Whittington Health NHS

T R U S T B O A R D PUBLIC

14.00 – 16:30
Wednesday 4 October 2017

Whittington Education Centre
Room 7

NHS
Whittington Health
NHS Trust

Meeting	**Trust Board – Public**
Date & time	**04 October 2017 at 1400hrs – 1700hrs**
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	Siobhan Harrington, 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 & Timing
Patient Story			
	Patient Story *Philippa Davies, Chief Nurse & Director of Patient Experience*	*Verbal*	*Note* 1400hrs
17/123	**Declaration of Conflicts of Interests** *Steve Hitchins, Chair*	*Verbal*	*Declare* 1420hrs
17/124	**Apologies & Welcome** *Steve Hitchins, Chair*	*Verbal*	*Note* 1425hrs
17/125	**Draft Minutes, Action Log & Matters Arising 6 September 2017**	1	*Approve* 1430hrs
17/126	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Note* 1435hrs
17/127	**Chief Executive's Report** *Siobhan Harrington, Chief Executive*	2	*Approve* 1445hrs
Patient Safety & Quality			
17/128	**Serious Incident Report Month 05** *Richard Jennings, Medical Director*	3	*Approve* 1455hrs
17/129	**Safer Staffing Report Month 05** *Philippa Davies, Chief Nurse & Director of Patient Experience*	4	*Approve* 1505hrs
17/130	**Learning From Deaths Q1 (April to June)** *Richard Jennings, Medical Director*	5	*Approve* 1515hrs

Performance			
17/131	**Financial Performance Month 05** *Stephen Bloomer, Chief Finance Officer*	6	*Approve* 1525hrs
17/132	**Performance Dashboard Month 05** *Carol Gillen, Chief Operating Officer*	7	*Approve* 1535hrs
Governance			
17/133	**Whittington Pharmacy Community Interest Company (CIC)** *Steve Bloomer, Chief Finance Officer*	8	*Approve* 1545hrs
17/134	**Board Assurance Framework & Corporate Risk Register** *Siobhan Harrington, Chief Executive & Philippa Davies, Chief Nurse & Director of Patient Experience*	09	*Approve* 1555hrs
17/135	**Freedom to Speak Up Report & Presentation** *Dorian Cole, Freedom to Speak up Lead*	10	*Approve* 1605hrs
17/136	**Research & Development Annual Report** *Richard Jennings, Medical Director*	11	*Approve* 1615hrs
17/137	**Evacuation Plan 2017/18** *Carol Gillen, Chief Operating Officer*	12	*Note* 1625hrs
Trust Board Committee Draft Minutes			
17/138	**Finance & Business Development** *Tony Rice, Non-Executive Director*	13	*Note* 1635hrs
AOB			
	None notified to the Trust in advance		
Questions from the public			
	None notified to the Trust in advance		
Date of next Trust Board Public Meeting			
01 November 2017 -1400hrs-1700hrs -Whittington Education Centre, 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, Jenner Building, Whittington Health, Magdala Avenue, London N19 5NF or lynne.spencer1@nhs.net

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ITEM: 01
Doc: 17/125

The draft minutes of the meeting of the Trust Board of Whittington Health held in public at 1400hrs on Wednesday 6th September 2017 in the Whittington Education Centre

Present:	Greg Battle	Medical Director, Integrated Care
	Stephen Bloomer	Chief Finance Officer
	Philippa Davies	Chief Nurse and 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:	Norma French	Director of Workforce
	Kate Green	Minute Taker
	Lynne Spencer	Director of Communications & Corporate Affairs

Patient Story

Philippa Davies introduced Dr Jane Young, Consultant Radiologist. Dr Young explained that she had been due to accompany the patient (Sian) scheduled to present that afternoon's story, however the patient concerned had been unable to attend and she was therefore giving the presentation on the patient's behalf.

The patient concerned was herself a consultant surgeon at UCH and the mother of a young daughter. Her daughter (aged five) had been taken to the GP with stomach pains, and although the GP had not felt the condition to be of serious concern, he had referred the daughter for an ultrasound scan so as to be sure. On arrival at the imaging department Sian had been quite anxious, and had asked the receptionist whether it might be possible to move the appointment forward. The receptionist had duly relayed this request to Dr Young, who had arranged for the scan to take place that day, and had been pleased to inform Dr Young that there was no indication of the conditions she had been concerned about and no serious underlying pathology.

Sian had been so pleased at the treatment her daughter had received that she had immediately submitted a formal expression of gratitude and appreciation through the PALS office, and this had subsequently been fed back to the paediatric imaging team. Dr Young informed the Board that the team did received a great deal of positive feedback, however much of providing a good service was attributable to being able to provide speedy interventions, and being able to do so was largely down to goodwill. She herself had worked at the Trust for almost 28 years, and hoped that future resource allocation would allow for rapid interventions in future. Steve Hitchins thanked her for her presentation.

17/110 Declaration of Conflicts of Interest

110.01 No member of the Board declared any interest in any of the business to be transacted that afternoon.

17.111 Welcome and apologies

111.01 Steve Hitchins welcomed everyone to the meeting. Apologies for absence had been received from Janet Burgess, and Tony Rice had apologised in advance for having to leave the meeting early.

17/112 Minutes, Matters Arising & Action Log

112.01 Siobhan Harrington corrected Minute 107.02 so that the fifth line read "at least three MDT meetings" rather than two. Other than this, the minutes of the Trust Board meeting held on 5th July were approved. There were no matters arising other than those already scheduled for discussion.

Action notes

112.02 Referring to 86.03 (junior doctor workforce and skill mix) Norma French reported that Richard Jennings had convened a task force which had already met twice and would be reporting back to the Trust Management Group.

99.01 (Serious Incident Report) was scheduled on the agenda for discussion.

17.113 Chairman's Report

113.01 Steve Hitchins reported on a number of meetings and events he had attended since the last Board meeting, highlighting in particular:

- the annual paediatric picnic
- the convention held by Voluntary Action Islington
- the junior doctors' summer party, with Simon Pleydell, Chief Executive
- a London Borough Haringey corporate planning event
- complaints training
- an event to highlight the treatment of sickle cell patients
- the senior nurse and midwifery forum.

113.02 Moving on to forthcoming events, Steve informed the Board that the current week was organ donation week. He urged everyone to attend the Trust Open Day on 16th September, paying tribute to the work that had been carried out by Delia Mills to arrange this, and thanked staff for the fantastic support they had offered.

113.03 On behalf of the Board, Steve congratulated Siobhan Harrington on her appointment as the next Chief Executive and she would take up her post on 16th September. Steve thanked everyone who had been involved in the appointment process particularly Norma French and Helen Gordon. The panel's decision had been unanimous and the focus groups extremely positive.

113.04 In addition, Steve formally thanked Simon Pleydell for serving as the Trust's Chief Executive over the past three and a half years, describing him as someone who 'not only knew what good looked like, but could deliver it'.

113.05 Drawing attention to the paper circulated, Steve said that he was pleased to announce that the formal process to change the Trust's name to Whittington Health was nearing completion with the revised Establishment Order expected by the end of October.

17/114 Chief Executive's Report

114.01 Simon welcomed the Trust's change of name as an important symbol for the organisation. Philippa Davies would talk about the CQC inspection, and Simon said that the aim was to resolve those areas deemed as requiring improvement during the previous inspection in order to secure a rating of 'good' across the Trust.

114.02 Simon went on to draw attention to the Trust's participation in the national heart survey audit, saying that the results showed that Whittington Health provides exceptionally good treatment in this area. Results from the cancer patient survey were also extremely positive, showing the Trust to have the second best results in London (after the Royal Marsden). Six or seven years ago results were not so good, so this year's results were a major tribute to all involved in cancer care. It was also very important, Simon said, to recognise the achievements of Simmons House, a Tier 4 service working within a particularly challenging environment.

114.03 Moving on to specific targets, Simon said that just one case of MRSA had been declared, however there had been six cases of C. Difficile; this was of some concern given the total number of cases declared the previous year had been seven. Cancer waits had been largely good, although the Trust had just missed the 62 day target.

114.04 Page 4 of the report announced the appointment of Nadine Jeal as Clinical Director for the Patient Access, Prevention & Planned Care ICSU. Nadine was an outstanding clinician, who had been closely involved in the redesign of the MSK service, and whose recent presentation to Haringey GPs had been commended.

114.05 Results of the Friends & Family Test for staff contained many positive messages, but there was an underlying trend of deterioration in answers to both questions. These results had been discussed at the Trust Management Group, who had looked at the free text answers submitted to all questions and was encouraging discussion within local areas. Simon acknowledged that the Trust was carrying out some tough actions and whether difficult things were being done in the right way. He hoped that the anti-bullying & harassment advisors plus Dorian Cole's role as Freedom to Speak Up Guardian would have a beneficial effect on the culture of the organisation.

114.06 The Trust's financial position continued to require improvement; however Whittington Health was by no means unique, and was in fact holding its own, although there would still be a need to look for some non-recurrent solutions in order to achieve the planned year-end position.

114.07 Concluding, Simon remarked on this being his last Board meeting at Whittington Health and said that it had been pleasure to work both with colleagues around that table but also the 'fantastically motivated' wider staff group. He hoped there was a firm foundation that the Trust could build on and that under Siobhan's leadership this could be further developed and taken forward.

17/115 Serious Incident Report

115.01 Richard Jennings informed the Board that there was no change to the format of the regular report, but this month two reports had been presented, one of which was the standard monthly report, and the second of which was an annual review of retrospective themes and trends.

115.02 Seven serious incidents (SIs) had been declared during June and July, the details of which were contained within the report. Two of these resonated with the annual review, namely cancer diagnoses made later than was optimal – this was a risk area categorised as a theme, as indeed it was in most if not all acute organisations.

115.03 Turning to the annual review, Richard highlighted some of the main themes identified over the course of the year and the key learning arising from them. In particular he mentioned the measures taken to reduce falls and the improvements made to ward rounds. In answer to a question from David Holt about the interpretation of results, Richard spoke about the wealth of data captured and the need to ensure processes were as robust as possible. He stressed that it was never possible to remove risk altogether, but every effort should be made to reduce it.

17/116 Inpatient Safe Staffing Report

116.01 Introducing this item, Philippa Davies said that the Trust had experienced an extremely challenging couple of months, with a high level of vacancies and an ongoing need to flex the bed base. Senior staff had to move people around to ensure services were as safe as possible.

116.02 A cohort of nurses from the Philippines was due to arrive next month, and a recruitment trip to India was planned for October. Efforts remained in hand to recruit locally, but this was difficult as little resource was available. In answer to a question from Steve Hitchins about nursing associates and apprenticeships, Philippa replied that progress was positive, however what was chiefly required were Band 5 nurses, and every effort was being made to attract this staff group. Siobhan Harrington stressed that recruitment and retention must be seen as key priorities for the Trust moving forward, as was staff morale.

116.03 Simon Pleydell said that recruitment remained a national problem (especially a London one), and he felt that there was a case now for a review of London weighting. Greg Battle enquired whether overseas recruitment was having a detrimental effect on the countries concerned; Norma French replied that the Department of Health maintained a list and guidelines of countries where to recruit would be inappropriate.

17/117 Quarterly Safety & Quality Board Report

117.01 Richard Jennings introduced the quarterly safety and quality Board report for Quarter 1 (April to June) of 2017/18. He began by speaking about falls, stressing that there was a need for constant vigilance – there had been six Serious Incidents with serious consequences during the year, and of those three, death had been directly attributable to the falls.

117.02 Moving to the section of the report on heart failure, Richard described this as an illustration of what Whittington Health did extremely well; the Trust had consistently performed better than the national average, with its mortality figures coming out as a small fraction of the national average. This bore out the objectives in the clinical strategy (heart failure, COPD and diabetes). Richard paid tribute to the superb clinicians leading work in this area.

117.03 Siobhan Harrington commended the format of the report, but commented that it remained fairly hospital-focused; she would like to see a greater emphasis on community services in future reports. Richard replied that although this might not be easily apparent from the report, much of the heart failure service was prevalent in the community.

17/118 Care Quality Commission (CQC) Inspection

118.01 The CQC had last carried out a major inspection in December 2015. Since then, their methodology had been revised, and inspections were now specifically targeted to focus on previous ratings, with information being collated from a variety of other sources. Organisations rated as inadequate were to be inspected annually, and those 'requiring improvement' every two years. CQC inspectors had arrived in the Trust the previous day; they had set up a stall in the N19 atrium, and were asking service users about their

experience. Focus groups for staff were also to be held in both hospital and community settings.

118.02 Within the next three months the CQC would be carrying out unannounced visits, these could take place anywhere where 'concerns' had been expressed. The team would carry out an exercise to assess whether the organisation was 'well led' in the following months. In preparation they had already submitted a provider information request, which had involved the submission of a great deal of information. The Trust Management Group (TMG) had carried out a self-assessment; followed by the Executive team reviewing Trust wide information and as a team their view was that they could see a level of improvement since the previous inspection, and their self-assessment had been rated as good for both the hospital and the community.

118.03 In answer to a question about the accuracy of any such self-assessment, Anu Singh informed Board colleagues that the Quality Committee maintained an overview, and Simon Pleydell expressed confidence that there had been objectivity over those areas that had been rated as 'requiring improvement' that were now believed to have moved to 'good'.

17/119 Financial Report

119.01 Stephen Bloomer informed the Board that the Trust had reported a £0.4m deficit at the end of Month 4, which meant there was a year to date deficit of £1.9m. Although some improvements had been seen in month, there had been a continued trend of overspend, with a key factor being a failure to achieve cost improvement programmes (CIPs). This then became a difficult gap to bridge, and there would be a need to move to non-recurrent measures to meet the year-end target.

119.02 Asked about specific areas, Carol Gillen replied that for dermatology there were capacity issues that were being addressed, and for general surgery, converting some under-utilised theatre space as part of the theatre utilisation programme will mitigate risks. Summarising, Simon reminded colleagues that it was generally far easier to increase productivity than to take costs out so the leadership team focus will be on increasing activity in key areas.

17/120 Performance Dashboard

120.01 Carol Gillen introduced the highlights from the performance dashboard covering July. ED performance had stood at 92% in July, and continued to show signs of improvement. In June however the department had seen seven 'black breaches' (during the heatwave), and work was ongoing to improve the LAS handovers. There had been some significant trolley waits.

120.02 Mental health patients remained a cause for concern, and the Trust was working with ECIP on possible solutions. Amongst these was ECIP's recommendation to introduce a mental health recovery room in ED, and the Trust had been successful in its bid for £1m capital costs to create this facility.

120.03 Turning to cancer targets, Carol reported that the Trust had fallen just short of the 62 day wait target, and there had been 2 breaches in gynaecology and 2.5 in urology. There had been three RTT 52 week breaches in July, in vascular, general surgery and spinal services. Two of these patients had already had their procedures, the third had declined.

120.04 There was a need to closely monitor delayed transfers of care, particularly in the period leading up to winter; additional capacity was to be put into the discharge team. The complaints performance had fallen in July, and some changes to the process had been

implemented accordingly. Appraisal and mandatory training figures had remained static for some time, but considerable work was currently being undertaken within the ICSUs and there was confidence that improvements would follow. Norma French added that following the review she had undertaken of the OD, learning and development resource Helen Kent and Charlotte Johnson would be both supporting staff and working with the subject matter experts to ensure courses were both accessible and appropriate.

17/121 Corporate Objectives

121.01 Siobhan reported that this paper demonstrates progress achieved up until the end of August. It is not currently rag-rated, but there are plans to introduce this for the next iteration of the report.

121.02 Turning to specifics, Siobhan acknowledged that there were a number of areas the team needed to increase its focus on; one example being the research agenda, where the Trust had not made the progress it had aspired to. It was agreed to ask Rob Sherwin to provide an update for the Board on research for the next meeting. David Holt asked about links with universities, and Norma replied that specific links were in place with UCL and (for nursing) City and Middlesex. Simon Pleydell explained that one barrier was an inability to recruit patients onto trials, and Graham Hart expanded on the work being undertaken to try to increase numbers in this area.

121.03 Steve Hitchins said that he would like to see the corporate objectives further co-ordinated rather than a stand-alone piece of work, and suggested that some indicators might perhaps be incorporated into the performance report.

17/122 North London Partners (formerly NCL Sustainability & Transformation Plan

122.01 Simon Pleydell introduced the refreshed and rebranded STP which had been circulated with the Board papers. He felt that it read well, and reflected much of what Whittington Health was itself trying to achieve both as an integrated care organisation and as part of the local health and wellbeing partnership. The Board was asked to endorse the refreshed plan. Steve Hitchins paid tribute to the contributions made by Simon and by Richard. SH planned to write to NCL Convenor to arrange to meet.

122.02 In answer to a question from David Holt about expectations on individual Trusts, Simon replied that the STP laid the foundations for a number of work streams which Trusts could take forward at their own pace and in line with their individual clinical strategies. He added that the governance element was overseen by the Joint Overview & Scrutiny Committee and each of the work streams had a public participation element to them.

122.03 Siobhan Harrington was pleased to note how much of the STP supported the aspirations of the Trust, and explained it was being used by the ICSUs to underpin their business planning processes, alongside the Trust Clinical Strategy.

17/123 Equalities & Inclusion Annual Report

123.01 Norma French introduced Charlotte Johnson, Head of Development & Inclusion, and Harri Weeks, Equalities Lead. Introducing the report, Charlotte explained that it captured all activity from 2016/17 including the WRES statements. Charlotte took Board members through her presentation, drawing particular attention to the recommendations on page 13, some of which, she said, would need to be addressed in more than one way.

123.02 David Holt had already observed the lack of equality amongst senior posts in the Trust, and was concerned there appeared to be no tangible target that challenged the Board to improve representation; Charlotte agreed this was a point well made. It was noted however that each of the ICSUs had an action plan arising from the results of the

previous year's staff survey, which addressed some of these issues. Richard Jennings echoed David's point, saying that he would like to see far more firm targets and specifics.

123.03 Norma French described the reports submitted to the Workforce Assurance Committee (WAC) and the work undertaken to benchmark the Trust's position. Graham Hart suggested that the WAC should have some ownership of the equalities and inclusion agenda and try to progress the recommendations contained within this report as part of its action plan. Steve Hitchins expressed his agreement with this proposal.

123.04 The Board agreed there were two distinct aspects to this work, one around workforce, where Norma led, the other around service delivery and access, led by Greg. Charlotte thanked everyone for the helpful discussion, which she said had helped to provide her with the hope and confidence that a real difference could be made for the future. She also drew attention to the equalities event planned for 27th September, thanking Deborah who had agreed to be on the panel and Siobhan and Greg who would be co-hosting the event. All Board members were encouraged to attend.

123.05 Deborah Harris reported on the informal group session held last month with youth aged 16-23 that supported the Trust's equality, diversity and inclusion values. As in the past, students received insights into roles, background and tips for successful careers in healthcare. The '*Inspiring Tomorrow*' project is now in its second year visiting Whittington Health. Deborah asked to thank the staff who volunteered on the hospital tours and group discussion: Charlotte Johnson (Head of Development & Inclusion), Sharmin Ahmed (L&D Administer - Apprentice) Ashwina Seerutun (Medical Devices), Rebecca Edwards (Pathology), Dale Carrington (Nursing - Lead District Nurse, Community Services), and Sola Makinde (Medical - Consultant Anaesthetist (Clinical Lead). The students once again found the experience life changing and hope the Trust will continue to give these behind the scenes sessions to youth interested in careers in healthcare in the NHS.

17/124 <u>Medical Appraisal and Revalidation Annual Report 2016/17</u>

124.01 Richard Jennings informed the Board that the production of this report was a requirement of NHSI who also specified the detail required therein. He explained that Table 1 (on page 6) demonstrated the progress made to date, highlighting the following:

- the Trust was doing well, with 90% of appraisals conducted within the appropriate timeframes
- ensuring compliance for Trust grade doctors was harder as they were often on fixed term contracts and moved around; compliance needed to be improved
- out of almost 200 consultants 63 were appraisers (voluntary) and extremely positive feedback was being received which demonstrated a significant cultural change
- the quality of some of the appraisals conducted could be improved, but on the whole the Board could feel assured that a clear majority of appraisals were conducted in a timely and positive way.

124.02 Richard thanked Ashleigh Soan and Rob Sherwin both for their work on this report and for all they had done to support the process over the year.

124.03 Graham Hart asked whether the consultants' job planning process was aligned with the appraisal process, and Richard replied that it was not yet, however a major piece of work was being carried out to implement electronic job planning and a new job planning toolkit, and he hoped to see a major improvement over the next year. In answer to a question from David Holt about the capturing of some of the important messages around quality and holding people to account, Richard replied that within Whittington Health, over half

the doctor workforce was non-white, and more than half female. There were issues around health and disability which required further consideration.

17/125 Modern Slavery Statement 2016/17

125.01 Lynne Spencer informed the Board that the Trust is required to produce a statement setting out compliance with the provisions of the Modern Slavery Act ('the Act'), namely the prevention of modern slavery and human trafficking in its business and supply chains. The Act applies to every organisation in the UK with a total turnover in excess of £36m. The statement must be agreed by the Trust Board and published within six months following the financial year end. The Trust will publish this statement on the Whittington Health website in accordance with the Act.

125.03 In answer to a question from David Holt about how the Trust could guarantee none of the organisations with whom the Trust had a business/procurement relationship breached any clauses of the Act, Lynne replied that the we procure many goods and services under frameworks endorsed by the Cabinet Office and Department of Health, under which suppliers adhere to a code of conduct on forced labour. The statement was formally agreed by the Board, and it was agreed that a high level list of compliance statements would be circulated to the Board.

17/126 Draft Minutes of Trust Board sub-committees:

126.01 The minutes of the:

- Charitable Funds Committee held on 5th July
- Quality Committee held on 12th July
- Remuneration Committee held on 12th July and
- Workforce Assurance held 2nd August

were formally received by the Board. No questions were raised.

17/127 Any other business

127.01 There being no other business, the meeting concluded with questions from members of the public and staff.

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Action Notes Summary

Minute	**Action**	**Date**	**Lead**
121.03	**Corporate objectives -** to be further co-ordinated rather than a stand-alone piece of work and some indicators to be incorporated into the performance report	**February 2018**	**Helen Taylor, Carol Gillen**
122.01	**North London Partners** (formerly NCL STP) – Chair to write to NCL Convenor to arrange to meet	**Complete**	**Steve Hitchins**
123.03	**Equalities and Inclusion** - WAC to have ownership of the equalities and inclusion agenda and progress the recommendations contained within the report as part of its action plan	**Complete**	**NF**
125.01	**Modern Slavery Statement** - The Trust will publish this statement on the Whittington Health website in accordance with the Act	**Complete**	**LS**
125.03	A high level list of compliance statements to be circulated to the Board	**Complete**	**LS**

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Title:	Chief Executive Officer, Siobhan Harrington Trust Board Report for August 2017, highlights from September and look forward for October		
Agenda item:	**17/127**	**Paper**	**02**
Action requested:	For discussion and information		
Executive Summary:	The purpose of this report is to update the Board on national, regional and local 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:	28 September 2017		

Author name and title:		**Lynne Spencer, Director of Corporate Affairs**		**Director name and title:**		**Siobhan Harrington, 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

WELCOME

This is my first Board meeting as Chief Executive and as someone who has been brought up in North London, and lived and worked here for many years it is a great privilege to lead Whittington Health. Among the many strengths of the organisation are our staff, our leadership teams and our Trust Board. I am looking forward to working with everyone to improve, innovate and integrate care and services with our local partners for the benefit of our patients.

Senior staff changes

I am pleased to announce changes from September. Leon Douglas began as our Chief Information Officer, Fiona Smith as our Strategic Communications Lead and Lynne Spencer is now our Director of Corporate Affairs. Helen Taylor will be acting Director of Strategy, alongside her role as Clinical Director of Clinical Support Services until a recruitment process in the new year of 2018.

Official name change to 'Whittington Health NHS Trust'

We became an Integrated Care Organisation in 2011 and have used the name 'Whittington Health NHS Trust' rather than the legacy name 'Whittington Hospital NHS Trust'. We are in the process of changing our name and we expect to receive a revised Establishment Order by the end of October which will enable us to use Whittington Health NHS Trust officially.

QUALITY AND SAFETY

Flu Campaign Winter 2017

We are teaming up with UNICEF to support their 'get a jab, give a jab' campaign. We will match every flu vaccination given to a member of staff with a donation of 10 tetanus vaccinations to a UNICEF project focused on eliminating neonatal tetanus worldwide. We achieved the best flu NHS staff uptake in London last year and we aim to be top again this year. The vaccination is the most effective way to protect everyone and reduce transmission of the virus, especially in healthcare settings.

MRSA Bacteraemia

One incident of MRSA bacteraemia has been reported for this reporting year (1 April to 31 August 2017). We will continue to manage our high profile infectious control campaign across the community and hospital to aim for no more reported cases in 2017/18 as part of our zero tolerance approach.

Clostridium Difficile

We have reported 6 cases of Clostridium Difficile up to the end of August. We have a target for no more than 17 cases this year.

Escherichia Coli (E. coli)

In December 2016, the Department of Health gave all Trusts a target to reduce the number of E. coli bacteraemias (blood culture infections) by 50% by the year 2020/21. In 2016/17 the Trust had 14 Trust attributable E. coli bacteraemias so we need to reduce this number to 7 by 2020/21. Locally we have agreed to reduce our numbers by 2% per year to result in less than 50% by 2020/21. For 2017/18 our local trajectory is 12. From 1 April to the end of September 2017 we have had 3 Trust attributable cases so we are on target to meet our performance trajectory.

Cancer Waiting Time Targets

We exceeded all but one of our cancer targets for July; reported in arrears in line with 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 86.7% against a target of 85%
- 14 days cancer to be first seen 95.7% against a target of 93%
- 14 days to be first seen for breast symptomatic 100% 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 August we recorded:

- 649 referrals received (10% lower than average)
- 434 patients entered treatment (3 below target but above target of 158 for the year)
- 56.5% recovered (highest record ever)
- 70.5% significant improvement
- Patients waited on average 18 days for a first appointment (increased from15 days in July)
- 98% satisfied with overall experience

STRATEGIC

Transformation of the Trust Estate

We are moving forward with the development of plans for how we will approach transforming the Trust's estate. Our future estate will be shaped by our clinical strategy, and in consultation with our staff, patients and wider community.

Our first step will be to develop a strategic masterplan for all of our estate, including community and hospital sites. We have identified a number of areas that require improvement including: maternity and neonatal services; community children's services; provision of staff accommodation; community facilities for primary care and community services; and the renewal of building infrastructure to make our buildings safer and more efficient.

The Trust is aiming to complete the estate masterplan and progress initial projects by the end of the financial year. Each specific project will be worked up into a business case for the Board to approve, and will include staff and patient engagement to inform operational improvements and design.

The Board will be provided with regular updates through the coming months.

OPERATIONAL

Emergency Department (ED)

Achieving the ED target of 95% people being seen within 4 hours has remained a challenge in August. The Trust achieved 90.5%. Key factors have included higher numbers of mental health patients and workforce issues.

There were five X 12 hour trolley waits in August and these were mental health patients requiring mental health bed transfers. To improve this pathway we are working with Camden and Islington Mental Health Trust to implement recommendations from our Emergency Care Improvement Plan Review. These actions include mental health CNS triage, creating a recovery room to reduce long waits and ensuring timely and robust escalation processes are embedded in practice for both in and out-of-hours. We have secured additional funding to create a mental health suite and this will improve our patients' experience and alleviate the pressures within the ED.

To improve our ED performance and ensure our hospital functions as efficiently as possible we held our fourth 'perfect week' in September. The initiative supports staff to change the way patients are seen, treated and discharged to improve safety, patient experience, and performance. This has supported our winter planning preparations as we face challenging months ahead in the North Central London health and social care system.

WORKFORCE

New Chief Executive Staff Forum

As part of my commitment to making sure I listen and learn from staff and find out their ideas on what we could do differently, I will be engaging with staff through a regular series of Friday lunchtime Chief Executive Forums. I will be visiting sites across the community and these have been widely advertised through our internal communication channels to encourage as many staff as possible to attend.

Equality and Inclusion Showcase

I was pleased to take part in our first Showcase in September. There were interactive marketplace stalls, a panel discussion with staff regarding difference, equality and inclusion. We highlighted opportunities for staff to get involved with initiatives such as the Anti-Bullying and Harassment scheme and our Inclusion Champions programme.

FINANCE MONTH 5 (April to August 2017)

We reported a £0.3m deficit for August (Month 5) leading to a year to date deficit of £2.2m. This is against a planned year to date deficit of £1.3m (and planned in month surplus £0.5m). The main drivers for the adverse performance were income, £1.1m below plan in month, and our cost improvement programme (CIP) delivery which is currently £3.5m behind plan for the year to date.

We are putting plans in place to address both the income position and CIP delivery, and we will be using enhanced financial controls and non-recurrent measures to mitigate some of the impact. We are forecasting delivery of our end of year control total.

AWARDS

Staff Excellence Awards

Congratulations to Delia Mills, PA to the Chief Operating Officer, who won the September staff excellence award. Delia works in a very busy team, liaising across seven Integrated Clinical Support Units (ICSUs) and during the summer she took on the coordination of our Trust open day in September. Delia with other teams from across the community and hospital worked tirelessly to ensure we had fantastic day.

Siobhan Harrington
Chief Executive

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Whittington Health

4 October 2017

Title:	Serious Incidents - Monthly Update Report for August		
Agenda item:	**17/128**	**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) during August 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:	6/9/2017		

Author name and title:		**Jayne Osborne, Quality Assurance Officer and SI Co-ordinator**		**Director name and title:**		**Richard Jennings, Medical Director**	
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) during August 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 6 serious incidents during August 2017, bringing the total of reportable serious incidents to 19 since 1st April 2017.

The Trust declared a Never Event in August under the categorisation of a retained foreign object (a retained tampon) that had been left in situ following a perineal suturing /repair procedure.

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
Unexpected Death Ref:14668	June 17	A patient suffered a cardiac arrest and died 48 hours after presentation to the hospital.
Information Governance Incident Ref:16783	July 17	A ward handover sheet with patient details was found by hospital staff in a public area in the Hospital.
Delayed Diagnosis Ref:16865	July 17	Following an elective procedure a patient had to be returned to theatre for revisional surgery to address an anastomatic leak (a recognised complication of colorectal surgery).
Medication Incident Ref:18101	July 17	A patient's prophylactic medication was suspended in error. Patient subsequently

Category	Month Declared	Summary
		collapsed on the ward and found to have developed a large pulmonary embolism.
Delayed Diagnosis/Maternity Ref:19650	Aug 17	A delay in diagnosing a bladder dysfunction led to a bladder injury resulting in a patient having to return to theatre.
Patient Fall Ref:19572	Aug 17	A patient had an unwitnessed fall resulting in a fractured neck of Femur.
Never Event Retained foreign object (tampon) Ref: 20098	Aug 17	During a postnatal follow up examination it was identified that a tampon had been left in situ following a perineal suturing /repair procedure.
Patient Fall Ref: 20794	Aug 17	A patient had a unwitnessed fall resulting in a fractured skull and intracerebral bleed. The patient subsequently died.
Infection Control Incident Ref: 20792	Aug 17	Staff member diagnosed with definite open pulmonary TB.
Delayed Diagnosis Ref: 21667	Aug 17	A delay in correctly diagnosing an abnormal CT scan resulted in a subsequent delay in treatment for a spinal cord compression.

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 details serious incidents by category reported to the NEL CSU between April 2016 – August 2017

STEIS 2017-18 Category	2016/17 Total		April 2017	May 2017	June 2017	July 2017	Aug 2017	Total 17/18ytd
Safeguarding	5		0	0	0	0	0	0
Attempted self-harm	1		0	0	0	0	0	0
Confidential information leak/loss/Information governance breach	6		0	0	1	1	0	2
Diagnostic Incident including delay	8		0	1	1	1	1	4
Failure to source a tier 4 bed for a child	1		0	0	0	0	0	0
Failure to meet expected target (12 hr trolley breach)	1		0	0	0	0	0	0
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	7		0	1	0	0	0	1
Maternity/Obstetric incident mother only	2		0	0	0	0	1	1
Medical disposables incident meeting SI criteria	1		0	0	0	0	0	0
Medication Incident	0		0	0	0	1	0	1
Nasogastric tube	1		0	0	0	0	0	0
Slip/Trips/Falls	7		0	1	0	0	2	2
Sub optimal Care	4		0	0	1	0	0	1
Treatment Delay	3		1	1	0	0	0	2
Unexpected death	10		1	0	1	0	0	2
Retained foreign object	1		0	0	0	0	1	1
HCAI\Infection Control Incident	0		0	0	0	0	1	1
Total	**58**		**2**	**4**	**4**	**3**	**6**	**19**

4. 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 August 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 '10@10' in Emergency Department. The 'Big 4' is a weekly bulletin containing

four key safety messages for clinical staff in theatres; this is emailed to all clinical staff in theatres, as well as being placed on notice boards around theatres. Learning from identified incidents is also published on the Trust Intranet making them available to all staff.

4.1 The Trust submitted 3 reports to NELCSU during August 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 August 2017.

Summary	Actions taken as result of lessons learnt include;
Treatment Delay Ref: 7557	Unexpected death of a patient with a learning disability following an elective procedure. • Whilst staff receive mandatory updates on the Mental Capacity Act (MCA) and have access to experts for advice, there is a variation in understanding how to apply the Act, including around the principles when caring for patients with learning disabilities. Therefore a review of the current training provision around the implementation of the MCA and the concept of reasonable adjustments has commenced and will be rolled out to all staff. • The Chair of the National Forum for Implementation of the MCA has agreed to speak to staff to promote the use of the MCA. This will form part of a workshop where staff will share examples of good practice in the use of MCA.
Information Governance Incident Ref:14218	Information Governance Incident – lost unencrypted memory stick • All staff have been reminded of the Mobile Device Management Policy and the use of encrypted USB sticks. Pop up warnings will appear now on all community desktops and laptops if unencrypted USB sticks are inserted. • Frequent reminders of all IG issues will be circulated via the Trust communications bulletin monthly. • All Whittington Health computers, both desktops and laptops, are now required to regularly link to the Trust network. This is so that the devices can receive upgrades, including security upgrades. • The Trust Information Management and Technology (IM&T) service has completed an audit of data loss prevention software coverage of all trust devices and users across the organisation. Regular audits will continue to be undertaken to ensure computers and laptops are up to date with data security software. • This incident is now included as part of the staff induction IG training.
Treatment Delay Ref:11957	A delay in a patient receiving their medication (antibiotics) in the District Nursing service. • The adoption of the new E community programme (a scheduling platform for district nursing that links demand, capacity and skills) in May 2017 will ensure that referrals are dealt with more robustly. All referrals for patients to be visited by a district nurse that have not been assisgned to a distric nurse (unallocated patients) are discussed on the teleconference every morning to ensure that patients are visited according to their needs. • The District Nursing (DN) Standard Operating Procedure (SOP)

Summary	Actions taken as result of lessons learnt include;
	is being updated to include clear guidelines on how to follow-up requests made to GPs. All relevant staff will be made aware once the SOP has been updated and agreed. A formal training session around follow-up requests to GPs was delivered at the DN forum on 29th August 2017. • DN staff to receive training on how to correctly complete laboratory forms, specifically microbiology request forms.

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. The Trust also runs a series of multi-disciplinary learning workshops throughout the year to share the learning from serious incidents and complaints, and learning is disseminated through 'Spotlight on Safety', the trust wide patient safety newsletter. Themes from serious incidents are captured in an annual review, outlining areas of good practice and areas for improvement and trust wide learning.

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.

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4 October 2017

Title:	Nursing and Midwifery Safe Staffing Report – August data		
Agenda item:	**17/129**	**Paper**	**04**
Action requested:	For information		
Executive Summary:	This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in August 2017. The key issues to note are: 1. The improved utilisation of Allocate 'Safe Care' and associated staffing levels to match the acuity and dependency needs of our patients. 2. An increased fill rate in Registered Nurse shifts as detailed in the UNIFY report, due partly to patient acuity assessment and monitoring and the allocation of staff as described above. 3. A decrease increase in shift requests to provide enhanced care to support vulnerable patients August (n=169) compared to July (n=213). 4. The system for reporting shifts as 'triggering' red is being reviewed. There were 55 shifts in August which initially triggered 'Red' prompting a review of the ward and available staff. These shifts were constantly reviewed to mitigate any risks to patient safety. 5. The number of Registered Mental Health Nurses used to provide enhanced care for patients with a mental health condition showed a reduction in August (n=1) compared to July (n=23). 6. The Care Hours Per Patient Day (CHPPD) measure during the month increased in August (9.07) compared to July (8.84). 7. There is continued use of agency and bank staff to support safe staffing. Most are Whittington Health staff undertaking additional shifts via the nurse 'Bank' or regular agency staff, who are familiar with the organisation and ward/department area. 8. There were no Datix reports submitted in August where 'staffing' was highlighted as an issue which resulted in 'Patient Harm'		
Summary of recommendations:	To note the August UNIFY return position and processes in place to ensure safe staffing levels in the hospital.		
Fit with WH strategy:	Efficient and effective care; Francis Report recommendations. Cummings recommendations; NICE recommendations.		
Reference to related / other documents:	Aligns to statutory framework		
Reference to areas of risk and corporate risks on the	3.4 Staffing ratios versus good practice standards.		

Board Assurance Framework:							
Date paper completed:		September 2017					
Author name and title:		**Sandra Harding-Brown - Clinical Workforce Systems Lead (Healthroster and HealthMedic)**		**Director name and title:**		**Philippa Davies – Chief Nurse and Director of Patient Experience**	
Date paper seen by EC	**Oct 17**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

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 August 2017.

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

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

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 and ITU. The data extracted provides information relating to the dependency and acuity requirements 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 measure the number of care hours 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 August data by ward please see section 4.2).

2.5 Staff fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st to 31 August for Whittington Hospital have 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.

Summary of Staffing Parameters

Standard	Measure	Summary
Patient safety is delivered though consistent, appropriate staffing levels for the service.	Unify RN fill rate	Day – 85.8% Night – 92.8%
	Care hours per Patient Day - CHPPD	Overall the CHPPD for July was 9.07 which is higher than last month, the RN delivered care continues to be consistent
Staff are supported in their decision making by effective reporting.	Red triggered shifts	55 shifts initially triggered 'Red' in August 2017

3.0 Safe staffing

At a number of points each day, the senior nurses review the nursing capacity on the wards to ensure that there are sufficient nursing hours to deliver safe care to patients. An assessment is made which takes into consideration the patient acuity and nurse hours available.

3.1 Patient Acuity

3.1.1 Each morning the care requirements of patients are assessed using the Safer Nursing Care Tool (SNCT) definitions. Those patients requiring a low level of care hours are assigned level 0 and those requiring intensive care are assigned level 3.

3.1.2 As would be anticipated, there were a low number of level 3 patients and a high number of level 0 patients during August. The number of level 1b patients remains high. The increased number of dependant patients require a greater level of nursing support.

3.2 Staffing Requirement

3.2.1 In order to deliver safe staffing levels it is essential that sufficient nursing care is planned for the wards. The new SaferCare module of the Healthroster system provides an estimate of the total 'actual' nursing hours required to provide the necessary care, taking the acuity and dependency of patients into consideration.

The Trust reports each month its ability to align the planned nursing requirement with the 'actual' number of staffing hours. The 'actual' is taken directly from the nurse roster system (Healthroster). On occasions when there is a deficit in 'planned' hours versus 'actual' hours, staff are redeployed

between wards and other areas to ensure safe staffing levels across the organisation. Over the past two months there has been flexing up and down of the number of beds on Victoria, Coyle, Cloudesley and Thorogood wards to manage acuity and flow. This is reflected in this month's submission and the Head of Nursing for integrated medicine will be working with the Clinical Workforce Systems Lead to set planned hours for September and October as we increase bed numbers in line with winter pressure allocation.

3.2.2 Appendix 1 details a summary of 'actual' versus 'planned' fill rates in August. The average fill rate was 85.8% for registered staff and 110.7% for care staff during the day and 92.8% for registered staff and 113.8% for care staff during the night.

3.2.3 The Trust fill rate for August is detailed below

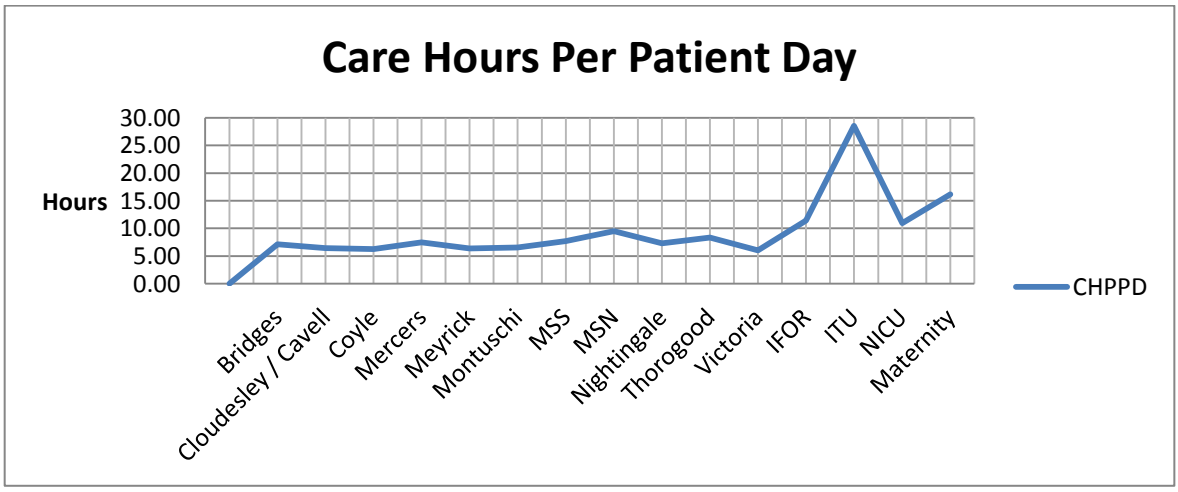
Day		**Night**	
Average fill rate registered Nurses /Midwives	Average fill rate Care Staff	Average fill rate registered Nurses/Midwives	Average fill rate Care Staff
85.8%	**110.7%**	**92.8%**	**113.8%**

3.2.4 The UNIFY report show some wards with unusually high percentage fill rates; for example, Mary Seacole North and South at above 200% for HCAs. In these areas a skill mix review has been completed and Band 4 Assistant Practitioners have been appointed to replace Band 5 nurses thereby increasing the HCA workforce on the wards. Where the percentages are low for Registered Nurses they are correspondingly high for Healthcare Assistants and vice versa. This is a professional decision which is taken by the Matron depending on the needs of the specific patient group.

4.0 Care Hours per Patient Day (CHPPD)

Care hours per patient day is used to show the number of care hours available. The value is calculated using the actual hours worked (split by registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight (23.59).

The graph below shows the average individual CHPPD for each clinical area, in August. ITU have the most care hours (28.54) and Victoria ward have the least (6.01)



4.1 Across the Trust the average number of hours of Registered Nurse time spent with patients in August was calculated at 6.35 hours and 2.72 hours for care staff. This provides an overall average of 9.07 hours of care hours per patient day.

	CHPPD (July)
Registered Nurse	**6.35**
Care Staff	**2.72**
Overall hours	**9.07**

4.2 The table below shows the CHPPD hours by ward over the last four months.There is a slight increase in hours of care delivered in August.

Ward Name	Aug	July	June	May
Cavell		7.18	6.53	7.03
Bridges rehab ward	7.12	6.67	7.73	6.55
Cloudesley / Cavell	6.43	6.11	5.89	5.77
Coyle	6.25	6.23	6.08	6.38
Mercers	7.48	7.41	6.99	7.07
Meyrick	6.40	6.43	6.08	5.63
Montuschi	6.52	5.78	5.74	5.94
MSS	7.69	8.32	8.22	7.79
MSN	9.49	10.08	10.26	9.90
Nightingale	7.31	7.04	6.00	6.91
Thorogood	8.32	8.89	8.77	8.14
Victoria	6.01	6.61	6.09	6.26
IFOR	11.43	6.22	12.00	11.65
ITU	28.54	26.96	26.67	26.32
NICU	10.97	11.10	11.72	13.25
Maternity	16.14	13.27	15.21	15.56
Total	**9.07**	**8.63**	**8.92**	**9.05**

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 CHPPD

and 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 as well as professional judgement of patient dependency and staffing levels by a senior nurse familiar with each clinical area. Actions are agreed to ensure all areas are made safe and a ward where 'red' staffing has triggered for more than half an hour it is constantly monitored by the Head of Nursing and matron while a plan is put in place to increase staffing, no ward is allowed to continue with red staffing levels throughout a shift. 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 (hours short > 22 hours)', 'amber (hours short > 11.5 hours)' or 'green (< 11 hours short)' according to figures generated by Safecare. This figure is a combination of nursing hours and takes into account patient numbers, acuity and dependency.

5.3 A decision as to whether a ward staffing triggers red is taken once the review of staffing and dependency has taken place in addition. A red trigger is classified as more than half an hour at red level. It will usually be when the hours short is greater than 22 hours for more than 30 mins after the review made at the bed meeting. This flag is added to Healthroster by Matron after an assessment and possible redeployments are made.

5.4 There were 55 red flags triggered in August. The Deputy Chief Nurse and Heads of Nursing have been reviewing the approach to recording red flags to make this process more robust and therefore there are a higher number reported than in previous months. This approach is still in its infancy and however it is anticipated that the number will reduce in September when the system is more robust. Frequency and trends will be regularly reviewed by the Deputy Chief Nurse throughout September and included in the October board report.

The table below indicates which wards triggered the 55 red flags during August,

Ward	number of shifts initially triggering red
CAVELL WARD	12
CLOUDESLEY	9
COYLE	8
MEYRICK	9
NEO-NATAL ICU	2
NIGHTINGALE	6
VICTORIA	9

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 August there were 26 Datix reports submitted relating to staffing, none of these incidences related to injury, harm or adverse outcome.

7.0 Additional Staff required to provide 1:1 enhanced care

7.1 When comparing August total requirement for one to one staffing to provide enhanced care with the previous month, there is an decrease in the number of shifts required (Appendix 2). In August there were 169 requests for 1:1 enhanced care provision compared to 190 requests in July. The requests made for this level of care were to ensure the safe management of particularly vulnerable groups of patients. There were 163 HCA shifts, 5 RN and 1 RMN shifts requested in August.

7.2 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 Aug (1) compared to July (23). 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.

7.3 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. The lead nurse for quality and safety is currently reviewing the process for the provision of one to one nursing care. This review will ensure that there is consistency in quality and care offered, and requests are made and authorised in line with best practice and an appropriate decision support tool.

8.0 Temporary Staff Utilisation

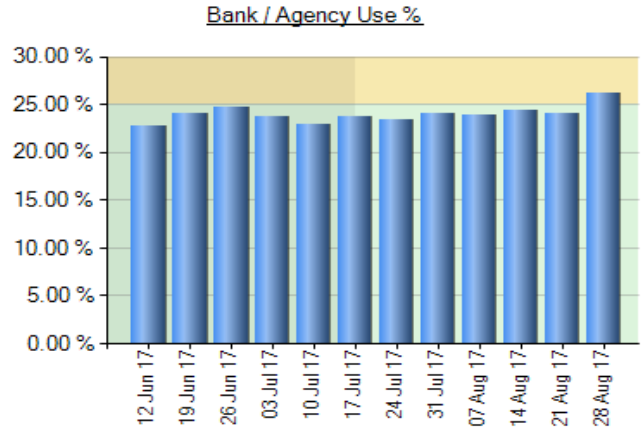
8.1 Temporary staff utilisation (nursing and midwifery) across the hospital is monitored regularly by the Deputy Chief Nurse and Heads of Nursing, a member of the temporary staffing team will attend or report unfilled shifts to the site management. All requests for temporary staff (agency) on the wards are reviewed by the Head of Nursing/Midwifery. A further review and final authorisation is then made by the Deputy Chief Nurse.

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

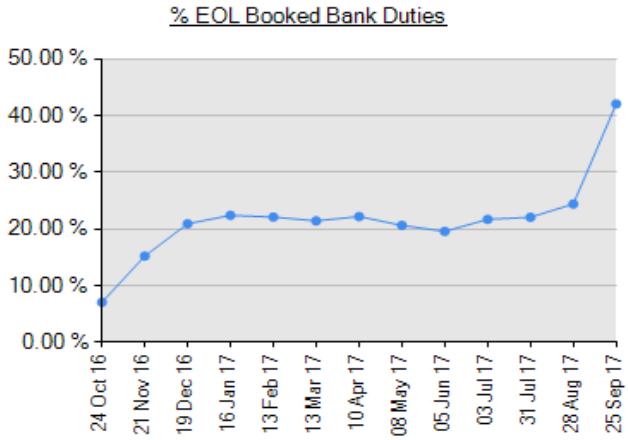
8.2.1 The system in place allows for the most appropriate use of temporary agency staff across the organisation and provides a positive challenge mechanism for all requests.

8.2.3 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.

8.2.4 Temporary staffing usage (Bank and Agency) across inpatients wards remains high and fluctuates between 20 – 24% depending on nurse vacancies and the need to provide additional support for 1:1 care or additional beds. Recruitment to reduce the current vacant posts is ongoing.



8.3 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.

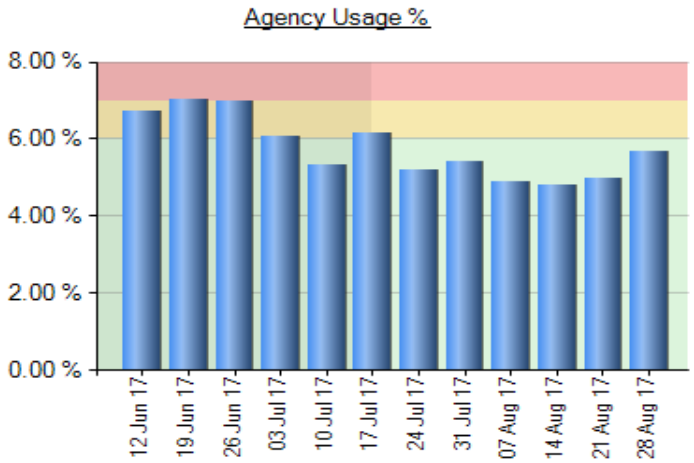


Whilst there is an upward trend in the direct booking process, less than 50% of bank shifts are booked by the staff themselves. This remains an area of service improvement.

9.0 Agency Usage Inpatient Wards (month ending Aug)

9.1 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 July (this is cumulative data captured from roster performance reports).

9.2 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.



10.0 Absence Management

10.1 The management of absence is crucial to effective resource management. The key absences to track are annual leave and sickness. 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. The Deputy Chief Nurse is currently reviewing accuracy of annual leave planning with the Heads of Nursing and effective use of the health roster system for this.

10.2 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. As a result the annual leave percentage has been over-delivered to compensate for being under in the previous months.

10.3 Sick leave percentage continues to be above the 3% threshold month on month. Heads of Nursing ensure all individuals reporting back from sick leave undergo a sickness review which is being actively managed with the HR Business Partners for each ICSU.

11.0 Conclusion

11.1 Trust Board members are asked to note the work currently being undertaken to proactively manage the nursing/midwifery resource across the ICSUs and the August UNIFY return position

Appendix 1

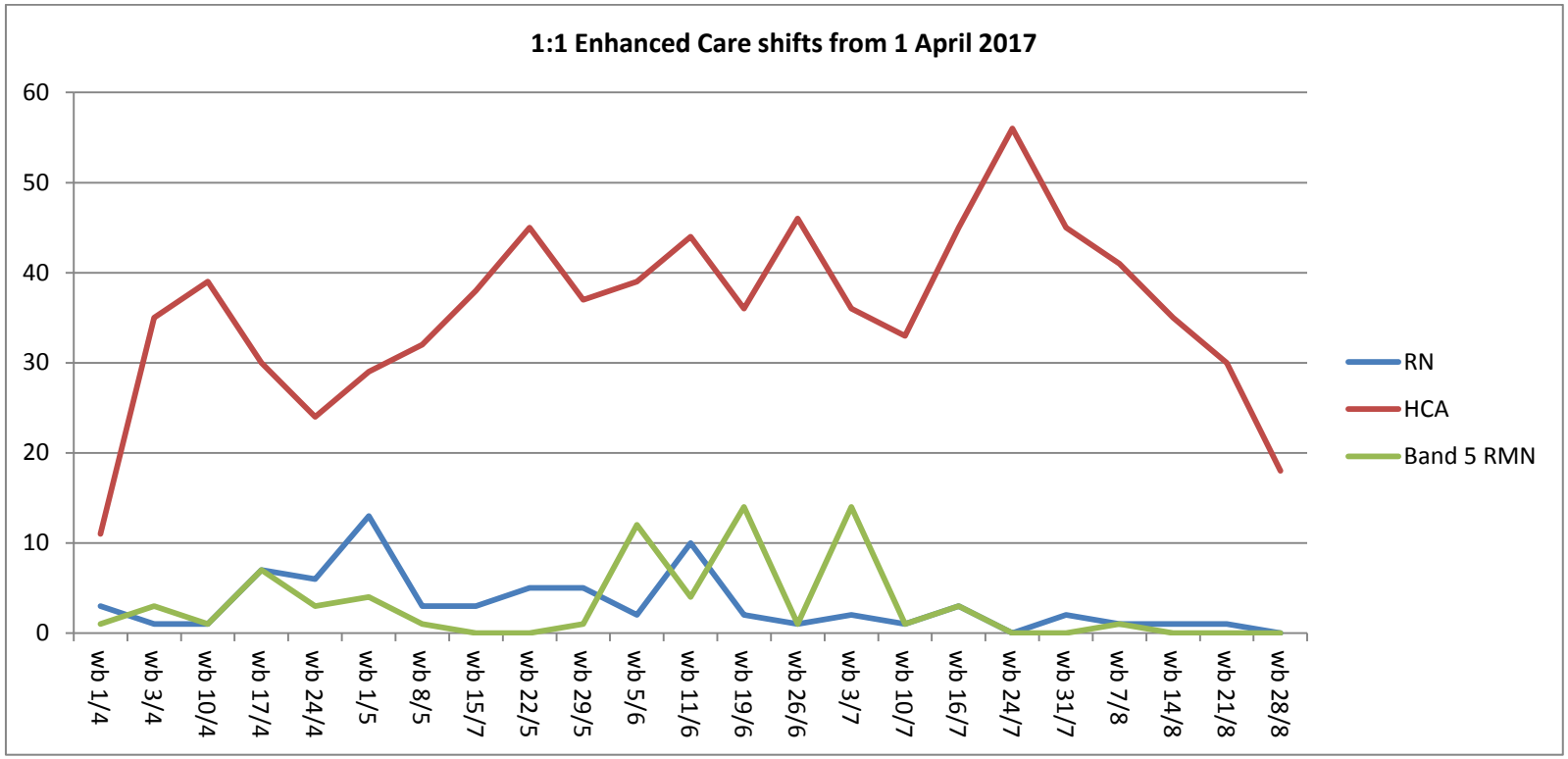
Fill rate data - summary
Aug 2017

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)				
33170	**28476**	**11539**	**12772**	**27923**	**25911**	**9268**	**10549**	**85.8%**	**110.7%**	**92.8%**	**113.8%**

Care Hours per Patient Day
July 2017

Total Patients at Midnight/Month	CHPPD Registered staff	CHPPD Unregistered staff	Average CHPPD (all staff)
8565	**6.35**	**2.72**	**9.07**

Appendix 2: **Enhanced Care requirement to date**



Appendix 3: Average fill rate for Registered and Unregistered staff day and night,

Aug	Day		Night	
	Nurses	**Care Staff**	**Nurses**	**Care Staff**
Ward Name	**%**	**%**	**%**	**%**
Bridges Rehab	**61.7%**	**66.0%**	**79.6%**	**49.3%**
Cloudesley / Cavell	**59.6%**	**77.0%**	**73.5%**	**85.0%**
Coyle	**80.7%**	**98.9%**	**111.4%**	**92.6%**
Mercers	**84.4%**	**114.2%**	**99.4%**	**97.5%**
Meyrick	**79.5%**	**137.6%**	**107.2%**	**173.4%**
Montuschi	**77.6%**	**236.3%**	**107.9%**	**NA**
MSS	**64.2%**	**181.5%**	**75.4%**	**217.4%**
MSN	**94.1%**	**131.8%**	**103.1%**	**211.1%**
Nightingale	**111.0%**	**129.3%**	**100.7%**	**104.4%**
Thorogood	**94.8%**	**93.4%**	**96.2%**	**0.0%**
Victoria	**106.8%**	**102.0%**	**108.8%**	**107.7%**
IFOR	**91.1%**	**100.0%**	**88.5%**	**100.0%**
ITU	**100.0%**		**100.0%**	
NICU	**80.9%**	**100.0%**	**83.2%**	**100.0%**
Maternity	**97.7%**	**132.4%**	**94.2%**	**119.4%**
Total	**85.8%**	**110.7%**	**92.8%**	**113.8%**

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

NHS
Whittington Health
NHS Trust

Whittington Health Trust Board

4 October 2017

Title:	Learning from Deaths Report – Quarter 1 (April to June 2017/18)		
Agenda item:	**17/130**	**Paper**	**05**
Action requested:	For information and discussion		
Executive Summary:	To give the Trust Board an overview of the "learning from death" reviews that formally commenced in April 2017 in line with new NHSE guidance. There were 99 inpatient deaths (including ED) in Q1 2017/18. 70% of all inpatient deaths were reviewed in a structured departmental mortality review meeting. In Q1 April to June 2017/18: • 90.5% of all category A deaths were reviewed (desired performance 90%) • 60% of all category B deaths were reviewed (desired performance 25%) There was 1 potentially avoidable death recorded in this time period. There is no benchmarking of data with other trusts yet as this is the first report that trusts have been asked to produce however 1 potentially avoidable death (1/99) is lower than the national benchmarking figure of 3%. A robust methodology to independently and systematically review deaths of inpatients has been developed but approval for administration support for the project is required to sustain and improve this. The learning from the mortality reviews is valuable to improve safety culture, cross team/organisational working and ultimately to improve experience for the patients' family/carers.		
Summary of recommendations:	For the Board to note the report and take assurance that the Trust is learning from deaths in line with the new requirement by regulators		
Fit WH strategy:	New requirement within CQC regulatory framework		
Refto related / other documents:	NHSE "learning from death" guidance https://improvement.nhs.uk/resources/learning-deaths-nhs/#h2-provider-policies-on-learning-from-deaths		
Ref to risks and BAF	Captured on the Trust Quality and Safety Risk Register		
Date completed:	27/09/2017		

Author name and title:		**Dr Julie Andrews Associate Medical Director**		**Director name and title:**		**Dr Richard Jennings, Medical director**	
Date paper seen by EC	**Oct 17**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Learning From Deaths - Trust Board Paper

Dr Julie Andrews, Associate Medical Director (Quality Improvement /Patient Safety) and Mortality Lead

Covering period 1st April 2017 to 30th June 2017 (Quarter 1 2017-2018)

Introduction/Background

There has been a system of departmental mortality review process at Whittington Health, in line with domain 2 of GMC good medical practice, for many years. Following the launch of the NHSE guidance "Learning from deaths" this paper gathers together this mortality review work more formally ensuring we systematically:

- Engage with patients' families and carers and recognise their insights as a source of learning, improving their opportunities for raising concerns and involvement in investigations and reviews.
- Embed a culture of mortality review learning in medical, nursing and allied health professional and managerial training in the Trust.
- Identify and learn from episodes relating to problems in care.
- Identify and learn from notable practice.
- Support the review of end of life care including reflecting on whether patient's wishes were identified and met.
- Embed the use of a Trust-wide agreed list of team actions following the death of a patient under the management of the Trust (the After Death Pro-forma - ADP)
- Enable informed reporting to Board with a transparent methodology.
- Identify **potentially avoidable deaths** and ensure these are fully investigated through the serious incident (SI) process. If any mortality review scores 1-3 on avoidability of death judgement scoring system (suggestive of a potentially avoidable death) they are automatically escalated to SIEAG for consideration.

Table 1 - Avoidability of Death Judgement Scoring System

Score	Description
1	**Definitely avoidable**
2	**Strong evidence of avoidability**
3	**Probably avoidable, more than 50/50**
4	Possibly avoidable but not very likely, less than 50/50
5	Slight evidence of avoidability
6	Definitely not avoidable

In 2016/17 inpatient deaths were reviewed but without using an objective avoidability scoring system. A retrospective review performed by the Trust Mortality Lead has estimated that there were 7 potentially avoidable inpatient/ED deaths in 2016/17 (1.7%). National data from PRISM study estimates 3% of all inpatient/ED deaths were "potentially avoidable".

"Learning from Death" Policy (Appendix A)

In line with the NHSE guidance we have published a "learning from death" policy on the intranet. It has been reviewed by the Trust Patient Safety Committee and departmental mortality leads. It broadly follows the NHSE guidance but gives clearer pragmatic guidance about which inpatient/ED deaths to review when time is limited. The policy outlines that 100% of "category A" deaths should be reviewed (family concern, staff concern, deaths secondary to sepsis/falls/VTE, maternal, surgical or paediatric deaths, deaths in patient with learning disabilities and those deaths referred to the Coroner). It outlines that a minimum of 25% of "category B" deaths (deaths that are not category A deaths) should be reviewed.

The focus of the policy is on relative/carer involvement, communication with all relevant teams about the death of a patient, process of mortality reviews and ensuring there is wider learning from any issues raised from these reviews.

NHS Mortality Dashboard (Appendix B)

The mortality dashboard provided by NHSE is shown in Appendix B and demonstrates both the total number of deaths reviewed plus the death avoidability scores given. There was 1 potentially avoidable death recorded in Quarter 1 2017/18. This was in a medical patient that missed doses of VTE prophylaxis in the form of Tinzaparin and then went on to develop a fatal pulmonary embolism. This was investigated as a Serious Incident and the family of the patient have been kept fully informed.

30 patient deaths in Q1 (30%) were not systemically reviewed in a department mortality review process but the majority (27/30) of these were "category B" deaths. Three category A deaths were not reviewed; (patient deaths in COOP, Surgery and Gastro).

The dashboard outlines the avoidability of death judgement scores for inpatient/ED deaths in Q1 and this is summarised below, in table 2. There were 2 deaths in patients with learning disabilities. These patients will be formally part of the national LeDeR mortality process but initial departmental mortality reviews have recorded these deaths as having avoidability score of 6 (definitely not avoidable).

Table 2 – Avoidability of death judgement scores for Q1: 2017/18

Quarter 1 data	Score	Number of patients with each avoidability score
	1	0
	2	**0**
	3	**1**
	4	**8**
	5	**10**
	6	**50**
	NOT REVIEWED	**30**

Local Mortality QI Dashboard

The mortality leads felt further QI outcome measures were required to help guide our performance so these are included as a local mortality performance dashboard below.

Month	Percentage of category A deaths reviewed	Percentage of category B deaths reviewed	Percentage of ADP's* completed (*If relevant)	Percentage of discharge summaries sent to GP within 72 hours of death (does not include Women's health data)	Missed coroners referrals
Desired performance	>90%	>25%	>90%	>90%	0
April	92%	65%	16%	67%	0
May	80%	80%	42%	92%	1
June	100%	35%	16%	75%	0

Themes from Mortality Reviews (not exhaustive)

i) Key areas for improvement

a) Administration support for departmental and corporate mortality processes. Mortality teams could potentially extend to reviews on patients that die after discharge (within 30 days) and all "category B" deaths but this would require additional investment from the Trust/CCG's for staff time for reviews and for administrational support.
b) Nursing home residents with community DNAR's in place died in ED/AAU (5 patients in Q1).
c) Need for more detailed and/or timelier and/or realistic treatment escalation plan completion, ensuring documentation available to all in patient pathway and patients/families involved in discussion.
d) Improving documentation of patient management plans including **explicit** discussion with patients and families/carers. This theme has also been identified as an issue in 7 day service audit.
e) Evidence of unrecorded medicine safety incidents (low/no harm) in 3 patients in Q1.
f) Evidence of delays in referrals of patients to other teams/investigations/ management whilst inpatients (11 patients). Inability to access previous Echo results out of hours was discussed in 2 mortality reviews. Delays in treatment of sepsis 2 mortality reviews.
g) Imprecise recording of Medical Cause of Death (MCCD) (2 patients in Q1).
h) Non-compliance with completion of after death pro-forma and discharge summaries. These are vital to improve communication of death to primary care and other relevant teams.
i) Improved engagement with families/carers to ensure they know how to raise concerns about care (via leaflets and direct communication).

j) Concerns raised about time taken to refer patients for specialist care via E-referral forms (neurosurgery and cardiothoracic) and time taken to physically transfer patients to other organisations (2 patients in Q1).
k) Need to improve process of mortality reviews in some teams.

ii) Notable practice

a) Process of mortality reviews in some teams – educationally focused, linked to trainee supervised learning events, multi-disciplinary, timely and sharing of learning across teams and organisations.
b) Evidence of excellent patient, family and carer involvement in End of Life (EoL) decision making by most teams.
c) Linking mortality reviews to grand rounds and other educational events in order to share learning.
d) Cross team and organisational working through the "learning from death" agenda improving although takes significant administrational time.
e) Improved sharing of expertise between teams e.g. breathlessness packs, how to provide LAS with patient specific protocols, earlier discussions about patient TEP's.
f) Improved safety culture – linking mortality reviews to guideline refinement (e.g. VTE, sepsis), ensuring feedback at patient safety forum, ensuring mortality reviews with score 1-3 are escalated to the SI panel, triangulating with complaints and litigation to improve learning.

Immediate "Learning from Death" Action Plan (reviewed at mortality forum)

Recommendation	Key actions	Lead	Date
Surgical ICSU requires admininistration support for M and M process/QI. Finances identified	Business case to be written Clearer idea of surgical data required before case written	Pratik Sufi/JA Pratik Sufi	30/11/17
Other teams may require access to administration support for mortality process. Identified through proposed QI budget	Review of admin support for other teams.	QI team	31/12/2017
Spread good practice from high functioning mortality meetings to other departments	Mortality forum quarterly	Mortality leads	Ongoing
Improve local performance dashboard metrics	Trust QI project – staff identified	Mortality leads	Ongoing
Specific themes identified 1) EoL discussion, documentation and management (NH	ReSPECT QI project Involvement – pilot through	Mortality leads ReSPECT project leads	31/12/2017

Recommendation	Key actions	Lead	Date
residents) 2) Encourage further family/carer involvement through partnership working	UCLP Specific educational project required in surgery Involvement of families/carers in educational projects through "learning together" project	TBC	

Summary

Trust board should expect to see quarterly "learning from death" data and a learning based report every other quarter.

We have had one potentially avoidable patient death this Q1 from the 70% of deaths that have been systematically reviewed in a mortality review meeting.

There is no benchmarking of data with other trusts yet as this is the first report that trusts have been asked to produce but at this point last year (Q1 2016/17) there had been 3 potentially avoidable deaths. 1 potentially avoidable death (1/99) is lower than the national benchmarking figure of 3%.

We have developed a robust methodology to independently and systematically review deaths of inpatients but to improve on this I am recommending that the administrational support for the project is approved.

The learning from the mortality reviews is valuable to improve safety culture, cross team/organisational working and ultimately to improve experience for the patients' family/carers.

Appendices

Appendix A – NHSI Learning from Deaths Policy Template
Appendix B – NHS Mortality Dashboard

Whittington Health NHS

Learning from Deaths Policy

Reference/Number			
Version:			
Ratified by:			
Ratification Date:			
Approval Committee			
Date Approved:			
Date Issued:			
Executive Owner:			
Name of Author(s) and Job Title(s):			
Target Audience:			
Review date:			
Procedural document linked to/Tagged:	**Tick as appropriate**	√	
	Regulatory Compliance	√	
	Organisation-wide	√	
	Directorate		
	Service		
	Shared document		
Keywords	Mortality, death, structured case note review		

This is an online document. Hard copies and downloaded versions are valid only on the day printed or downloaded. It is the responsibility of staff to verify current status from the Intranet.

Dissemination and Implementation

Responsible person for coordinating dissemination and implementation			
Methods of dissemination	Intranet	Other	Email to key Stakeholders
(Delete as appropriate)	Yes/No		Yes/No

Consultation

List of those consulted	
Period of consultation	

Version Control Summary

Version No	Description of change	Author	Date
1	First draft	Ashleigh Soan	13/07/2017
2	Edits to first draft	Julie Andrews	20/07/2017
3	Addition to involvement of family and carers	Ashleigh Soan	31/07/2017
4	Addition of Dissemination of Learning and further minor amendments	Julie Andrews	03/08/2017
5	Addition of information relating to After Death Proforma	Louise Restrick	27/08/2017

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1.0 INTRODUCTION

The *'National Guidance on Learning from Deaths'*[1] was published in response to a number of high level reviews that have concluded that learning from deaths was not being given sufficient priority in some NHS organisations and that this meant that there were missed opportunities to improve NHS services including patient and family experience through the review of deaths. This policy has been written in response to this guidance.

2.0 PURPOSE

This policy has been written to set out how we will respond to and learn from deaths of patients who die while under the management and care of Whittington Health ('the Trust'). This policy also provides guidance for all staff involved in the mortality review process.

The aim of the mortality review process is to:

- Identify and minimise deaths due to problems in care across the ICO.
- Identify and learn from episodes of sub-optimal care.
- Identify and learn from notable practice.
- Support the review of end of life care including reflecting on whether patients' wishes were identified and met.
- Embed the use of a Trust-wide agreed list of team actions following the death of a patient under the management and care of the Trust (the After Death Proforma)
- Engage with patients' families and carers and recognise their insights as a source of learning, improving their opportunities for raising concerns and involvement in investigations and reviews.
- Enable informed reporting to Board with a transparent methodology.
- Promote organisational learning and improvement.
- Embed a culture of mortality review learning in medical, nursing and Allied Health Professional training in the Trust
- To identify potentially avoidable deaths and ensure these are fully investigated through the serious incident (SI) process.

3.0 SCOPE

This policy relates to all staff involved who may be involved in the mortality review process:

- Medical staff

[1] '*National Guidance on Learning from Deaths*', National Quality Board (March 2017), available from https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

- Nurses and Allied Health Professionals
- Mortuary staff
- Quality Improvement staff
- Performance Analysts

The mortality review process is applicable to all in-hospital deaths in all specialities, including emergency medicine, paediatrics and maternity. All deaths of former inpatients that die within 30 days of discharge may be subject to review in the future.

4.0 DEFINITIONS

Medical Certificate of Cause of Death (MCCD)

Referred to as a 'death certificate'. A MCCD enables the deceased's family to register the death. This provides a permanent legal record of the fact of death and enables the family to arrange disposal of the body, and to settle the deceased's estate.

Coroner

Coroners are judicial office holders. They are completely independent and are appointed directly by the Crown. Coroners investigate all deaths where the cause is unknown, where there is reason to think the death may not be due to natural causes, or which need an inquiry for some other reason.

Category A deaths

Category A deaths are:

- Deaths where families, carers or staff have raised concern about the quality of care provision;
- All inpatient deaths of patients with learning disabilities;
- All inpatient deaths of patients with a mental health diagnosis;
- All deaths in a service where concerns have been raised either through audit, incident reporting processes or other mortality indicators;
- All deaths in areas where deaths would not be expected, for example deaths during elective surgical procedures;
- Deaths where learning will inform the provider's existing or planned improvement work, for example deaths where the patient had sepsis, diabetic ketoacidosis, or a recent fall.
- All paediatric, neonatal, maternal deaths and stillbirths
- Deaths that are referred to the Coroner.

Category B deaths

Category B deaths are all deaths of inpatients and deaths of patients within 30 days of discharge from hospital that do not meet any of the criteria of Category A deaths.

Mortality review/ case note review

The review of a deceased patient's medical records to determine whether there were any problems in the care provided to the patient. The purpose of these reviews is to identify any challenges and issues and learn from any care and service delivery problems, and also to identify notable practice.

Potentially avoidable death

A potentially avoidable death is a death that has been clinically assessed using a recognised methodology of case note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

After Death Proforma (ADP)

Trust-wide agreed list of team actions following the death of a patient under the management and care of the Trust.

5.0 DUTIES (Roles and Responsibilities)

Executive Medical Director

The Executive Medical Director is the executive responsible for the oversight of the mortality review process.

Associate Medical Director for Patient Safety

The Associate Medical Director for Patient Safety is the Trust's Mortality Lead. The Associate Medical Director for Patient Safety is responsible for:

- Oversight and regular review of the mortality review process including use of the ADP for all deaths
- Holding the central Mortality Review Database
- Identifying relevant Departmental Mortality Leads to ensure completion of all relevant mortality reviews
- Reporting to the Trust Board on patient mortality based on the review of the care received by those who die under the Trust's care including use of the ADP
- Ensuring that feedback and learning points are shared across ICSUs or trust-wide.

Departmental Mortality Leads

Departmental Mortality Leads are responsible for:

- Ensuring all deaths within their area have an ADP completed and are reviewed according to this policy
- Identifying suitable clinicians to complete the first, second and case note reviews
- Ensure all reviews and findings are electronically and retrievably stored on the trust's I-Drive
- Ensure that action plans for improvement are developed where required and shared within the ICSU
- Overseeing progress on the implementation of action plans.

Nurses and Allied Health Professionals (AHPs)

Nursing staff and AHPs are responsible for participating in mortality reviews.

Mortuary staff

Mortuary staff are responsible for:

- Providing daily lists of deceased patients
- Providing copies of all deaths certificates on a weekly basis.
- Forwarding coroner referral forms when these have been completed and sign off by the coroner.

Serious Incident Executive Approval Group (SIEAG)

The SIEAG is jointly chaired by the Executive Medical Director and Chief Nurse and Director of Patient Experience. Any patient deaths that have been highlighted by the case note review process as being potentially related to problems with care should be reviewed by the trust's multi-disciplinary SIEAG.

The SIEAG will then consider whether any highlighted cases meet the criteria to be investigated as serious incidents, or whether any other process would be suitable, for example feedback of learning to specific services or professional groups.

Informatics team

The informatics team provides monthly lists of patients who died as an inpatient in the previous month. The informatics team also provides a record of all patients who have died within 30 days of discharge from hospital.

6.0 Mortality review process

The mortality review process following the death of a patient under the management and care of the Trust starts with completion of the ADP.

The components of the ADP include:

A. A doctor speaking to a patient's family and offering condolences from the team.
B. A consultant-led discussion to agree the contents of the death certificate or the need for referral to the Coroner.
C. A 'death discharge summary being completed and shared within 24 hours.
D. Information about a death being shared promptly with other teams/professionals involved in a patient's care.

The full content of the Trust ADO is in Appendix 2. It is downloaded by a ward team as a three part document at the time of a death; Part 1 supports the process of the confirmation of death, Part 2 is the ADP and the third section is the Last Offices Check List for the Ward staff.

The process for the conduct of mortality reviews is outlined in the flow chart at Appendix 1.

6.1 Notification of patient deaths

- Patient deaths are notified through daily lists of deceased patient sent by the Mortuary. The Mortuary also provides information on the content of all death certificates for patients in a weekly email.

6.2 Recording patient deaths

- All patient deaths received are entered onto the Mortality Review Database by the Administration Lead for Patient Safety including information on completion of the ADP.

6.3 Reviewing patient deaths

- The Trust Mortality Lead reviews all patients' deaths on the Mortality Review Database and completes an initial review on whether the death would be considered a Category A death or a Category B death.
- All 'Category A' deaths should be reviewed.
- A minimum of 25% of all Category B deaths should be reviewed.
- All deaths identified to be reviewed will receive an initial review by an individual practitioner and a second departmental mortality review (usually within the structure of a mortality meeting).
- All first departmental mortality reviews need to include the patient's hospital number, date of death, content of the death certificate, information on completion of the components of the ADP and have a score using the Confidential Enquiry into Stillbirths in Infancy (CESDI) bandings (Diagram 1) or Avoidability of Death Judgement Scoring System (Table 1) as a minimum. An example mortality form is given at Appendix 3.

Diagram 1: Confidential Enquiry into Stillbirths in Infancy (CESDI) bandings

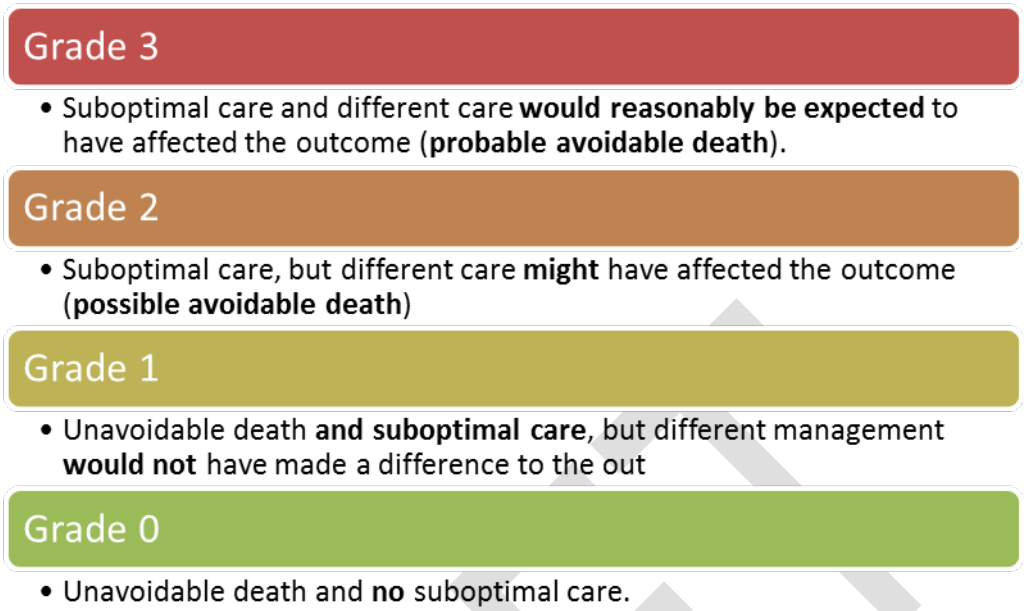


Table 1: Avoidability of Death Judgement Scoring System

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

- Second departmental mortality reviews should be multi-disciplinary and include consultant representation.

- If the second mortality review records a CESDI score of 2 or 3 then a thorough structured case review (SCR)will be undertaken. This will be completed by a consultant, specialty registrar or senior nurse/AHP.

- If a SCR assigns a potentially avoidable death (PAD) score of 1, 2 or 3 then a Datix incident report will be completed. This will also be escalated to the ICSU senior management team and the case note review sent to the SIEAG for consideration.

- Deaths of inpatients with learning disabilities will be undertaken in compliance with the national LD mortality review programme.

6.4 Recording mortality and structured case reviews

The outcome of all reviews will be electronically and retrievably stored on the Trust's I-drive.

7.0 Involvement of families and carers

The new national guidance outlines a clear expectation that trusts should be involving bereaved families and carers in the review process of their loved one's death. Previous feedback from families was one of the drivers for the design and formal introduction of the Trust ADP in 2016.

The trust's '*Being Open and the Duty of Candour* Policy[2]', describes the approach to Being Open when an incident has resulted in a patient's death, or where an incident harmed a patient who is now deceased, this includes establishing open channels of communication with the patient's family and/or carers and including them appropriately in the investigation process. The patient's family and/or their carers can reasonably expect to be fully informed of the issues surrounding an incident and its consequences in a face-to-face meeting.

Where a deceased patient's care is subject to a Serious Incident investigation the patient's family and/or carers should be informed that a Root Cause Analysis investigation will be completed, and it would be expected that a patient's family and/or carers will be invited to help develop the terms of reference for the investigation. The final Root Cause Analysis report should be shared with the patient's family and/or carers. These expectations are outlined in the trust's '*Policy for the Management of Serious Incidents*[3]'.

[2] Whittington Health '*Being Open and Duty of Candour Policy'* (2015), available from http://whittnet.whittington.nhs.uk/document.ashx?id=8436

[3] Whittington Health '*Policy for the Management of Serious Incidents'* (2015), available from http://whittnet.whittington.nhs.uk/document.ashx?id=8436

8.0 Dissemination of Learning

It is essential that clinicians and other stakeholders are informed of the outcomes of the Mortality Review Process if they are to learn and improve outcomes for patients.

Mechanism for the outputs of the mortality governance process to be fed back to clinical staff including plans for improvement, lessons learnt and pathway redesign will be developed and implemented by the Mortality lead

Key metrics on mortality review will be reported to trust board as a mortality dashboard including completion of the ADP.

9.0 MONITORING COMPLIANCE and EFFECTIVENESS

What key area(s) need(s) monitoring on this document? (Consider the purpose of the document; processes, procedures, timelines, patient outcomes etc)	Who will lead on this aspect of monitoring? Name the lead and what is the role of the multidisciplinary team or others if any.	What tools / methods will be used to monitor report and review the identified areas? (Consider audit, observation, minutes, complaints, incidents, claims, reports and Documentation etc.)	How often is the need to monitor each area? How often is the need to produce a report? How often is the need to share the report?	Responsible Committee for scrutiny and arrangements for feedback.
Element/s to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting and feedback arrangements**

10.0 ASSOCIATED DOCUMENTS

Title	Intranet Hyperlink
LEARNING FROM SERIOUS INCIDENTS STANDARD OPERATING PROCEDURE (SOP)	http://whittnet.whittington.nhs.uk/document.ashx?id=10427
POLICY FOR THE MANAGEMENT OF SERIOUS INCIDENTS (SI)	http://whittnet.whittington.nhs.uk/document.ashx?id=8436
STANDARD OPERATING PROCEDURE FOR SENIOR MANAGEMENT OF INCIDENTS THAT MAY REQUIRE REPORTING TO THE POLICE	http://whittnet.whittington.nhs.uk/search/?q=serious+incident

11.0 REFERENCES

- '*National Guidance on Learning from Deaths*', National Quality Board (March 2017), available from https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf
- '*Learning, candour and accountability'*, Care Quality Commission (December 2016), available from https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf
- Whittington Health Board paper, *Identifying and learning from avoidable mortality - mortality review process for the Whittington* (February 2016)
- Whittington Health Board paper, National Guidance on Learning from Deaths (April 2017)

12.0 APPENDICES

Appendix 1: Mortality review process flowchart
Appendix 2: After Death Proforma
Appendix 3: Example Trust mortality review form
Appendix 4: Royal College of Physicians case note review form

13.0 EQUALITY IMPACT ANALYSIS

Whittington Health – Equality Impact Analysis Form

Access guidance via this link: **http://whittnet/default.asp?c=9308**

1. **Name of Policy or Service**

2. **Assessment Officer**

3. **Officer responsible for policy implementation**

4. **Completion Date of Equality Analysis** *(In this format;12/May/2015***)**

5. **Description and aims of policy/service**

6. **Initial Screening**

An initial analysis has been carried out to explore whether the XXXXX is likely to have a detrimental impact in terms of people included in one or more of the following equality categories:

- Race
- Disability
- Gender
- Age
- Sexual orientation
- Religion and belief
- Gender Reassignment
- Marriage and civil partnership
- Pregnancy and maternity

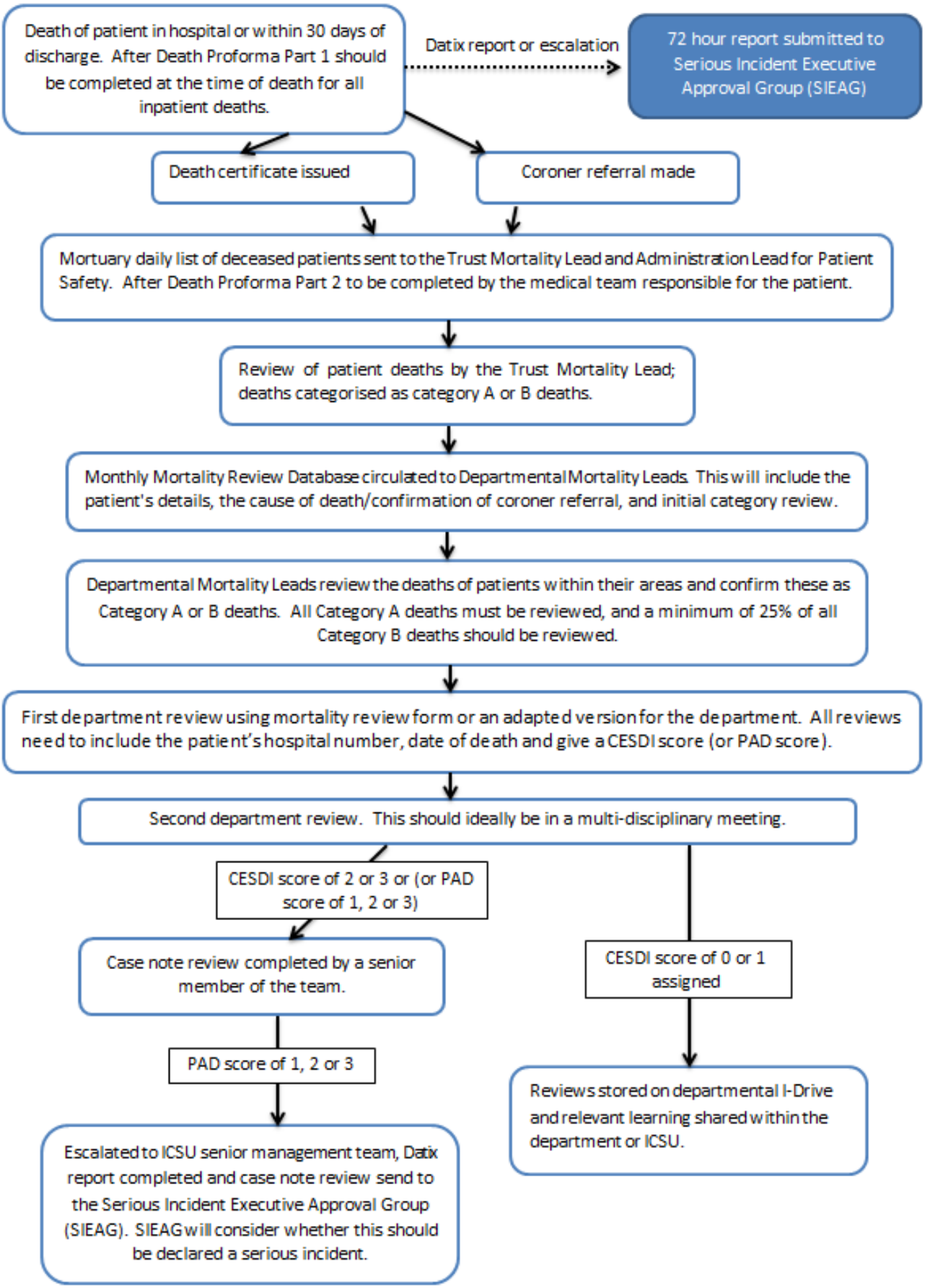
7. **Outcome of initial screening**

8. Monitoring and review/evaluation

9. Publication of document

(Intranet or other)

Appendix 1: Mortality review process flowchart



Appendix 2: After death proforma (ADP)

The Whittington Hospital NHS
NHS Trust

PART 1: CONFIRMATION OF DEATH IN HOSPITAL

Please complete at time of death and place in front of the patient's medical records

Patient Name _____

Hospital Number _____NHS Number_____

Date of Birth _____ Age _____

1) Date of death _____/_____/_____ Certified time of death _____ : _____

2) Print name of clinician who confirmed death_____ Bleep _____

3) Ward _____ Consultant _____

4) Relatives present at death? **Yes / No**

   Name and relationship _____

5) Name of nursing staff present at time of death? _____

6) Has clinician spoken to the family and offered condolences? **Yes / No**

   Name and role of clinician _____

   Name and relationship of family member _____

7) Patient under DOLS? **Yes / No / Unsure** (*If YES will need to refer to the Coroner)

8) Phone mortuary to inform them of the death (X5330) ☐

Confirming Death
(document in the notes):
- Confirm identity of patient
- Pupils fixed and dilated
- No respiratory effort
- No palpable central pulses
- No heart sounds
- No breath sounds

The Whittington Hospital NHS
NHS Trust

PART 2: AFTER-DEATH PROFORMA

To be completed by the medical team responsible for the patient (on the ward/in the mortuary)

Name of Dr completing the death certificate _____

Signature & role _____

Bleep _____ Date completed death certificate ____ / ____ / ____

A) A doctor has spoken to the family and offered condolences ☐

Name & role of doctor _____

Name and relationship of family member _____

B) There has been a consultant led discussion to agree the contents of the death certificate or the need for referral to the Coroner ☐

C) Death Discharge Summary completed on ICE ☐ Date: ____ / ____ / ____

* To be completed and sent **within 24 hours** of the death, to include:
- The cause of death as per the death certificate
- Very short summary to communicate to the GP any issues/pertinent facts about the patient's care
- If referred to Coroner document as 'Referred to Coroner'

D) Consider who else has been involved in the care of this patient and needs to be informed (via the medical team/ward manager/ward clerk?):

a. ☐ Critical Care Outreach Team/ICU/Anaesthetist

b. ☐ CORE team/Specialist nurses/Community teams

c. ☐ Other hospital teams who have cared for the patient (eg. at WH/RFH/UCH)

d. ☐ Learning disability team

e. ☐ District nurses

The Whittington Hospital NHS
NHS Trust

LAST OFFICES CHECKLIST

Name	Hosp number (If not known Write D.O.B.)	Ward/Dept.

TO BE COMPLETED PRIOR TO THE DECEASED BEING REMOVED FROM THE WARD
IT MUST BE SENT TO THE MORTUARY WITH THE DECEASED

Religious Denomination			COMMENTS	Signature
Jewellery kept on body If YES, please give details / Description and state location Record in valuables book & on death notice	Y/N			
Any other property If YES, please give details and state location (i.e. false teeth) **Record in property book**	Y/N			
Identification Bracelets *Must have two* *Check same name, DOB & Hospital Number on both*	Wrist	Y/N		
	Ankle	Y/N		
Eyes Closed If NO, use small piece of damp gauze to hold lids closed	Y/N			
Mouth Closed	Y/N			
Artificial Prosthetics left on body e.g. eye, leg, wig, hearing aid,dentures	Y/N			
Pacemaker in situ N.B. can explode during cremation	Y/N			
Internal defibrillator in situ N.B. can explode during cremation	Y/N			
Infectious/Communicable Disease (see appendix 3A for guidance	Y/N			
Body Fluids Leaking If YES, use body bag	Y/N			
Deceased in Body Bag If YES, please state reason if one other than above	Y/N			
Note: If death was anticipated, remove all cannulae and tubing. *In other events, leave all cannulae and tubing in situ, disconnected and sealed.*				

Body details checked by:

RN. Nurse Print Name Date

RN / Support staff Print Name

Relatives/Next of Kin Informed Yes/No Print Name of Informant

Appendix 3: Example Trust mortality review form

Patient's NHS/Hospital Number	
Patient's Age	
Date of review	
Reviewer 1	
Reviewer 2	
Dates of stay (admission to death)	
Day of the week of admission	
Time of admission (**must state**)	
Location of death	

	Yes/No	**10 words or less comments**
The Patient		
Main diagnosis on admission		
Confirmed main diagnosis (after tests etc)		
Cause of death (taking all information into account including PM) 1a 1b 1c II		
Was there a hospital post mortem?		
Was the Coroner informed/consulted?		
Was there a Coroner's Post mortem?		
Was malignancy present even if not the main diagnosis? Specify primary only, nodal metastases, distal spread		

The Start of the Admission	**Hours**	**10 words or less comments**
Number of hours from decision to admit to first consultant review		
In the first 24 hours:	**Yes/No**	**10 words or less comments**
Was there evidence of a clear management plan?		
Were the initial management steps appropriate?		
Was the After Death Proforma Part 1 completed?		
During the admission	**Yes/No**	**10 words or less comments**
Were there any periods when the patient was not reviewed by a consultant >72 hours? If yes, how many such periods?		
General Care. During the admission that led to the patient's death did the patient have any of the following?	**Yes/No**	**10 words or less comments**
Documented patient fall?		
Documented fall resulting in significant harm (e.g. a fracture).		
Sepsis (as currently defined in the trust guideline – see appendix A)? If yes, was the sepsis pathway followed?		
Acute kidney injury? If yes, then was a medicines review carried out in a timely manner?		
Documented Learning Disability? If yes, was any note made of the patient's particular needs?		
Pressure sores at the time of admission?		

Pressure sores that developed during the admission?		
Lack of mental capacity? If yes, a) Was a mental capacity assessment carried out on Anglia ICE? b) Was Deprivation of Liberty Safeguard (DoLS) assessment completed?		
Escalation of care: did the following take place?	**Yes/No**	**10 words or less comments**
Was the patient transferred to Intensive Care/ High Dependency Unit?		
Was a treatment escalation plan completed on admission?		
Was a Do Not Attempt Resuscitation form completed? If yes, a) Was this documented on Anglia ICE? b) Is there a clear record of a discussion between a named clinician and the patient or a named relative?		
Surgery or procedure or invasive procedure (e.g. OGD, endoscopy, central venous catheter)	**Yes/No**	**10 words or less comments**
Did the patient have a surgical procedure? If yes: a) What was the investigation b) What date was the investigation c) Is there clear documentation of consent d) If yes, does the consent documentation include evidence that there was a discussion around risk vs benefits, including the do nothing option.		
Medication	**Yes/No**	**10 words or less comments**
Is there any documentation of a drug error?		
Never events	**Yes/No**	**10 words or less comments**
During admission, did any of the following Never Events occur: Wrong site surgery		

Retained instruments Misplaced naso- or orogastric tube Inpatient suicide Absconding of prisoner In-hospital maternal death post-partum Administration of concentrated potassium chloride		
End of life care	**Yes/No**	**10 words or less comments**
Was a decision made that end of life care was appropriate? If yes, a) Were appropriate end of life care medicines prescribed? b) Was the patient referred to the inpatient palliative care team? c) Was the patient referred to the community palliative care team? d) Was specific advice given by palliative care specialists?		
Organ and tissue donation	**Yes/No**	**10 words or less comments**
Is there evidence that organ and tissue donation was discussed?		
On reviewing the whole case please categorise the death using the Confidential Enquiry into Stillbirths in Infancy (CESDI) bandings;		**Yes/No**
Grade 3 – Suboptimal care and different care would reasonably be expected to have affected the outcome (probable avoidable death).		
Grade 2 – Suboptimal care, but different care might have affected the outcome (possible avoidable death).		
Grade 1 – Unavoidable death and suboptimal care, but different management would not have made a different to the outcome.		
Grade 0 – Unavoidable death and no suboptimal care		
On reviewing the whole case:	**Comments:**	
Standard of documentation was: please score 1 to 5 (1 = very poor, 5 = excellent)		

Highlight any aspects of notable ‘good quality’ care *Eg good evidence of regular communication with the patient/family, ‘being open’, addressing* *advance care planning when appropriate*	

If the care was sub-optimal, how could it have been done better and what is the key learning? (Please restrict to 250 words maximum).

Appendix 4: Case note review template

National Mortality Case Record Review Programme: Structured case note review data collection

Please enter the following.

Hospital number:	
Date of Birth:	
Age at death (years):	
Gender:	M/F
Ethnicity:	
Day of admission/attendance:	
Time of arrival:	
Day of death (Date of incident) :	
Time of death	
Number of days between arrival and death:	
Month cluster during which the patient died:	Jan/Feb/Mar Apr/May/Jun Jul/Aug/Sept Oct/Nov/Dec
Specialty team at time of death:	
ICSU:	
Specific location of death:	
Type of admission:	
The certified cause of death (if known):	

Guidance for reviewers

1 Did the patient have a learning disability?

- No indication of a learning disability.

Action: proceed with this review.

- Yes – clear or possible indications from the case records of a learning disability.

Action: after your review, please refer the case to the hospital's clinical governance group for linkage with the Learning Disability Mortality Review Programme.

2 Did the patient have a serious mental health issue?

- No indication of a severe mental health issue.

Action: proceed with this review.

- Yes – clear or possible indications from the case records of a severe mental health issue.

Action: after your review, please refer the case to the hospital's clinical governance group.

3 Is the patient under 18 years old?

- No the patient is 18 years or older.

Action: proceed with this review.

- Yes – the patient is under 18 years old.

Action: after your review, please refer the case to the hospital's clinical governance group for linkage with the Child Death Review Programme.

Structured case note review data collection

Phase of care: **Admission and initial management (approximately the first 24 hours)**

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

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

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

Please circle only one score.

Phase of care: **Ongoing care**

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

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

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

Please circle only one score.

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

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

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

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

Please circle only one score.

Phase of care: **Perioperative care**

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

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

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

Please circle only one score.

Phase of care: **End-of-life care**

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

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

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

Please circle only one score.

Phase of care: **Overall assessment**

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

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

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

Please circle only one score.

Please rate the quality of the patient record.

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

Please circle only one score.

Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick)

No ☐ (please stop here) **Yes** ☐ (please continue below)

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

Problem types

1 **Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

2 **Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

3 **Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE)* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

4 **Problem with infection management Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

5 **Problem related to operation / invasive procedure** *(other than infection control)* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

6 **Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise and respond to changes)* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

7 **Problem in resuscitation following a cardiac or respiratory arrest** *(including cardiopulmonary resuscitation (CPR))* **Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

8 **Problem of any other type not fitting the categories above Yes** ☐
Did the problem lead to harm? No ☐ **Probably** ☐ **Yes** ☐

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

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

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

Score 1 Definitely avoidable

Score 2 Strong evidence of avoidability

Score 3 Probably avoidable (more than 50:50)

Score 4 Possibly avoidable but not very likely (less than 50:50)

Score 5 Slight evidence of avoidability

Score 6 Definitely not avoidable

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

For scores of 1 or 2, you must report this as an incident on DATIX and escalate to your ICSU Leads for discussion at SIEAG. Please note, this case review represents the 72 hour report required

DATIX number		Date incident discussed at M&M (Date identified):	
Reporter name:		Reporter job title:	
Duty of Candour/Being Open Lead:		Has Duty of Candour process been completed?	
Were any junior/trainee staff involved?		Are there any safeguarding concerns? If so, contact the Adult Safeguarding Lead	
Any media interest? If so, contact the communications team		Is this externally reportable? Please Indicate who externally reported to; (i.e HSE, DoH, NHS England, CQC, Information Commissioner.)	

Provide brief chronology

Date/ Time	Description

Describe any risk mitigating action taken

Whittington Health: Learning from Deaths Dashboard - June 2017-18

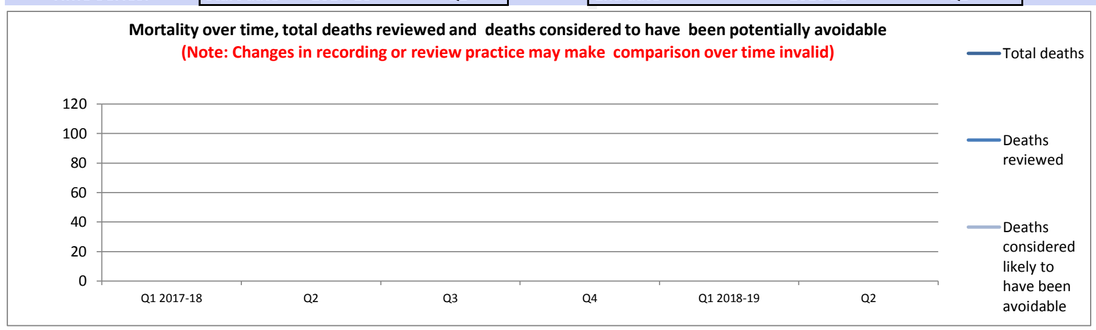
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
31	32	16	27	1	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
97	0	69	0	1	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
97	0	69	0	1	0

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q2



Total Deaths Reviewed by RCP Methodology Score

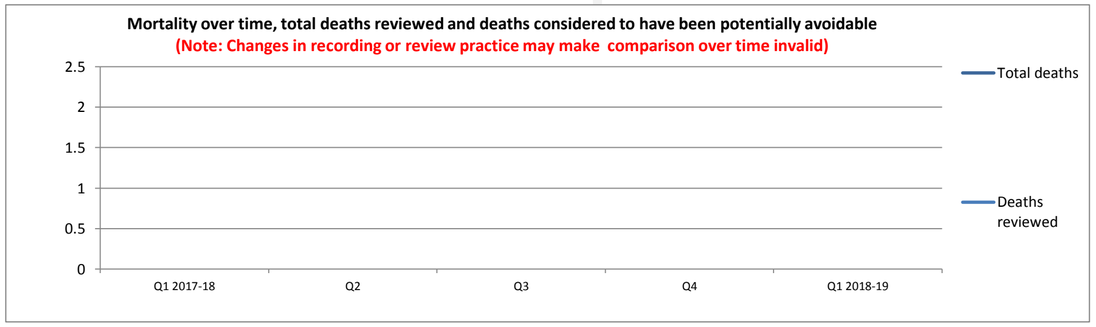
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	1	6.3%	This Month	2	12.5%	This Month	1	6.3%	This Month	12	75.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	1.4%	This Quarter (QTD)	8	11.6%	This Quarter (QTD)	10	14.5%	This Quarter (QTD)	50	72.5%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	1.4%	This Year (YTD)	8	11.6%	This Year (YTD)	10	14.5%	This Year (YTD)	50	72.5%

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

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

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

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q1



Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board

4 October 2017

Title:	August (Month 5) 2017/18 – Financial Performance		
Agenda item:	**17/131**	**Paper**	**6**
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 £0.3m deficit for August (Month 5) leading to a year to date deficit of £2.2m. This is against a planned year to date deficit of £1.3m (and planned in month surplus £0.5m). The main drivers for the adverse performance were income, £1.1m below plan in month, and CIP delivery which is currently £3.5m behind plan for the year to date. The Trust is putting plans in place to address both the income position and more importantly CIP delivery, and has used enhanced financial controls and non-recurrent measures to help mitigate some of the impact. Currently the Trust is forecasting delivery of its end of year control total.		
Summary of recommendations:	To note the financial results relating to performance during August 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 Finance & Business Committee and Trust Board. Operational Plan papers. Board Assurance Framework (Section 3).		
Date paper completed:	25 September 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

Within the Trust's annual planning submission to NHSI it was expected that there would be a step change (increase) in the delivery of savings from Month 5, which would lead to a surplus in month as the Trust worked from a cumulative deficit position back towards its control total of a £0.6m surplus at year end.

Reporting on the actual position for Month 5, the step change in savings delivery has not materialised and this combined with lower than planned income sees the Trust post a £0.3m deficit in month, which is £0.8m adverse to plan. As a result the year to date deficit is now £2.2m, which is £0.9m adverse to plan (£1.3m deficit).

Statement of Comprehensive Income	In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	YTD Budget (£000s)	Ytd Actuals (£000s)	Variance (£000s)
NHS Clinical Income	22,581	21,092	(1,489)	110,338	108,502	(1,836)
Non-NHS Clinical Income	1,907	1,539	(368)	9,654	8,813	(841)
Other Non-Patient Income	1,910	2,680	770	9,750	10,718	968
Total Income	**26,398**	**25,310**	**(1,088)**	**129,742**	**128,033**	**(1,709)**
Pay	(17,928)	(17,614)	314	(91,107)	(91,014)	93
Non-Pay	(6,633)	(6,597)	36	(33,397)	(32,890)	507
Total Operating Expenditure	**(24,561)**	**(24,211)**	**350**	**(124,504)**	**(123,904)**	**600**
EBITDA	**1,837**	**1,099**	**(738)**	**5,238**	**4,129**	**(1,109)**
Depreciation	(721)	(668)	53	(3,605)	(3,340)	265
Dividends Payable	(345)	(346)	(1)	(1,729)	(1,730)	(1)
Interest Payable	(255)	(364)	(109)	(1,273)	(1,314)	(41)
Interest Receivable	3	2	(1)	15	8	(7)
P/L on Disposal of Assets	0	0	0	0	0	0
Total	**(1,318)**	**(1,376)**	**(58)**	**(6,592)**	**(6,376)**	**216**
Net Surplus / (Deficit) - before IFRIC 12 adjustment	**519**	**(277)**	**(796)**	**(1,354)**	**(2,246)**	**(892)**
Add back impairments and adjust for IFRS & Donate	(13)	(8)	5	(65)	(39)	26
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**532**	**(269)**	**(801)**	**(1,289)**	**(2,208)**	**(919)**

As highlighted above the main drivers for the adverse variance are income, in particular NHS Clinical Income, and the delivery of savings (CIPs). The Trust has been part of the National Financial Improvement Programme (FIP – Wave 2), which provided additional support in terms of the annual CIP programme. Through this work the Trust's Programme Management Office (PMO) is now anticipating that pace of CIP delivery will improve later in the year, rather than from Month 5 as originally planned.

Currently the Trust is still forecasting the achievement of its end of year control total, and is putting in place plans to rectify both the income position and more importantly the delivery of savings. To respond to the predicted CIP shortfall the PMO is leading work on cross cutting initiatives and helping ICSUs to complete the final detail and quality impact assessments for schemes which are still in the planning stage. In addition to this ICSUs are working with Finance to look at non-recurrent actions that can be taken to ensure that the agreed budgets are achieved.

Income & Activity

In month, income was below plan with an adverse variance of £1.1m, increasing the year-to-date underperformance to £1.7m.

The adverse variance was driven by the performance across a number of areas of activity, most notably in non-elective, outpatients, elective and day cases.

Key points of note:

- The trust continues to be off plan for NHS clinical income with a significant worsening of the position in Month 05.

- Outpatient attendances continue to be below plan, with an in month adverse variance of £0.3m and year to date adverse variance of £1.0m, of which First Attendances accounts for £0.6m.
  The largest areas of under-performance are in General Surgery & Dermatology. ICSUs have put in place plans to improve this under-performance, the effectiveness of which will be monitored over the coming months.

- Elective and Outpatient Procedures performed worse in month, with a combined under-performance for the first time this year. Annual leave taken in August has impacted upon performance more so than originally planned. Whilst the position was below plan in should be noted that both Medicine and Surgery exceeded their recovery plans for August.

- Non electives continued on trend (year to date £0.6m adverse) and are significantly down against plan in General Medicine.

- Other Clinical Income is below plan, but is offset by Other Non-Clinical Income.

Month 05

Category	In Month Income Plan	In Month Income Actual	In Month Variance	YTD Income Plan	YTD Income Actual	YTD Variance	In Month Activity Plan	In Month Activity Actual	In Month Variance	YTD Activity Plan	YTD Activity Actual	YTD Variance
Accident and Emergency	893	863	(30)	4,409	4,513	104	5,175	5,241	66	25,790	28,261	2,471
Adult Critical Care	702	1,035	334	3,464	3,259	(205)	641	751	110	3,163	2,738	(425)
Community Block	5,861	5,865	4	29,320	29,324	4	0	0	0	0	0	0
Day Cases	1,238	1,133	(105)	5,860	5,523	(337)	1,815	1,586	(229)	8,692	7,812	(880)
Diagnostics	240	245	6	1,134	1,111	(23)	2,379	2,332	(47)	11,247	11,034	(213)
Direct Access	1,044	909	(136)	4,938	4,555	(383)	95,547	88,913	(6,634)	451,676	445,062	(6,615)
Elective	743	682	(60)	3,559	3,806	247	188	182	(6)	893	992	99
Maternity - Deliveries	1,110	1,076	(34)	5,480	5,258	(222)	334	314	(20)	1,647	1,541	(106)
Maternity - Pathways	801	696	(105)	3,788	3,684	(104)	750	680	(70)	3,547	3,438	(109)
Non-Elective	4,215	3,759	(456)	20,658	19,578	(1,080)	1,526	1,548	22	7,687	7,505	(182)
OP Attendances - 1st	999	808	(191)	4,726	4,130	(596)	5,502	4,455	(1,047)	26,136	23,197	(2,939)
OP Attendances - follow up	880	733	(147)	4,167	3,762	(404)	12,927	11,508	(1,419)	61,491	60,878	(613)
Other Acute Income	2,197	1,859	(338)	10,703	11,490	786	11,616	9,704	(1,912)	55,169	52,871	(2,297)
Outpatient Procedures	333	361	28	1,573	1,864	291	1,859	1,964	105	8,803	10,301	1,498
Total SLA	**21,255**	**20,023**	**(1,231)**	**103,778**	**101,856**	**(1,922)**	**140,259**	**129,177**	**(11,082)**	**665,939**	**655,630**	**(10,309)**
Marignal Rate	0	(68)	(68)	0	432	432						
	21,255	**19,955**	**(1,299)**	**103,778**	**102,288**	**(1,490)**						
Other Clinical Income	3,091	2,672	(419)	15,498	15,017	(480)						
Other Non Clinical Income	2,052	2,683	630	10,466	10,728	262						
Total Other	**5,143**	**5,355**	**211**	**25,963**	**25,745**	**(218)**	**0**	**0**	**0**	**0**	**0**	**0**
Grand Total	**26,398**	**25,310**	**(1,088)**	**129,742**	**128,033**	**(1,709)**	**140,259**	**129,177**	**(11,082)**	**665,939**	**655,630**	**(10,309)**

Monthly Run Rates – Expenditure

The Trust is reporting a favourable expenditure position against plan. However, as noted above this includes non-recurrent measures which have mitigated, to an extent, the underperformance on income and CIP delivery.

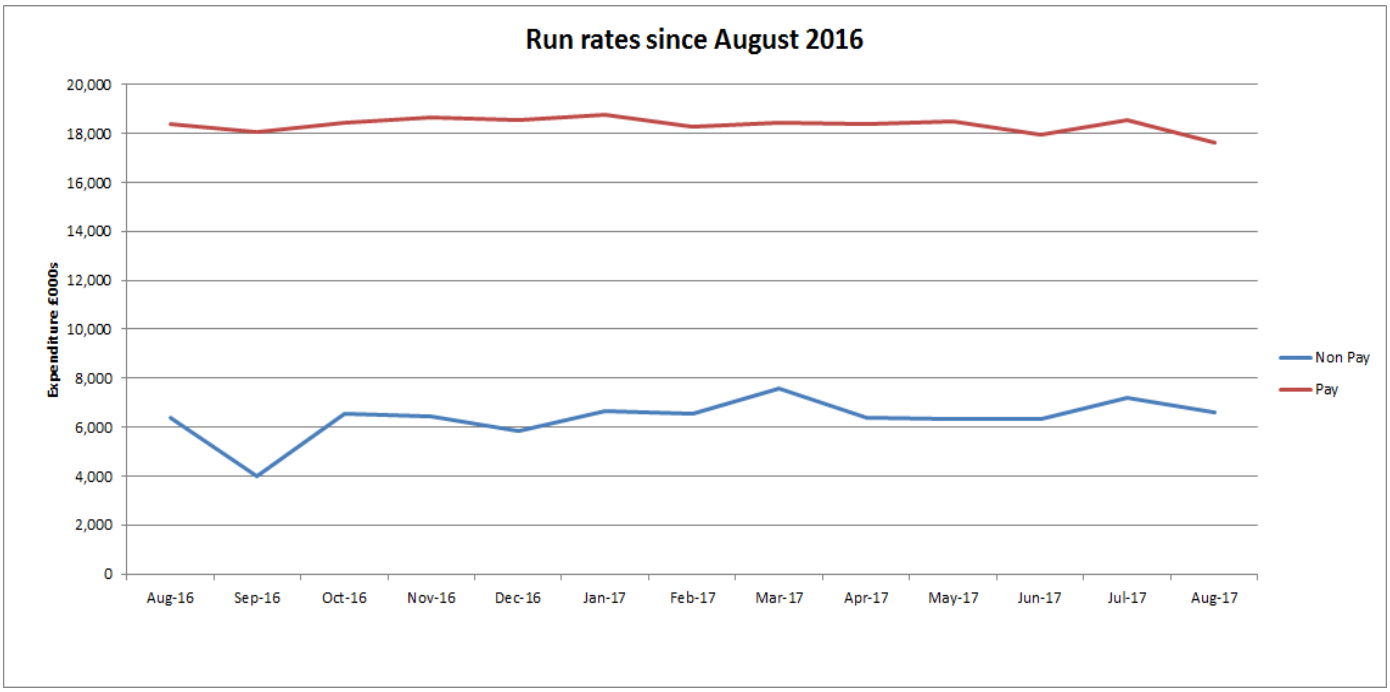
In run rate the key highlights for pay are:

- Total pay expenditure for August was £17.6m, which is £0.9m less than the previous month and £0.7m less than the 12 months rolling average. NB – there was a spike in spend in the previous month linked to dental mobilisation, which was non-recurrent and offset by income.

- Agency staff related costs were £0.2m representing 1.2% of the August pay bill. However, this includes a one-off £0.8m benefit and therefore the underlying spend is £1.0m, which is in line with Month 4 and £0.1m more than each of the first three months of this financial year. The Trust has established a staffing taskforce group, led by the Director of HR, to reduce temporary staffing costs which will include a focus on agency spend. The Trust is currently exceeding the NHSI agency ceiling.

Non pay expenditure for August was £6.6m, an improvement on July (£7.2m) and similar to the average for the first four months.

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



As highlighted above the step change in delivery of savings has not occurred in Month 5, as planned, and as a result remains a key risk to the delivery of the Trust's end of year control total. In order to address this a series of actions are being undertaken, led by the PMO, which are described in the CIP section below.

ICSU position

The table below provides an analysis of the expenditure run rates within clinical ICSUs for 2017/18. When looking at ICSU trends it shows that cost is not reducing as required to achieve the CIP target.

Pay

	Run Rate - Actual								
	2016/17 Month 11 £'000	2016/17 Month 12 £'000	2017/18 Month 1 £'000	2017/18 Month 2 £'000	2017/18 Month 3 £'000	2017/18 Month 4 £'000	2017/18 Month 5 £'000	Average for M1-4	M5 variance from Avg
Children's & Young People	3,975	3,934	3,896	3,955	3,945	3,941	3,862	3,934	73
Clinical Support Services	1,334	1,352	1,423	1,314	1,423	1,334	1,343	1,373	30
Emergency & Urgent Care	2,036	2,042	1,992	1,969	2,036	2,133	2,120	2,032	-88
Integrated Medicine	3,239	2,936	2,953	2,926	2,820	2,779	2,780	2,869	90
Patient Access, Prevention & Planned Care	1,025	1,038	1,018	1,014	977	943	979	988	9
Surgery & Cancer	2,796	3,124	3,138	3,006	3,059	3,007	3,197	3,053	-144
Women's Health	1,619	1,565	1,553	1,571	1,614	1,444	1,456	1,546	89
Total Pay - Clinical ICSUs	16,024	15,991	15,973	15,757	15,873	15,581	15,737	15,796	59

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	2017/18 Month 3 £'000	2017/18 Month 4 £'000	2017/18 Month 5 £'000	Average for M1-4	M5 variance from Avg
Children's & Young People	142	215	180	219	180	203	227	196	-31
Clinical Support Services	1,214	1,580	1,506	1,563	1,543	1,522	1,602	1,533	-69
Emergency & Urgent Care	203	265	223	234	327	277	281	265	-16
Integrated Medicine	199	393	273	277	231	276	282	264	-18
Patient Access, Prevention & Planned Care	172	287	154	134	187	220	201	174	-27
Surgery & Cancer	555	797	973	836	858	874	874	885	11
Women's Health	131	223	163	197	193	119	112	168	56
Total Non Pay - Clinical ICSUs	2,616	3,760	3,472	3,461	3,519	3,490	3,579	3,486	-93

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	2017/18 Month 3 £'000	2017/18 Month 4 £'000	2017/18 Month 5 £'000	Average for M1-4	M5 variance from Avg
Children's & Young People	4,117	4,149	4,076	4,174	4,125	4,145	4,088	4,130	42
Clinical Support Services	2,548	2,932	2,929	2,877	2,965	2,856	2,945	2,907	-39
Emergency & Urgent Care	2,239	2,307	2,215	2,203	2,363	2,410	2,402	2,298	-104
Integrated Medicine	3,438	3,329	3,226	3,203	3,051	3,055	3,062	3,134	72
Patient Access, Prevention & Planned Care	1,197	1,325	1,172	1,148	1,164	1,163	1,180	1,162	-18
Surgery & Cancer	3,351	3,921	4,111	3,843	3,917	3,882	4,071	3,938	-133
Women's Health	1,750	1,788	1,716	1,768	1,808	1,563	1,568	1,714	145
Total Non Pay - Clinical ICSUs	18,640	19,751	19,445	19,217	19,392	19,072	19,316	19,282	-34

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. Corporate includes the dental mobilisation income and expenditure which has a net nil effect on the Trust bottom line but is material in run rate

Cost Improvement Programme

Against the Trust's full year CIP target of £17.8m, to date £9.1m of plans have been agreed and recognised. As part of an ongoing process this value is being reconciled against the value of road-mapped schemes held by the Programme Management Office (PMO) to ensure that recognised schemes are still planned to deliver the values previously identified, with new schemes being proposed and validated to address the gap in plans compared to target (currently £8.7m).

At Month 5, £2.7m has been recognised as delivered against the CIP programme, which is £3.5m adverse when compared to the Trust's planning submission. Originally it was expected that there would be a step change in delivery of savings from Month 5, which has not proved to be the case.

Current performance by ICSU is:

Integrated Clinical Service Unit	Annual Plan £'000	Identified £'000	Gap £'000	YTD Target £'000	YTD Actual £'000	YTD Variance £'000
Children's services	3,065	1,559	1,506	1,079	398	(681)
Clinical Support Services	2,334	1,086	1,248	822	205	(617)
Emergency & Urgent Care	2,157	525	1,632	759	198	(561)
Medicine, Frailty & Network Services	2,132	1,160	972	751	338	(413)
PPP	874	368	506	308	281	(27)
Surgery	3,159	1,894	1,265	1,112	616	(496)
Women's services	1,498	882	616	527	235	(292)
Estates & Facilities	1,322	993	329	465	120	(345)
Corporate	1,236	637	599	435	355	(80)
Total	**17,777**	**9,104**	**8,673**	**6,259**	**2,746**	**(3,513)**

From work as part of the National Financial Improvement Programme (FIP – Wave 2) the Trust's PMO is now anticipating pace of CIP delivery will accelerate later in the year. Whilst fully road-mapped schemes had been delivering in line with PMO expectations, it remains the case that there are two critical issues for the Trust, being:

1. The gap against the annual target, where schemes are not fully identified and signed off as road mapped; and
2. The phasing of the road mapped schemes is creating further slippage in delivery.

Failure to achieve in-year cost reduction is a key financial risk to the Trust and current forecasts put the shortfall in the region of £6.5m. In order to address this the PMO is leading work to close the gap on CIP by:

a) Working with ICSUs to complete the planning on schemes so that they have rigorous and detailed delivery plans, are quality impact assessed and be committed as road mapped status schemes
b) Working with ICSU leadership teams to convert opportunity and draft plans in to full schemes
c) Taking forward cross cutting initiatives e.g. community productivity, procurement and staffing taskforce to create savings that will count towards the targets; and
d) Working on non-recurrent schemes to plug the gap created in-year through slippage

Statement of Financial Position

			Year to Date
Statement of Financial Position	As at 31 August 2017 £000	Plan 31 August 2017 £000	Plan variance 31 August 2017 £000
Property, plant and equipment	207,683	201,599	6,084
Intangible assets	3,388	2,111	1,277
Trade and other receivables	457	851	(394)
Total Non Current Assets	**211,528**	**204,561**	**6,967**
Inventories	1,615	150	1,465
Trade and other receivables	26,747	29,060	(2,313)
Cash and cash equivalents	7,252	3,730	3,522
Total Current Assets	**35,614**	**32,940**	**2,674**
Total Assets	**247,142**	**237,501**	**9,641**
Trade and other payables	42,772	42,449	323
Borrowings	516	2,656	(2,140)
Provisions	577	756	(179)
Total Current Liabilities	**43,865**	**45,861**	**(1,996)**
Net Current Assets (Liabilities)	**(8,251)**	**(12,921)**	**4,670**
Total Assets less Current Liabilities	**203,277**	**191,640**	**11,637**
Borrowings	59,047	63,853	(4,806)
Provisions	1,513	1,513	0
Total Non Current Liabilities	**60,560**	**65,366**	**(4,806)**
Total Assets Employed	**142,717**	**126,274**	**16,443**
Public dividend capital	62,404	62,404	0
Retained earnings	(14,856)	(14,206)	(650)
Revaluation reserve	95,169	78,076	17,093
Total Taxpayers' Equity	**142,717**	**126,274**	**16,443**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**

The key highlights for Month 5 are:

Cash: The Trust is holding £7.3m in cash at Month 5, £3.5m higher than planned due to receipt of STF monies that have been earmarked to spend on capital projects later in 2017/18. The Trust's cash position is being managed proactively and is expected to return to plan later in the year as the capital programme accelerates.

Receivables (Debtors) are currently £2.3m below plan. A number of material debtors have been settled, including NHS (particularly Royal Free) and non-NHS (particularly London Borough of Haringey) that have supported this position.

Payables (Creditors) are currently £0.3m above plan. NHS creditors have increased by £2.6m between Month 4 and Month 5. Of note were increases in amounts owed to Community Health Partnerships and PDC dividend due to DH, though this has been paid in September.

Capital: £0.9m of capital expenditure has been incurred in year to date against a plan of £1.5m. A number of additional projects have been approved following the Capital Monitoring Committee meeting in August. As a result the capital expenditure is expected to accelerate over the coming months.

Property, Plant & Equipment: As previously reported the value held for assets is and will remain higher than plan (£7.4m inc. intangibles) as a full valuation exercise undertaken as at 31 March 2017 created a higher value than the planning expectation.

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Whittington Health Trust Board

4"' October 2017

Title:	Trust Performance report September 2017 (August data)		
Agenda item:	**17/132**	**Paper**	**07**
Action requested:	To receive assurance of Trust performance compliance		
Executive Summary:	**Emergency Department (ED) four hours' wait** Performance against the 95% target dropped to 90.5%. The drop in performance can be attributed to challenges around staffing in terms of ED locum doctors, with a high number of unfilled shifts and inpatient nurses - the latter impacting on flow from speciality wards. **RRT 18 week waits – 52 weeks** One out of the 3 patients identified in July is still to be treated. This is due to patient choice. **DNA rate:** The Trust is going live with a pilot of DrDoctor within Imaging in October 2017. **DToC:** There was a spike in DToCs in early August reaching a total of 20 DToCs during this period. **Re-admission**: The increase in bed base in August compared to July had an impact on re-admission numbers.		
Summary of recommendations:	That the board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan		
Fit with WH strategy:	Clinical Strategy		
Reference to related / other documents:	N/A		
Reference to risk and corporate risks on the BAF:	N/A		
Date paper completed:	26th September 2017		

Author name and title:		**Hester de Graag, Risk and Quality Manager**		**Director name and title:**		**Carol Gillen, Chief Operating Officer**	
Date paper seen by EC	**3 Oct 17**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Whittington Health NHS

Integrated Performance Report

September 2017

Month 5 (2017 – 2018)

Date & time of production: 27/09/2017 14:00

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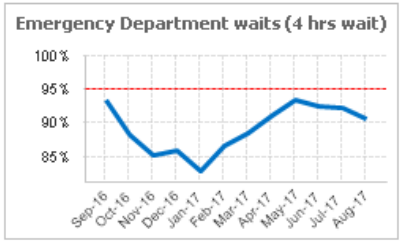
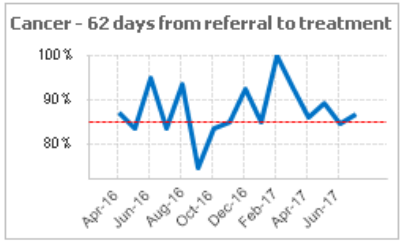
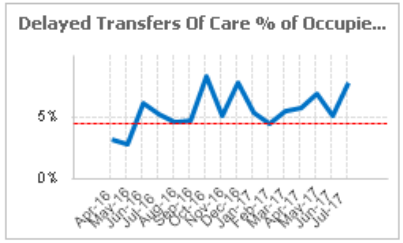
Well Led Services	15
Activity	17/18

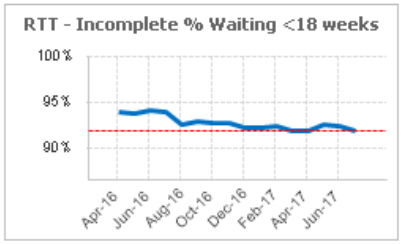
Summary Page - Indicators

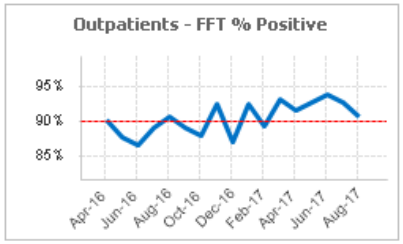
Category	Indicator	17_18 Target	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	2017-2018
ED	Emergency Department waits (4 hrs wait)	>95%	93.4%	88.1%	85.1%	85.8%	82.9%	86.6%	88.4%	91.1%	93.5%	92.4%	92.2%	90.5%	92.0%
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	62	75	88	76	77	69	72	72	68	63	59	64	65
Cancer	Cancer - 14 days to first seen	>93%	96.6%	97.8%	95.5%	93.4%	94.8%	96.8%	94.6%	93.2%	93.2%	95.3%	95.7%		94.4%
Cancer	Cancer - 62 days from referral to treatment	>85%	74.5%	83.3%	85.0%	92.3%	84.9%	100.0%	92.9%	86.0%	89.1%	84.4%	86.7%		86.6%
Admitted	Non Elective Re-admissions within 30 days	<5.5%	5.7%	5.9%	5.9%	6.0%	4.8%	5.7%	6.3%	6.1%	6.0%	5.8%	6.7%	7.0%	6.3%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	4.6%	8.2%	5.1%	7.7%	5.3%	4.5%	5.5%	5.8%	6.9%	5.0%	7.8%		6.4%
Access	RTT - Incomplete % Waiting <18 weeks	>92%	93.1%	92.9%	92.8%	92.2%	92.2%	92.4%	92.0%	92.0%	92.6%	92.4%	92.0%	92.1%	92.2%
Outpatients	Outpatients - FFT % Positive	>90%	89.2%	88.0%	92.6%	87.0%	92.5%	89.4%	93.1%	91.6%	92.8%	93.9%	92.8%	90.8%	92.6%
Community	Community - FFT % Positive	>90%	98.4%	98.1%	98.2%	98.7%	98.0%	96.8%	96.0%	98.5%	94.9%	93.9%	94.8%	96.7%	95.5%
Staff	Staff - FFT % Recommend Care	>70%	76.2%						74.6%			69.0%			69.0%

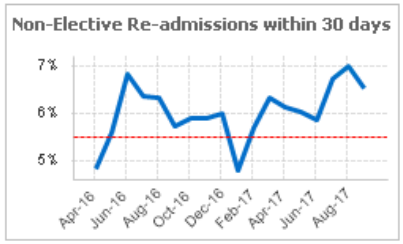












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Safe Services - Indicators and Performance

Category	Indicator	17_18 Target	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	Q1 Jun-17	Q2 Jul-17	Q2 Aug-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	0	0	0	0	0	1	1	2	3	0	1	0	6	
All Areas	CAS Alerts Outstanding	0	0	0	0	0	0	3	0	0	0	0	0	0	0	
All Areas	Actual Falls	400	38	45	30	45	56	45	31	31	44	45	34	31	185	
All Areas	Avoidable Grade 3 or 4 Pressure Ulcers	0	5	5	1	3	2	1	2	2	2	3	2	2	11	
All Areas	Harm Free Care %	>95%	90.8%	93.3%	92.6%	93.2%	94.3%	92.9%	92.5%	93.2%	93.9%	96.6%	93.5%	93.8%	94.2%	
Maternity	Non Elective C-Section % Rate	>15%	20.2%	17.7%	21.6%	17.4%	20.5%	18.0%	21.4%	19.2%	18.9%	19.7%	22.5%	18.8%	19.8%	
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	1	0	0	0	1	0	0	0	1	0	0	1	
Admitted	Never Events	0	0	1	0	0	0	0	0	0	0	0	0	0	0	
All Areas	Proportion of reported Patient Safety Incidents Causing Harm	N/A	21.8%	19.9%	20.1%	21.1%	21.3%	19.5%	22.4%	18.1%	16.6%	18.3%	17.3%	21.7%	18.3%	
All Areas	Serious Incidents	0	6	9	8	3	4	5	4	2	4	4	3	6	19	
Admitted	VTE Risk Assessment %	>95%	96.6%	97.3%	96.4%	95.9%	96.1%	96.0%	96.5%	95.2%	95.4%	95.6%	95.3%		95.4%	

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Safe Services - Commentary

Avoidable pressure ulcers

Whittington Health reported 2 avoidable pressure ulcers in August 2017. One was on Coyle ward; Grade 3 to heel, sacrum and elbow. Patient was admitted with a fractured neck of femur, protocol of placing patient on pressure relieving mattress was not followed, nursing assessment was inadequate and no pressure ulcer prevention plan implemented.

One in South East Islington DN team- Patient developed bilateral heel pressure ulcers. The pressure ulcer policy was not followed, no completion of assessments, so no prevention plan implement or advice given to the patient.

Both incidents have been fully investigated with action plan to reduce further incidents of avoidable pressures ulcers

Non Elective C-section rate

The Non-elective section rate has decreased to 18.8% - this is the lowest it has been in the last 6 months.

Upon reviewing the NCL Trust, the Trust is in line with the 4 other Trusts. There is an increase in Induction of Labour, in line with the GAP Grow and Reduced Fetal Movements which is similar to other NCL trusts. The Trust dashboard (unlike NCL) also includes premature and multiple pregnancies.

Serious incidents

The Trust reported 6 SI in August 2017.

Two in Integrated Medicine, two in EUC and two in Woman & Family Services.

All serious incidents are being investigating using the Root Cause Analysis tool.

Caring Services - Indicators and Performance

Category	Indicator	17_18 Target	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	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	2017-2018	Performance
ED	ED - FFT % Positive	>90%	95.6%	89.9%	82.1%	83.8%	83.4%	83.9%	83.0%	84.0%	87.4%	84.0%	85.5%	83.0%	84.9%	
ED	ED - FFT Response Rate	>15%	4.1%	4.1%	16.6%	16.6%	14.6%	16.0%	14.6%	16.9%	15.6%	13.8%	13.1%	13.7%	14.6%	
Admitted	Inpatients - FFT % Positive	>90%	95.1%	95.8%	92.7%	95.8%	92.1%	96.1%	94.1%	98.0%	94.2%	97.0%	95.8%	95.2%	96.0%	
Admitted	Inpatients - FFT Response Rate	>25%	20.4%	18.3%	18.0%	12.6%	7.2%	17.1%	26.8%	21.6%	22.7%	19.8%	20.9%	14.9%	20.0%	
Maternity	Maternity - FFT % Positive	>90%	91.1%	91.6%	93.8%	94.8%	88.0%	89.4%	92.4%	93.6%	90.2%	88.1%	92.7%	89.4%	90.8%	
Maternity	Maternity - FFT Response Rate	>15%	24.2%	23.1%	12.8%	24.6%	30.4%	24.0%	27.8%	24.7%	22.2%	20.1%	23.5%	30.1%	24.1%	
Outpatients	Outpatients - FFT % Positive	>90%	89.2%	88.0%	92.6%	87.0%	92.5%	89.4%	93.1%	91.6%	92.8%	93.9%	92.8%	90.8%	92.6%	
Outpatients	Outpatients - FFT Responses	400	305	408	516	193	481	407	551	357	623	537	485	338	2340	
Community	Community - FFT % Positive	>90%	98.4%	98.1%	98.2%	98.7%	98.0%	96.8%	96.0%	98.5%	94.9%	93.9%	94.8%	96.7%	95.5%	
Community	Community - FFT Responses	1500	621	645	880	549	697	1095	1169	725	1192	970	1224	858	4969	
Staff	Staff - FFT % Recommend Care	>70%	76.2%						74.6%			69.0%			69.0%	
All Areas	Complaints responded to within 25 working day	>80%	85.7%	100.0%	100.0%	89.3%	66.7%	90.0%	100.0%	100.0%	83.3%	93.9%	76.0%	81.0%	86.1%	
All Areas	Complaints (including complaints against Corporate division)	N/A	32	25	19	32	22	34	38	22	24	38	32	24	140	

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Caring Services - Commentary

FFT

Comments from ICSUs:

WHS: dropped to 89.4% from 92.7%. This is due to the non-availability of volunteers and target therefore not achieved.

Surgery: Outpatients dropped to 84.7% from 91.6%. Non availability of volunteers coupled with a higher number of vacancies over August impacted on target.

EUC: dropped to 83% from 85.5%. Continue plan in place with junior doctors to take a lead in collating FFT.

Complaints

During August 2017 the Trust closed 24 complaints; 21 required a response with 25 working days and 3 complaints were allocated 40 working days for investigation.

In regard to the 25 working day target, the Trust achieved a performance of 81%, exceeding its 80% target. Of the 3 complaints allocated 40 working days, two hit their target (67%); the remaining 1 complaint is still outstanding and overdue i.e. IM (1).

The majority of the complaints were allocated to IM 25% (6), S&C 21% (5) and PPP 17% (4). 12% (3) were designated 'high' risk, 37% (9) were designated 'moderate' risk and 50% (12) were designated 'low'.

A review of the complaints for August shows that 'medical care' 25% (6) continues to be the main issue in the majority of complaints, followed 'nursing care' 17% (4) and communication 17% (4).

In regard to 'medical care' most patients 67% (4) felt that 'no treatment' or 'inadequate treatment' had been provided and in regard to 'communication' the issues related primarily to 'poor communication or a lack of communication between patients and professionals' 50% (2).

Of the complaints that have closed, (including those allocated 40 working days), 38% (8) were 'upheld', and 48% (10) were 'partially upheld', meaning that at present 86% have been upheld in one form or another.

Effective Services - Indicators and Performance

Category	Indicator	17_18 Target	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	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	2017-2018	Performance
Maternity	Breastfeeding Initiated	>90%	90.6%	94.2%	90.2%	90.1%	90.1%	90.6%	91.6%	90.2%	91.6%	93.3%	94.5%	92.3%	92.4%	
Maternity	Smoking at Delivery	<6%	4.8%	3.2%	5.1%	4.8%	3.6%	5.6%	3.0%	5.4%	3.4%	5.7%	7.5%	4.8%	5.3%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	5.7%	5.9%	5.9%	6.0%	4.8%	5.7%	6.3%	6.1%	6.0%	5.8%	6.7%	7.0%	6.3%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	61.1	82.4	92.6	61.7		81.0	83.3	56.8	67.7	72.9			65.2	
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	89.3	80.9	90.7	22.9	108.3	30.2	59.4	62.0	63.4				62.8	
Trust	Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 mont...	1.14	0.69			0.69			0.71							
Admitted	Mortality rate per 1000 admissions in-months	14.4	4.2	6.5	7.9	7.2	11.7	9.1	7.9	7.2	7.6	6.5	6.4	7.2	7.0	
Community	IAPT Moving to Recovery	>50%	52.3%	45.7%	47.1%	52.4%	50.4%	49.1%	48.4%	50.3%	53.0%	56.4%	52.3%		53.1%	

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Effective Services - Commentary

Non Elective re-admission

The increase in bed base in August compared to July had an impact on re-admission numbers. There are a high number of patients who are frequently admitted. These patients invariably have high needs with some from Nursing care homes. .

Plan - a quality improvement audit will be undertaken (from October17) to review discharge and ongoing management plans for these specific patients.

Responsive Services - Indicators and Performance

Category	Indicator	17_18 Target	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	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	2017-2018	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	93.4%	88.1%	85.1%	85.8%	82.9%	86.6%	88.4%	91.1%	93.5%	92.4%	92.2%	90.5%	92.0%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	62	75	88	76	77	69	72	72	68	63	59	64	65	
ED	Ambulance handovers waiting more than 30 mins	0	16	26	45	68	113	68	60	28	14	40	27		109	
ED	Ambulance handovers waiting more than 60 mins	0	0	1	4	22	37	13	3	1	0	7	4		12	
ED	12 hour trolley waits in A&E	0	1	1	1	0	2	3	2	5	4	3	2	5	19	
Cancer	Cancer - 14 days to first seen	>93%	96.6%	97.8%	95.5%	93.4%	94.8%	96.8%	94.6%	93.2%	93.2%	95.3%	95.7%		94.4%	
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	100.0%	97.2%	98.2%	100.0%	93.4%	98.7%	92.9%	96.0%	94.1%	100.0%	100.0%		97.3%	
Cancer	Cancer - 62 days from referral to treatment	>85%	74.5%	83.3%	85.0%	92.3%	84.9%	100.0%	92.9%	86.0%	89.1%	84.4%	86.7%		86.6%	
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%	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%	
Cancer	Cancer - 62 Day Upgrade															
Access	DM01 - Diagnostic Waits (<6 weeks)	>99%	99.7%	99.5%	99.8%	99.1%	99.1%	99.6%	99.2%	99.0%	99.1%	99.1%	99.0%	99.0%	99.1%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	93.1%	92.9%	92.8%	92.2%	92.2%	92.4%	92.0%	92.0%	92.6%	92.4%	92.0%	92.1%	92.2%	
Access	Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	0	0	0	0	0	0	0	3	1	4	

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Responsive Services - Commentary

Emergency Department (ED) four hours' wait and Ambulance handover time

Performance against the 95% target dropped to 90.5% in Aug, whilst the median time to treat rose to 64 minutes against a target of 60. The drop in performance can be attributed to challenges around staffing in terms of ED locum doctors, with a high number of unfilled shifts and inpatient nurses - the latter impacting on flow from speciality wards.

There were in addition a higher numbers of Mental Health patients (219) with an average length of stay of 9.6 hours.

There was also a higher number of Delayed Transfer of Care (DToC) over the month which had an adverse impact on bed capacity.

12 hour trolley waits in A&E

There were 5 12 hour trolley waits in August. All 5 breaches were informal mental health patients requiring mental health bed transfers. WH is working with C&I to implement the recommendation of the ECIP review. (final copy sept 17) The key recommendations include – mental health CNS triage, at front of house, a mental recovery room as an alternative to long waits in the Department and improve the experience of mental health patients.

Whittington Health has secured £1m capital funding via the UEC capital fund to build a mental health recovery room within this financial year.

Clinical and operational teams are working closely together on the clinical pathway with support from ECIP.

The organisation also continues to work closely with the trust to ensure that timely and robust escalation processes are embedded in practice both in an out of hours.

RRT 18 week waits – 52 weeks

Of the three over 52 week waiters that were identified in July two have been treated and one is still to be treated. This is due to patient choice. This treatment will be completed on 2nd October 2017.

Responsive Services - Indicators and Performance

Category	Indicator	17_18 Target	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	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	2017-2018	Performance
Theatres	Hospital Cancelled Operations	0	1	4	6	2	15	7	5	6	9	9	2		26	
Theatres	Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	0	0	2	0	0	0		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	199	364	267	348	236	192	255	245	300	210	334		1089	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	4.6%	8.2%	5.1%	7.7%	5.3%	4.5%	5.5%	5.8%	6.9%	5.0%	7.8%		6.4%	
Maternity	Women seen by HCP / midwife within 10 weeks	>50%	72.8%	69.4%	67.2%	67.8%	54.1%	57.5%	50.9%	45.8%	52.8%	48.7%	58.0%	61.4%	53.6%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%	94.6%	94.4%	94.3%	97.2%	97.2%	93.6%	93.3%	97.5%	96.5%	94.7%	94.7%		95.9%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	94.2%	91.8%	92.2%	91.6%	91.3%	93.3%	87.5%	88.6%	93.8%	91.9%	88.7%		99.0%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	88.3%	93.3%	94.1%	94.6%	94.8%	93.3%	90.7%	90.3%	94.1%	96.1%	91.7%		93.0%	
Community	Haringey - HR1 % carried out before child aged 15 months		49.4%	40.1%	41.8%	36.7%	33.2%	35.7%	42.9%	44.0%	38.0%	45.1%	44.4%		42.9%	
Community	Haringey - HR2 % carried out before child aged 30 months		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	37.2%	32.5%	33.6%	47.5%		37.6%	
Community	Islington - HR1 % carried out before child aged 15 mths		54.3%	55.8%	54.7%	67.1%	56.2%	62.2%	68.1%	71.0%	69.8%	69.2%	60.7%		67.3%	
Community	Islington - HR2 % carried out before child aged 30 mths									78.1%	74.7%	72.4%	82.2%		77.0%	
Community	Haringey - 8wk Review % carried out before child aged 8 weeks		1.0%	3.5%	3.6%	11.3%	10.7%	13.9%	17.2%	20.8%	27.2%	32.5%	41.6%		30.8%	
Community	Islington - 8wk Review % carried out before child aged 8 weeks		5.4%	4.6%	4.8%	3.9%	5.6%	3.6%	2.1%	15.2%	29.4%	42.7%	46.7%		34.3%	

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Responsive Services - Commentary

Cancelled operations
Two patient's operations were cancelled last minute.
1 routine patient cancelled, for a Breast patient there was no anaesthetic nurse available in theatre, as a bank member of staff did not turn up for the booked shift.
1 urgent patient cancelled, a Urology patient, as the list overran.

Delayed Transfer of Care
There was a spike in DToCs in early August reaching a total of 20 DToCs during this period. There were issues in capacity in North Islington social care teams and capacity at St Pancras NHS beds continues to be challenging.
As part of winter planning we will have an onsite social work presence from both Barnet and Islington, similar to the Haringey social work onsite model.

NBV narrative:
Islington: 10 (4.4% late)
Islington performance fell from 96.1% in June to 91.7% in July.

Haringey: 32 (6% late)
Haringey's performance also fell from 92% in June to 88.7% in July. It is significant that 10 visits were carried out on day 15 - with better planning of visits Haringey NBV would have achieved 94%.

Reasons given for late visits across both boroughs include:
- in hospital
- late notification/incorrect address
- parental preference
- interpreter unavailable
- HV error/cause

Responsive Services - Commentary

Newly added indicators for Health Visiting, 8 weeks review and Health Review 1 and 2

Local authorities are mandated to ensure that all pre-school age children are offered five key health assessments as part of the Healthy Child Programme (HCP). The 5 mandated reviews are undertaken at:

- Antenatal from 28 weeks
- New birth visit (NBV) at 10 - 14 days
- 6-8 weeks
- 1 year
- 2 - 2 1/2 years

The Islington HV service has had a well-established universal HCP for the NBV, 1 & 2 year review for some years and has made significant improvements to the delivery of the 1 & 2 year reviews since the reviews have been recorded in the Early Years dataset sent by local authorities to NHSE on a monthly basis.

Until 2016, Haringey was a highly targeted service and only delivered the NBV universally. In April 2016, the service was delivering less than 10% of 1 & 2 year reviews universally and although performance has plateaued around the low 40s for the 1 year review and low 30s for the 2 year review the service expects to see a significant improvement for Q3. The lack of progress has been due to an increased backlog and children then seen outside the timeframe, as well as issues within our appointing processes. We have since:

- increased the number of available appointments
- established an appointing system for the 1&2 year reviews within our newly implemented single point of contact (SPOC) hub
- addressed the backlog.

Both Boroughs have now introduced the 6-8 week assessment and both are making steady and sustained progress

We are yet to introduce the universal antenatal assessment as there have been pan-London difficulties in receiving booking information from maternity units since CHI services were transferred to sector hubs

Well Led Services - Indicators and Performance

Category	Indicator	17_18 Target	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	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	2017-2018	Performance
HR	Appraisals % Rate	>90%	63%	66%	66%	67%	72%	75%	80%	80%	79%	79%	78%	78%		
HR	Mandatory Training % Rate	>90%	80%	81%	81%	82%	81%	82%	82%	82%	82%	82%	82%	82%		
HR	Permanent Staffing WTEs Utilised	>90%	87.0%	88.1%	88.1%	87.7%	87.7%	87.8%	87.8%	88.7%	88.9%	87.4%	86.1%	87.4%	87.7%	
HR	Staff FFT % recommended work	>50%	59.7%						60.5%			54.5%			54.5%	
HR	Staff FFT response rate	>20%	24.9%						24.4%			18.1%			18.1%	
HR	Staff sickness absence %	<3.5%	3.6%	3.8%	3.8%	3.7%	3.7%	3.6%	3.2%	3.3%	3.3%	3.4%	3.2%	3.4%	3.3%	
HR	Staff turnover %	<10%	15.7%	15.4%	14.9%	15.4%	15.3%	15.1%	14.3%	14.8%	14.4%	14.0%	14.7%	15.0%	14.6%	
HR	Vacancy % Rate against Establishment	<10%	13.0%	11.9%	11.9%	12.3%	12.3%	12.2%	12.2%	11.3%	11.1%	12.6%	13.9%	12.6%	12.3%	

Category	Staff Type	17_18 Target	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	Q1 Jun-17	Q2 Jul-17	Trend
Medical	Average staff cost per patient		92	98	88	101	94	89	125	107	91	95	96	
Nursing	Average staff cost per patient		171	173	160	186	182	174	237	190	169	169	171	
Other	Average staff cost per patient		174	191	178	200	188	194	256	217	198	194	209	

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Well Led Services - Commentary

Human Resources

There has been a decline in the percentage of staff who would recommend the Trust as a place to work. This is correlated with a reduced response rate. The CEO Briefings as well as Trust Management Group discussions have focussed on this topic in recent weeks.

Although the Trust is doing lots to combat bullying such as the introduction of Anti Bullying & Harassment Advisors, it is still a concern or current experience for a number of staff. We need to ensure that we continually share what is available to staff and be proactive whenever we see instances of bullying. Our Equality and Inclusion Conference in September will be used as a springboard to better engage staff and re-launch the Adviser role.

Friendly staff and excellent team working continue to be two of the top reasons why staff would recommend the Whittington as a place to work. There were a number of positive comments about supportive managers as well as a supportive organisation which provides good training and learning opportunities.

Mandatory Training and Appraisal compliance continue to remain static. Our new CEO has already begun to remind colleagues of the importance of improving this.

There has been a slight improvement of the vacancy rate overall – however much work is ongoing to tackle the vacancy factor in nursing in particular.

Activity - Indicators and Performance

Category	Indicator	17_18 Target	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	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Activity
ED	ED Attendances	8285	8020	8253	8271	8238	8254	7430	8527	8285	8699	8239	8537	7855	
ED	ED Admission Rate %		16.7%	16.2%	16.6%	17.5%	17.2%	17.1%	16.9%	17.2%	17.3%	17.3%	16.4%	17.4%	
Community	Community DNA Rate %	<10%	5.6%	5.3%	5.5%	5.6%	5.5%	5.5%	5.2%	4.9%	5.3%	5.6%	5.2%	5.6%	
Community	Community Face to Face Contacts		59726	59155	63796	53850	60483	56388	66464	52673	62723	60869	59675	48750	
Admissions	Elective and Daycase		1937	1948	1876	1714	1879	1686	1850	1618	1790	1931	1903	1829	
Admissions	Emergency Inpatients		2078	2036	2124	2110	2067	1926	2200	2117	2212	2131	2162	2143	
Referrals	GP Referrals to an Acute Service		6339	5947	6284	5145	5795	5381	6694	5136	6242	5744	5552	5767	
Referrals	% of GP Referrals that were completed via ERS		19.9%	20.4%	18.9%	20.4%	21.5%	20.5%	18.9%	20.5%	19.7%	21.6%	23.2%	29.1%	
Referrals	% ERS Slot Issues	<4%							36.1%	35.1%	32.7%	39.1%	35.7%	25.0%	
Maternity	Maternity Births	333	336	315	324	300	312	274	309	301	331	321	313	320	
Maternity	Maternity Bookings	377	301	353	365	319	323	308	382	309	414	304	337	335	
Outpatients	Outpatient DNA Rate % - New	<10%	12.3%	11.1%	11.3%	12.6%	12.4%	11.8%	12.0%	12.4%	11.9%	11.3%	11.9%	12.6%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	11.2%	10.0%	10.0%	11.6%	12.4%	12.1%	11.9%	11.6%	11.7%	10.2%	11.8%	12.3%	
Outpatients	Outpatient New Attendances		8916	8731	9638	7965	8838	8438	9205	7557	9400	9096	8589	8638	
Outpatients	Outpatient FUp Attendances		18525	18728	19876	17244	18668	17062	18952	15605	18584	18890	17552	16659	
Outpatients	Outpatient Procedures		6017	6268	6186	5628	5957	5244	5793	4979	6100	6357	5748	5786	
Theatres	Theatre Utilisation	>85%	81.8%	81.5%	83.7%	83.5%	72.8%	81.1%	82.7%	84.9%	85.9%	82.7%	83.4%	80.8%	

Date & time of production: 27/09/2017 14:00

Average Tariff by Point of Delivery (POD)

Category	Point of Delivery (POD)	17_18 Target	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	Q1 Jun-17	Q2 Jul-17	Trend
Average Tariff	Daycases		616	663	694	664	682	664	657	739	727	709	699	
Average Tariff	Elective		4027	3831	4099	4402	2522	3785	4214	3772	2701	3726	4014	
Average Tariff	Non-Elective		2117	2153	2196	2132	2383	2180	2165	1790	1883	2356	2199	

Activity - Commentary

DNA rate

The Trust is going live with a pilot of DrDoctor within Imagining in October 2017. The pilot will see the text reminder, patient portal and basic rescheduling turned on. It is expected to reduce DNA rates by 20%, improve patient experience and reduce the amount of wasted doses within Nuclear Medicine. The plan is to implement fully across all ICSUs in November. DrDoctor are also currently working with System C to build further functionality for the patient portal where patients will be able to rebook and cancel appointments in real time.

Maternity Births

Maternity Services are delivering and average of 12 babies a day. This means that, going forward, the predicted monthly average of 333 deliveries should be achieved.

Theatre Utilisation

Theatre utilisation in August 2017 was 80.8% against a threshold of 85%.

Typically in August although a number of lists are cancelled due to staff holiday leave, there is usually a drop in utilisation as often patient cancel their procedure as it is traditional holiday time.

A number of consultants have now been identified as outliers compared to their peer group for theatre utilisation. These consultants will have a number of their theatre lists removed as they are not using them efficiently. This is now in place over seen by ICSU Clinical and Operational Directors. Performance for September is currently at 84%.

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Whittington Health Trust Board

4 October 2017

Title:	Whittington Pharmacy Community Interest Company (CIC) Board Vacancy		
Agenda item:	**17/133**	**Paper**	**08**
Action requested:	To approve the appointment of a new Director		
Executive Summary:	Whittington Pharmacy CIC, registered company 10593765 is wholly owned by Whittington Health NHS Trust. The Whittington Pharmacy CIC board has noted the resignation of Siobhan Harrington as a Director of the board following her appointment as Chief Executive of Whittington Health NHS Trust. The Articles of Association of Whittington Pharmacy CIC require the Trust to appoint Directors by written notice to the Company.		
Summary of recommendations:	The Whittington Health Trust Board is asked to approve the appointment of Carol Gillen, Chief Operating Officer to the Whittington Pharmacy CIC Board.		
Fit with WH strategy:	Statutory Responsibility		
Reference to related / other documents:	Whittington Pharmacy CIC Articles of Association		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	n/a		
Date paper completed:	22 September 2017		

Author name and title:		**James Wood Managing Director Whittington Pharmacy CIC**		**Director name and title:**		**Steve Bloomer, Chief Finance Officer**	
Date paper seen by EC	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

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Whittington Health Trust Board

4 October 2017

Title:	Trust Board Assurance Framework and Corporate Risk Register						
Agenda item:	**17/134**		**Paper**		**09**		
Action requested:	For review and approval						
Executive Summary:	This paper contains the latest updated Board Assurance Framework (BAF), High Level Risk Profile Matrix and a summary review of the Corporate Risk Register (CRR risks >15). Information and evidence that informs the BAF and CRR have been reviewed from: • Integrated Clinical Service Unit (ICSU) Board meetings • ICSU Quarterly Performance Reviews with the Corporate Director team • Trust Board sub-committee Risk Registers • Trust Executive Team meetings • Trust Management Group meetings • Trust senior risk quality assurance team (Chief Executive, Chief Nurse, Director of Corporate Affairs, Deputy Director of Strategy and the Head of Integrated Risk Management)						
Summary of recommendations:	To review and approve the Board Assurance Framework (BAF) and summary of the Corporate Risks and high level mitigations						
Fit with WH strategy:	Aligned with the Trust Clinical Strategy 2015/2020 and 2016/17 Corporate Objectives						
Reference to related / other documents:	Whittington Health Standing Financial Instructions and Standing Orders						
Reference to areas of risk and the BAF:	As detailed in the BAF and CRR						
Date paper completed:	28 September 2017						
Author name and title:	**Lynne Spencer, Director of Corporate Affairs, Helen Taylor Deputy Director of Strategy**		**Director name and title:**		**Siobhan Harrington Chief Executive & Philippa Davies, Chief Nurse & Director of Patient Experience**		
Date paper seen by EC:	**Sep 17**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Board Assurance Risk (BAF) – movement

There are 4 risks that have been downgraded as part of the regular review process. These risks have transferred to the responsible sub-committee or group responsible for monitoring each particular risk. The 4 risks downgraded during this period are:

- BAF01 - failure to maintain quality of patient care (Quality Account and Clinical Strategy)
- BAF11 - failure to effectively manage the maintenance of medical devices
- BAF12 – failure of regulatory compliance with NHSI Single Oversight Framework and CQC
- BAF13 - failure to ensure high quality data

The highest risks continue to be rated at 20:

- BAF05 - failure to deliver CIPs and transformation savings in 17/18
- BAF06 - failure to maintain liquidity and sufficient working capital

The following risks are being monitored closely as they may be escalated from 16 to 20 if mitigating actions are not resulting in clear movement over the following months:

- BAF14 - ED 95% performance compliance
- BAF10 - Recruitment and retention across clinical, medical and nursing areas

Quarterly Review – summary of Corporate Risk Register (CRR)

The Trust's Senior Risk Quality Assurance Team comprise of the:

- Chief Executive
- Chief Nurse and Director of Patient Experience
- Director of Corporate Affairs
- Acting Director of Strategy
- Head of Integrated Risk Management

The have set up a new Working Group to review and assure the Corporate Risk Register on a regular basis to ensure a strategic overview of monitoring, moderating and implementation of mitigating actions.

This senior Group will escalate and de-escalate risks according to evidence and assurance received and discussed at the meetings.

Summary of Corporate Risk Register (CRR) and High Level Mitigation:

Ref CRR	Risk Area	High Level Mitigation	Ref BAF
693 754 768 779 830	**Workforce staffing levels** • Nursing • Consultants - Neo natal and breast services • Junior Doctor rotas Surgery • Paediatric consultants	• Workforce Taskforce set up leading a multiple range of high impact initiatives • Recruitment and Retention Plan progress reports to Executive team monthly • New process for consultant recruitment	BAF4 BAF10 BAF17
697	**Maternity / Neonatal Redevelopment**	• Second Theatre agreed to commence build from 2017 • Estate Strategy Implementation from 2017	BAF7
189 683	**Emergency Department** • Overcrowding • 95% 4hr target compliance	• ECIP plan being implemented • £1m capital funding secured for MH suite modernisation • Winter 2017 funding £2m received	BAF14 BAF3
773	**Lower Urinary Tract Services (LUTs)** • Sustainability of service • Governance and Safety • New patients • Funding	• Action Plan being implemented • Multi-disciplinary Team (MDT) in place • LUTs patient group meet regularly with the senior WH team and commissioners	BAF2
798	**Safeguarding (children) training compliance**	• ESR data cleanse in place • Lead Safeguarding Manager rolling out training plan	n/a

Recommendation

To review and approve the Board Assurance Framework (BAF) and summary of Corporate Risks held on the Corporate Risk Register.

Appendices

1. Board Assurance Framework High Level Risk Profile 4 October 2017

2. Board Assurance Framework 4 October 2017

Board Assurance Framework (BAF) High Level Risk Profile - Trust Board October 2017

	BAF01: Failure to maintain the quality of patient care expected from Quality Account and Clinical Strategy targets	**BAF02:** Failure to provide an ongoing service to LUTS patients	**BAF03:** Failure to meet performance targets, in particular ED and MSK services	**BAF04**: Failure to recruit and retain quality staffing	**BAF05:** Failure to deliver CIPs and transformation savings for 2016/17	**BAF06:** Failure to maintain liquidity and a sufficient level of working capital	**BAF07:** Failure to access capital funding for maternity and neonatal FBC will delay building a second collocated theatre	**BAF09**: Failure to align WH population health model to the final NCL STP	**BAF10**: Failure to sustain the breast service due to workforce changes	**BAF11:** Failure to effectively manage the maintenance of medical devices will lead to patient safety and quality risks	**BAF12:** Failure to ensure regulatory compliance with the NHSI single oversight framework and CQC	**BAF13:** Failure to ensure high quality data will result in poor decision making that will impact on the Trust reputation, income and quality of services	**BAF14**: Failure to maintain patient flow will result in poor patient experience, impact on patient safety and cost more financially	**BAF 15**: Failure to modernise the Trust's estate may detrimentally impact on quality and safety and patient experience and the Trust's financial sustainability	**BAF 16** Failure to establish cyber security	**BAF 17** Failure to deliver compliant junior doctor rotas across the Trust	
Red >15		**16**	**16**	**16**	**20**	**20**	**16**	**16**	**16**				**16**	**16**	**16**	**16**	
Amber 11-15	**12**									**12**	**12**	**12**					
Yellow 06-10																	
Green <06																	

Risks >15 – oversight by the Trust Board

All risks – quality assured and signed off for escalation/de-escalation to appropriate Committee/Working Group by the Trust Senior Risk Management Group: Chief Executive, Chief Nurse and Director of Patient Experience, Director of Corporate Affairs, Director of Strategy, Head Integrated Risk Management

All risks – oversight and management by leadership teams at all levels across the Trust (Corporate, ICSU, district teams, wards, etc)

The Trust 'Risk Appetite' is governed by the former National Patient Safety Agency (NPSA) 5X5 consequence and likelihood scoring model that aligns to best practice for the effective and efficient management of risks

Whittington Health NHS

Board Assurance Framework (BAF) v4 September 2017 DRAFT

Key: Text highlighted red indicates the changes that have been made to the BAF since it was last presented to the Trust Board

Strategic Goals2015-20

To secure the best possible health and wellbeing for all our community
To integrate and coordinate care in person-centred teams
To deliver consistent, high quality, safe services
To support our patients and users in being active partners in their care
To be recognised as a leader in the fields of medical and multi-professional education, and population-based clinical research
To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population

BAF Ref	Corporate Objective	Risk	Accountable Director	Current risk rating	Existing Controls in Place	Possible Sources of Assurance	Positive Assurance Received 2016/17	Gaps in controls/ assurance and	Action plans to mitigate risk	Reporting/ Monitoring arrangements	Progress	Action Deadline	Next Review Date	Forecast risk rating (post actions)	Risk Register Codes (for reference)
BAF02	CO1. Deliver quality, patient safety and patient experience.	Failure to provide an ongoing service to LUTS patients	Medical Director	16	Since the temporary suspension the service has continued without interrruption. The Consultant is continuing to work in the post and is on a fixed term contract. Improvement plan in place against the RCP review recommendations.	Safety and governance concerns raised by the Royal College of Physicians (RCP) review are being addressed and are being monitored.	Updates to Action plan developed in response to the RCP report TB updates on progress against action plan	Multidisciplinary meetings to ensure governance process and patient safety are not currently in place. Succession plan for clinical leadership progressing but not finalised.	Ongoing regular review and update of the action plan. The Executive Medical Director is gathering information to learn from the previous attempts to run an MDT to inform the set up of a sustainable MDT for the future MDT assurance September 2017 desk top review to be completed	Executive Team Trust Board	February 2017 -Desk top review completed Childrens pathway agreed in principle UCLH/WH and CCG meeting taken place Meetings with with JML S ervice user meetings held regularly in 2017 - Discussionswith UCLH, the commissioners, UCL and engagement with patients to secure a sustainable future for the service. Desktop review underway against RCP action plan September 2017 - MDT in place Business case in development Agreed joint post UCLH	Oct-17	july 2017	8	w32973 Steis 2015 33773 Surgery ICSU RR
BAF03	CO1. Deliver quality, patient safety and patient experience	Failure to meet performance targets in ED	Chief Operating Officer	16	• Performance management monitoring • Improvement plan to meet ED target includes work with intermediate care and discharge to assess work monitored at operational meetings. •monthly wholesystems delivery group oversees and monitors progress. Enhanced recovery programme in place including the SAFER care bundles which include the 'red to green' initiative. implement full capacity model	Performance reports to Trust Board and Quarterly Performance Review meetings ECIP report and action plan weekly operational meeting.	Monthly performance reports to TMG and TB ED consultant recruitment SI reports to TB monthley whole system improvement group	ED Target not met although met agreed trajectory April 2017	ECIP review and report plus fullcapcity protocol set up. Oversight of whole system improvement plan. Ongoing recruitment of consultants for ED Bed management and escalation policies all in place Red to Green programme in place - to support improvements in flow cycles of perfect week in place	ICSU performance reviews, Trust Operational meetings, TMG and TB	ECIP progress acheived and trajectory in April ontrack to acheived and ontrack for May. CEO chair of Urgent and Emergency Care workstream at STP level 4 out of 6 ED Consultants recruited Q1 STP trajectory achieved. Embedding improvement work with the support of ECIP and PMO clinical lead. Including plus one in place for winter 17/18 Dishcarge 2 assess progressed with implementation for September	Ongoing in year	June 2017	8	605/ 279/ 189/ 683
BAF04	CO2. Develop and support our people and teams.	Inability to increase substantive workforce capacity	Director of Workforce	16	*Agency Reliance Reduction Taskforce Established in August 2017* Workforce strategy in place • ICSU governance structure with strong clinical leadership and Performance Reviews quarterly with Executives •Workforce Assurance Committee in place with responsibility for R&R KPIs monitored •HR business partners in place • Weekly Vacancy Scrutiny Panel meetings • Workforce Assurance Committee (WAC) established • Recruitment & Retention Strategy agreed • Workforce KPIs reported to WAC • E-rostering and real time data • weekly tracking of temporary staffing by Executive team	•Trust Board safety/quality/safe staffing reports and monthly performance report • Quality Committee safety/quality reports • Workforce KPI reports Reports to Trust Board Reports to TMG Reports to Workforce assurance committee ICSU performance reviews and challenge in place	Workforce strategy approved Monthly performance reports Reports to Worforce Assurance Committee Staff survey results Assurance on quality of care provided received through weekly executive challenge and ICSU performance reviews, and e-rostering live data.	Agency spend greater than planned	Implement Recruitment and retention Stratgey Monitor WAC workplan to strengthen controls and compliance with agency cap Continue to monitor KPIs New bank rates agreed Work with the STP on cross NCL agreed rates Develop rotations with UCLH and agreements for staff to work across both organisations. Overseas recruitment included in the wider ongoing recruitment drives Action to improve retention in relation to staff survey and FFT results for staff automation of VSP	Performance Reviews; TMG Workforce assurance Committee and TB	Regular recruitment days held including some international recruitment Workforce Assurance Committee meeting regularly Developing Vacancy Scrutiny Panel to be an automated process designed with Clinical Director input new bank sates agreed (except A&C). Calnder of recruitment events. Overseas recruitment drive Exit interviews conducted.	Ongoing in year	June 2017	12	WAC5
BAF05	CO3. Develop our business to ensure we are financially sustainable.	Failure to deliver CIPs and transformation savings for 2017/18 and failure to plan for 2018/19 • Failure to deliver CIPs and savings to £17.3m • Non identification of credible CIP schemes • Non achievement of agreed Cost Reduction schemes	Chief Operating Officer	20	Agreed as priority clinical area to collaborate with UCLH MDT in place Locum surgeon and radiologists i	Reports to Trust Board Reports to TMG Reports and deep dive monitoring to Finance and Business Development Committee Internal Audit reports and recommendations which are agreed with management actions monitored and reported as implemented Performance reviews with ICSUs	16/17 outturn Deep dives to F&BD Communication to all staff Plan/roadmap/& gap analysis ILG reports	Unindentified CIP Continuing internal phasing	• ILG action plan & decision points • Targetted support from BCG to identify further schemes. Service Planning • Grip & Control Project	Trust Board TMG Finance and Business Development Committee	• ICSU CIP targets agreed and signed off • ILG agenda • FIP2 partner in place CIP £10.2m 16/17 ICSUs to develop further schemes to close gap. QIA process in place. Monitoring and governance in place. Weekly road map check in. Fortnighly ILG meetings. CIP delivery group. Targetted support.	Mar-18	Oct 2017	10	F&BD007
BAF06	CO3. Develop our business to ensure we are financially sustainable.	Failure to maintain liquidity and a sufficient level of working capital due to delayed CCG payment and/or Insufficient working capital facility and delay in STF payment	Chief Financial Officer	20	• Monthly Contract Meetings • Regular CFO/Deputy CEO and CCG meetings • Regular CFO/Deputy CEO and NHSI meetings • Weekly monitoring of cash and working capital by the Finance team • Increased monitoring and reporting to Finance and Business Development Committee • Monitored and reported to TMG, F&BD & Board - Ability to use draw-down facility if agreed borrowing is exceeded	Reports to Trust Board Reports to TMG Reports and deep dive monitoring to Finance and Business Development Committee Capital analysis Regularising Contracts	• 97% of income backed by signed contracts • 16/17 outturn • Finance Report to TB • Finance and Business development committee • Internal and external audit reports • Q1-Q3 2016/17 delivery to control total • Capital Plan • Improved CCG debt	• No guarantee on working capital/EFL 17/18 as expected in July	• Performance reviews with ICSUs focus on corrective financial actions to meet control total • Monitor and report cash & liquidity at NHSI monthly performance meetings • Cash managment discussed at F&BD and reported to Board • Capital spend trajectory reported within financial reports • Improved cash monitoring in grip & control	Trust Board TMG Finance and Business Development Committee	Additional controls put in place to deliver control total to secure the STF monies - February 2017 All forecasts and mitigating actions agreed Discussion with NHSI colleagues ongoing Business Plan including EFL/Working Capital expectations	Mar-18	Oct 2017	15	F&BD010
BAF07	CO3. Develop our business to ensure we are financially sustainable. CO1. Deliver quality, patient safety and patient experience.	Failure to access capital funding for the Maternity and Neonatal Full Business Case (FBC) will delay the modernisation of the unit and delivering the safety requirements of a second co- located theatre	Chief Financial Officer/ Deputy Chief Exec	16	Meetings with NHSI Capital planning process and report to Trust Board Maternity dashboard in place with reporting of KPIs and SIs	Capital to be sourced from NHSI or internal capital programme or from SEP arrangement Trust Board updates and papers re capital and maternity and SEP process ICSU performance reviews TMG papers	STP letter of support received regarding the Maternity and neonatal redevelopment Patient experience feedback to Patient Experience committee	Gaps in controls Clear updated plan for Maternity and neonatal redevelopment underway but not yet complete	Updated plan in place by July 2017 and linked to Trust Capital programme 2017/18 Continued work with NHSI to mitigate financial risks Develop and implement a fundraising campaign when the plan is finalised to enable a comprehensive marketing plan to be developed Complete procurement process for a SEP partner Meet maternity targets to demonstrate market growth Through the clinical collaboration work with UCLH develop joint schemes to deliver better outcomes for local women	Finance and Business Development Committee Trust Management Group and Trust Board Maternity Steering Group and Transformation Board	ICSUs engaged in discussions regarding options and timescales. NHSI negotiations continue SEP procurement process to complete July 2017	Ongoing in year	Oct 2017	8	F&BD011
BAF09	CO4. Further develop and expand our partnerships and engagement.	Failure to align Whittington Health's population health model to the final NCL STP	Deputy Chief Executive/Director of Strategy	16	• Engagement with NCL STP process • WH Medical Director as co-Clinical Lead for STP process • Haringey and Islington Wellbeing Partnership Governance • Clinical Collaboration with UCLH	Final STP submission Open and transparent public engagement in place HWB meetings	Current clinical models being described align with agenda of integrated care and population health Development of CHIN model for NCL founded on integrated care model in Islington and work of the integrated care pioneer	STP work not complete Public engagement process not yet fully evolved Business plans for CHINS not yet complete and model evolving.	Progress the work of the Haringey and Islington Wellbeing Partnership and enabling the workstreams to deliver with momentum Engage fully with primary care locally on the development of CHINs Review the business plans with ICSUs re their integrated care plans to align with evolving CHINs	Joint HWB TMG Trust Board	Joint governance in place and Programme Director for the Haringey and Islington Wellbeing Partnership Workstreams being developed with clinical engagement from Trust Briefings on the development of CHINS and member of the Care Closer to Home Board at the NCL STP level Engaged in CHIN development meetings in both Islington and Haringey GPs being engaged and discussions with both commissioners and providers taking place	Ongoing in year	Ongoing	8	n/a

BAF Ref	Corporate Objective	Risk	Accountable Director	Current risk rating	Existing Controls in Place	Possible Sources of Assurance	Positive Assurance Received 2016/17	Gaps in controls/ assurance and	Action plans to mitigate risk	Reporting/ Monitoring arrangements	Progress	Action Deadline	Next Review Date	Forecast risk rating (post actions)	Risk Register Codes (for reference)
BAF10	CO1. Deliver quality, patient safety and patient experience.	Failure to sustain the breast service due to workforce changes.	Surgery ICSU CD/ Chief Operating Officer	16	Agreed as priority clinical area to collaborate with UCLH MDT in place Locum surgeon and radiologists in place with plan to recuit and also agreement of sessions from UCLH team	Performance targets for Breast Cancer; NCL Cancer Board and Breast Cancer commissioning Board.	Clinical team in place New breast cancer lead in place	Improvement plan not formally in place with UCLH although agreement on direction of travel	Moved room timetables to relieve pressure on the service Arranged weekly meetings with Breast Service manager Arranged outsourcing for complex procedures on ad hoc basis Arranging joint post breast consultant radiographer with UCLH Agreeing surgical arrangements with UCLH	TMG Surgery ICSU Board NCL Cancer Board	Progress being made with developing relationship with UCLH clinical colleagues. Risks being managed however needs weekly monitoring and detail of improvement plan	Ongoing in year	Ongoing	8	666
BAF14	CO3. Develop our business to ensure we are financially sustainable.	Failure to deliver safe and high quality urgent and emergency pathway resulting in patients waiting for care and treatment with risk identified in care of people with mental health care needs	Chief Operating Officer	16	Urgent and emergency care Board in place with all partners ECIP review conducted and action plan in place Real time information and review in place Management across ED now fully established within urgent and emergency care ICSU Working with C&I mental health trust to improve care pathways for people with mental health needs External review commissioned Implement full capacity model	ECIP review and further external reviews TB performance report to Board TMG reports and discussion at Trust operational meeting	ECIP review which identified areas of good practice and areas for improvement CQC report 2016 Patient safety huddles monthly whole systen improvement group	Gaps in assurance: shortage of mental health beds and ability of mental health providers to respond effectively ED consultants being recruited but not yet fully established	ECIP action plan in place and being monitored through ICSUs, Trust operational meeting and TMG Complete recruitment of 2 further ED Consultants Focus on flow through hospital including increasing pre 11 discharges and active management of any DTOCs Review of mental health care pathways underway and close working with C&I mental health trust.	ICSUs, Trust operational meeting, TMG and Trust Board	External review of mental health care pathway and learning from recent incidents underway and closer working with mental health colleagues and others across the system to improve care. ECIP progress acheived and trajectory in April ontrack to acheived and ontrack for May. CEO chair of Urgent and Emergency Care workstream at STP level 4 out of 6 ED Consultants recruited. External review by ECIP complete. Clear recommnede actions (whole system) Whole system improvement plan in place and monitored at the ED delivery board. Full roll out of SAFER bundle and RED2GREEN.	Ongoing in year	Ongoing	12	688
BAF15	CO1. Deliver quality, patient safety and patient experience.	Failure to modernise the Trust's estate may detrimentally impact on quality and safety of services, poor patient outcomes and affect the patient experience.	Director of Strategy	16	Estates Strategy and delivery plan in place Controls in place to monitor quality and safety and patient experience and ICSU management structure through to TMG and Executives and Trust Board Director of Environment in place and procurement for a strategic estates partner underway	Estates Strategy Estates Strategy Delivery Plan	Estates Strategy agreed at Trust Board, Feb 2016 Estates Strategy delivery vehicle agreed at Trust Board, June 2016 Competitive dialogue procurement process due to conclude July 2017	Gaps in control: Estates and Facilities directorate undergoing improvement Approvals will be needed for agreement of SEP partner from NHSI and STP Gaps in assurance: Lack of ongoing stakeholder and community engagement	SEP project plan to ensure process runs to time and resourced Communication plan in place and being reviewed to ensure engagement with staff and the public and other stakeholders regarding the SEP Engagement of all potential stakeholders regarding approvals processes	Executive Team TMG Trust Board	Second stage of competitive dialogue completing with regard to SEP so on track for potential prefered provider recommended to TB in July Engagement through next three months with stakeholders and public being planned	Ongoing 2017	Dec 2017	6	697
BAF 16	CO1. Deliver quality, patient safety and patient experience.	Failure to establish cyber security across the Trust	Chief finance officer	16	I&MT Meetings with workplan Chief Information Officer recruited Fast Follower awarded with additioin funding £5m Patching work completed during 2017	Digital strategy in place and approach to investment agreed Audit and Risk Committee	Impact of recent NHS cyber attack Internal audit capital monitoring group IG committee	Older PCs still in place in some areas of Trust	Delivering the digital strategy - fast follower exemplar programme Continuing to mitigate risk of cyber attack and learning from other Trusts Investment in cyber security as part of capital programme Escalation protocol in place - agreed across RF, UCL & WH with C& I London Compact - in place from autumn 18' 72 hour report for all waits in excess of 12 hours including any risks as a consequence if delay.	TMG ; Audit & Risk committee; TB	Investment in latest technologies to strengthen cyber security Patches rolled out to the organisation to mitigate vunerabilities	Ongoing 2017	March 2018	8	I&MT
BAF17	CO1. Deliver quality, patient safety and patient experience.	Failure to deliver compliant junior doctor rotas across the Trust	Director of workforce / Chief Operating Officer//CSU CDs	16	Junior Medical Staffing Taskforce Established in August - Chaired by Medical Director Workforce strategy in place • ICSU governance structure with strong clinical leadership and Performance Reviews quarterly with Executives •Workforce Assurance Committee in place with responsibility for R&R KPIs monitored •HR business partners in place • Weekly Vacancy Scrutiny Panel meetings • Workforce Assurance Committee (WAC) established • Recruitment & Retention Strategy agreed • Workforce KPIs reported to WAC • weekly tracking of temporary staffing by Executive team • New bank rates agreed	Trust Board safety/quality/safe staffing reports and monthly performance report • Quality Committee safety/quality reports • Workforce KPI reports Trust has recently appointed its first substantive Medical HR Business Partner	Workforce strategy approved Monthly performance reports Reports to Worforce Assurance Committee Staff survey results Assurance on quality of care provided received through weekly executive challenge and ICSU performance reviews, and e-rostering live data.	Agency spend greater than planned rotas non-complaint in some areas due to lack of junior doctors	Implement Recruitment and retention Stratgey Monitor WAC workplan to strengthen controls and compliance with agency cap Continue to monitor KPIs New bank rates agreed Work with the STP on cross NCL agreed rates Develop rotations with UCLH and agreements for staff to work across both organisations. Overseas recruitment included in the wider ongoing recruitment drives Action to improve retention in relation to staff survey and FFT results for staff automation of VSP	Performance Reviews; TMG Workforce assurance Committee and TB	Regular recruitment days held including some international recruitment Workforce Assurance Committee meeting regularly Developing Vacancy Scrutiny Panel to be an automated process designed with Clinical Director input new bank sates agreed (except A&C). Calendar of recruitment events. Overseas recruitment drive Exit interviews conducted. New CD fast track VSP process for urgent clnical need in place	Oct-17	march 2018	8	693,754, 768, 779, 830

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NHS Trust

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Whittington Health Trust Board 4th October 2017

Title:	**Report from Freedom To Speak Up Guardian (F2SUG)**		
Agenda item:	**17/135**	**Paper**	**10**
Action requested:	For information and agreement		
Executive Summary:	• This paper provides a brief overview of the work of the Freedom To Speak Up Guardian (F2SUG) from November 2016 to August 2017 • Background information regarding the F2SUG role is provided • Anonymous data regarding casework undertaken by the F2SUG, and data from feedback of this service, is presented, with benchmarking against national data where possible • This information was considered at the Trust Board Seminar in August 2017 • The National Guardian Office has recently published results from their National survey with resulting recommendations. Two of these recommendations will be considered further in due course.		
Summary of recommendations:	It is reccomended that the Trust considers implementing a network of Whistleblowing ammbassadors as part of the approach to further promote a culture of 'Speaking Up'		
Fit with WH strategy:	To deliver consistent high quality, safe services		
Reference to related / other documents:	http://www.cqc.org.uk/sites/default/files/20170915_freedom_to_speak_up_guardian_survey2017.pdf		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured on relevant risk registers		
Date paper completed:	26 September 2017		

Author name and title:		**Dorian Cole, HoN and Freedom To Speak Up Guardian**		**Director name and title:**		**Philippa Davies, Chief Nurse**	
Date paper seen by EC	**Sept 17**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

1 Background

1.1 The role of the Freedom to Speak Up Guardian was created as a result of recommendations from Sir Robert Francis' Freedom to Speak Up review, published in February 2015. Freedom to Speak Up Guardians are expected to work with trust leadership teams to create a culture where staff are able to speak up in order to protect patient safety and empower workers.

2 Local Trust Background

2.1 The F2SUG was appointed November 2016. The role is part time 0.6wte, with the current post-holder also having responsibility as Head of Nursing for the Patient Access, Planned Care and Prevention ICSU

2.2 The key objectives of the F2SUG in the first 8 months was to raise the profile of the F2SUG role across the Trust, review and re-launch the Trusts Whistleblowing policy, develop and use publicity material, and to begin to provide a caseworker service to staff who raise concerns.

2.3 Activities undertaken within the Trust November 2016 to date

- Local policy review completed and uploaded to intranet, and the national NHS policy adopted and added alongside this.
- Re-launch of the whistleblowing micro site on the intranet, linked to related documentation and posters
- New' raising concerns' access system created - dedicated email address, web based one click referral form (with option for anonymous referrals) , dedicated mobile telephone access, option for adding Whistleblowing concern on Datix
- Smart phone App has been developed and is currently being tested
- F2SUG has established Buddy support with North Middlesex University Hospital F2SUG
- F2SUG is member of London Network and National programme
- A system for managing referrals and casework has been established, including the collection of wide ranging data only accessible to the F2SUG, thereby maintaining confidentiality.
- A range of visits to clinical teams to present and promote Speak Up Issues continue to be undertaken..

2.4 Further developments planned

- App to be launched
  Speak Up - Patient Safety Huddles to commence October 2017

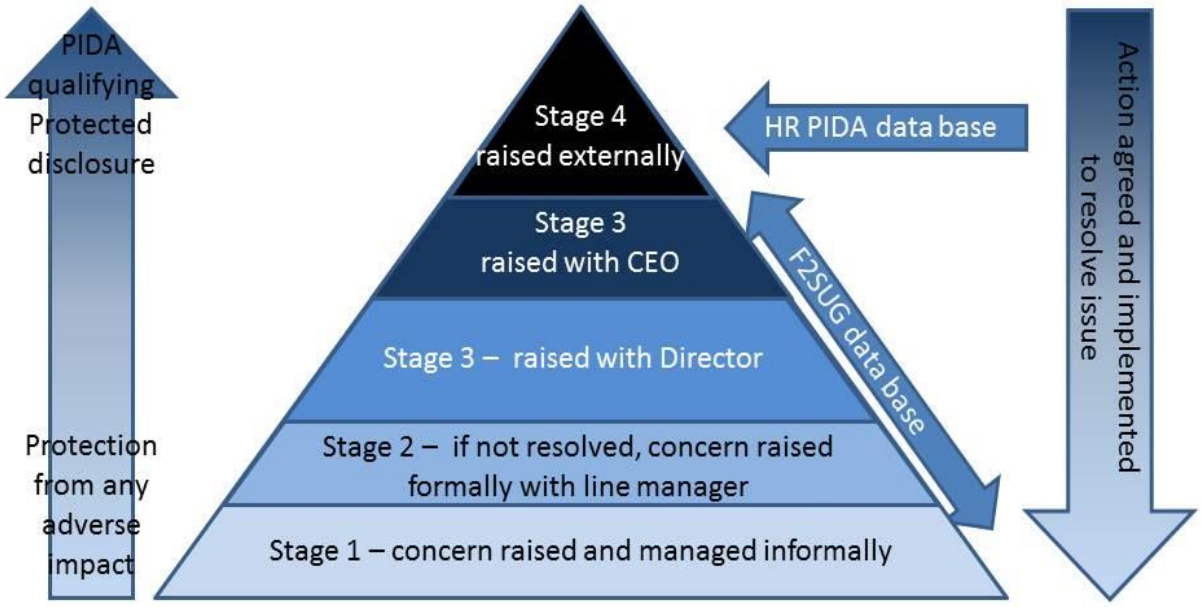
2.5 Policy Framework:

Our policy statement states, 'Speaking up about any concern you have at work is really important. In fact, it's vital because it will help us to keep improving our services for all patients and the working environment for our staff.'

We want to make raising concerns as easy and clear as possible. We are aiming to promote a culture where raising concerns is seen as positive and helpful , and ensure that we have in place systems and structures that support and encourage staff across the organisation to do this.

Following discussion at Trust Board Seminar in August 2017, agreement was reached that further additions that will be made to the Trust Whistleblowing Policy with the aim of clarifying the dynamic nature of raising concerns and whistleblowing, and the support and protections that are in place around these. These are illustrated in figure 1 overleaf.

Figure 1



3 Casework Undertaken by F2SUG:

3.1 Seventy-seven referrals were made to the F2SUG since November 2017. Of these, twenty-four required additional action. Twenty-one were managed informally at stage 1. One was managed at stage 2.

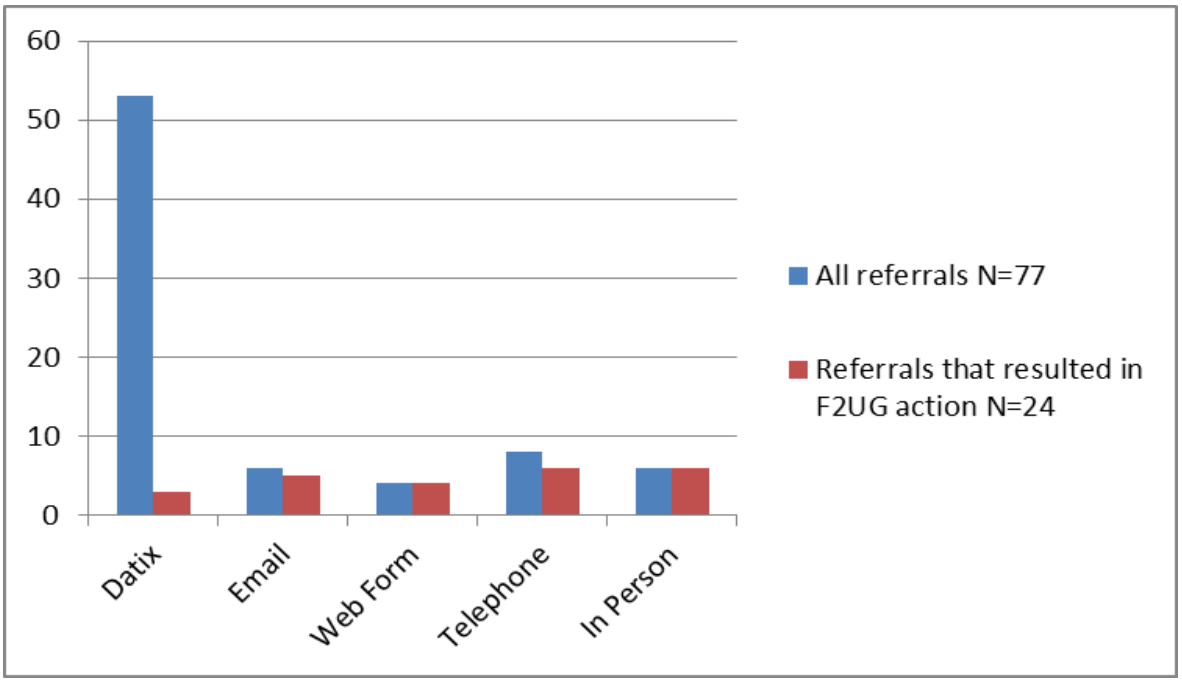
Two were managed at stage 3. No cases required formal referral to Chief Executive or escalation externally. Seventeen of the seventy-seven referrals were from community teams or sites.

3.2 Pathway:

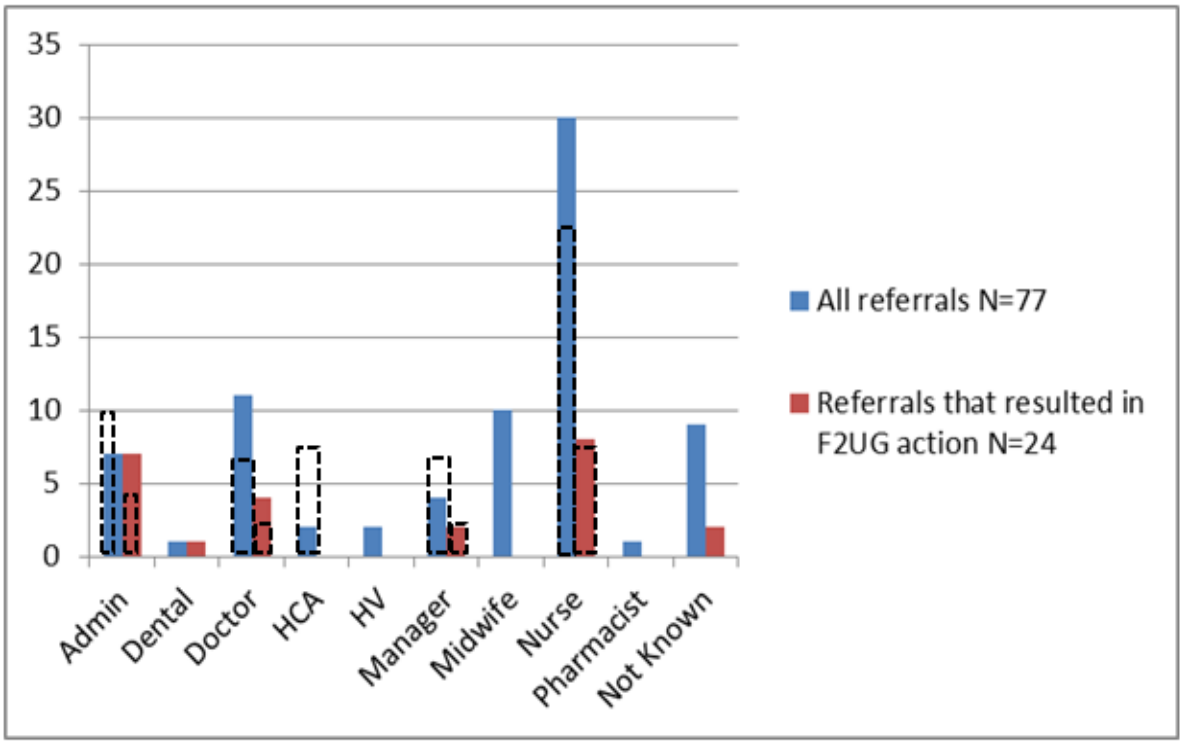
When a referral is received by the F2SUG, the referrer is contacted within 48 hours in order to determine further details of the concern being raised, and to ascertain what, if any action is required.

One of the twenty four cases required a specific whistleblowing investigation to be set up and conducted. The other twenty three cases were managed using existing Trust processes, and one to one support from the F2SUG.

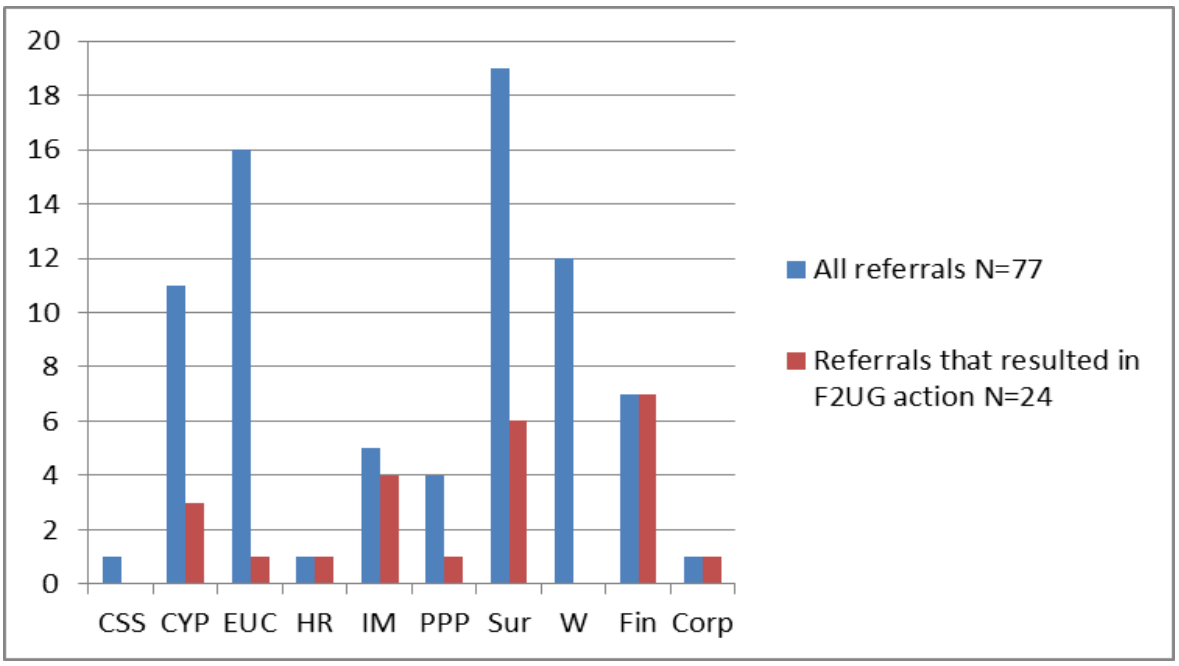
3.3 Source of Referrals to Whittington F2SUG since November 2017



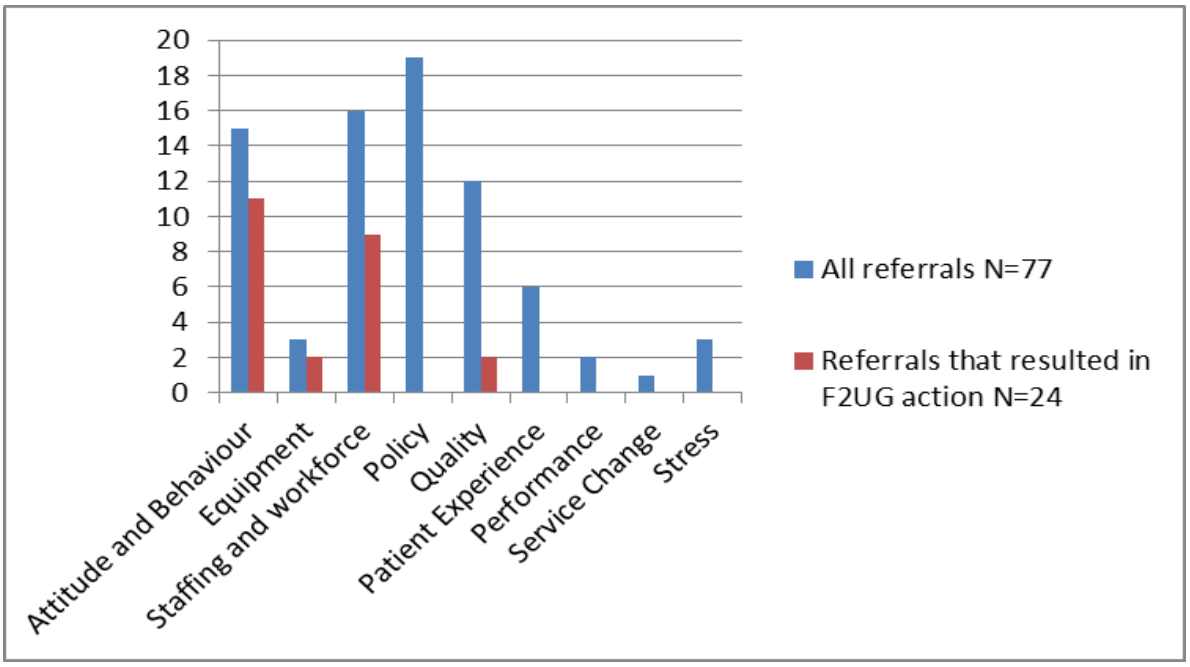
3.4 Role of Referrer (national comparison data in dotted line)



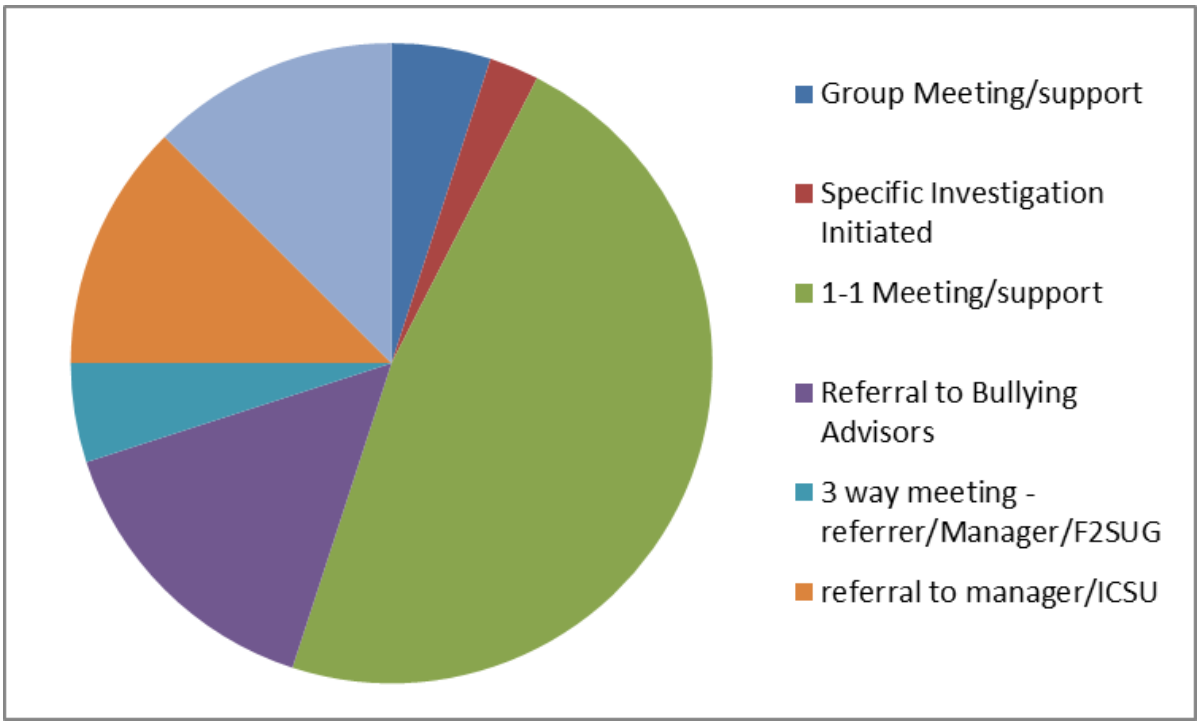
3.5 ICSU of Referree/Issue



3.6 Theme of Issue Raised



3.7 Type and Proportion of Intervention provided by F2SUG to the 24 cases

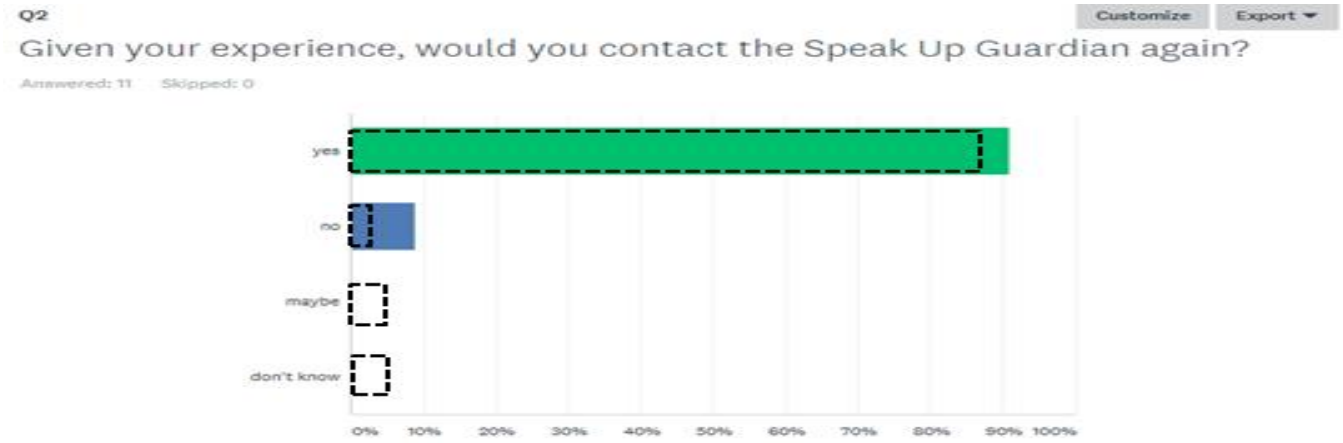


4 Feedback for the F2SU Service

Feedback results from users of the service indicate that 91% of Trust staff who accessed F2SUG found the experience helpful, supportive and positive or very positive overall. 100% of users found it accessible and responsive. (n=11). 91% said they would use the service again. This compares similarly to recent national F2SUG data.

4.1 All staff requesting additional F2SUG support were sent a web link to a Survey at the conclusion of support from the F2SUG, in order to generate anonymous feedback of the service.

4.2 As part of this feedback staff were asked, 'Given your experience, would you contact the F2SUG again?' 90% of respondents said yes. National data comparison is shown in black dotted line.



ANSWER CHOICES	RESPONSES	
yes	90.91%	10
no	9.09%	1
maybe	0.00%	0
don't know	0.00%	0
TOTAL		11

5 National Freedom To Speak Up Guardian Survey Recommendations and Implications for the Trust

5.1 In September 2017, The National Guardian Office published a 'Freedom To Speak Up Guardian Survey', which presented findings and recommendations from their national survey of Trust's and F2SUGs. The full findings are published on the National Guardian web site http://www.cqc.org.uk/sites/default/files/20170915_freedom_to_speak_up_guardian_survey2017

5.2 Of the findings 10 recommendations, there are 2 that will require further consideration These recommendations are detailed below;

Potential conflicts of interest	We recommend that all guardians / ambassadors / champions reflect on the potential conflicts that holding an additional role could bring and that they devise mechanisms to ensure that there are alternative routes for Freedom to Speak Up matters to be progressed should a conflict become apparent when supporting someone who is speaking up. We see particular potential for conflicts to arise where a guardian also has a role as a human resources professional and recommend that guardians do not have a role in any aspect of staff performance or human resources investigations.
Local networks	We recommend that all trusts consider developing a local network of ambassadors / champions, depending on local need, to help provide assurance that all workers have appropriate support and opportunities to speak up, and to give guardians alternative routes to pursue speaking up matters should they be faced with a real or perceived conflict. Members of a local network could also cover the guardian role when the guardian is absent, on leave etc.

.

6.0 In conclusion, the role of the F2SUG is continuing to embed within Whittington Health. The current reporting structure of executive lead for F2SUG held by the Chief Nurse, in addition to a Non-Executive Director provides a robust structure to ensure that additional reporting routes exist for staff when there may be possible conflicts of interest.

Over the coming months, consideration will be given as to whether an additional network of Whistleblowing ammbassadors could enhance the current approach to further promote a Speaking Up culture

It is anticipated that the Trust Board will receive updates from the F2SUG on a quarterly basis

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Whittington Health Trust Board

4 October

Title:	Whittington Health Research Annual Report 2016/17						
Agenda item:	**17/136**		**Paper**			**11**	
Action requested:	To note the 2016/17 Annual Report for Whittington Health Research						
Executive Summary:	Whittington Health is a research active organisation and is committed to research as we believe it improves the care of our patients. Our research strategy outlines our research objectives: a) Increasing research in clinical areas where we have a research track record. b) Developing research in integrated clinical care. c) Increasing income from commercial research studies. d) Increasing the culture of research within Whittington Health. This report details our work throughout 2016/17.						
Summary of recommendations:	To note the 2016/17 Annual Report for Whittington Health Research						
Fit with WH strategy:	Aligns with the Trust Clinical Strategy						
Reference to related / other documents:	Complies with the Trust regulatory framework						
Reference to risk and corporate risks BAF:	Captured on relevant risk registers						
Date paper completed:	September 2017						
Author name and title:	**Dr Rob Sherwin, Associate Medical Director**		**Director name and title:**		**Dr Richard Jennings, Medical Director**		
Date paper seen by EC	**Oct 17**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Research and Development Annual Report 2016-17

Introduction

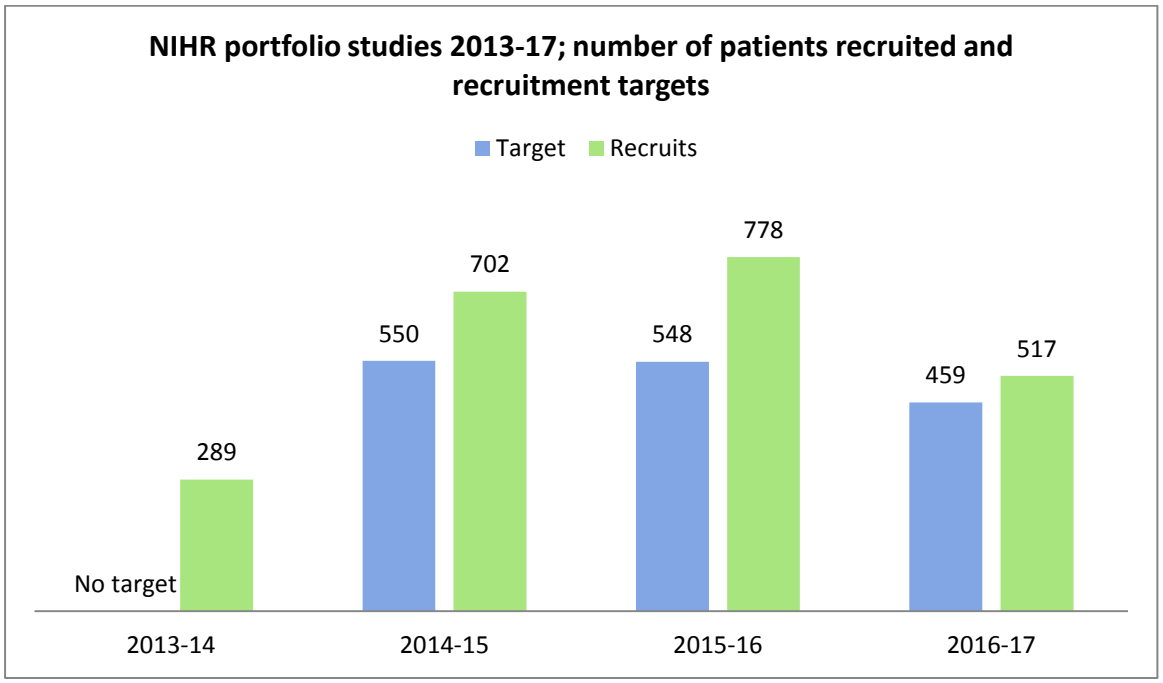
Whittington Health is a research active organisation and is committed to research as we believe it improves the care of our patients[1]. Our research strategy[2] outlines our research objectives as:

a) Increasing research in clinical areas where we have a research track record.
b) Developing research in integrated clinical care.
c) Increasing income from commercial research studies.
d) Increasing the culture of research within Whittington Health.

Review of recruitment into NIHR studies 2016-17

We have continued to successfully recruit patients into National Institute of Health Research (NIHR) portfolio studies. These are studies that are recognised as nationally important by the NIHR, where the funding for the studies has been awarded in open competition eg from the Medical Research Council (MRC) or charitable funding eg Wellcome Trust. In 2016-17 we exceeded the recruitment target, which was set by the North Thames Clinical Research Network (CRN); see graph 1 below. The recruitment target is agreed annually between the Trust and the North Thames CRN. The target takes into account the number of research studies that are open within the trust and also in the research pipeline at the beginning of the financial year. The recruitment target does not reflect the complexity of studies eg simple observational studies compared to complex interventional drug trials. Whittington Health has a track record of recruiting patients into complex interventional studies, which was again the case this year.

Graph 1: Whittington Health recruitment into NIHR portfolio studies 2013 to 2017



The reduction in the recruitment target between 2015-16 and 2016-17 reflected the closure of a number of simple observational studies that had boosted recruitment in 2015-16. The studies that recruited the most numbers of patients are shown in table 1. The clinical areas in which these patients were recruited from, have historically been areas of research strength at Whittington Health. Thus we have been successful in our research strategy of building on research in clinical areas where we have a research track record. In addition we have developed research capability within community children's services as evidenced by recruitment into the Healthy Start, Happy Start study. Whittington Health was the highest recruiting site in the country for this study. Furthermore, we have been very successful in recruiting patients within the orthopaedic service.

Table 1 Examples of highly recruiting NIHR research studies open in 2016-17

Study Title	Local Investigator	Whittington ICSU	2016-17 patient recruitment
Epidemiology of Critical Care provision after Surgery (EpiCCS) SNAP2 The Second UK Sprint National Anaesthesia Project: Epidemiology of Critical Care provision after Surgery	Jane Silk	*Surgery and Cancer*	134
Diabetes Alliance for Research in England (DARE)	Maria Barnard	*Medicine, Frailty and Network Services*	61
Healthy Start, Happy Start: Helping parents with children's behaviour	Morris Zwi	*Children's Services*	57
Multifunctional Integrated Microsystem for rapid point-of-care TB Identification (MIMIC)	Michael Brown	*Medicine, Frailty and Network Services*	34
Observational Study Protocol ca209-116 treatment patterns, outcomes and resource use study for advanced stage non-small cell lung cancer (squamous and non-squamous) in Europe - canc4707	Pauline Leonard	*Surgery and Cancer*	27
A prospective, observational, multi-centre, cohort study of the G7™ acetabular system used with compatible femoral stems in patients with degenerative disease of the hip	William Bartlett	*Surgery and Cancer*	27

The total number of patients recruited into NIHR portfolio studies per ICSU is shown below in table 2. Again these recruitment numbers show our on-going development of recruitment into areas of research strength.

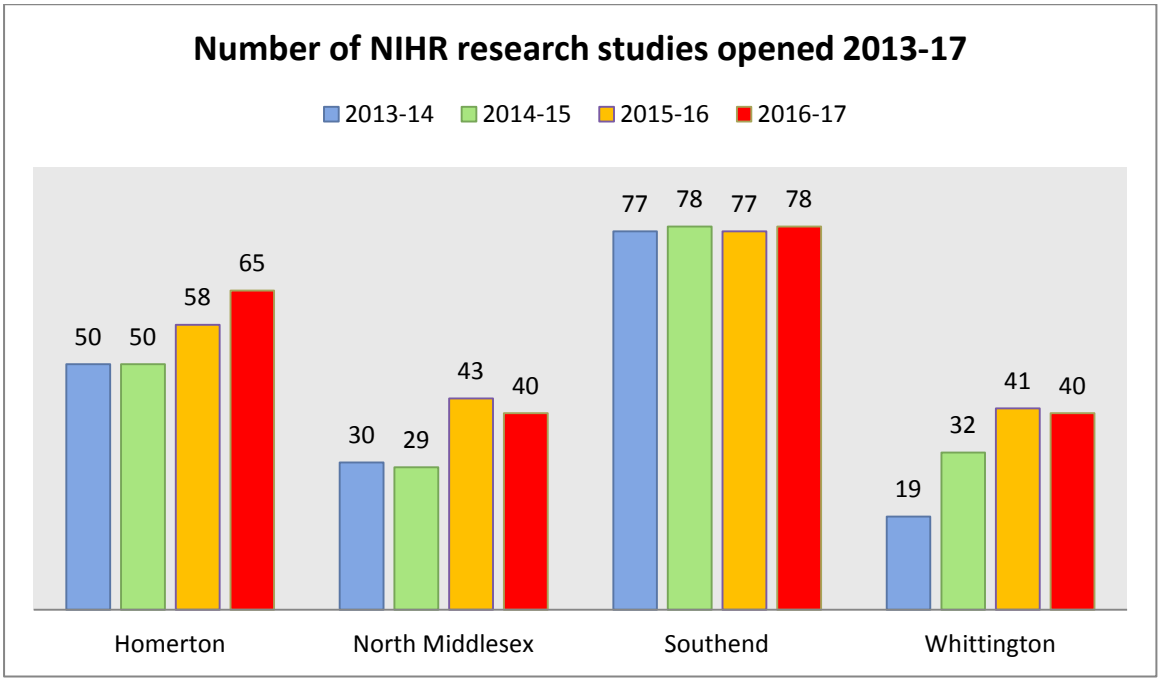
Table 2 NIHR portfolio study recruitment in 2016-17 per iCSU.

iCSU name	NIHR recruits in 2016-17	Number of NIHR studies open
Integrated Medicine	153	12
Patient Access, Prevention and Planned Care	9	1
Surgery and Cancer	266	18
Women's Health	12	2
Children and Young People	64	4
Clinical Support Services	1	1
Emergency and Urgent Care	12	2

Benchmarking of recruitment into NIHR portfolio studies

When compared to other similar size acute trusts in the North Thames CRN, the number of studies that are open and recruiting at Whittington Health is similar to the North Middlesex Hospital, but significantly less than the Homerton and Southend Hospitals; see graph 2

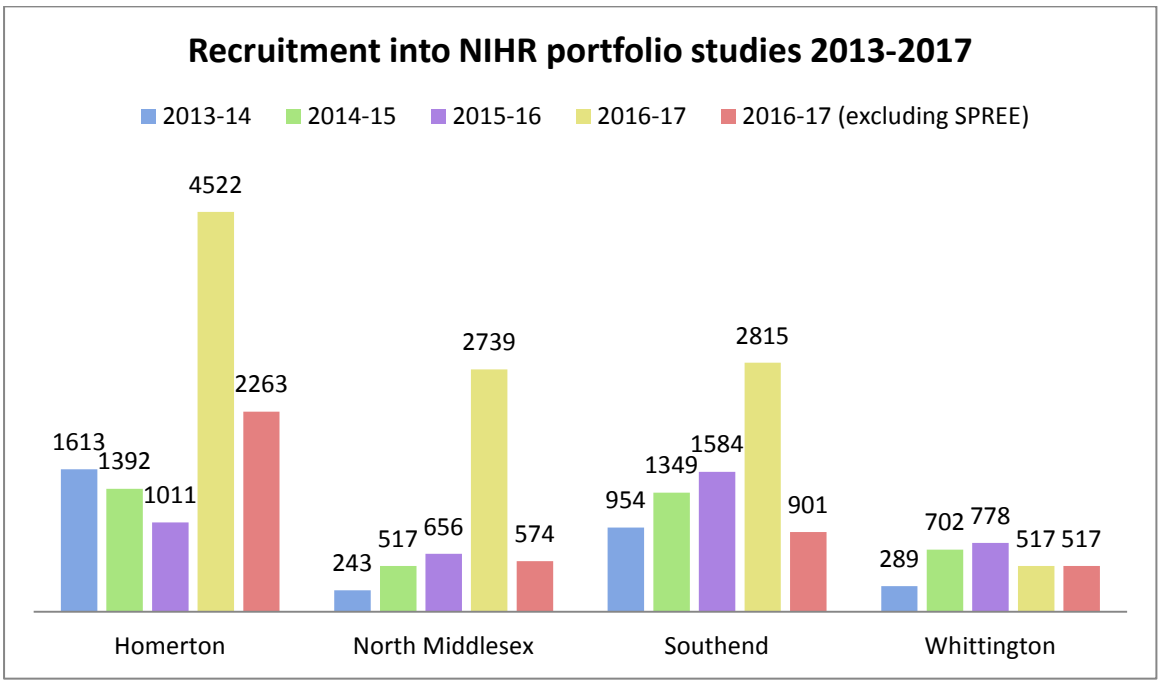
Graph 2: Number of NIHR portfolio studies open in benchmarked acute trusts within the North Thames CRN (2013 to 2017).



In 2016-17 the Homerton, North Middlesex and Southend Hospitals all opened and recruited into the SPREE (Screening programme for pre-eclampsia) study, which resulted

in 2259, 2165 and 1914 patients respectively, being recruited in to this study at the various sites. We are enquiring through the CRN as to why Whittington Health was not asked to complete an expression of interest for recruitment into this study. With this in mind the recruitment numbers for the last four years for these trusts are shown below.

Graph 3 Recruitment of patients into NIHR portfolio studies in benchmarked trusts within the North Thames CRN (2013-17)



Whittington Health did recruit fewer patients into NIHR portfolio studies in 2016-17 compared to benchmarked trusts. Although the accruals at these other trusts was increased by recruitment into the observational SPREE study.

Financial Support to R&D from the North Thames CRN in 2017/18

When compared to other similar size trusts in the North Thames CRN, the allocated financial support to Whittington Health, from the North Thames CRN in 2017/18, is significantly less. This is then reflected in the number of research nurses and support workers that are employed within Whittington Health compared to other trusts. The income received from the CRN is pre-allocated for specific research nurse posts or for recharge to clinical support services.

	2017/18 CRN Salary support	Band 7 (wte)	Band 6 (wte)	Band 5 (wte)	Band 4 (wte)	2016/17 CRN Clinical services support	2017/18 Total CRN Support
Homerton	Unknown	22 research nurses/co-ordinators					£614,706
North Middlesex*	Unknown	14 research nurses/co-ordinators					£374,804
Southend*	£777,780	2.2	13.5	1	3.5	£190,992	£1,076,501
Whittington**	£312,098	1	5.8	0	0	£12,639	£369,334

*Southend NHS trust does not contribute to R&D income and 5PAs of Consultant time are paid via income from commercial studies.

**Whittington Health does not contribute to R&D income

The funding formula that the North Thames CRN uses to allocate money is based on historical apportionment of money and also the number of patients recruited into NIHR portfolio studies, especially in the second half of the financial year. Our allocation to fund research nurse posts in 2016/17 was £269,000 and this has been increased in 2017/18 to £312,000. This increase is in part due to high numbers of patients recruited into studies during the second half of the 2016/17 financial year and in part in response to a request for extra funding to allow us to recruit more research nurses. This will lead to an increase in the number of patients recruited into portfolio studies.

Grant applications submitted within 2016-17

A number of grant applications for large sums of money have been made over the year by some key researchers associated with the Trust.

Applicant	Study Title	Funding Competition	Costing Status	Grant Outcome
Dr. Elena Nikiphorou	Providing personalised, integrated care to Rheumatoid Arthritis patients with multi-morbidity: the impact of treatment intensification	NIHR Doctoral Research Fellowship 2016 (DRF) Stage 2 - Full Grant	Submitted	Unsuccessful
Profesor Monica Lakhanpaul	Optimising Antibiotic Use for Respiratory Tract Infections in Young Children with Down Syndrome	NIHR (RfPB) Competition 30 Stage 1 – Outline Grant	Completed	Progressed to next stage
Professor Ibrahim Abubakar	Research to Improve the Detection and treatment of latent tuberculosis infection (RID-TB)	NIHR (PGfAR) Competition 23 Stage 2 - Full Grant	Submitted	Awaiting decision

We await the outcomes of the grant applications by Professors Lakhanpaul and Abubakar. Both of these grants will achieve our aims of researching areas of clinical need to our populations.

Research Infrastructure in 2016-17

During 2016-17 the expansion of the R&D department's infrastructure included the creation of a band 7 lead research nurse post. This resulted in the existing team of two full time research nurses, and a part time research practitioner, a research health visitor and a research midwife being managed centrally within R&D and not within the iCSUs. This has lead to more accountability and flexible working amongst the research team. In addition to the lead research nurse role, extra funding was secured for three further posts, an additional research nurse, a second practitioner and a research assistant. This increased capacity has enabled the trust to participate in more complex studies and support an increased number of commercial trials as well as expanding the number of specialities engaging in research.

With the support of Dr Doug Charlton (Former Deputy Director of Nursing) we have now recruited to permanent research posts, rather than on fixed term contracts. This has resulted in an increase in the number of applications for research posts and also in the quality of the applicants. Therefore vacancies that had previously taken several rounds of recruitment have been quickly filled.

Commercial research

Historically, commercial research within the trust has centred on haematology and diabetes studies. More recently the teams within dermatology, oncology, gynaecology and orthopaedics have also engaged in commercial research. The success of the dermatology and gynaecology commercial research has been impressive, with each delivering a study to the NIHR recruitment to time and target metrics, which attracted additional resource allocation of £6,028 from the North Thames CRN during the financial year. Both specialities have delivered studies to a high standard and each has seen sponsors return to the trust to discuss future studies. The gynaecology team, who were the only UK site to meet their recruitment target for the BAYER study ASTEROID 2 (A study into the treatment of uterine fibroids), have been selected as the lead UK site for the next phase of the trial (ASTEROID 5) with Robert Sherwin as the Chief Investigator.

In addition to the success that the study brought for the gynaecology department, one of the ASTEROID 2 study patients agreed to share her story at the Whittington Health Research symposium and also to provide written feedback, which is shown below.

> *"Having suffered for many, many years with gynaecological challenges, the study that I undertook late last year/early part of this year was to be pivotal in my health for the better. ……my quality of life was not good however the study showed that I didn't have to suffer any longer and that I could have a social life without having to consult with my diary first hand.*

Due to the severity of my fibroids I decided to have a hysterectomy as my pre-trial life was something that I wasn't about to revert back to. 6 months post-operative and 12 months post commencement of the trial I am a different woman. I am back running and exercising, going away short notice on trips and most importantly I'm pain free.

The support from the study team was great and I always felt I was in excellent hands with Sarah-Kate and Claire – monitoring my bloods throughout the trial was an eye opener as I didn't realise how anaemic I was – I suppose we just learn to deal with it. Please keep up the good work of research as fibroids are the one of the most debilitating and toxic things that women can go through and to give women some respite from these symptoms is just wonderful and life enhancing."

Raising the Profile of Research

Two events were held during 2016-17 to improve the visibility of research within the Trust. International Clinical Trials Day is held in May, each year. This proved a good forum to engage both staff and patients and to inform them of the research activity ongoing within the trust and also with the NIHR 'It's OK to Ask' [about research] campaign. The research delivery team ran the 'chocolate trial': a mock research study that explains the process of consent and randomisation in clinical trials. In November 2016 the R&D department also hosted its second Research Symposium with speakers including:

Professor Ibrahim Abubakar, Director at the Institute for Global Health, UCL

Professor John Yudkin, Emeritus professor of Medicine UCL

Dr Emma Drasar, Consultant Haematologist

Dr Emma Spurrell, Consultant Medical Oncologist

Silvia Ceci, Lead Clinical trials Pharmacist

Sarah-Kate McLeavey, research Midwife

Summary and Conclusion

In 2016-17, the R&D team along with the Principal Investigators within Whittington Health, continued to recruit patients into NIHR portfolio studies. The recruitment number was in excess of the target set by the NIHR. In addition, a number of grant applications have been submitted by researchers at Whittington Health; the results of these are awaited. Furthermore we have expanded the number of commercial studies that are open at the trust and have been rewarded for our successful recruitment by pharmaceutical companies approaching us for follow-up studies.

There is however still scope for further development. Our ambition of creating a commercial income stream to support a clinical researcher who specialises in studies of integrated clinical care has not been realised. To achieve this we will have to fill all research vacancies

within the R&D team (2 x wte at present), continue to build our links with industry, the North Thames CRN and other links to commercial research studies. We also need to consider whether as a trust we have an appetite to fund a part time research appointment that will be the focus of our research into integrated care.

References

1. Boaz A, Hanney S, Jones T, et al. Does the engagement of clinicians and organisations in research improve healthcare performance: a three-stage review. BMJ Open 2015; 5
2. Whittington Health Research Strategy

Whittington Health NHS

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Trust Board

Date 04th October 2017

Title:	Evacuation Plan Whittington Health 2017/2018		
Agenda item:	**17/137**	**Paper**	**12**
Action requested:	For Trust Board to note and sign off the new plan		
Executive Summary:	The Whittington Hospital NHS Trust has a central role in planning for and responding to incidents that could have major consequences for health or threaten to disrupt the delivery of health services. The evacuation of a hospital within the Trust will normally be the last resort when the lives and safety of the staff, patients and visitors are at risk. The decision will only be taken when all other options have been reviewed and totally exhausted and following a full risk assessment by Gold on call. This plan does not replace the Trust Major Incident Plan or the Trust Business Continuity Plan but compliments them. This plan assumes that a Major Incident/Business Continuity Incident will have been declared and the usual responses to the declaration will have been instigated		
Summary of recommendations:	1) Establish Evacuation Plan 2) Develop and Update Training Program for Clinical Staff in an Evacuation 3) Train and Drill Staff on Evacuation 4) Evaluate Training and Exercise to amended plan as reasonably practicable		
Fit with WH strategy:	Providing safe care in a safe environment		
Reference to related / other documents:	CCA 2004 Health and Social Care Act 2013		
Reference risk and corporate risks on the BAF:	This plan is in response to the Local Authority and national Risk Register		
Date paper completed:	22/09/2017		

Author name and title:		**Lee Smith**		**Director name and title:**		**Carol Gillen**	
Date paper seen by TMG	**19/09 /2017**	**Equality Impact Assessment complete?**	**NA**	**Quality Impact Assessment complee?**	**NA**	**Financial Impact Assessment complete?**	**NA**

Whittington Health NHS

Hospital Evacuation Plan

Emergency Preparedness, Resilience and Response (EPRR)

It is not the time to read this in a Major Incident find your Action Card in Appendix 3

Subject:	Full site hospital evacuation plan
Ratified By:	Emergency Management Steering Committee
Date Ratified:	
Version:	0.7
Policy Executive Owner:	Chief Operating Officer – Accountable Emergency Officer
Designation of Author:	Emergency Planning and Business Continuity Officer
Name of Assurance Committee:	Trust Management Group
Date Issued:	
Review Date:	
Target Audience:	All staff
Key Words:	Evacuation, Major Incident
Document Purpose	This plan has been developed to ensure that the Acute Services of the Trust is capable of responding to a full site evacuation.
Related Document	Major Incident Plan Business Continuity Plan

Distribution list

In order to comply with the requirements of being a category 1 responder under the terms of the Civil Contingencies Act 2004 the Trust has a responsibility to share its plans with partner agencies.

Internal Distribution List

Department /Role	Format
Access Room Major Incident box	Hard copy
Operations Room, Jenner Building (back up major incident room)	Hard copy
Whittington Health Intranet Policies folder	Electronic
Silver and Gold dropbox	Electronic
Bronze, Silver & Gold shared I drive folder	Electronic

External Distribution List

Organisation	Format
NHS England (London)	Electronic Copy
Islington Borough Resilience Forum	Electronic Copy
Haringey Borough Resilience Forum	Electronic Copy

Amendment Record

No unauthorised amendments permitted.

This plan is a living document and is under constant review. A record of amendments follows any comments or suggestions for future versions are appreciated and should be directed to the Emergency Planning and Business Continuity Officer.

Version	Date	Author	Reason
0.1	November 2013	Rebecca Allsopp	Creation of plan
0.2	May 2014	Rebecca Allsopp	Inclusion of LBI rest centre venue information
0.3	July 2014	Rebecca Allsopp	Communications section updated
0.4	September 2014	Rebecca Allsopp	Added glossary
0.5	November 2014	Rebecca Allsopp	Further comments from sub committee
0.6	February 2015	Rebecca Allsopp	
0.7	June 2017 September 2017	Lee Smith	subcommittee comments and agreement, TMG agreement

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GLOSSARY

Evacuation Definitions	
Evacuation	Removal, from a place of actual or potential danger to a place of relative safety, of people and (where appropriate) other living creatures.[1]
Horizontal Evacuation	Moving away from the area of danger to a safer place on the same floor as the individual 9s) is on. If fire is the cause of evacuation, movement should be to the next fire compartment section on that floor (i.e. through at least one set of fire doors). If necessary those who have evacuated horizontally may need to consider a vertical evacuation. [2]
Vertical Evacuation	Using a stairwell, or lift (if safe and appropriate (i.e. only a designated fire lift should be used during a fire)) to move to either the floor above or below, as appropriate, to move from the area of danger to a safer place. [2]
Evacuation Assembly Point	The Evacuation Assembly Point (EAP) is an area where all evacuated staff and patients should go to. This area should be cleared prior to being occupied to ensure there are no further hazards.
Joint Emergency Services Control Centre (JESCC)	A location near the scene of an incident where the blue light services site their command vehicles.
Scene Access Control	A police controlled point, where those people, who are not blue light responders, but need access through the cordons, report, have their identifies and access requirements confirmed before going through the cordons.
Shelter	A place giving temporary protection. It may be necessary to move patients into temporary shelters until such time as they are able to return to the affected healthcare facility, or until they are able to be transported to another healthcare facility.[2]
Shelter in place /invacuation	In certain situations the safest place to take refuge or cover is to remain in the current location. This is often referred to 'shelter in situ' or 'invacuation'. [2]
Defining Patients Dependency	
Independent Patient	Patient mobility is not impaired in any way and they are able to physically leave the premises without staff assistance, or if they experience some mobility impairment and rely on another person to offer minimal assistance. This would include being sufficiently able to negotiate stairs unaided or with minimal assistance, as well as being able to comprehend the fire exit signage around Whittington Hospital.
Dependent Patient	Patients who are classed as neither "independent" nor "very high dependency" are classed as dependent patients.
Very High Dependency Patient	Patients with very high dependency are those with clinical treatment and/or a condition that creates a high dependency on staff. This will include those in critical care areas, operating theatres and those where evacuation would prove potentially life threatening.

[1] Cabinet Office (2013) Lexicon of Multi Agency Emergency Management Terms. Version 2.1.1 https://www.gov.uk/government/publications/emergency-responder-interoperability-lexicon

[2] NHS England (2015) Planning for the Shelter and Evacuation of people in healthcare settings. Version1.0 http://www.england.nhs.uk/wp-content/uploads/2015/01/eprr-shelter-evacuation-guidance.pdf

SECTION 1: Introduction

The evacuation of a hospital within the Trust will normally be the last resort when the lives and safety of the staff, patients and visitors are at risk. The decision will only be taken when all other options have been reviewed and totally exhausted and following a full risk assessment by Gold on call.

The decision to evacuate a hospital would be taken jointly by the Chief Operating Officer (EPLO) and Strategic (Gold) Commander and the Tactical (Silver) Commander, in conjunction with other multi-agency partners. The whole-site evacuation of a hospital site will be deemed a Major Incident and must be reported accordingly.

Before the decision to evacuate is taken the following needs to be considered:

- The overall risk to patients and staff
- Appropriate transport and patient tracking mechanisms and
- A pre-planned and suitable equipped destination.

This plan does not replace the Trust Major Incident Plan or the Trust Business Continuity Plan but compliments them. This plan assumes that a Major Incident/Business Continuity Incident will have been declared and the usual responses to the declaration will have been instigated.

1.1 Aim

To provide guidance specifically to be implemented, in response to a significant partial or full evacuation of any hospital site ensuring an effective evacuation of patients, staff and visitors.

1.2 Objectives

- To establish clear command, control and communications procedures
- To establish clear roles and responsibilities for staff
- Provide clear guidance on the triage and tracking of Patients
- Provide site specific information to assist with any evacuation
- To clearly state the support from partner agencies if required.

1.3 Phases of an Evacuation

The evacuation of patient areas can seriously jeopardise the health and welfare of patients, so it is critical to avoid unnecessary evacuation. In the context of a healthcare facility, Table 1 defines the phases of evacuation:

Table 1 – The Phases of an Evacuation and the implications[2]

Phase	Implication
1	Evacuation of a single ward/department (horizontal)
2	Evacuation of one floor (horizontal, maybe vertical required)
3	Evacuation of an entire block/building
4	Evacuation of an entire site

[2] NHS England (2015) Planning for the Shelter and Evacuation of people in healthcare settings. Version1.0 http://www.england.nhs.uk/wp-content/uploads/2015/01/eprr-shelter-evacuation-guidance.pdf

SECTION 2: Command and Control Structures

The command and control of a hospital evacuation is a mirror image of the Trust's Major Incident Plan. It is imperative that the structure is compatible with emergency services and is recognised by local partners. It should also mirror fire evacuation plans that are already in existence for the Trust.

2.1 Hospital Strategic (Gold) Command and Control Roles

The primary functions of Hospital Strategic Team are to;

- Formulate a strategic plan for the evacuation and to communicate this to the Tactical Team, multi-agency partners, and NHS England (London)
- Liaise with multi-agency partners to ascertain the method of transport and the onward destination of evacuated patients
- To confirm the decision to undertake a whole site evacuation
- The Strategic Coordination Protocol-Escalating co-ordination arrangements in the event of a disruption that requires evacuation.
- Contact the Local Authority to determine if support is required through setting up the London Local Authority Co-ordination Centre. The SCG would collectively decide if a Borough Emergency Control Centre (BECC) is required.

2.2 Hospital Tactical (Silver) Command and Control Roles

The primary functions of the Hospital Tactical Team are to;

- Designate evacuation zones according to the reason for the evacuation.
- Inform the Strategic Team of the zones for onward communication to multi agency partners
- Decide the means of communicating to staff that evacuation is required (consider phased manual activation of the required fire alarm panel and the use of runners)
- Instigate the triage and classification of all patients being evacuated
- Maintain a list of all patients being transferred to sites outside the hospital.
- To Liaise with tactical commanders external to Whittington Health NHS Trust

2.3 Hospital Operational (Bronze) Command and Control Roles

The primary functions of the Hospital Operational Managers are to:

- Triage patients into priorities for evacuation
- Ensure the safe evacuation of patients, staff and visitors to the designated evacuation zones
- Ensure accompanying patient records are with the right patient and patient evacuation sheets are completed for every evacuated patient (see appendix 3)
- Provide assistance and expertise to ambulance services, including NHS, private or charitable ambulance services, with regard to individual patients' clinical needs

2.4 Location of the Command and Control

In the event of an evacuation seeming likely the Incident Control room will be activated and staffed.

The location of the Incident Control Room if a full site evacuation is required will be moved to the secondary control room in the operations meeting room, first floor Jenner Building.

2.5 Decision to Evacuate

The decision to evacuate either a ward, building or whole site is taken by the senior management within the Trust. Requests to evacuate can be made by the Police or Fire Service but, ultimately, the final decision rests with the individual Trust's command and control team. If however, the reason for evacuation is due to an act or potential act of terrorism, the Police can order evacuation.

Consideration should be given to declaring 'Major Incident Standby' at the earliest opportunity, allowing time for supporting agencies and services to get into a state of readiness.

PLEASE NOTE: Whilst experts from outside of the Trust can advise the Trust of the need to evacuate ultimately the decision to evacuate will be made by the Chief Operating Officer (EPLO) and Trust Gold Commander.

2.6 Risks/Triggers for Evacuation

The risk of a significant partial or full evacuation of a site is low, but the impact could be catastrophic. The following scenarios are considered risks to hospital accommodation that potentially could lead to an evacuation:-

- Severe fire, where normal horizontal evacuation plans are no longer viable (see the Trust Fire Policy);
- Severe flood, where normal horizontal evacuation plans are no longer viable;
- Hazardous materials (HazMat)/Chemical, Biological, Radiological, Nuclear (CBRN) incidents, where the contamination is not contained within one area;
- Terrorist incidents i.e. explosion;
- Catastrophic and prolonged utility failure;
- Major threat of any of the above;

Advice should be sought from public health professionals before evacuating due to a CBRN incident.

2.7 Speed of Evacuation

Depending upon the circumstances requiring the hospital to be evacuated the speed within which evacuation should be completed by will differ.

2.7.1 Fast time

This is where an incident had occurred that requires an immediate evacuation. In this instance the evacuation will be led by the Silver commander with decisions over which areas are evacuated first being on the basis of doing the greatest good for the greatest number. This will have the greatest effect on clinical areas with patients that are dependent or of a very high dependency on the Trust. Patients would be evacuated in priority order, assessed using a sliding scale, from those that are most able (independent patients) to evacuate first to those least able (dependent and very high dependency patients) who require the most time and assistance last.

2.7.2 Slow time

The need to evacuate is known in advance and there is time to organise the evacuation. This pre-warning will allow more time for an organised shutdown of the hospital and allow greater opportunity for movement of at risk patient groups.

SECTION 3: Evacuation Prioritisation

3.1 Patient Evacuation Classification

In an evacuation situation, each patient in individual clinical areas will need to be prioritised and scored in order of evacuation. Patients are to be reviewed by the most Senior Nurse at the time and classified as per Table 3. As the notice for evacuation progresses, the patient classification, or scoring, will need to be reviewed. An evacuation where time is available and with provision of appropriate resources to support the onward transfer of critically ill patients, it may be realistic to evacuate those patients first, however, if a no notice full-scale evacuation is in progress, those same patients would move last from the inpatient ward area.

3.2 Dynamic & Reverse Triage

The concept of moving patients is based on doing **the most for the most**. It is important to recognise that the triage priorities, in a full-scale evacuation will be the reverse of that used during a normal emergency response. Once a patient has reached their holding destination (external Assembly Point) and is ready for onward transfer, the normal triage priorities are to be reinstated. Table 3 details the methods of Reverse Triage and the priorities for onward transfer.

Table 2 – Patient classification, reverse triage & priorities for onward transfer

Classification	Triage Level	Reverse Triage Evacuation Priority	Priority for Onward Transfer
Evacuation Priority 1 (Most Able requiring least assistance)	**EP1**	These patients require minimal assistance and can be moved **FIRST** from the ward. Patients are ambulatory and 1 x staff member can safely lead several patients who fall into this category to the holding area	These patients will be moved **LAST** as transfers from the hospital holding area to another healthcare/reception facility
Evacuation Priority 2	**EP2**	These patients require some assistance and should be moved **SECOND** in priority from the inpatient ward area. Patients may require wheelchairs or stretchers and 1-2 staff members to aid evacuation	These patients will be moved **SECOND** in priority as transfers from the holding area to another hospital
Evacuation Priority 3	**EP3**	These patients require maximum assistance to move. In an evacuation, these patients move **LAST** from the inpatient ward area. These patients may require multiple staff members to enable their evacuation.	These patients require maximum support to sustain life. These patients move **FIRST,** once stable, from the hospital holding area to another hospital
Evacuation Priority 4 (Expectant or least able requiring most assistance)	**EP4**	This category uses the '**three wise men'** principles in accordance with national ethical guidance. Its invocation is only for the period of time the incident is 'live'. Patients who are in this category are **unlikely to survive evacuation** from the	If evacuated these patients should only be transferred to another hospital if sufficient resources are available. All clinical care should be palliative. The decision to

		hospital and would require significant resources to move them. They should only be moved once all other patients have been evacuated and if sufficient resources are available	allocated an EP4 category would be made by the Clinical Director for their specialty team in liaison with the Medical Director

SECTION 4: How can patient evacuation be conducted

4.1 Specific roles required for evacuation of patients

4.1.1 Evacuation/Fire Marshal

They will be responsible for:

- Ensuring that occupants attend the designated fire evacuation points
- Reporting missing persons to the fire service as well as the Command team.

Fire Marshalls, (Wearing Hi-Vis Tabards) Porters and security staff will assist with patient movement and evacuation procedures.

The senior nurse should take the medical records, IPAD and staff Rota with them and undertake a “Roll Call”. This should be signed off by another member of staff. The Bronze Commander will print out a list of all inpatients and outpatients for the Whittington Hospital. If it is impractical to print a list, 9 runners will be delegated the responsibility by the tactical commander to access Medway through their IPAD or Laptops. The runners will attend each of the 9 evacuation locations and cross check the Medway lists against persons present at each evacuation point. The runners will liaise with the patient tracking loggists and senior Nurses then take a photo of their complete list. All photos will be collected at the Incident Command Centre. Any patients on Medway that have not been accounted for will be communicated to the multi-agency team members (Police, London Fire Brigade, London Ambulance Service and The Local Authority) in the command centre. The list will be distributed to each senior nurse to cross check against their role call. This will allow areas that may require further checking to be identified. See action card number 1 in appendix 3.

If safe to enter all rooms should be checked by the Fire Marshall or Senior Manager to ensure that all staff and patients, where necessary, have evacuated and that the doors are closed.

4.1.2 Patient Tracking Loggists

Patient tracking loggists will be necessary to track the movement of all patients from their originating department or ward to a patient holding area, other Trust location or outside of the Trust. A patient loggist can be any member of staff but would ideally be administrative staff. A patient tracking proforma is in each patient area and can be seen in action card number 6 Appendix 3.

All patients **must be tracked during evacuation**. Patient records should, where possible, go with the patient. In some cases, it may not be possible to take a full set of patient records with an evacuated patient and in this case, it should be realistic to only take the most relevant notes that relate to a patient’s current episode of care.

It should be noted that patient records are the property of the originating hospital trust and should be repatriated to that trust as part of the recovery process.

4.1.3 Tracking Officer

The tracking officer will be a dedicated command role who will receive information from the patient tracking loggists on the patients as they are evacuated. These will be located at each of the holding areas set up. See section 5.1 for locations. See action card number 7 and patient tracking proforma.

As a minimum, the evacuating hospital should ensure that the patient has on his/her person the following details:

- Name
- Date of Birth
- Current prescription sheet (medicines)
- Clinical observation charts
- Allergies
- Evacuation triage priority

4.2 Evacuation resources

Manual techniques for emergency evacuation are methods of last resort as they are extremely demanding and strenuous.

Methods of Evacuation in order of Priority:

Priority	Method	Location/s	Access/Management
EP1	Walking		
EP2	Wheeled transport i.e. beds, wheel chairs and sanichairs		
EP3	Fire evacuation lifts (x2)	Between D –E blocks (Maternity building)	These would be operated by either Security or Estates who have been trained on the fire evacuation operation.
EP4	Sliding along floor – Evacuation Mats (total number = 64 (32 on each floor) (4 x bariatric patients)	1. 2x red cabinets in L block, level 5 staff stair case (near victoria ward) 2. 2x red cabinets in L block Level 6 corridor outside Meyrick Ward	Keys for the red cabinets are currently held in the Access Control Room – major incident box (should be in ward area sealed in envelope in the drugs cupboard)

The least strenuous method should be used for evacuating

It may be necessary to evacuate some patients bodily, using bed linen or as a last resort being dragged in sheets or on a mattress. Patients who are determined to be “Walkers” must not be allowed to wander and should be supervised by a member of staff.

4.3 Destinations for Evacuation

Depending upon the patient, there are a number of different ways in which the patients could be evacuated:

- Transfer of patients to other wards within the Trust
- Discharge as many patients as possible into the community

- Redirection of patients away to other available services elsewhere
- Transfer of patients direct to other local Trusts
- Transfer of patients to care commissioning facilities
- Evacuate patients to temporary holding area prior to transfer to other NHS bodies e.g. community centres/town halls.

Evacuation Priority 1 (EP1) - Independent
Those patients who can self-evacuate will be encouraged to do so via pre-designated Assembly Point(s). EP1 patients will be evacuated to on site facilities for example the Whittington Education Centre or off-site facilities for example Archway Hall or go home with appropriate records.

Reception Centres are to be supported by the evacuating Trust's staff as follows:
- A senior nurse capable of managing/supporting nurses from other agencies (minimum Band 6 or higher)
- A senior manager to act a liaison officer for the hospital

Evacuation Priority 2 (EP2) - Dependant
They are patients that require some assistance to mobilise, which may involve the use of wheelchairs, beds and trolleys etc. These patients will need to be transferred to another facility that contains appropriate clinical equipment and with appropriate medical and nursing care.

A list of who these patients are, the care they need and where they are reallocated to must be kept by the Hospital Control Team. It is assumed that most of these patients will need stretcher-based ambulance transfers. Communication with the Ambulance Service and other ambulance providers must be effective to ensure appropriate use of blue light transfers.

Evacuation Priority 3 (EP3) - Very Dependent
Very dependant patients are those with clinical treatments and/or conditions that create a high dependency on staff. This will include those in critical care areas, operating theatres, coronary care units etc. and those for who evacuation would prove potentially life threatening. These patients will require transfer to an appropriate medical facility.

Evacuation Priority 4 – Expectant or P4 Expectant Patients
There may be a need to prioritise which P4 patients are evacuated and it may be necessary to invoke a 'P4 Expectant' category, based upon guidance on ethical issues[1]. The evacuation triage category of 'Expectant' is to be used for those patients whose injuries or clinical support requirements are so extensive that they will not be able to survive evacuation and/or onward transportation, given the clinical care resources and time available.

The Expectant category arises when there are such large numbers of patients and the resources and the time to prepare patients for evacuation is severely limited, that the ability of the hospital to respond to the clinical needs of every individual during the evacuation is compromised. Patients with potentially un-survivable injuries may not be evacuated, thus allowing the hospital, and other responding organisations, to do "**the greatest good for the greatest number".**

[1] NHS Emergency Planning Guidance 2009: Planning for the evacuation and sheltering of people in health sector settings: Interim strategic national guidance

The Expectant category is only to be used with the authority of the Hospital Control Team, following appropriate clinical diagnosis at consultancy level. The decision to designate an expectant category would require authorisation from the Medical Director or deputy. This category uses the 'three wise men' principles in accordance with national ethical guidance.

4.3.1 Alternative Care Provision

Due to the nature of the hospital it may be necessary to establish temporary alternative care provision, especially for areas such as the Emergency Department and Maternity where patients are likely to self-present. Alternative care provision should be established in a safe location and is likely to be operating with limited resources, and need the support of the ambulance service for onward movement of patients during the initial phase. Alternative care provision may involve the triage of cases and stabilisation of patients before they are transported to alternative locations.

The Emergency Bed Service is available for the identification of beds in hospital settings for the emergency transport of patients. This service should be notified immediately on the need to evacuate the site if alternative care is to be provided in alternative acute hospital settings.

4.3.2 High risk areas/patients

Intensive care unit – The ICU has its own evacuation plan due to the care requirements and specialist equipment needed by its patients. During any evacuation the ICU will require additional staff to assist with the movement of patients lead clinician or nurse in charge will liaise with hospital control team to ensure sufficient additional staff are provided.

ICU nurse in charge or consultant will:

- Contact the Emergency Bed Service (EBS) for other ICU beds
- They will then contact the hospital direct with available beds to be accepted by another ICU
- They will contact London Ambulance Service to transfer the patient
- Keep the Hospital Control Team up to date

NOTE: high risk patients are not to be moved to a patient holding area until there is confirmation that there are transportation resources and destination sites, unless the situation necessitates a rapid reaction to reduce risk to both patients and staff. The patient will remain the responsibility of Whittington Health NHS Trust until a patients is handed over to another ITU facility in person.

NICU and SCBU

NICU is located on Level 3 and SCBU on Level 4 of Kenwood Wing.
In the event of partial or Full evacuation the decision to evacuate will be lead in this clinical area by the Paediatric Consultant. In the event of a partial evacuation the fall back location if safe is the Day Treatment/Surgery Centre and Cellier Ward. The Paediatric Consultant will allocate a responsible nurses and team members to each patient that is being transferred to a safe place. In the event of evacuation of NICU, NICU will exit via either its Main Entrance and along the Corridor to DTC Or through its Rear Exit and along the Road to DTC. SCBU will evacuate through its Main Entrance and along the corridor to Cellier Ward or across the Balcony to Murray Ward and onto Cellier Ward.
Then if necessary move down via Lift D or down the Stairs to Level 3 and along the corridor to DTC.

The porters be required to ensure there is additional oxygen supplies in the event that a full sight evacuation is required. The two transport groups responsible for transport way from the Whittington health site are Neonatal Transport Service and London Ambulance Service. The minimal support required for transport out without a paramedic crew is a Paediatric Registrar and Band 6 Nurses able to manage an intubated patient.

Mental Health Patients – There are reciprocal arrangements in place with the Royal Free London and University College London hospitals for a 'place of safety' for mental health patients. In the event of a full site evacuation the Operational Service Manager (OSM): Crisis Resolution and Liaison Teams will be contacted by the Tactical Commander. The OSM will review all mental health patients within Whittington Health NHS Trust.
Key responsibilities:

- Deploy MHLT staff to follow the patients until discharge or admission in supporting hospital
- Liaise with security to endure safe transport to destination
- Contact supporting hospital or mental health facility to communicate patients care needs and time of arrival
- Contact Silver (Tactical Commander) with brief when patients has left and been received by supporting hospital.
- OSM to conduct risk assessment with security lead and request secure vehicle use as required.

4.3.3 On-site Visitors, Contractors & Other Workers

All patients' visitors and other personnel such as contractors, visiting healthcare colleagues, shop staff etc. on-site at the time of evacuation is assumed to be Evacuation Priority 1, unless otherwise proven.

4.4 Multi Agency Support

Multi-Agency support will be required in the event of any evacuation of the site in its entirety and some support may be needed in the event of smaller evacuations.

Table 3 – Multi Agency Support

Partner Organisation	Support Provision	Activation Route
Ambulance Services	Transport of High Dependency and immobile patients	Notify of declared Major Incident and Evacuation
Local Authorities	Rest Centres for Evacuated Patients	Notify of declared Major Incident and Evacuation
Metropolitan Police Service (MPS)	Traffic Management Cordons Requisition of Transport	Notify of declared Major Incident and Evacuation
NHS England (London)	Co-ordination of Health Response	Notify of declared Major Incident and Evacuation
North East London Commissioning Support Unit	Co-ordination of Local Health Response	Notify of declared Major Incident and Evacuation
Clinical Commissioning Groups	Co-ordination of Local Health Response	Notify of declared Major Incident and Evacuation
Transport for London	Transport of P3 and mobile patients	Via Metropolitan Police Service

SECTION 5: Holding Areas and Reception Centres

5.1 Holding areas on site

- Walking or wheel chair patients
  - Move to (N19)
  - Whittington Education Centre
- Bedded patients
  - Forecourt – Magdala Avenue
  - Area outside maternity

5.2 Holding areas/reception centres off-site

A hospital evacuation that results in patients having to move off site will require support from the Local Borough Resilience Forum. It may be necessary to move patients to local authority managed Reception Centres, either for temporary shelter until they are able to return to the affected hospital or until they are able to be transported to another receiving hospital.

All patients being evacuated remain the responsibility of the evacuating Trust and will be accompanied by suitable Trust staff until a formal handover is given to either ambulance personnel at the point of onward transportation or to an appropriately qualified member of staff at the receiving destination, after transit.

The Islington Council Emergency Planning Unit have 27 pre identified venues across Islington Borough that are suitable for use as Evacuation/Rest Centres. They differ in size and in the facilities they offer.

If evacuation venues outside the Hospital are required Whittington Hospital Control team should contact the 'on call' Islington Local Authority Liaison Officer (LALO) stating the nature of the incident and the type of assistance that the hospital require.

Whittington Hospital have an undertaking from Islington Emergency Planning Unit that they will actively support the hospital in dealing with any incident where such support is requested particularly when the resources of the hospital are exhausted or are not available.

NHS England (London) will need to act as liaison with the local authorities to ensure that Emergency Reception Centres are set up and staffed appropriately and may also include:-

- A GP
- District nurses
- Nurse practitioner
- Pharmacist
- Social Worker – adult and child
- Spiritual leaders
- Voluntary Services (British Red Cross, St. John Ambulance, WRVS etc)

If a temporary 'field' style holding centre is required, the Ambulance Service will lead the deployment of the facility, with support from Fire & Rescue Service and the NHS England (London) in consultation with local commissioners. In this instance, the redeployment of acute hospital staff to the temporary facility will be necessary.

Table 4: Location to evacuate patients to temporary holding areas off-site

Venue and Address	Capacity	Facilities	Contact Details	Information	Type of patients
Archway Central Hall Archway Close N19 3UB In middle of Archway roundabout opposite Archway Tube	305 seating 180 sleeping <u>Ground floor:</u> entrance hall leading to carpeted lobby. Unisex toilet with wheelchair access. Very small kitchen with fridge & sink and kettles. **Octagonal room** has 8 tables with 40 chairs will take 40 sitting or 20 sleeping. **Wesley Room Chapel** 50 seating <u>First Floor:</u> Disabled stair lift from ground floor. 25 stairs in 3 sections from ground to first floor (4 foot wide stairwell). 6 cubical toilets 3 female, 3 male. Large kitchen with 2 cookers, fridge, 2 microwaves, 2 water urns. **Primary Room** lots of chairs & tables, 100 sitting or 50 sleeping.	<u>First Floor:</u> **Beginners Room**: no chairs or tables, will take 35 sitting or 20 sleeping. Access available from hall and primary room. **Church Parlour Room** no chairs or tables will sit 30 or sleep 15. <u>Second Floor</u>**:** 26 steps up from first floor (5 foot wide stairwell) no lift. **Youth Hall:** 150 sitting or 75 sleeping, 2 ladies toilets, 1 gents' toilet. Other rooms on this floor are private let.	Islington Borough: 0207 527 6336/5456/8006 (24/7/365) Islington LINKLINE/Telecare Ask for: • Team Leader stating: o nature of the incident, o giving your name and o phone number and o requesting that the 'on call' Islington LALO be contacted and asked to phone you back. The Islington LALO has access to the Islington 'on call' Emergency Planning Officer (EPO) whose role it is to co-ordinate the Council response to any incident. The EPO will then liaise with the hospital to obtain additional information and detail to assist in identifying the suitable LBI response to include identifying evacuation venues according to the nature, size and possible duration of the incident.	All fully heated. No beds or bedding on site. Ground floor only could be used for small evacuation. First floor has good kitchen with 3 separate rooms for evacuees which would help re segregation, admin office.	EP1

See map in appendix 2 for location of Archway Hall.

SECTION 6: Traffic Management Planning

During a full scale evacuation, it is key to ensure ambulances (blue light and patient transport) are able to enter and exit the site as quickly as possible. It is also important that visitors should be able exit the site and, where possible, this route should be different from any ambulance/emergency services route.

Each entry/exit road to the hospital site will need to be cordoned off to control the vehicles entering and exiting from the site. Visitors should be strongly discouraged from returning to the hospital car park and collecting their cars as this can create a gridlock, cause accidents and further hamper access to and from the hospital site by emergency vehicles.

SECTION 7: Site and Asset Security

During any evacuation, it is important that the security of the hospital site and its assets are maintained. The following areas should be planned for during each evacuation stage:

- Designated senior nurse/Fire Marshal to conduct a full sweep of evacuated area to include; sluices, linen areas and toilets/bathrooms. Ensure drug cabinets are locked and the keys are evacuated with the staff.
- Report the area clear to Hospital Command Team
- The primary aims once evacuation is complete are to prevent unauthorised re-entry into the building and to protect the hospital's assets, as far as is reasonably practicable. Consideration should be given to controlling access using internal security manpower only.
- Any mechanical 'locking down' systems should not be utilised at this point.
- If it has been necessary to conduct a whole site evacuation, the prevention of unauthorised re-entry is the primary consideration. An authorised stand down is likely to be issued by the Police Service or the Fire Service in this instance.

SECTION 8: Communications

The communications team is able to work remotely if they are unable to get into their office.

The below should be actioned alongside the communications action card in the Major Incident Plan.

8.1 Internal communications

Staff should be kept updated and informed. Information will be shared using a number of tools including: verbally through managers, all staff emails, pop up message on all computers, PageOne and intranet updates.

8.2 Media

The media will expect regular updates on any evacuation. Updates will be managed and co-ordinated by the communications team. Information is to be provided to them from the Silver Commander. This may be done by issuing press statements or holding a press briefing.

In the event of a large evacuation we can expect media arriving on site. This will include reporters and camera equipment. The media should be directed to a safe location as per the Major Incident Plan or off site. Support from security may be required in removing the media if they are on the site. In the event of a cordon or restriction to the site, it is expected that the police would support us with this.

In the event of multiple agencies being involved, communications will work with the appropriate other communications teams to agree a lead communications team and ensure one clear message is being delivered.

The messages being given to the media should include: Information on the evacuation and decisions leading to it, managing expectations – how it is affecting services and the local area, reassurance on safety and security and any advice on how the public can help or what the public should do.

8.3 Social media

Social media will play an important role is distributing any messages and the communications team will use the Trust social media accounts to do this.

Patients and visitors involved in any evacuation may choose to share their experiences on social media. They may film or photograph what is happening and also share these on social media.

Anything shared on social media may then be reproduced in online and print press. The media may also use social media to directly contact patients, visitors and staff involved. If this happens, staff should redirect them to the communications team as per the normal media protocol.

Twitter

Twitter should be used as an information tool to provide clear messages to the public.

8.4 Evacuation of Switchboard – Actions to be taken

Switchboard is located on the ground floor of K block (outpatients building) and provides a 24 hour telecoms service for internal and external calls as well as being the hub for a number of clinical emergency procedures, for example; Maternity code reds, patient cardiac arrests and calling the fire brigade in the event of a fire alarm.

If for any reason the Switchboard department needs to be evacuated for a short period of time, 2-3 hours, either as part of a wider Hospital evacuation or an evacuation of K block there is a procedure in place that would enable the Switchboard staff to continue to provide a Switchboard service. This service would be somewhat limited and priority would be placed on clinical emergencies and internal calls

The procedure involves Switchboard operators relocating to Highgate Wing level 6 which is the necessary distance away from K block if the evacuation relates to a suspect package or a bomb warning.

The Multi-tone bleep consoles would not be transferred to Highgate wing and therefore the procedure used to deal with Multi-tone breakdowns would be initiated, namely the distribution of two way radio to all wards as per the distribution lists (in hours or out of hours) held in the Security office.

In the event of a prolonged evacuation of Switchboard an agreement is in place with the Royal Free Hospital to divert Whittington lines to the Royal Free Switchboard. Whittington staff would relocate to the Royal Free to handle the increase call volume and speak to Whittington patients to explain the situation.

This agreement is reciprocated by The Whittington in the event that The Royal Free Hospital switchboard is out of action for longer than a day.

Evacuating Switchboard

- Turn any active consoles to night service
- Contact security if escort to Highgate Wing (HGW) is required
- Put out voice bleep message to Major Incident group
  "**Switchboard is evacuating to Highgate Wing level 6, please collect radio from security as bleep voice over emergency activations will no longer be available**"

- Collect evacuation bag (containing – basic analogue handset, access card to HGW, directions to HGW, instructions for using flatbed console located on level 6 HGW, note book and pens)
- Collect radio

Arriving on Level 6 Highgate Wing

- Turn on the flat bed console located in the Large Meeting room
- Plug in the analogue handset to allow number 0207 263 5555 to be accessible
- Using the radio Inform site manager and security of arrival in HGW
- Assign responsibilities; switchboard operator, radio operator & note taker
- Take calls as per the following priority list:
  - 2222
  - Internal calls
  - External calls
- Maintain communication with Silver on call and Facilities on call

All clear received

- If more than one operator present – one operator returns to main switchboard (operator 1), one operator continues service from HGW (operator 2)
- Operator 1 turns console onto day service and put out voice bleep message to Major Incident group
  "**Normal switchboard service has resumed, emergency activations back to bleeps**"

- Operator 1 informs operator 2 by radio that main switchboard is operational
- Operator 2 closes down flatbed console and returns to main switchboard with evacuation bag

- Follow instructions from Bronze or Silver on call regarding stand down communications

SECTION 9: Redeployment of Staff

Staff from the evacuating hospital may need to be redeployed in order to support the evacuated patients, as the clinical care of evacuated patients will remain the responsibility of the trust. The clinical care responsibilities extend until a formal handover is given to either an ambulance paramedic at the point of onward transportation or to an appropriately qualified member of staff at the receiving destination, after transit. As with acute hospital plans for managing pandemic influenza, this plan relies on existing trust policies for the redeployment of staff.

In the event of a full scale evacuation of the hospital site, staff from the affected hospital will need to remain with patients that they have a designated duty of care to, during transit. The Ambulance Service will provide support to the hospital by the provision of equipment to sustain life support, onward transportation to receiving hospitals and temporary shelter. The Ambulance Service do not have resources to provide continuous nursing and medical care. The welfare of all hospital staff remains the responsibility of the evacuating hospital. Assistance for displaced persons can be sought from the Borough Resilience Forum partners. It may be necessary to move staff to local authority Reception Centres.

SECTION 10: Post Incident

10.1 Recovery

Recovery planning should commence as soon as possible during the evacuation. Recovery and restoration of acute services are likely to be dedicated under the circumstances at the time of the event, however the recovery plan must highlight some likely areas for consideration in the medium long term including:

- Longer term placements if it is not possible to reoccupy the site immediately
- Relief for evacuated staff and information for the next shift
- Support for friends and relatives of these patients evacuated to other hospital trusts.
- Support for staff working temporarily at other sites
- Counselling for staff, as required
- Clear up and reoccupation of the site and return to ‘new normality’

10.2 Debriefing

The evacuation of part or all of a hospital is a stressful event for staff, patients and visitors. At the earliest opportunity following ‘stand down’ a short ‘hot debrief’ should be held. This should allow staff to ‘voice’ pressing issues and express any immediate concerns that they may have. The

debrief session should be kept short, structured and recorded. Depending on the incident, it may be necessary to have a debrief with partnered agencies.

Current guidance on supporting staff following a traumatic or highly stressful event recognises that after an initial short debrief, no further professional intervention (i.e. counselling) should be given. Staff should be given the opportunity to seek advice, reassurance and comfort from their close friends and relatives in the following 2 week period after the event, before seeking professional services. At this point, close monitoring of staff involved in the incident should take place, with support offered and given, where required. See the Trust Major Incident Plan.

APPENDIX 1: EVACUATION MATRIX FOR ALL ACUTE INPATIENT AREAS

Block	Floor Level	Zone	Area Name	Clinical Speciality	Staffing	Capacity	Additional people required	Means of Escape	Evacuation Priority	Assembly Point	On-site Holding Area	Off-site Holding Area
E	5	47	Ante Natel	Maternity				E block stairs, D block (lift) stairs, D block evac lifts, external fire escape to Bridges Ward				
E	5	46	Community Midwives	Maternity				E block stairs, D block (lift) stairs, D block evac lifts, external fire escape to Maternity Day Unit				
E	5	39	Parent Craft Room	Maternity				E block stairs, D block (lift) stairs, D block evac lifts				
D	5	34	Bridges Ward			12+4		E block stairs, D block (lift) stairs, D block evac lifts, external fire escape to Ante Natel				
D	5	39	Maternity Day Unit	Maternity				E block stairs, D block (lift) stairs, D block evac lifts, external fire escape to Community				

								Midwives				
E	4	45	Cellier Ward	Maternity		24		E block stairs, D block (lift) stairs, D block evac lifts, external fire escape to Eddington Ward				
E	4	44	Murray Ward	Maternity		18		E block stairs, D block (lift) stairs, D block evac lifts, external fire escape to SCBU				
E	4	38	Midwives offices & Shubbos Room	Maternity				E block stairs, D block (lift) stairs, D block evac lifts				
D	4	32	Eddington ward					E block stairs, D block (lift) stairs, D block evac lifts, external fire escape to Cellier Ward				
D	4	33	SCBU	Maternity				E block stairs, D block (lift) stairs, D block evac lifts, external fire escape to Murray Ward				
E	3	43	Cearns Ward	Maternity				level 3 corridor to				

								A block				
E	3	42	Labour Ward	Maternity		8		level 3 corridor to A block atrium /N19				
D	3	30	Betty Mansell					level 3 corridor to A block atrium /N19				
D	3	31	NICU	Maternity				level 3 corridor to A block atrium /N19				
D	3	37	Chapel & store					level 3 corridor to A block atrium /N19				
E	2	41	Birthing Unit	Maternity		5		level 2 corridor to A block atrium/N19				

Area/department	Assembly point number	Designated assembly point
C, D and E blocks (Kenwood wing) levels 3,4 + 5	**1**	Outside Jenner exit
C, D and E blocks (Kenwood wing) level 2	**2**	On mortuary road
K block	**3**	Outside K block entrance
New acute wing/GNB levels 2, 3,4,5 & 6	**4**	Outside K block entrance

New acute wing/GNB level 1	**5**	Adjacent to mortuary
New acute wing/GNB level 0	**6**	To side of new main entrance
Jenner Building, School of Nursing, Nurses Home	**7**	Grass outside nurses home
Doctors accommodation	**8**	Between Jenner and School of Nursing
Highgate wing	**9**	Rear of building

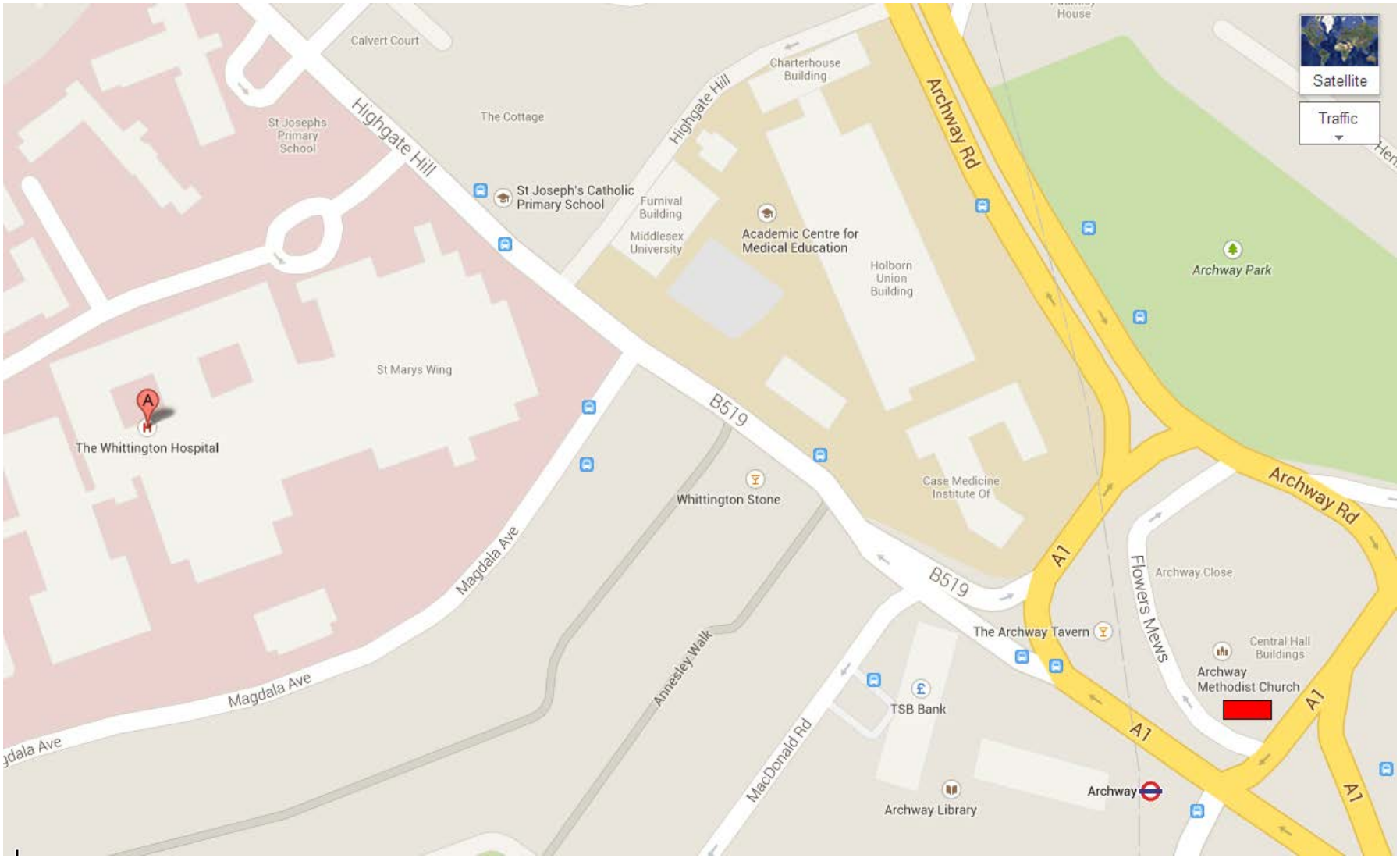
WHITTINGTON HOSPITAL
SITE PLAN ON COMPLETION OF PFI DEVELOPMENT

Whittington Hospital NHS
NHS Trust

DEVEREUX ARCHITECTS

Map of Evacuation Assembly Points off-site

Off-site holding area: Archway Hall


Calvert Court
St Josephs Primary School
Highgate Hill
The Cottage
St Joseph's Catholic Primary School
Furnival Building
Middlesex University
Academic Centre for Medical Education
Charterhouse Building
Highgate Hill
Archway Rd
Holborn Union Building
Archway Park
Satellite
Traffic
St Marys Wing
The Whittington Hospital
B519
Whittington Stone
Case Medicine Institute Of
Archway Rd
A1
Flowers Mews
Archway Close
Magdala Ave
Annesley Walk
B519
The Archway Tavern
Central Hall Buildings
Archway Methodist Church
Magdala Ave
TSB Bank
A1
A1
MacDonald Rd
Archway
Archway Library

APPENDIX 3: KEY ROLE ACTION CARDS

Incident Role:	Senior Nurse/Manager for the Ward/Area (Fire Marshall)	Action Card No. 01
Location:	Wards	

Task	Description	✓	Time
1	Identify reason for Immediate Action to Evacuate		
2	Senior Nurse/Manager in conjunction with, London Fire Brigade and Fire Marshall to INVESTIGATE, DECIDE, and INSTIGATE evacuation of patient area		
3	Ring Trust Emergency Number (i.e. 2222) and give the following information: 1. Evacuation of 'Location' 2. Reason for evacuation 3. Number of Patients in situ		
4	Activate Fire Alarm, put on the allocated High Visibility Jacket		
5	• Encourage all staff and visitors to leave as quickly as possible • Begin Reverse Triage of patients in area. Ask visitors to remain to assist with evacuation. 1. Independent – First out 2. Dependant – Second out 3. Very dependant – Third out 4. (Expectant) – Very dependant and unlikely to survive – Last out Ensure that a hospital evacuation tracking form is completed for each patient. This category can only be allocated by the treating consultant in liaison with the medical director.		
6	Prepare patients to evacuate by: 1. Ensuring any fluid bags are detached from stands and a spare is available 2. Ensure sufficient blankets are with the patient 3. Explain need to evacuate to patient and any visiting friends/relatives 4. Ensure Patient ID wrist labels are in place on all patients 5. Ensure patient notes and charts accompany the patient		
7	Prepare staff to evacuate by: 1. Ensure the named nurse completes the Hospital Evacuation Tracking Form for their patients 2. Ensure the named nurse places all prescription cards, observation sheets and any integrated care plans with each of their patients.		

	3. Collect staff rota and admissions diary as available 4. Designate a nurse to co-ordinate evacuation of patient cohort.		
8	Begin progressive horizontal evacuation to designated Patient Evacuation Point (as indicated by Ward Evacuation Plan)		
9	Carry out a thorough and methodical check to ensure that staff and visitors have left the area, including toilets and store rooms but only whilst taking the nearest and safest route out of the building.		
10	Ensure that the fire doors are closed on the escape route.		
11	Conduct a roll call at the appointed assembly point to ensure that all staff within their area of responsibility has reported to the assembly point If staff are unaccounted for then inform the Site Manager and Senior Fire Brigade Officer if in attendance.		
ESSENTIAL NUMBERS – confidential			

Incident Role:	**Silver and Gold Commander**	**Action Card No. 02**
Location:	**Incident Control Room (Access Room)** ***Back up Incident Control Room*** **(Operations meeting room, 1st Floor,** **Jenner Building)**	

Task	**Description**	✓	**Time**
1	Slow time evacuation - the Hospital Control Team to meet formerly and agree need for evacuation.		
2	Undertake a rough and quick risk assessment taking into account environmental conditions (day/ night / weather etc.)		
3	If imminent threat declare Major Incident for the Trust (gold)		
4	Alert all staff for need to evacuate and timescale involved via switchboard and sending out cascade message via emergency notification system.		

5	Request assistance from London Ambulance Service, Met Police, London Fire Brigade		
6	Inform NHS England (London) 0844 822 2888 request pager NHS01. Ensure that NHS England (London) communicates to all Trusts and CSU to assist where appropriate		
7	Confirm location of Command team		
8	Ensure appropriate communication with patients as well as TCI's.		
9	Liaise with Director of Communications responding to media enquiries and co-ordinate on-going Trust wide staff communications (e.g. all staff email updates – especially for staff in unaffected areas/sites.)		
10	Consider the cancellation of elective surgery within the hospital if additional bed space is required		
11	Coordinate the departments local responses		
12	Prepare for the possible needs of staff remaining with patients for extended period e.g. accommodation sleeping feeding and toilet facilities.		
13	Oversee the transport response and agree safe access and egress routes.		
14	Note where patients are not evacuated and their care arrangements		
15	Agree rota for Command team over a protracted period of time.		
16	Continually re-evaluate threat and Trust response to ensure that both are appropriate and speed of evacuation is suitable		
Major incident stand down:			
17	When suitable agree the stand down from the Major Incident, communicate stand down to all staff and organisations and nominate a group of staff to deal with outstanding issues. Co-ordinate recovery process.		
18	Co-ordinate return of patients to site.		
19	Ensure that cost of evacuation is known as part of overall report.		
20	Keep hold of any documentation used.		
21	The silver commander and EPLO are responsible for running the post incident debrief.		

22	Prepare for any public or legal enquiry following deaths or injuries caused by the evacuation		
23	Work with any investigating organisations to determine the cause of the incident		

ESSENTIAL NUMBERS

Major Incident Control Room (Access Room) - confidential

Back up Major Incident Control Room: confidential

Incident Role:	**Bronze Commander**	**Action Card No. 04**

Task	Description	✓	Time
1	Work with the bed managers to tell Silver Commander of the current bed state and location and number of particularly vulnerable patients.		
2	Create a list of prioritised vulnerable patients and resources required for their safe evacuation.		
3	Working with Silver Commander and Department / Ward Managers identify staging areas to evacuate patients to.		
4	Oversee the progressive timely evacuation of patients ensuring those patients most at risk are evacuated first.		
5	Ensure that additional bottled oxygen is immediately requested under emergency request procedures. Work with Police to blue light this to the Trust or staging areas. Estates to provide support to logistical process		
6	Work with LAS Ambulance Liaise Officer to co-ordinate the movement of the most vulnerable patients from the affected location		
7	Ensure that all areas utilise the patient tracking documentation contained within this plan.		
8	Ensure that patients whose location isn't known is communicated to the Silver Commander immediately		

9	Ensure that all non-essential staff are evacuated from the site as soon as possible.		
Major Incident Stand down			
10	Working with the Trust Control Team, prioritise the services to be restored and the resources required for this to occur.		
13	Ensure that all areas of the Trust carryout a Hot debrief immediately following stand down and that the immediate learning points are fed back during the cold debrief.		

ESSENTIAL NUMBERS

Major Incident Control Room (Access Room) Line 1 - Confidential

Back up Major Incident Control Room: Operations Meeting Room (Jenner Building) - Confidential

Incident Role:	**Facilities Coordinator**	**Action Card No. 05**

Task	Description	✓	Time
1	Ensure that non essential staff are evacuated from the location		
2	Lockdown evacuated areas with Security.		
3	Work with security to co-ordinate the securing of evacuated locations. Ensure that space evacuated isn't reoccupied until agreed by the Command team and that equipment or resources are secured		
4	Ensure that arrangements are instigated early for a continued prolonged incident and subsequent lockdown.		
5	Work with other Trusts' Facilities co-ordinators to identify equipment and resources that can be utilised. (Where necessary this can be direct or through mutual aid arrangements that can be instigated by NHS England.		
6	Ensure that an appropriate communications message is added to the Switchboard automated message.		
7	Draft additional portering security and technician staff from sites to the affected		

	incident location. If all sites are affected call in additional staff.		
8	Ensure that catering at non affected sites provides assistance to affected sites		
Major Incident stand down:			
9	Ensure that equipment utilised in the evacuation is returned to the Trust.		
10	Ensure that resources from outside of the Trust are returned or that appropriate financial compensation agreements are followed.		
11	Work with partner organisations to ensure that the Trust buildings are retuned to previous standards in order to facilitate the return of patients		
ESSENTIAL NUMBERS			
Major Incident Control Room (Access Room) - confidential **Back up Major Incident Control Room:** Operations Meeting Room (Jenner Building)- confidential			

Incident Role:	**Patient tracking loggist (wards/departments)**	**Action Card No. 06**
Location:	**Holding areas**	

Task	**Description**	✓	**Time**
1	Utilise the individual ward registers to collate into the patient tracking form - see reverse for patient tracking form provide copy to the hospital control team		
2	A clinical assessment to re-triage the patients to assess their need to decide on their next destination - see table below patient classification, reverse triage & priorities for onward transfer		

3			

ESSENTIAL NUMBERS

Major Incident Control Room (Access Room)

Back up Major Incident Control Room: Operations Meeting Room (Jenner Building)

Classification	Triage Level	Reverse Triage Evacuation Priority	Priority for Onward Transfer
Evacuation Priority 1 (Most Able requiring least assistance)	**EP1**	These patients require minimal assistance and can be moved **FIRST** from the ward. Patients are ambulatory and 1 x staff member can safely lead several patients who fall into this category to the holding area	These patients will be moved **LAST** as transfers from the hospital holding are to another healthcare/reception facility
Evacuation Priority 2	**EP2**	These patients require some assistance and should be moved **SECOND** in priority from the inpatient ward area. Patients may require wheelchairs or stretchers and 1-2 staff members to aid evacuation	These patients will be moved **SECOND** in priority as transfers from the holding area to another hospital
Evacuation Priority 3	**EP3**	These patients require maximum assistance to move. In an evacuation, these patients move **LAST** from the inpatient ward area. These patients may require multiple staff members to enable their evacuation.	These patients require maximum support to sustain life. These patients move **FIRST,** once stable, from the hospital holding area to another hospital
Evacuation Priority 4 (Expectant or least able requiring most assistance)	**EP4**	This category uses the **'three wise men'** principles in accordance with national ethical guidance. Its invocation is only for the period of time the incident is 'live'. Patients who are in this category are **unlikely to survive evacuation** from the hospital and would require significant resources to move them. They should only be moved once all other patients have been evacuated and if sufficient resources are available	If evacuated these patients should only be transferred to another hospital if sufficient resources are available. All clinical care should be palliative

HOSPITAL EVACUATION PATIENT TRACKING FORM

Patients accounted for						
	Originating Ward	Patient Name	Patient Hospital Number	Patient currently located	Patient destination	Patient Evacuation Triage EP 1 2 3 4
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						

Patients NOT accounted for				
	Originating Ward	**Patient Name**	**Patient Number**	**Location Patient Last Seen**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Incident Role:	**Tracking Officer**	**Action Card No. 07**
Location:	**Holding Areas (forecourst Magdala Avenue or outside maternity)**	

Task	**Description**	✓	**Time**
1	Utilise the individual ward registers to collate into the patient tracking form - see reverse for patient tracking form provide copy to the hospital control team		
2	A clinical assessment to re-triage the patients to assess their need to decide on their next destination - see table below patient classification, reverse triage & priorities for onward transfer		
3			

ESSENTIAL NUMBERS

Major Incident Control Room (Access Room)

Back up Major Incident Control Room: Operations Meeting Room (Jenner Building)

Classification	Triage Level	Reverse Triage Evacuation Priority	Priority for Onward Transfer
Evacuation Priority 1 (Most Able requiring least assistance)	**EP1**	These patients require minimal assistance and can be moved **FIRST** from the ward. Patients are ambulatory and 1 x staff member can safely lead several patients who fall into this category to the holding area	These patients will be moved **LAST** as transfers from the hospital holding are to another healthcare/reception facility
Evacuation Priority 2	**EP2**	These patients require some assistance and should be moved **SECOND** in priority from the inpatient ward area. Patients may require wheelchairs or stretchers and 1-2 staff members to aid evacuation	These patients will be moved **SECOND** in priority as transfers from the holding area to another hospital
Evacuation Priority 3	**EP3**	These patients require maximum assistance to move. In an evacuation, these patients move **LAST** from the inpatient ward area. These patients may require multiple staff members to enable their evacuation.	These patients require maximum support to sustain life. These patients move **FIRST,** once stable, from the hospital holding area to another hospital
Evacuation Priority 4 (Expectant or least able requiring most assistance)	**EP4**	This category uses the **'three wise men'** principles in accordance with national ethical guidance. Its invocation is only for the period of time the incident is 'live'. Patients who are in this category are **unlikely to survive evacuation** from the hospital and would require significant resources to move them. They should only be moved once all other patients have been evacuated and if sufficient resources are available	If evacuated these patients should only be transferred to another hospital if sufficient resources are available. All clinical care should be palliative

HOSPITAL EVACUATION PATIENT TRACKING FORM

Patients accounted for						
	Originating Ward	Patient Name	Patient Hospital Number	Patient currently located	Patient destination	Patient Evacuation Triage EP 1 2 3 4
1						
2						
3						
4						
5						
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7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						

Patients NOT accounted for				
	Originating Ward	**Patient Name**	**Patient Number**	**Location Patient Last Seen**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

APPENDIX 4: BLUE LIGHT SERVICES KEY RESPONSIBILITIES

- **Ambulance responsibilities**:-
- **Liaise with Acute Hospital Incident Management Team**
- Declare **Major Incident** if appropriate
- Deploy Mass casualties vehicle
- Deploy HART and use as appropriate
- Assess, resource and coordinate sufficient appropriate resources
- Liaise with other responding agencies
- Liaise with media teams for coordinated message
- Liaise with hospitals now taking diverted and evacuated patients
- Coordinate names and locations of transferred patient
- Assist with decontamination if required
- Provide and erect tentage and ancillary equipment as required
- Assist with triage and treatment as appropriate
- Liaise with Acute Incident Management Team to enable return or discharge of evacuated patients

-
-

- **Fire & rescue Service**
- **Liason Officer to Acute Hospital Incident Management Team**
- Declare **Major Incident** if appropriate
- Liaise with emergency responders
- Respond appropriately to incident
- Request Mutual aid if required
- Assist with evacuation

• **Police** • **Liaison Officer to Acute Hospital Incident Management Team** • Declare **Major Incident** if appropriate • Liaise with emergency responders • Apply cordon if required • Traffic management off site and on-site if appropriate • Crime scene investigation • Family liaison • Casualty bureau if required

APPENDIX 5: KEY CONTACTS LIST - Confidential

APPENDIX 6: LINKED PLANS AND REFERENCES

Linked Plans

Internal:

- Fire Policy
- Lock down policy
- Ward evacuation plans
- Major Incident Plan
- Business Continuity Plans

External:

London Resilience Partnership Mass evacuation framework https://www.london.gov.uk/sites/default/files/London%20Mass%20Evacuation%20Framework%20V2%200.pdf

References

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NHS England 2015. Planning for the Shelter and Evacuation of people in healthcare settings [online] Available: http://www.england.nhs.uk/wp-content/uploads/2015/01/eprr-shelter-evacuation-guidance.pdf

Finance & Business Development Committee, 18th July 2017 - Minutes

Attendance: Tony Rice, Deborah Harris-Ugbomah, Graham Hart, Stephen Bloomer, Jason Burn, Carol Gillen, Mark Inman, John Watson, Andrew Read for item 17/018 & Vivien Bucke (Secretary).

Apologies: Simon Pleydell & Siobhan Harrington

1. Minutes of the previous meeting and Action Notes

The minutes of the previous meeting were agreed as an accurate record with the following updates:

2.3 - The Final CIP target was £17.8m.

2.6 - The Trust achieved £10,241k recognising £600k flow through from 2015/16 = £2,546k of Trust wide non pay benefit.

4.1 - The final month 12 Position was £3.7m deficit against £6.4m Plan and the Trust had received a bonus STF payment of £2.6m.

2. Finance Report

Action

2.1 The Trust reported a £0.8m surplus for June (month 3) leading to a year end deficit of £1.5m. This is in line with the planned year to date deficit of £1.3m (planned in month deficit £0.6m). The pay position includes a £0.5m benefit following the release of one quarter of the holiday pay provision. Within non-pay a review had been undertaken on the Trust's arrangements with regard to commercial invoice accruals and this has been reflected in the position. The Trust is on plan and has received the full STF.

2.2 The enhanced controls have remained in place and continue to work so performance against planned expenditure was favourable. However, CIP delivery is currently behind plan and requires strong focus to ensure plans are delivered and additional schemes are identified to hit the requirement for £15.5m of cost out in year from new schemes. Income is below plan and ICSUs have been asked for rectification plans to assure the agreed targets are met. It was emphasised that unless the Trust addresses these two fundamental items it will not achieve its control total for 2017/18.

2.3 TR said he would circulate notes to the Board prior to September Committee. **TR**

3. CIP/PMO Full Plans Presentation

3.1 JW reported the CIPs £1.5m adrift currently, and at present it was taking longer than planned to achieve savings. However, there is a strong governance structure and a robust sign-off process to provide a high degree of delivery assurance. Regular tracking and reporting cycles had been implemented to flag these deviations which would be discussed in formal sessions. All initiatives likely to impact clinical quality are required to go through a formal and independent quality impact assessment before 'go live'.

3.2 The Committee noted the key schemes, their issues and risks as highlighted in the report. In response to a query JB felt that historically roadmaps were perceived as the final process in CIPs but SB stated the finance team have been clear on making sure everyone understands in-year requirements. Training will be provided and a paper had gone today to TMG on the in-year requirements.

3.3 JW stated £15.5m of recurrent full year effect schemes were not yet road mapped but JB emphasised the need to follow through on the £9m road mapped to date as well focus on the gap. The Committee discussed the need to not discuss process in depth but to focus in on detail with ICSUs to attend the Committee to discuss the detail. However, it was felt that the focus on QIA had led to a more valid projected figure.

3.4. The next F&BD Committee meeting in September will look at every area of planned and actual CIP activity and review the gaps and actions to compensate and report back to the Board. **JW**

4. Reference Costs Submission

4.1 The Committee reviewed the Reference Cost Submission Process for calculating such costs, agreed Chairs Actions and endorsed it for recommendation to the Board. The final calculations will be available early next week for sign off and submission by the end of the month and will be reported to the Board in September.

5. Business Development Review of bids and learning & new initiatives Contribution to overheads

5.1 MI presented the paper, which set out the proposed treatment of overhead in costing bids. SB emphasised the paper had been well received at the Trust Management Group.

5.2 Future bids will see Finance issuing a standard costing template to ICSUs and Corporate areas and the Income and Contracting team will work on the final elements of the bid before sign off. Contribution to overhead will be calculated using a risk based approach and Bids over £100,000 will go to the Trust Management Group and the Finance & Business Development Committee. The committee was asked to agree the approach to calculating contribution to overheads and the revised Governance Structure. **This was agreed.**

6. Service Review

Lessons learnt from the Dental Tender – reflections from the Dental Team

6.1 The Committee reviewed the Dental contractual win with Andrew Read, the lead in this area. AR stated that all Whittington contracts in Dental, whether local authority or NHS commissioned, have to be acquired via the tender process and have been for 7-8 years; although are often very small tenders. The Dental service is culturally used to tendering and aware of the Trust reputation as a good service provider. AR shared his view on the recent process which the Committee discussed and thanked AR for this feedback and the excellent result of winning the contract.

6.2 Following discussions, MI confirmed he was writing a paper for the next Committee on a future bid strategy which includes an improved update to the governance structure for bids including ICSU contribution.

7. Risk Register

7.1 The Committee noted the Risk Register.