NHS
Whittington Health
NHS Trust

Meeting	**Trust Board – Public**
Date & time	**05 July 2017 at 1400hrs – 1630hrs**
Venue	**Whittington Education Centre, Room 7**

AGENDA

Members – Non-Executive Directors	**Members – Executive Directors**
Steve Hitchins, Chair Deborah Harris-Ugbomah, Non-Executive Director Tony Rice, Non-Executive Director Anu Singh, Non-Executive Director Prof Graham Hart, Non-Executive Director David Holt, Non-Executive Director Yua Haw Yoe, Non-Executive Director	Simon Pleydell, Chief Executive Siobhan Harrington, Director of Strategy & Deputy Chief Executive Stephen Bloomer, Chief Finance Officer Dr Richard Jennings, Medical Director Philippa Davies, Chief Nurse & Director of Patient Experience Carol Gillen, Chief Operating Officer

Attendees – Associate Directors
Dr Greg Battle, Medical Director (Integrated Care)
Norma French, Director of Workforce
Lynne Spencer, Director of Communications & Corporate Affairs
Secretariat
Kate Green, Minute Taker

Contact for this meeting:lynne.spencer1@nhs.net or 07733 393178

Agenda Item		Paper	Action and Timing
Patient Story			
	Patient Story *Philippa Davies, Chief Nurse & Director of Patient Experience*	*Verbal*	*Note* 1400hrs
17/094	**Declaration of Conflicts of Interests** *Steve Hitchins, Chair*	*Verbal*	*Declare* 1420hrs
17/095	**Apologies & Welcome** *Steve Hitchins, Chair*	*Verbal*	*Note* 1425hrs
17/096	**Draft Minutes, Action Log & Matters Arising 7th June 2017** *Steve Hitchins, Chair*	1	*Approve* 1430hrs
17/097	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Note* 1440hrs
17/098	**Chief Executive's Report** *Simon Pleydell, Chief Executive*	2	*Approve* 1450hrs
Patient Safety & Quality			

17/099	**Serious Incident Report Month 02** *Philippa Davies, Chief Nurse & Director of Patient Experience*	3	*Approve* 1500hrs
17/100	**Safer Staffing Report Month 02** *Philippa Davies, Chief Nurse & Director of Patient Experience*	4	*Approve* 1510hrs
Performance			
17/101	**Financial Performance Month 02** *Stephen Bloomer, Chief Finance Officer*	5	*Approve* 1520hrs
17/102	**Performance Dashboard Month 02** *Carol Gillen, Chief Operating Officer*	6	*Approve* 1530hrs
Strategy			
17/103	**Strategic Business Continuity Plan** *Carol Gillen, Chief Operating Officer*	7	*Approve* 1540hrs
17/104	**Lower Urinary Tract Services (LUTs)** *Siobhan Harrington, Deputy Chief Executive/Director of Strategy*	8	*Approve* 1550hrs
Governance			
17/105	**Nursing and Midwifery Revalidation** *Philippa Davies, Chief Nurse & Director of Patient Experience*	9	*Approve* 1600hrs
AOB Urgent Business and Questions from the public			
	None notified to the Trust		1610hrs
Date of next Trust Board Meeting and Annual General Meeting			
	06 September 2017 at 1400hrs to 1630hrs at the Whittington Education Centre Room 7, Magdala Avenue, N19 5NF		

Register of Conflicts of Interests:
The Register of Members' Conflicts of Interests is available for viewing during working hours from Lynne Spencer, Director of Communications & Corporate Affairs, at Trust Headquarters, Ground Floor, Jenner Building, Whittington Health, Magdala Avenue, London N19 5NF - communications.whitthealth@nhs.net.

Whittington Health NHS

ITEM: 17/096
Doc: 01

The draft minutes of the meeting of the Trust Board of Whittington Health held in public at 1400hrs on Wednesday 7th June 2017 in the Whittington Education Centre

Present:	Greg Battle	Medical Director, Integrated Care
	Stephen Bloomer	Chief Finance Officer
	Philippa Davies	Chief Nurse & Director of Patient Experience
	Carol Gillen	Chief Operating Officer
	Deborah Harris-Ugbomah	Non-Executive Director
	Siobhan Harrington	Director of Strategy/Deputy Chief Executive
	Graham Hart	Non-Executive Director
	Steve Hitchins	Chairman
	David Holt	Non-Executive Director
	Richard Jennings	Medical Director
	Simon Pleydell	Chief Executive
	Tony Rice	Non-Executive Director
	Anu Singh	Non-Executive Director
	Yua Haw Yoe	Non-Executive Director
In attendance:	Helen Gordon	Deputy Director of Workforce
	Kate Green	Minute Taker
	Lynne Spencer	Director of Communications & Corporate Affairs

Patient Story

Philippa Davies introduced Jo Baldwin, a nurse from the Haringey Family Nurse Partnership, who in turn introduced Yasmin and Abdas and their twin children. Jo explained that she herself was based in Haringey, but the Family Nurse Partnership (FNP) also provided a service to the boroughs of Islington, Camden and Hackney.

Jo explained that the FNP focused on early intervention in pregnancy and the early years of the child through a structured programme which includes prenatal care, parent/child attachment, behavioural development and school readiness. Home visits take place initially every week, then fortnightly, then weekly again following the birth of the child, then fortnightly again. Visits cover looking at the home environment, relationships with family and friends, and, where necessary, signposting to other services.

Yasmin and Abdas were first referred to the FNP in February 2015 following their move to London from Cardiff. At this time Yasmin was 17 years old and 27 weeks pregnant. She and her husband had no home but were living with extended family. Her English was not good and an interpreter was required for appointments. Initially Jo had described, step by step, what the FNP was able to do to help the family, which as well as supporting Yasmin through her pregnancy also included assistance with finance and housing.

Two years on, Yasmin and Abdas are very happy and pleased with the services they have received. The children are healthy, developing well and due to start nursery in September and Abdas has been granted leave to remain in the country, is actively seeking citizenship and working as a chef. Yasmin, now she has graduated from the FNP, plans to attend a course to improve her English still further, enrol at college, and then seek employment.

In answer to a question about what support had been most valued by the family, Yasmin replied that the staff at the FNP had been key, as had her midwife. Also of value had been having a regular interpreter. She herself was now making local friends and was part of a wide social network which included parents' groups.

Steve Hitchins commented that their presentation illustrated well the benefits of investment in the FNP service. Concluding, Jo commented on how hard it was to part company with parents after having built up a relationship over two to three years, but the programme included sessions on how to conduct 'graceful endings', which in their case had included a celebration of all that had been achieved and ensuring parents were confident going forward. Families were also referred to the Trust's Universal Services (for health visiting).

Lower Urinary Tract Services Patient Group (LUTS)
Representatives of the LUTS group read a prepared statement to the Board. This is attached as Appendix 1. Reference was made to a further and more detailed statement prepared for the Board, which had been emailed that afternoon to the Director of Communications and Corporate Affairs to disseminate to the Board.

Simon Pleydell, responding, said that he fully understood the disappointment of the group. Progress had been made, but he acknowledged this was not enough, and he hoped to be able to provide a more positive statement to the JOSC on 9th July. He gave his personal assurance that the Trust would continue to focus on this, but the situation remained complicated. Issues outstanding were around internal governance, and in particular the need to have established a fully functioning Multi-Disciplinary Team (MDT). It was agreed that the group would hold a further meeting with Siobhan Harrington prior to the JOSC.

In answer to a question about whether the Board could give its assurance about the opening of the clinic to new patients, Simon replied that these were complex issues, and the Board would have to be satisfied that not only were things in place but that they were working in an effective way. He added that on the research side, which was critical, real progress had been made, and there was a knowledge and understanding of how that would be managed in future. He would make no categorical guarantee to a particular date, but assured the group of his absolute commitment.

The group expressed disappointment that no interim message had been issued by the Trust, and Siobhan Harrington apologised for this and thanked group members for their promise of assistance with the drafting. It was also noted that Simon Pleydell's departure would not delay progress and there would be no question of returning to the beginning. In the meantime Simon would keep the LUTS clinic at the top of his personal agenda.

17/74 Declaration of Conflicts of Interest

75.01 No member of the Board declared any conflicts of interest in the business scheduled for discussion at that afternoon's Board meeting.

17.75 Welcome and apologies

75.01 Steve Hitchins welcomed everyone to the meeting, and in particular Helen Gordon, Deputy Director of Workforce, standing in for Norma French. Apologies were noted from Norma French and Janet Burgess.

17/76 Minutes, Matters Arising & Action Log

76.01 The minutes of the Trust Board meeting held on 3rd May were approved. There were no matters arising other than those already scheduled for discussion.

Action notes

76.02 66.01: A review of 'flu was to be included in the next Quality & Safety Report to the Board; all other items had been completed and could therefore be closed.

17.77 Chairman's Report

77.01 Steve Hitchins began his report by informing Board colleagues that he had attended the annual nursing conference in May; this had been an extremely good and positive event

and he paid tribute to Philippa Davies and Lisa Smith for their part in organising it. He had been particularly pleased to see Kay Delaney receive an 'outstanding service to nursing special award'. The previous Saturday Steve had attended a diabetes day organised by Maria Barnard and her team, where the feedback from patients had been fantastic. The Trust was to hold an Open Day on Saturday 16th September, and Steve and Carol were working on planning and preparation for this event. The following day Steve was to begin a programme of visits to community dental services.

77.02 Simon Pleydell had announced his intention to leave the Trust in September, and Steve informed the Board that Odgers had been engaged to begin the process of recruiting a new Chief executive for the Trust. Interviews would take place over 17-18 July, with the first day comprising presentations in the morning and focus groups in the afternoon, and formal panel interviews being held on the second day. Steve would be seeking wide representation from the Trust's stakeholders on the focus groups, to include staff, partners and patients. Anyone wishing to discuss any part of the process with Steve was most welcome to contact him.

77.03 Graham Hart informed the Board that Caroline Fertleman had recently won a UCLH Provost Award for teaching, and the Board expressed their congratulations.

17/78 Chief Executive's Report

78.01 Simon was pleased to report that the Trust had recently been awarded the CHKS Quality of Care Award; performance was based on evidence and was a significant achievement in which the Trust should take real pride. Less good, however, was the fact that 5 C. Difficile cases had been declared by the end of May; this was against a target of declaring no more than 17 for the year and in comparison with the previous year's figure of 7 in total was of concern and would require close monitoring.

78.02 Simon expressed his thanks to all those staff who had dealt with the effects of the recent cyber-attack. The IT team had performed really well, with many staff spending the entire weekend working to ensure that services were not adversely affected. The situation was now being assessed by the NHS in terms of potential vulnerability; however Whittington Health's systems had afforded good protection. Deborah Harris asked about the Trust's return to NHS Improvement; it was confirmed this had not yet been submitted however no serious risks had been identified.

78.03 Four members of staff had been out to the Philippines to recruit nursing staff, and it was estimated that approximately 60 nurses had been signed up and would be joining the Trust later in the year. Our staff had been extremely impressed with the quality of the staff they had interviewed. The Trust's Occupational Health & Wellbeing team continued to promote initiatives to support staff in the workplace, the latest of which was a drive to recruit a cohort of Health & Wellbeing Champions. The Annual Staff Awards are scheduled to take place on Thursday 29th June at the Royal College of Surgeons. The panel of judges had met and considered around 250 nominations made within a range of different categories.

17/79 Serious Incident Report

79.01 Philippa Davies informed the Board that two serious incidents had been declared during April. One concerned the delay of a patient's treatment due to referral letters not being received; after it had been ascertained that no harm had come to the patient as a result this incident was de-escalated. The second incident, which involved the sudden death of a patient admitted for surgery, was currently being investigated. Richard Jennings said that he would like to include a summary of SIs involving surgery to the Board as part of his next quality and safety report.

79.02 David Holt commented that although he understood the rationale for reports to start afresh in line with the business year, this removed the ability to track and compare numbers and he would therefore prefer to see a rolling pattern with trends. Philippa replied that she had recently appointed a new Head of Governance & Risk, and one of her first tasks would be to review the content, format and timing of such reports.

79.03 Referring back to the incident about referral letters, Yua Haw Yoe enquired whether the Trust had monitoring measures for such incidents. Philippa Davies replied that this particular incident had been directly attributable to the human error of one team member, and as such she was confident there would be no repetition.

17/80 Safer Staffing Report

80.01 Philippa Davies informed the Board there was little of significance to bring to the Board's attention since the previous month's report. Her newly-appointed Deputy Chief Nurse was working with the Heads of Nursing to interrogate performance against target. The staff who had been to the Philippines to recruit nursing staff were confident they had recruited some extremely high quality staff.

80.02 Steve Hitchins said that he had heard anecdotally from some of the Trust's consultants that the new bank rates introduced by the Trust had resulted in a loss of nursing staff in some areas. Replying, Helen Gordon said that there had been no actual reduction in bank rates, rather the payment of the appropriate rates for the relevant grade of staff. Heads of nursing had seen no evidence of staff leaving as a result of the implementation of the new bank rates.

80.03 In answer to a question from David Holt about staff sickness, Helen replied that addressing sickness rates remained a high priority for the team, and this was something that the HR Business Partners were working actively on with support from Occupational Health. Return to work interviews were routinely carried out. In addition, training in HR issues for managers had recently been re-launched, and a module on staff sickness held the previous week, which had covered return to work interviews, had been well attended. It was further noted that the training had been co-designed with Staff Side members, who were also jointly delivering the training for some of the modules.

17/81 Financial Report

81.01 Stephen Bloomer introduced the financial report for the first month of the new financial year. At the end of Month 1 the Trust had declared a deficit of £1.7m; this was against a forecast position of £1.4m. Expenditure had remained under tight control, and less had been spent in-month than had been expected. The key driver for the month had been income, with the focus on the ICSU teams to ensure they were driving through planned activity levels, and Carol Gillen added that this was actively monitored through her weekly Trust Operational meetings.

81.02 The Trust was also slightly behind in the progression of its CIP plans, but Stephen was confident that as plans began to be actively implemented the organisation would be broadly on track of its plan. There was a £17.3m target, and currently a gap of £8.5m; however there were additional ideas which were being worked through with the assistance of Boston Consulting and the PMO. These would be further discussed at the Board seminar the following week. Stephen stressed that the work being carried out by the PMO would ensure that schemes were worked up in sufficient detail to make them robust.

81.03 It was further noted that all schemes were subject to a quality impact assessment which was carried out by the Medical Director and Chief Nurse. Each of the ICSUs participated in a weekly 'phone-in to maintain their focus on timely delivery. Carol was aware of where the delays were and was confident progress would be seen in reports of months 2 and 3; she agreed that some of the delays were attributable to April's being a short month.

17/81 Capital Plan 2017-20

81.01 Stephen presented the capital plan for the three years 2017-20, explaining that this year was shown as worked up in the most detail. The plan had already been presented at the Trust's Capital Monitoring Group and Trust Management Group. Funding of the plan had been significantly enhanced by the STF monies, and it detailed how priorities had been determined through use of risk registers and the Board Assurance Framework. All schemes would be completed within the current financial year with the exception of maternity, which due to its size and complexity would straddle two years.

81.02 The Trust was required to produce its next submission to NHSI this month; this would include the increased capital spend, as technically all Trusts needed to request formal agreement from the centre and at the time of writing the Trust had not received the agreed external funding or capital spending limits.

81.03 David Holt commented that the IT strategy presented at the Board had led him to believe there would be more plans for IT expenditure. Stephen replied that these schemes were subject to a business case methodology; Simon Pleydell added that IT plans would also be affected by whether or not Whittington Health became a 'fast follower' but was unable to comment on this in more detail at present due to general election 'purdah'.

17/82 Performance Dashboard

82.01 Carol Gillen began by talking about ED performance, which had improved significantly in recent weeks, with trajectories being achieved – and exceeded – in April and May despite continued demand on the service and a record number of attendances. The improvement was attributable not just to improvements within the ED but to patient flow throughout the hospital. The ECIP team had been working with the Trust on board rounds and embedding the 'red to green' methodology. Ten clinical champions had been identified. Mental health continued to present a challenge, and had been identified as such at the recent ESIP workshop. Carol had been holding constructive dialogues with the newly-appointed COO at Camden & Islington Mental Health Trust.

82.02 For the first time the breast symptomatic had not been achieved; this was due to 3 patients DNA. On delayed transfers of care, Carol explained that a great deal of work was taking place around the recording of medically optimised patients – some of the red to green work would help with this. There had been an increase in re-admissions, with the reason for this being a small cohort of patients who had been re-admitted several times over a short period.

82.03 There had been a fall in the Friends & Family Test, but Carol felt this was due to April's being a short month including the Easter holiday period. Turning to HR data, Carol said that both appraisal and mandatory training figures remained broadly static across the ICSUs. She did however pay tribute to the particularly impressive work carried out in the Women's Health and PPP ICSUs to improve their figures, saying that this was something others should aspire to.

82.04 Steve Hitchins asked why there were several gaps in the figures for April data, and Carol replied that this was due to the validation and sign-off process. The change in 2018 dates of Board meetings will remedy this.

17/83 Quality Account

83.01 Richard Jennings introduced the Quality Account, which covered the review of 2016/17 and the Quality Account for 2017/18. It had, he said, been through a number of iterations, and he thanked all who had worked to develop it. The document had also been sent to external stakeholders for their comments.

83.02 Richard drew attention to the treatment of sepsis as one of the key achievements for the previous year. Looking forward to 2017/18, he said that the commitments for the coming year included the Trust's 'Sign up to Safety' pledges. Siobhan drew attention to the external audit which had been carried out.

83.03 Tony Rice praised the quality of the document. It was noted that one comment received was that it focused on too much positive activity, however Richard robustly defended this, saying that in his view it struck the correct balance between achievement and recognition there were areas where improvements could be made. David Holt said that he had been pleased at the opportunities to comment on the document this year – it had been twice to the Audit & Risk Committee and also to a Board Seminar – and he congratulated everyone who had helped to ensure its timely production.

17/84 Annual Accounts

84.01 David Holt informed the Board that the accounts had been presented to the Audit & Risk Committee two weeks ago, along with the audit letter, annual governance statement and annual report. Provided Stephen Bloomer could assure him that no material changes had been made to the documents since then, he would have no hesitation in recommending adoption to the Board. Stephen replied that no numerical changes had been made; there had been a small presentational change, and all other points were covered by the wording in the accompanying notes. David therefore recommended approval and to endorse the signing of the letter.

84.02 It was noted however that for the first time the Head of Internal Audit had given a qualified opinion, and Stephen explained that this was due not to the processes and measures the Trust had in place but specifically about its ability to apply them in practice. Considerable debate had taken place between the Head of Internal Audit and the Executive Team, and lessons had undoubtedly been learned to take forward.

84.03 Although it was the practice of most NHS organisations for the Audit & Risk Committee to make recommendations to the Board, it was agreed firstly that the draft be circulated more widely – and earlier – in future, and secondly that the Board needed to be made aware of and given the opportunity to discuss the process for sign-off each year. The annual accounts were formally approved by the Board.

17/85 Service Improvement Strategy

85.01 Introducing this item, John Watson, Director of Service Improvement, explained that the strategy derived from joint working which had contributed to the creation of a service improvement culture. John's paper contained two slides, the first of which illustrated the different elements referred to, and the second of which set out the leadership and management development action plan in detail.

85.02 John had spent a day with the East London NHS Foundation Trust (ELFT) who had carried out a significant amount of work in this area, and he had been impressed by what he had seen. He drew attention to the table 'Lessons from ELFT', which showed the key elements driving their strategy, and how progress had been achieved over a period of the last five years. It was noted that ELFT now had 88 coaches trained in service improvement techniques; also that they had removed 80% of audits which they had felt had added little or no value to the organisation.

85.03 In answer to a question about measures of success, John replied that some areas – for example numbers of staff trained – were relatively straightforward, but there were other areas where there would need to be more of a structured focus on outcomes. Richard Jennings expressed his wholehearted support for the strategy and direction of travel.

17/86 Board Assurance Framework

86.01 Siobhan Harrington informed the Board that a constructive discussion about the Board Assurance Framework (BAF) had taken place at Trust Management Group, and the accompanying front sheet showed details of the amendments that had been agreed. Two new risks had been added; one on cyber-security, the other around compliant junior doctors' rotas. Some risks had been downgraded. The current highest risks were numbers 5 (failure to deliver CIPs and transformation savings) and 6 (non-receipt of STF funding).

86.02 TMG discussion of risk 5 had included the medical workforce element of the workforce strategy, and Helen Gordon explained some of the risks inherent in the introduction of the new junior doctors' contract, including the shift from non-compliance with rotas and exception reporting. The Trust had already received a fairly high number of exception reports (not in itself a bad thing as it showed the Trust had fostered a culture of 'safe reporting') but there were significant risks, and mitigating actions remained a challenge.

86.03 It was noted that both short and long term solutions needed to be considered, with a more strategic focus in the future. This might involve training nurses and AHPs differently, as it was clear that the doctors in the training workforce was changing and reducing. Whittington Health was fortunate in having an excellent reputation as a training organisation. Simon Pleydell suggested that a series of meetings would be required to discuss future planning in this area, and it would be important to look at the situation across all professional groups.

86.04 Additionally, there was a need to look at some of the tasks carried out by junior doctors, some of which required skills and training but not necessarily a formal qualification. This might include, for example, taking bloods at night; the national 'hospital at night' work contained some key lessons in this area. Anu Singh added that NHS England was looking at workforce across arms' length bodies with a view to bringing together all commitments made by those bodies in a new national team. Simon added that the Royal College of Physicians had the 'Small Hospitals Project', and it seemed timely to engage with that work whilst the Trust had a unique opportunity to do so.

NHSI Board Self-Certification Statement

86.05 Siobhan reminded Board members that the former TDA self-certification statement had in the past been signed off by the Board on a monthly basis; there was now a requirement to self-assess annually by the NHSI. She reported that the Trust had met its corporate governance requirements, but she recommended reviewing the assurance at the forthcoming Board seminar as there will be NHSI selected audits from July onward to assess compliance across Trusts.

17/87 Board Sub-Committees Terms of Reference

- 92 The terms of reference for all of the Trust Board sub-committees were approved. Anu pointed out however that there were some areas where there was a degree of cross-over between different committees, and it was agreed the sub-committee chairs should meet to discuss this. It was also noted that there was opportunity to raise such issues in year when each set of sub-committee draft minutes were received by the Board.

17/93 Draft Sub-Committee Minutes

Finance & Business Development Committee

93.01 Chair of the Finance & Business Development Committee Tony Rice had left the Board early, but had said there was nothing of significance to add to the written account of the meeting that the Board had received.

93.02 It was noted that Philippa Davies had approved these draft minutes in Anu's absence. They drew attention to a lively debate which had taken place about the Quality Account and how this could best be monitored going forward. The meeting had also received the non-medical education annual report.

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Action Notes Summary

Minute	**Action**	**Date**	**Lead**
LUTs	It was agreed that the LUTs patient group would hold a further meeting with Siobhan Harrington prior to the JOSC Interim message to be issued and LUTs patient group assist with drafting	**Completed Meeting held 4 July** **By end July**	**SMH** **SMH**
79.01	**SIs** - Richard Jennings said that he would like to include a summary of SIs involving surgery to the Board as part of his next quality & safety report	**On forward planner**	**RJ**
79.02	**SIs** - Add ability to track and compare numbers with a rolling pattern and trends	**On forward planner**	**PD**
84.03	**Internal Auditor Annual Opinion** - It was agreed firstly that the draft be circulated more widely – and earlier – in future, and secondly that the Board needed to be made aware of and given the opportunity to discuss the process for sign-off each year.	**On forward planner**	**SB**
86.03	**Junior Doctor Workforce & skill mix** - Pleydell suggested that a series of meetings would be required to discuss future planning and it would be important to look across all professional groups	**Deadline tbc**	**RJ & NF**
86.04	**Junior Doctor Workforce & Skill mix** - Simon noted the Royal College of Physicians 'Small Hospitals Project' and to engage with that work whilst the Trust had a unique opportunity to do so	**On forward planner**	**SMH**
86.05	**NHSI Annual Self-Assessment** - SMH reported the Trust had met its corporate governance requirements, but she recommended reviewing further at the forthcoming Board seminar	**Completed reviewed June Seminar**	**SMH**

ORAL STATEMENT TO WHITTINGTON NHS TRUST BOARD – 7 JUNE 2017

We met with members of the hospital executive, local CCGs and clinicians on 11th April of this year to discuss the ongoing work to bring about the reopening of the clinic which has now been closed to new NHS patients since October 2015. At this meeting, it was noted that:

1. The Professor's contract has been extended so that he may continue working in clinic, currently with existing NHS patients.

   A business proposal including clinical leadership and identifying how the research governance will strengthen the clinical service model was currently underway with the participation of Professor Malone-Lee and other parties internal and external to the Whittington Hospital including UCL, UCLH and the Royal Free. We were assured that a paper would be presented to the June Trust Board about the LUTS clinic and its progress.

2. Mr Pleydell and executives representing other hospital trusts would be reporting to the North London Joint Health and Oversight Steering Committee on June 9th with an interim report as requested by them at their last meeting on 17th March. We have subsequently been advised that, due to the general election, the JHOSC has been postponed until 9th July. Members of our team representing the patient group have been asked to keep the committee updated on progress and will be attending this meeting - as, we understand will Mr Pleydell. We are also updating the significant group of interested MPs and Ministers who are tracking the situation closely.

3. Key messages were to be communicated by the hospital to all parties including patients, that good progress was being made and that the Trust is committed to reopening the LUTS clinic.

In Mr Pleydell's statement to the board today he acknowledges that progress is being made against the clinical leadership issue and research governance strengthened by consultations with UCLH and UCL and we thank them for their efforts in continuing this work. This statement is not however the full report of progress that we were lead to believe would be presented to the trust Board.

We are dismayed to note that the business plan and timeline for opening to new patients that was to be presented to this June meeting is not forthcoming and that the Trust consider there are still remaining issues around clinical governance.

We are also disappointed that there appears to have been yet another desk top review undertaken in May and that the further extension is delaying the treatment of new patients.

We have verbally been assured that the team is working towards potentially reopening to new patients by September this year, and we would like to be assured of the progress towards this date. Unfortunately, the only date mentioned in Mr Pleydell's statement is that of June 2018 when the new consultant will be in place to lead the clinic.

Whilst we welcome this new consultant appointment we request that the board give a clear indication of when the clinic will be reopened to new patients and that these dates will be respected and adhered to.

This is a vulnerable patient group unable to access effective treatment elsewhere and we wish to state once again that the delays in enabling them to access the clinic are wholly unacceptable and cannot be allowed to continue.

We anticipate this lack of progress and a clear statement of intent may trigger significant distress and worry, thus jeopardising the health of many patients.

On Monday of this week, we were advised that Mr Pleydell is stepping down from his role as Chief Executive from September and we would like to thank him for the support he has given to the LUTS clinic, progressing a solution and to patients. We urgently seek reassurances that the necessary and immediate work towards reopening the LUTS clinic will not be delayed during the recruitment and appointment process for a new Chief Executive.

Finally, we thank the Trust board again for their time in allowing us to speak at the meeting and we look forward to working further with the hospital trust, both on any patient communications and at a follow up meeting and at the JHOSC in July. This is a shortened version of a written statement and both have been provided to Lynne Spencer by email and are available in hard copy with us today.

Whittington Health

5 July 2017

Title:	Chief Executive Officer's Report for May 2017		
Agenda item:	**17/098**	**Paper**	**02**
Action requested:	For discussion and information		
Executive Summary:	The purpose of this report is to highlight specific issues to the Trust Board and to update the Board on local, regional and national key issues facing the Trust		
Summary of recommendations:	To note the report		
Fit with WH strategy:	This report provides an update on key issues for Whittington Health's strategic intent		
Reference to related / other documents:	Whittington Health's regulatory framework, strategies and policies		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Risks captured in risk registers and/or Board Assurance Framework		
Date paper completed:	30 June 2017		

Author name and title:		**Lynne Spencer, Director of Communications & Corporate Affairs**		**Director name and title:**		**Simon Pleydell, Chief Executive**	
Date paper seen by EC n/a	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

CHIEF EXECUTIVE OFFICER'S REPORT

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

Annual Awards Ceremony

We were delighted to host an Annual Awards Ceremony for staff last week. This was the first time we had arranged an annual event and it was a tremendous success. We would like to thank everyone involved in organising the evening and especially our celebrity surprise guest Harriet Thorpe who is a star of TV and the West End stage. She has starred in TV shows such as Wicked, Chicago, the Brittas Empire and Absolutely Fabulous. It was a difficult task to choose the winners and below are the nominations and the winners:

Category	Nominations	Winners
Improving Patient Safety	Kerry Wykes, IANDS Children's Occupational Therapy Team, Sepsis Team, Ai-Nee Lim	Kerry Wykes
Research and Innovation	Clinical Leadership and Management Programme, Sheik Pahary, Osinachi Egole, Silvia Ceci	Silvia Ceci
Outstanding Contribution to Education	Pre-Registration Student Nurse Development Team, Celia Bielawski, Ahmed Chekairi, Kerry Wykes, Julie Andrews, Lucy Parker	Julie Andrews
Paula Mattin: Emerging Leader	Alison Kett, Nadine Jeal, Becky Owen, Emma Cox, Catherine Fahey, Sharon Pilditch, Vera Santos	Becky Owen
Improving Patient Experience	Cancer Nursing Team, Colette Datt, Richard Tuitel, Jennifer Wilkins, Catherine McNally, Hasan Rabbani	Hasan Rabbani
Bringing our values to Life	Evi Aresti, Integrated Network Coordination Team, Ali Berquez, North Central London TB Nursing Service, Charlene Brownlie, Orla Hillary, Kam Gunnoo	Charlene Brownlie
Administrator of the Year	Vicky Pantelli, Anne Marie Campbell, Sheila Juste, Maura Barber, Tracy Fowl, Ade Adeboye, Madeline Ioannou	Ade Adeboye
Unsung Hero	Eileen Willis, Robert Kiss, Savio Bellinati, Toby Kent, Beveen Ashley, Samina Bhurtun, Ambulatory Care and ED Porters, Richard Tuitel, Demos Nicolaou	Richard Tuitel
Clinician of the Year	Kay Delaney, Nadine Jeal, Elly Baker, Heidi Edmundson, Clarissa Murdoch, Katie Jeitz, Catherine Fahey	Nadine Jeal
Patient Choice	Professor James Malone-Lee, Elaine Cronin, Jane Laking, Anthony Lerman	Jane Laking
Volunteer of the Year	Theresa O'Dwyer, David Collins, Henry Webb, Derek Eddleston, Brenda Cansick	Theresa O'Dwyer
Team of the Year Community	Children's Hospital @ Home, Improving Access to Psychological Therapies IAPT, Community Dental Team, ICAT Team, Leg Ulcer and Ambulatory Catheter Clinic, South West Islington District Nursing Team	Community Dental Team
Team of the Year Acute	Imaging Team, Emergency Department, Outpatient Team, IFOR Ward, Site Team, Diabetes and Hypertension Specialist Nursing Team, Pioneer Pharmacist Team	Site Team
Chairman's Award	Special award of the Chairman	Sepsis Team

Schwartz Round

A Schwartz Round is a structured forum that provides an opportunity for staff from all disciplines, both clinical and non-clinical, to reflect on the emotional aspects of their work. We have reintroduced these events during recent months and they are proving extremely popular with staff to support our collective learning. We held another successful Schwartz Round this week and will continue throughout 2017/18 to host sessions for both community and hospital service reflections.

MRSA Bacteraemia

We have reported zero cases up to the reporting month of May for hospital acquired MRSA bacteraemia. We will continue to manage our high profile infectious control campaign across the community and hospital to aim for zero reported cases in 2017/18.

Clostridium Difficile

We have reported 5 cases of Clostridium Difficile up to the end of May; 2 in April and 3 in May. The target is for no more than 17 cases this year.

Cancer Waiting Time Targets

We were pleased to have exceeded all our cancer targets for April; reported in arrears in line with the national cancer data validation process.

- 31 days to first treatment 100% against target of 96%
- 31 days to subsequent treatment (surgery)100% against target of 98%
- 31 days to subsequent treatment (drugs)100% against a target of 93%
- 62 days from referral to treatment 85.4% against a target of 85%
- 14 days cancer to be first seen 93% against a target of 93%
- 14 days to be first seen for breast symptomatic 96% against a target of 93%

Community Access Targets

We are pleased that our Improving Access to Psychological Therapies (IAPT) targets continue to improve and for the month of April we recorded:

- 869 referrals received (200 higher than average)
- 596 entered treatment (159 above target, 101 above for the year)
- 52.99% recovered (and 66.93% had a reliable improvement)
- Average waiting time of 15 days (down from 18 days in April)
- 96% seen within 6 weeks and 100% seen within 18 weeks
- 97% satisfied with overall experience

STRATEGIC

Pharmacy

We are planning to open our new pharmacy this month and are pleased that this important development will enable the expansion of the pharmacy service so that we will provide a larger range of stock of over the counter medicines.

We would like to thank everyone involved for their tremendous hard work in managing the transition and our patients for their patience throughout the minor disruption to the service. This new service will greatly assist our patients to access medicines to support their treatment, care and recovery.

Open Day 16 September

We will be hosting a special open day at our hospital on Saturday 16 September. The event will be a fantastic opportunity for our local community to find out more about what we do, including tours of our operating theatre, health promotion and information stalls with expert advice from our staff and special performances from local artists and choirs. We will be joined by our colleagues from the London Fire Brigade and Ambulance Service as part of the celebration of the work that all staff do to support our communities.

OPERATIONAL

Sexual Health Services transferred to CNWL

Haringey Sexual Health Services have changed provider as part of a London-wide drive to improve quality and access to services. Central and North West London NHS Foundation Trust (CNWL) started to provide 2 different services on 3 July for Haringey residents. Young people (under 25) contraception and sexually transmitted infection screening is now provided at community clinics located in the borough. These clinics also support women with family planning services. Those aged over 25 now access services in Camden and Islington at Mortimer Market Centre and Archway. Both clinics have modern, up-to-date state of the art facilities.

Finsbury Park Mosque

We received patients from the recent Finsbury park incident and are proud of our staff and other emergency service colleagues for their professionalism and dedication in caring for patients during such difficult times.

As a thank you to NHS and other public service staff the Mayor of London, as part of the his Healthy London Partnership, has provided free tickets for London's emergency service heroes for 2 separate sporting events; the much publicised IPC World Para Athletics Championships and a brand new indoor 6-a-side football tournament at the O2 later this month. There will be a galaxy of stars at this event including Gerrard, Owen, Ferdinand, Pires, Ballack, Deco, Puyol, Roberto Carlos, Rivaldo and Del Piero.

Support for Staff

We have offered special support drop-in sessions for staff who have you been affected by the recent events in London (Grenfell Tower, London Bridge, Finsbury Park Mosque or other tragic events). We recognise we all need comfort and support during times of such distress and we are working with our occupational health team, supported by trained counsellors. Our condolences, thoughts and prayers remain with all those affected.

Emergency Department

Performance against the 95% target continued improved during May despite facing continued demand and increased attendances *(in excess of 310 against an average of 260)* on a number of days over May. The improvements we are making reflect the implementation of continued changes within ED and across the hospital.

We achieved our trajectory of 93.5% for May which has been agreed to support the attainment of 95% performance by July 2017.

We are confident that our focus on the emergency care pathway across the hospital and community will ensure we meet our target of 95% for the reporting year of 2017/18 and most importantly will ensure our patients receive continued high quality and timely care.

WORKFORCE

Support for Staff

We have offered special support drop-in sessions for staff who have you been affected by the recent events in London (Grenfell Tower, London Bridge, Finsbury Park Mosque or other tragic events).

We recognise that our staff need comfort and support during times of such distress and we are working closely with our occupational health team who are supported by professionally trained counsellors. Our condolences, thoughts and prayers remain with all those affected by the tragic events that have occurred in London over the past months.

British 10k Run

We have 46 runners for this Sunday's (9 July) major fundraising event for our Trust. This is fantastic news for our charity and this is a record number of participants taking part this year.

Thank you to staff who have been training for the event and working so hard to ensure their fitness levels are up to the challenge. The route will take place in some of London's most iconic sights from Piccadilly to Westminster. We have invited everyone to come along and cheer on our staff and there is still time to sponsor the runners to support our charity at http://www.whittington.nhs.uk/default.asp?c=20859.

FINANCE MONTH 2 (April and May 2017)

We are reporting a £0.6m deficit at the end of May (month 2) against a planned deficit of £0.4m in line with our annual planning submission to NHSI. This means we are off plan by £0.2m up to the end of May and year to date by £0.6m. The reason for this is the performance against income with £0.5m off plan in May and £1m year to date.

Expenditure run rates continue to remain in line with those reported at the end of 2016/17 and for April, although further actions are required in relation to our cost improvement programme as this is behind plan with schemes not delivering as originally planned.

We are significantly under plan for NHS clinical income, with outpatients improved compared to April, but remaining £141k off plan in May and £305k year to date off plan. The largest under-performance was reported in paediatrics, general surgery and dermatology. Day cases under-performed by £130k in May and remained off plan by £150k year to date. This mainly relates to urology, which is offset by an increase in urology outpatient procedures.

Total pay expenditure for May was £18.5m, slightly higher than the previous three months and our 12 months rolling average (£18.4m). Within total pay expenditure, agency staff costs were £0.9m. This is 5% of our May pay bill and is a reduction compared to April and

the average of the previous 12 months. Whilst overall there has been a reduction, children and young people the corporate teams and Integrated Clinical Service Unit for surgery had an increase in agency costs compared to April.

Reducing the cost of agency remains a top priority and all teams are in the process of agreeing improvement trajectories to ensure we meet the national capped rate.

Non pay expenditure for May was £6.3m, in line with the previous 12 months and slightly lower than April. The enhanced measures introduced in the final quarter of 2016/17 continue to have a positive effect in reducing and maintaining expenditure levels and these will remain in place to ensure a strong focus on the management of our finances to ensure we meet our challenging targets.

Simon Pleydell
Chief Executive

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

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health

July 2017

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	**17/099**	**Paper**	**03**
Action requested:	For Information		
Executive Summary:	This report provides an overview of serious incidents (SI) submitted externally via StEIS (Strategic Executive Information System) as of the end of May 2017. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.		
Summary of recommendations:	None		
Fit with WH strategy:	1. Integrated care 2. Efficient and Effective care 3. Culture of Innovation and Improvement		
Reference to related / other documents:	• Supporting evidence towards CQC fundamental standards (12) (13) (17) (20). • Ensuring that health service bodies are open and transparent with the relevant person/s. • NHS England National Framework for Reporting and Learning from Serious Incidents Requiring Investigation, • Whittington Health Serious Incident Policy. • Health and Safety Executive RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013).		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	**Corporate Risk 636.** Create a robust SI learning process across the Trust. Trust Intranet page has been updated with key learning points following recent SIs and RCA investigations.		
Date paper completed:	13-06-2017		

Author name and title:		**Jayne Osborne, Quality Assurance Officer and SI Co-ordinator**		**Director name and title:**		**Philippa Davies, Chief Nurse and Director of Patient Experience**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Serious Incident Monthly Report

1. Introduction

This report provides an overview of serious incidents submitted externally via StEIS (Strategic Executive Information System) as of the end of May 2017. This includes serious incident reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.

2. Background

The Serious Incident Executive Approval Group (SIEAG), comprising the Executive Medical Director/Associate Medical Director, Chief Nurse and Director of Patient Experience, Chief Operating Officer, Head of Governance and Risk and SI Coordinator meet weekly to review Serious Incident investigation reports. In addition, high risk incidents are reviewed by the panel to determine whether these meet the reporting threshold of a serious incident (as described within the NHSE Serious Incident Framework, March 2015).

3. Serious Incidents

3.1 The Trust declared 4 serious incidents during May 2017, bringing the total of reportable serious incidents to 6 since 1st April 2017. One incident (2017.12338), relating to an unexpected admission to NICU has been referred to the NELCSU for a de-escalation as further investigation found trust processes had been followed appropriately and there was no harm to the baby. The incident therefore does not meet the criteria for an SI.

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

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

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

Category	Month Declared	Summary
Delayed Diagnosis Ref:2722 Submitted 9/6/2017	Jan 17	A delay in diagnosing a perforation of the gastrointestinal tract.
Treatment Delay Ref: 4095 Submitted 7/6/2017	Feb 17	Patient was discharged home following planned surgery, and later presented to a neighbouring hospital with a CVA.
Unexpected Death- Influenza Ref: 4856	Feb 17	Patient was admitted and treated for community acquired pneumonia.
Treatment Delay Ref:7557	Mar 17	Unexpected patient death following an elective procedure.
Sub optimal Care of deteriorating patient Ref:7662	Mar 17	Patient death following emergency surgery

Category	Month Declared	Summary
Treatment Delay Ref: 9668.	Apr 17	Patient referral letters were not received resulting in a delay of treatment. *De-escalation request has been made, Trust awaiting outcome.*
Unexpected Death Ref:9728	Apr 17	Patient was admitted for an urgent surgical intervention and subsequently had a cardiac arrest and died.
Treatment Delay Ref: 2017.11957	May 17	A delay in a patient receiving their medication (antibiotics) in the District Nursing service.
Patient Fall Ref: 2017.12014	May 17	Patient had an unwitnessed fall in the toilet resulting in a non-displaced impacted medial tibial plateau fracture.
Ref: Delayed Diagnosis Ref: 2017.12022	May 17	A delay in diagnosing an adenocarcinoma.
Unexpected admission to NICU 2017.12338	May 17	Baby admitted to NICU, after category two caesarean section, to be assessed for intubation. Signs of sepsis were evident and baby and mother were treated appropriately. *A de-escalation has been requested for this incident*.

3.3 **The table below detail serious incidents by category reported to the NEL CSU between April 2016 – March 2017.**

STEIS 2016-17 Category	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Safeguarding	0	1	1	0	1	0	1	0	0	0	1	0	5
Attempted self-harm	0	0	0	0	0	0	0	1	0	0	0	0	1
Confidential information leak/loss/Information governance breach	1	2	1	0	1	1	0	0	0	0	0	0	6
Diagnostic Incident including delay	2	1	0	0	0	1	1	1	0	1	1	0	8
Failure to source a tier 4 bed for a child	0	0	0	1	0	0	0	0	0	0	0	0	1
Failure to meet expected target (12 hr trolley breach)	0	0	0	0	0	0	1	0	0	0	0	0	1
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	1	1	1	0	0	2	1	0	0	0	0	1	7
Maternity/Obstetric incident mother only	0	0	0	0	1	0	1	0	0	0	0	0	2
Medical disposables incident meeting SI criteria	0	0	0	0	0	0	1	0	0	0	0	0	1
Nasogastric tube	0	0	0	0	0	0	1	0	0	0	0	0	1
Slip/Trips/Falls	0	0	0	1	0	0	0	0	2	3	0	1	7
Sub optimal Care	0	0	0	0	0	0	1	1	0	0	1	1	4
Treatment Delay	0	0	0	0	0	0	1	0	0	0	1	1	3
Unexpected death	0	1	0	1	0	1	0	5	1	0	1	0	10
Retained foreign object	0	0	0	0	0	1	0	0	0	0	0	0	1
Total	4	6	3	3	3	6	9	**8**	**3**	**4**	**5**	**4**	**58**

3.4 The table below detail serious incidents by category reported to the NEL CSU between April 2016 – May 2017

The Trust reported 4 serious incidents during May 2017.

STEIS 2016-17 Category	2016/17 Total		April 2017	May 2017	Total 17/18ytd
Safeguarding	5		0	0	0
Attempted self-harm	1		0	0	0
Confidential information leak/loss/Information governance breach	6		0	0	0
Diagnostic Incident including delay	8		0	1	1
Failure to source a tier 4 bed for a child	1		0	0	0
Failure to meet expected target (12 hr trolley breach)	1		0	0	0
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	7		0	1	1
Maternity/Obstetric incident mother only	2		0	0	0
Medical disposables incident meeting SI criteria	1		0	0	0
Nasogastric tube	1		0	0	0
Slip/Trips/Falls	7		0	1	1
Sub optimal Care	4		0	0	0
Treatment Delay	3		1	1	2
Unexpected death	10		1	0	1
Retained foreign object	1		0	0	0
Total	**58**		**2**	**4**	**6**

4.0 Submission of SI reports

All final investigation reports are reviewed at the weekly SIEAG meeting chaired by an Executive Director (Trust Medical Director or Chief Nurse and Director of Patient Experience). The Integrated Clinical Support Unit's (ICSU) Operational Directors or their deputies are required to attend each meeting when an investigation from their services is being presented.

The remit of this meeting is to scrutinise the investigation and its findings to ensure that contributory factors have been fully explored, root causes identified and that actions are aligned with the recommendations. The panel discuss lessons learnt and the appropriate action to take to prevent future harm.

On completion of the report the patient and/or relevant family member receive a final outcome letter highlighting the key findings of the investigation, lessons learnt and the actions taken and planned to improve services. A 'being open' meeting is offered in line with duty of candour recommendations.

The Trust has executed its duties under the Duty of Candour for the investigations completed and submitted during May 2017.

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

4.1 **The Trust submitted 4 reports to NELCSU during May 2017.**

The table below provides a brief summary of lessons learnt and actions put in place relating to a selection of the serious incident investigation report submitted in May 2017.

Summary	Actions taken as result of lessons learnt include;
Patient Fall (ward 3) • **Ref: 2017.2706**	Patient had an unwitnessed fall resulting in subdural haematoma. • All nursing staff in ED, and on wards have been reminded of the importance of accurate completion of the falls risk assessments and care plans on admission and on ward transfer • Falls training is being added to the Mandatory training programme and will be run daily in a rolling session during our Falls awareness week in June 2017. • The transfer checklist has been updated to incorporate falls risks and is used for ward to ward handover. • We are piloting a new MDT approach to maintaining patient safety at all times, especially for those identified as being at high risk of falls called 'Baywatch'. The initiative ensures that if the named nurse needs to leave the bay unattended at any point another MDT member of staff will be asked to be in the bay and on 'Baywatch' until the named nurse returns.
Sub optimal care of deteriorating patient • **Ref: 2017.4094**	Patient was admitted with exacerbation of Chronic Obstructive Pulmonary Disease (COPD). • Early senior review of all unstable patients is essential, this is being reinforced with all clinical staff and included in our staff induction and training programme. • The introduction of post arrest debriefs with the cardiac arrest teams will be undertaken and include the provision of rapid refresher training to staff.
Delayed Diagnosis • **Ref: 2017.5501**	Delay in follow up CT scan and subsequent diagnosis. • The development of clear guidelines for the arrangement of clinic follow up appointments and imaging follow up referrals post in-patient discharge • The imaging department are continuing to work towards the implementation of a full paperless system. A project is currently underway to find a paperless solution to the non-interfacing IT systems. • The imaging department are currently compiling a business case to secure funding for additional resourse to ensure that regular data checks can be carried out reliably • Retrospective data quality checks have been undertaken to ensure there are no patients awaiting imaging tests outside of expected timescales. .

5. Sharing Learning

In order to ensure learning is shared widely across the organisation, a dedicated site has been created on the Trust intranet detailing a range of patient safety case studies.

6. Summary

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

Whittington Health NHS

Executive Offices

Direct Line: 020 7288 3939/5959

www.whittington.nhs.uk

The Whittington Hospital NHS Trust

Magdala Avenue, London

N19 5NF

Whittington Health Trust Board

July 2017

Title:	Safe Staffing - Nursing and Midwifery – May data		
Agenda item:	**17/100**	**Paper**	**04**
Action requested:	For information		
Executive Summary:	This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in May 2017. The key issues to note are: 1. An increased fill rate for Registered Nurse shifts displayed in the UNIFY report 2. Decreased shift requests to provide enhanced care to support vulnerable patients May (35) vs April (179) 3. No shifts staffed at red were reported in April 4. The number of RMN used to provide enhanced care for patients with a mental health conditions was lower in May (5) compared to April (31) 5. CHPPD measure during the month was increased to (9.05) in May compared to (8.84) on April 6. The continued use of agency and bank staff to support safe staffing 7. There were no Datix reports in May highlighting staffing as an issue which were defined as 'Patient Harm'		
Summary of recommendations:	Trust Board members are asked to note the May UNIFY return position and processes in place to ensure safe staffing levels in the organisation. Unify is the online collection system used for collating, sharing and reporting NHS and social care data.		
Fit with WH strategy:	Efficient and effective care; Francis Report recommendations Cummings recommendations; NICE recommendations.		
Reference to related / other documents:			
Reference to areas of risk and corporate risks on the Board Assurance Framework:	3.4 Staffing ratios versus good practice standards		
Date paper completed:	June 2017		

Author name and title:		**Sandra Harding-Brown** **Clinical Workforce Systems Lead (Healthroster)**		**Director name and title:**		**Philippa Davies – Director of Nursing and Patient Experience**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Risk assessment undertaken?**		**Legal advice received?**	

Ward Staffing Levels – Nursing and Midwifery

1.0 Purpose

1.1 To provide the Trust Board with assurance in regard to the management of safe nursing and midwifery staffing levels for the month of May 2017.

1.2 To provide context for the Trust Board on the UNIFY safe staffing submission for the month of May 2017.

1.3 To provide assurance of the constant review of nursing/midwifery resource using Healthroster.

2.0 Background

2.1 Whittington Health is committed to ensuring that levels of nursing staff, which include Registered Nurses (RNs), Registered Midwives (RMs) and Health Care Assistants (HCAs), match the acuity and dependency needs of patients within clinical ward areas in the hospital. This includes an appropriate level of skill mix of nursing staff to provide safe and effective care.

2.2 Staffing levels are viewed alongside reported outcome measures, patient acuity, registered nurse to patient ratios, percentage skill mix, ratio of registered nurses to HCAs and the number of staff per shift required to provide safe and effective patient care.

2.3 The electronic HealthRoster (Allocate) with its 'SafeCare' module is utilised across all inpatient wards. The data extracted provides information relating to the dependency and acuity of patients. This, in addition to professional judgement is used to manage ward staffing levels on a number of occasions on a daily basis.

2.4 Care Hours per Patient Day (CHPPD) is an additional parameter to manage the safe level of care provided to all inpatients. This measure uses patient count on each ward at midnight (23.59hrs). CHPPD is calculated using the actual hours worked (split by registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight (for March data by ward please see Appendix 1).

2.3 Staff fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st to 31st May 2017 for Whittington Hospital has been uploaded and submitted on UNIFY, the online collection system used for collating, sharing and reporting NHS and social care data. Patients and the public are able to see how hospitals are performing on this indicator on the NHS Choices website.

2.4 Summary of Staffing Parameters

Standard	Measure	Summary
Patient safety is delivered though consistent, appropriate staffing levels for the service.	Unify RN fill rate	Day – 87.1% Night – 93.7%
	Care hours per Patient Day - CHPPD	Overall the CHPPD for May was 9.05 which is lower than last month, the RN delivered care continues to be consistent
Staff are supported in their decision making by effective reporting.	No Red triggered shifts	No shifts triggered 'Red' in May 2017

3.0 Fill rate indicator return

3.1 The 'actual' number of staffing hours planned is taken directly from our nurse roster system (Allocate). On occasions when there was a deficit in 'planned' hours versus 'actual' hours, and additional staff were required, staff were reallocated to ensure safe staffing levels across our organisation. Staff are also reallocated to ensure wards/areas are staffed to a safe ratio of permanent to temporary staff.

3.2 Appendix 1 details a summary of 'actual' versus 'planned' fill rates. The average fill rate was 87.1% for registered staff and 121.2% for care staff during the day and 93.7% for registered staff and 124.1% for care staff during the night.

3.3 On the day shift, seventeen occurrences reported below 90% fill rates for qualified nurses. Twenty two occurrences with above 100% fill rate for unqualified nurse and ten occurrences with above 100% fill rate for qualified nurses.

3.4 The UNIFY report shows some wards with unusually high percentage fill rates; for example, Mary Seacole North and South (Acute Admissions Unit) at above 200% for HCAs. In these areas Band 4 Assistant Practitioners (HCA) have been appointed to skill mix and replace RNs on the wards. Where the percentages are low for RNs they are correspondingly high for HCAs and vice versa. This is a professional decision which is taken by the Matron and Head of Nursing depending on the needs of the specific patient group.

It must be remembered if the establishment of the ward for HCAs is 1 wte and two staff work then this represents a 100% increase.

Day		Night	
Average fill rate registered Nurses /Midwives	Average fill rate Care Staff	Average fill rate registered Nurses/Midwives	Average fill rate Care Staff
87.1%	**121.2%**	**93.7%**	**124.1%**

4.0 Additional Staff to provide 1:1 enhanced care

4.1 When comparing April's total requirement for one to one staffing staff to provide enhanced care with the previous month, there is an increase in the number of shifts required (Appendix 2). In May there were 35 requests for 1:1 enhanced care provision compared to 179 requests in April. The requests made for this level of care were to ensure the safe management of particularly vulnerable groups of patients.

4.2 The number of Registered Mental Health (RMN) nurses booked for shifts to provide enhanced care for patients with a mental health condition was lower in May (5) compared to April (31). All requests for RMNs are validated by the Heads of Nursing and a clinical assessment made as to the therapeutic need. These requests may then be downgraded to provide an HCA rather than an RMN.

4.2 There continues to be a high level of need for provision of enhanced care for patients with mental health conditions and for caring for patients who require constant supervision to prevent falls.

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

5.1 Safe staffing levels are reviewed and managed three times daily. At the daily 08.30am bed meeting, the Deputy Chief Nurse and Heads of Nursing in conjunction with matrons, site managers and other senior staff review all registered and unregistered workforce numbers by ward. Consideration is given to bed capacity and operational activity within the hospital which may impact on safe staffing. Actions are agreed to ensure all areas are made safe. Matrons and Heads of Nursing review staffing levels again at 13.00 and 17.00 to ensure levels remain safe.

5.2 Ward shifts are rated 'red' 'amber' or 'green' according to numbers of staff on duty, taking into account patient numbers, acuity and dependency.

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

- Amber shifts are determined to be at a minimum safe level and are managed in conjunction with patient dependency and acuity. The matron will be alerted, and take appropriate action. Staff will prioritise their work and adjust their workload through the shift accordingly, with a continual review of any changes to the acuity and dependency of patients.

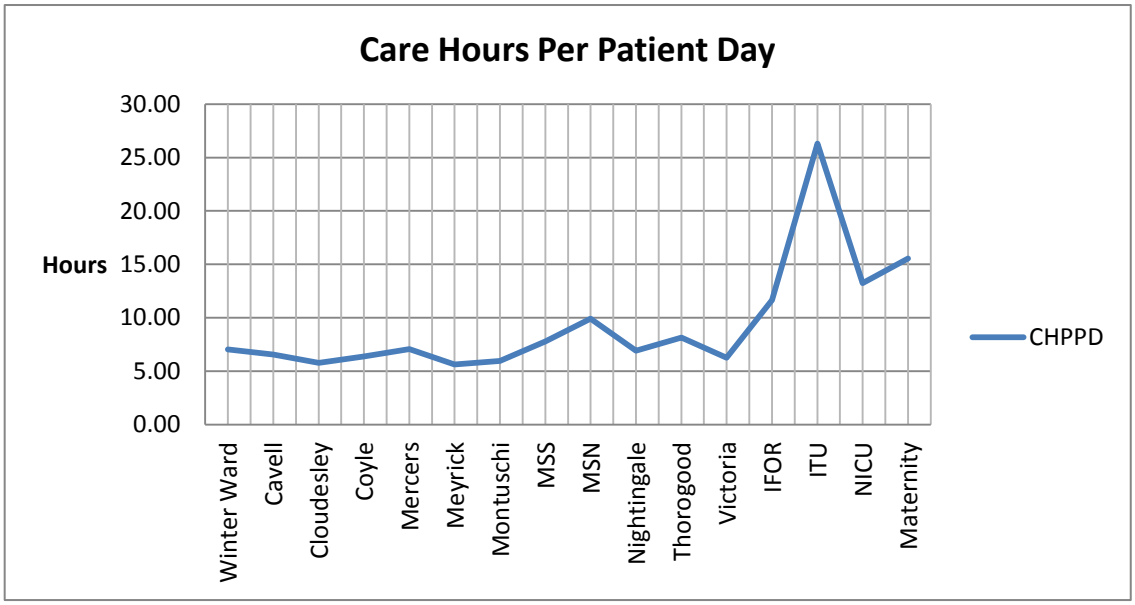
- Red shifts are determined to be at an unsafe level. Mitigating actions will be taken, and documented, which may include the movement of staff from another ward and utilisation of supernumerary staff within the numbers or reducing the number of patients on the ward to match the staff availability.

6.0 Reported Incidents of Reduced Staffing (Datix Reports)

6.1 Staff are encouraged to report, using the Datix system, any incident they believe may affect safe patient care. During April there were 25 Datix reports submitted relating to staffing, none of these incidences related to injury, harm or adverse outcome.

7.0 Care Hours per Patient Day (CHPPD)

7.1 Care hours per patient day is calculated using the patient count on each ward at midnight (23.59hrs). CHPPD is calculated taking the actual hours worked (split by registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight. The graph below shows the average individual care hours per patient for each clinical area. ITU have the most care hours (26.32) and Meyrick ward have the least (5.63).



7.2 The average number of hours of Registered Nurse time spent with patients was calculated at 6.38 hours and 2.67 hours for care staff. This provides an overall average of 9.05 hours of care per patient day.

	CHPPD
Registered Nurse	**6.38**
Care Staff	**2.67**
Overall hours	**9.05**

7.3 The total care hours per patient day is one of the metrics used on a daily basis by the Senior Nursing Team to monitor the level of nursing hours required to delivery care on our inpatient wards.

7.4 The new SaferCare module of the Healthroster system provides an estimate of the total time required to provide the necessary care using the acuity and dependency of patients and calculates the available nursing time.

7.5 The data from CHPPD indicates the total amount of care hours delivered to patients over the last four months has remained similar. Each ward maintained a high level of care delivery when comparing the total registered nurses hours available.

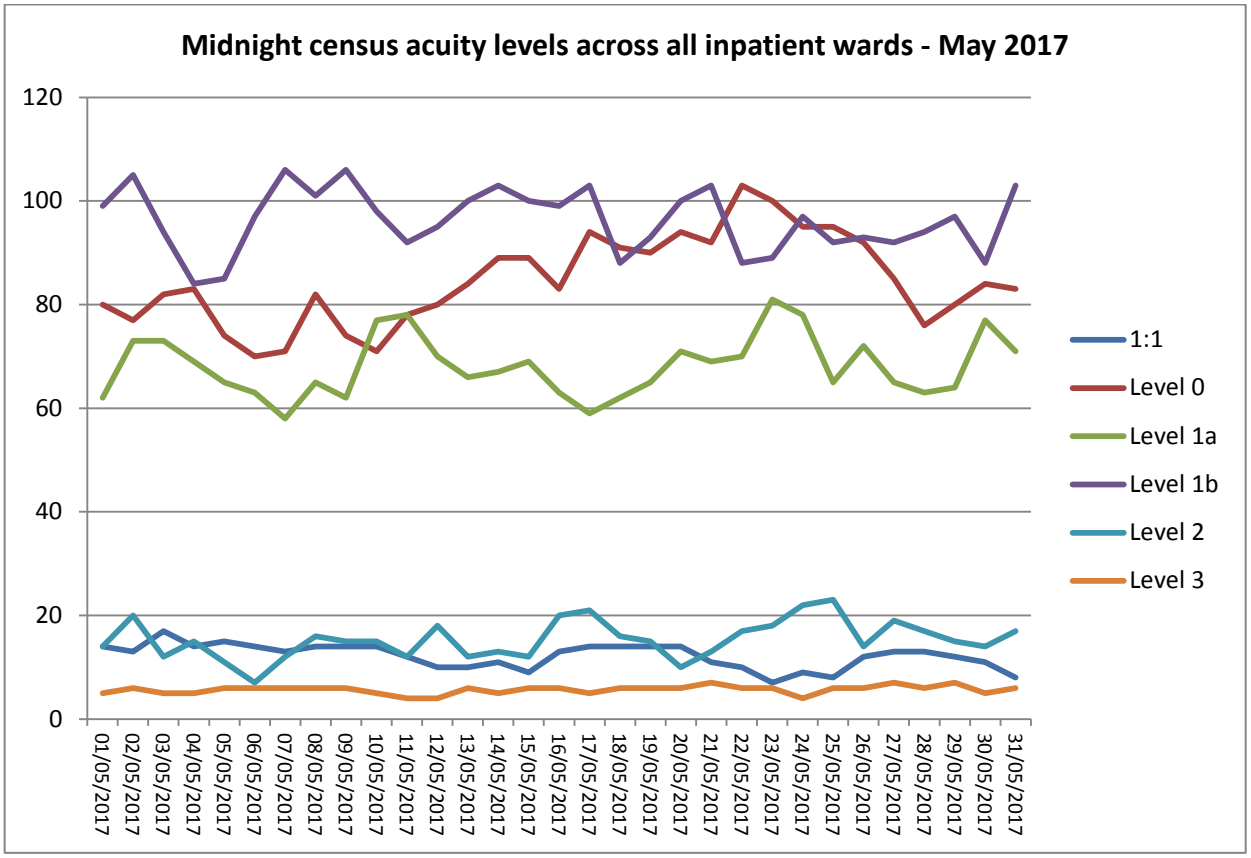
7.6 The table below shows the CHPPD hours for each in patient ward over the last four months and indicates the level of need remained stable overall. There is a slight increase in hours of care delivered in April compared to March.

Ward Name	May	April	March	Feb
Bridges				
Winter Ward	7.03	6.97	6.05	5.97
Cavell rehab ward	6.55	6.55	6.55	6.70
Cloudesley	5.77	5.57	5.68	5.59
Coyle	6.38	5.78	5.82	6.04
Mercers	7.07	6.90	6.72	6.54
Meyrick	5.63	6.19	6.05	5.82
Montuschi	5.94	5.99	5.16	5.94
MSS	7.79	7.76	7.79	7.02
MSN	9.90	10.43	9.32	9.17
Nightingale	6.91	6.84	6.63	6.02
Thorogood	8.14	9.66	10.36	7.93
Victoria	6.26	6.18	6.17	6.03
IFOR	11.65	11.88	12.45	12.97
ITU	26.32	25.87	26.31	25.36
NICU	13.25	10.77	11.70	11.33
Maternity	15.56	16.00	15.84	13.84
Total	9.05	8.84	8.78	8.46

8.0 Patient Acuity

8.1 The acuity of patients is dependent on their care requirements. Those patients requiring a low level of care are assigned level 0 and those requiring intensive care are assigned level 3. The trust is experiencing a high number of patients with levels of acuity at level 1b. This level indicates that a patient is requiring a high level of nursing support. Many patients required total support with their activities of daily living which would include washing, toileting and feeding. These patients require two staff to care for their daily needs.

8.2 The graph below demonstrates the level of acuity across inpatient wards at Midnight in May. As expected, there are a low number of level 3 patients and a high number of level 0 patients. The number of level 1b patients remains high. This increased number of dependant patients requires a greater nursing support.



9.0 Temporary Staff Utilisation

9.1 Temporary staff utilisation (nursing and midwifery) is monitored daily by the Deputy Chief Nurse. All requests for temporary staff (agency) are reviewed by the Head of Nursing/Midwifery. A further review and final authorisation is then made by the Deputy Chief Nurse.

9.2 Monitoring the request for temporary staff in this way serves two purposes:

a) The system in place allows for the most appropriate use of high cost temporary agency staff across the organisation and provides a positive challenge mechanism for all requests.

b) The process allows for an overview of the total number of temporary staff (agency) used in different clinical ward areas and provides a monitoring mechanism for the delivery of safe quality care.

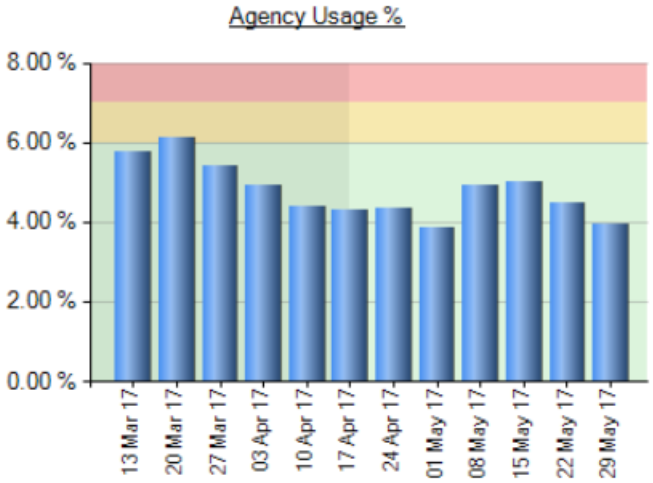
10.0 Agency Usage Inpatient Wards (month ending May)

10.1 The utilisation of agency staff across all inpatient wards is monitored using the Healthroster system. The bar chart below graphically represents total usage of agency staff on inpatient wards month ending May (this is cumulative data captured from roster performance reports).

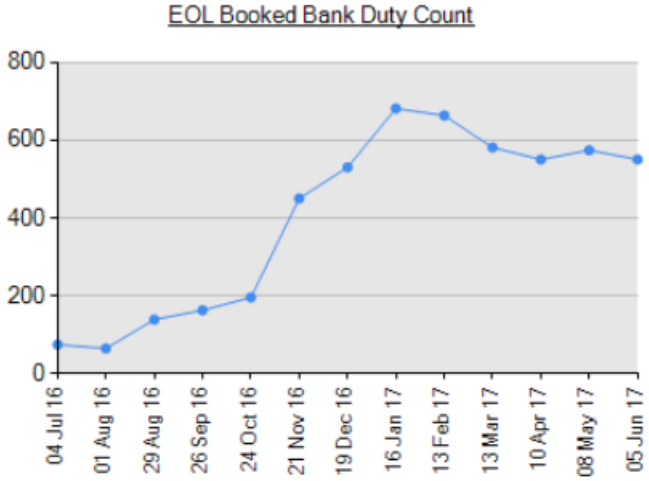
10.2 A key performance indicator (KPI) of less than 6% agency usage (agency shifts compared to total shifts assigned) was set to coincide with the NHS England agency cap. The percentage continues to fluctuate close to the agreed 5% target, less that the agreed KPI

The increase in Agency usage during May relates to the opening of additional in-patient

beds.

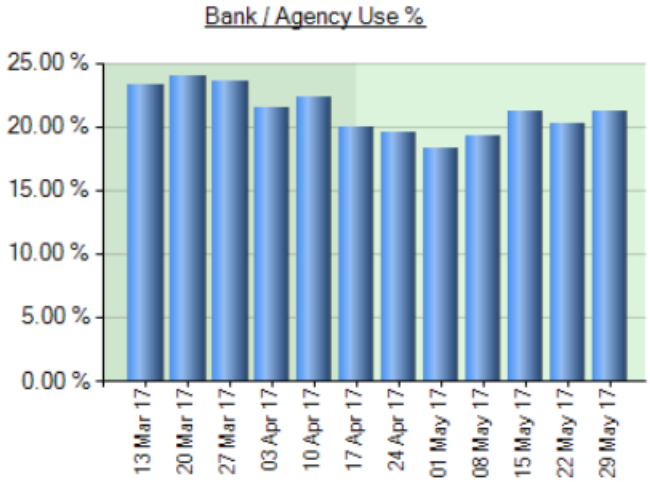


Bank staff continue to book themselves directly into shifts and this is improving over time. This is however reliant on the wards making these shifts available with sufficient notice.



10.3 Temporary staff usage across the inpatient wards fluctuates depending on nurse vacancies and the need to provide additional support for 1:1 care or additional beds.

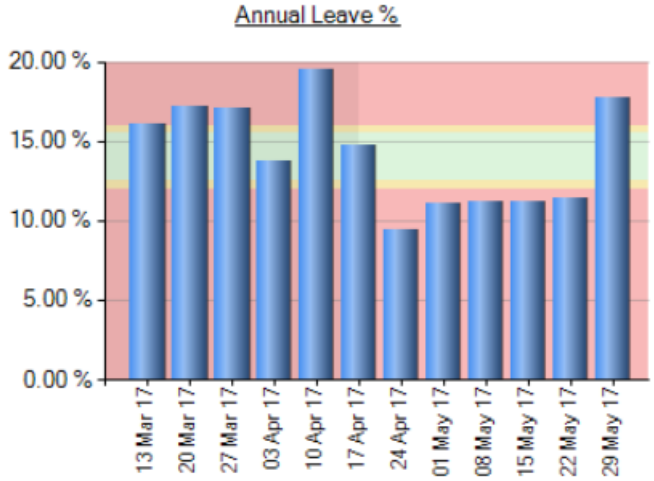
10.4 Temporary staffing usage (Bank and Agency) across inpatients wards remains high and fluctuates between 20 – 24%. Recruitment to reduce the current vacant posts is ongoing.



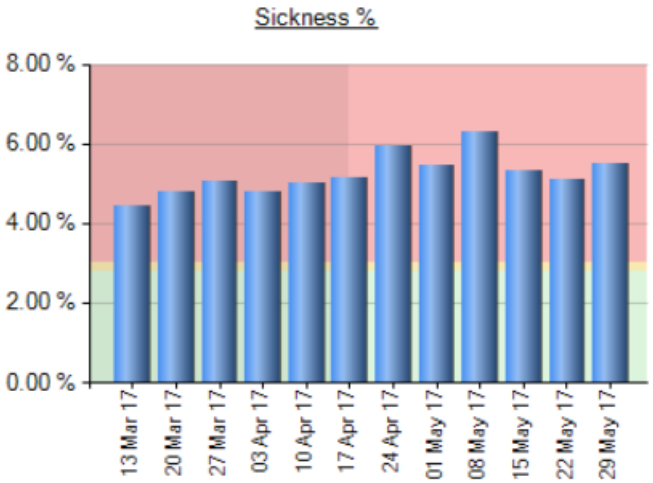
11.0 Managing Staff Resource

11.1 Annual leave taken from April to date varied over the month spanning the set tolerances of 14 -16%. These tolerance levels ensure all staff are allocated leave appropriately and an even distribution of staff are available throughout the year.

11.2 Heads of Nursing are aware of the need to remind staff to request and take holiday. This was monitored closely over the last couple of months to ensure sufficient staff take annual leave in a more consistent way by year end. The action for 2017/18 will be to monitor this more proactively



11.3 Sick leave reported in April was above the set parameter of less than 3%. Heads of Nursing ensure all individuals reporting back from sick leave undergo a sickness review. Work is underway with the HR Business Partners to review the sickness more regularly.



12.0 Conclusion

12.1 Trust Board members are asked to note the work currently being undertaken to proactively manage the nursing/midwifery resource across the ICO and the May UNIFY return position

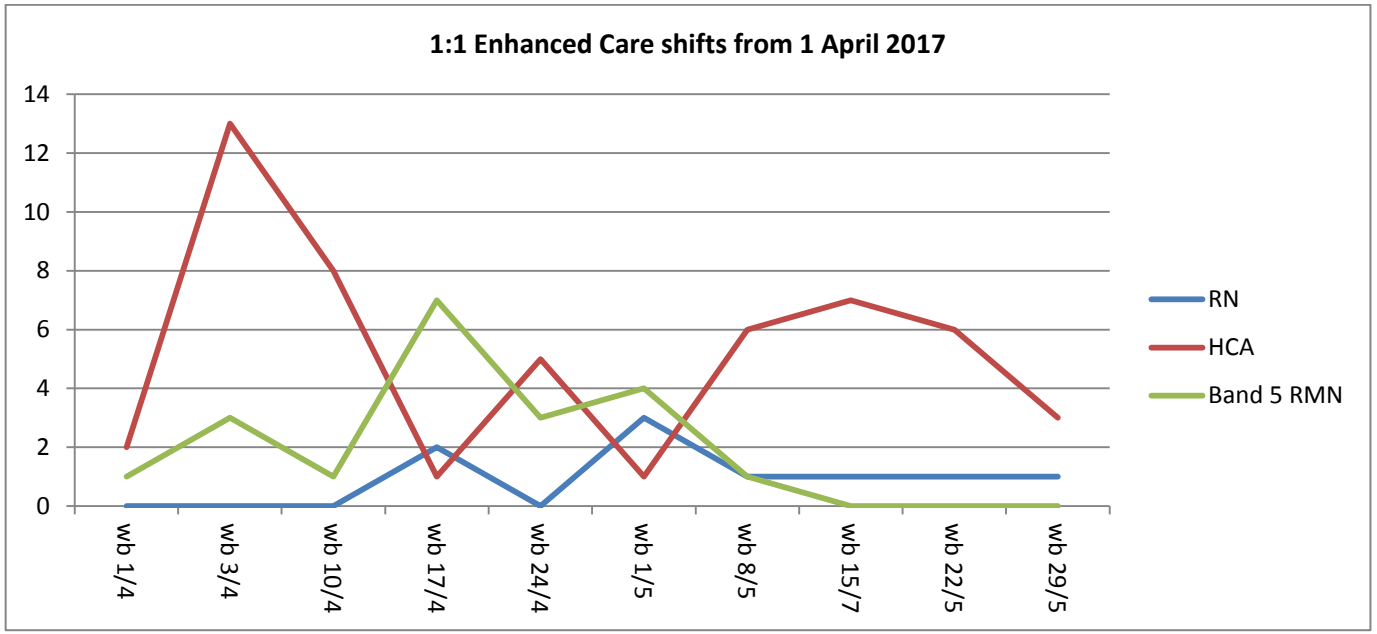
Updated tables

Fill rate data - summary
May 2017

Day				Night				Average fill rate data- Day		Average fill rate data- Night	
Registered nurses/ midwives		Care staff		Registered nurses/ midwives		Care staff		Registered nurses/ midwives	Care staff	Registered nurses/ midwives	Care staff
Planned (hrs)	Actual (hrs)	Planned (hrs)	Actual (hrs)	Planned (hrs)	Actual (hrs)	Planned (hrs)	Actual (hrs)				
33961	**29570**	**10964**	**13293**	**27958**	**26191**	**8073**	**10021**	**87.1%**	**121.2%**	**93.7%**	**124.1%**

Care Hours per Patient Day
May 2017

Total Patients at Midnight/Month	CHPPD Registered staff	CHPPD Unregistered staff	Average CHPPD (all staff)
8742	**6.38**	**2.67**	**9.05**


1:1 Enhanced Care shifts from 1 April 2017
14
12
10
8
6
4
2
0
wb 1/4
wb 3/4
wb 10/4
wb 17/4
wb 24/4
wb 1/5
wb 8/5
wb 15/7
wb 22/5
wb 29/5
RN
HCA
Band 5 RMN

Appendix 3

Average fill rate for Registered and Unregistered staff day and night

	Day		Night	
	Nurses	**Care Staff**	**Nurses**	**Care Staff**
Ward Name	**%**	**%**	**%**	
Winter Ward	**70.0%**	**133.9%**	**89.2%**	**125.7%**
Cavell	**92.8%**	**103.3%**	**101.2%**	**102.6%**
Cloudesley	**88.9%**	**112.6%**	**112.1%**	**120.1%**
Coyle	**89.2%**	**133.7%**	**97.5%**	**155.9%**
Mercers	**86.6%**	**104.6%**	**101.1%**	**105.9%**
Meyrick	**82.1%**	**131.2%**	**113.3%**	**117.6%**
Montuschi	**80.5%**	**198.6%**	**113.1%**	
MSS	**58.4%**	**239.3%**	**76.1%**	**208.1%**
MSN	**74.4%**	**139.9%**	**90.0%**	**273.9%**
Nightingale	**110.5%**	**109.9%**	**101.2%**	**110.0%**
Thorogood	**101.3%**	**95.4%**	**102.0%**	
Victoria	**66.4%**	**38.9%**	**57.1%**	**52.3%**
IFOR	**87.7%**	**100.0%**	**89.4%**	**100.0%**
ITU	**100.0%**		**100.0%**	
NICU	**74.9%**		**77.3%**	
Maternity	**102.4%**	**156.6%**	**99.4%**	**131.7%**
Total	**86.3%**	**116.8%**	**92.3%**	**121.7%**

Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board

5 July 2017

Title:	May (Month 2) 2017/18 – Financial Performance		
Agenda item:	**17/101**	**Paper**	**05**
Action requested:	To agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends.		
Executive Summary:	The Trust reported a £0.6m deficit for May (month 2) against a planned deficit of £0.4m, per the Trust's annual planning submission to NHSI. Actual performance therefore represents an adverse variance of £0.2m in month. The key driver for the adverse variance is the performance against income, with the combined pay and non-pay expenditure position being favourable to plan. Expenditure run rates continue to remain in line with those noted at the end of 2016/17 and for month 1. However, CIP delivery is behind plan and requires continuing focus to ensure plans are delivered and additional schemes identified where required.		
Summary of recommendations:	To note the financial results relating to performance during May 2017		
Fit with WH strategy:	Delivering efficient, affordable and effective services. Meet statutory financial duties.		
Reference to related / other documents:	Previous monthly finance reports to the Trust Board. Operational Plan papers. Board Assurance Framework (Section 3).		
Date paper completed:	22 June 2017		

Author name and title:		**Anis Choudhury, Head of Financial Planning and Analysis**		**Director name and title:**		**Stephen Bloomer, Chief Financial Officer**	
Date paper seen by EC	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

Financial Overview

The Trust is reporting a £0.6m deficit at the end of May (month 2) against a planned deficit of £0.4m, per the Trust's annual planning submission to NHSI. Actual performance therefore represents an adverse variance of £0.2m. Year to date the adverse variance against plan is £0.6m

The key driver for the adverse variance is the performance against income (£0.5m adverse in month and £1m adverse YTD), with the combined pay and non-pay expenditure position being favourable to plan. Expenditure run rates continue to remain in line with those noted at the end of 2016/17 and for month 1, although further actions are required in relation to the Trust's efficiency (CIP) programme as this is behind plan with schemes not delivering as originally planned.

Statement of comprehensive income

2017/18, Month 2 (May 2017)

Statement of Comprehensive Income	Month 2 Plan (£000s)	Month 2 Actual (£000s)	Month 2 Variance (£000s)	YTD Plan (£000s)	YTD Actual (£000s)	YTD Variance (£000s)
Nhs Clinical Income	20,884	20,367	(517)	40,677	40,031	(646)
Non-Nhs Clinical Income	3,152	3,210	58	6,305	6,023	(282)
Other Non-Patient Income	1,961	1,898	(63)	3,877	3,816	(61)
Total Income	**25,997**	**25,475**	**(522)**	**50,859**	**49,870**	**(989)**
Pay	18,266	18,471	(205)	36,537	36,875	(338)
Non-Pay	6,780	6,324	456	13,418	12,715	703
Total Operating Expenditure	**25,046**	**24,795**	**251**	**49,955**	**49,590**	**365**
EBITDA	**951**	**680**	**(271)**	**904**	**280**	**(624)**
Depreciation	721	668	53	1,442	1,336	106
Dividends Payable	346	345	1	692	692	0
Interest Payable	254	277	(23)	508	549	(41)
Interest Receivable	(3)	(2)	(1)	(6)	(3)	(3)
Total	**1,318**	**1,288**	**30**	**2,636**	**2,574**	**62**
Net Surplus / (Deficit) - before IFRIC 12 adjustment	**(367)**	**(608)**	**(241)**	**(1,732)**	**(2,294)**	**(562)**
Add back impairments and adjust for IFRS & Donate	(13)	(15)	(2)	(26)	-15	11
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**(354)**	**(593)**	**(239)**	**(1,706)**	**(2,279)**	**(573)**

Income & Activity

The trust continues to be significantly under plan for NHS clinical income. Outpatients improved compared to month 1 but was still £141k adverse in month (£305k adverse YTD) with the largest under-performances in Paediatrics, General Surgery & Dermatology.

Day Cases underperformed by £130k in month, giving an £150k adverse YTD variance. This mainly relates to Urology, which is offset with an increase in Urology Outpatient Procedures.

Due to the nature of the contract signed with commissioners, which has a 50% marginal rate applied to over or under-plan activity, the under-performance was offset by a favourable marginal rate adjustment of £0.7m.

Other Clinical income is below plan linked to the phasing of expenditure in relation to Dental Mobilisation. Therefore there is a corresponding benefit within the Trust's expenditure position.

The tables below provide the split of activity and income by category, together with a split of total income across ICSUs.

Month 02	INCOME						ACTIVITY					
	In Month			Year to Date			In Month			Year to Date		
Category	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	893	904	11	1,758	1,768	10	5,661	5,790	129	11,140	11,177	37
Adult Critical Care	833	712	(122)	1,640	1,362	(278)	716	654	(62)	1,409	1,193	(216)
Community Block	5,865	5,865	0	11,730	11,730	0	0	0	0	0	0	0
Day Cases	1,186	1,056	(130)	2,205	2,055	(150)	1,758	1,515	(243)	3,269	2,896	(373)
Diagnostics	229	227	(2)	425	416	(9)	2,271	2,247	(24)	4,219	4,150	(69)
Direct Access	997	826	(171)	1,852	1,634	(218)	91,201	78,753	(12,448)	169,433	158,167	(11,266)
Elective	721	818	97	1,364	1,558	194	189	211	22	354	396	42
Maternity - Deliveries	1,113	1,082	(32)	2,193	2,113	(80)	335	322	(13)	659	620	(39)
Maternity - Pathways	765	891	126	1,422	1,582	161	737	781	44	1,372	1,418	46
Non-Elective	3,223	3,232	9	6,346	6,361	15	1,597	1,661	64	3,145	3,126	(19)
OP Attendances - 1st	956	883	(73)	1,779	1,667	(112)	5,494	5,002	(492)	10,214	9,409	(805)
OP Attendances - follow up	842	775	(68)	1,569	1,375	(193)	13,174	12,108	(1,066)	24,493	22,465	(2,028)
Other Acute Income	2,941	2,737	(204)	5,803	5,755	(48)	12,087	10,782	(1,305)	22,672	21,503	(1,169)
Outpatient Procedures	319	359	41	592	654	63	1,789	1,976	187	3,323	3,584	261
Total SLA	**20,884**	**20,367**	**(517)**	**40,677**	**40,031**	**(646)**	**137,009**	**121,802**	**(15,207)**	**255,703**	**240,104**	**(15,599)**
Other Clinical Income	3,152	3,210	58	6,305	6,023	(283)						
Other Non Clinical Income	1,961	1,898	(63)	3,877	3,816	(61)						
Total Other	**5,113**	**5,108**	**(5)**	**10,182**	**9,839**	**(344)**						
Grand Total	**25,997**	**25,475**	**(522)**	**50,860**	**49,870**	**(990)**	**137,009**	**121,802**	**(15,207)**	**255,703**	**240,104**	**(15,599)**

Month 02		In Month			Year to Date		
Income breakdown by ICSU		Budget	Actual	Variance	Budget	Actuals	Variance
Children's Services	Clinical Income	1,734	1,766	32	3,388	3,289	(100)
	Other Non Clinical Income	42	120	78	84	129	45
Children's services total		**1,776**	**1,885**	**109**	**3,472**	**3,418**	**(54)**
Clinical Support Services	Clinical Income	1,763	1,781	19	3,368	3,268	(100)
	Other Non Clinical Income	59	73	14	118	86	(31)
Clinical Support Services total		**1,822**	**1,854**	**33**	**3,486**	**3,355**	**(131)**
Corporate Services	Clinical Income	8,100	7,810	(289)	16,198	16,456	259
	Other Non Clinical Income	1,333	788	(546)	2,622	2,564	(58)
Corporate Services total		**9,433**	**8,598**	**(835)**	**18,819**	**19,020**	**201**
Emergency & Urgent Care Services	Clinical Income	1,331	1,587	257	2,600	2,897	297
	Other Non Clinical Income	2	5	2	5	5	0
Emergency & Urgent Care Services total		**1,333**	**1,592**	**259**	**2,604**	**2,901**	**297**
Integrated Medicine	Clinical Income	3,618	3,353	(265)	6,986	6,357	(629)
	Other Non Clinical Income	261	503	242	521	522	0
Integrated Medicine		**3,879**	**3,856**	**(23)**	**7,507**	**6,879**	**(629)**
PPP services total	Clinical Income	62	61	(1)	121	97	(24)
	Other Non Clinical Income	-	0	0	-	0	0
PPP services total		**62**	**61**	**(1)**	**121**	**97**	**(24)**
Surgery	Clinical Income	4,863	4,415	(448)	9,391	8,590	(801)
	Other Non Clinical Income	225	339	114	450	437	(13)
Surgery total		**5,088**	**4,754**	**(334)**	**9,841**	**9,027**	**(814)**
Women & Family Services	Clinical Income	2,565	2,802	237	4,930	5,100	170
	Other Non Clinical Income	39	71	32	78	73	(6)
Women & Family Services total		**2,604**	**2,874**	**270**	**5,008**	**5,173**	**164**
Total Revenue		**25,997**	**25,475**	**(522)**	**50,860**	**49,870**	**(990)**

Monthly Run Rates – Expenditure

As noted above, whilst in total the Trust is reporting an adverse variance to plan, the combined pay and non-pay position is favourable. Main issues of note are:

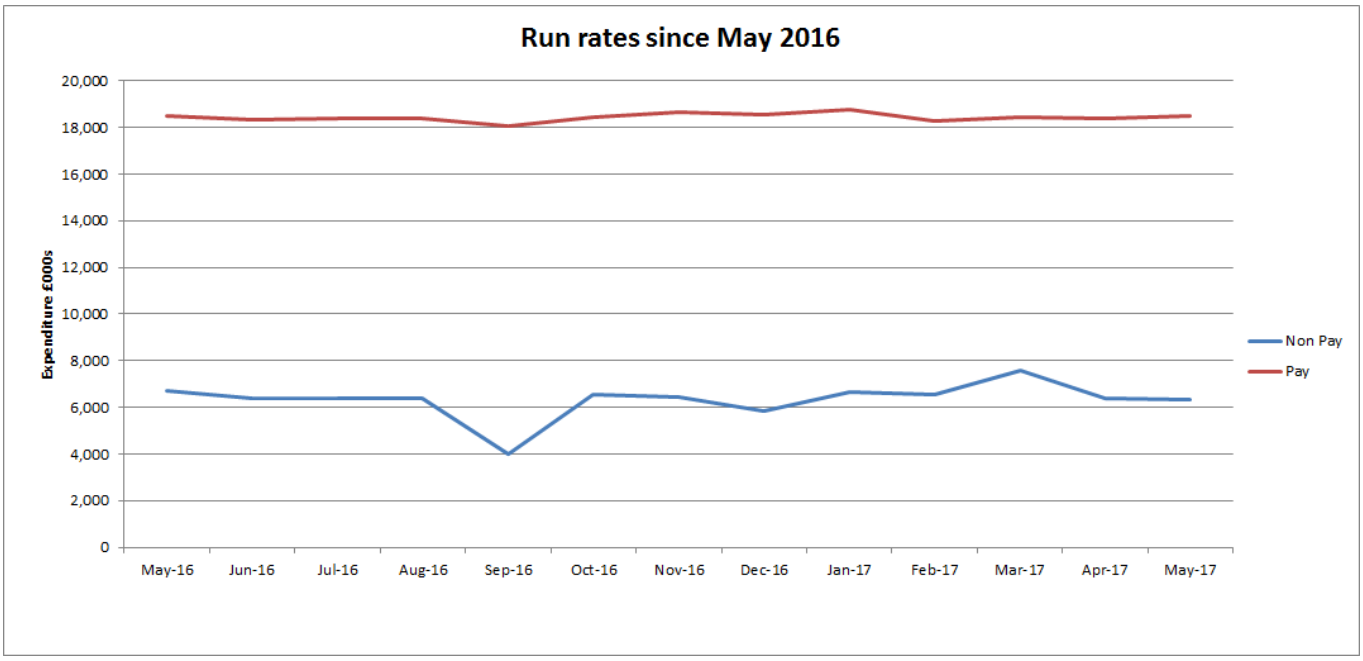
- **Pay**
  Total pay expenditure for May was £18.5m, which is slightly higher than the previous three months and the 12 months rolling average (£18.4m).

  Within total pay expenditure, agency staff related costs were £0.9m. This represents 5% of the May pay bill and is a reduction on both the April figure and the average of the previous 12 months. Whilst overall there has been a reduction, Children & Young People, Corporate and Surgery ICSUs had an increase in agency costs compared to month 1.

  Reducing the cost of agency remains a priority for 2017/18. All ICSU and corporate management teams are in the process of agreeing improvement trajectories and progress in the area will be reported frequently via the Finance & Business Development Committee.

- **Non Pay**
  Non pay expenditure for May was £6.3m, which is in line with the average spend of the previous 12 months and slightly lower than month 1. The grip and control measures introduced in the final quarter of 2016/17 continue to have a positive effect in reducing and maintaining expenditure levels and will remain in place for the foreseeable future.

The graph below provides the pay and non-pay expenditure run rates over a 13-month period from May 2016 to May 2017.



The table below provides an analysis of the last four month's pay and non-pay expenditure run rates together with Month 2.

Pay

	Run Rate - Actual			
	2016/17 Month 11 £'000	2016/17 Month 12 £'000	2017/18 Month 1 £'000	2017/18 Month 2 £'000
Children's & Young People	3,975	3,934	3,896	3,955
Clinical Support Services	1,334	1,352	1,423	1,314
Emergency & Urgent Care	2,036	2,042	1,992	1,969
Integrated Medicine	3,239	2,936	2,953	2,926
Patient Access, Prevention & Planned Care	1,025	1,038	1,018	1,014
Surgery & Cancer	2,796	3,124	3,138	3,006
Women's Health	1,619	1,565	1,553	1,571
Total Pay - Clinical ICSUs	16,024	15,991	15,973	15,757

Non Pay

	Run Rate - Actual			
	2016/17 Month 11 £'000	2016/17 Month 12 £'000	2017/18 Month 1 £'000	2017/18 Month 2 £'000
Children's & Young People	142	215	180	219
Clinical Support Services	1,214	1,580	1,506	1,563
Emergency & Urgent Care	203	265	223	234
Integrated Medicine	199	393	273	277
Patient Access, Prevention & Planned Care	172	287	154	134
Surgery & Cancer	555	797	973	836
Women's Health	131	223	163	197
Total Non Pay - Clinical ICSUs	2,616	3,760	3,472	3,461

Combined Pay & Non Pay

	Run Rate - Actual			
	2016/17 Month 11 £'000	2016/17 Month 12 £'000	2017/18 Month 1 £'000	2017/18 Month 2 £'000
Children's & Young People	4,117	4,149	4,076	4,174
Clinical Support Services	2,548	2,932	2,929	2,877
Emergency & Urgent Care	2,239	2,307	2,215	2,203
Integrated Medicine	3,438	3,329	3,226	3,203
Patient Access, Prevention & Planned Care	1,197	1,325	1,172	1,148
Surgery & Cancer	3,351	3,921	4,111	3,843
Women's Health	1,750	1,788	1,716	1,768
Total Non Pay - Clinical ICSUs	18,640	19,751	19,445	19,217

NB – an increase in expenditure run rates for Surgery is to be expected having secured new contracts for dental activity. This is offset by an increase in the Trust's income.

Cost Improvement Programme

The Trust has a £17.8m CIP target for 2017/18. To date £9.9m of plans have been identified and confirmed, with a balance of c. £7.9m to be identified from additional initiatives.

The Trust's planning submission identified a delivery of £2.1m YTD at month 2. Actual delivery achieved was £0.9m resulting in a shortfall of £1.2m against plan.

Integrated Clincial Service Unit	Annual Plan £'000	Identified £'000	Gap £'000	YTD Actual £'000
Children's services	3,065	2,174	891	125
Clinical Support Services	2,334	1,187	1,147	49
Emergency & Urgent Care	2,157	970	1,187	81
Medicine, Frailty & Network Services	2,132	1,424	708	120
PPP	874	640	234	85
Surgery	3,159	2,078	1,081	244
Women's services	1,498	218	1,280	66
Estates & Facilities	1,322	546	776	22
Corporate	1,236	668	568	116
Total	**17,777**	**9,905**	**7,872**	**908**
TFMS planned delivery as at month 2				2,156
Shortfall against plan as at month 2				**(1,248)**

The Trust has taken advantage of the Finance Improvement Programme – Wave 2 contract, to procure the support of the Boston Consulting Group to ensure that the Trust identifies £17.8m of plans that are within the roadmap project management system, quality impact assured and demonstrating delivery by the end of July.

Statement of Financial Position

THE WHITTINGTON HEALTH NHS TRUST

Statement of Financial Position

	As at 31 May 2017 £000	Plan 31 May 2017 £000	Year to Date Plan variance 31 May 2017 £000
Property, plant and equipment	208,650	202,203	6,447
Intangible assets	3,855	2,543	1,312
Trade and other receivables	1,087	851	236
Total Non Current Assets	**213,592**	**205,597**	**7,995**
Inventories	1,703	150	1,553
Trade and other receivables	25,016	28,085	(3,069)
Cash and cash equivalents	5,821	3,830	1,991
Total Current Assets	**32,540**	**32,065**	**475**
Total Assets	**246,132**	**237,662**	**8,470**
Trade and other payables	40,340	42,539	(2,199)
Borrowings	820	3,124	(2,304)
Provisions	371	756	(385)
Total Current Liabilities	**41,531**	**46,419**	**(4,888)**
Net Current Assets (Liabilities)	**(8,991)**	**(14,354)**	**5,363**
Total Assets less Current Liabilities	**204,601**	**191,243**	**13,358**
Borrowings	60,158	63,894	(3,736)
Provisions	1,773	1,513	260
Total Non Current Liabilities	**61,931**	**65,407**	**(3,476)**
Total Assets Employed	**142,670**	**125,836**	**16,834**
Public dividend capital	62,404	62,404	0
Retained earnings	(13,435)	(14,644)	1,209
Revaluation reserve	93,701	78,076	15,625
Total Taxpayers' Equity	**142,670**	**125,836**	**16,834**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**

Property, Plant & Equipment: The value held at the end of May is £7.8m above plan following the full valuation exercise undertaken as at 31 March 2017. The results of valuation were higher than those in the Trust's planning submission in December.

Receivables (Debtors) are currently £3.0m below plan. Whilst STF monies are still to be paid, the Trust continues to pro-actively manage debts with other organisations (both NHS and non-NHS), which has reduced the level of debtors overall.

Payables (Creditors) are currently £2.2m below plan. This positive variance is largely driven by significant clearance of outstanding creditors prior to year end. To date in 2017/18 the Trust has been paying an increased proportion of creditors within the statutory 30 day period.

Cash: The cash balance is £2.0m above plan at the end of month 2. This is due to the receipt of settlements for 2016/17 from CCGs immediately after the year end. The Trust continues to manage cash in a sustainable way to ensure that it remains a going concern through 2017/18.

Capital: At it's meeting in June the Trust Board approved the final capital programme for 2017/18. After taking account of contractual commitments for PFI, Managed Equipment Service, and DH capital loans, the proposed capital allocation for the year is £8.1m. This includes £2.6m to be re-invested as a result of achieving the Trust's 2016-17 control total and qualifying for STF incentive and bonus payments.

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

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

Whittington Health Trust Board
5th July 2017

Title:	Trust Board Report June 2017 (May 2017 data)		
Agenda item:	**17/102**	**Paper**	**06**
Action requested:	For discussion and decision making		
Executive Summary:	**Highlights** **Emergency and Urgent Care** Performance against the 95% target continues to improve as a result of the ED improvement plans embedding into practice and improved flow through the system. Our performance in May was 93.5% against an agreed trajectory of 93%.. **12 hour trolley waits in A&E** All four 12 hour trolley waits in May were informal mental health patients requiring transfer to mental health beds and who were not suitable for a medical admission. A health summit was held on the 13th June to identify solutions for the current challenges in mental health. This includes preventing admission, escalation and review (in the department) and bed capacity and flow within mental health. ECIP (emergency care improvement) will provide targeted support to working with both organisations over the next few weeks. **Cancer** The Trust failed the Two week wait standard with a performance of 92.37% against a standard of 93%. The issues in endoscopy have been rectified and have seen improvement over the last few weeks. We are expecting a compliant position for May 2017 for this standard. **Delayed Transfer of Care % of Occupied Bed days** Ongoing work to improve recording of medically optimised patients continues and as expected there has been negative impact on the level of DTOC patients for May 2017. An early indication for June data suggests a significant improvement in DTOC **Emergency Re-Admission within 30 days** Above target, although decrease of 0.2%, showing downward trend since peak during winter month in March 2017. Sickle cell patients and regular attenders continue to cause an increase in readmission. Issues around recording patient data as a readmission, despite the patient not leaving the hospital particularly from DTC and ambulatory care have been identified. and corrective actions are in place. . Readmission are predominately relate to Integrated Medicine and Emergency and Urgent ICSUs		

	FFT An increase in positive responses in ED and increase in response rate in Inpatients services observed. Community response rate back to expected level. **HR** Appraisals continue to progress overall on an upward trajectory, despite the slight reduction in rates between April and May. Compliance with statutory and mandatory training has remained stable during this period.
Summary of recommendations:	That the board notes the performance.
Fit with WH strategy:	All five strategic aims
Reference to related / other documents:	N/A
Reference to areas of risk and corporate risks on the Board Assurance Framework:	N/A
Date paper completed:	28th June 2017

Author name and title:		**Hester de Graag, Performance Lead**		**Director name and title:**		**Carol Gillen, Chief Operating Officer**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

Whittington Health NHS

Integrated Performance Report

June 2017

Month 2 (2017 – 2018)

Date & time of production: 29/06/2017 08:35

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Summary Page - Indicators

Category	Indicator	17_18 Target	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	2017-2018
ED	Emergency Department waits (4 hrs wait)	**>95%**	87.7%	87.9%	92.7%	93.4%	88.1%	85.1%	85.8%	82.9%	86.6%	88.4%	91.1%	93.5%	92.3%
ED	ED Indicator - median wait for treatment (minutes)	**<60 mins**	85	87	60	62	75	88	76	77	69	72	72	68	70
Cancer	Cancer - 14 days to first seen	**>93%**	96.4%	97.3%	97.7%	96.6%	97.8%	95.5%	93.4%	94.8%	96.8%	94.6%	92.4%		92.4%
Cancer	Cancer - 62 days from referral to treatment	**>85%**	94.9%	83.3%	93.5%	74.5%	83.3%	85.0%	92.3%	84.9%	100.0%	92.9%	85.4%		85.4%
Admitted	Non Elective Re-admissions within 30 days	**<5.5%**	6.8%	6.4%	6.3%	5.7%	5.9%	5.9%	6.0%	4.8%	5.7%	6.3%	6.2%	6.0%	6.1%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	**<4.5%**	6.1%	5.1%	4.5%	4.6%	8.2%	5.1%	7.7%	5.3%	4.5%	5.5%	5.8%		2.8%
Access	RTT - Incomplete % Waiting <18 weeks	**>92%**	94.2%	93.9%	92.7%	93.1%	92.9%	92.8%	92.2%	92.2%	92.4%	92.0%	92.0%	92.6%	92.3%
Outpatients	Outpatients - FFT % Positive	**>90%**	86.7%	89.1%	90.8%	89.2%	88.0%	92.6%	87.0%	92.5%	89.4%	93.1%	91.6%	92.8%	92.3%
Community	Community - FFT % Positive	**>90%**	97.5%	97.9%	97.5%	98.4%	98.1%	98.2%	98.7%	98.0%	96.8%	96.0%	98.5%	94.9%	96.2%
Staff	Staff - FFT % Recommend Care	**>70%**	80.1%			76.2%						74.6%			

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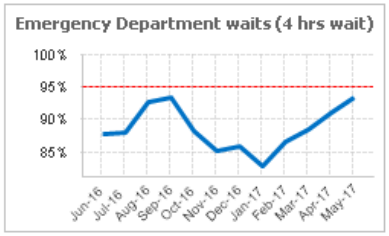

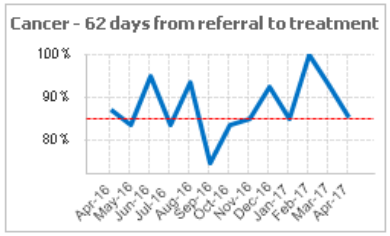

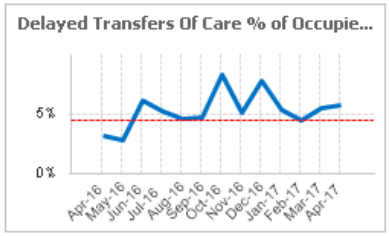

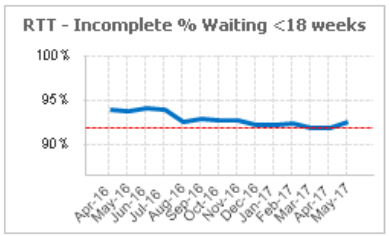

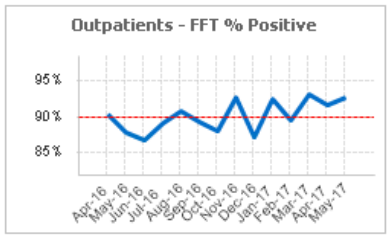

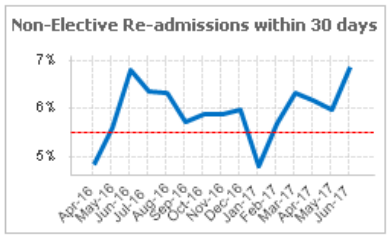

Safe Services - Indicators and Performance

Date & time of production: 29/06/2017 08:35

Category	Indicator	17_18 Target	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	2017-2018	Performance
Admitted	Admissions to Adult Facilities of pts under 16 yrs of age	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	
Admitted	HCAI C Difficile	**<17**	1	1	0	0	0	0	0	0	1	1	2	3	5	
All Areas	CAS Alerts Outstanding	**0**	0	0	0	0	0	0	0	0	3	0	0	0	0	
All Areas	Actual Falls	**400**	36	26	31	38	45	30	45	56	45	31	31	44	75	
All Areas	Avoidable Grade 3 or 4 Pressure Ulcers	**0**	1	3	5	5	5	1	3	2	1	2	2	2	4	
Admitted	Harm Free Care %	**>95%**	93.5%	93.8%	91.9%	90.8%	93.3%	92.6%	93.2%	94.3%	92.9%	92.5%	93.2%	93.9%	93.5%	
Maternity	Non Elective C-Section % Rate	**>15%**	17.7%	16.4%	17.4%	20.2%	17.7%	21.6%	17.4%	20.5%	18.0%	21.4%	19.3%	18.9%	19.1%	
All Areas	Medication Errors causing serious harm	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	
Admitted	MRSA Bacteraemia Incidences	**0**	0	0	0	0	1	0	0	0	1	0	0	0	0	
Admitted	Never Events	**0**	0	0	1	0	1	0	0	0	0	0	0	0	0	
All Areas	Proportion of reported Patient Safety Incidents Causing Harm	**N/A**	20.8%	22.6%	21.6%	21.8%	19.9%	20.1%	21.1%	21.3%	19.5%	22.4%	18.1%	16.6%	17.3%	
All Areas	Serious Incidents	**0**	3	3	4	6	9	8	3	4	5	4	2	4	6	
Admitted	VTE Risk Assessment %	**>95%**	96.3%	98.0%	96.2%	96.6%	97.3%	96.4%	95.9%	96.1%	96.0%	96.5%	95.2%		95.2%	

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Safe Services - Commentary

C.difficile associated diarrhoea
There were 3 patients diagnosed with trust attributable C. difficile associated diarrhoea in May 2017.
The cases have been diagnosed on 3 different wards (Victoria, Coyle and Cloudesley) and early investigation has not pointed to evidence of cross contamination as an underlying cause nor do any cases appear to be related to lapses in care. The wider IPC team have high vigilance about early detection and testing for CDAD in our patients and regular communications about CDAD are included in staff briefings/education sessions.

Actual falls
Out of the 44 falls in May 17, nine were reported as low harm, 35 as no harm to patients.

Avoidable pressure ulcer
The information in the table above is incorrect and will be corrected next month. There was only 1 avoidable pressure ulcer reported in May 2017.This was District Nursing, as a result of the pressure relieving cushion not being check and was no longer providing adequate pressure relief. It was promptly replaced.

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

Non Elective C-section rate
The emergency C-section rate has improved marginally from the previous month. The rate is influenced by the rise in induction of labour rates secondary to measures in the NHSE Reducing stillbirth bundle (Induction of Labour for small babies on GAP/GROW and for women attending with reduced foetal movements). Whittington Health rate is in line with the other NCL trusts.

Serious incidents
The trust reported 4 SI in May 2017. One in Integrated Medicine, one in Women and Family Services and two in Emergency and Urgent Care. All serious incidents are being investigating using the Root Cause Analysis tool.

Caring Services - Indicators and Performance

			Q1	Q2	Q2	Q2	Q3	Q3	Q3	Q4	Q4	Q4	Q1	Q1		
Category	Indicator	17_18 Target	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	2017-2018	Performance
ED	ED - FFT % Positive	>90%	87.7%	89.4%	92.4%	95.6%	89.9%	82.1%	83.8%	83.4%	83.9%	83.0%	84.0%	87.4%	85.7%	
ED	ED - FFT Response Rate	>15%	5.1%	4.5%	3.4%	4.1%	4.1%	16.6%	16.6%	14.6%	16.0%	14.6%	16.9%	15.6%	16.2%	
Admitted	Inpatients - FFT % Positive	>90%	95.7%	96.7%	96.0%	95.1%	95.8%	92.7%	95.8%	92.1%	96.1%	94.1%	98.0%	94.2%	95.9%	
Admitted	Inpatients - FFT Response Rate	>25%	15.5%	19.3%	15.4%	20.4%	18.3%	18.0%	12.6%	7.2%	17.1%	26.8%	21.6%	22.7%	22.2%	
Maternity	Maternity - FFT % Positive	>90%	94.6%	91.6%	93.2%	91.1%	91.6%	93.8%	94.8%	88.0%	89.4%	92.4%	93.6%	90.2%	91.9%	
Maternity	Maternity - FFT Response Rate	>15%	18.3%	10.5%	18.9%	24.2%	23.1%	12.8%	24.6%	30.4%	24.0%	27.8%	24.7%	22.2%	23.4%	
Outpatients	Outpatients - FFT % Positive	>90%	86.7%	89.1%	90.8%	89.2%	88.0%	92.6%	87.0%	92.5%	89.4%	93.1%	91.6%	92.8%	92.3%	
Outpatients	Outpatients - FFT Responses	400	166	229	229	305	408	516	193	481	407	551	357	623	980	
Community	Community - FFT % Positive	>90%	97.5%	97.9%	97.5%	98.4%	98.1%	98.2%	98.7%	98.0%	96.8%	96.0%	98.5%	94.9%	96.2%	
Community	Community - FFT Responses	1500	628	563	609	621	645	880	549	697	1095	1169	725	1192	1917	
Staff	Staff - FFT % Recommend Care	>70%	80.1%			76.2%						74.6%				
All Areas	Complaints responded to within 25 working day	>80%	82.1%	95.5%	85.3%	85.7%	100.0%	100.0%	89.3%	66.7%	90.0%	100.0%	100.0%	83.3%	89.7%	
All Areas	Complaints (including complaints against Corporate division)	N/A	31	26	38	32	25	19	32	22	34	38	22	24	46	
Community	End of Life % of patients dying in Pref. Place of care - DN	>70%	96.0%	84.4%	85.7%	72.0%	71.4%	85.7%	83.3%	90.9%	90.7%	89.5%	83.3%	87.0%	85.4%	

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Caring Services - Commentary

FFT

An increase in positive responses in ED and increase in response rate in Inpatients services observed. The Community response rate is back to expected level.

End of life percentage of patients dying in preferred choice of care

Target achieved

Complaints

During May 2017 the Trust closed 25 complaints, one of which was subsequently withdrawn. Of the remaining 24 complaints that required a response, 18 were required within 25 working days and 6 complaints were allocated 40 working days for investigation.

In regard to the 25 working days target, the Trust achieved a performance of 83%, exceeding its target of 80%. . 6 complaints currently remain outstanding and overdue i.e. CYPS (1), IM (2), S&C (2) and WH (1).

The majority of the complaints had been allocated to S&C 29% (7) and EUC 17% (4). 12 (50%) complaints were designated 'moderate' and 12 (50%) 'low'. No complaints were risk assessed has high during this period.

A review of the complaints for May shows that, as in April, 'medical care' 21% (5) and 'communication' 21% (5), accounted for the majority of complaints. In regard to medical care most patients 60% (3) felt that 'inadequate treatment' had been provided, and in regard to communication the issues related to a variety of areas including 'a lack of information', 'inadequate information', 'no reply to telephone contact' and 'breach of confidentiality'. In addition, 17% (4) complaints highlighted 'attitude' as the main concern with 75% (3) indicating that "inappropriate behaviour" had been displayed by a staff member.

Of those complaints that have closed (including those allocated 40 working days) 50% (9) were 'upheld', whilst 39% (7) were 'partially upheld', meaning that 89% of the 18 closed complaints were upheld in one form or another.

Effective Services - Indicators and Performance

Category	Indicator	17_18 Target	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	2017-2018	Performance
Maternity	Breastfeeding Initiated	>90%	90.5%	95.2%	91.5%	90.6%	94.2%	90.2%	90.1%	90.1%	90.6%	91.6%	90.2%	91.3%	90.8%	
Maternity	Smoking at Delivery	<6%	6.2%	3.9%	4.4%	4.8%	3.2%	5.1%	4.8%	3.6%	5.6%	3.0%	5.4%	3.4%	4.4%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	6.8%	6.4%	6.3%	5.7%	5.9%	5.9%	6.0%	4.8%	5.7%	6.3%	6.2%	6.0%	6.1%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	75.0	117.4	89.4	62.3	79.3	84.5	59.7	74.9	78.0					
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	63.4	82.8	97.4	90.7	81.9	90.2	21.9	97.6	29.3					
Trust	Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 mont...	1.14	0.69			0.69			0.69							
Admitted	Mortality rate per 1000 admissions in-months	14.4	6.1	5.8	5.8	4.2	6.5	7.9	7.2	11.7	9.1	7.9	7.2	7.6	7.4	
Community	IAPT Moving to Recovery	>50%	48.0%	50.0%	51.7%	52.3%	45.7%	47.1%	52.4%	50.4%	49.1%	48.4%	50.3%		50.3%	

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Effective Services - Commentary

Non Elective Re-admission
Above target, although decrease of 0.2%, showing downward trend since peak during winter month in March 2017.
Sickle cell patients and regular attenders continue to cause an increase in readmission. Issues around recording patient data as a readmission, despite the patient not leaving the hospital particularly from DTC and ambulatory care have been pinpointed. Corrective action in place.
These readmissions are predominately in Integrated Medicine and Emergency and Urgent ICSUs

IAPT
Target achieved

Responsive Services - Indicators and Performance

Category	Indicator	17_18 Target	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	2017-2018	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	87.7%	87.9%	92.7%	93.4%	88.1%	85.1%	85.8%	82.9%	86.6%	88.4%	91.1%	93.5%	92.3%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	85	87	60	62	75	88	76	77	69	72	72	68	70	
ED	Ambulance handovers waiting more than 30 mins	0	28	31	13	16	26	45	68	113	68	60	28		28	
ED	Ambulance handovers waiting more than 60 mins	0	9	0	1	0	1	4	22	37	13	3	1		1	
ED	12 hour trolley waits in A&E	0	1	1	0	1	1	1	0	2	3	2	5	4	9	
Cancer	Cancer - 14 days to first seen	>93%	96.4%	97.3%	97.7%	96.6%	97.8%	95.5%	93.4%	94.8%	96.8%	94.6%	92.4%		92.4%	
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	99.2%	100.0%	100.0%	100.0%	97.2%	98.2%	100.0%	93.4%	98.7%	92.9%	96.0%		96.0%	
Cancer	Cancer - 62 days from referral to treatment	>85%	94.9%	83.3%	93.5%	74.5%	83.3%	85.0%	92.3%	84.9%	100.0%	92.9%	85.4%		85.4%	
Cancer	Cancer - 31 days to first treatment	>96%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Cancer	Cancer - 31 days to subsequent treatment - surgery	>98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%		100.0%	
Cancer	Cancer - 31 days to subsequent treatment - drugs	>93%			100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%		100.0%	
Cancer	Cancer - 62 Day Screening	>90%		100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%		100.0%	
Cancer	Cancer - 62 Day Upgrade															
Access	DM01 - Diagnostic Waits (<6 weeks)	>99%	99.9%	99.3%	99.5%	99.7%	99.5%	99.8%	99.1%	99.1%	99.6%	99.2%	99.0%	99.1%	99.1%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	94.2%	93.9%	92.7%	93.1%	92.9%	92.8%	92.2%	92.2%	92.4%	92.0%	92.0%	92.6%	92.3%	
Access	Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

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Responsive Services - Commentary

ED four hours' wait and Ambulance handover time

Performance against the 95% target continued to improve in May as did median time to treat. The continued improvement was a result of the ED improvement plans embedding into practice and improved flow through the system. Achieved 93% agreed trajectory for month.

12 hour trolley waits in A&E

All four 12 hour trolley waits in May were informal mental health patients requiring a mental health bed and who were not suitable for a medical admission. Senior leads across acute and mental health providers and CCG attended an NCL summit regarding Mental Health on the 13th June to look at system wide improvements that could be made and actioned will be taken forward. The organisation also continues to work closely with C&I who are now part of the 11am daily CSU surge call so that any issues can be discussed in a timely manner and escalated appropriately

Cancer – 14 days to first seen

The Trust failed the Two week wait standard with a performance of 92.37% against a standard of 93%. Areas of concern are colorectal at 89.25%, this is due to 10 patients having been seen over two weeks, Gynaecology was 92.41% just under the standard and Upper GI was 39.13%. This was predominantly due to delay in straight to test for endoscopy. This issue in endoscopy has been addressed and has seen an improvement over the last few weeks resulting. Expected compliant position for May 2017 for this standard.

Responsive Services - Indicators and Performance

Category	Indicator	17_18 Target	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	2017-2018	Performance
Theatres	Hospital Cancelled Operations	0	7	1	6	1	4	6	2	15	7	5	6		6	
Theatres	Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	0	0	0	0	0	2		2	
Theatres	Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0	0	0	0		0	
Admitted	Delayed Transfers Of Care - Days Lost	N/A	273	240	191	199	364	267	348	236	192	255	245		245	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	6.1%	5.1%	4.5%	4.6%	8.2%	5.1%	7.7%	5.3%	4.5%	5.5%	5.8%		2.8%	
Maternity	Women seen by HCP / midwife within 10 weeks	>50%	63.7%	74.5%	69.1%	72.8%	69.4%	67.2%	67.8%	54.1%	57.5%	50.9%	45.8%	52.8%	49.8%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%	90.5%	95.1%	93.8%	94.6%	94.4%	94.3%	97.2%	97.2%	93.6%	93.3%	97.5%		97.5%	
Community	GUM - Appointment Offered within 2 days	>98%	99.7%	95.6%	97.8%	99.2%	99.9%	99.6%	99.8%	99.3%	99.5%	99.3%	98.7%	99.3%	99.0%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	87.9%	93.2%	94.6%	94.2%	91.8%	92.2%	91.6%	91.3%	93.3%	87.5%	88.6%		88.6%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	94.4%	94.9%	93.7%	88.3%	93.3%	94.1%	94.6%	94.8%	93.3%	90.7%	90.3%		90.3%	

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Responsive Services - Commentary

Hospital Cancelled Operations
There were six cancelled ops in April 2017, all were routine patients. Three patients were gynaecology that had been booked to attend when the surgeon was on annual leave.
Two patients under the vascular surgeon were booked for surgery which required specific procedure packs which had not been specified when the appointment was set up.
One patient list overran as list was overbooked (General Surgery).

Action in place: PPC's (patient pathway co-ordinators)/Rota administrator to inform waiting list co-ordinators of Surgeons Annual Leave.

Cancelled Operations not re-booked within 28 days
The two vascular patients were not booked within 28 days, 1) this list only occurs every fortnight. 2) The Surgeon was on annual leave for the list a fortnight later, and for the following list the company rep, required to be present for this particular procedure, was on leave. The patients were re-booked within 6 weeks.

Delayed Transfer of Care % of Occupied Bed days
Ongoing work to improved recording of medically optimised patients continues, as expected as a result of this work, there has been negative impact on the level of DTOC patients for May 2017. An early indication from June data suggests there is a significant improvement in DTOC.

New Birth Visits September 2016
There is a slight improvement for Haringey and Islington remains the same.

Well Led Services - Indicators and Performance

Category	Indicator	17_18 Target	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	2017-2018	Performance
HR	Appraisals % Rate	>90%	68%	67%	66%	63%	66%	66%	67%	72%	75%	80%	80%	79%		
HR	Mandatory Training % Rate	>90%	81%	81%	81%	80%	81%	81%	82%	81%	82%	82%	82%	82%		
HR	Permanent Staffing WTEs Utilised	>90%	87.8%	86.2%	87.1%	87.0%	88.1%	88.1%	87.7%	87.7%	87.8%	87.8%				
HR	Staff FFT % recommended work	>50%	65.1%			59.7%						60.5%				
HR	Staff FFT response rate	>20%	19.6%			24.9%						24.4%				
HR	Staff sickness absence %	<3.5%	3.2%	3.2%	3.2%	3.6%	3.8%	3.8%	3.7%	3.7%	3.6%	3.2%	2.7%	2.4%	2.5%	
HR	Staff turnover %	<10%	15.8%	15.7%	15.5%	15.7%	15.4%	14.9%	15.4%	15.3%	15.1%	14.3%	14.8%	14.4%	14.6%	
HR	Vacancy % Rate against Establishment	<10%	12.2%	13.8%	12.9%	13.0%	11.9%	11.9%	12.3%	12.3%	12.2%	12.2%				

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Well Led Services - Commentary

Human Resources

Appraisals continue to progress overall on an upward trajectory, despite the slight reduction in rates between April and May. Compliance with statutory and mandatory training has remained stable during this period.

Staffing utilisation data is in the process of being loaded on to ESR from the updated ledger, following budget sign off for this financial year hence these figures were not available as the report was produced. Vacancy rates were produced just after the close date to be incorporated into the table above, but are 11.05% for April 2017.

As reported previously, there is a time lag in uploading sickness data on to ESR which may explain the reduction noted between end quarter 1 and beginning of quarter 2; a recommendation will be forthcoming to the Board on retrospective reporting once the options have been fully explored.

Activity - Indicators and Performance

Category	Indicator	17_18 Target	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	Activity
ED	ED Attendances	**8285**	7908	8277	7513	8020	8253	8271	8238	8254	7430	8527	8285	8699	
ED	ED Admission Rate %		17.8%	18.1%	17.8%	16.7%	16.2%	16.6%	17.5%	17.2%	17.1%	16.9%	17.2%	17.3%	
Community	Community DNA Rate %	**<10%**	5.6%	5.7%	5.6%	5.5%	5.2%	5.4%	5.5%	5.3%	5.5%	5.1%	4.8%	5.2%	
Community	Community Face to Face Contacts		64391	61152	56756	62825	62113	67325	56554	63623	59192	69827	55206	64949	
Admissions	Elective and Daycase		2083	2004	1769	1937	1947	1876	1714	1878	1686	1849	1617	1790	
Admissions	Emergency Inpatients		2177	2322	2117	2078	2036	2124	2110	2067	1927	2200	2117	2206	
Referrals	GP Referrals to an Acute Service		5924	5574	5365	5807	5464	5776	4716	5314	4901	5944	4350	5066	
Maternity	Maternity Births	**333**	311	340	299	337	315	324	301	312	274	309	301	332	
Maternity	Maternity Bookings	**377**	403	354	299	301	353	365	319	323	308	382	309	414	
Outpatients	Outpatient DNA Rate % - New	**<10%**	11.7%	11.7%	11.9%	12.3%	11.1%	11.3%	12.7%	12.4%	11.8%	12.0%	12.4%	12.1%	
Outpatients	Outpatient DNA Rate % - FUp	**<10%**	10.2%	10.3%	9.8%	11.2%	10.1%	10.1%	11.7%	12.5%	12.2%	11.9%	11.7%	12.0%	
Outpatients	Outpatient New Attendances		9492	8837	8362	8908	8660	9575	7910	8771	8361	9149	7477	9112	
Outpatients	Outpatient FUp Attendances		18671	17860	18091	18524	18665	19769	17110	18503	16873	18832	15445	17800	
Outpatients	Outpatient Procedures		6284	6163	6258	6014	6265	6181	5628	5957	5238	5793	4958	5962	
Theatres	Theatre Utilisation	**>85%**	80.7%	78.3%	78.2%	81.8%	81.5%	83.7%	83.5%	72.8%	81.1%	82.7%	84.9%	85.9%	

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Activity - Commentary

Hospital DNA

The area of high DNA's are in Women's Health community gynaecology, Integrated Medicine Therapies and Urology. All are improving showing the Out-patients Improvement Programme having a positive impact.

Theatre Utilisation
Target achieved.

DRAFT - Finance Indicators at Trust Level

Average Tariff by Point of Delivery (POD)

Category	Point of Delivery (POD)	17_18 Target	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	Trend
Average Tariff	Daycases		655	588	616	663	694	664	682	664	657	739	727	
Average Tariff	Elective		4084	3601	4027	3831	4099	4402	2522	3785	4214	3772	2701	
Average Tariff	Non-Elective		1949	2107	2117	2153	2196	2132	2383	2180	2165	1790	1883	
Average Tariff	Outpatient FA		166	165	168	169	167	167	166	168	167	181	181	
Average Tariff	Outpatient Follow Up		75	73	73	75	74	72	73	72	73	61	64	
Average Tariff	Outpatient Procedures		183	188	184	200	196	199	195	202	203	186	185	

Average Staff Cost Per Patient

Category	Staff Type	17_18 Target	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	Trend
Medical	Average staff cost per patient		97	96	92	98	88	101	94	89	125	107	91	
Nursing	Average staff cost per patient		175	180	171	173	160	186	182	174	237	190	169	
Other	Average staff cost per patient		196	196	174	191	178	200	188	194	256	217	198	

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

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

Whittington Health Trust Board
5 July 2017

Title:	Business Continuity Plan – Annual Refresh						
Agenda item:	**17/103**		**Paper**		**07**		
Executive Summary:	Business Continuity Management is a system that helps to identify risks and provide robust mitigations with the aim of maintaining services and critical functions in the event of a disruption. It aims to provide clear direction on when and how an organisation can recover from disruptive events. The Trust is legally obliged to fulfil the duties set out by the Civil Contingencies Act (CCA) 2004. The CCA 2004 asserts that Category 1 responders are to implement plans that can maintain health services, especially critical functions so far as reasonably practicable. The Plan presented in public has been redacted where contact points, logistical and sensitive information, names and numbers are held in strict confidence by the Trust. The Trust Management Group and Trust Operational Management Group have reviewed the plan in full detail and approved the annual refresh. This paper provides assurance of compliance for the Trust that it has reviewed its Business Continuity Plan, that it is fit for purpose and that it meets all regulatory and statutory requirements.						
Summary of recommendations:	For annual approval on recommendation from the Trust Management Group and Trust Operational Management Group						
Fit with WH strategy:	Forms part of the Emergency Planning and Resilience arrangements for the Trust						
Reference to related / other documents:	Aligns with national and local emergency planning policy including NHS England Emergency guidance policy						
Reference to areas of risk and corporate risks on the BAF:	Risks captured on risk register as appropriate						
Date paper completed:	30 June 2017						
Author name and title:	**Lee Smith, Emergency Planning Officer**		**Director name and title:**		**Carol Gillen, Chief Operating Officer**		
Date paper seen by EC	**June 16**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

Whittington Health NHS

Strategic Business Continuity Plan

Subject:	Strategic Business Continuity Plan
Ratified By:	Emergency Management Steering Committee
Date Ratified:	14th July 2014
Version:	3.2
Policy Executive Owner:	Chief Operating Officer – Accountable Emergency Officer
Designation of Author:	Emergency Planning and Business Continuity Officer
Name of Assurance Committee:	Executive Committee
Date Issued:	1 August 2014
Review Date:	February to May 2017
Next Review:	February to May 2018
Target Audience:	All staff
Key Words:	Business Continuity
Document Purpose	This plan has been developed to ensure that the Acute and Community Services of the Trust is capable of responding to significant emergencies.
Related Document	Major Incident Plan Pandemic Influenza Plan, Severe Weather Plans.

EMERGERNCY RESPONSE – notification, escalation and activation

- If a problem can be dealt with at a ward, departmental level or within a community based service, it should be managed by implementation of their Business Continuity Plan (BCP).
- If there is an activation of a BCP then this must be escalated.
- Any incident which affects building continuity, patient access to care or staff safety must be escalated.

In normal hours 09.00- 17.00 Mon- Fridays			**Out of hours 17.00- 09.00 Weekend & Public holidays**	
Escalation to	**Required action**		**Escalation to**	**Required action**
Manager of service / head of department, Facilities team, IT team. ⇩	• Initial assessment in liaison with person reporting, support department and department head. Will it affect service delivery? • Manage incident and the recovery within department • Minor or Moderate Incidents		Manager of service / head of department, Estates on call, IT on call. ⇩	• Initial assessment in liaison with person reporting, support department and department head. Will it affect service delivery? • Manage incident and the recovery within department
Clinical Site Manager ⇩	• Support department to assess impact in liaison with site support lead as necessary Is impact significant? • High impact business continuity incident • Critical or Major Incident		**BRONZE** (Clinical Site Manager) ⇩	• Support department to assess impact in liaison with site support lead as necessary Is impact significant? • High impact business continuity incident • Critical of Major Incident
Divisional Director of Operations ⇩	• Implement service Business Continuity Plan in liaison with specialist personnel as required • Consider a need to involve external agencies • NB regular report and major developments must be communicated. • Agree incident response plan • Form an Incident Control Team in the Incident Control Centre. Notify EPO • Keep a log of all decisions and actions • Consider activation of Strategic Business Continuity Plan or Major Incident Plan		**SILVER** Commander ⇩	• Implement service Business Continuity Plan in liaison with specialist personnel as required • Consider a need to involve external agencies • NB regular report and major developments must be communicated. • Conduct a risk assessment of unforeseen events. • Engage specialist staff to plan and mitigate against risk items. • Gold to agree on plan
			GOLD Commander ⇩	Consider activation of Strategic Business Continuity Plan or Major Incident Plan
Chief Operating Officer EPLO (Emergency Planning Liaison Officer) and or CEO			**Chief Operating Officer (EPLO) and or CEO**	

Distribution list

Department /Role	Format
Major Incident Control Room Cupboard	Hard copy
Access Room emergency management box	Hard copy
Whittington Health Intranet Major Incident Policies folder	Electronic copy
Silver and Gold dropbox	Electronic
Bronze, Silver & Gold shared 'I' Drive	Electronic

Amendment Record

This document is a controlled document. It replaces all previous versions. This document will be updated annually or as a result of lessons learnt following an activation or exercise of this plan. The issue date is shown in the footer, if the issue date is more than one year ago please speak to the Emergency Planning & Business Continuity Officer to obtain the latest version.

Change History				
version	**Status**	**Date**	**Author/Editor**	**Details of Change**
1.1	Draft	22-02-2012	Richard Moss for WHNHST	New draft
1.2	Draft	26-03-2012	Richard Moss for WHNHST	Amendment to s.10 & 12 to form a closer link between the main plan and service/departmental plans
1.3	Draft	26-04-2012	Richard Moss for WHNHST	Amendments requested by Mary Jamal to sections: • 13.1; 13.2;13.3 reference to the Silver and Gold on call in and out of hours to ensure effective communication • 13.13 requirements for BC manager clarified • P.20 ref to MI plan added
1.4	Draft	01-05-2012	Richard Moss for WHNHST	Additional appendices added: • Serious infectious disease plan • Disruption to road fuel supply • Water supply failure
1.5	Final/Issued	11/06/2012	Mary Jamal	Approved at Executive Committee
1.6	Draft	April 2013	Rebecca Blake	Updates on escalation and contacts due to changes in health system from April 2012.
2.6	Final/Issued	July 2014	Rebecca Allsopp	Full revision and rewrite of plan following updated NHS England (London) guidance
2.7	Final/issued	16/02/2015	Rebecca Allsopp	Updated contacts
2.8, 2.9 3.0-3.2	Draft Draft Draft	08/2016 27/02/2017 25/05/2017	Lee Smith Lee Smith Lee Smith	Updates from Directors Updated NHS England BC Toolkit Updates essential services

Approval

This plan has been approved by the Emergency Management Steering Committee and the Trust Executive Committee.

Consultation

To comply with the requirements of the Business Continuity Management Strategy and Emergency Preparedness, Resilience and Response Policy this document has been consulted with the following internal and external partners:

- Whittington Health NHS Trust Emergency Management Steering Committee

- North East and North Central London Commissioning Support Unit
- NHS England (London)
- London Boroughs of Islington and Haringey

CONTENTS PAGE

Background

Business Continuity Management (BCM) is a system that helps to identify risks and provide clear mitigations with the aim of maintaining services and critical functions in the event of a disruptive challenge. BCM also aims to provide clear direction on when and how an organisation can recover from disruptive events. Whittington Health is legally obliged to fulfil the duties set out by the Civil Contingencies Act (CCA) 2004. The CCA 2004 says that Category 1 responders are to implement plans that can maintain health services, especially critical functions so far as reasonably practicable. When Whittington Health is exercising its function so far as reasonably practicable there are the aspects to consider in accordance with the CCA 2004; Criticality, Service Levels and Balance of Investments.

SECTION 1: Managing an Incident

1.1 Command and control structures

During the initial assessment phase of an incident the Chief Operating Officer or the Gold On-call out of hours, should decide on the most suitable management approach to the incident, this will be based upon the type of incident and the frequency of action monitoring and issuing of new actions. For rising tide emergencies or those with a slow "battle rhythm" there will be no requirement for a continuous command and control structure to be in place.

1.1.1 Incident Control Team

During a business disruption the Incident Control Team can be used to manage the response. Any meetings of this team should have a Loggist (Major Incident Plan) and record actions and decisions relating to the incident. This structure follows the standard Gold, Silver, Bronze approach without the requirement to establish a control room see the command and control arrangements in the Major Incident Plan including a breakdown of all roles (Section 2 page 9). The Chair of the group is responsible for arranging an appropriate meeting facility such as the Access Room depending on the incident.

Where established the Incident Control Team will be responsible for any mutual aid requests and support arrangements required by the incident.

1.2 Incident Control Room

1.2.1 Location

The Trust's Control Room is initially in the Access Room (next to Ambulatory Care) and can be transferred to the main Incident Control Room in the Emergency Department Seminar Room if deemed necessary by the Gold or Silver Commander.

1.2.2 During normal working hours

The rooms may be used for meetings or training sessions; in the event of an emergency those using the room will need to be displaced to enable the room to be used as the Incident Control Room.

The first member of the Incident Control Team to arrive at the room should inform those using it that:

- The Incident Control Room is being activated
- They will have to leave the room and carry on their work elsewhere

1.2.3 Access, Set-up & Processes

There are instructions on how to access the Incident Control Room, how to set it up, and the processes to be used in its operation. Copies are held:

- In the On-Call Information Pack of every member of On-Call staff
- In Major Incident cupboard
- Access room emergency management box
- On-call handbook in the shared I drive
- On-call dropbox facility

1.3 Definition of an 'Critical Incident' and 'Major Incident' -

From the NHS England (London) EPRR framework 2013 a significant incident or emergency can be described as any event that cannot be managed within routine service arrangements. Each require the implementation of special procedures and may involve one or more of the emergency services, the wider NHS or a local authority.

1.3.1 Business Continuity Incident

A business continuity incident is an event of situation that may or does cause disruption to Whittington Health's service delivery. This event implies that there has been a decrease in service standards below predefined levels, in which case special arrangements must be employed to return service levels to an acceptable standard.

1.3.2 Critical Incident

A critical incident is any event within Whittington Health that causes temporary or permanent ability to provide critical services. This event could cause harm to patients and cause the environment to be unsafe which would require special measures and cooperation from supporting agencies to restore normal functions

1.3.3 Major Incident - (Standby, declared, stand down)

Number or type of casualties overwhelm or threaten to overwhelm normal services or pose threat to the health of the community, special arrangements are needed to deal with them. These may include multiple casualty incidents, terrorism or national emergencies such as pandemic influenza. (Refer to Trust major incident plan).

The Civil Contingencies Act (2004) defines a Major Emergency as:

'An event or situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, war or terrorism which threatens serious damage to the security of the UK.'

SECTION 2: KEY ROLES AND RESPONSIBILITIES

In the event of a disruption that affects multiple services, a Trust-wide response may be necessary. This response will be led by the Gold on-Call (or an equivalent level replacement called out by the Gold on-Call). Should they decide it is necessary, on-call staff may choose to call out an Incident Control Team and use the Trust's Incident Control Room to co-ordinate the response and recovery to the disruptive event.

2.1 Incident Control Team

The team will consist of the following:

Table 1: Incident Control Team membership

Core Emergency Management Members	Role	Responsibilities
Chief Operating Officer	Accountable Emergency Officer Emergency Planning Liaison Officer	Support the Incident Control Team review and scrutinise the plan for the response to and recovery from the disruption. Liaise with the Communication Team Communicate with NHS 01 when there is a high impact business continuity, critical or major incident Participate in the Strategic Coordination Group as requested at a regional level.
In hours: Director of Operations or Directors with specialist knowledge external to ICSU's Out of hours: Gold on-Call Refer to **ACTION CARD** in Major Incident Plan	Tactical controller of the disruptive event. Logs all decisions and actions with Loggist	• Lead the Trust's response to the disruptive event • Set the Trust's strategy for managing the response to the incident • Initiate services' status reporting process (if deemed necessary) for Bronze to manage • Allocate all necessary resources to maintain the Trust's essential services • Prioritise the deployment of resources; including the allocation of alternative work locations • Initiate the recovery planning process, appointing Recovery Managers as required • Keep the Executive Team informed of service delivery status • Keep Commissioners informed of service delivery status
In hours: Director of Environment (or deputy in absence) for a critical or major incident Out of hours: Facilities and/or Estates on-call as well for business continuity disruptions	Logistics	Estates, facilities and security: Identify what resources are required to achieve the priorities and ascertain their availability.

Refer to **ACTION CARD** in Major Incident Plan		
Communications Team representative Refer to **ACTION CARD** in Major Incident Plan	Communications	• Support the Gold on-call in preparing and disseminating communications to staff, partners and the public as required • Advise the Incident Control Team on communications matters
In hours: Manager of service or department/ Operational Director Out of hours: Silver on-Call Refer to **ACTION CARD** in Major Incident Plan	Planning – Response & Recovery	• Support the Gold on-call in managing the Trust's incident response • Retain responsibility for non-incident related operational management issues out-of-hours
In hours: Clinical Site Manager Out of hours: Site Manager Operational Bronze Commander Refer to **ACTION CARD** in Major Incident Plan	Status reporting of Trust	See section 6 Response on page 14
Emergency Planning and Business Continuity Officer (in office hours **only**)	Support to Incident Control Team	• Undertake tasks in support of the Incident Control Team as requested by the leading tactical commander
Loggist Refer to **ACTION CARD** in Major Incident Plan	Recording of actions and decisions of the Gold Commander	• Record the Gold and Silver on-Call's decisions, actions and information received for the duration of the response • Once the response has been stood down, review the log with the Silver and Gold on-Call and make any annotations necessary • Pass the log to the Emergency Planning Lead
Any other person deemed necessary for the management of the incident		

Contact numbers for the Incident Control team and key leads are listed at Appendix 1.

SECTION 3: Activation

3.1 Initial activation

This plan will be activated by the Gold on-Call and or the Chief Operating Officer in the event of a disruptive incident that:

- affects building continuity or patient access to care.
- is of a serious nature (i.e. an event that completely disrupts a service's essential or critical functions and requires substantial support from other services)

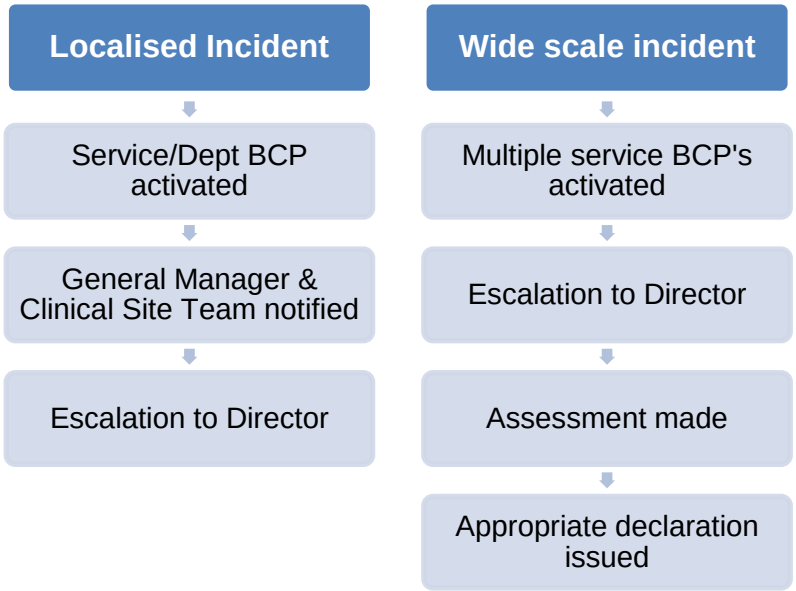
3.2 Activation Process

The driver for activating this plan will be noInctification by a service or services of a disruption that affects their ability to deliver their essential services.

The Gold on-Call and or Chief Operating Officer will decide whether the plan should be activated and, if the decision is to activate it, will notify the Trust's senior management of this decision (see contact details at Appendix A).

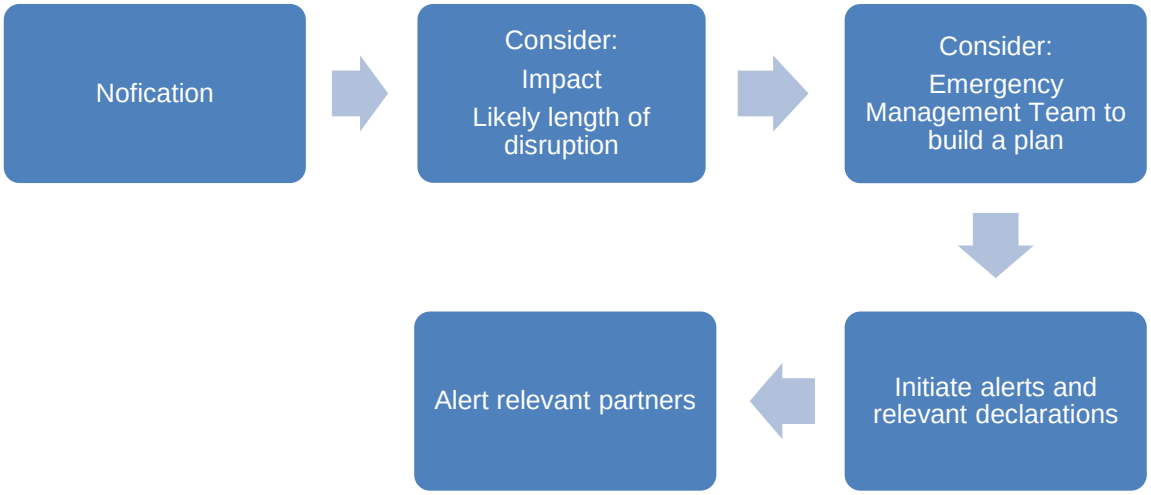
This plan will be triggered following activation by the Gold On-call and or Chief Operating Officer in the following circumstances:

- Failure of a major utility requiring on-going monitoring
- Loss of an essential service impacting on patient safety beyond the capacity of the individual service plan
- In anticipation of an event that will potentially disrupt services and require coordinated management



3.3 Assessment

Following the notification of an incident the Gold On-call or nominated deputy should assess the situation. At this time a decision should be taken on alerting staff, defining the management structure to be implemented and if a "significant or major incident" is to be declared. When considering the incident the Director should take into account the number of services impacted and the likely length of disruption.



3.4 Immediate actions

Upon activation the Gold On-call and or the Chief Operating Officer or in their absence the Clinical Site Manager/Silver On-call will:

- Issue an appropriate declaration message to pager holders, and ensure Service Continuity Leads are notified
- Conduct an impact assessment
- Use PageOne to request support internally to form an Incident Control Team
- Establish how the incident will be controlled
- Inform the Chief Executive, nominated Deputy, or other senior officer
- Act on any additional information received.

3.4.1 Use during a declared "critical or major incident"

This plan may be used during a "significant, critical or major incident" to support the reallocation of resources for an extended response. In these circumstances the Chief Operating Officer, or Gold On-call, will decide how the business continuity response will be managed in accordance with this plan.

3.5 Declaration of a 'Critical Incident' or 'Major Incident'

The Chief Operating Officer or nominated deputy (Gold On-call) is responsible for declaring a Critical Incident or Major Incident for Whittington Health NHS Trust.

The Silver On-call may declare an incident for the hospital on discussion with the Gold On-call or Chief Operating Officer.

3.5.1 Service / Department Continuity Plans

All services across the Trust have a local Service/Department Continuity Plan; this can be used to manage the impact of a disruption locally, and contains actions so the continuity of the service can be maintained. These plans are activated by the Service/Department Planning Leads in the event of a disruption. Plans can be requested for activation by Gold or Silver to support responses outside of the service.

3.5.2 Functional Plans

In addition to the Trust Strategic Business Continuity Plan (this document) and the Service/Department Continuity Plans, there are the following functional Business Continuity Plans:

- IM & T Incident Response Recovery Plan.
- Facilities Business Continuity Plans and Specific Project Plans

- Emergency Department Escalation Plan
- Emergency Department Full Capacity Protocol

These plans will be used to:

- Manage specific aspects of an incident under the direction of the appropriate lead Trust (e.g. network recovery, generator use).
- Take overall control of a premises or IT related incident.

3.6 Staff alerting

If, after assessing the situation, the Gold On-call decides that the incident is, or might, progress into an Emergency, he/she will implement such parts of the Strategic Business Continuity Plan as are appropriate, advise the Chief Operating Officer, Chief Executive or appointed Deputy accordingly and similarly advise all other key staff.

Initial Alerting of staff may be achieved through the use of the Major Incident Alerting System accessed via switchboard. This allows the alerting of predetermined staff groups based upon the type of incident to be declared. This will include General Managers and Service Leads as identified in the Service Department Continuity Plans. Service Leads will then call out further staff as may be required via their own staff alerting processes in hours. Critical and Business continuity incidents can be communicated via the PageOne communication system. Please refer to the Gold on call handbook in relation to communicating to the smart groups. Out of hours the Operational Commander (Bronze) will call staff relevant to respond and escalate their plan to the Tactical Commander (Silver). The Tactical Commander will escalate all decisions and actions to the Strategic Commander (Gold).

3.6.1 Alerting messages

The following messages may be issued via switchboard. It may be necessary to vary the alerting level across the Trusts hospital sites depending on the impact on hospital services. Alerts sent via the alerting system are sent via text, pager, bleep and email. This alert must be authorised by the Chief Operating Officer, Gold or Silver On-call. High Impact business continuity and critical incidents will be escalated via switch board.

'**Incident** Please acknowledge with switchboard.
Report to **department** and activate your service continuity plan. This is not a test.'

If you receive a "Business Continuity Incident" message – an Internal Incident is occurring at the Trust and affected departments may have to activate their service continuity plans.

'Business Continuity Incident **Stand down'**

On receiving a "Business Continuity Incident Stand Down" message - Departments will return to their normal service delivery procedures.

3.6.2 Alerting partners & mutual aid

The Gold On-call will inform partners of the declaration of an incident. This notification should be a call to the appropriate On-call Director. They should inform the following organisation as required depending on the impact of the disruption:

- NHS England (London)

- Commissioning Support Unit
- London Ambulance Service NHS Trust
- London Borough of Islington & Haringey

Contact numbers for the external partners are listed at Appendix 2.

3.7 Stand down

Activity from the incident is likely to gradually decline over time, however the Trust needs to be preparing for the stand down from the initial incident declaration and should establish a recovery group as per section 9 of this plan. At the point where activity has declined to a point it can be managed as business as usual or the coordination of response is no longer required a stand down should be issued.

SECTION 4: Resource Management

4.1 Service Delivery Priorities

Each service business continuity plan details the individual services:

- service activities
- minimum resources required over time
- dependencies, and
- the impact should the essential function not be delivered
- options for replacing unavailable essential resources

Service activities are prioritised as one of the following:

Essential – An activity that cannot be stopped

Critical – An activity that can be delayed up to 4 hours (4 hours)

High – An activity that can be delayed up to 8 hours (24 hours)

Medium – An activity that can be delayed up to 24 hours (72 hours)

Low – An activity that can be suspended for up to 3 days (1 week)

Within the services, these will be used determine the deployment of resources to ensure that service identified essential functions receive the resources they need during the disruption. See appendix 5 for list of services categorised for their priority.

4.2 Resource Management

The Trust's resources may need to be redeployed to ensure that essential functions are re-established or maintained during an incident; the COO or Gold on call out of hours has the responsibility of leading and managing this during a serious disruptive incident.

4.3 Staff

Where a service's essential functions have been disrupted due to a loss of staff (e.g. flu, D&V etc.), the COO or Gold on-Call has the authority to re-deploy staff from other services to ensure that the Trust can meet its essential functions.

In the event of a widespread and serious incident affecting staff availability (e.g. flu pandemic) the COO or Gold on-Call has the authority to decide which essential functions will be restricted or stopped in order to free staff to enable other essential functions staffing needs to be met.

4.4 Premises

In the event of a loss of services' premises, either short-term[1] or longer term[2], the COO or Gold on-Call has the authority to displace staff from their work space to provide work space for staff from the affected service(s) in order to maintain their essential functions.

4.5 Utilities

For loss of utilities, services are to implement their own business continuity plans whilst on-call staff should liaise with management contractors who will lead on restoring the service. In the event that the loss of electricity or water is an extended one, consideration should be given to establishing an Incident Management Team and deciding whether this is a Major Incident for the Trust. It is the responsibility of each ICSU director to ensure that management contractors provide recovery time objectives within their contract of service which are in accordance to Whittington Health NHS Trust objectives for response and recovery.

4.6 IT

Should an incident cause significant disruption to the Trust's IT network, the IT Incident Response and Recovery Plan is likely to have already been activated - this would have been triggered by IT staff (in office hours). The services will have to implement their 'work-around' continuity options (detailed in service level plans) until IT support staff business as usual.

Incident Control Team should use the Incident Management Plan for loss of IT service in Appendix 5.

4.7 Mutual Aid

Should the Trust be unable to sustain essential functions due to a major incident - i.e. an inability to source additional / replacement staff, equipment or other resources, the Gold on-Call should consider requesting mutual aid assistance.

[1] e.g. Police cordon preventing access, water damage requiring clean-up and maintenance to make safe
[2] e.g. loss due to fire, serious flood or serious structural damage

The need for mutual aid must be notified to NHS England (London) who will broker the arrangement. The principle of 'shared risk' recognises the fact that the risk of a major incident occurring, which results in the need for mutual aid, is equal amongst all NHS providers.

4.7.1 Charging Arrangements for Mutual Aid

Any mutual aid provided by one provider to another will be on the basis of 'shared risk' and costs will lie where they fall unless otherwise negotiated. Consequently, there will be no immediate cross charging for mutual aid between providers.

As part of the risk sharing agreement, the provider requesting and receiving mutual aid is to collate all associated mutual aid costs for audit purposes.

If any supplying provider wishes to discuss associated costs of supplying mutual aid with the receiving provider, then discussions may take place between the relevant Finance Directors once the Incident has been stood down.

4.7.2 Information Needed before Request is made

The form at Appendix 4 should be completed to ensure that the appropriate information is available to support the request for mutual aid before the initial contact is made.

SECTION 5: Response

5.1 Impact assessment & responding to threats

Following the initial assessment it will be necessary for more detailed impact assessments to be carried out according to the information available. This information should be used to ensure the appropriate management system is used to control and respond to the incident. Upon meeting the Incident Control Team should use the following agenda to assess the situation and develop a response strategy:

1. Situation assessment/summary. Risk Assessment
2. Agreement of strategic priorities (Review of actions and priorities in subsequent meetings)
3. Service continuity measures
4. Service reporting
5. Welfare and vulnerable people
6. Staff concerns
7. Public information
8. Recovery Management

It may also at times be necessary to establish a response group where there is a perceived threat from an event or hazard which may or may not be realised. This allows the development of mitigation prior to any impact occurring. Such events may include industrial action, disruption to other hospitals and services, or civil disturbances. Also where support is required on a project or planned works the Emergency Planning & Business Continuity Officer will liaise directly with services to review Service Continuity arrangements which may be required to produce an emergency plan providing information on any anticipated impacts.

5.2 Tracking of the incident and recovery progress

To manage an incident successfully it will be necessary to collate information from each of the services within the Whittington Health NHS Trust. This can be achieved through situation reporting, these reports should be established to monitor service impact. Situation reports are required for the planning of the recovery process for the Trust, with a focus on the individual recovery requirements of each service. Where required this can be a verbal update to the control or recovery group rather than a written report.

5.3 Record Keeping

The immediate demands of an incident can easily fully occupy staff to the point where no records are kept, and people try to remember what they did “after the event”. This is not acceptable as we are required to keep detailed logs / records of our individual actions, decisions, communications and instructions, which should be timed, dated and initialed.

This is to help following a Significant Incident as the Trust may be invited or required to provide evidence to an appropriate enforcement agency (e.g. the Health & Safety Executive), a judicial inquiry, a coroner's inquest, the police or a civil court hearing compensation claims. Under no circumstances must any document which relates or may in any way relate (however slight) to the incident, be destroyed, amended, held back or mislaid. Records will also be used to improve the way we respond to emergencies in the future. All decision and actions made in the community in response to a Business Continuity Disruption will be communicated to the Incident Control Team (Relevant Lead, Community Manager, Emergency Planning Officer and Emergency Planning Liaison Officer)..Contemporaneous written records will be needed and it is ideal for the Incident Coordination Centre (Site Office/Access Room) to have a loggist at all times to record what was said, to whom and what decisions were made. See Loggist action card.

5.4 Loggist

The loggist role is to capture information related to the decision made during an incident or emergency. A comprehensive record should be kept of all events, decision, reasoning behind key decisions and actions taken. After any high impact business continuity incident, a review will be conducted to identify any lessons so that future planning and response can be improved. In some cases, inquiries may be conducted into the management of the business continuity, critical and major incident. There may be requests made for evidence to support the course of events. Records should be kept in order to facilitate the identification of lessons and actions needed to improve the management of significant incident as well as to support any inquiries.

***Notepads/Incident Log Sheets*:** A numbered log book will be issued to each control room where a detailed and timed record of all instructions received, actions taken and other events which may enable the Trust to assess the success of the emergency response and provide evidence to any enquiry which may follow. The log book should remain intact; no part should be destroyed or erased because, no matter how trivial notes may appear, the total content may form an important contribution in later assessment of the continuity of response. The log books are to be handed on if the holder is relieved during the incident and following stand-down all log books from both the Gold and Silver Control rooms should be returned to the Major Incident Control Room with a receipt being obtained.

Apart from the log books, every scrap of paper must be kept, including notes, post-it notes audio and video tapes, electronic documents, memos and message pads. A simple box file into which all such documents can be temporarily stored will be sufficient during the incident. Email messages should be printed out so that a written record of all emails is available. Email is a well utilised communications mechanism, but is, by its nature, ephemeral and messages could be accidentally erased.

SECTION 6: Communications

6.1 Internal communications

Internal communications messages will be issued by the Communications Team, via an appropriate method during an incident. The appropriate method will be decided by the Communications Team during the assessment phase. Internal communications should briefly describe the situation, what is being done to resolve it, and actions that staffs need to take or be reminded of.

Keep staff informed/updated via the Communications Team: all staff email and novel broadcast message (pop up) – message to be agreed with Emergency Management team and always go through the Communications team.

6.1.1 Use of RAGW Status Reporting

The Gold on-call may choose whether to require all services to report their status or only selected ones. Bronze should contact the service management and require them to report their status to the Trust's emergency e-mail account whh-tr.majorincident@nhs.net

The reports may be asked for as a one off request or as part of an on-going information gathering process. For an on-going information gathering process, the following information must be specified in the initial communication:

- Frequency of reporting (e.g. daily or twice daily, weekdays only etc.)
- Deadline for reports (e.g. 10:00)
- Whether second and subsequent reports should be exception only, i.e. only report when service is Red or Amber

Each report should give the service's RAGW rating (see box below) and a brief summary of any staffing or service delivery issues, i.e.

- whether the service is Red, Amber, Green or White (as per the definitions set out below)
- the challenges being faced, service delivery affected and support required

RAGW Rating	Description
RED	Essential activities have been affected/ are not being maintained
AMBER	Only essential activities are being maintained/ other activities are affected
GREEN	Some non-essential activities have been affected the impact
WHITE	Service is operating normally/ is unaffected by the incident

6.2 Partner & stakeholder communications

This section lists the stakeholders with which the Trust has key relationships, and gives guidance on who will communicate with each. The Incident Control Team responsibility is to manage all communication needs.

Stakeholder type	Organisation or group	Communication method	Responsibility
Patients	The public Businesses/ voluntary organisations and their employees	Media information Call centre / PALS Website	Communications Team Communications Team to brief PALS Communications & IT
Trust Board	Members of the Trust Board	Briefing as required	Chief Executive or nominated deputy
Commissioners	NHS England (London) CSU CCG	NHS01 NELCSU1	Gold on-call
Partners	Other public bodies and agencies	As required	As required
Suppliers	Contractors Agencies Voluntary sector	Email or phone call	Service with responsibility for contact/ relationship
Trades Unions	Unison, NUT, etc.	Briefing as required	Human Resources
The media	TV Radio Newspapers etc.	Press release, press conference, selective briefings etc.	Communications Team

6.3 Media management

Activation of business continuity measures may result in the requirement to establish media management protocols as described in the Major Incident Plan. As part of the assessment process the Communications Team will indicate the likely interest and establish an appropriate response. All incidents will be notified to the NHS England (London) Gold, and where necessary NHS England (London) Communications Team.

6.4 Helplines

During business continuity incident it may be necessary to establish a helpline for staff to contact, this process should follow that outlined in section 7 pages 31 of the Major Incident Plan.

SECTION 7: Recovery Management

Once the initial response to the incident has been managed, the COO or Gold out of hours is responsible for initiating the recovery process. Dependent upon the seriousness of the incident, it may require the establishment of a Recovery Management Group. The COO will appoint a Director of Senior Manager deputy to lead the group. Membership of a Recovery Management Group should encompass representatives from all areas of the Trust affected as well as involving Finance, IT, HR, Estates & Facilities and Communications, as necessary. Recovery planning should include the elements in table 2 below.

Table 2: Recovery Planning Process

Recovery Planning Process
Understanding Losses and Impacts
Undertake gap analyses for • Staffing - numbers and core skills available v's needed • Service delivery - current levels of delivery v's commissioned levels • Resources - current v's required (e.g. clinical consumables, equipment etc.)
Undertake an impact assessment based upon the gaps identified
Identify staff affected by: • bereavement • stress/ anxiety/ fear
Assess (with partners) the impact upon community health
Assess the impact upon performance and financial targets
Assess the impacts upon budgets across the Trust
Impact Management
Staffing: • co-ordinate redeployment/ recruitment of staff to fill gaps identified in numbers/ core skills • arrange staff training where appropriate to fill skill gaps • ensure sufficient availability of and access to Occupational Health/ counselling services for all staff that need it; publicise it widely • ensure service managers/ team leaders provide what support that can be provided to staff in their teams • ensure support for line managers is put in place
Resources: • replenish stock of clinical supplies • identify premises/ areas within premises requiring deep-cleaning/ decontamination • undertake routine/ required maintenance of equipment and replace as necessary • plan the return of facilities to normal use

Service delivery:
• Establish a prioritised list of services/ functions to be recovered – the priorities listed in Business Continuity Plans may form the basis of this – see appendix 5.
• re-establish core functions first then work outwards to peripheral functions
• service managers/ team leaders to draw up plans for re-establishing functions within their services/ teams in line with the prioritised list:
  ○ manage flow of patients
  ○ review appointments/ waiting lists for services – establish priorities
  ○ manage the backlog

- ensure resources are managed across services towards re-establishment of the priority functions
- Group Managers to provide regular updates to the Recovery Manager on progress against plan

Community Health:

- participate in multi-agency recovery group led by Local Authority (if established)
- agree joint priorities and develop action plans to meet required outcomes
- integrate requirements of multi-agency community recovery with internal service delivery recovery planning
- deploy staff and resources to undertake agreed actions

Management and Finance:

- ensure rigorous financial controls are/ remain in place
- negotiate reduction in targets/ performance indicators for current business year with commissioners
- assess expenditure required based upon revised targets/ performance
- identify income streams to meet anticipated expenditure
- identify any shortfall between income and expenditure due to the response
- identify actions to be taken to remedy any shortfalls in finance

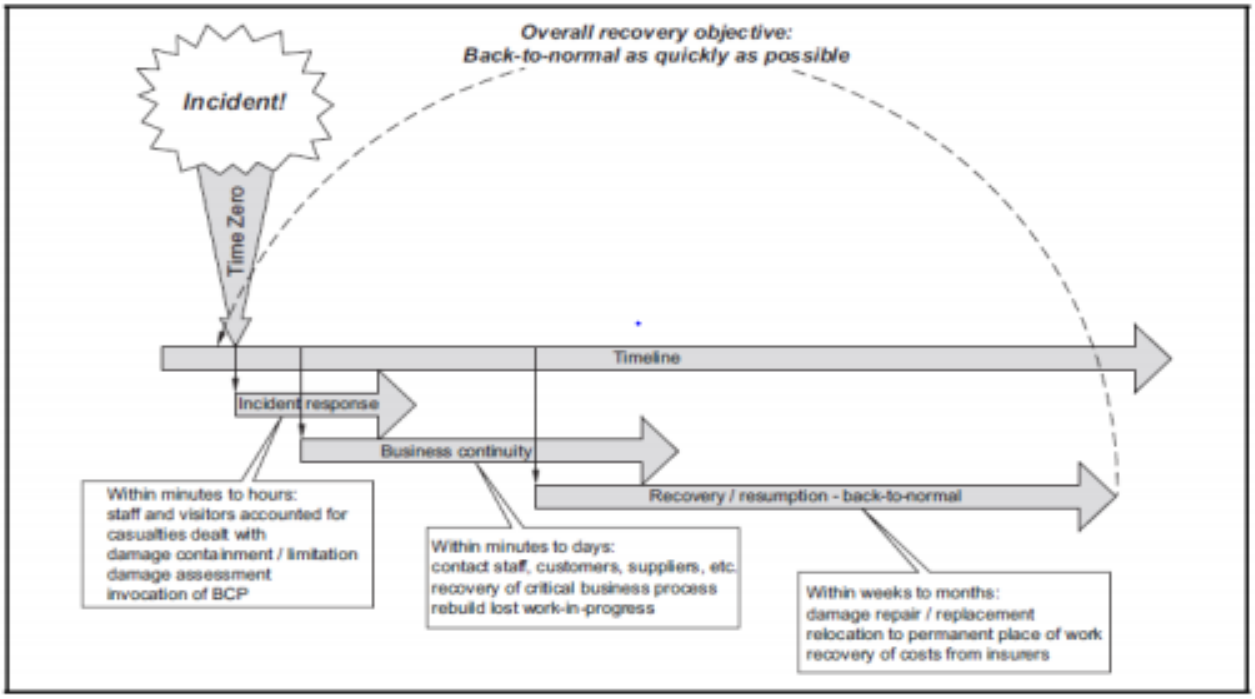
Identification of Opportunities

Collate lessons learned from debriefs

Consideration to be given to the possibility of improving upon what was in place previously. Service/ senior managers to consider:

- procedures
- processes
- resilience
- redundancy
- cost effectiveness
- value for money

Incident Timeline



BS 25999:2006 BRITISH STANDARD Business Continuity Management Part 1: Code of Practice [19]

SECTION 8: Stand Down & Post Incident Debrief

Once the response to the disruption has been controlled to the point that the Business Continuity response may be stood down, the COO or Gold on call out of hours will issue the 'Business Continuity Incident Stand-down' command and initiate the post-incident debrief.

Two types of debrief can be carried out for business continuity incidents:

1. **Hot Debrief**

The Hot Debrief should be run immediately after the incident; however should the incident end during the night it may be undertaken the following day; captures the thoughts of those involved at the point that they are highest in their minds. The format for the hot debriefing should be as follows:

- What went well?
- What did not go as well as would be expected?
- How can we improve?

Areas to be explored include:

- the activation process
- communications
- resource availability and suitability
- welfare
- command and control

A record of the debriefing should be made and disseminated to all who took part. The Hot Debrief notes will inform the subsequent Cold Debrief process.

2. **Cold Debrief**

The Cold Debrief should take place within three weeks of the incident response being stood down; captures the thoughts of those who were involved in the response once they have had time to reflect upon what had happened. Responsibility for organising it rests with the Emergency Planning and Business Continuity Officer. The debriefing should be carried out in a manner that will enable open and frank contributions from attendees. There must be no blame apportioned during the debrief; its only purpose is organisational learning. Attendees should be those who participated in the incident response. The chair will invite representatives from outside agencies as deemed appropriate in order to discuss the incident. The format of the debriefing is set out as described in table 3 below:

Table 3: Format of debrief

Item	Action	Description
1	Introductions	
2	Outline of debrief objectives	
3	Incident details	Date, time & description
4	Walk through of incident timeline	• How notified • How information obtained • Response activities • Incident stand down • Aftermath
5	Review of Incident Logs	Agreement of sequence of events
6	Identify problems experienced/ issues and their causes	Gather all information needed to draft the Post-Incident Report Draw up an Action Plan allocating actions to individuals Consideration to be given to: • Activation process – timeliness/ effectiveness • Communications - internal/ external/ media • Resources – availability/ suitability • Command & Control – effectiveness/ appropriateness • Welfare - issues
7	Identify: • What went well • What didn't go well & lessons learned • Agree actions, who will be responsible for them and timescale for resolution	
8	Identify areas for improvement/ areas to be researched	
9	Any Other Business	
10	Summarise key points/ actions	
11	End of debrief	

Post incident report

After the debriefing, the Emergency Planning and Business Continuity officer will draft the Post-Incident Report and distribute both it and the Post-Incident Action Plan to the Emergency Management Steering Committee for approval and to monitor progress and the Trust Operational Board and Executive Committee for information. .

SECTION 9: Psycho-Social Support

9.1 Staff Support and Wellbeing Following the Event

The welfare and wellbeing of all staff during a Major Incident is highly important. Major Incidents can be traumatic events, and staff will probably need some additional support in the time following the incident. Many members of staff could find the experience of dealing with an incident extremely stressful. An incident is managed as a team and all members of the team maybe affected and have the right to be considered equally. The first step in dealing with a stressful situation is to talk through it with someone you trust and who can listen. In the first instance this is likely to be a work colleague. But no-one has to talk about how they feel, some will choose not to disclose or express personal feelings. If you have concerns about a colleague you should consider sharing your concerns with your line manager.

Managers are asked to note any particular needs of staff and in extreme cases to refer to Health and Wellbeing department for help with stress related issues.

The Trust has access to a full range of support service to support patients, relatives and staff post incident. This includes access to the following key services, see section 8.10 of the Major Incident Plan for more details:-

- Health & Well Being Department
- Employee Support Service
- Fast Track Access to Clinical Services
- Improving Access to Psychological Therapies (IAPT)

SECTION 10: Purpose, Scope, Aim & Objectives

10.1 Purpose

This plan documents the response of Whittington Health NHS Trust to an incident that impacts directly on the provision of multiple Trust Services. This plan:

- Establishes a framework for the management of disruption caused by an incident, and the use of business continuity measures to support incident response
- Describes the roles and responsibilities with regard to a business disruption, and the interrelations between service level plans
- Outlines roles required to effectively respond to an incident
- Establishes the priority of services for recovery across the organisation
- Sign posts the reader to other useful documents as required

10.1.1 Background

The Trust is required to put in place arrangements to respond to emergencies and major incidents as defined by the Civil Contingencies Act 2004, the NHS Emergency Preparedness Framework 2013, and NHS Core Standards for Emergency Preparedness, Resilience and Response 2013. The Civil Contingencies Act (2004) requires Category 1 responders to: *"Maintain plans to ensure that they can continue to perform their functions in the event of an emergency, so far as is reasonably practicable."* Whilst the NHS Core Standards requires *"suitable plans which set out how each organisation will maintain continuity of its services during a disruption… in line with ISO22301".* Business Continuity Management (BCM) is a system that helps to identify risks and provide clear mitigations with the aim of maintaining services and critical functions in the event of a disruptive challenge. BCM also aims to provide clear direction on when and how an organisation can recover from disruptive events.

10.2 Scope

This plan deals with the management and recovery of services during a disruption to normal business. This plan may be supported by the use of elements of the Major Incident Plan where coordination requirements dictate the requirement of a control room. This document considers:

- Critical activities across all Services
- External suppliers on whom these activities depend
- Resources and all staff involved.

The arrangements for responding to external major incidents are described in the Major Incident Plan, and are not part of this document.

10.3 Supporting documents

This plan is supported by the following additional documents and files:

- Major Incident Plan
- Service / Department Continuity Plans

10.4 Aim

The aim of this Strategic Business Continuity Plan is:

- To enable the delivery of the Trust's critical/essential services in the event of a serious disruption

10.5 Objectives

To meet the aim of this plan, the objectives are:

- To establish an effective command and control structure for the management of incidents
- To identify the critical/essential functions and activities that the Trust must maintain through-out disruptive events
- To identify resources that may be deployed in support of essential activities
- To establish the communication and reporting processes necessary for the management of an incident
- To provide tools to support the management of a business continuity incident requiring corporate level co-ordination.

SECTION 11: Insurance

The Trust has insurance cover from the NHS Litigation Authority for the following areas:

Insurance	Cover	Contact No.
Employers Liability	unlimited cover	
Public Liability	unlimited cover	
Product liability	unlimited cover	
Professional Indemnity	unlimited cover	

In the event of an incident that may expose the Trust to litigation, the Gold on-Call should inform the Chief Finance Officer who will give direction on these matters

SECTION 12: Training and Testing

In line with the Trust's Business Continuity Management Policy, business continuity training workshops will be undertaken on an annual basis. These workshops will be followed by an exercise to test the Trust's Business Continuity Plans.

SECTION 13: Statute, Policy & Guidance

This plan has been drawn up to meet the requirements of the following legislation, policies and guidance:

Civil contingencies Act 2004

Health and Social Care Act 2013

CQC Essential Standards for Quality and Safety, standards 4B, 6D & 10E

NHS Commissioning Board Business Continuity Management Framework (service resilience) 2013

NHS Commissioning Board Core Standards for Emergency Preparedness, Resilience and Response (EPRR) 2013

ISO 22301:2012 International Standard for Societal Security - Business Continuity Management Systems – Requirements

PAS 2015:2010 Framework for Health Services Resilience

NHS England Emergency Preparedness Resilience and Response – Business Continuity Management Toolkit 2016

NHS England Emergency Preparedness Resilience and Response Framework 2015

SECTION 14: Governance

The Emergency Management Steering Committee has a responsibility to assure the Trust Operational Board and Executive Committee of the Trust's state of emergency preparedness. Business Continuity plans must therefore be reviewed and signed off by the Emergency Management committee as fit for purpose. To ensure that this plan remains current, it will be reviewed and updated by the Emergency Planning and Business Continuity officer annually or in the event of a change in circumstances rendering a part of the plan out-of-date and ineffective.

SECTION 15: Publication of Plan

A sanitised version of this plan will be publicised on the Trust intranet to provide staff and managers with an understanding of how a large scale business continuity incident would be managed.

Appendix 3: Incident Lead Checklist

Action/Considerations/Information Received **Ensure all information is logged – especially the rationale behind the decisions made.**	**Completed**
Ascertain the following: 1. What is the incident: 2. When it happened 3. Where did it happen 4. Casualties: number, type and condition: 5. Is access to the Hospital site affected/ what are the risk implications: 6. What are the current issues 7. What response is required.	
Does the incident: 1. Impact on patient safety? 2. Impact on staff safety? 3. Has an implication for the continuance of the normal day to day delivery of Trust services? 4. Requires an evacuation of patients/staff? 5. Have reputation implications for the Trust, local/national news? 6. Involve loss of a utility (electric and water)? 7. Require a response outside of what is considered normal day to day operations?	
If yes to any of the above declare a critical incident	
Contact switchboard and request the internal incident cascade is activated and the following message sent “critical incident declared at (hospital/office site) due to...” There is a limit of 60 characters per message – keep it brief, individuals required to act should be contacted directly depending on the nature of the incident. High impact business continuity incidents will be communicated internally via the Page One system and relevant stakeholders will be followed up with a phone call if necessary. Critical incidents and major incidents will be internally and externally communicated via Page One and the Switch Board by the COO during the day and Gold on call out of hours.	
Convene an Emergency Management Team to meet to start to build a plan. In hours: • Operations – Head of Operations • Logistics – Facilities Director/Deputy • Communications – Communications Director • Planning – Site Manager/ Emergency Planning Officer Out of hours: • Operations – Gold Commander • Logistics – Silver Commander • Communications – Communications Director • Planning – Site Manager Dependent on the incident may also include: • IT Response Lead Director • Security Adviser • Head of nursing • Infection control • Operational Directors • Clinical Directors	

OPERATIONS – patient and site management Health and welfare issues Patients Do inpatients need to be moved? Does outpatient activity need to be cancelled? Are patient lists for the day/week available? Does a helpline need to be set up? Employees Do staff need to be moved/relocated Is a member of workforce required Consider the need for a staff helpline Do not let staff leave without taking contactable information **LOGISTICS – estates, facilities and security** Identify what resources are required to achieve the priorities and ascertain their availability. Are suppliers and contractors affected - contact and communicate incident Hotel accommodation required for staff Transport arrangements for patients and staff **COMMUNICATIONS – internal and external (See section 6)** Agree corporate message, agree communication methods to be used Inform staff not to speak to the media Agree media message, agree methods of delivery. **PLANNING – response and recovery – next steps**	
Delegate responsibilities to leads; provide them with a radio for updates and to communicate with them. Radios available from access room.	
Request that a message via Communications Team goes to staff, patients and our partners if required. Partners could include: GPs, the Clinical Commissioning Groups and the Local Authority, this will change depending on the nature of the incident.	
Is access to the hospital affected – road blocks etc. If yes, notify patient transport and security via switchboard.	
Are the lifts working? During certain incidents (fire, electrical failure, lockdown) it will not be safe to use the lifts, place signs on all lifts to inform staff and patients they are not to be used.	
Are the security doors working, additional security may be required to protect vulnerable areas – NICU, Paeds, Maternity, ITU, everywhere else.	
Are the fire alarms working – if no, seek guidance from the Trust Fire Adviser or their deputy?	
Are utilities working (gas, electric and water). If no, contact Facilities – who will contact the companies for an update.	
IT/telephone availability, if not available ensure IT are contacted. If loss of IT is impacting upon critical services, ensure call is logged as a priority 1 with the IT helpdesk on extension: 5351.	
Are suppliers affected – is there access to the goods yard. Can deliveries be directed to another site – contact procurement to assist	
Bronze/Silver to inform NHS England (London) via NHS 01 of the incident – they can contact partner agencies, GPs and other hospitals about the incident and any assistance required. Call 0844 822 2888 and request pager: NHS01	
Bronze/Silver can also inform the North Central London Commissioning Support Call: and send a message to pager holder:	

Appendix 4: Information required to make a mutual aid request.

Which NHS Provider is the aid being requested from? • Trust/ Provider name	
Date	
What resources are requested? • Type • Numbers • Qualifications • Specialisation • Other relevant Info	
Role/ tasks/ purpose to be fulfilled? This must be as precise as possible; do not request resources for ad hoc use - this would be mis-use of Mutual Aid	
Required for what period of time?	
Reporting location and start time?	
Receiving Manager? • Name • Service • Contact Tel. No.	
Welfare arrangements for Mutual Aid staff? • Senior Manager contact point for issues • Arrangements for breaks/ refreshments etc.	
Mutual Aid staff to bring? E.g. • Photo identification • Personal mobile phone number (if carried) • Emergency contact	
Other relevant information	

Appendix 5: Service Activity Priority

	Service Priority: Essential & Critical	Service Priority: High & Medium	Service Priority: Low
1.	Accident & Emergency	Child & Family Psychiatric Services	Care Practice and Policy Advisors
2.	Acute Medicine/Integrated Medicine	Child Development Team (CDT)	Child Health Information
3.	Anaesthetics	Community COPD	Dorothy Warren AEC
4.	Antenatal Services	Community Adolescent Service	Child Health Service
5.	Clinical Site Manager	Children in care service	Fundraising
6.	Biochemistry	Dental Practices	Children's Audiology (Hearing) Service
7.	Blood Transfusion	Department of spiritual and pastoral care	Knowledge & Library Service
8.	Cancer Care Services/Surgery	Children's Community Nursing	Acupuncture Service
9.	Care of Elderly	Falls Clinic	Education and training
10	Catering	Finance	Administration and Premises Management
11	Cavell Ward	Chest medicine	Children's Nurse Led Eczema Clinic
12	Child Protection & Children's Safeguarding	Health Records	Manual Handling
13	Resuscitation Services	Admissions	Children's Occupational Therapy
14	Coyle Ward	Haringey Community Respiratory Team	Children's Outpatients
15	Critical care	Health Visiting and Early Years Services (Child Health Promotion Programme and Immunisation) Oral health	E-Prescribing
16	Cytopathology	Community Dental Services	Equality & Diversity
17	Decontamination/CBRN(E)	Audiology Services	North London Obesity Service (NLOSS) (also see Bariatric surgery)
18	Discharge Planning	Community Diabetes Service	Ethnic Group Information
19	District Nursing	Heart Failure Service	Community Booking Team
20	Environment/ Facilities & Estates Management	Children's Physiotherapy Service	Nursing Preceptorship
21	Facilities Helpdesk	Finsbury Health Centre	Nutrition & Dietetics
22	Emergency Surgery	Chiropody	Obesity surgery (also see Bariatric surgery)
23	Gynaecology	Chronic obstructive pulmonary disease (COPD)	Occupational Health & Wellbeing
24	Haemaglobinopathies (Sickle Cell and Thallassaemia)	Community Mental Health	Haringey Contraception and Sexual Health Services (CASH)
25	Haematology	Community paediatrics Islington Haringey	Maternity Services Liaison Committee (MSLC)
26	Pathology	Heart Failure Specialist Nursing	Expert Patients Programme
27	ICT	Community Rehabilitation Team	Medical Education
28	Imaging	Audiovestibular Medicine Service	Car Parking
29	Intensive therapy unit (ITU)	Highbury Grange Health Centre	Counter Fraud
30	Interpreting Service	Histopathology	Falls Care Pathway

31	Islington Specialist children's service	Holloway Community Health Centre	Health & Safety
32	IM & T Patient Systems	Chronic Pain Service	Adolescent Outreach Team
33	Labour Ward	Hornsey Central/park Road Health Centre	Family Nurse Partnership (Haringey and Islington
34	Legal Services	Diabetes & Endocrinology	Clinical Ethics Group
35	Lifeforce (Children's Palliative Care)	Endoscopy	Bariatric Surgery
36	Looked After Children Teams	Continence service	Behaviour Change & Self-Management
37	Mary Seacole Ward	Hornsey Rise Health Centre	Medical Photography
38	Maternity Services	Fracture clinic	Fertility services
39	Medical Records	Child & Adolescent Mental Health Service (CAMHS)	Breast Screening
40	Mercers Ward	Communications	Health Promotion
41	Meyrick Ward	Continuing Care	HIV Testing
42	Microbiology	Chronic Respiratory Support Team	Improving Access to Psychological Therapies (IAPT)
43	Montuschi Ward	Diabetes Specialist Nursing	Information Governance
44	Multi-agency safeguarding hub (MASH)	Bladder & Bowel Care	Breastfeeding Drop-Ins
45	Murray Ward	Bounds Green Health Centre	ICAT
46	Mortuary	COPD Specialist Nursing	MEND
47	Neonatology	Bowel surgery	Freedom of Information (FOI)
48	NICU and SCBU	Breastfeeding & Weaning	Front of House
49	Nursing & Midwifery	Clinical Nutrition	Clinical Governance
50	Obstetrics/Gynaecology/Maternity	Camden and Islington Diabetic Eye Screening Service	Dermatology
51	Oncology	Camden and Islington Sickle Cell and Thalassemia	Clinical Guidelines
52	Victoria Ward	Gastroenterology	Business Support
53	Pharmacy	Cardiology	Clinical Skills Training
54	X-Ray	Crouch End Health Centre	CAMHS Education Service
55	Security	Cardiovascular Medicine	Outpatients
56	Simmons House Adolescent Unit	Dietetics	Overseas Visitors
57	Supported discharge and rehabilitation services	Domestic Services	Parent and Infant Psychology Services (PIPS)
58	Surgery	Domestic Violence	Patient Advice and Liaison Service (PALS)
59	Theatres	Drug & Alcohol Services	Pension Department
60	Thorogood Ward	Ear, nose and throat (ENT)	Photography
61	Trauma & Orthopaedics	ECG	Planning & Programmes
62		Electroencephalogram (EEG)	Policies & Guidelines
63		Care of Older People	Postgraduate Medical Education
64		Child & Family Consultation Service (CFCS)	Pre-operative Assessment Clinic
65		Day Surgery Unit/General Surgery (non-emergency)	Pre-Qualifying Nursing Education & Training

66		Day Treatment Centre	Private Patients and Overseas Visitors
67		Clinical Psychology	Professional Development & Education
68		Community Child Psychology Service	Psychological Therapies
69		Clinical Supervision	Pulse
70		Palliative Care	Recruitment
71		Endocrinology	Research & Development (R&D)
72		Community Children's Nursing Service	Resuscitation
73		Cearns Ward	RiO Project
74		Colorectal Surgery	Risk Management
75		Cellier Ward	Seating and Mobility Solutions
76		Colposcopy	Sickle Cell & Thalassaemia Counselling Service
77		Chesnut Ward inpatient stroke and rehabilitation unit (Jult 2012) (Greentrees)	Simulation Centre
78		Colposcopy	Speech & Language Therapy
79		Day Surgery Unit	Stop Smoking Service
80		Colposcopy	Vulval service
81		Hospital transport	Weight loss service (link to Bariatric surgery)
82		ICT Support Services	Weight Management
83		Ifor Ward	Whittington Education Centre (WEC)
84		Infant feeding support service	Whittington Radio
85		Infection control	
86		Information & Communication Technology (ICT)	
87		Inpatient Therapy	
88		Integrated Community Therapies Team (ICTT)	
89		Integrated Therapies and Specialist Nursing Services for Children with Additional Needs (Haringey and Islington)	
90		Intermediate Diabetes Services	
91		Integrated Respiratory Team	
92		Ambulatory Care Adults/Children	

Build a Plan

Operations

Reference: Trust Policy - Water Hygiene and 'Safe' hot water policy.

Whittington Hospital Supply: Water is supplied by Thames Water. There are two supply pipes to the site:

- Mains (potable - drinking water)
- Hydrant supply

Water is stored in a number of tanks on site and at full capacity can supply normal demand for 24 hours. However for the purpose of Legionella control, full capacity is only achieved at the weekends and nights when demand is low.

The hydrant supply can be diverted to replenish the storage tanks. Stored water should be circulated and be no more than 24 hours old to reduce the risk of colonisation.

***Incident Control Group strategies for maintaining service whilst remedial action is taken*:**

Based on the scope and impact of the incident, and taking into account its likely duration, the Deputy Director of Estates and Facilities (or engineer on call if out of hours) is responsible for deciding whether to notify the on-call Gold and recommend declaring an Significant Incident. **If the disruption is likely to cause a risk to patient or staff safety and welfare the Gold on-call must be informed**.

- Ensure that the fault is reported immediately to the Estates and Facilities Department (or the Engineer on Call if out of hours) and that they are aware of the following information:
    - the time that the water supply was disrupted
    - the nature of the disruption (failure of flow, discolouration, smell etc.)
    - the precise location(s)
    - risks to patient safety and service continuation
    - any urgent requirements
- Establish the cause of disruption, estimated length of time for resolution and potential for further disruption
- Ascertain whether appropriate onsite water storage options are operating normally.
- Patient care areas will be prioritised for restoration
- Patient care areas are prioritised for repair by service providers under contractual arrangements
- Ensure areas requiring water supplies are receiving appropriate a resilient and safe supply.
- Consider whether alternative areas have been affected locally by the loss of water supply. If not, consider the appropriateness of relocating essential services in areas currently occupied by non-essential services
- Carry out an assessment of services, support services and management functions and prioritise issues for action and resolution

Critical and non-critical areas

Clinical - critical

- All inpatient care areas
- Theatres
- Emergency Department
- MRI, CT
- Biochemistry and haematology laboratories

Clinical areas - that could be isolated

- Other pathology laboratories
- Radiology
- Outpatients

Non-clinical - critical

- Catering areas
- Public toilets
- Cooling systems

Non-clinical - that could be isolated

- Various showers
- Urinals in Staff and Public areas

Logistics

Head of Estates & Facilities: Director of Environment

A failure is more likely to occur when there is work being carried out on the water distribution system e.g. replacement of old pipes, or when external works such as replacement of mains systems occur. The Deputy Director of Estates and Facilities will ensure that there is a business continuity plan in place which includes as a minimum:

- arrangements for coping with increased amounts of clinical and/or infected waste
- arrangements for the supply of bottled/ tankered water
- arrangements for the storage and disposal of empty plastic water containers
- cleaning and decontamination of pipework following any contamination
- restoration of water supplies as quickly as is reasonably practicable
- Quantity of water currently stored on site and estimated length of time before supplies exhausted without conservation measures in place
- Tanker availability
- Area isolation options available and effect taking into account critical area supply
- Use of a secondary supply (hydrant water)
- Conservation of reserve stock of stored water by reducing demand
- Suspending supply of water to non-critical areas
- Consider Fire and Rescue Service option (999) if conventional resources do not resolve water issue for non-drinking
- Hydrant supply status (if compromised, have LFB be informed and when)

Communications

REFER TO SECTION 6

Planning - Response

- Start a log and keep a complete record of events and actions taken, including timings
- Ensure health and safety legislation is adhered to at all times
- Contamination issues (if any)
- Mobilise transport and/or arrange temporary accommodation for displaced staff, if necessary
- Consider phased suspension or reduction of services if necessary
- Consider use of alternative premises, resources and staffing for critical and essential services
- Establish initial recovery timetable to stabilise situation and establish essential services
- Establish a budget line and keep records for the purchase of any emergency supplies

Infection Prevention and Personal Hygiene:

The person in charge of the affected ward or department will liaise with the Infection Prevention team and ensure that:

- There is a supply of hand "wet wipes"
- Foam cleansers are available for sanitizing skin when changing soiled patients
- Nursing staff maintain hand hygiene using hand wipes and alcohol rub
- Surfaces are cleaned using disinfectant wipes

Waste Disposal:

The person in charge of the affected ward or department will ensure that:

- Patients are informed that toilets will not flush
- Disposable equipment is used wherever possible and disposed of using standard disposal practices
- Human waste is disposed of as clinical waste or infected waste depending on source
- Arrangements are in place for the regular removal of waste.

Person in charge of the catering department:

The person in charge of the catering department is responsible for ensuring that there is a business continuity plan in place which ensures, so far as is reasonably practicable, that food and drink is provided to wards and departments which meets or exceeds minimum nutritional standards, and takes into account the needs of those with special dietary requirements.

Planning - Recovery

- Debrief
- Adequacy of alternative water supplies, establish the reason for the loss of water supplies
- Remedial action.

schools. As a result, these staff may wish to stay at home to care for dependent children and, in other cases, staff may be caring for partners or other dependents, such as older relatives.

***Incident Control strategies for maintaining service whilst remedial action is taken*:**

- Ascertain the proportion of staff affected.
- Establish whether commonalities exist in loss of staff, e.g. are staff missing from particular areas of a Directorate / Division, within a particular professional group, etc.
- Assess whether staff from non-essential areas be redeployed to essential services, dependent upon the skill profile.
- Consider the temporary redeployment of staff that have experience working in the affected area (e.g. staff members who have recently left the department, staff members who have been promoted within the Trust.)
- Establish the appropriateness of redeploying non-clinical staff to clinical support duties (e.g. portering, etc.)
- Consider the closure of non-essential services to create additional staff capacity for deployment to essential services. Liaise with lead Director with regards to this course of action, which may require agreement with commissioners.
- Consider availability of staff from other NHS trusts in agreement with the sector

Logistics

- Use of staff accommodation options and other options such as hotel accommodation

Communications

REFER TO SECTION 6

Planning - Response

The following outlines actions in place to respond to varying types of Incidents:

Deploying Staff Where Needed

If required, staff will be moved to alternative areas of work within their levels of competence, depending upon service needs.

In order to facilitate the effective redeployment of staff in responding to an Incident, it is necessary to know the skills of our employees (including those they may not use in their substantive role but would qualify them for redeployment in certain circumstances – e.g. critical care and paediatric nursing) and any restrictions which may hinder their ability to work in the event of an Incident (such as travel distance and carers' responsibilities).

Redeployment of staff in clinical areas will be closely aligned with the prioritisation of services that has been completed as part of Business Continuity Plans.

Staff within non-essential Corporate functions will be redeployed into clinical and essential Corporate areas to provide support and maintain services.

The usual Command Structure (bronze and tactical Silver Commander) through the central Incident Response Team will coordinate movement of staff based on the named 'critical services'.

Details of a local pool of 'potential employees' (those who have recently retired, are on a career break or maternity leave and students as applicable) to assist us in an Incident that may last for weeks (e.g. a pandemic) have been drawn up and options considered to utilising these staff through flexible working options (i.e."Keep in Touch" days for those on maternity leave).

Criminal Records Bureau (CRB) checks will continue to be a requirement for all relevant staff and must be part of the planning for obtaining staff from alternative sources. The workforce directorate will ensure appropriate resources are allocated to deal with this.

Managing Planned Leave / Training Days
During a protracted Incident there may be a need to consider at what point to cancel or not approve further annual, study or other planned leave.

It is proposed that if 'critical services' were not staffed adequately, all planned leave (annual, study, conferences) should be cancelled. This would be an unpopular decision, so it is proposed that the situation should be closely monitored and this action applied only with the Chief Executive's (or nominated deputy in his absence) approval.

It is also proposed that no new requests for leave should be approved at that point, for a fixed period.

It is possible that the Trust may need to agree to consider reimbursing costs for a staff member if they have booked and paid for travel or other arrangements during their leave. This will require the discretion of the line manager and will need to take into account all the circumstances, in particular the essential nature of the skills of the employee. Sign off from a Director would also be required.

The arrangements for cancellation of planned and ban on new leave is proposed to apply to all staff (not just front-line clinical) as all staff will become essential to cover services if the Trust is seriously affected by an Incident (e.g. pandemic influenza).

Self-certification
Staff will self-certificate up to seven days sickness absence. Staff absent for periods longer than seven days require a GP certificate to cover their illness.

In order to minimise the impact of staff sickness on services, it is not recommended that the Executive Board authorises any increase to the current self-certification arrangements outside of legislative changes.

Staff Support Arrangements
A general service will continue to be provided by the Employee Relations Team, together with senior HR support. The Trust's confidential counselling service will also continue to provide support services to staff.

Information and accurate Incident communication for staff is required to avoiding rising levels of anxiety in the workplace, possibly resulting in higher levels of absence than necessary. Staff communications are being managed through the Trust's Communications Department via the Intranet and Internet sites (to enable staff to access information if they are at home).

Accommodation and Travel Arrangements
Options for accommodation and alternative travel arrangements will be considered, should there be difficulties with transport and travel for some staff. We have captured information about distance to travel to work through the skills audit and will be able to make an assessment of the likely impact and requirements.

Planning - Recovery

- It will be vital to allow staff sufficient time and space to recover from dealing with an Incident situation. For some Incidents (e.g. Flu Pandemic) it is expected that it may take two to three months for the workforce to fully recover.
- Debrief
- Cost of additional staff
- Causes of staff loss
- Accommodation for overnight stays
- HR and Occupational Health issues

4. Don't carry unnecessary weight

A rooftop carrier provides additional baggage space and may allow you to meet all your driving needs with a smaller vehicle. However, a loaded rack can increase fuel consumption by as much as five per cent in motorway driving. Even the most streamlined empty rack will increase fuel consumption by about one per cent when it's not loaded. If the carrier is not permanently fixed to your vehicle, remove it when it is not needed.

5. Be a steady driver

Fuel can be saved by using a steady driving technique where the driver anticipates what is ahead and keeps as constant a speed as possible. In general, a one-unit increase in speed requires a three-unit increase in power consumption. It is therefore beneficial if a driver can avoid high speeds while at the same time maintaining the overall average speed. This can be achieved by anticipating what lies ahead on the road and by selecting the most suitable route.

6. Restrict your speed

For most fuel-efficient cruising do not exceed 50 miles per hour (DfT estimate). Most cars use about 10% less fuel when driven at 50mph rather than 62mph and a reduction in speed from 68mph to 50mph can reduce fuel consumption by 20%. The optimum speed for HGVs is also below 50mph and large vehicles can achieve similar savings in fuel consumption by reducing their speed to this level.

7. Don't idle

No matter how efficient your car, idling consumes fuel. One minute of idling uses up more fuel than restarting your engine. Turn off the ignition if you are waiting (it would also help to relieve air pollution).

8. Use electrics less

Car electrics impose an extra load on the engine, making it work harder and burn more fuel. Air conditioning can increase fuel consumption by up to ten percent in stop-go traffic. At motorway speeds, air conditioning increases fuel consumption by three to four per cent. Flow-through ventilation reduces the need to drive with air conditioning on or with windows open, both of which consume more fuel. A sun roof can reduce the need for air conditioning, but when the roof is open at motorway speeds, wind resistance is increased and greater fuel consumption will result.

Planning - Response

Fuel restrictions: likely to be preceded by considerable press warning:

Development of long-term response – avoiding problems

The following desirable developments will help manage the situation:

- Staff travel plans including green alternatives and current travel plans used by staff
- Use through Trust purchasing of more fuel-economical vehicles
- Shared use of other bulk areas with the permission of those areas and within the national framework.

National response:

Demand calming measures:

Communications campaign to reduce demand

Forecourt Supply Management (FSM): Maximum Purchase Scheme

FSM has three main purposes:

- To quickly conserve the fuel available at sites by restricting the supply to customers at times of very high demand and thereby ensuring as wide availability of fuel as possible
- To provide a fair allocation of fuel to customers if there are longer term shortages of transport fuels.
- To encourage drivers not to keep their fuel tanks more full than they normally do.

Emergency and Utility priority fuel schemes for defined responders

- Implemented in conjunction with Designated Filling Stations (DFS) - as a process to control the supply of road transport fuels to a defined number of UK filling stations that will receive supplies for priority use only. Unlike the previous priority use scheme, these schemes work on the basis of identification by vehicle type and logo rather than driver-based pre-registration

- The purpose of priority schemes for the emergency services and other defined responders in an emergency, to make the best use of reducing quantities of fuel to minimise the impact on emergency and other essential services which underpin daily life. The schemes would be introduced quickly.
- The priority schemes would be introduced under the emergency powers in the Energy Act 1976.
- Under the 1976 Act criminal penalties maybe imposed if it is found that fuel products supplied for priority use are used for other purposes.

Activities which must be continued	Activities which could be scaled down if necessary	Activities which could be suspended if necessary
• Encourage staff to use public transport/bicycles/walking where practicable • Advise staff about responsible purchasing of fuel and fuel conservation as well as cascading central government messages to staff. • Prepare lists of essential staff who will receive priority should the situation escalate	• Encourage staff to use public transport/bicycles/walking where practicable • Advise staff about responsible purchasing of fuel and fuel conservation as well as cascading central government messages to staff.	• Encourage staff to use public transport/bicycles/walking where practicable • Advise staff about responsible purchasing of fuel and fuel conservation as well as cascading central government messages to staff.
As above plus: • Implement car sharing • Stop all non-essential travel between sites unless undertaken by public transport e.g. reduce the need for DNs to go to team bases • Use video and teleconferencing where possible	• **As above plus:** • Identify sites which could be temporarily closed to concentrate resources and reduce the amount of travel should the situation escalate	• **As above plus:** • Staff to work from home where it is practicable for them to do so • Consider whether some staff can work in WHNHST premises nearer to their homes to reduce the need to travel
• **As above plus:** • Distribute car logos/permits to designated staff as issued via the SHA • Use any spare patient transport capacity for staff transport This would be managed through the Chief Executive Chief Operating Officer and the Emergency Planning Officer via NHS England (London).	• **As above plus:** • Staff to work from home where it is practicable for them to do so • Consider whether some staff can work in WHNHST premises nearer to their homes to reduce the need to travel	• **As above plus:** • Scale back services according to priority as established by BIA

Planning - Recovery

- Debrief
- Accounting – personal and corporate – of Temporary Logo Scheme permits
- Remedial action.

GOODS OR SERVICES (ALPHABETICAL ORDER)	CRITICALITY[3]	MAIN SUPPLIER(S)	NATURE OF ASSURANCE	POTENTIAL ALTERNATIVE SUPPLIER(S) OF CRITICAL GOODS OR SERVICES	RESIDUAL RISK RATING[4]	FURTHER ACTION REQUIRED/COMMENTS
1. Clinical waste disposal	Critical	Main supplier - GW Butler	Nature of Assurance - 7 years good service	Potential alternative - Grundons	Low	Further Action - don't think we need any
2. Domestic waste disposal	Critical	ARG	7 years of average service	Bywaters	Low	no further action
3. Electricity	Essential	UKPN	NA	Back Up Generators	High	Supply of electrical power not affected by Olympic activities – no road transport required. Failure of supply for other reasons covered by on site generation.
4. Food	Critical	Sodexo Healthcare Services	Assurance statements received including information regarding the Business Continuity documents from both providers	In-house production of meals plus the procurement of frozen meals from alternative suppliers	Low	No further action required
5. Gas	Critical	Corona Energy	Statement by e-mail and on web site	No available alternative for supply of gas	Medium	Failure of supply most unlikely, but in event of failure there is option of burning oil to provide heating and hot water
6. Heating oil	Low	Pace Fuelcare Ltd		Numerous including Watson Shell texaco	Low	This product not required unless as a back up to failure of gas or electricity supplies of more than a few hours. In this event on site storage provide 7 day usage before delivery required.
7. Housekeeping services	High	In house service (Hospital staff),	Employment terms	Buzz housekeeping	Low	no further action

[3] See Criterion table bel

[4] Risks are assessed in direct relation to WHNHST and its services, taking into account the measures currently in place to mitigate the risks. Risks calculated using the scoring method set out in the WHNHST Risk Management Strategy.

		40 staff contracted out	and conditions	Community Cordant		
8. IT critical systems	Critical	McKesson EPR BT RIO	IT disaster recovery plan.	No alternative supplier for either EPR or RIO. In event of catastrophic failure revert to manual downtime procedures	Medium	EPR remotely managed 24 x 7 by System C in Trust data centre (Jenner). Option for disaster recovery onto 2nd data centre. RIO managed from BT Datacentre with full DR from second Datacentre in London Connected via 2 divergent N3 links
9. IT services	Critical	See DR plan above	See DR plan above	See DR plan above	Medium	Highly resilient IT infrastructure in place using virtualised technology from divergent data centres on site + fully resilient LAN + Wi-Fi + option to run services from 2 secondary data centres in community
10. Linen supplies	Critical	Berendsen	Extensive contingency plans in place	Synergy	Low	no further action
11. Medical disposables	High	NHS Supply Chain	BCP received from NHHSC Bulk store will increase stock holding during this event	N/A	Low	Bulk store will increase stock holding of agreed products
12. Medical gases[W1]	Essential	BOC	Remotely Monitor Site.		Low	Emergency delivery to be organised by pharmacy
13. Office supplies	Meduim	Stationery Store	Increase stock holding on site top 150 products	N/A	Low	Bulk store will increase stock holding of agreed products
14. Patient transport (non - LAS)	High	MSL LTD	Access to a wider fleet of vehicles including RFH fleet.	N/A	Medium	Continue to monitor MSL performance. The service is currently out to tender with a view of having a new provider in place before the end of 2014
15. Pharmaceuticals	Essential		Set Stock Levels	Stores Euston Mutual Aid Data Base	Low	Can borrow from other h Ration stocks Consider alternative

16. Portering	Critical	In house service (Hospital staff), 40 staff contracted out	Employment terms and conditions	Buzz housekeeping	Low	no further action
17. Sterile supplies	Critical	IHSS		Multiple stores with stocked items	Medium	IHSS Park Royal default to Ruslip In the event of a logistics or supply problem.
18. Telecoms	Critical Core ISDX PABX Contact Centre, Remind + Voicemail , Speech Recognition Core Incoming Out Going Lines Internal Bleeps	Maintel (ISDX)& HighSpan (Mitel Voip) Netcall Virgin Media Multitone	IT Incident response and recovery plan	Mitel Voip phones Work issued Mobiles,& Air call pagers Dual server provides resilience across suite BT Emergency Lines, BT N3 Link Work Mobiles, pagers Dual Server provides resilience Walkie Talkies	Medium	Reviewing Telephony services across ICO with a view to linking up Whittington with Haringey and Islington to improve resilience across networks. Capital Investment Required
19. Water	Critical	Thames Water		No alternative supplier	Low	In the event of failure of water supplies, contingency plans may involve road transportation.
20. Medical equipment supplies	High	ASTERAL	Covered by contract	N/A	Low	Continue to monitor MSL performance.

SUPPLIES ASSESSMENT TOOL[5]

Criterion 1: Criticality	**Product or service not critical to activity**	**Product or service not immediately critical (e.g. annual equipment service)**	**Lack of product or service has an effect on delivery of service**	**Lack of product or service harms patient care**	**Critical service fails if product or service not available**
Criterion 2 Availability of alternative	**Readily available alternative**	**Alternative only from specialist suppliers**	**Alternative only from a small number of suppliers**	**Alternative only from overseas sources**	**No available alternative**
Criterion 3: Legal/ regulatory	**Product/service falls below threshold for alternative quotes**	**Provision of product/service requires alternative quotes**	**Provision of product/service requires a tendering process**	**Provision of product/service requires full OJEU tender**	**Provision of product / service requires OJEU and external (e.g. DH) approval**

[5] Developed from PAS 2015, British Standards Institute, October 2011

Executive Offices
Direct Line: 020 7288 3939/5959
www.whittington.nhs.uk

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

5 July 2017

Title:	The Lower Urinary Tract Service (LUTs) Update		
Agenda item:	**17/104**	**Paper**	**08**
Executive Summary:	The Trust continues to work to secure the succession plan and be assured of the safety and governance of the LUTS service. The paper summarises the progress to date and work over the summer to enable us to be in a position to open to new patients.		
Summary of recommendations:	To note progress and next steps for the Lower Urinary Tract Service		
Fit with WH strategy:	Aligns with clinical strategy		
Reference to related / other documents:	Compliance with Nice guidelines and health national policies and guidance		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured on BAF		
Date paper completed:	30 June 2017		

Author name and title:		**Siobhan Harrington Director of strategy/ Deputy CEO**		**Director name and title:**		**Siobhan Harrington Director of strategy/ Deputy CEO**	
Date paper seen by EC	**N/A**	**Equality Impact Assessment complete?**	**N/A**	**Risk assessment undertaken?**	**N/A**	**Legal advice received?**	**N/A**

The LUTs Service
Trust Board Update
July 2017

1. Background

The LUTs service was subject to an RCP invited service review in May 2016. Since that time the Trust has been working to identify a succession plan for the clinic following the retirement of Professor James Malone Lee and to ensure that there is assurance of safety and improved governance in place.

This paper describes the progress made and proposes the next steps to enable the reopening to new patients.

- There have been two desk top reviews against the RCP recommendations and action plan since February 2017. Both reviews have demonstrated progress against the recommendations.

- The clinic has remained open to current patients throughout this time. Professor James Malone Lee has continued to work with the Trust and there have been regular meetings with him throughout this time.

- There have been six meetings with members of the patient group over the last 12 months to engage them fully in planning and progress.

- There continue to be meetings with commissioners, UCL and colleagues from UCLH to finalise arrangements.

2. Succession Plan

Professor James Malone Lee retired in June 2016. He has continued to work with the Trust following retirement. A key recommendation of the RCP report was to work with UCL and ULCH to identify a succession plan and work towards a tertiary setting for the clinic.

There has been significant progress with agreement from UCLH, within the context of our Clinical Collaboration, to a shared Consultant post in Urogynaecology. This post will be subject to the business case process and approvals process in each Trust.This will allow us to have clinical leadership in place. Target date for new consultant in post will be June 2018.

UCLH Foundation Trust and the Whittington Health NHS Trust with support from UCL are working together to agree the research governance for the clinical service. Each Trust is responsible for the clinical research studies conducted within its service areas. UCL can support the development of clinical research proposals and also applications for funding grants if need be. UCL provides the governance for related basic research located on its Royal Free Campus. The academic activities, i.e. basic research work, of Professor Malone-Lee are governed by UCL. With regard to the future LUTs service, proposals to establish research trials are being

developed; principle and clinical investigators are being explored. It is aimed that these studies will be part of the new service from June 2018, but it is important that the board recognises securing funding and ethical agreement and sponsorship for trials is a long process which may go well beyond June 2018.

As recommended by the RCP we will work towards the service being based in a tertiary setting. Pending the MDT functioning, initially new referrals for the WH service will be accepted only via secondary care providers. Appropriate onward referrals can then be made to the existing service which will continue to be provided from the Hornsey Central site with a long term plan, pending acceptance of a clinical research framework, to enable the clinic to be within a tertiary governance setting.

3. Safety and governance

The Board asked for assurance regarding the safety and governance for the clinic being in place. Again progress has been made in both areas.

- Monitoring of compliance with practice restrictions in place
- Improved consent forms and patient information
- IT systems integrated
- Standard operating procedure in place
- Protocol for use of skype in consultations in place
- Audit programme integrated into Trust audit programme
- Paediatric pathway in place with Great Ormond Street Hospital

4. Multidisciplinary team working

In order to be able to reopen to new patients the Trust needs assurance that there is a functioning multidisciplinary team (MDT) in place. This was a recommendation of the RCP report and is the advice from NHSE and NHSI. This has proved challenging and now with learning from different approaches to developing an MDT we are instigating a new MDT at Whittington Health for this service. Draft terms of reference are in place. The first reconstituted MDT will meet in July. Local commissioners will be members of the MDT. New patients will be accepted into the clinic on a phased approach and with the agreement of local commissioners that there is a functioning MDT in place.

We continue as a priority to work with partners to enable the service to reopen to new patients. We will discuss with the patient group this week the key messages that we will be sending to all current patients of the LUTs service.

The Board are asked to note the progress and next steps.

Whittington Health NHS

Whittington Health

5 July 2017

Title:	Nursing & Midwifery Revalidation Annual Report 2016/17		
Agenda item:	**17/105**	**Paper**	**09**
Action requested:	The board is asked to approve this report.		
Executive Summary:	This is the annual update report on the revalidation of nurses and midwives in the organisation. A new process for nursing and midwifery revalidation was introduced by the Nursing and Midwifery Council in April 2016 requiring registrants to revalidate every 3 years in order to practice. This report reviews revalidations undertaken in 2016/17. It then outlines the actions that have been taken to ensure organisational readiness and support offered to registrants to revalidate from April 2016, as well as the ongoing monitoring process of revalidation that is now in place.		
Fit with WH strategy:	SG1- Deliver consistent high quality safe services. Clinicians will strive to deliver safe high quality care 'right first time, every time' and exceed patient expectations		
Reference to related / other documents:	Aligns with Clinical Strategy		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	None		
Date paper completed:	27th June 2017		

Author name and title:		**Sarah Hayes Deputy Chief Nurse Lisa Smith Assistant Chief Nurse**		**Director name and title:**		**Philippa Davies Chief Nurse**	
Date paper seen by EC	**3 May**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

Nursing and Midwifery Revalidation

Annual Board Report June 2017

1. Introduction and Executive Summary

A new process for nursing and midwifery revalidation was introduced by the Nursing and Midwifery Council in April 2016 requiring registrants to revalidate every 3 years in order to practice.

This paper provides an overview of the current process required by the Nursing & Midwifery Council (NMC) that nurses and midwives must renew their professional registration every three years. The paper includes actions taken in terms of organisation preparedness for implementation of revalidation and describes the robust system now in place to support and monitor revalidation. Revalidations undertaken in 2016/17 are also described.

2. NMC Revalidation process

2.1 Background

The revalidation process was introduced by the NMC in April 2016 and is the process by which registered nurses and midwives demonstrate to the NMC that they continue to be fit to practice. Revalidation takes place every three years and has replaced the post registration education and practice (PREP) standards. The aim of the revalidation process is to improve upon the PREP system by setting new requirements for registered nurses. The revalidation process requires registered nurses and midwives to declare that they have;

- Met the requirements for practice hours (practice of at least 450 hours during the previous 3 years or 900 hours if holder of two professional qualifications)
- Met the requirements for continuing professional development (undertaken at least 35 hours of continuing professional development relevant to the registrants scope of practice as a nurse with a minimum of 20 hours being participatory learning)
- Reflected on their practice based on the requirements of the NMC Code (2015), using feedback from service users, patients relatives colleagues and others.
- Provided a health and character declaration and declare any conviction for criminal offence or the issuing of a formal caution
- Professional indemnity arrangements – confirmation of having or will have when practicing, appropriate cover under an indemnity scheme
- Received confirmation from a third party (referred to as a confirmer) that their declaration is reliable in accordance with the NMC Code (2015)

Revalidation aims to protected the public, increase public confidence in nurses and help those on the NMC register to meet the standards required of them.

Revalidation for nurses and midwives by the NMC is not the same as medical revalidation undertaken by the General Medical Council (GMC). The NMC register is larger and professionals on it practice in more diverse health care settings. The NMC operates under different legislation from the GMC and as such, NMC legislation around revalidation does not allow for the introduction of responsible officers.

2.2 Responsibility

Nurses and Midwives are responsible and held accountable for their own revalidation process. Every three years at the point of renewal of registration, they are required to demonstrate the requirements of revalidation and their fitness to practice in order to remain on the NMC register. The NMC has published detailed guidance for nurses and midwives to follow.

From April 2016, all nurses due to re-register commenced revalidation. By April 2019 everyone on the NMC register will be expected to have undergone revalidation.

3. Collection of Evidence

Nurses and Midwives are required to collect evidence demonstrating compliance with the NMC requirements. The NMC have strongly recommended that evidence should be collected in a portfolio demonstrating compliance with the revalidation process.

4. Whittington Health Approach

4.1 Trust readiness

The nursing executive supported aligning the revalidation process to annual appraisal which is an approach now adopted by most employers. The majority of nurses and midwives working in Whittington Health are line managed by NMC registrants who are therefore best placed to hold the detailed professional discussion surrounding the requirements for revalidation.

Where a registrant's line manager is not another registrant, the revalidation part of the appraisal is undertaken by the Head of Nursing/Midwifery for that ICSU or the person who is identified as having professional accountability within the posts holders' job description.

The confirmer does not need to be a registrant and therefore is sometimes the non-registrant line manager if meeting criteria issued by the NMC.

The nursing revalidation task and finish group led by the Deputy Director of Nursing used NMC guidance to develop a framework and planned and executed the first

series of communications with key stakeholders aimed at raising awareness. A revalidation policy was ratified and communicated to nurses and midwives.

4.2 Trust Support for Individual Registrants

In the last quarter of 2015 and throughout 2016, a series of support services to all its nurse/midwife registrants was provided to assist them through the process of revalidation.

4.3 Active Professional Support

The Deputy Chief Nurse, Assistant Chief Nurse, Heads of Nursing/Midwifery and senior nurses provide support and advise appraisers in the ICSUs to ensure the necessary skills to assess revalidation requirements of each registrant. This is linked to the appraisal system already in operation within the organisation.

Nurses were invited to a seminar on revalidation, three months before its due date. The seminars were run every month and covered the following topics: The NMC Code and revalidation, revalidation requirements and signposting to NMC Online – the portal through which nurses must submit their revalidation application. Nurses were also given the opportunity to ask questions throughout. In addition to this, nurses were invited to join the reflective reading club. Topics included emotional labour, truth-telling to dementia patients and the importance of hope to the dying patient.

There has been very little attendance at these seminars in the last three months now that the process of revalidation has been embedded and a decision has therefore been made that they are no longer needed.

4.4 Trust monitoring of Revalidation

The Deputy Chief Nurse, Heads of Nursing/Midwifery receive a list from the Human Resources Team each month of nurses and midwives due to revalidate in each ICSU. This list is provided three months in advance of the revalidation date to ensure sufficient time to support the individual nurse or midwife.

The revalidation process is undertaken via the appraisal system and the nurse/midwife confirms this using the appropriate NMC Online process.

Where concerns exist about a registrants ability to revalidate because of lack of information or failure to comply with all the NMC requirements; the confirmer (senior nurse) provides information regarding the actual requirements not achieved to the registrant. The confirmer then supports the registrant to achieve the required missing elements. This is managed using existing Human Resources policy.

Following support, if the registrant does not comply with NMC requirements the Head of Nursing informs the Chief Nurse or Deputy Chief Nurse and informs the Registrant that they may lose their licence to practice and as such will be unable to comply with their contract of employment.

Should a nurse/midwife not revalidate the Head of Nursing manages the process using the Trust existing Human Resource policy – Registration of Professional Staff - POL/COR/0217 pg. 10 -13.

4.5 Revalidation data

380 Registrants revalidated in 2016/17.

2016	
April	21
May	10
June	6
July	25
August	33
September	71
October	72
November	23
December	23
2017	
January	18
February	33
March	45
Total	380

There have been no cases of registrants within the trust being unsuccessful in revalidating in 2016/17 due to not meeting NMC requirements.

5. Recommendations

The board is asked to accept the report.