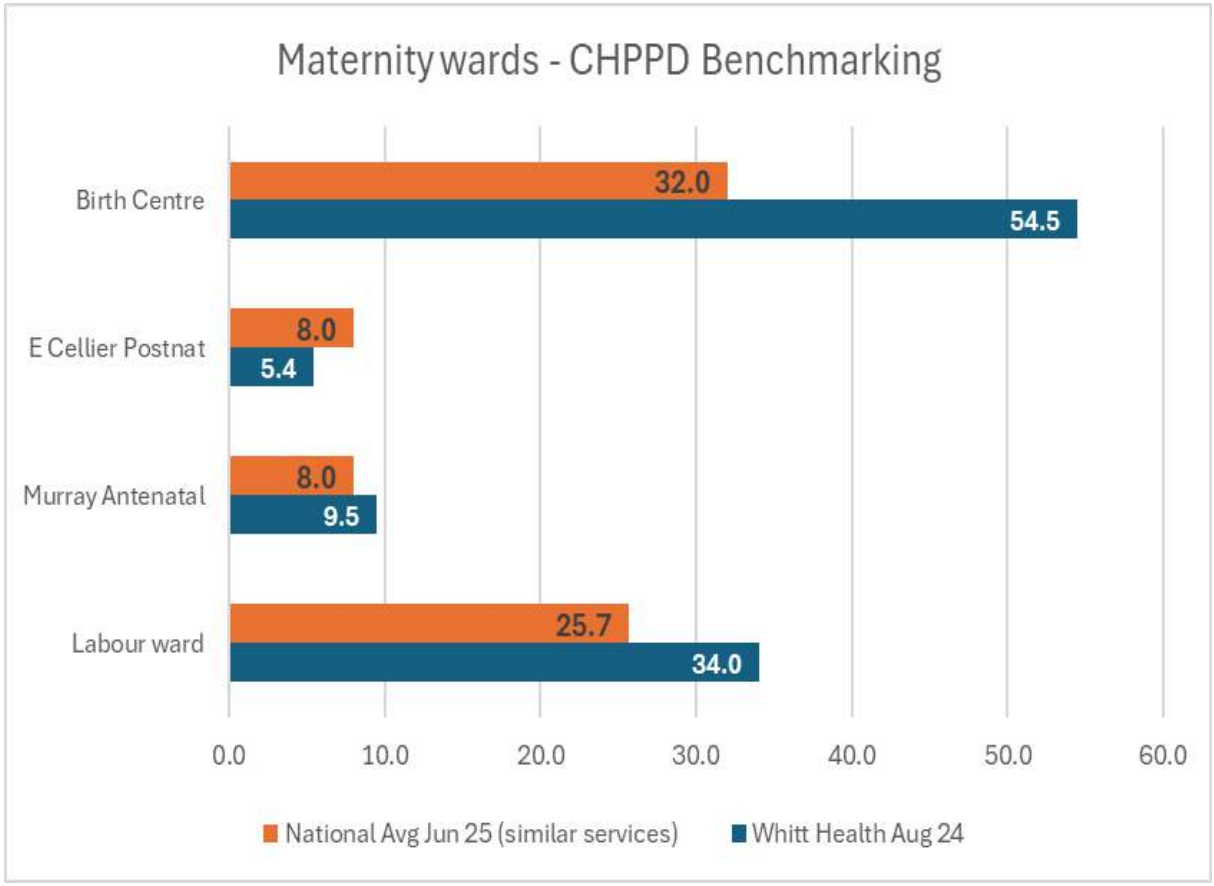
Table 3 – EIM CHPPD	Narrative
	There is a mixed picture of how local CHPPD compares to national average. There is a big variance with the national average CHPPD on the AAUs (MSS, MSN). Higher than usual activity with MH patients. CHPPD on Victoria, Cavell, Meyrick, and Cloudesley wards exceed the national average by more than 1.5 units. Common rationale has been the high acuity and requirement for EC. CHPPD on Montuschi was below the national avg. Acuity of patients is lower than in standard cardiology wards. A HCA at night was added to the daily deployment and establishment.

Table 4 – Maternity CHPPD	Narrative
	CHPPD takes account of mothers and babies. CHPPD on Cellier ward has been consistently below the national avg. CHPPD include all staff on roster plus NIPPE RM. Very high CHPPD in Birth Centre in comparison to the national average for several consecutive establishment review rounds. Service to consider sustainability of the existing service and staffing model. Staff redeployments from Birth Centre are not always reflected in the eRoster, therefore there is a degree of excessive calculation of the CHPPD for the setting and potentially undercalculation for Cellier and Murray wards. CHPPD on Labour ward also significantly above the national average.

Appendix 4 - Outcome summary tables (Enhanced Care included in SNCT recommendations where applicable).
Table 1: Surgery and Cancer

Table 2: Children and Young People

Table 3a and 3b: Emergency and Integrated Medicine

Table 4: Maternity Services

Table 1 – Surgery & Cancer (S&C)							
Ward/ clinical setting	**Description**	**Funded Bed capacity**	**Funded Establishment August 2025 (WTE)- after rebasing paper approval** **R**: Registered **U:** Unregistered	**Establishment recommendation as per August 25 SNCT Audit (WTE)** Enhance Care Included	**Professional Bodies &/or guidelines recommendations**	**Registered staff to patient ratio (per roster planning)**	**Outcome from Establishment review meetings**
						Day / Night	
Coyle ward	Non-elective orthopedic, trauma, general surgery.	26 beds	47.63 wte 23.73 wte **R** 18.90 wte **U**	37.52 wte 27.00 **R** 10.52 **U**	RCN critical Ratio 1RN:8pt	1:5 / 1:5	No change
Mercers ward	Surgical ward for **spinal, bariatric**, emergency laparotomies, 8 single-rooms	18 beds	31.00 wte 19.70 wte **R** 11.30 wte **U**	25.67 wte 16.69 wte **R** 8.98 wte **U**	RCN critical Ratio 1RN:8pt	1:5 / 1:5	No change
Critical Care Unit (ICU)	Care of patients with single/multiple organ failure. Fluctuating occupancy above bed-base. 4 single rooms	10 (+2)	66.9 Reg **R**	Not applicable	Intensive Care Society: 68.5 WTE for 11 beds	1:1 for Level 3 1:2 for Level 2	No Change

Table 2 – Children and Young People (CYP)								
Ward/ clinical setting	**Description**	**Funded Bed capacity**	**Funded Establishment August 2025 (WTE)** **R**: Registered **U:** Unregistered	**Establishment recommendation as per August 25 SNCT Audit (WTE)** Enhance Care Included	**Professional Bodies &/or guidelines recommendations**	**Registered staff to patient ratio (per roster planning)**		**Outcome from Establishment review meetings**
						Day	Night	
Ifor ward	For children with acute physical & mental health illness.	15 (19 approved funding Nov 2025-March 2026)	39.7 wte 31.41 wte **R** 8.29 wte **U**	39.6 wte 31.7 wte **R** 7.9 wte **U** **Plus 4 WTE RN for PDN, w/m, matron d/c coordinator**	RCN/NQB guidance for 19 patients 47.91 wte (37.27 RNs, 10.65 HCAs)	1:3	1:4	Approved increased 19 beds occupancy until March 2026. Proposed establishment adjustment as below Repurpose RMN vacancies: convert B5 vacancies to 5.2 x B3 WTE of MH HCAs to meet EC needs and increase 1 HCA on each shift. Recruit as part cost pressure to meet the 19 beds demand (1.5 WTE identified in current budget)
Neo Natal Unit (NICU)	Funded for 6 Level 3, 6 Level 2 and 11 special care cots	23 cots	63.8 wte 57.80 wte **R** 6.0 wte **U**	Not applicable	RCN/NQB guide - 23 cots. 67.40 wte (90% RNs)	1:1 - Level 3 1:2 - Level 2 1:4 - Sp Care		To support Ifor staffing as activity allows No Change

Table 3a - Emergency & Integrated Medicine (EIM) – ED, Urgent care, and AAU								
Ward/ clinical setting	**Description**	**Funded Bed capacity**	**Funded Establishment August 2025 (WTE)-** after rebasing paper approval at TMG 12-8-2015 **R**: Registered **U:** Unregistered	**Establishment recommendation as per August 25 SNCT Audit (WTE)** Enhance Care Included	**Professional Bodies &/or guidelines recommendations**	**Registered staff to patient ratio (per roster planning)**		**Outcome from Establishment review meetings**
						Day	Night	
ED- Adult	Emergency department	230 avg attend/day Jan-Sept 2025	99.79 wte 70.50 wte **R** 29.29 wte **U**	98.0 wte 68.60 wte **R** 29.40 wte **U**	NICE 2015 & NQB 2018 See r/v pack	Not applicable		No change
ED- Paeds	Emergency department	61 avg attend/day Jan-Sept 2025	15.78 wte **R**	27.2 wte **R**	RCPCH 2022 & RCN 2024 See r/v pack	Not applicable		Add 2.5 WTE band 5 (for a 4th RN at twilight shift)
SDEC/Amb care	Ambulatory and same day care		19.49 wte 4.25 wte **R** 5.24 wte **U**	Not applicable	Activity, performance & professional judgement	Not applicable		No change
Urgent Care Centre	Consisted of ACPs, ENPs & RD PDNs		13.44 wte **R**	Not applicable	Activity, pathways, performance & professional judgement	Not applicable		No change
Acute Assessment Units (AAU)	For patients admitted from ED and require assessment and treatment prior to discharge or transfer to a ward	**34 beds**	**72.01 wte** **41.44 wte R** **30.66 wte U**	**69.60 wte** **50.09** wte **R** **19.48** wte **U**	**RCN critical Ratio 1RN:8pt** **N/A for AAUs**	1:4.2	1:5.6	No change
Mary Seacole North (AAU)		16 beds	36.05 wte 20.72 wte **R** 15.33 wte **U**	33.71 wte 24.27 wte **R** 9.44 wte **U**	RCN critical Ratio 1RN:8pt N/A for AAUs	1:4	1:5.3	
Mary Seacole South (AAU)		18 beds	36.05 wte 20.72 wte **R**	35.86 wte 25.82 wte **R** 10.04 wte **U**	RCN critical Ratio 1RN:8pt N/A for AAUs	1:4.5	1:6	

			15.33 wte **U**					

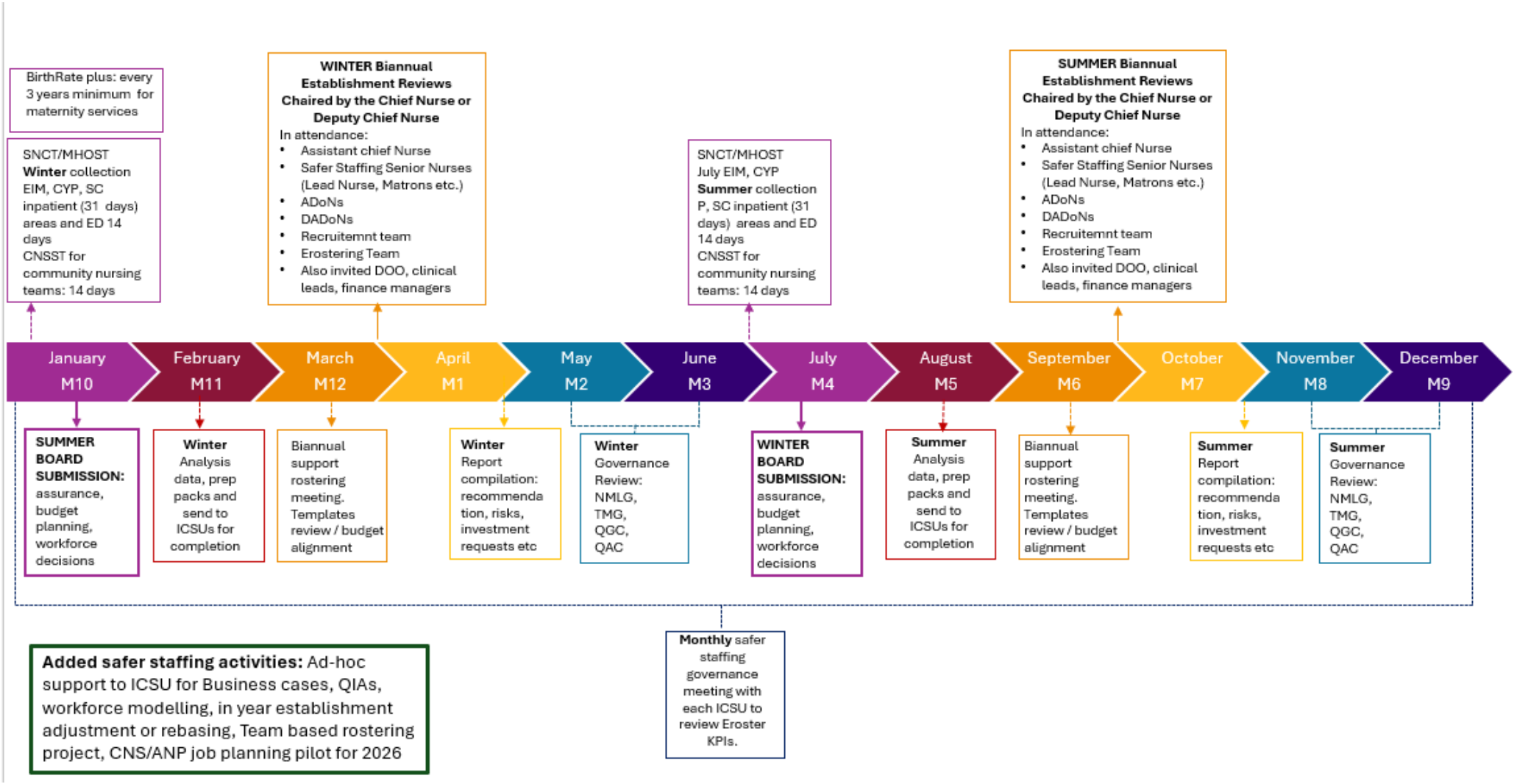
Table 3b - Emergency & Integrated Medicine (EIM) – Inpatient wards								
Ward/ clinical setting	**Description**	**Funded Bed capacity**	**Funded Establishment August 2025 (WTE)** after rebasing paper approval at TMG 12-8-2015 **R**: Registered **U:** Unregistered	**Establishment recommendation as per August 25 SNCT Audit (WTE)** Enhance Care Included	**Professional Bodies &/or guidelines recommendations**	**Registered staff to patient ratio (per roster planning)**		**Outcome from Establishment review meetings** (Add HCAs from the rebasing paper)
						Day	Night	
Cavell ward	Care of Older People (COOP), high % of pts dependent or require EC.	24 beds	44.19 wte 21.19 wte **R** 23.0 wte **U**	44.00 wte 22.00 wte **R** 22.00 wte **U**	RCN critical Ratio 1RN:8pt 16.5 RNs wte	1:6	1:8	No change
Cloudesley ward		25 beds	44.19 wte 21.19 wte **R** 23.0 wte **U**	51.72 wte 25.86 wte **R** 25.86 wte **U**	RCN critical Ratio 1RN:8pt 17.1 RNs wte	1:6	1:8	No Change
Meyrick ward		25 beds	44.19 wte 21.19 wte **R** 23.0 wte **U**	53.28 wte 26.64 wte **R** 26.64 wte **U**	RCN critical Ratio 1RN:8pt 17.1 RNs wte	1:6	1:8	No change
Montuschi ward	Cardiology ward with 4 Level 2 Coronary Care beds	17 beds	24.08 wte 16.42 wte **R** 7.66 wte **U**	25.52 wte 18.37 wte **R** 7.14 wte **U**	RCN critical Ratio 1RN:8pt 11.7 RNs wte	1:6	1:6	No change
Nightingale ward	Acute & chronic respiratory care, 4 Level 2 beds, 9 single-rooms.	23 beds	40.75 wte 25.45 wte **R** 15.30 wte **U**	35.8 wte 25.26 wte **R** 9.82 wte **U**	RCN critical Ratio 1RN:8pt 16 RNs wte	1:5	1:6	No change

Thorogood ward	Medical ward for patients with low acuity and Haematology patients	20 - 25 beds	Staff in post Aug25 34.18 wte 22.79 wte **R** 11.39 wte **U**	30.58 wte 22.02 wte **R** 8.56 wte **U**	RCN critical Ratio 1RN:8pt 18 RNs wte	1:5	1:6	Funding Oct-March
Victoria ward	Acute medical ward for gastro, endocrine conditions	20 - 25 beds	45.42 wte 26.30 wte **R** 19.12 wte **U**	40.12 wte 28.89 wte **R** 11.23wte **U**	RCN critical Ratio 1RN:8pt 18 RNs wte	1:5	1:6	Th'good & Victoria wards swapped specialty and staff in May 25

Table 4 – Maternity Summary

Ward/ clinical setting/ service	**Description**	**Annual Births activity**	**Additional Annual Intrapartum Activity** (includes postnatal readmissions, antenatal cases requiring 1:1 etc)	**Funded Establishment** **Feb 2025 (wte)** **R**: Registered **U:** Unregistered	**BirthRate Plus workforce assessment. Nov 2023**	**Professional Bodies & guidelines (wte)**	**Comments, recommendations, actions, proposed changes from Establishment r/v meeting**
Maternity	Acute and community maternity services	2983	508	201.61 wte 155.87 wte **R** 45.74 wte **U**	171.02 wte	BR+ endorsed by NICE, RCM & RCOG	Service underwent a restructure in late 2024 resulting in adjustments to the establishments in several parts of the service.

Appendix 5: Nursing & Midwifery yearly Establishment Review and Safer Staffing Processes Timeline



Meeting title	**Trust Board – public meeting**	**Date: 30.01.2026**
Report title	**Maternity Incentive Scheme (MIS) Year 7 – Submission**	**Agenda item: 7**
Executive lead	Sarah Wilding (Trust Board Chief Nursing Officer and Allied Health Professionals – Trust Board Maternity Safety Champion)	
Report authors	Isabelle Cornet, Director of Midwifery, Rhonda Flemming and Stuart Richardson, Clinical Directors for ACW Clinical Division, and Meg Wilson, 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. 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 with in order receive the financial rebate. The Declaration Form for the submission was published by NHS Resolution on the 6 November 2025, and the submission date is 12 noon on the 3 March 2026. The submission update for Whittington Health NHS Trust, with the details in Declaration Form attached as **Appendix 1:** - Safety Action 1: Fully compliant - Safety Action 2: Fully compliant - Safety Action 3: Fully compliant - Safety Action 4: Not Compliant The maternity unit is not compliant with the requirements regarding the criteria for employment of short-term locum doctors in Obstetrics and Gynaecology. An Action plan has been developed and is presented on slide 6 of the **appendix 2 and appendix 3.** - Safety Action 5: Fully compliant - Safety Action 6: Fully compliant Evidence of compliance with some of the requirements will need to be presented at the Public Trust Board as per the Saving Babies Lives Care Bundle (SBLCB) Guidance:	

	▪ Element 4.5: “Trust Board should specifically confirm to the system that within their organisation: o a dedicated lead midwife (min 0.40 WTE) – WH Maternity Unit has 1.00 WTE. o lead obstetrician (min 0.10 WTE) per consultant led unit have been appointed and are in post.” – WH Maternity Unit has 4 hours per week, equating to 0.10 WTE and 1 PA. o WH can confirm this position as there is 1.00 WTE Fetal Wellbeing specialist midwife in post currently with the job description as per **Appendix 4**, and there is a lead consultant (1PA) as well. ▪ Element 5.1: “Trust Board should specifically confirm to the system that within their organisation they have appointed and have in post the leads specified:” o An obstetric consultant lead for preterm birth, delivering care through a specific preterm birth clinic or within an existing fetal medicine service – WH Maternity Unit has an obstetric consultant lead for preterm birth. o An identified local preterm birth / perinatal optimisation midwife lead. (Appendix 5) – WH Maternity Unit has a Preterm Birth Specialist midwife. o A neonatal consultant lead for preterm perinatal optimisation – WH has a neonatal consultant lead for preterm perinatal optimisation. o An identified neonatal nursing lead for preterm perinatal optimisation – WH has a neonatal nursing lead for preterm perinatal optimisation. - ▪ Element 6.1: “The multidisciplinary team should consist of, as a minimum: o obstetric consultant – WH Maternity Services have 2.5 PA for the Obstetric team wiche makes the unit compliant. o diabetes consultant – WH Maternity services have diabetic consultants which makes the unit compliant. o diabetes specialist nurse (DSN) – WH Maternity services have 1 PA for the diabetic specialist nurse which makes the unit compliant. o diabetes dietitian - WH Maternity services have 1 PA for the dietician which makes the unit compliant. o diabetes specialist midwife (DSM).” **Appendix 6** is the job description and person specification for the DSM at WH. WH Maternity services have 1.00 WTE specialist midwife which makes the unit compliant. - Safety Action 7: Fully compliant o Action Plan established by NCL LMNS and escalated via the Perinatal Quality Oversight Model (PQOG) at trust, ICB and regional level. It was approved at the Quality Assurance Committee in January 2026. The next self-assessment with NCL LMNS is planned for February 2026.

	- Safety Action 8: Fully compliant o Action Plan established and approved at the Quality Assurance Committee to ensure 90% of Obstetric rotational medical staff that commenced working at the Trust on or after the 1st July 2025 are compliant with the Multi-Disciplinary Fetal monitoring and surveillance training within a maximum of 6 months from starting at the Trust. - Safety Action 9: Fully compliant - Safety Action 10: Fully compliant
Purpose	For the Trust Board to: i. approve and sign-off the submission of the MIS Year 7 Declaration Form to NCL LMNS and NHS Resolution. The LMNS sign-off is scheduled for 9 February 2026. ii. confirm the roles and leads specified as required by SBLCB Guidance.
Recommendation(s)	For Trust Board to approve and sign-off the submission of the MIS Year 7 declaration form to NCL LMNS and NHS Resolution by the deadline of 3 March 2026, at 12:00 (noon).
Risk Register or Board Assurance Framework	BAF entry 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	• Maternity Clinical Governance and Safety Champion Meeting – MIS Update at every Maternity Clinical Governance and Safety Champion Meeting – Latest on 11 December 2025. • ACW ICSU Board – MIS Update at every ACW ICSU Board – Latest on 4 December 2025. • Quality Governance Committee – 14 October and 9th December 2024. • Quality Assurance Committee – 14 January 2025. • TMG – 27 January 2025.
Appendices	Appendix 1 – MIS Year 7 Board Notification Form for Submission Appendix 2 - Short term and long-term locums Audit 2025 Appendix 3 - Obstetric Locums Booking Cribsheet Appendix 4 - Fetal Wellbeing Specialist Midwife JDPS Appendix 5 - Fetal Growth & Preterm Birth Specialist Midwife JDPS Appendix 6 - Diabetes specialist midwife JD and PS 2021

Maternity incentive scheme - Year 7 Guidance

Trust Name	**Whittington Hospital NHS Trust**
Trust Code	**T221**

This document must be used to submit your trust self-certification for the year 7 Maternity Incentive Scheme safety actions.
A completed action plan must also be submitted for any safety actions which have not been met (tab C).

Please select your trust name from the drop-down menu above. The trust code will automatically be added below. Your trust name will populate each page. If the trust name box above is coloured pink please update it.

Tabs A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed in each element of the safety action. Please complete these entries starting at the top.
'N/A' (not applicable) is available only for set questions and may only be visible following a response to a previous question.
The information which is added on these pages, will automatically populate onto tabs B & D (which is the board declaration form).

Tab B - safety action summary sheet - This will provide you with a detailed overview of the information entered so far on the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. Please review any pages that show there are responses that require checking, or are showing as not filled in.
This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet – If you are declaring non-compliance with any safety actions, this sheet will enable your Trust to insert action plan details and bid for discretionary funding. If you are declaring full compliance, you do not need to complete this tab.
All action plans for non-compliant safety actions must be:
•Submitted on the action plan template in the board declaration form.
•Specific to the safety action(s) not achieved by the Trust (these do not need to be added in numerical order).
•Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and should include details of the funding requested (please enter 0 if no funding is required).
•Any new roles to be introduced as part of an action plan must include detail regarding banding and Whole Time Equivalent (WTE) with associated costs.
•Action plans must be sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
•Action plans should not be submitted for achieved safety actions.
If you require any support with this process, please contact **nhsr.mis@nhs.net**

Tab D - Board declaration form - This is where you can view your overall reported compliance with all of the maternity incentive scheme safety actions. This sheet will be protected and compliance fields cannot be altered manually.
If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the Trust board, ICB and before submission to NHS Resolution.

Upon completion of your submission please add electronic signatures into the allocated spaces within this page. Signatures of both the Trust's Chief Executive Officer (CEO) and Accountable Officer (AO) of the Integrated Care System (ICS) will be required in Tab D in order to confirm compliance as stated in the board declaration form with the safety actions and their sub-requirements. Both signatures will show that they are 'for and on behalf of' the trust name, rather than the ICS. The signatories will be signing to confirm that they are in agreement with the submission, the declaration form has been submitted to Trust Board and that there are no external or internal reports covering financial years 2024/2025 or 2025/2026 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 3 March 2026

If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhsr.mis@nhs.net**

Technical guidance and frequently asked questions can be accessed in the year 7 MIS document:
MIS-Year-7-guidance.pdf

The Board declaration form must be sent to NHS Resolution via **nhsr.mis@nhs.net** between 17 February 2026 and 3 March 2026 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2026.

Submissions for the maternity incentive scheme year 7 must be received no later than 12 noon on 3 March 2026 and must be sent to **nhsr.mis@nhs.net**
Submissions and any comments/corrections received after 12 noon on 3 March 2025 will not be considered.
This document will not be accepted if it is not completed in full, signed appropriately and dated.
Please do not send evidence to NHS Resolution unless requested to do so.

Version Name: MIS_SafetyAction_2025

Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? (If this process has not been completed within three years due to measures outside the Trust's control, you can declare compliance but evidence of communication with the BirthRate+ organisation (or equivalent) MUST demonstrate this.)	Yes
2	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board every 6 months (in line with NICE midwifery staffing guidance) on an ongoing basis. This must include at least one report in the MIS period 2 April - 30 November. Every report must include an update on all of the points below: ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● 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 on duty at the start of every shift. ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour ● Is a plan is in place for mitigation/escalation to cover any shortfalls in the points above?	Yes
3	**For Information Only:** We recommend that Trusts continue to monitor and include NICE safe midwifery staffing red flags in this report, however this is not currently mandated, This includes: •Redeployment of staff to other services/sites/wards based on acuity. •Delayed or cancelled time critical activity. •Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). •Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). •Delay of more than 30 minutes in providing pain relief. •Delay of 30 minutes or more between presentation and triage. •Full clinical examination not carried out when presenting in labour. •Delay of two hours or more between admission for induction and beginning of process. •Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). •Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally.	No

4	Can the Trust Board evidence that the midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● 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
5	Where Trusts are not compliant with a funded establishment based on the above, 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.	N/A
6	Where deficits in staffing levels have been identified must be shared with the local commissioners.	N/A
7	Evidence from an acuity tool (may be locally developed) that the Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
8	**For Information Only:** A workforce action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the workforce action plan will NOT enable the trust to declare compliance with this sub-requirement.**	N/A
9	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Yes
10	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the improvement plan will enable the Trust to declare compliance with this sub-requirement. This improvement plan does not need to be submitted to NHS Resolution**	N/A

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Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 1 December 2024 to 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose N/A)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 75% of all reports completed and published within 6 months of death? MIS verification period: Dec 2024 to April 2025 60% of cases. 2 April 2025 to 30 Nov 2025 75% of cases	Yes
5	For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT? MIS verification period: 2 April 2025 - 30 Nov 2025	Yes
6	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans.	Yes
7	Were quarterly reports discussed with the Trust Maternity Safety and Board level Safety Champions?	Yes

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Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No)
1	Did July 2025's data contain valid birthweight information for at least 80% of babies born in the month? This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405)	Yes
2	Did July 2025's 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

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Safety action No. 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are pathway(s) of care into transitional care in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice?	Yes
2	**Or** Can you evidence progress towards a transitional care pathway from 34+0 in alignment with the BAPM Transitional Care Framework for Practice, and has this been submitted this to your Trust Board and the Neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards?	N/A
Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation.		
For units commencing a new QI project		
3	By 2 September 2025, register the QI project with local Trust quality/service improvement team.	Yes
4	By 30 November 2025, present an update to the LMNS and Safety Champions regarding development and any progress.	Yes
Or **For units continuing a QI project from the previous year**		
5	Demonstrate progress from the previous year within the first 6 months of the MIS reporting period, and present an update to the LMNS and Safety Champions.	N/A
6	By 30 November 2025, present a further update to the LMNS and Safety Champions regarding development and any progress at the end of the MIS reporting period	N/A

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Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing all short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 and before submission to Trust Board (select N/A if no short-term locum doctors were employed in this period): Locum currently works in their unit on the tier 2 or 3 rota OR 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)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	No
2	Has the Trust ensured that the RCOG guidance on engagement of long-term locums has been implemented in full for employing long-term locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 to 30 November 2025 (select N/A if no long-term locum doctors were employed in this period)	Yes
3	**For information only:** RCOG compensatory rest (not reportable in MIS year 7) Have you met, or are working towards full implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist 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.	No
4	Is the Trust compliant with the Consultant attendance in person to the clinical situations guidance, listed in the RCOG workforce document: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate a minimum of 80% compliance through audit of any 3-month period from February 2025 to 30 November 2025.	Yes
5	Do you have evidence that the Trust position with the above has been shared with Trust Board?	Yes

6	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?	Yes
7	Do you have evidence that the Trust position with the above has been shared with the LMNS?	Yes
b) Anaesthetic medical workforce		
8	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) Representative month rota acceptable for evidence.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	Yes
10	Is this formally recorded in Trust Board minutes?	Yes
11	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	N/A
12	Was the above action plan shared with the LMNS?	N/A
13	Was the above action plan shared with the Neonatal ODN?	N/A
d) Neonatal nursing workforce		
14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	Yes
15	Is this formally recorded in Trust Board minutes?	Yes
16	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	N/A
17	Was the above action plan shared with the LMNS?	N/A
18	Was the above action plan shared with the Neonatal ODN?	N/A

Return to Guidance Sheet

Safety action No. 6

Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3.2 is fully in place, and can you evidence that the Trust Board have oversight of this assessment?	Yes
2	Where full implementation is not in place, has the ICB been assured that all best endeavours and sufficient progress has been made towards full implementation, in line with the locally agreed improvement trajectory?	N/A
3	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 7 to track compliance with the care bundle? These meetings must include: ● Initial agreement of a local improvement trajectory against these metrics for 25/26, and subsequently reviews of progress against the agreed trajectory. ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.	Yes
4	Following these meetings, has the LMNS determined that sufficient progress has been made towards implementing SBLCBv3, in line with the locally agreed improvement trajectory?	Yes
5	If the available Implementation Tool is not being utilised to show evidence of SBL compliance, has a signed declaration from the Executive Medical Director been provided declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB	N/A

Return to Guidance Sheet

Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have evidence of an action plan co-produced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge	Yes
2	● Has progress on the co-produced action above been shared with Safety Champions?	Yes
3	● Has progress on the co-produced action above been shared with the LMNS?	Yes
4	**Do you have evidence of MNVP infrastructure being in place from your LMNS/ICB, in full as per national guidance, and including all of the following:** • Job description for MNVP lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost	No
5	**If MNVP infrastructure is not in place and evidence of an MNVP, commissioned and functioning in full as per national guidance, is unobtainable (and you have answered N to Q4):** Has this has been escalated via the Perinatal Quality Oversight Model (PQOM) at trust, ICB and regional level? In this event, as long as this escalation has taken place the Trust will not be required to provide any further evidence as detailed below to meet compliance for MIS for this safety action.	Yes

6	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Terms of Reference for Trust safety and governance meetings, showing the MNVP lead as a quorate member of trust governance, quality, and safety meetings at speciality/divisional/directorate level including all of the following: •Safety champion meetings •Maternity business and governance •Neonatal business and governance •PMRT review meeting •Patient safety meeting •Guideline committee	N/A
7	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	N/A

Return to Guidance Sheet

Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2025? Rotational medical staff in posts shorter than 12 months can provide evidence of applicable training from a previous trust within the 12 month period using a training certificate or correspondence from the previous maternity unit.		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) contributing to the obstetric rota? (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank midwives employed by Trust and maternity theatre midwives who also work outside of theatres)?	Yes
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants?	Yes
6	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows,foundation year doctors and GP trainees contributing to the obstetric rota?	Yes
7	For rotational obstetric staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust?	Yes
9	90% of maternity support workers and health care assistants? (to be included in the maternity skill drills as a minimum).	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors?	Yes

11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2025) including any anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This requirement is supported by the RCoA and OAA?	Yes
12	For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
13	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in any clinical area or at point of care during the whole MIS reporting period? This should not be a simulation suite.	Yes
	Neonatal resuscitation training	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births?	Yes
16	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
17	90% of neonatal nurses? (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes
19	**For Information Only:** 90% of maternity support workers, health care assistants and nursery nurses? (dependant on their roles within the service - for local policy to determine)	Yes
20	90% of midwives? (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust)	Yes
21	In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance? Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance.	Yes

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Safety action No. 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?

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded with evidence of working towards the Perinatal Quality Oversight Model (PQOM)?	Yes
2	Has a non-executive director (NED) been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM/PQOM at least quarterly, and presented by a member of the perinatal leadership team to provide supporting context?	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent?	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM/PQOM?	Yes
6	Ongoing engagement sessions should be being held with staff as per previous years of the scheme. Is progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025?	Yes
7	Is the Trust's claims scorecard reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period 2 April - 30 November)?	Yes

8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period 2 April - 30 November) and that any support required of the Trust Board has been identified and is being implemented? **Where the infrastructure is in place, this should also include the MNVP lead as per SA7.**	Yes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented?	Yes

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Safety action No. 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 1 December 2024 until 30 November 2025?	Yes
2	Have you reported all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 until 30 November 2025?	Yes
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them?	Yes
4	For any occasions where it has not been possible to provide a format that is accesible for eligible families, has a SMART plan been developed to address this for the future?	N/A
5	Has 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
6	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution?	Yes
7	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible with the SMART plan to address this?	Yes
8	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
9	When reporting EN cases, have you completed the field showing whether families have been informed of NHS Resolution's involvement? Completion of this will also be monitored, and externally validated.	Yes

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Section B : Action plan details for Whittington Hospital NHS Trust

An action plan should be completed for each safety action that has not been met

Please refer to the guidance sheet to ensure correct entries into the action plan: Return to Guidance Sheet

Action plan 1

Safety action	Q4 Clinical workforce planning	**To be met by**	Q1 = 2026/27

Work to meet action	*1. No CVs will be forwarded to the department until Bank Partners has received the checklist for the doctor from their agency. The checklist now includes "does the worker have a CEL certificate" tick box. – Embedded* *2. Bank Partners will independently check each doctor against the CEL database. – Embedded*

Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes

Action plan owner	*Rhonda Flemming and Stuart Richardson, Clinical Directors of the ICSU*
Lead executive director	*Clarissa Murdoch, Acting Up Chief Medical Officer*
Amount requested from the incentive fund, if required	*£0.00*
Reason for not meeting action	*Bank staffing provider process and communication breakdown - The agencies provided wrong information to the Trusts Bank Partners - Agencies that have sent unsuitable candidates have been identified and their details were passed to NHSE (NC Care and Medsol) - This affected 2 locum doctors who covered 13 shifts.*
Rationale	*The action plan has been implemented and is monitored through Trust Governance. Since the episodes in April 2025, and the implementation of the action plan, the materntiy unit has ben fully compliant with the requirement.*
Benefits	*The action plan ensures safety for the unit and that the short term locum registrars meet the requirements. This is monitored through the Trust governance and Bank Partners.*
Risk assessment	*Controls and regular audits are in place to monitor compliance. A Crib Sheet has also been developped for the On Call Obstetric staff.*

	How?	**Who?**	**When?**
Monitoring	quarterly audits	Bank Partners	Quarterly - Q3 2025/26 was Compliant

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Maternity Incentive Scheme - Year 7 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	No	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	**9**	**1**		
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 (2025/26) or the previous financial year (2024/25)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports must be brought to the MIS team's attention.
* If declaring non-compliance, the Board and ICS agree that any discretionary funding 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 will be escalated 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:	Selina Dougles
Position:	Chief Executive Officer
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
In respect of the Trust:	Whittington Hospital NHS Trust
Name:	
Position:	
Date:	

NHS Resolution

Section A : Maternity safety actions - Whittington Hospital NHS Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	No
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
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?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Yes

ICARE EQUITY

NHS
Whittington Health
NHS Trust

Short Term and Long Term Locums

MIS action 4 requirements

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:

a. Locum currently works in their unit on the tier 2 or 3 rota
OR
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)?
OR
c. they hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?

Short term locums

- Do not work for more than two weeks
- A Certificate of Eligibility to undertake short term locums in Maternity is required if the doctor does not already work or has not recently worked in the department

- The majority of locum shifts are filled by internal trainee doctors on the current rota, and failing that, doctors on tier 2 or 3 rotas at other local Trusts.

Long term locums

- We do not have doctors in training who undertake locums for longer than 2 weeks on the bank
- Trust Doctors with an employment contract are subject to required checks. They are allocated a consultant educational supervisor.

Audit results – February to August 2025

Short-term locums (< 2 weeks)

While most of the shifts covered on a locum basis are covered by our own doctors, thus compliant with criteria 4.1, we have had a few shifts covered by agency locums as below

- 4 night shifts covered by non-compliant locum 1 (JS) between 20-24 February
- 2 night shits (17 &18 March) covered by the same locum 1
- 2 long days (12 & 13 April) and 4 nights (14, 18, 19, 20 April) covered by non-compliant locum 1 (JS)
- 1 night shift on 26/6 covered by a non-compliant locum 2 (KD).

A total of 13 shifts were covered by locums with no experience of the department and without a CEL certificate between February and August 2025

Long-term locums (> 2 weeks)

The department has not used long-term locum doctors over the period of the audit

Root Cause and Impact of Non-compliant Shifts

Root cause

- Bank staffing provider process and communication breakdown
- Misunderstanding of the specificity of the Certificate of Eligibility requirement (Bank Partners and Agencies

Complaints

No complaints were raised about the work of the doctors that covered the 13 shifts over the period

Incidents

A total of 12 incidents were raised in Maternity at times concurrent with the shifts covered by the non-compliant locums. These incidents have since been investigated and closed with no concerns being linked or raised around the clinical practice of the locums.

Other mitigations

The service also employed a short-term locum to cover 3 long days in April 2025, knowing they did not have a CEL certificate. This was done to mitigate the higher risk of not having any doctor whatsoever and the doctor was rostered to cover gynaecology only – thus outside the requirements of MIS action 4

Action Plan

The Trust bank staffing provider has been instructed since 2024 that all ST3 and above agency locum doctors booked for shifts in the department must hold a valid Certificate of Eligibility (CEL) issued by the Royal College of Obstetricians and Gynaecologists. This document is in line with MIS action 4 requirements and certifies that the doctor meets the criteria for working as short-term locum in NHS Maternity units. The existing process has failed and a new process has now been put in place

1. No CVs will be forwarded to the department until Bank Partners has received the checklist for the doctor from their agency. The checklist now includes “does the worker have a CEL certificate” tick box. – **Embedded**
2. Bank Partners will independently check each doctor against the CEL database. – **Embedded**
3. CV will be sent to the Service Manager / Rota coordinator confirming CEL checks. – Embedded
4. Service Manager / Rota coordinator confirms booking. – **Embedded**
5. On arriving for the shift the O&G team will confirm identity – to be done by Obstetric Consultant On-Call (as per cribsheet). – **Embedded**
6. Any candidates without CEL will be rostered for gynae only work and the rota will be risk assessed. – Rota coordinator to escalate to Service Manager / Service Manager, Rota Lead and On-Call Consultant. – **in place for all new bookings**.
7. Share CV (inc phone number) of bank doctor with on-call consultant. – Rota Coordinator to share. – **in place for all new bookings.**
8. Bank Partners will undertake quarterly audits to ensure they are following the correct booking processes. – **First Quarterly Audit in November 2025 – compliant.**
9. When suitable doctors cannot be identified to cover gaps the OPEL maternity framework will be triggered. – Via Site Manager and in consultation with Midwife in Charge and Maternity Bleep Holder. – **Embedded in the SitRep.**
10. Emergency cover to be booked via out of hours Bank Partners support. – Via Site Manager - **Embedded**

Final remarks

The Maternity department has failed to meet the requirements of MIS Safety Action 4 over the period between February-August 2025

Local impact (incidents and complaints) has been reviewed with no further safety concerns raised as a result of this failure

A new process has been devised and deployed to safeguard against further breaches

The Framework has been asked to send a reminder to all agencies of the CEL requirements

Agencies that have sent unsuitable candidates have been identified and their details were passed to NHSE (NC Care and Medsol)

Learning continues to be shared with the wider NCL and NHS network

Booking locum doctors on the registrar rota in Maternity

Authors: Rhonda Flemming, Co-Clinical Director for ACW ICSU and Adrian Iuga, General Manager for Women's Health – November 2025 – version 1 final.

Step 1

Rota coordinator submits booking request to Bank Partners stating doctor is required for work in **maternity (obstetric rota)**

Step 2

Bank Partners identifies suitable candidates and forwards them to rota coordinator / service manager

- Candidates **must have a valid Certificate of Eligibility to work in Maternity** as defined by the RCOG as checked on the official database NHS Locum Certificate search | RCOG Training
- CVs will be sent along with confirmation of eligibility

Step 3

Booking is confirmed and candidate CV including contact phone number is forwarded to the Obs on-call consultant

Step 4

Upon arrival for the shift, on-call consultant checks the identity of the locum doctor.

Step 5

If none of the candidates have a valid CEL, rota coordinator will escalate this to the Service or General manager, Rota lead and On-call consultants to decide if in the interest of patient safety, the candidate can be rostered to work on the gynae rota only

Step 6

When no candidates at all can be identified the OPEL maternity framework will be triggered by the on-call consultant and the Head of Midwifery (can be contacted via switchboard)

OUT of HOURS BOOKINGS

Emergency cover to be booked via out of hours Bank Partners support – via the **Site Manager**

Whittington Health NHS

Job Description

Title:	**Fetal Wellbeing Specialist Midwife**
Grade:	**Band 7 AfC**
Hours per week:	**1.00 WTE – 37.5 hours per week**
Annual Leave:	27 days per annum increasing to 29 days after 5 years NHS service and 33 days after 10 years NHS service
Department:	**Maternity**
Responsible to:	**Matron for Intrapartum Care**
Accountable to:	**Director of Midwifery**

Role of the post holder:

The post holder will be expected to:

- Be responsible for personal and professional development of all staff and learners within Maternity team in relation to Fetal Wellbeing, specifically cardiotocographs (CTGs) and Intelligent Intermittent Auscultation. This will be in collaboration with the Lead Practice Development Midwife, Maternity Matrons, Head and Director of Midwifery.
- Lead and facilitate a programme aimed at equipping both midwives and obstetricians to increase their knowledge and competence in identifying fetal well-being, potential fetal compromise and actual fetal compromise in all clinical settings and to improve timely clinical decision making.
- Work as a change agent within the organisation wide multidisciplinary team in taking forward and shaping the future of midwifery practice in the light of the local, national and professional agenda.
- Play a pivotal role in education provision within the department. The practice development Midwife – Fetal Wellbeing Specialist will be a proficient, approachable role model in addition to an expert clinician, with a proven track record of clinical achievement.
- Work with the Intrapartum Lead Consultant Obstetrician, the Fetal Wellbeing Consutlant Obstetrician, Maternity Matrons, and Practice Development team to develop a comprehensive training and competency- assessment package to give assurance that all staff responsible for fetal assessment and wellbeing are competent. This must be electronically archived and directly accessible for audit or recording purposes.
- Project Lead the safe implementation of a Centralised CTG system in collaboration with the Intrapartum Lead Consultant Obstetrician, the Fetal Wellbeing Consultant Obstetrician, Maternity Matrons, and Lead Practice Development Midwife. To include staff training, guideline development and implementation.

- Continuous Review of fetal monitoring training packages, assessments and educational resources to develop new ways of learning.

The role/duties of the post are outlined below. In undertaking this role, the employee will be expected to behave at all times in a way that is consistent with and actively supports the organisation's I-care values.

MAIN DUTIES

Education and Staff Support

- To continue embeding and developing the current competency assessment for fetal monitoring to assess and improve the knowledge and skills of all staff providing intrapartum and antenatal care across all maternity settings
- To ensure that all midwives and obstetricians providing antenatal and intrapartum care undertake the competency assessment in assessing fetal wellbeing
- Identify learning needs of staff in relation to Fetal Wellbeing. Responsible for addressing identified learning needs through the development of an action plan.
- Help to deliver the training within the Maternity Unit in conjunction with the practice development team. To include preparation of subject matter and delivery through lectures, seminars and practical's of the relevant material.
- Help to assess Preceptees, Midwives and students knowledge and understanding of fetal monitoring interpretation by partaking in practical assessments where necessary.
- Maintain a database of all training relating to fetal monitoring undertaken by maternity staff .
- Facilitate and encourage personal and professional development of staff
- Provide direct clinical expertise, advice and support to staff within the clinical area in relation to Fetal Wellbeing.
- Have a particular responsibility to support newly appointed Preceptorship Midwives.
- Promote a positive learning environment and actively encourage innovation in clinical practice.
- Work clinically with staff in order to facilitate the acquisition and enhancement of clinical skills and assist in the achievement of appropriate levels of competence.
- Instrumental in the identification, development and implementation of policy, procedure, guidelines and audit in relation to local, national and professional agendas and monitor adherence taking appropriate action.
- Propose changes to policies within own area but also organisation wide clinical and education policies.
- In collaboration with other Practice Development Midwives integrate theory and practice and sustain effective partnerships with Higher Education Institutions (HEIs).
- Contribute to curriculum development to ensure that they respond to clinical needs.
- Responsible for training staff in the safe use of CTG machines, fetal dopplers and a Centralised CTG system.
- To further develop, in conjunction with the Intrapartum Lead Consultant Obstetrician, the Fetal Wellbeing Consutlant Obstetrician, Maternity Matrons, and Lead Practice Development Midwife an audit form for case reviews of all emergency deliveries (i.e. instrumental and caesarean sections) in the previous twenty-four hours to review the interpretation of CTGs and subsequent management of care.

- Work clinically in one day per week. The post-holder should rotate their clinical time between triage, birth centre, labour ward and Antenatalward.

Management

- Assess clinical competence, capabilities and needs of staff in conjunction with the dependency of the patients and case mix.
- Motivate staff, promote team-building, exercise and develop leadership skills in creating a suitable environment for efficient team working.
- Promote and participate in reflective practice, clinical risk management and critical incident analysis.
- Maintain accurate staff training records.
- Liaise with IM and T to ensure that all relevant educational resources are posted on the intranet/appropriate drive on the computer network.
- Actively participate in the recruitment and selection of staff.
- Act as an educational resource providing advice and support on personal, professional and career development in order to maximize potential of staff at all levels.
- In conjunction with the Lead Practice Development Midwife, Maternity Matrons,Head and DIrector of Midwifery, coordinate the Annual Training Needs Analysis.
- Assist in supporting and contributing to staff appraisal, analyse and respond to identified training needs and develop an appropriate action plan.

Practice

- Demonstrate expert midwifery practice when caring for patients by using research-based evidence and in accordance with agreed policies and standards.
- Act as a credible clinical role model promoting high quality patient care.
- Act as a resource for others requiring clinical knowledge and experience, offering advice and support to staff and others in the multi-professional team in clinical decision-making.
- Demonstrate clinical competence when caring for patients within maternity, being aware of personal limitations.
- Ensure patients' interests are considered within the context of care by participating in ethical decision making and supporting staff through this process.
- Establish a mechanism to ensure proficiency with new practices and new equipment.
- Contribute to organisation-wide initiatives as appropriate, in particular, by networking and collaborative working etc.
- Responsible for clinical decision making on a regular basis, directly influencing patient care.
- Demonstrating excellent clinical documentation and record keeping, and acting as a role model.

Research

- Promote evidence/research based Midwifery practice.
- Disseminate and utilise audit and research results as appropriate.
- Act as a change agent and support other staff in the implementation of new practices.
- Evaluate the quality of midwifery practice through the clinical audit cycle and contribute to quality initiatives within the clinical area.

Professional

- Identify personal objectives, reflect on progress and set a personal development plan annually.
- Following individual performance management, liaise with the Matron and the senor practice development Midwife in agreeing how identified training and development needs are to be met.
- Ensure that own practice is kept updated, using an acceptable model of clinical supervision.
- Take every opportunity to expand practice in line with current guidelines.
- Ensure that registered midwives are aware of, and practice in accordance with, all current guidelines and policies.
- Contribute to meeting the trusts strategic objectives.
- Develop management and leadership skills abilities under the direction of the Maternity Matrons and the Lead Practice Development Midwife and produce a strategy for problem solving.
- Demonstrate an awareness of global issues relating to own specialist area of midwifery.
- Undertake any other duties that may reasonably be required.

Communication

- The post holder is responsible for ensuring accurate and timely records are kept within the Trusts Electronic Health Records System and which comply with the Trust policy and relevant professional bodies' guidance (Nursing and Midwifery Council), reporting on any issues as appropriate.
- The post holder is responsible for ensuring they comply with current good practice in informing/updating all members of the multi-disciplinary team, their colleagues, women and appropriate others, of changes in care plans.
- The post holder is responsible for ensuring that they clearly communicate with women, actively listen to establish an understanding of the needs of the service user.
- Act as an ambassador for the Trust and develop external networks ensuring continuous development and improvement of internal systems and clinical practice.

Governance

The post holder will:

- Be aware of and contribute to the national and Trust governance agenda, to include risk management, complaints, clinical audit, research, regular submission of statistics and other quality initiatives.
- Maintain standards of midwifery care and take appropriate action if standards are not met.
- To implement change resulting from risk investigations and complaints.
- To provide comprehensive statements, reports and responses, as required, to a highly professional standard.

- Promote a culture of continuous quality improvement through the use of audit, patient/client feedback and reflection and practice by self and other members of the team.
- Help with the necessary audit/monitoring/implementation of necessary change required for MIS in the clinical area.
- Support the Risk Management and Clinical Governance Strategy.
- Attend department and hospital meetings when appropriate.

Operational Overview

- Manage duty rotas/annual leave and study leave to always ensure adequate midwifery/nursing cover and appropriate skill mix within the staffing resources as well as ensuring safe level of care is provided by appropriate skill mix and deployment of staff.
- Ensure processes are in place to manage sickness/absenteeism and take appropriate action inline with trust policies.
- Attend all huddles as required for maternity and the Trust if required or requested by senior managers
- When the Labour ward coordinator or ward managers or flow coordinator/bleep holder has concerns regarding activity and/or acuity, this must be escalated with the matron/ HoM/ DoM within hours. Out of hours, this should be escalated to Bronze on call (site team) who will liaise with silver on call. If necessary supporting Maternity Escalation OPEL 3 or above for mutual aid. Specialist midwives must be familiar with this process and assist when necessary
- Support staff by helping with clinical duties as required - this will include helping cover for breaks, administration of intravenous antibiotics for Neonates (if required), help with MEOW checks, assisting with discharges or undertaking drug rounds, NIPE, supporting preceptees for perineal repair, etc

Other

The post holder in carrying out their duties will occasionally be exposed to blood, urine and other bodily fluids and should ensure they are up to date with all immunisations and adhere to strict infection control practice.

The job description is not intended to be exhaustive and it is likely that duties may be altered from time to time in the light of changing circumstances and after consultation with the post holder.

You will be expected to actively participate in annual appraisals and set objectives in conjunction with your manager. Performance will be monitored against set objectives.

Revalidation and Registration

It is the responsibility of all staff registered with a professional body to:

- Act within the Professional Bodies Code of Practice.
- Maintain their own work profile to ensure revalidation standards are met, and assist junior registered staff in achieving revalidation.
- Contribute and participate in the development of colleagues' professional practice across the trust through leading ward and/or department projects, and supporting training.
- Ensure optimum use is made of working time.

Equal Opportunities

Our latest policy known as "Promoting Equality, Diversity and Human Rights" outlines the Trust's commitment to ensuring that no job applicant or employee receives less than favourable treatment on grounds of sex, marital and civil partnership status, gender reassignment, pregnancy and maternity, race, colour, creed, religion or belief, physical disability, mental health, learning difficulty, age or sexual orientation and is not placed at a disadvantage by conditions or requirements that cannot be shown to be justifiable.

For more information about our policy and commitment to equality, click: http://www.whittington.nhs.uk/default.asp?c=10505&q=equality "

Infection control

All staff has a responsibility to prevent and control infections within the Whittington. This includes ensuring personal and team compliance with all relevant policies; especially hand hygiene, the trust dress code, and MRSA screening policies.

Working patterns

The Trust is currently exploring ways in which patients can be given more choice about when they can attend appointments at the hospital. In order to make this possible there may be a future requirement for administrative staff scheduling appointments for patients to contact them by telephone in the evenings or at weekends. This means that administrative staff may be required to work a shift pattern in future. Shifts will not normally operate beyond 9 pm in the evenings and appropriate pay enhancements will apply. Staff will be consulted about the introduction of / changes to shift systems.

Staff working in any department where an on 'call rota' operates will be required to participate in the rota. Managers will discuss with staff the level of 'on call' cover required taking into account their individual circumstances.

Staff in nursing posts may be requested to work in any area throughout the Trust by the matron or the site manager.

Health & Safety Policy

Employees must be aware of the responsibilities placed on them under the Health and Safety at Work Act 1974, to ensure that the agreed safety procedures are carried out to maintain a safe environment for employees and visitors.

Safeguarding

To comply with the Trust's Safeguarding Children and Adults policies, procedures and protocols. All individual members of staff (paid or unpaid) have a duty to safeguard and promote the welfare of children, young people and vulnerable adults this will require you to:

- Ensure you are familiar with and comply with the London Child Protection Procedures and protocols for promoting and safeguarding the welfare of children and young people.
- Ensure you are familiar and comply with the Croydon Multi Agency Safeguarding Vulnerable Adults Pan London Procedures.
- Ensure you are familiar and comply with local protocols and systems for information sharing.
- Know the appropriate contact numbers and required reporting lines.
- Participate in required training and supervision.
- Comply with required professional boundaries and codes of conduct

Whittington Health is committed to safeguarding all children and vulnerable adults and expects all staff and volunteers to share this commitment.

Data Protection

This post has a confidential aspect. If you are required to obtain, process and/or use information in any format whether electronic or paper based, you should do so in a fair and lawful way. You should hold data only for the specific registered purpose and not use or disclose it in any way incompatible with such a purpose and ought to disclose data only to authorised persons or organisations as instructed. Breaches of confidence in relation to data will result in disciplinary action, which may result in dismissal.

Confidentiality

You are required to maintain confidentiality of any information concerning patients or staff which you have access to or may be given in the course of your work, in accordance with current policy on confidentiality at Whittington Health.

Whittington Mission, Vision and Goals

We have an excellent reputation for being innovative, responsive and flexible to the changing clinical needs of the local population. We are treating more patients than ever before and are dedicated to improving services to deliver the best for our patients.

Our mission
Helping local people live longer, healthier lives.

Our vision
Provide safe, personal, co-ordinated care for the community we serve.

Our goals
We have developed six key strategic goals to make sure we continue to support people to live longer, healthier lives.

- To secure the best possible health and wellbeing for all our community
- To integrate and coordinate care in person-centred teams
- To deliver consistent, high quality, safe services
- To support our patients and users in being active partners in their care
- To be recognised as a leader in the fields of medical and multi-professional education, and population-based clinical research
- To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population

Whittington Values

Our values underpin everything we do. Our staff are committed to delivering the following values in everything they do.

Our ICARE values have been created by our staff and are embedded in our appraisal and planning processes and form part of our staff excellence awards.

Carbon Reduction

All staff has a responsibility to contribute to a reduction in the organisation's carbon footprint. You should actively encourage others through your own actions to reduce their contribution to carbon emissions. This includes switching off electrical appliances that are not in use, turning down heating, closing windows, switching off lights and reporting carbon waste.

Security

It is the responsibility of all employees to work within the security policies and procedures of the Whittington Health NHS Trust to protect the patients, staff and visitors and the property of the Trust. This duty applies to the specific work area of the individual and the Hospital in general. All staff is required to wear official identification badges.

No Smoking

Whittington Health promotes a No Smoking Policy as part of employee's healthy living style. You will be required to work within the framework of this policy. Smoking is not permitted within Whittington Health premises.

Method of Payment

Payment of salaries is made into your bank account/building society account by direct bank system. Details of a bank account or building society account will be required on the first day at work. There is no facility for any other form of payment.

Probationary Period

Employment at Whittington Health is offered subject to successful completion of a 6 month probationary period for all staff with the exception of GMC Registered Doctors.

Person Specification

Post:	Fetal Wellbeing Specialist Midwife	Grade:	
Department	Maternity	Candidate Name	
Attribute		Essential	Desirable
Education / Qualifications	Registered Midwife with current NMC registration = First Degree	E	
	Non-Medical prescribing		D
	Evidence of teaching and developing junior staff	E	
	Mentorship Course Degree or equivalent clinical experience or Post Graduate Certificate in Education	E	
	Master's Degree in Midwifery or suitable subject or working towards		D
	Evidence of recent Fetal Monitoring Training	E	
Knowledge & Experience	Consolidated Post registration experience in all aspects of Midwifery Care	E	
	Have a knowledge of the wider social and psychological factors for women and their families with multiple pregnancies and/ or preterm birth.	E	
	Evidence of clinical competence in all aspects of midwifery care	E	
	Understand fetal physiology.		D
	Experience in developing and implementing guidelines		D
	Experience of data collection and analysis. Ability to use audit and research in the clinical setting	E	
	Evidence of teaching and developing junior staff, Proven teaching and assessing skills using innovative delivery methods	E	
	Good communication skills	E	
		E	

Skills & Abilities	Good leadership skills Ability to work under pressure and on own initiative Demonstrates skills in IT systems and use of word, excel and powerpoint Good presentation skills and ability to share data/ case studies with wider colleagues across the LMNS Ability to influence and manage change, including the promotion of evidence based practice Ability to manage and prioritize own workload meetings Able to think creatively, analyse and solve problems	E E E E E E E	
PERSONAL QUALITIES	Evidence of recent personal development activity Demonstrates an ability to work as part of a multidisciplinary team Act as a role model	E E E	
Other			

Completed by: …….. Date:……

Offer post Yes/ No Comments ……..

Job Description

Title:	**Fetal Growth and Preterm Birth Specialist Midwife**
Grade:	**TBC Pending Evaluation**
Hours per week:	**0.50 WTE – 18.75 hours per week**
Annual Leave:	27 days per annum increasing to 29 days after 5 years NHS service and 33 days after 10 years NHS service
Department:	**Maternity**
Responsible to:	**Matron for Community and Maternity Outpatients**
Accountable to:	**Director of Midwifery**

Role of the post holder:

The post holder will be able to undertake routine growth scans for low risk singleton pregnancies as requested, and liaise with the fetal medicine and obstetric teams to ensure high quality and evidence based fetal surveillance.

The post holder will be responsible for the monitoring and auditing of the gap/ grow protocol, and ensure reports and audits are completed to comply with the Saving Babies Lives Care Bundle version 3 (and as updated) and shared locally and regionally.

The postholder will also be the named midwife for preterm birth, and contribute to the ongoing audits and reporting regarding preterm birth the comply with SBLCBv3. They will organise the set up of joint MDT Clinic for women and birthing people with a risk of Preterm Birth. They will also provide education and training to staff regarding the identification and treatment of women and birthing people at risk or experiencing preterm birth.

Job summary

Fetal Growth

- Ensure all midwives have the latest teaching re Gap/Grow protocol during their mandatory training.
- Complete monthly audit of SGA births with review of care pathways and feedback to team midwives if a missed SGA is identified.
- Work with FMU Consultants to ensure all standards outlined in SBLV3 Element 2 are complied with.
- Ensure quarterly reports are completed for clinical governance and present audits to Maternity safety Champions, LMNS and perinatal team as requested.

- Acts as the liaison between the Trust and the Perinatal Institute for the Gap/Grow protocol

Preterm Birth

- To be the named midwife for preterm birth and work closely with the other named individuals to continually improve and enhance the experience of women and birthing people who have, or are at risk of preterm births.
- Set a joint MDT clinic for women and birthing people with a risk of preterm birth.
- Review and share their process and outcome indicator data across the perinatal team, maternity safety champions and LMNS quarterly.
- Develop and maintain clear audit and QI pathways for preterm birth prevention, prediction and perinatal optimisation and share results and across clinical networks.
- Support the maternity team in identifying women and birthing people at risk of preterm birth and ensure women and birthing people are given correct and evidence based information.
- Ensure regular and early communication with the neonatal team should a preterm birth be imminent
- Take part in risk reviews involving preterm births and perinatal reviews as requested, and support a continuous process of learning and improvement following recommendations.

Education

To undertake such duties as may be required from times as are consistent with the responsibilities of the grade and the needs of the service.

- Be familiar and competent in reviewing IT systems, work, excel, PowerPoint and any other role specific IT systems.
- Support the Clinical Governance Team in risk reviews regarding fetal growth, multiple or preterm births.
- To ensure confidentiality is maintained at all times, only releasing confidential information obtained during the course of employment to those acting in an official capacity in accordance the provisions of the Data Protection Act and its amendments.
- To work in accordance with the Trust's Equal Opportunities policy to eliminate unlawful discrimination in relation to employment and service delivery.
- To ensure skills are up to date and relevant to the role, to follow relevant Trust policies and professional codes and to maintain registration where this is a requirement of the role.
- To work with staff in a variety of settings to ensure midwifery practice is evidence based.
- Support, with the PDM, education and clinical research within the unit.
- Contribute to the structure of local and regional guidelines, policies/protocols and data collection locally and regionally

Professional

- Responsible for participation in the Trust appraisal process, and take a lead in identifying own mandatory professional, supervisory, personal development and training needs.
- Responsible for ensuring that the post holder accesses and participates in clinical supervision.
- Responsible for the safe custody and administration of medicines, where applicable.
- To participate and contribute appropriately in research, service modernisation and clinical governance
- To ensure that the agreed philosophy approach is adopted and followed, whilst respecting and valuing the different therapeutic approaches available within the multi-disciplinary team
- Responsible for ensuring confidentiality is maintained at all times in accordance with the General Data Protection Regulations (2018), Trust policy and good practice.
- Responsible for maintaining and conducting oneself in a professional manner towards women, their infants and family, carers, colleagues and other agencies.
- Participate in joint working with appropriate experts/agencies

Communication

- The post holder is responsible for ensuring accurate and timely records are kept within the Trusts Electronic Health Records System and which comply with the Trust policy and relevant professional bodies' guidance (Nursing and Midwifery Council), reporting on any issues as appropriate.
- The post holder is responsible for ensuring they comply with current good practice in informing/updating all members of the multi-disciplinary team, their colleagues, women and appropriate others, of changes in care plans.
- The post holder is responsible for ensuring that they clearly communicate with women, actively listen to establish an understanding of the needs of the service user.
- Act as an ambassador for the Trust and develop external networks ensuring continuous development and improvement of internal systems and clinical practice.

Governance

The post holder will:

- Be aware of and contribute to the national and Trust governance agenda, to include risk management, complaints, clinical audit, research, regular submission of statistics and other quality initiatives.
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- To implement change resulting from risk investigations and complaints.
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- Promote a culture of continuous quality improvement through the use of audit, patient/client feedback and reflection and practice by self and other members of the team.
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- Support the Risk Management and Clinical Governance Strategy.
- Attend department and hospital meetings when appropriate.

Operational Overview

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- Ensure you are familiar and comply with local protocols and systems for information sharing.
- Know the appropriate contact numbers and required reporting lines.
- Participate in required training and supervision.
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Whittington Mission, Vision and Goals

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Our mission
Helping local people live longer, healthier lives.

Our vision

Provide safe, personal, co-ordinated care for the community we serve.

Our goals
We have developed six key strategic goals to make sure we continue to support people to live longer, healthier lives.

- To secure the best possible health and wellbeing for all our community
- To integrate and coordinate care in person-centred teams
- To deliver consistent, high quality, safe services
- To support our patients and users in being active partners in their care
- To be recognised as a leader in the fields of medical and multi-professional education, and population-based clinical research
- To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population

Whittington Values

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Method of Payment

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Probationary Period

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Person Specification

Post:	Fetal Growth and Preterm Birth Specialist Midwife	Grade:	
Department	Maternity	Candidate Name	
Attribute		**Essential**	**Desirable**
Education / Qualifications	Registered Midwife with current NMC registration = First Degree	E	
	Have undertaken a Consortium of Accredited Sonographic Education (CASE) programme of training for ultrasound in early pregnancy or similar.		**D**
	Non-Medical prescribing	E	**D**
	Evidence of teaching and developing junior staff	E	
Knowledge & Experience	Have knowledge and skills, which includes understanding all aspects of effective care for women expecting a multiple pregnancy or preterm birth during the antenatal, intrapartum, and postnatal period.	E	
	Consolidated Post registration experience in all aspects of Midwifery Care	E	
	Have a knowledge of the wider social and psychological factors for women and their families with multiple pregnancies and/ or preterm birth.	E	
	Designing and monitoring care pathways to ensure a streamlined service in all areas of care, including the co -ordination of services, appointments, and referrals to other services.		**D**
	Evidence of clinical competence in all aspects of midwifery care	E	
	Understand imagery and interpretation of results.	E	**D**
	Experience in developing and implementing guidelines	E	
	Experience of data collection and analysis		**D**

Skills & Abilities	Evidence of teaching and developing junior staff Good communication skills Good leadership skills Good counselling and listening skills and ability to deal with delivering distressing news. Ability to work under pressure and on own initiative Demonstrates skills in IT systems and use of word, excel and powerpoint Good presentation skills and ability to share data/ case studies with wider colleagues across the LMNS Sensitive to the diverse needs of women and birthing people Ability to influence and manage change, including the promotion of evidence based practice	E E E E E E E E	**D**
PERSONAL QUALITIES	Evidence of recent personal development activity Demonstrates an ability to work as part of a multidisciplinary team Act as a role model	E E E	
Other			

Completed by: …….. Date:……

Offer post Yes/ No Comments ……..

Whittington Health NHS

Job Description

Title:	**Diabetes Specialist Midwife**
Grade:	**7**
Annual Leave:	27 days per annum increasing to 29 days after 5 years NHS service and 33 days after 10 years NHS service
Department:	ACW
Responsible to:	Matron for Maternity Outpatients and Birth Centre
Accountable to:	Director of Midwifery

POST SUMMARY

The postholder will need to be an experienced midwife who will lead, support and co-ordinate the care for women on their journey, both with gestational and pre-existing diabetes.
The postholder will deliver high quality, evidence based and safe care to women with diabetes throughout pregnancy and into the postnatal period.
The postholder will need to have excellent communication skills and be able to work effectively within the multi-disciplinary team

MAIN DUTIES

1. **CLINICAL RESPONSIBILITIES**

- Booking women with pre-existing diabetes
- Review results daily and arrange to see women as required
- Be able to teach women to monitor their blood sugars at home and set them up with the GDM health app
- Discuss basic dietary and lifestyle changes to ensure good glycaemic control
- Review blood sugars on a regular basis both face to face and remotely
- Manage the diabetes midwifery clinics daily
- Teach insulin administration and discuss medication changes
- Participate in pre conceptual sessions for pre-existing diabetes
- Be responsible for keeping databases up to date and participate in local and national audits
- Participate in the review and development of guidelines
- Participate in group sessions
- Participate in teaching student midwives and medical students

2. **RESPONSIBILITY FOR PATIENTS**

- Maintain high standards of midwifery care at all times. Ensure confidentiality and safe practice is maintained working in accordance with the NMC Midwives rules and standards (2012) and NMC Code of Conduct (2008)

- Ensure own up to date professional knowledge of Diabetes related care in antenatal, intrapartum and postnatal care in accordance with sound evidence based research and national standards

- Be competent in all areas of midwifery practice, and act as professional lead in Diabetes related care in pregnancy and provide professional clinical leadership and expertise

- Act as a source of information and knowledge to all health care professionals as well as women and their families in relation to Diabetes related care

3. Educational Responsibilities

- Facilitate teaching updates to midwives and other members of the multi-disciplinary team and co-ordinate and develop clinical practice in conjunction with the practice development team

  Act as an effective role model to all staff and create an environment conducive to learning

- Lead in house training forums for all levels of staff; midwifery, medical and nursing on areas of interest for the ANC team including case reviews in conjunction with the MDT.
-
- Act as a resource to midwives, nurses, students and medical staff to provide information, support and advice regarding care of women with diabetes in pregnancy

- Participate in the orientation of new members of staff and contribute to an effective orientation package

- Initiate and participate in research and audit, including data collection and analysis and dissemination of findings to promote learning for all relevant staff

- Participate and support teaching

4. Managerial Responsibilities

- Undertake the management and coordination of a designated clinical area and/or team liaising with midwifery, medical, nursing and any other colleagues, as appropriate

- Be proactive in the undertaking of staff appraisals where required

- Ensure appropriate guidelines are in place and updated in line with best evidence based practice and national standards

- Facilitate effective communication with other members of the multidisciplinary Team

5. Professional Responsibilities

- Participate in risk management/complaint procedures. Investigate clinical incidents, complaints, and user feedback and ensure implementation and recommendations.

- Be proactive in resolving complaints at local level through discussion with women and their families, documenting information and action outcomes.

- Practice within the policies, procedures, protocols and guidelines agreed by the Whittington Hospital NHS Trust, the Nursing and Midwifery Council (NMC) and the maternity service

- Ensure adequate records are kept in line with NMC Guidelines for record keeping.

- Identify own ongoing professional development and meet NMC revalidation requirements, taking personal responsibility for completing all mandatory and statutory training in line with Trust requirements

6. General Responsibilities

- To be aware of responsibility for the health, safety and welfare of women, visitors, staff and others, and to comply with the requirements of the Health and Safety Regulations.

- Ensure confidentiality at all times, only releasing confidential information obtained during the course of employment to those acting in an official capacity.

- Provide support and counselling to bereaved and grieving parents/relatives. This includes discussing abnormal results following antenatal screening tests.

- To be aware of the Data Protection Act and Access to Medical Records Act.

- To promote equal opportunity for all staff and patients in accordance with Whittington Health NHS Trust policies.

- This job description is under constant review and is a general guide to the scope of duties. It is not intended to be either a definitive or restrictive list of duties and responsibilities. The job description may be amended following discussion and negotiation between the post-holder and the lead midwife.

Revalidation and Registration

It is the responsibility of all staff registered with a professional body to:

- Act within the Professional Bodies Code of Practice
- Maintain their own work profile to ensure revalidation standards are met, and assist junior registered staff in achieving revalidation.
- Contribute and participate in the development of colleagues professional practice across the trust through leading ward and/or department projects, and supporting training.
- Ensure optimum use is made of working time.

Equal Opportunities

Our latest policy known as “Promoting Equality, Diversity and Human Rights” outlines the Trust’s commitment to ensuring that no job applicant or employee receives less than favourable treatment on grounds of sex, marital and civil partnership status, gender reassignment, pregnancy and maternity, race, colour, creed, religion or belief, physical disability, mental health, learning difficulty, age or sexual orientation and is not placed at a disadvantage by conditions or requirements that cannot be shown to be justifiable.

For more information about our policy and commitment to equality, click: http://www.whittington.nhs.uk/default.asp?c=10505&q=equality ”

Infection control

All staff have a responsibility to prevent and control infections within the Whittington. This includes ensuring personal and team compliance with all relevant policies, especially hand hygiene, the trust dress code, and MRSA screening policies.

Working patterns

The Trust is currently exploring ways in which patients can be given more choice about when they can attend appointments at the hospital. In order to make this possible there may be a future requirement for administrative staff scheduling appointments for patients to contact them by telephone in the evenings or at weekends. This means that administrative staff may be required to work a shift pattern in future. Shifts will not normally operate beyond 9 pm in the evenings and appropriate pay enhancements will apply. Staff will be consulted about the introduction of / changes to shift systems.

Staff working in any department where an on 'call rota' operates will be required to participate in the rota. Managers will discuss with staff the level of 'on call' cover required taking into account their individual circumstances.

Staff in nursing posts may be requested to work in any area throughout the Trust by the matron or the site manager.

Health & Safety Policy

Employees must be aware of the responsibilities placed on them under the Health and Safety at Work Act 1974, to ensure that the agreed safety procedures are carried out to maintain a safe environment for employees and visitors.

Safeguarding

To comply with the Trust's Safeguarding Children and Adults policies, procedures and protocols. All individual members of staff (paid or unpaid) have a duty to safeguard and promote the welfare of children, young people and vulnerable adults This will require you to:

- Ensure you are familiar with and comply with the London Child Protection Procedures and protocols for promoting and safeguarding the welfare of children and young people.
- Ensure you are familiar and comply with the Croydon Multi Agency Safeguarding Vulnerable Adults Pan London Procedures.
- Ensure you are familiar and comply with local protocols and systems for information sharing.
- Know the appropriate contact numbers and required reporting lines.
- Participate in required training and supervision.
- Comply with required professional boundaries and codes of conduct

Whittington Health is committed to safeguarding all children and vulnerable adults and expects all staff and volunteers to share this commitment.

Data Protection

This post has a confidential aspect. If you are required to obtain, process and/or use information in any format whether electronic or paper based, you should do so in a fair and lawful way. You should hold data only for the specific registered purpose and not use or disclose it in any way incompatible with such a purpose and ought to disclose data only to authorised persons or organisations as instructed. Breaches of confidence in relation to data will result in disciplinary action, which may result in dismissal.

Confidentiality

You are required to maintain confidentiality of any information concerning patients or staff which you have access to or may be given in the course of your work, in accordance with current policy on confidentiality at Whittington Health.

Whittington Mission, Vision and Goals

We have an excellent reputation for being innovative, responsive and flexible to the changing clinical needs of the local population. We are treating more patients than ever before and are dedicated to improving services to deliver the best for our patients.

Our mission
Helping local people live longer, healthier lives.

Our vision
Provide safe, personal, co-ordinated care for the community we serve.

Our goals
We have developed six key strategic goals to make sure we continue to support people to live longer, healthier lives.

- To secure the best possible health and wellbeing for all our community
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Person Specification

Post:	Diabetes Specialist Midwife	Grade:		7	
Department	ACW/ Antenatal Clinic	Candidate Name			Notes
Attribute		**Essential**	**Desirable**	**How Assessed**	
Education / Qualifications	• Registered Midwife • NMC registration (in date) • First Degree or working towards in relevant subject	• E • E	**D**	• A / I • A / I • A / I	
Skills & Abilities	• Good communication skills • Understanding of principles of good leadership • Good counselling and listening skills • Ability to work under pressure and on own initiative • Understanding of current issues in diabetes care • Understanding and knowledge of key performance indicators in screening • Demonstrates skills in IT systems and use of word, excel and powerpoint • Good presentation skills • Sensitive to the diverse needs of women	E E E E E E E E E		A / I A / I A / I A/ I A/ I A/ I A/ I A / I A/I	
	• Post registration experience in all aspects	E		A / I	

Knowledge & Experience	of Midwifery Care • Evidence of clinical competence • Experience in antenatal care • Experience in developing and implementing guidelines • Experience of data collection and analysis • Experience of counselling • Evidence of teaching and developing junior staff both formally and informally	E E	 D D D D	 A / I A / I A / I A / I A/ I A/I	
PERSONAL QUALITIES	• Evidence of recent personal development activity • Demonstrates an ability to work as part of a multidisciplinary team • Role model	E E E		A / I A / I A / I	
Other					

Completed by: …….. Date:……

Offer post Yes/ No Comments ……..

Meeting title	**Trust Board – public meeting**	**Date: 30.01.2026**
Report title	**Integrated Performance Report**	**Agenda Item: 9**
Executive lead	Chinyama Okunuga, Chief Operating 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. **Infection Prevention and Control** During December 2025 there was 1 HCAI C Difficile infections and 0 MRSA Bacteraemia bringing the total number of MRSA Bacteraemia's to 0 for the year (April 2025 – March 2026). **Emergency Care Flow** During December 2025 performance against the 4-hour access standard was 69.14% which is lower than the NCL average of 76.6%, and the National average of 73.8%. In December 7.8% of patients spent more than 12 hours in ED. **Cancer: 28-Day Faster Diagnosis Standard (FDS) November Performance – 81.3%** This is a worsening of **1.4**% compared to October's performance of 82.7%. **Cancer: 31 Days to First & Subsequent Treatment November Performance – 100%** This is an improvement of 4.3% compared to October's performance of 95.7%. **Cancer: 62-Day Combined Treatments November Performance – 83.6%** This is an improvement of 10.6% compared to October s performance of 73%. At the end of December 2025, the Trust's position against the 62-day backlog was 52 patients. **Referral to Treatment: 52+ Week Waits** Performance against 18-week standard for December 2025 was 59.1% this is a worsening of 0.9% from November's performance of 60% The Trust position against the 52-week performance worsened from 520 patients waiting more than 52-weeks for treatment in November 2025 to 658 in December 2025, this equates to 2.29% of the total RTT waiting list. The Trust had 7 patients waiting over 65 weeks at the end of December 2025 this is an improvement of 36 from 43 in November 2025. **DNA** The Trusts overall DNA rate for December 2025 was 11% against a target of less than 9%, this is a worsening of 0.8% from 10.2% in November 2025.	

	Complaints Complaints responded to within 25 or 40 working days worsened by 15%, from 73.2% in November 2025 to 58.2% in December 2025. The Complaints Team continues to work closely with Divisions to support the timely completion of all complaint investigations and ensure sustained improvement.
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	Quality 1; Quality 2; People 1; and People 2.
Report history	Trust Management Group
Appendices	1: Integrated Performance Report 2: Key Performance Targets by March 2026

Whittington Health NHS Trust

Integrated Performance Report

January 2026

Integrated Performance Report Overview

The Whittington Health Integrated Performance Report provides an overview of the Trust's operational, clinical, and workforce performance, highlighting key achievements and areas requiring attention as we continue to deliver safe, effective, and timely care.

Slide	Section
3-4	Key Exceptions for Noting
5-11	Performance Overview
12	Emergency Department and Patient Flow
13	Referral-to-Treatment and Diagnostics
14	Cancer
15-16	Activity and Productivity
17	Quality and Safety
18	Workforce
19	Community – Children and Young People
20	Community – Adults

Key Exceptions for Noting

Emergency Department and Patient Flow

Urgent and Emergency Care (UEC) performance declined in December despite lower attendances, driven by out-of-hours variability, workforce pressures, North Middlesex University Hospital (NMUH) diverts, increased mental health demand, and estates-related flow constraints.

Twelve-hour Emergency Department (ED) trolley breaches reduced overall, though mental health breaches rose slightly.

The Trust is progressing system-wide actions to improve flow, reduce delays, and support timely discharge. Priorities include optimising out-of-hours pathways, expanding use of the Clinical Decision Unit (CDU) and the Emergency Department Same Day Emergency Care (EDSDEC) footprint, and strengthening admission-avoidance pathways to improve performance.

Referral-to-Treatment and Diagnostics

Referral to Treatment (RTT) performance declined slightly in December, though the Trust remains on track toward its March 2026 recovery target, with all remaining 65-week patients clinically reviewed and treatment plans confirmed.

The Trust received formal recognition from the NHS England London Region for its work to eliminate long waits.

Quarter 4 Performance Sprint actions are now focused on reducing 52-week waits, improving RTT compliance, and accelerating activity delivery.

Diagnostic (DM01) performance has fallen due to capacity pressures—particularly in non-obstetric ultrasound—with recovery actions underway to restore compliance.

Cancer

Performance against the 28-Day Faster Diagnosis Standard (FDS) remains above target, improving from 81.3% in November to an unvalidated 82.9% in December, though pathway delays continue in Gynaecology and Urology. The redesigned Urology one-stop pathway went live in January 2026, with further actions underway to strengthen diagnostic capacity.

All services achieved 100% performance against the 31-Day Treatment Standard in both November and the unvalidated December position.

Performance against the 62-Day Combined Treatments Standard improved from 83.6% in November to a forecasted 86.5% in December, with operational focus continuing in Gynaecology and Urology to address pathway delays.

Activity and Productivity

Elective and day-case activity remained ahead of plan in December despite industrial action, with outpatient activity only marginally below plan and expected to improve once outstanding outcomes are completed.

DNA rates show slight improvement but remain above the 9% target in several specialties, prompting enhanced Trust-wide monitoring. Operational pressures—including high cancellations driven by bed constraints, the temporary closure of Coyle Ward due to flu, and anaesthetic workforce shortages—continue to limit capacity.

Theatre productivity workstreams are being strengthened, alongside reviews of data quality and standard operating procedures to support consistent practice and sustained improvement.

Key Exceptions for Noting

Quality and Safety

Pressure ulcer incidence increased in the community, with eighteen category 3 and four category 4 ulcers, alongside twenty-seven community-acquired cases under District Nursing care, while the hospital reported five category 3 and one category 4 ulcer now under Division-level investigation. Reviews highlight recurring issues including delayed skin assessments, incomplete SSKIN bundles, equipment delays, and patient non-concordance, with strengthened monitoring, training, and equipment oversight in place. The Tissue Viability Service continues to support improvement through joint reviews and expanded training programmes for staff.

Complaint themes remained consistent—communication, medical care and delays—with 66% of closed complaints in December upheld or partially upheld.

Workforce

Appraisal compliance remained at 78% in December, with a Trust-wide improvement plan going to the Workforce Assurance Committee (WAC) in February to support under-performing teams.

Sickness absence remains above target at 4.8%, driven by seasonal variation and hotspots in several clinical and non-clinical staff groups, with the impact of the new online reporting module to be reviewed.

Mandatory training compliance remains above the Trust target overall, though gaps persist—particularly in Basic Life Support among medical and dental staff—prompting targeted actions and a planned deep dive for March 2026. Updated appraisal documentation and additional training are in place to improve staff experience and support delivery of March 2026 trajectories.

Community – Children and Young People

Health Visiting teams continue to face challenges meeting New Birth Visit (NBV) timeframes, with targeted local actions underway, including strengthened booking processes, improved reporting, and enhanced engagement—particularly within Barnet. Haringey performance was largely stable, with delays mainly linked to babies remaining in hospital and isolated staffing issues.

Barnet has introduced new systems to better identify avoidable breaches and will shift NBV booking to Health Visiting Assistants from January 2026 to improve timeliness.

Marginal progress is being made on reducing patients waiting over 52 weeks, though the position remains non-compliant.

Community - Adults

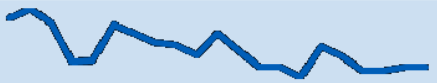
Continuing Healthcare met the North Central London (NCL) 28-day assessment target but remained below the national standard, with performance affected by high assessment volumes, new demand linked to over 200 identified Funded Nursing Care and Mental Health beds, and staffing pressures; an improvement plan is being developed with the ICB.

Urgent Community Response (UCR) experienced sickness-related staffing gaps, leading to periods of temporary closure in line with safety procedures.

Virtual Ward utilisation declined to 60% due to inconsistent referral pathways, variable clinical engagement, and sickness in key roles, with a winter recovery plan now in development under executive oversight to restore performance.

Performance Overview

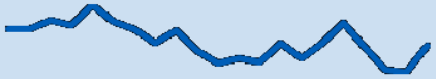
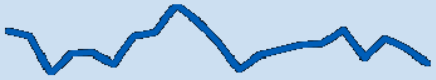
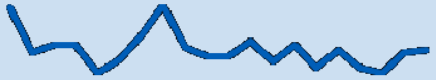
4	• Significant performance variance from target or trajectory and/or SPC analysis shows special cause concerning variation • Performance is expected to continue to deteriorate in the short term
3	• Significant performance variance from target or trajectory and/or SPC analysis shows special cause concerning variation • Performance improvement is expected in the short term
2	• Marginal performance variance from target or trajectory • Performance improvement is being achieved/expected
1	• Performance achieving target or trajectory and/or SPC analysis shows special cause improvement variation

Status	Metric	Trend	Target	Performance	
				Period	Trust
Emergency Department and Patient Flow					
3	Percentage of Patients Arriving at the Emergency Department by Ambulance Handed Over Within 30 Minutes		95% or higher	December 2025	88.5%
3	Percentage of A&E Patients Admitted, Transferred, or Discharged Within Four Hours		78% or higher by March 2026	December 2025	69.14%
2	Percentage of Patients Spending More Than 12 Hours in A&E		7.3% or less	December 2025	7.8%
2	Number of Mental Health Patients With a Decision to Admit Who Spent Over 12 Hours in A&E		Less than 174 for 2025/26	December 2025	26
2	Average Length of Stay for Non-Elective Admissions (General and Acute)		7.7 days or less	December 2025	9.4 Days
2	Number of Patients Not Meeting Criteria to Reside and Not Discharged		40 or less	December 2025	46

Performance Overview

Status	Metric	Trend	Target	Performance	
				Period	Trust
Referral-to-Treatment and Diagnostics					
3	Total Number of Patients on the Referral to Treatment (RTT) Waiting List		Less than 26,501 by March 2026	December 2025	28,783
4	Percentage of Incomplete RTT Pathways Waiting Less Than 18 Week		72% or higher	December 2025	59.1%
3	Percentage of Patients Waiting Over 52 Weeks for Elective Treatment		1% or less by March 2026	December 2025	2.29%
4	Percentage of Patients Waiting Under Six Weeks for a Diagnostic Test		99% or higher by March 2026	December 2025	72.73%
Cancer					
1	Faster Diagnosis Standard: Percentage of Patients with Cancer Diagnosed or Ruled Out Within 28 Days		80% or higher by March 2026	November 2025	81.3%
1	Percentage of Patients Receiving First Definitive Treatment Within 31 Days of Cancer Diagnosis		96% or higher	November 2025	100%
1	Percentage of Patients Receiving First Definitive Cancer Treatment Within 62 Days of an Urgent GP Referral		75% or higher	November 2025	83.6%

Performance Overview

Status	Metric	Trend	Target	Performance	
				Period	Trust
Activity and Productivity					
1	First to Follow-Up Appointment Ratio (Acute)		2.3	December 2025	1.04
3	Did Not Attend (DNA) Rates for New Appointments		9% or less	December 2025	11%
2	First Outpatient Attendances: Percentage of Activity Delivered Against Plan		100% or higher	December 2025	91.05%*
2	Outpatient Procedures: Percentage of Activity Delivered Against Plan		100% or higher	December 2025	94.18%*
1	Ordinary Elective Care: Percentage of Activity Delivered Against Plan		100% or higher	December 2025	104.98%*
1	Day Case Activity: Percentage of Activity Delivered Against Plan		100% or higher	December 2025	109.62%*
3	Operating Theatre Utilisation Rate		85% or higher	December 2025	72.76%
3	Number of Hospital Cancelled Operations		0	November 2025	10
2	Number of Births per Month		320 or higher	December 2025	232

*Figures are based on flex positions and are subject to change.

Performance Overview

Status	Metric	Trend	Target	Performance	
				Period	Trust
Quality and Safety					
1	Percentage of Patients Assessed for Venous Thromboembolism (VTE) Risk		95% or higher	December 2025	95.3%
1	Inpatient Falls		Less than 400 for 2025/26	December 2025	26
1	Number of Clostridioides Difficile Infections (C. Diff)		Less than 22 for 2025/26	December 2025	1
1	Number of Methicillin-Resistant Staphylococcus Aureus (MRSA) Infections		0	December 2025	0
2	Number of Acute Pressure Ulcers (Grades 3 to 4)		Less than 68 for 2025/26	December 2025	6
1	Percentage of Patients Readmitted as an Emergency Within 30 Days of Discharge		5.5% or less	December 2025	3.89%
1	Summary Hospital-Level Mortality Indicator (SHMI)		1	August 2024 – July 2025	0.9
1	Inpatient Survey Satisfaction Rate: Positive Responses		90% or higher	December 2025	96.7%
4	Percentage of Complaints Responded to Within 25 or 40 Days		80% or higher	December 2025	58.2%

Performance Overview

Status	Metric	Trend	Target	Performance	
				Period	Trust
Workforce					
1	Mandatory Training Completion Rate		85% or higher	December 2025	88.3%
2	Percentage of Completed Appraisals		85% or higher	December 2025	77.7%
2	Percentage of Sickness Absence		3.5% or less	November 2025	4.81%
1	Staff Turnover Rate: Percentage Leaving in Last 12 Months		13% or less	December 2025	8.6%
1	Vacancy Rate Percentage		10% or less	December 2025	5.8%
1	Average Time to Hire (Days)		63 days or less	December 2025	50

Performance Overview

Status	Metric	Trend	Target	Performance	
				Period	Trust
Community – Children and Young People					
2	New Birth Visits by Health Visitors (Haringey)		95% or more completed within 14 days	November 2025	90.7%
1	New Birth Visits by Health Visitors (Islington)		95% or more completed within 14 days	November 2025	97.42%
1	New Birth Visits by Health Visitors (Barnet)		95% or more completed within 30 days	November 2025	86.98%
4	Percentage of CYP Patients Waiting Over 52 Weeks		Less than 1% of total service	December 2025	8.56%
1	Average Wait Time to First Appointment: Occupational Therapy (OT)		18 weeks or less	December 2025	8.4
1	Average Wait Time to First Appointment: Speech and Language Therapy (SLT)		13 weeks or less	December 2025	8.2
1	CAMHS Wait Times to First Appointment (Excluding Neurodevelopmental Disorders)		4 weeks or less	December 2025	3.5 Weeks

Performance Overview

Status	Metric	Trend	Target	Performance	
				Period	Trust
Community – Adults					
1	Average Wait Time to First Appointment (All ACS Services)		6 weeks or less	December 2025	5.5 Weeks
1	Percentage of Patients Waiting Over 52 Weeks for an Appointment		Less than 1% of total service	December 2025	0.02%
3	Percentage of Patients with Urgent Rapid Response Referrals Seen Within 2 Hours		80% or higher	December 2025	74.2%
1	Continuing Healthcare 28-Day Referral to Complete Assessment		50% or higher	December 2025	59%
	Total appointments for District Nursing		No target – Monitoring only	December 2025	31,039
1	Percentage of Patients Seen Within 48 Hours of Referral to District Nursing		80% or higher	December 2025	98.4%
2	Number of Category 3 and 4 Pressure Ulcers in Adult Community Care		Less than 211 for 2025/26	December 2025	22
3	Percentage of Virtual Ward Occupancy		80%	December 2025	61.1%

Emergency Department and Patient Flow

Whittington Health NHS Trust

Urgent and Emergency Care (UEC) Performance Summary – December

In December UEC performance declined to 69.1% from 72.4% in November. This drop occurred despite a decrease in attendances to 9,135 from 9,340. Ambulance conveyances remained stable at 1583 for both months.

Key Drivers of 4-Hour Performance Challenges

- Out-of-hours variability: Continued fluctuations in performance, particularly during evenings and weekends.
- Workforce pressures: Elevated sickness levels among medical and nursing staff.
- Sustained impact from NMUH diverts impacting on flow and performance.
- Increased MH presentations.
- Estates work impacting flow within department.

12 hr ED trolley breaches have seen a decrease to 260 in December from 317 in November, however the mental health related breaches has increased to 26 from 24 in November, continuing its downward trend
The Trust is actively collaborating with system partners to reduce delays for mental health patients, which we feel is starting to take some affect, yet more need to be done to support increases in demand.

Positive Developments

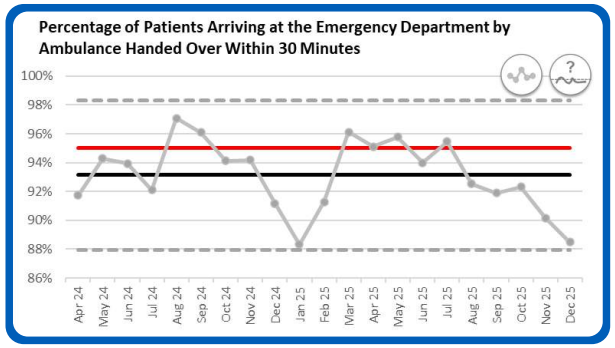
- Average Length of Stay (ALoS) has increased alongside our NCTR and LOS metrics, we also saw a decrease in our weekend discharges to 392 from 562 in November.

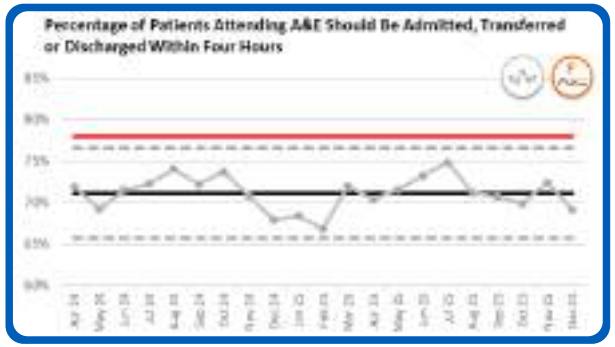
Strategic Priorities Moving Forward

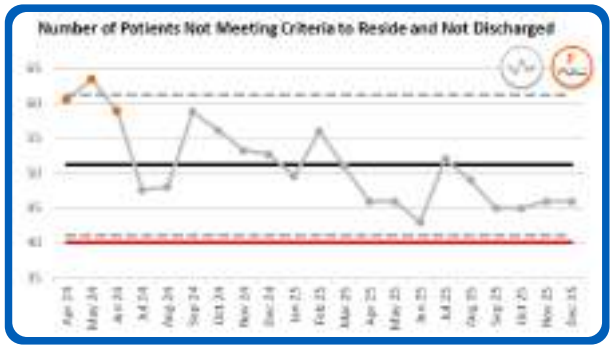
- Early system-wide discharge escalation: Engaging community services, social care, mental health providers, and local councils, following DAG discussion.
- Full implementation of Flow Improvement Programme actions.
- Reducing criteria to reside and long length of stay (LLoS).

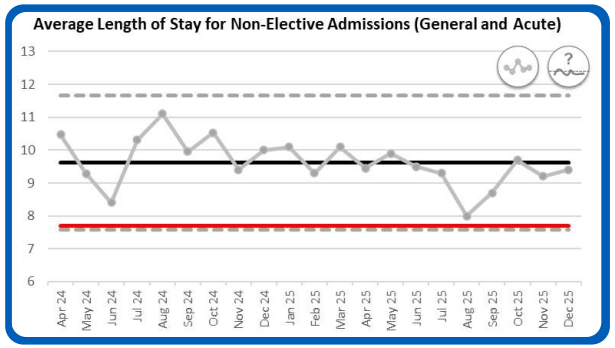
Targeted Performance Goals

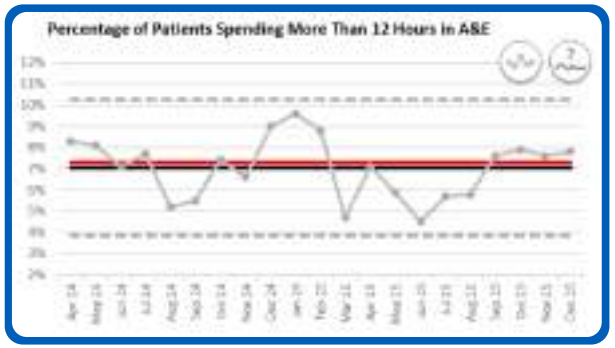
- Optimising out-of-hours care to reduce variation in waiting time through better use of pathways and streaming.
- Increased use of Clinical Decision Unit (CDU).
- Enhanced admission avoidance pathways to support flow and patient care.
- Expanded EDSDEC footprint to support treatment times











ICARE EQUITY

Referral-to-Treatment and Diagnostics

Referral-to-Treatment and Diagnostics

RTT performance has seen a slight decline against the 18-week standard, with achievement of 59.12% in December 2025 compared to 60.08% in November 2025.

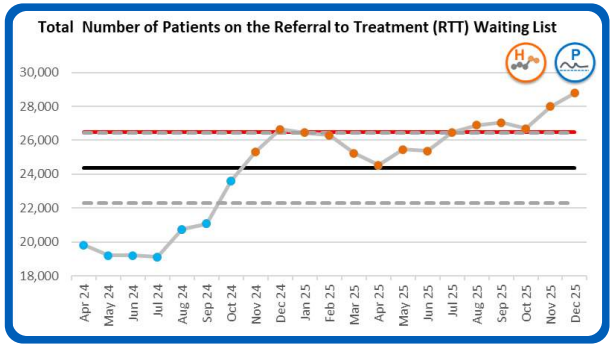
The Trust's recovery plan remains focused on delivering sustained improvement, with a target of achieving 71% compliance by the end of March 2026. In line with NHS England's requirement that no patients should be waiting longer than 65 weeks for treatment by 31 December 2025, a full validation and clinical review was undertaken. As a result, seven patients remained above the 65-week threshold at month end. Each of these patients has been individually reviewed and clinically prioritised, with definitive management and treatment plans in place for January 2026.

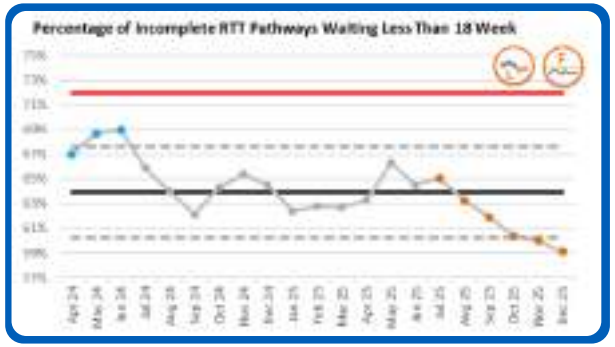
In recognition of this work, the Trust received a formal letter of thanks from Dame Caroline Clark, Regional Director for the London Region, acknowledging the actions taken to eliminate the remaining long waits. She commended the clarity of the Trust's commitment and thanked the organisation for its continued efforts.

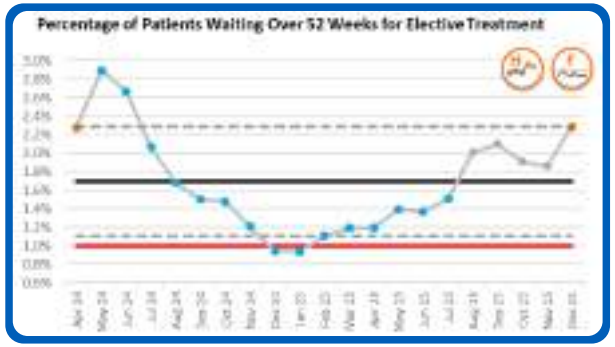
Operational teams are now actively engaged in the Quarter 4 Performance Sprint. This initiative is focused on accelerating recovery by delivering improvements over and above the original activity plans, with particular emphasis on reducing the number of patients waiting over 52 weeks, improving performance against the 18-week RTT standard, and supporting delivery of the wider RTT recovery plan.

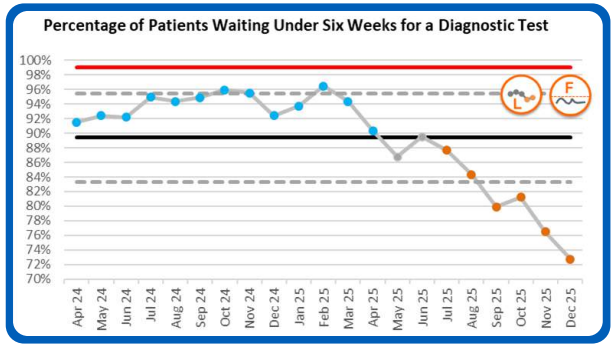
DM01 performance for December 2025 was 72.73%, this is a decline of 3.76% from 76.49% in November 2025.

DM01 performance remains non-compliant, driven by capacity constraints and increased demand across several services including Neurophysiology and Audiology. However, non-obstetric ultrasound has become a key pressure point, with both backlog and demand contributing significantly to underperformance. This challenge is reflected across the region, and work is underway as part of the Quarter 4 Sprint to identify solutions and improve compliance.









Cancer

Cancer

The 28-Day Faster Diagnosis Standard (FDS) performance for November was 81.3%. The unvalidated performance for December is slightly improved at 82.9%.

Performance against the 28-Day Faster Diagnosis Standard (FDS) remains above target and reached 81.3% in November, with unvalidated December data indicating a slight improvement to 82.9%.Within Gynaecology, performance for November stood at 67.6%, and the service continues to experience pathway delays driven largely by workforce constraints and planned periods of sick leave. Targeted operational focus remains in place to stabilise capacity and reduce delays.

Performance for the Urology service was 52.7% in November, reflecting delays linked to the postponed implementation of the one-stop pathway. The service redesign has now been completed, and the revised pathway went live in January 2026 with support from Radiology. This change is expected to streamline diagnostics and improve overall pathway efficiency. Training for CNS and clinical teams is progressing to support the launch of the nurse-led Lower Anterior Tract Procedures (LATP) pathway, which will further strengthen diagnostic capacity and resilience.

The 31 Days Treatment target was met at 100% performance in November. The unvalidated performance for December is 100%.

All services have achieved 100%.

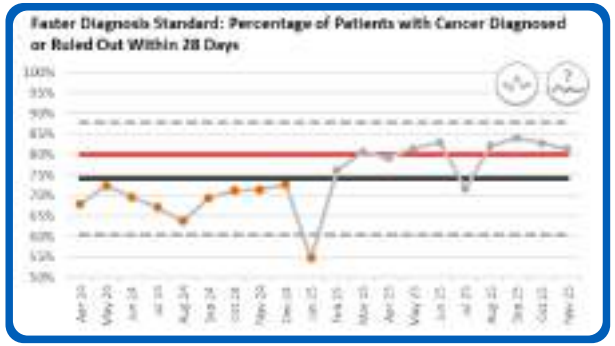
Performance against the 62-Day Combined Treatments standard was 83.6% in November, with unvalidated December data indicating a further improvement to 86.5%.

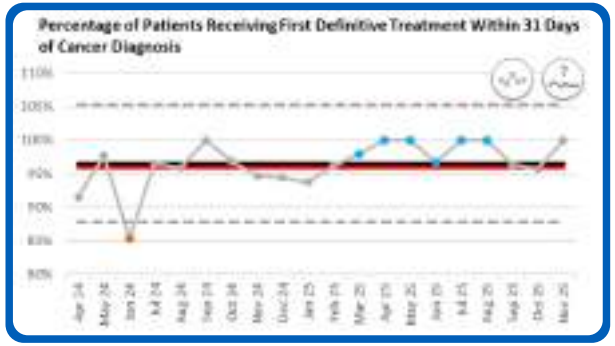
There remains a strong operational focus on improving performance within both Gynaecology and Urology.

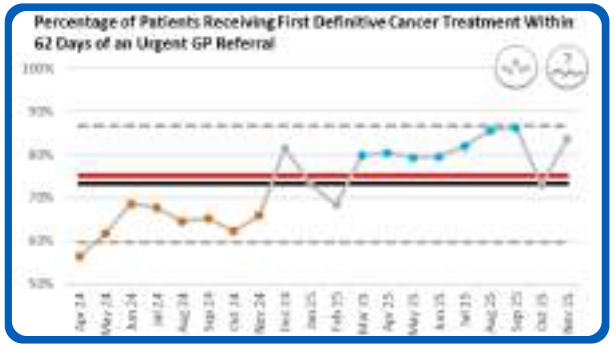
Performance for the Urology service was 70.4% in November, ongoing delays are linked to the slow implementation of the one-stop pathway. Work is underway to understand the barriers to full adoption and to identify actions that will accelerate progress. A revised, streamlined pathway is scheduled to go live in January 2026, which is expected to improve flow and reduce delays.

Performance for the Gynaecology service was 66.7% in November, with performance affected by workforce challenges that continue to limit capacity and impact the pathway.

Performance for the Upper GI service was 66.7% in November, with a forecasted improvement to 100% in December. In Colorectal, performance reached 75% in November, with a forecasted improvement to 90% in December.



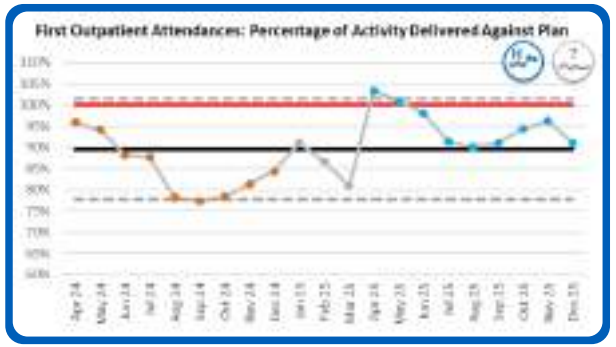


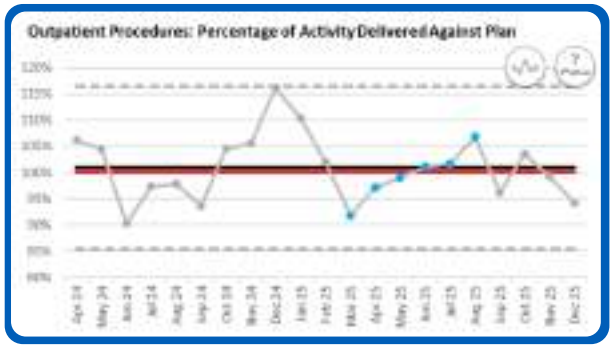


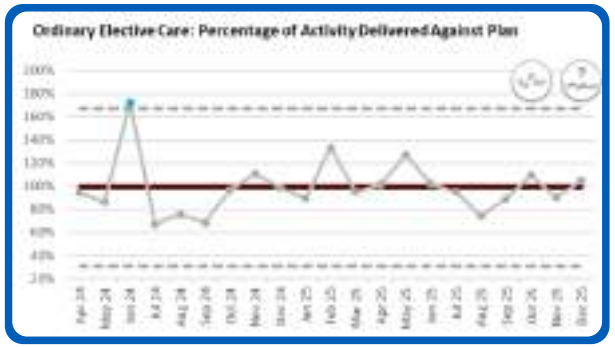
Activity and Productivity

Activity

Despite industrial action activity for December 2025 was ahead of plan for both Elective Care and Day Case activity, and only marginally behind plan for outpatient attendances and procedures. However there has been a delay in outcoming due to the holiday period and the performance figure is expect to improve once outcoming is completed.



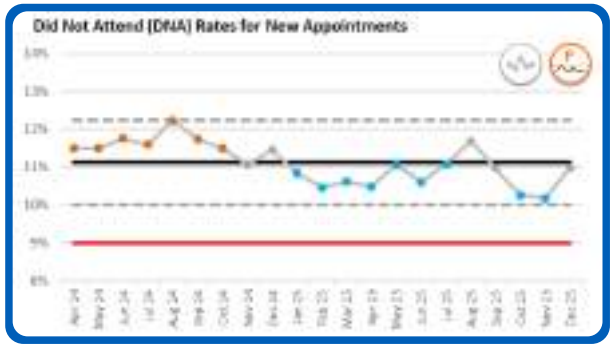




DNA

A recent review of “Did Not Attend” (DNA) appointments, shared in the Trust Board papers for November 2025, shows a small improvement in attendance. However, some services are still seeing DNA rates above the Trust target of 9%. This includes areas such as Nephrology, Occupational Therapy, Physiotherapy, the TB service, and several surgical specialties including ENT, Ophthalmology and Vascular Surgery.

To improve access to care and reduce delays for patients, the Trust will now monitor DNA rates more closely across all services. This will help ensure we make the best use of appointment slots, support our activity plans, and reduce waiting times for treatment.



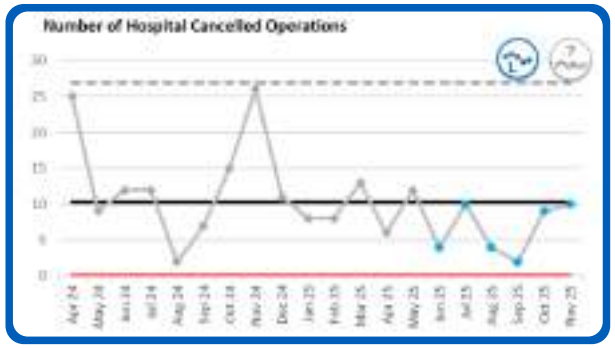
Activity and Productivity

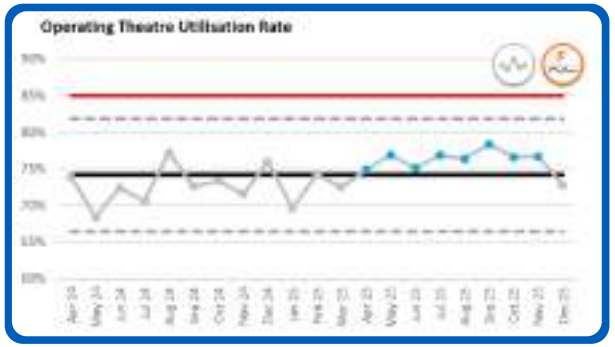
Theatres

Current performance continues to be affected by a number of operational pressures. High cancellation rates persist, primarily driven by bed capacity constraints, including the temporary closure of Coyle Ward due to flu, which has reduced available inpatient capacity. In addition, an increase in long-term sickness within the anaesthetic service is limiting the ability to fully staff theatre lists, further impacting activity levels.

Work is underway to strengthen theatre productivity and reduce avoidable delays. This includes embedding scheduled progress monitoring and the ‘Golden Patient’ approach to support timely starts. Theatre improvement workstreams remain focused on key efficiency measures such as knife-to-skin times, early finishes, and booking and cancellation rates.

A review of data quality submissions is in progress to ensure accuracy and strengthen performance reporting. Alongside this, a review of standardised operating procedures, including Theatres and Admission Booking SOPs, is being undertaken to support consistent practice and drive sustained improvement.





Quality and Safety

Pressure Ulcers

In the hospital setting there were five category 3 pressure ulcers and one category 4 pressure ulcer.

The category 4 pressure ulcer occurred during the patient's admission on Cloudesley ward and has been referred for Division-level investigation.

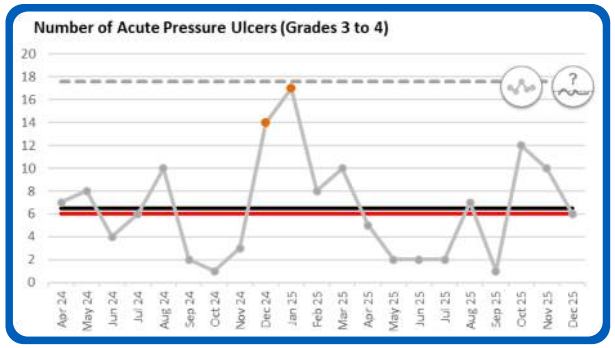
In the community setting, eighteen category 3 and four category 4 pressure ulcers developed on nineteen patients, an increase of twelve pressure ulcers and four more patients affected compared to November 2025.

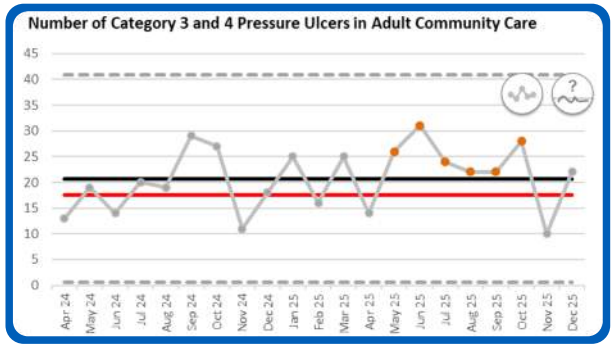
The incident reviews demonstrated a pattern of previously noted issues, such as delayed skin assessment, suboptimal competition of SSKIN bundles, reduced engagement by patients and carers, and occasions where patients declined scheduled visits.

The transition to the new equipment contractor has led to better availability of specialist products. Despite this, staff report ongoing issues with equipment malfunction and delays in arranging repairs through the company. Several products have been out of stock for an extended period, and the company has not provided clear information on expected availability. To mitigate these risks, the service has increased oversight of stock availability, escalated communication concerns, and provided additional support to staff to maintain safe clinical practice.

The Tissue Viability Service continues to collaborate with acute and community services by supporting staff during face-to-face reviews and offering face-to-face pressure ulcer and wound care study days. In addition, the service will continue its partnership with the HCSW team to deliver practical SKILLS day training for healthcare support workers throughout 2026.

For narrative relating to District Nursing and Pressure Ulcers please see Community – Adults on slide 20





Complaints

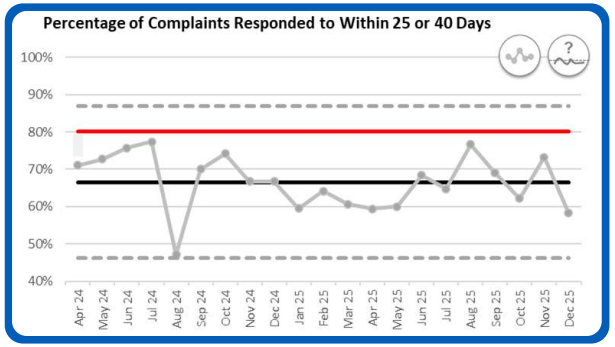
Performance for December remains non-compliant at 58.2%.

The 55 complaints due a response in December 2025 were allocated to the Divisions as follows: S&C 36% (19), EIM 29% (16), ACW 24% (13), CYP 9% (5), ACS 1% (1), and E&F 1% (1).

Severity of complaints: 5% (3) were designated 'high' risk, 15% (8) were designated as 'moderate' risk, and 80% (44) were designated as 'low risk'.

Themes: The main themes from the complaints due a response in December 2025 remained consistent with previous months, Communication, Medical Care and Delay. Divisions and the complaints team continue to work together to address these.

Of the 32 complaints that have closed, 6 (19%) were 'upheld', 15 (47%) were 'partially upheld', and 11 (34%) were 'not upheld' meaning that 66% of the complaints closed in December were upheld in one form or another.



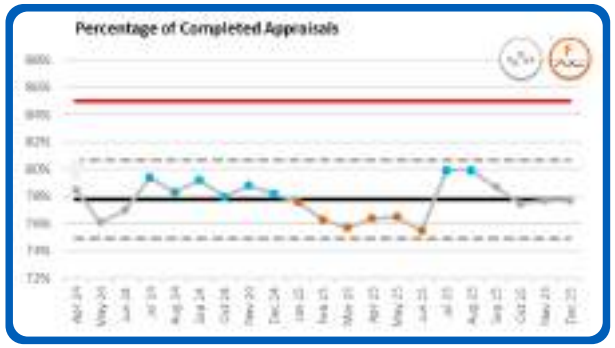
Workforce

Appraisals

December saw appraisal compliance remain at 78%. There is one division on target for appraisals - Children and Young People at 85%.

A review and improvement action plan is being submitted for consideration at WAC on 9th February recommending divisional leadership support for teams below trust target and a trajectory to achieve 85% by the end of March 2026.186 teams are below trust target for appraisal completions.

The appraisal paperwork has recently been updated after extensive staff consultation so this should offer an improved experience to both appraisers and appraisees. Training is available, provided by the Organisational Development Team.



Sickness Absence

The sickness absence rate remains above the Trust target - 4.8% as at the end of November. However, levels are consistent with expected seasonal variation. The Trust launched the on-line sickness absence module in October, and the uptake of the training will be reported on in the next Performance report, by that time it will have been in place a full three months to begin assessing its impact.

Hotspot analysis includes Additional Clinical Services (7.8%), Admin and Clerical (4.3%), Estates and Facilities (7.9%) and Nursing and Midwifery (5.7%) as occupational groups with sickness absence levels above the Trust 3.5% target.

The following Divisions /Directorates are compliant (as at end of November) with the sickness absence threshold– IT, Medical Directors Office, Procurement, Trust Secretariat and Workforce. All other divisions sit outside of the Trust target.

Mandatory Training

Overall compliance remains above the trust target of 88% for training. Variation remains at team, staff group and divisional level, creating pockets of risk that require targeted intervention. Areas for improvement include Adult Basic Life Support at 64% and Moving and Handling at 81%.
All divisions are at, or above, the trust target for mandatory training except strategy and improvement at 84%.All staff groups are at or above trust target for mandatory training except medical and dental at 72%. A significant hot spot for improvement is medical and dental staff compliance with basic life support which is currently at 41% across the trust. A review and improvement action plan is being submitted for consideration at WAC on 9th February recommending divisional leadership support for teams below trust target and a trajectory to achieve 85% on overall compliance by the end of March 2026.
It is recommended that a deep dive of Basic Life Support capacity and compliance is completed for review at the March 2026 ‘Mandatory and Induction Oversight Group’ a reminder will also be sent to all medical and dental staff to complete or send evidence of basic life support training.

Community – Children and Young People

CYP

Health Visiting – New Birth Visits
In each borough the target is for 95% of new birth visits (NBVs) to be completed within a specific timeframe. In Haringey and Islington the target is completion of visits within 14 days, in Barnet the target is 30 days.
Actions are being taken in each team in response to this month's performance. Actions include review of local processes for bookings and increasing the number of slots available to ensure visits can be completed within timeframe

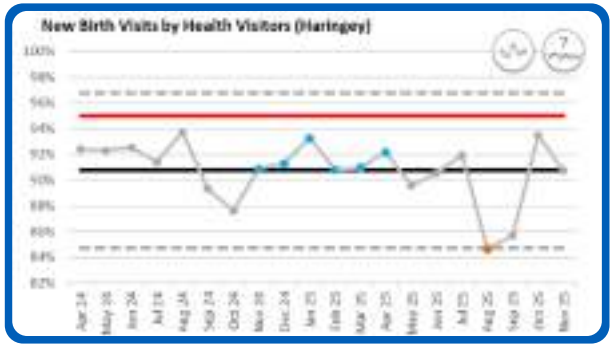
Haringey Health Visiting
There were 212 babies born in the month and 196 NBVs that took place within timeframe.
3 NBVs were not completed (1.4%) because babies were still in hospital. All will be offered an appointment when discharged home

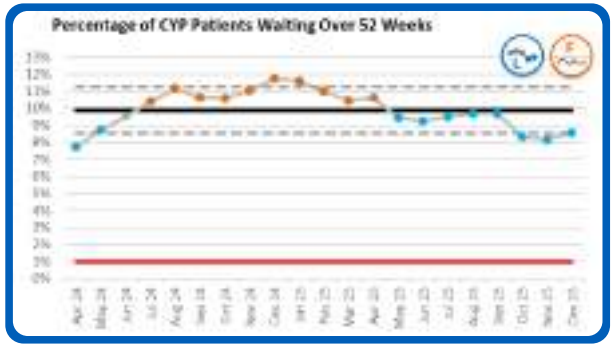
13 NBVs were completed late, (6.1%), of which:
- 8 were in hospital at 14 days
- 2 were in Beis Brucha mother and baby unit
- 1 was a late notification
- 2 visits were not completed due to staff sickness on the day of the appointment and could not be rearranged within timeframe

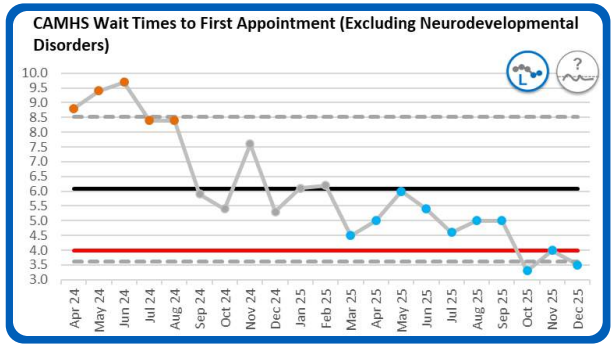
Barnet Health Visiting
- 42 babies were not seen within target timeframe for NBVs in November
- 22 were parental choice, 17 of which from one of the 3 localities. Work has been completed with the Jewish Family Centre, including a survey with families attending to understand reasons for the higher number of appointments declined. From February the service plans that two staff will be working in the centre regularly and supporting the baby clinic to strengthen relationships and support better engagement with the service offer

Further work has been completed to strengthen systems including:
- New system introduced to visit templates so that breaches (visits not completed within timeframe) linked to booking errors or management of visits can be identified
- A weekly NBV report is reviewed by the management team. The report includes information on upcoming potential breaches
- From January 2026 NBVs will be booked by Health Visiting Assistants

Patients Waiting Over 52-Weeks
Marginal improvements are being made with patients waiting over 52-weeks. However, it continues to be non-compliant.







Community - Adults

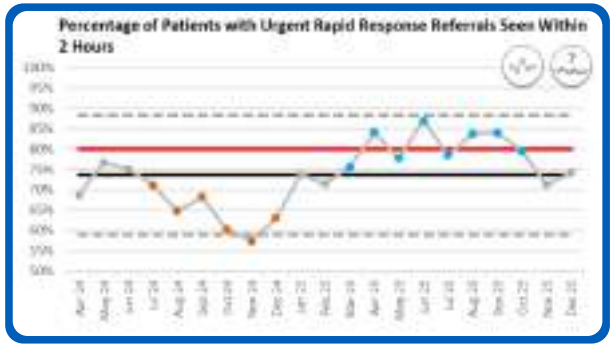
Community

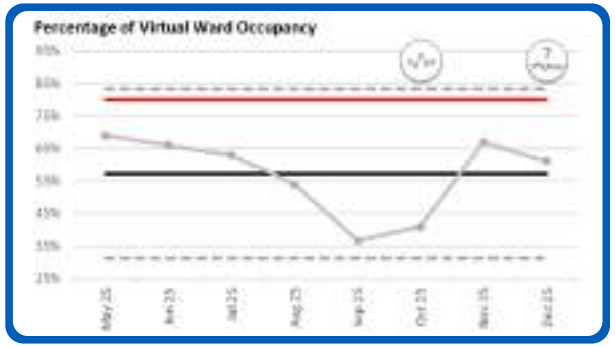
District Nursing / Pressure Ulcers - There were 27 community-acquired pressure ulcers under District Nursing care during the period (8 x Category 3, 1 x Category 4). This is comparable to the same period last year and remains above agreed targets (10% reduction in community-acquired Category 3 & 4 pressure ulcers and 20% reduction overall for Category 2–4). Recurring themes remain unchanged, including adherence to the SSKIN care bundle, complex comorbidities, equipment provision, and non-concordance. A pressure ulcer improvement plan is in place, with weekly case reviews, bite-size training sessions, and Tissue Viability Nurse (TVN) involvement, alongside a clear focus on support and accountability.

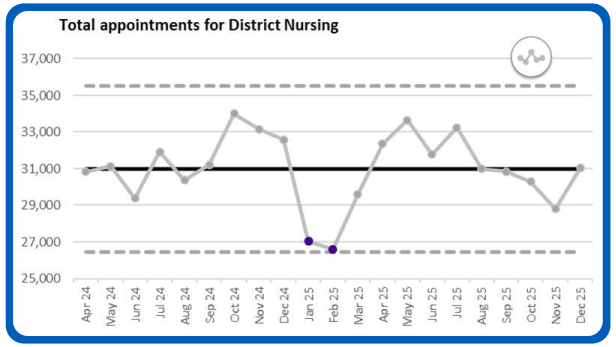
Continuing Healthcare - Performance met the NCL target for completing assessments within 28 days this month but did not meet the national target of 80%. Performance continues to be impacted by the substantial volume of documentation required (often exceeding 100 pages per assessment).
A significant new demand has emerged following the identification of over 200 Funded Nursing Care (FNC) and Mental Health (COP) beds, with an estimated financial exposure of c.£2m. The service is under additional pressure due to sickness absence and vacancies. An improvement plan is being developed jointly with the ICB.

Urgent Community Response (UCR) - Experienced multiple episodes of sickness absence, impacting its ability to consistently maintain the 2-hour response standard. Although bank shifts were authorised, capacity remained challenged. In line with SOPs, the service temporarily closed to referrals during periods of unsafe staffing; this position is reviewed twice daily.

Virtual Ward - Utilisation has declined to 60%, against a national target of 80%. Contributing factors include inconsistent referral pathways, variable clinical engagement, limitations of the current remote monitoring model, and sickness affecting the case-finder role.
A winter recovery plan is in development, with executive oversight from the Chief Medical Officer and Deputy Associate Medical Director, aimed at restoring utilisation and achieving target performance.







Meeting title	**Trust Board – public meeting**	**Date: 30.1.2026**
Report title	**Finance Report - December (Month 9) 2025/26**	**Agenda item: 10**
Executive director lead	Terry Whittle, Chief Finance Officer	
Report author	Senior Finance Team	
Executive summary	The Trust is reporting a deficit of £11.2m for December, which is £5.5m adverse to plan. The variance is attributed to unfunded industrial action, pay overspends and slippage in delivery of planned efficiencies. Capital expenditure at end of December was £12.17m against a plan of £10m The Trust's capital allocation for the year is £48.02m. The Trust's cash balance on 31st of December was £35.22m, which is £2.62m lower than November.	
Purpose:	To note financial performance.	
Recommendation(s)	To note the financial performance for December 2025.	
Risk Register or Board Assurance Framework	BAF risks S1 and S2	
Report history	TMG	
Appendices	None	

Trust is reporting a deficit of £11.2m at end of December. This is £5.5m adverse to plan.

The Trust is reporting a YTD deficit of £11.2m in December, this is £5.5m adverse to plan. The in-month position was £1.5m surplus which was £2m favourable to plan. The year-to-date performance includes £17.6m of non-recurrent mitigations to offset expenditure overspends.

Income was above plan in December mainly due to receipt of Industrial Action funding for November and December of £1.3m. The trust did not receive any support for industrial action costs in July.

At end of December the Trust is above its ERF target by £0.9m.

The Trust delivered £15.1m of savings against an internal target of £20.6m YTD.

Key drivers for the variance in month include impact of Industrial Action (£0.6m adverse on expenditure and £1.3m favourable on income), continued pay and non-pay cost pressures (e.g., sustained UEC ambulance diverts from NUMH and flu pressures) and slippage in delivery of financial efficiency schemes.

Some of the key drivers impacting the year-to-date pay position are:

- Industrial action costs YTD - £1.8m (partially offset by £1.3m of IA support)
- A&E including temporary escalation space - £1.9m
- Unfunded paediatric capacity - £0.4m
- Ward general overspends - £1.1m due to additional beds and safer staffing levels.
- Enhanced care - £1.3m
- Childcare packages - £0.9m
- Medical staffing sickness and gaps - £0.4m
- Pay pressures in phlebotomy and pathology - £0.3m

Overall, non-pay was £3m overspent. However, £2m of this was pass through high-cost drugs expenditure offset by income. The December position included £4.3m in non-recurrent mitigations. Pressure on non-pay include:

- Minerva (community step-down) costs of £0.5m
- Clinical supplies overspend of £2.4m
- Overspend on HSL pathology £0.4m
- Community equipment and dressings - £0.8m
- Overspend on histopathology and blood products - £0.5m
- Patient catering - £0.3m
- Domestic supplies and Postage - £0.5m
- IT and software maintenance - £0.6m

Cash of £35.22m as of 31st December	The Trust's cash balance on 31st December was £35.22m, which is £5.94m favourable to plan, and £2.62m lower than November closing. Reliance on non-recurrent mitigations to support financial performance is also adversely impacting the cash balance.
Capital Allocation for 2025-26 is £48.02m	The Trust capital expenditure at end of December was £12.17m against a YTD plan of £10.00m.
Better Payment Practice Performance – 94.76% for non-NHS by value	Overall, the Trust's BPPC is 95.65% by volume and 93.86% by value for the nine months year-to-date. The BPPC for non-NHS invoices is 96.01% by volume and 94.76% by value.
Trust is continuing to forecast to deliver plan for 2025-26	The Trust continues to forecast delivery of its planned deficit position of £1.46m for 2025–26. However, the impact of unfunded industrial action, winter-related capacity pressures (ambulance diverts), and other year-to-date overspends remain a concern and cannot be sustained across the full financial year without adversely affecting delivery of the financial plan. Pay expenditure remains broadly stable, with minimal variation in both substantive and bank staffing costs. Work is underway to identify and implement recovery actions aimed at reducing pay expenditure and supporting achievement of the planned financial position.

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	28,733	30,866	2,134	260,280	265,999	5,719	346,917
High Cost Drugs - Income	1,094	1,145	51	9,809	11,829	2,020	13,063
Non-NHS Clinical Income	1,665	1,847	182	14,984	16,688	1,704	19,978
Other Non-Patient Income	2,400	2,673	273	21,606	23,262	1,656	28,805
Elective Recovery Fund	4,727	4,806	79	47,441	48,318	877	62,735
	38,619	**41,338**	**2,718**	**354,120**	**366,096**	**11,976**	**471,499**
Pay							
Agency	(51)	768	819	(180)	(3,138)	(2,959)	(303)
Bank	(128)	(1,136)	(1,008)	(1,002)	(16,002)	(14,999)	(1,359)
Substantive	(29,151)	(29,302)	(151)	(260,760)	(257,902)	2,858	(348,258)
	(29,330)	**(29,670)**	**(340)**	**(261,942)**	**(277,042)**	**(15,100)**	**(349,920)**
Non Pay							
Non-Pay	(6,342)	(6,521)	(180)	(67,530)	(68,558)	(1,028)	(82,338)
High Cost Drugs - Exp	(1,003)	(1,281)	(279)	(9,026)	(11,049)	(2,024)	(12,034)
	(7,345)	**(7,803)**	**(458)**	**(76,556)**	**(79,607)**	**(3,051)**	**(94,373)**
EBITDA	**1,944**	**3,865**	**1,921**	**15,622**	**9,447**	**(6,175)**	**27,206**
Post EBITDA							
Depreciation	(1,906)	(1,905)	1	(17,152)	(17,144)	8	(22,869)
Interest Payable	(73)	(48)	25	(657)	(441)	216	(876)
Interest Receivable	76	146	70	1,005	1,452	447	1,185
Dividends Payable	(506)	(506)	0	(4,554)	(4,554)	(0)	(6,072)
P/L On Disposal Of Assets	0	0	0	0	0	0	0
	(2,409)	**(2,313)**	**96**	**(21,358)**	**(20,687)**	**671**	**(28,632)**
Reported Surplus/(Deficit)	**(465)**	**1,552**	**2,016**	**(5,736)**	**(11,240)**	**(5,504)**	**(1,426)**
Impairments	0	0	0	0	0	0	0
IFRS & Donated	(5)	(6)	(1)	(45)	(53)	(8)	(60)
Reported Surplus/(Deficit) after Impairments and IFRIC12	**(470)**	**1,546**	**2,015**	**(5,781)**	**(11,293)**	**(5,512)**	**(1,486)**

- In December the Trust is reporting a surplus of £1.5m (excluding donated asset depreciation and impairments) which included a net benefit of £0.7m relating to prior months Industrial Action costs. The YTD position includes non-recurrent benefits of £17.6m and unfunded industrial action costs £0.6m.

- Though the Trust is reporting a year to date over performance of £0.9m on its ERF activity, there is a significant risk of not being paid for activity above ERF plan.

- Although the Trust has significantly reduced its agency expenditure, it still needs to identify £3m of expenditure reduction per month to deliver plan for 2025-26.

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	Income Diff £'000 £000's
Elective	2,180	2,313	133	22,522	22,798	276
Outpatients	2,466	2,493	27	24,901	25,520	620
Other clinical Income	81	0	(81)	19	0	(19)
Total ERF	**4,727**	**4,806**	**79**	**47,441**	**48,318**	**877**
Total Variable Imaging	**468**	**435**	**(34)**	**4,838**	**5,841**	**1,002**
Total HCD (Variable)	**836**	**879**	**43**	**7,484**	**9,639**	**2,156**
Total Devices	**123**	**110**	**14**	**1,230**	**1,108**	**122**
Total Chemo Deliveries	**80**	**108**	**29**	**823**	**861**	**38**
Total Variable	**6,234**	**6,337**	**130**	**61,816**	**65,767**	**4,195**
A&E	2,411	2,507	97	21,386	21,246	(139)
Critical Care	642	160	(482)	5,695	2,378	(3,317)
Direct Access	1,115	937	(178)	11,521	9,598	(1,923)
Elective	81	64	(17)	812	798	(14)
Imaging	134	385	250	1,385	1,839	454
Non-Elective	5,817	5,901	84	51,669	56,214	4,545
Outpatients	1,804	1,696	(108)	18,147	17,773	(374)
Community	6,945	6,945	0	62,502	62,502	0
Ambulatory	381	493	112	3,928	4,680	462
HCD Block	261	261	0	2,348	2,348	0
Block Adjustment	0	242	242	0	307	307
Other clinical Income NHS	8,729	10,890	2,161	76,321	80,694	4,374
NHS Clinical Income	**34,554**	**36,817**	**2,263**	**317,530**	**326,146**	**8,616**
Non NHS clinical income	**1,665**	**1,847**	**182**	**14,984**	**16,688**	**1,704**
Income From Patient Care Activities	**36,219**	**38,664**	**2,445**	**332,514**	**342,834**	**10,320**
Other Operating Income	**2,400**	**2,673**	**273**	**21,606**	**23,262**	**1,656**
Total	**38,619**	**41,337**	**2,718**	**354,120**	**366,096**	**11,976**

Current Month Variances

For December, the Trust is reporting £2.7m income over recovery

£2.3m is from patient care activities that includes:

- £1.3m of additional funding for industrial action
- Additional funding of £0.4m relating to virtual wards offset by expenditure
- Non-recurrent benefits of £0.4m

Other operating income is £0.3m above plan and includes:

- Research is £0.1m – offset by expenditure
- Procurement hosted service £0.1m offset by expenditure

YTD Variance

Year to date the trust is £12m favourable to plan Income from patient care activities is £10.3m better than plan. Key drivers include

- HCD £1.8m offset by expenditure
- £1.3m of funding for IA
- £2.3m Non Recurrent Income
- Imaging £0.7m favourable offset by expenditure
- ERF overperformance of £0.9m favourable
- Start for life Workforce Pilot of £0.5m favourable offset by additional expenditure

Other operating income over recovery of £1.7m predominantly reates to research income offset by expenditure

2.2 Elective recovery fund (ERF) ICSU Income – December

ERF Income by ICSU

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	8,168	598	509	(89)	6,150	6,156	6
CYP	7,373	539	559	20	5,552	5,026	(526)
EIM	22,790	1,691	1,735	44	17,153	17,245	92
S&C	24,665	1,818	2,003	186	18,568	19,892	1,324
Corp	(261)	81	0	(81)	19	(0)	(19)
Balancing Figure	0	0	0	0	0	0	0
Grand Total	62,735	4,727	4,806	79	47,441	48,318	877

For Month 9 the trust is reporting an in month variance 79k favourable variance.

The YTD variance is £.09m favourable largely being driven by surgery and cancer division partially offset by CYP under performance.

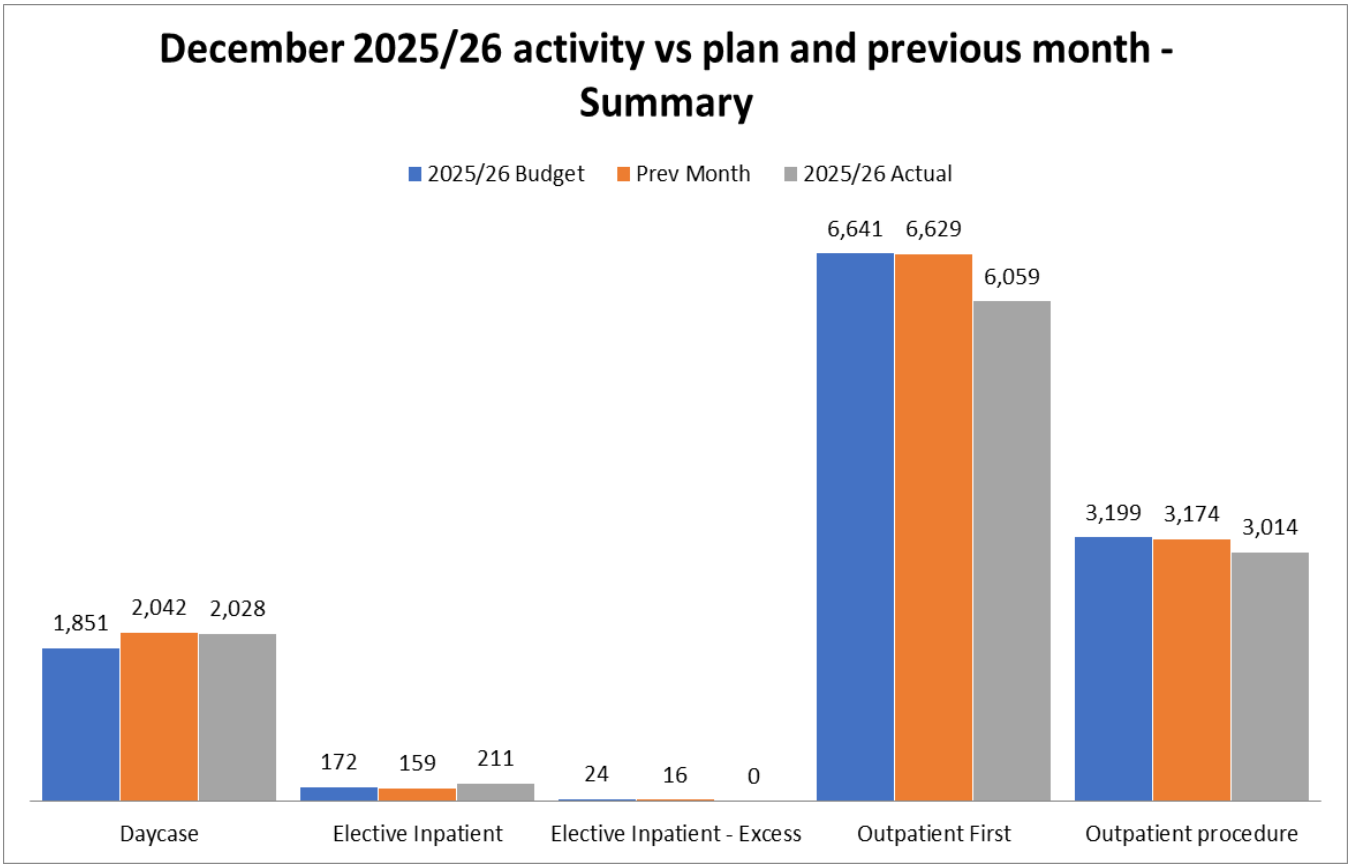
2.3 ERF Performance Activity Group Income – December

ERF Income by POD

POD	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
DC	22,943	1,672	1,738	66	17,277	16,966	(311)
EL	6,965	508	575	68	5,245	5,832	587
OP First	22,628	1,804	1,752	(52)	17,239	17,371	132
OP Procedure	10,199	743	741	(2)	7,680	8,149	469
Balancing Figure	0	0	0	0	0	0	0
Grand Total	62,735	4,727	4,806	79	47,441	48,318	877

YTD we are reporting £0.9m overperformance for ERF which is largely driven by outpatients.

2.3 ERF Activity Performance – December



Day cases and electives are above plan for December, and we have seen similar levels of activity compared to November activity.

Outpatient firsts are behind plan for December however we have seen a 9% reduction in activity compared to November

Outpatient procedures are behind planned for December but we have seen a 5% reduction in activity compared to November.

3. Expenditure – Pay & Non-pay

3.1 Pay Expenditure

Pay expenditure for December was £29.7m. Included in month was non recurrent benefits of £1.8m.

- There was an increase of £0.3m on substantive pay which was predominantly due to industrial action (£0.6m)
- The Trust is £3.9m below the bank and agency spend cap YTD of £25.2m.
- Enhanced care costs (bank and agency) further increased in December due to Winter pressures.

	2025-26							
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Mov^t
Agency	407	485	379	400	358	312	343	31
Bank	1,883	2,222	1,653	1,684	1,789	1,899	1,846	(53)
Substantive	27,268	27,565	32,405	28,401	28,518	28,800	29,163	363
Total Operational Pay	**29,557**	**30,272**	**34,437**	**30,484**	**30,665**	**31,011**	**31,352**	**341**
Non Operational Pay Costs	792	1,442	(3,236)	(199)	(101)	221	(1,682)	(1,903)
Total Pay Costs	**30,349**	**31,714**	**31,201**	**30,286**	**30,563**	**31,231**	**29,670**	**(1,561)**

Industrial Action Costs

Month	Division	Substantive	Bank	Non Pay	Total
July	ACW	60,342	5,999	17,853	84,194
July	EIM	232,491	65,302	-	297,793
July	S&C	72,591	61,214	-	133,805
July	CYP	52,909	25,834	-	78,743
Total July		**418,333**	**158,349**	**17,853**	**594,535**
November	ACW	43,500	29,810	8,322	81,632
November	EIM	188,363	153,330	-	341,693
November	S&C	- 1,501	97,035	-	95,534
November	CYP	87,152	9,452	-	96,604
Total November		**317,514**	**289,627**	**8,322**	**615,463**
December	ACW	5,374	25,123	7,853	38,350
December	EIM	250,256	91,437	-	341,693
December	S&C	53,774	41,761	-	95,535
December	CYP	66,661	21,730	-	88,391
Total December		**376,065**	**180,051**	**7,853**	**563,969**
Total YTD IA Impact		**1,111,912**	**628,027**	**34,028**	**1,773,967**

YTD Industrial Actions costs is £1.8m. The Trust received £1.3m of funding relating to IA costs in November and December. The Trust is still expected to mitigate the July strike costs.

Enhanced Care

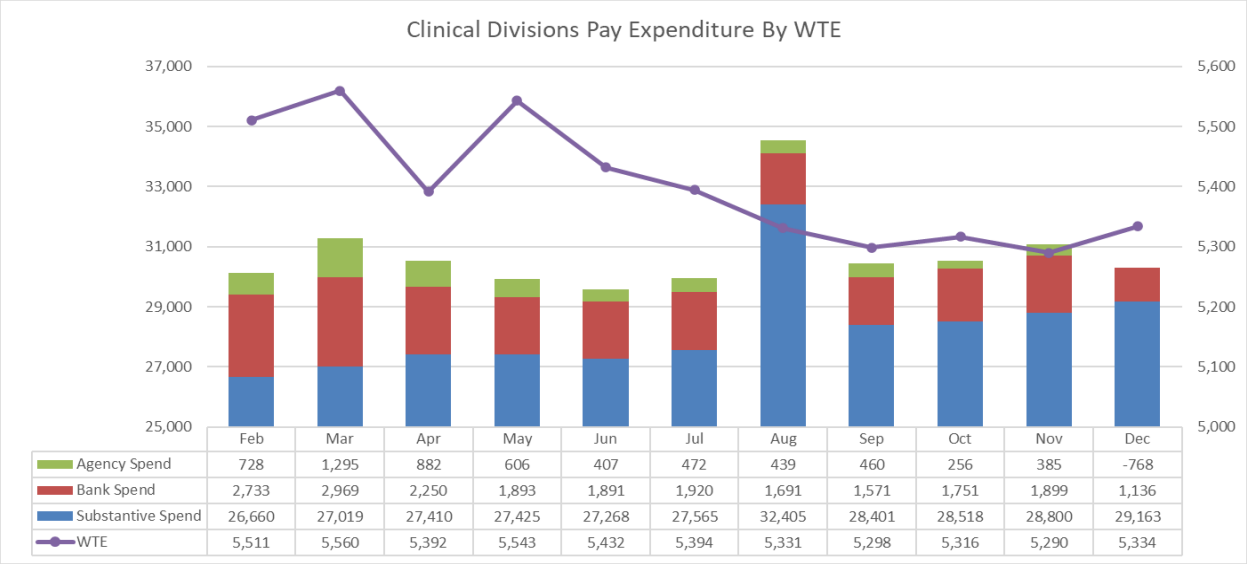
Enhanced care usage in December was above funded establishment by 47.52wte. Temporary staffing usage to cover enhanced care was equivalent to 56.87 WTE (higher than November).

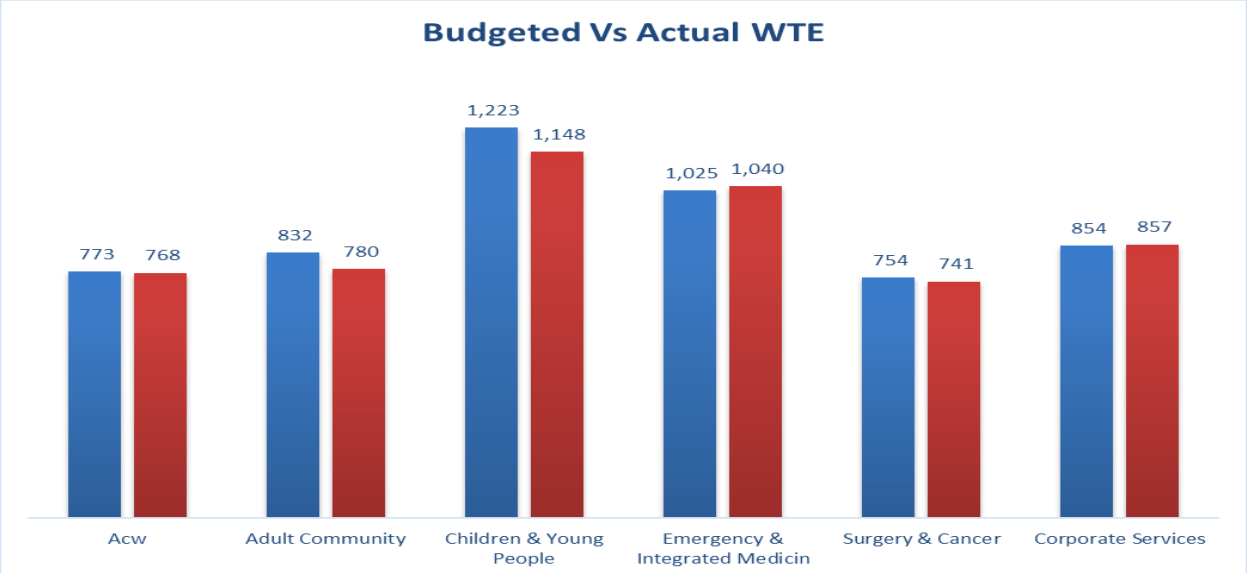
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Enhanced Care - Registered Hours	536.0	468.0	372.0	264.0	72.0	432.0	348	0	540.0
Enhanced Care - Unregistered Hours	13,556.0	17,140.0	14,736.0	15,168.0	14,094.0	12,444.0	13272	13832	14,808.0
Total Hours	**14,092.0**	**17,608.0**	**15,108.0**	**15,432.0**	**14,166.0**	**12,876.0**	**13,620.0**	**13,832.0**	**15,348.0**

WTE equivalent	87.68	106.03	94.01	92.92	85.30	80.12	82.01	86.07	92.42
Funded WTE	43.9	43.9	43.9	43.9	43.9	43.9	43.9	43.9	44.9
WTE Above funded level	**43.78**	**62.13**	**50.11**	**49.02**	**41.40**	**36.22**	**38.11**	**42.17**	**47.52**

Of which temporary staffing hours are

Enhanced care - Bank Hours	6,360.0	9,696.0	8,568.0	8,712.0	6,425.0	5,352.0	7028	8280	8988
Enhanced care - Agency Hours	0.0	0.0	0.0	0.0	0.0	0.0	312	0	456
Total	6,360.0	9,696.0	8,568.0	8,712.0	6,425.0	5,352.0	7,340.0	8,280.0	9,444.0
WTE equivalent	**39.57**	**58.38**	**53.31**	**52.46**	**38.69**	**33.30**	**44.20**	**51.52**	**56.87**





3.2 Non-pay Expenditure

Non-pay expenditure excluding high-cost drugs decreased by £0.3m compared to November. Key movements include:

- In month non recurrent benefits of £2.2m mainly on other expenditure relating to prior year expenses.
- Increase supplies & services – clinical mainly due to prior month non recurrent release of £2.1m.

	2025-26							
Non-Pay Costs	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Mov^t**
Supplies & Servs - Clin	4,447	3,836	3,950	4,186	4,256	2,235	3,611	1,375
Supplies & Servs - Gen	356	382	427	396	427	411	236	(175)
Establishment	309	299	276	256	(83)	310	261	(49)
Healthcare From Non Nhs	(151)	95	93	92	65	98	96	(2)
Premises & Fixed Plant	2,297	2,275	2,269	2,343	1,756	1,788	2,004	216
Ext Cont Staffing & Cons	221	210	233	88	277	316	181	(134)
Miscellaneous	726	1,146	615	(644)	1,027	1,631	120	(1,511)
Chairman & Non-Executives	11	11	10	11	11	11	11	0
Non-Pay Reserve	0	0	0	0	0	0	0	0
Total Non-Pay Costs	**8,217**	**8,254**	**7,873**	**6,727**	**7,737**	**6,800**	**6,521**	**(279)**

Excludes high-cost drug expenditure and depreciation.
Included in miscellaneous is CNST premium, Transport contract, professional fees, and bad debt provision.

Miscellaneous Expenditure Breakdown

	2025-26							
Miscellaneous Breakdown	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Mov^t**
Ambulance Contract	173	157	196	175	168	207	173	(34)
Other Expenditure	(1,159)	(185)	(667)	(1,999)	(249)	265	(1,412)	(1,678)
Audit Fees	14	14	14	14	23	15	15	(0)
Provision For Bad Debts	156	(160)	(268)	(128)	(341)	(21)	(14)	7
Cnst Premium	810	798	807	819	809	810	804	(6)
Fire Security Equip & Maint	33	17	13	15	12	23	10	(14)
Interpretation/Translation	69	43	25	19	164	(99)	44	142
Membership Subscriptions	133	136	150	137	138	139	135	(3)
Professional Services	385	187	221	206	199	160	215	56
Research & Development Exp	1	1	1	1	2	0	0	(0)
Security Internal Recharge	13	12	12	13	34	15	16	1
Teaching/Training Expenditure	95	124	109	80	68	112	131	20
Travel & Subs-Patients	2	3	2	3	2	5	3	(1)
Work Permits	0	0	0	0	0	0	0	0
Write Down Of Inventories	0	0	0	0	0	0	0	0
Total Non-Pay Costs	**726**	**1,146**	**615**	**(644)**	**1,027**	**1,631**	**120**	**(1,511)**

3.3 Cost Improvement Programme (CIP)

The CIP target in the Trust plan for 2025–26 is £22m. The internal target set for clinical divisions and corporate services, is £27m to account for a proportion of the brought forward liability associated with non-recurrent savings schemes in the prior year (2024/25). The increased internal efficiency target (of £5m) has been set to focus improvement on the Trust underlying financial position, which will otherwise deteriorate due to unfunded growth in the recurrent cost-base.

Forecast

As of Month 9, £22m has been identified of which the recurrent forecast delivery is £8.6m. There is £5.3m slippage against the internal target of £27.3m

Target		25/26 Delivery						2026/27 Recurrent Delivery		
Divisions	25/26 CIP Target £000	Recurrent £'000	Non Recurrent £'000	Forecast £'000	Variance against Target £'000	Recurrent gap £'000	Forecast Run-rate £'000	Full Year Effect £000	Variance to target £000	% of target
ADULT COMMUNITY	3,560	1,325	117	1,442	(2,118)	(2,235)	588	1,541	(2,019)	43%
CHILDREN & YOUNG PEOPLE	4,464	2,389	195	2,584	(1,880)	(2,075)	400	2,943	(1,521)	66%
EMERGENCY & INTEGRATED MEDICINE	4,830	1,155	39	1,194	(3,636)	(3,675)	384	869	(3,961)	18%
SURGERY & CANCER	4,651	486	292	778	(3,873)	(4,165)	87	492	(4,159)	11%
ACW	4,968	612	594	1,206	(3,762)	(4,356)	2,093	673	(4,295)	14%
DIVISIONS TOTAL	**22,473**	**5,967**	**1,237**	**7,204**	**(15,269)**	**(16,506)**	**3,552**	**6,518**	**(15,955)**	**29%**
CORPORATE SERVICES	2,585	933	339	1,272	(1,313)	(1,652)	646	1,025	(1,560)	40%
ESTATES AND FACILITIES	2,272	835	805	1,640	(632)	(1,437)	1,800	919	(1,353)	40%
CENTRAL	0	1,102	10,982	12,084	12,084	1,102	0	1,119	1,119	0%
TRUST TOTAL	**27,330**	**8,837**	**13,363**	**22,000**	**(5,330)**	**(16,493)**	**5,998**	**9,581**	**(17,749)**	**35%**

YTD Performance

As of Month 9, the YTD shortfall of £5.3m (26% of the YTD internal target) is mainly due to unidentified gap with some schemes coming on-line from Q4.

With regards to the schemes in plan, there is no slippage in delivery.

The central position captures £6.6m of non-recurrent benefits.

Divisions	25/26 CIP Target £000	YTD CIP target £000	YTD Actuals Recurrent £000	YTD Actuals Non-Recurrent £000	Total YTD Actuals Total £000	YTD Variance to target £000
ADULT COMMUNITY	3,560	2,670	1,143	96	**1,239**	(1,431)
CHILDREN & YOUNG PEOPLE	4,464	3,348	1,646	177	**1,823**	(1,525)
EMERGENCY & INTEGRATED MEDICINE	4,830	3,623	948	20	**967**	(2,655)
SURGERY & CANCER	4,651	3,488	424	272	**696**	(2,792)
ACW	4,968	3,726	464	463	**926**	(2,800)
DIVISIONS TOTAL	**22,473**	**16,855**	**4,625**	**1,027**	**5,652**	**(11,203)**
CORPORATE SERVICES	2,585	1,939	704	274	**978**	(961)
ESTATES AND FACILITIES	2,272	1,704	437	788	**1,225**	(479)
CENTRAL	0	0	663	6,627	**7,290**	7,290
TRUST TOTAL	**27,330**	**20,498**	**6,430**	**8,715**	**15,145**	**(5,352)**

24% of open schemes are currently under development, with £2.5m of schemes currently sitting in opportunities. These are being worked upon by the PMO workstreams and Divisions, awaiting full approval (e.g. completed Project Initiation Document and Quality Impact Assessment).

4.0 Statement of Financial Position (SoFP)

The net balance on the Statement of Final Position as of 31st December 2025 is £203.70m, £2.95m higher than 30th November 2025, as shown in the table below.

Statement of Financial Position as at 31st December 2025	2024/25 M12 Balance	2025/26 M08 Balance	2025/26 M09 Balance	Movement in Month
	£000	£000	£000	£000
NON-CURRENT ASSETS:				
Property, Plant And Equipment	242,623	236,586	235,379	(1,208)
Intangible Assets	4,079	2,405	2,218	(188)
Right of Use Assets	36,104	33,983	33,570	(413)
Assets Under Construction	18,226	22,699	24,451	1,753
Trade & Other Rec -Non-Current	806	851	850	(0)
TOTAL NON-CURRENT ASSETS	**301,837**	**296,523**	**296,467**	**(56)**
CURRENT ASSETS:				
Inventories	1,308	1,117	1,147	31
Trade And Other Receivables	23,121	20,430	20,845	416
Cash And Cash Equivalents	46,276	37,834	35,219	(2,615)
TOTAL CURRENT ASSETS	**70,705**	**59,381**	**57,211**	**(2,169)**
CURRENT LIABILITIES				
Trade And Other Payables	(90,246)	(86,721)	(83,729)	2,992
Borrowings: Finance Leases	(1,025)	(1,025)	(1,025)	0
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	(227)	(706)	(704)	2
Other Liabilities	(3,207)	(5,921)	(4,282)	1,638
TOTAL CURRENT LIABILITIES	**(99,190)**	**(98,859)**	**(94,226)**	**4,633**
NET CURRENT ASSETS / (LIABILITIES)	**(28,485)**	**(39,478)**	**(37,015)**	**2,464**
TOTAL ASSETS LESS CURRENT LIABILITIES	**273,352**	**257,045**	**259,453**	**2,407**
NON-CURRENT LIABILITIES				
Borrowings: Dh Revenue and Capital Loan - Non-Current	(1,392)	(1,334)	(1,334)	0
Borrowings: Finance Leases	(1,282)	(280)	(155)	125
Borrowings: Right of Use Assets	(32,055)	(30,248)	(29,835)	413
Provisions for Liabilities & Charges	(25,033)	(24,432)	(24,432)	0
TOTAL NON-CURRENT LIABILITIES	**(59,762)**	**(56,294)**	**(55,755)**	**538**
TOTAL ASSETS EMPLOYED	**213,591**	**200,751**	**203,697**	**2,946**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	138,320	138,320	139,720	1,400
Retained Earnings	1,634	(11,205)	(9,660)	1,546
Revaluation Reserve	73,637	73,637	73,637	0
TOTAL TAXPAYERS EQUITY	**213,591**	**200,751**	**203,697**	**2,946**

The most significant movements in the month to 31st December were as follows:

NON-CURRENT ASSETS
Non-Current assets closed at £296.47m on 31st December 2025, a net decrease of £0.06m from previous month due the following:

- Capital expenditure for owned assets £1.84m
- Monthly depreciation: Owned assets (£1.49m)
- Monthly depreciation: Right of Use assets (£0.41m)

CURRENT ASSETS
Current assets closed at £57.21m in December 2025, a net decrease of £2.17m from the previous month. Principal movements comprised of an increase in Trade and Other Receivables £0.45m and a decrease in cash £2.62m.

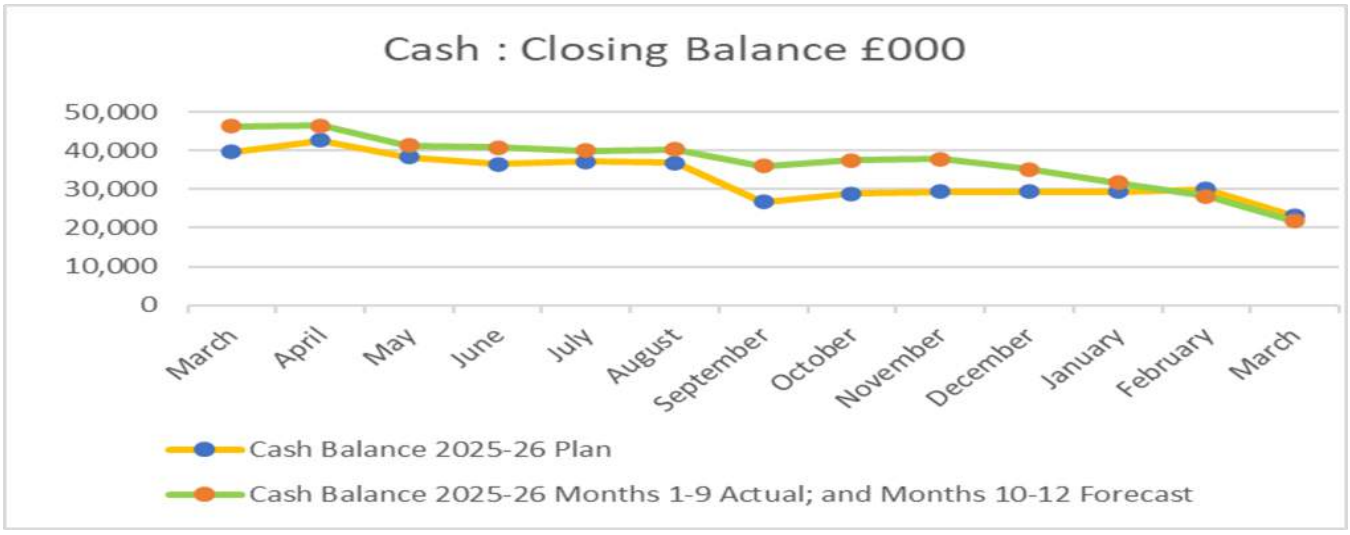
CURRENT LIABILITIES
Current liabilities decreased by £4.63m during the month. This movement was driven primarily by a £2.99m decrease in Trade Payables and £1.64m reduction in Other Payables, relating to reduced payment in month & NHS Deferred Income.

NON-CURRENT LIABILITIES
Non-current liabilities closed at £55.76m in December 2025, reflecting a net decrease of £0.54m compared to the previous month. This movement has primarily driven by reduction of Right of Use and other finance lease liabilities.

TAXPAYER EQUITY
Public Divided capital closed at £139.72m in December, an increase of £1.40m due to PDC draw down for the Fire Remediation Project.

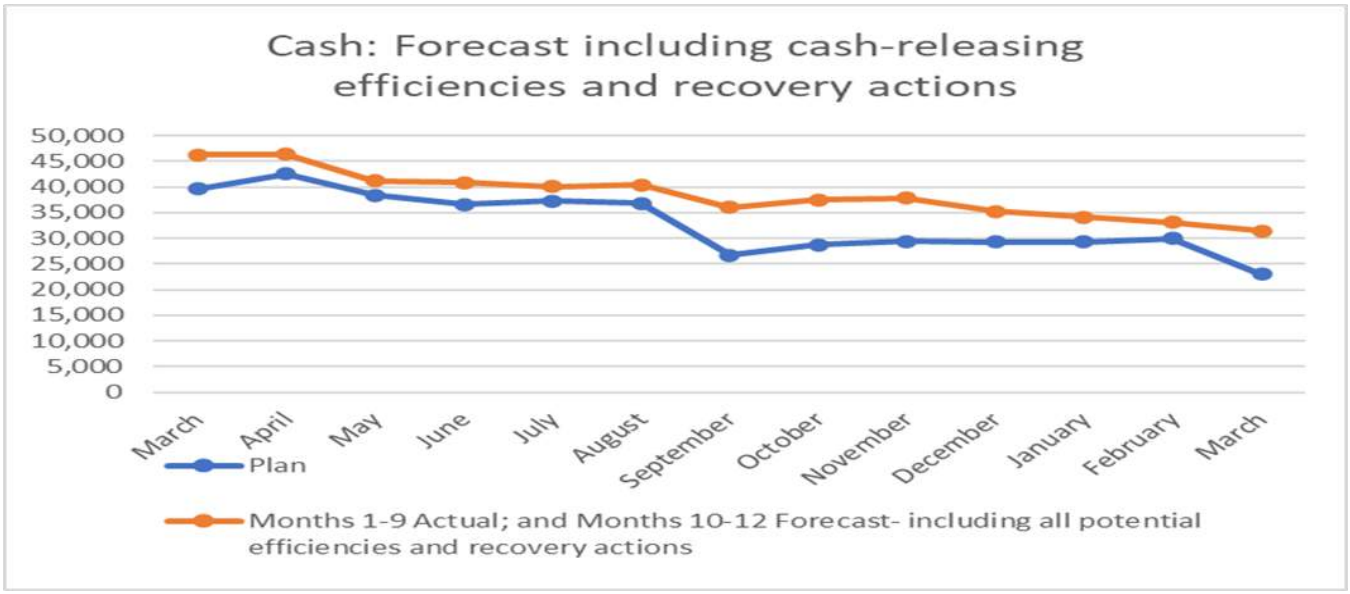
Retained Earnings closed at (deficit) (£9.66m) in December 2025, a net decrease in cumulative (deficit) of £1.55m from December surplus closing figure.

CASH
The Trust's cash balance on 31st December was £35.22m, which is £5.94m favourable to Plan, and a decrease of £2.62m from November's closing balance.



The in-month decrease is due to the delay receipts NHSE Education income for Quarter 3 High-Cost Drugs (now resolved), which partially offset the PDC drawdown receipt of £1.40m.

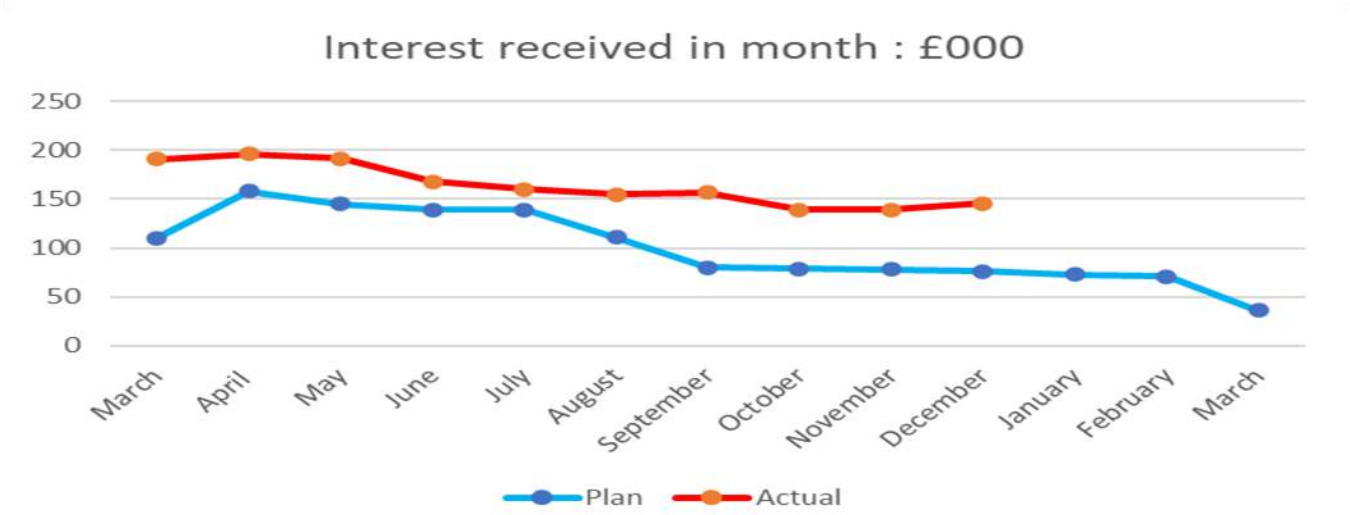
The Trust's underlying deficit of £3.5m per month has modelled in the chart above for the months of January to March 2026. This forecast indicates that the Trust's cash balance on 31st March 2026 would equate to sixteen days' trading in the absence of significant cash-releasing recovery actions or efficiency savings. The achievement of both cash-releasing recovery actions of £7.7m and efficiency savings of £6.5m would together increase the projected days' cash held on 31st March 2026 from 16 days as shown above, to 24 days as shown below.



The Trust forecasts and closely monitors its cash position against Plan.

Interest Received

The interest received during December 2025 was £0.14m, which is £0.07m above Plan. December's interest received reflected the impact of the favourable-to-plan cash balance during the month. The interest rate received by the Trust is now lower at 3.64%, reflecting the recent base rate reduction. Year-to-date, interest received is £447k favourable to Plan.



5.0 Capital Expenditure

The total forecast capital expenditure for 2025/26 is £48.02m, of which £47.99m approved by North Central London (NCL). A further £3.50m for the Start Well project has been agreed in principle, with PDC funding subject to final confirmation.

Capital Summary Month 09: 31st December 2025

all figures: £000	Allocation				In Month			Year to Date			FOT
	Allocation	Subsequent Allocation	Total Allocation	Total Programme	In-Month Forecast	In-Month Actual	In-Month Variance	YTD Forecast	YTD Actual	YTD Variance	FOT YTD M12
ESTATES AND STRATEGIC PROJECTS CAPITAL PROGRAMME 2025/26	9,030	500	9,530	9,530	1,640	407	(1,233)	5,852	5,180	(672)	9,530
ICT	1,500		1,500	1,500	0	12	12	156	1,449	1,293	1,500
PACS	400		400	400	0	0	0	0	80	80	400
Equipment	500		500	500	0	8	8	156	73	(83)	500
Divisions	200		200	200	0	18	18	78	70	(8)	200
Contingency	425		425	425	0	229	229	0	229	229	425
Pharmacy Robot	402		402	402	0	8	8	0	15	15	402
Total Owned Assets	**12,457**	**500**	**12,957**	**12,957**	**1,640**	**683**	**(958)**	**6,242**	**7,095**	**854**	**12,957**
PDC funded	0	29,582	29,582	29,582	1,636	1,172	(464)	3,770	3,447	(323)	29,582
Total PDC funded	**0**	**29,582**	**29,582**	**29,582**	**1,636**	**1,172**	**(464)**	**3,770**	**3,447**	**(323)**	**29,582**
RoU assets (new leases)	0		0	0	0	0	0	0	0	0	
RoU assets (remeasures)	5,476		5,476	5,476	0	0	0	0	1,631	1,631	5,476
Total Right of Use	**5,476**	**0**	**5,476**	**5,476**	**0**	**0**	**0**	**0**	**1,631**	**1,631**	**5,476**
Total	**17,933**	**30,082**	**48,015**	**48,015**	**3,277**	**1,855**	**(1,422)**	**10,011**	**12,173**	**2,162**	**48,015**

As of 31 December 2025, the Trust's year-to-date (YTD) capital expenditure was 12.17m, compared to the YTD plan of £10.00m.

This represents a variance of £2.16m, of which:

- £1.29m is attributable to the 2025/26 ITM project spent well in advance of plan.
- The remaining variance reflects timing differences across other approved capital projects.

Better Payments Practice Code

The Trust has 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 95.65% by volume and 93.86% by value for the 9 months year-to-date. The BPPC for non-NHS invoices is 96.01% by volume and 94.76% by value for the 9 months year-to-date. The charts below show performance for March to December 2025.