Whittington Health
NHS Trust

TRUST BOARD
PUBLIC

14.00 – 17:00
Wednesday 31st January 2018

Whittington Education Centre
Room 7

NHS
Whittington Health
NHS Trust

Meeting	**Trust Board – Public**
Date & time	**31st January 2018 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 Carol Gillen, Chief Operating Officer

Attendees – Associate Directors
Sarah Hayes, Acting Chief Nurse
Dr Greg Battle, Medical Director (Integrated Care)
Fiona Smith, Communications
Norma French, Director of Workforce

Secretariat
Kate Green, Minute Taker

Contact for this meeting: fiona.smith19@nhs.net

Agenda Item		Paper	Action & Timing
Patient Story			
	Patient Story *Sarah Hayes, Acting Chief Nurse*	*Verbal*	Note 1400hrs
18/001	**Declaration of Conflicts of Interests** *Steve Hitchins, Chair*	*Verbal*	*Declare* 1420hrs
18/002	**Apologies & Welcome** *Steve Hitchins, Chair*	*Verbal*	*Note* 1425hrs
18/003	**Draft Minutes, Action Log & Matters Arising 6 Dec 2017** *Steve Hitchins, Chair*	1	*Approve* 1430hrs
18/004	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Note* 1440hrs
18/005	**Chief Executive's Report** *Siobhan Harrington, Chief Executive*	2	*Discuss* 1450hrs
Patient Safety & Quality			
18/006	**Quarterly Safety & Quality Report** *Richard Jennings, Medical Director*	3	*Approve* 1500hrs
18/007	**Quarterly Learning from Mortality Report** *Richard Jennings, Medical Director*	4	*Approve* 1510hrs
18/008	**Serious Incident Report Month 09** *Richard Jennings, Medical Director*	5	*Approve* 1520hrs
18/009	**Safer Staffing Report Month 09** *Sarah Hayes, Acting Chief Nurse*	6	*Approve* 1530hrs

Performance			
18/010	**Financial Performance Month 09** *Stephen Bloomer, Chief Finance Officer*	7	*Approve* 1550hrs
18/011	**Performance Dashboard Month 09** *Carol Gillen, Chief Operating Officer*	8	*Approve* 1600hrs
Strategy and Governance			
18/012	**Quarterly Corporate Objectives Report** *Helen Taylor, Acting Director of Strategy*	9	*Approve* 1620hrs
18/013	**Fire Safety Update** *Adrien Cooper, Director of Environment*	10	*Approve* 1630hrs
18/014	**Emergency Preparedness Resilience and Response 2017/18 Annual Report** *Carol Gillen, Chief Operating Officer*	11	*Receive* 1640hrs
AOB			
	None notified to the Trust in advance		1650hrs
Questions from the public on matters covered on the agenda			
	None notified to the Trust in advance		1655hrs
Date of next Trust Board Public Meeting			
28 February 2018 -1400hrs-1700hrs -Whittington Education Centre, Magdala Avenue, N19 5NF			

Register of Conflicts of Interests:

The Register of Members' Conflicts of Declarations of Interests is available for viewing during working hours from Fiona Smith, Communications Lead, at Trust Headquarters, Jenner Building, Whittington Health, Magdala Avenue, London N19 5NF or Fiona.smith19@nhs.net

or www.whittingtonhealth@nhs.net

NHS
Whittington Health
NHS Trust

ITEM: 18/003
Doc: 01

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

Present:	Greg Battle	Medical Director, Integrated Care
	Stephen Bloomer	Chief Finance Officer
	Philippa Davies	Director of Nursing and Patient Experience
	Carol Gillen	Chief Operating Officer
	Deborah Harris-Ugbomah	Non-Executive Director
	Siobhan Harrington	Chief Executive
	Graham Hart	Non-Executive Director
	Steve Hitchins	Chairman
	David Holt	Non-Executive Director
	Richard Jennings	Medical Director
	Tony Rice	Non-Executive Director
	Anu Singh	Non-Executive Director
	Yua Haw Yoe	Non-Executive Director
In attendance:	Norma French	Director of Workforce
	Jayne Osborne	Minute Taker
	Fiona Smith	
	Sarah Hayes	Deputy Chief Nurse

Patient Story

James Wood presented Amanda's story (starting in 2012) as she was unable to be present.

In 2012 there had been a high level of complaints about out-patient pharmacy, largely concerning long waiting times but also the environment and workload. This particular patient story involved a lady named Amanda who wrote to PALS and Helen Taylor in February 2012 explaining how she had waited an hour for 1 item on her prescription and whilst waiting had recorded her observations.

She had felt the whole environment was inadequate for both patients and staff. Her observations included a lack of management of the system for accepting prescriptions, less than welcoming staff, and a junior staff member having to deal with a queue of approximately 50 people as well as acting as the main point of contact.

Much work had since been undertaken to transform the environment, and Helen Taylor as lead pharmacist had worked with the Design Council to co-design the pharmacy, involving patients and multidisciplinary team, with Amanda acting as the patient representative throughout the process. It was noted that few adjustments were required after the new service opened, which was a real testament to the design principals used.

Key to the new service was the visibility of the dispensing process – patients were now able to observe progress, so that although there were still periods when demand was high patients could see how hard staff were working. It was emphasised that the change was not merely about the design - though this was a large part of the project – but also about new ways of working. Part of the success was helping the small Pharmacy team to think about the culture

within the team and their role as a dedicated and caring team, considering how best to be responsive to people's needs.

One of the main changes was the improved connection between staff and patients which was not previously possible as staff locations were screened by walls. The team culture has changed they are more engaging with people and have conversations whilst working which is a very positive development. Waiting times have also improved, complaints have all but ceased and there has been positive feedback about the service.

The new pharmacy had been formally opened by the mayors of Haringey and Islington, and Steve Hitchins commented on how well this event had gone. He thanked all involved in recounting this story, and would be meeting Amanda when she attended in January.

17/160 Declaration of Conflicts of Interest

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

17.161 Welcome and apologies

161.01 Steve Hitchins welcomed everyone to the meeting. No apologies were received.

17/162 Minutes, Matters Arising & Action Log

162.01 The minutes of the Trust Board meeting held on 1st December were approved.

162.02 Action log

The Board assurance framework and corporate risk register are being reviewed. They will be discussed at a future Board seminar and return to the Board in March 2018 following this work.

17/163 Chairman's Report

163.01 Steve Hitchins reminded the panel that from next year Trust Board meetings would be moving to the last Wednesday of each month as this will enable the Board to see data from the previous month. The next meeting would therefore will be held on 31/1/2018. Seminars would remain unchanged.

163.02 Steve Hitchins highlighted the following events and visits he had attended since the last meeting:

- On Remembrance Sunday he had attended the Northern Health Centre to lay a wreath on behalf of staff at Whittington.
- A visit to children's and young people's forum event with partners at the Arsenal community hub
- Expert patient awards within the Bangladeshi community, the first time the Trust had carried out an expert patient training course in Bengali.
- Steve thanked Lee Smith and his colleagues for their great work on his recent emergency planning exercise, which had been a great success. Feedback was to be provided the following week.
- A group of Barristers from the coroner's chambers had attended to talk to the paediatric department on Child Protection Issues; this useful event had been very well received.

- A meeting had been held with LB Haringey to discuss their corporate plan for the next few years.
- Carol Gillen and Steve had met with Islington Law Centre to explore having a regular advice surgery on the Whittington site, they currently had little in the north of the borough and it would be good to work with them.
- The Trust had completed a comprehensive round of complaints training which Steve had introduced. There had been good attendance and much engagement. The understanding of staff about the relevance of complaints had been enhanced by the training and he thanked Angel and her team for their hard work.
- Steve and Siobhan had been invited to a public meeting at Islington Town Hall on January 11th 2018 by the Defend the Whittington Coalition concerning the strategic estates partnership.
- The CQC 'well led' inspection had now concluded, and Steve thanked everyone for their engagement and mature approach, saying how proud he was of the Board.

163.03 Steve informed members that Christmas activities had begun that afternoon with the switching on of the Christmas tree lights.

163.04 There would be a large number of groups, schools and players serenading patients, visitors and staff from the atrium throughout the Christmas period and Fiona Smith could provide a list of these if so required.

163.04 Sodexo was providing mince pies for all staff on the afternoon of 22/12/2018, and several of the executive team would be visiting community health centres to make sure all staff in the community were included.

163.05 Steve Hitchins and Siobhan Harrington would be visiting wards on Christmas morning.

163.06 Steve Hitchins informed members that this would be Philippa Davies's, Chief Nurse and Director of Patient Experience last meeting, and expressed his gratitude on behalf of the Trust for the way she had shown energy, drive, commitment and delivery. He commented that Philippa would leave Whittington Health a much better place for having worked here for so long; she would be much missed and he wished her all the best for the future. David Holt echoed his thanks and good wishes. Sarah Hayes would be acting up as Chief Nurse from 1st January 2018 and Michelle Johnson the new Chief Nurse would take up post on 12nd February 2018.

The Board noted the report

17/164 <u>Chief Executive's Report</u>

164.01 Ian Dalton has been appointed as the new Chief Executive Officer of NHS Improvement and took up post on 4/12/2017.

164.02 Siobhan Harrington began her report by thanking the executive team for their work and support through the 3 months of the CQC inspection process. She advised the Board that she expected the CQC report at the end of February 2018.

164.03 Julie Andrews is leading on the development of a new Quality Improvement process, which included ensuring staff are trained in QI systems. The intention is to have a launch of this across the organisation.

164.04 Staff take-up of the 'flu vaccination was currently at 66%, and it is anticipated that this will improve. The Trust continues to run regular 'flu vaccination sessions for staff. The national target is 70% so there is some way still to go. Norma French added that Philippa

and Richard are sending a joint communications to staff to advise them of their duty of care to patients, and encouraging them to be vaccinated. Richard added that he would make clear that staff who are patient facing have an ethical duty to be vaccinated unless they have a medical reason not to, and would remind staff that they could have no symptoms yet still be infectious to others. Two patients had died of 'flu in hospital the previous year.

164.05 Siobhan Harrington advised the Board that staff were encouraged not to be complacent about infection control, and that leaders are focussing on maintaining high infection control standards.

164.06 ED performance reached 90.1% for October which compared with organisations across London was a favourable performance. Completion of the national staff survey currently stands at 40% of the whole staff group. Norma French added that this had been achieved with input from Communications and the L&D team. Results would be published February/March 2018.

164.07 The Trust's financial performance remained challenging, and the executive team were working with ICSUs and departments to focus on delivering the control total. In month 7 the Trust reported a breakeven position, maintaining the year to date deficit of £1.1 million. There were challenges around our income and activity; however CIP delivery was the bigger risk. NHSI have undertaken a deep dive review of the Trusts CIP programme, and Siobhan thanked all who had taken part in that.

164.08 Gurjit Mahil, Director of Operations for Woman's Services had received the monthly staff award. She is acting Operational Director for Children's Services until the new Director of Operations took up post in March 2018.

The Board approved the report

17/165 Serious Incident Report

165.01 Richard Jennings informed the Board that this report described the incidents reported in October 2017, and noted that as the Trust Board has moved to later in the month he will in future be reporting on incidents reported in the previous calendar month. Richard reminded Board colleagues that the learning from such incidents reminded staff of high risk areas such as the management of sepsis and patient falls, and there was always scope for further learning and therefore improvement.

The Board approved the report

17/166 Safe Staffing Report

166.01 Introducing this item, Philippa Davies presented actual versus planned staffing levels in October as set out in the report.

166.02 Philippa Davies informed Board colleagues that October had been another challenging month and the Trust continued to have a high number of vacancies and unfilled shifts. The staff bank bonus scheme has been implemented has seen an increase in bank filled shifts. There are new recruits coming from abroad, and Sarah Hayes would lead on ensuring these new nurses were allocated appropriately across the organisation to areas of highest need.

166.03 Steve Hitchins queried the figures in appendix 2, as there appeared to be fluctuation in the HCA figures, and wondered if there was any mitigation required to resolve this.

Philippa Davies responded that this was primarily dependant on the number of patients and in particular those requiring special 1-1 care.

The Board approved the report

17/167 Quality and Patient Safety Report Q2 July to September

167.01 Richard Jennings began his report by informing Board colleagues there is a detailed focus on pressure ulcers as one of the "Sign up to Safety" priorities. He described the comparison between last year and this year's figures and the distinction between hospital and community. He advised the Board that patients in hospital were under our care 24 hrs a day which meant that every intervention could be made to prevent pressure ulcers, and prevention of pressure ulcers was far more of a challenge when caring for patients in the community.

167.02 Richard told the Board of a day he spent with the North East Haringey District Nursing team, visiting patients in their homes and seeing the interventions required to prevent patients getting pressure ulcers. There was a need to understand that preventability had a very different meaning in the community to the hospital. Explicit co-ordination between family member, carers, DN and other primary care services were really important and had underlined for him the challenge it is to reduce numbers in the community. The trend was however one of improvement although the Trust was not yet where it wanted to be in terms of the reduction of grade 3 and grade 4 pressure ulcers. Steve Hitchins commented that he was struck by the challenges of treating pressure ulcers in the community especially with those patients who might be reluctant to take advice.

167.03 The National cardiac arrest audit data that showed Whittington Health's position compared to the rest of the country in terms of the number and outcome of the cardiac arrests. A review of the rate of cardiac arrests per 1000 admissions puts Whittington Health as the 6th lowest in the country.

167.04 Richard drew the Boards attention to the C. Diff figures on Cloudsley ward. He reported that whilst action had been taken at the time some had wondered whether there was more long term action that needed to be taken. Richard did not feel that there was a fundamental issue on Cloudsley ward, but at the same time felt some focused work was required to minimise the risk of a recurrence. This was a timely reminder that we must not depart from best practice, and take every necessary step to prevent any risk of transmission. This will be kept under close observation, and further interventions will be taken if required.

167.05 Richard Jennings confirmed that the next and Patient Safety Report will be provided for the Board meeting in January 2018.

The Board approved the report. Patient Safety Report to be provided for the Board meeting in January 2018.

17/168 Finance report

168.01 Steve Bloomer reported that the Trust had broadly broken even in the month, against a planned surplus of £700,000. The operational income in the month was to plan and the Trust had received STF monies. There was an improvement overall in clinical income. In expenditure, however, both pay and non-pay had increased despite the cost improvement programme having been stepped up in month 5. The main issue for the Board to note was the run rate which continued to move further away from the target required to achieve the STF funding at the end of Quarter 3.

168.02 Steve Bloomer reminded the Board there were only two points in the year in which the organisation could negotiate its control target with NHS Improvement (month 6 and month 9). As the next Trust Board is 31/1/18 and the returns for month 9 reporting period are required by 15/01/18, Steve Bloomer requested that the Board delegate to the Finance and Business Committee the decision to review next month's report, and confirm whether the Trust should enter into discussions with NHS Improvement.

168.03 Siobhan Harrington confirmed that she would meet with Steve Bloomer, Carol Gillen and the team to discuss what corrective action was required and feed back to the Finance and Business Development Committee on 15/12/2017 the actions being taken providing assurance that the organisation would meet the control total.

The Board approved the report and recommendations

17/169 Performance Dashboard month 7

169.01 Carol Gillen opened her report by talking about the ED target, reiterating that 90.1% had been achieved in October. The improvement was attributed to a strong focus on flow co-ordination throughout Whittington Health and other organisations in the pathway. One challenge over the summer had been around 12 hour mental health breaches, of which there had been no further breaches since October. This reflected the ongoing work to streamline the pathway for mental health patients.

169.02 Cancer targets and RTT had been achieved. Complaints response times were still at 72%. Dedicated support was being provided to the PALS team and performance continued to be monitored at the quarterly performance review meetings.

169.03 Included in this report was the 2 hour DN response times for twilight and out of hours services. Carol advised that from January more of the community indicators (particularly waiting times) would be profiled in the dashboard.

169.04 Siobhan Harrington noted the new community indicators for Health Visiting in the report. Carol Gillen explained that the Children's ICSU was to look at a range of metrics which would be included in future Board reports.

169.05 Steve Hitchins requested assurance that reports would include progress on those targets not currently being met, also that there should be inclusion of more indicators which are outcome focussed. He would also like to see indicators that showed how the Trust was performing against its corporate objectives.

The Board approved the report. It was agreed that the revised dashboard is presented at a the January Board meeting.

17/170 Section 75 Annual Report Islington LA

170.01 Janet Burgess highlighted the main points from the Annual Report which she indicated had been previously presented to the Council's Executive. This included the development of the discharge to assess pathways where patients are assessed at home for what is needed within 2 hours of discharge rather than in the hospital. Islington continues to perform well in maintaining a low number of delayed transfers of care (delays of people leaving the hospital).

170.02 One of the priorities for next year was to develop a sustainable and robust single point of access to social care. Much work was being undertaken on this process to make it more effective so that when people contacted social care it was clear what the next steps should be.

170.03 Janet Burgess reported that there is strong partnership working between Islington Social Services and health services within Whittington Health NHS Trust and this continues to move in a positive direction.

The Board approved the report

17/171 Workforce Assurance Committee draft minutes

171.01 Graham Hart highlighted the main points from the minutes. Helen Gordan had presented a report on quarter 2 where there was reference to an increase in bank and agency staff. An agency reduction task force has been established to assist in this area; the bank bonus scheme will also support this process. A series of deep dives were planned to look at individual ICSUs.

171.02 The committee had also congratulated the team on the huge effort made to recruit nurses from abroad with 40 staff recruited from the Philippines and a very successful visit to India with offers to 138 potential staff members. There had been much discussion about how we recruit and retain and support staff from abroad once they arrive.

The Board noted the report

17/172 Any Other Business

Steve Hitchins reminded members that the Christmas tree lights were being turned on in the atrium at 4.20pm.

Questions from the Public

No questions raised.

Date of next Trust Board Public Meeting

Wednesday 31st January 2018,

* * * * *

Action Notes Summary

Minute	**Action**	**Date**	**Lead**
159.01	Board Assurance Framework and Corporate Risk Register are being reviewed. They will be discussed at a future Board seminar and return to the Board in March 2018 following this work.	March 2018	SMH
167.05	Patient Safety Report to be provided for the Board meeting in January 2018.	Jan 2018	RH
168.03	SMH, SB and CG to meet report to finance and business committee on the corrective action to address CIP underperformance	Jan 2018	SMH
169.05	The revised dashboard, incorporating new community metrics, presented at a the January Board meeting.	Jan 2018	CG

Whittington Health
NHS Trust

Trust Board
31 January 2018

Title:	Chief Executive Officer's Report for the Trust Board		
Agenda item:	**18/005**	**Paper**	**02**
Action requested:	For discussion and information		
Executive Summary:	The purpose of this report is to highlight specific issues to the Trust Board and to update the Board on local, regional and national key issues facing the Trust		
Summary of recommendations:	To note the report		
Fit with WH strategy:	This report provides an update on key issues for Whittington Health's strategic intent		
Reference to related / other documents:	Whittington Health's regulatory framework, strategies and policies		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Risks captured in risk registers and/or Board Assurance Framework		
Date paper completed:	24 January 2018		

Author name and title:		**Fiona Smith Communications & engagement lead**		**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 REPORT

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

QUALITY AND SAFETY

The Trust has remained busy throughout January and we have implemented our Winter Plan. Staff across the community and hospital have continued to work incredibly hard and are focused on quality and safety at this time.

On the afternoon of 17th January we experience a fire incident. The fire was put out quickly by staff, and limited damage was incurred. Staff teams responded well as some smoke spread to wards and necessitated the movement of patients. The movement was executed swiftly and professionally, with Fire Marshalls and teams working well together, so no patients or staff were adversely affected. The incident is being dealt with as a serious incident.

Emergency Department

Performance against the 95% target increased to 91.3% in November 2017. Performance was challenged in December at 86.5%, however this is an improvement on performance in the previous year, where performance was 85% for both November and December 2016.

In November and December 2017 the Trust saw an extra 300 patients each month compared to the same months in 2016. The Trust reached 100,000 ED attendances over the previous 12 months for the first time in early January 2018.

Cancer Performance

The Trust underperformed against the 62 days cancer target for November 2017, with a performance of 83.1% against the standard of 85%. More detail on the performance will be provided under the performance report on the agenda.

MRSA Bacteraemia

There was 1 new MRSA bacteraemia reported in November 2017.

Community Average Waits

This is the first time this data is added to the dashboard. The format reflects the national waiting time indicator.

Flu vaccine uptake

We are at 78% staff immunised against the flu, against a target of 70%. We continue to be one of the highest London NHS Trust for the flu vaccine uptake. We will continue providing the vaccine up to the end of the financial year. It is really important as many of our staff as possible are vaccinated in order to protect vulnerable patients and friends and family from a virus that can kill.

GOVERNANCE

Risk management strategy

The current Risk Management Strategy is for the period 2015 – 2018. This is now being reviewed and updated, and will identify any implications for the reporting of risks through

the Board sub committees, and changes needed to the BAF and Corporate Risk Register.

The revised Risk Management Strategy and recommendations will be presented to the Executive Management Group in February and brought to a Board Seminar for review. It will be presented to the March Trust Board for discussion and approval.

Lower Urinary Tract Service

The Trust met with the LUTs patient group 23 January and attended the JHOSC on 26 January.

The clinic is currently not open to new patients. The Board is reminded that the RCP Invited Service Review Panel recommended that "until the future of the service has been determined by the Trust and commissioners, no new patient referrals should be accepted into the LUTS clinic". However, the clinic has remained open to current NHS patients.

A Whittington Health Multi-Disciplinary Team (MDT) has been established – the Pelvic Floor MDT. Commissioners are determining how well this MDT is working to meet the governance and safety purpose for which it was set up. The Trust awaits the receipt of the Commissioners report.

A draft service specification is currently being reviewed by Commissioners. Once this is approved by commissioners, Whittington Health and UCLH will write a business case that outlines the Trusts approach and costs to delivering the service, demonstrating compliance with the commissioner approved service specification.

Should commissioners approve the business case and include the service in the 2018/19 contract, the Trust can progress the succession plan to replace Professor James Malone Lee, who retired from University College London (UCL) in September 2016, and since that time has been employed on a locum contract by the Trust to continue working part time to help deliver the LUTS.

It is currently intended to progress a joint appointment with UCLH of a consultant to provide leadership to the LUTS once Professor James Malone Lee is no longer working there.

STRATEGIC

Estates Strategy

The Trust attended the public meeting called by Defend the Whittington Hospital Coalition on 11 January 2018. We also attended the LB Islington Health and Care Scrutiny Committee on 22 January 2018.

The Trust described the Strategic Estates Partnership and outlined the procurement process undertaken to choose the Strategic Estates Partner. We described the current state of the Whittington Health estate, maintenance backlog and need for development and housing to ensure sustainable service for local people into the future. We responded to questions raised by local politicians, MPs and local people.

The Trust remains committed to ongoing engagement with local people and staff in the development of its estate masterplan.

The Trust awaits approval from its regulator, NHS Improvement, to proceed to awarding the contract to its preferred bidder.

North Central London Health and Care Partners

I have recently taken up the NCL lead for the Workforce workstream and will be attending both the NCL Chief Executives Group and The Delivery Board in future.

WORKFORCE

Staff Survey

The results from the Staff Survey will be sent throughout January and February with the full results published on Tuesday 6th March. Every Trust remains under embargo until 6th March and so no results are to be shared outside of the organisation. HR and members of the OD team will be working with teams to consider what action to take in response to any results which require further exploration or intervention. This year the OD team have undertaken numerous team activities in different ICSUs and Departments with positive feedback, as well as provide coaching for individuals. The final response rate was higher than originally though (to be confirmed early March). The Housekeeping team increased their response rate the most of all teams responding to the survey, and so won the £250 vouchers as a prize.

Leadership Development

This week we celebrated 'graduates' of our 'Moving Forward' and 'Stepping Stones' programmes. Programme leaders and managers supported their staff at the presentations, and members of the Stepping Stones cohort shared with us their learning and aspirations. We are in the process of commissioning for the next cohort of Stepping Stones and combine with apprenticeships. For those who might have thought about joining the 'Moving Forward' programme, we hope to welcome them instead onto apprenticeships programmes. Modern apprenticeships are offered at a wide range of levels including degree apprenticeships, and can be offered to existing staff.

Culture

The Trust continues to embed the ICARE values and behaviours across the organisation. We have commissioned Professor Duncan Lewis to carry out research into bullying and harassment in the Trust. This work will commence over the coming month. His report, which we be published is expected after the end of this quarter.

Overseas nurse recruitment

In the week starting 22 January we have welcomed the first 4 arrivals from our overseas nursing recruits from the Philippines. The next, larger cohort of staff from the Philippines is scheduled for March. Out of 58 Philippines applicants still going through stages of pre-employment tests and checks, there are a further 24 nurses either awaiting deployment or booked to future cohorts. We are also currently finalising the cohort management for our Indian recruits, with 138 staff offered employment. We have worked with Network Homes to provide accommodation and a bespoke induction and orientation programme for these overseas staff to ensure that they pass their adaptation and secure NMC registration in the shortest possible timeframe, and to support their retention in the Trust.

This work sits alongside a new programme of domestic nurse recruitment which started earlier this month, and which will centrally handle all band 5 nursing recruitment, as well

as support the faster processing of band 5 staff through pre-employment processes and keeping our new recruits in touch with the service

UCLH/WH Workforce Framework Agreement

Late last year this agreement was formally signed between WH and UCLH, designed to improve the portability of staff across both organisations and to enable the mobility of staff between the two Trusts in support of the clinical objectives arising from the trusts' clinical collaboration. The agreement has been developed to ensure observance of clinical governance on all sites, whilst preventing any unnecessary bureaucracy which might impact the work of the Trusts.

FINANCIAL

December Financial Position

The Trust is reporting a £1.0m surplus in Month 9 against a planned deficit of £0.7m. As a result the year to date deficit has reduced to £0.5m and is therefore slightly better than plan, £0.6m deficit, at the end of the third quarter.

The control total has been increased to a £1.3m surplus following the allocation of additional funding (£0.7m) by NHSI and NHSE to support A&E costs currently being incurred in relation to winter.

Having taken into account the improved income run rate, predicted increase in CIP delivery in quarter 4, the non-recurrent actions taken to date and non-recurrent actions agreed with ICSUs the Trust is forecasting the achievement of the 2017/18 control total which is a material improvement.

CIP performance remains significantly behind plan at Month 9, with delivery of savings recorded as £6.1m against an original target of £12.7m. Delivery against the Trust's CIP programme therefore, remains the key risk for the Trust to mitigate in order to achieve its control total.

Good news this month:

- Letter received from National Medical Director for Clinical Effectiveness, congratulating the Trust on its performance in caring for people with Sepsis and the improvements made.
  'I am delighted to inform you that you are one of the trusts which has seen the greatest improvements in indicators 2a) timely identification and 2b) timely treatment of sepsis from the data we have received on the CQUIN'

- We have been accredited as an Endometriosis Centre

- Whittington Health started providing UCLH@Home service on 8 January

- The Trust has signed up to the 'NHS Smoke Free Pledge'

Siobhan Harrington
Chief Executive

Whittington Health

Trust Board

31st January 2018

Title:	**Quarterly Safety & Quality Board Report** **Quarter 3 2017/18 (01 October 2017 – 31 December 2017)**		
Agenda item:	**18/006**	**Paper**	**03**
Action requested:	For the Board to discuss and make any additional recommendations.		
Executive Summary:	This is the regular paper for the Trust Board to provide an overview of safety and quality in the organisation.		
Summary of recommendations:	It is recommended that the contents are discussed		
Fit with WH strategy:	To deliver consistent high quality, safe services.		
Reference to related / other documents:	Quality Account 2016-17 Sign up to Safety Pledges Clinical Strategy 2015-20 CQC standards 7 day services clinical standards		
Date paper completed:	19th January 2018		

Author name and title:		**Richard Jennings, Executive Medical Director**		**Director name and title:**		**Richard Jennings, Executive Medical Director**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**NA**	**Risk assessment undertaken?**	**NA**	**Legal advice received?**	**NA**

1) Executive Summary

This is the regular paper for the Trust Board to provide an overview of safety and quality in the organisation.

This report provides an update on mortality and the Trust's HSMR and SHMI figures remain assuring. On this occasion this report provides an update on the progress against our Sign up to Safety pledge for Learning Disabilities (LD).

2) Contents

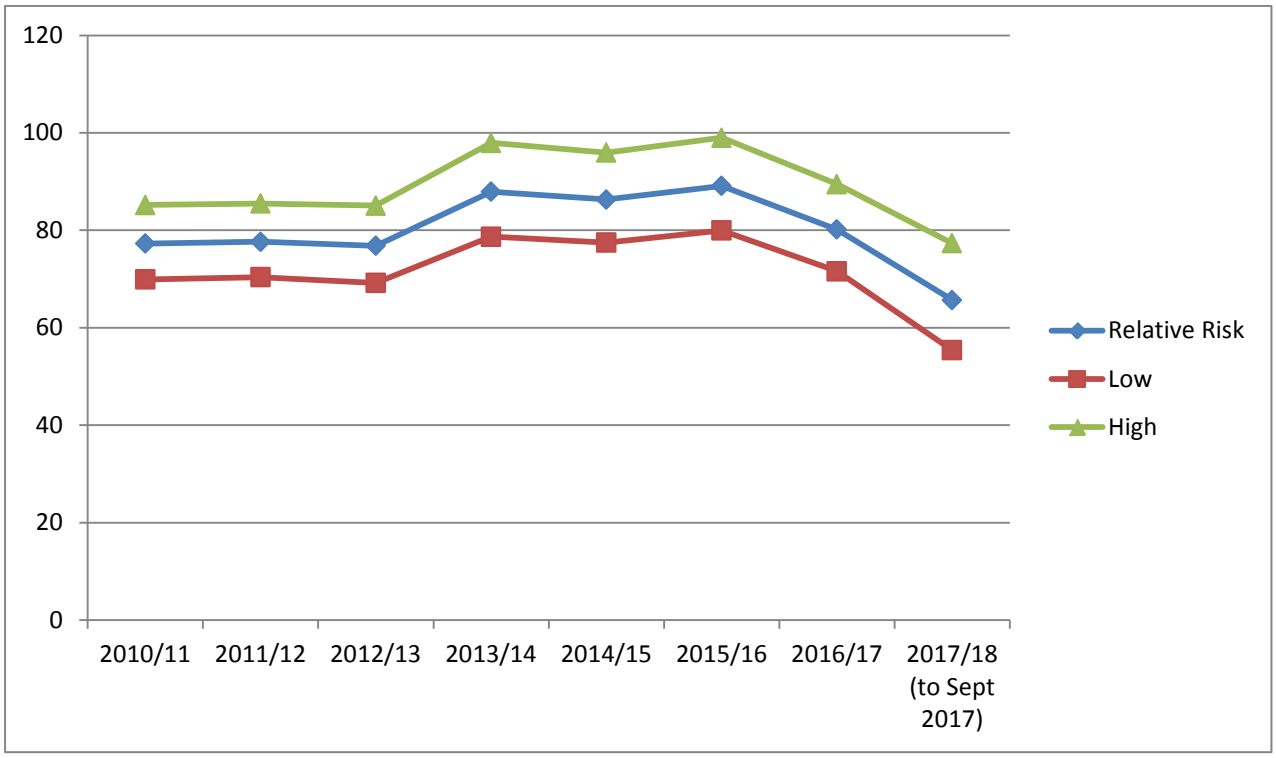
3. Mortality

This Trust's HSMR and SHMI have both been 'lower than expected' since 2005/06.

3.1 Hospital Standardised Mortality Ratio (HSMR)

The Hospital Standardised Mortality Ratio (HSMR) is a measure of the number of deaths in a hospital expressed as a number which is a ratio of the national average, which is set at 100. HSMR is an overall quality indicator that compares a hospital's mortality rate with the average national experience, accounting for the types of patients cared for. It has been used by many hospitals worldwide to assess and analyse mortality rates and to identify areas for improvement. HSMR is calculated as the ratio of the actual number of deaths to the expected number of deaths, multiplied by 100. A ratio less than 100 indicates that a hospital's mortality rate is lower than the average national rate of the baseline year.

Chart 1: Whittington Health Hospital Standardised Mortality Ratio (HSMR) by financial year (April 2010 – September 2017)



The blue diamonds on the above Chart 1 represents this Trust's HSMR. The HSMR reported for each trust includes High and Low values which make up a 'confidence interval' – set here with 95% certainty. This defines the range that can be explained by normal variation within the system and states where 95% of values will fall. If the entire confidence interval range is *below* the standardised mean of 100, there have been fewer (with 95% certainty) deaths in the trust than expected. The opposite is true when the interval range is above the standardised mean.

3.2 Summary Hospital-level Mortality Indicator (SHMI)

SHMI was developed in response to the public inquiry into the Mid Staffordshire NHS Foundation Trust. It is used along with other information to inform the decision making of Trusts, regulators and commissioning organisations.

National guidance emphasises that SHMI is not a measure of quality of care, but is meant as an indicator that may suggest the need for further investigation.

SHMI is calculated in a way that is similar to the HSMR calculation, but unlike HSMR, the SHMI calculation takes into account deaths within 30 days of discharge of hospital as well as inpatient deaths.

Whittington Health continues to have the lowest SHMI score in England. We consider this data is as described because the data is obtained from Hospital Episodes Statistics data and sourced via the HSCIC Indicator portal.

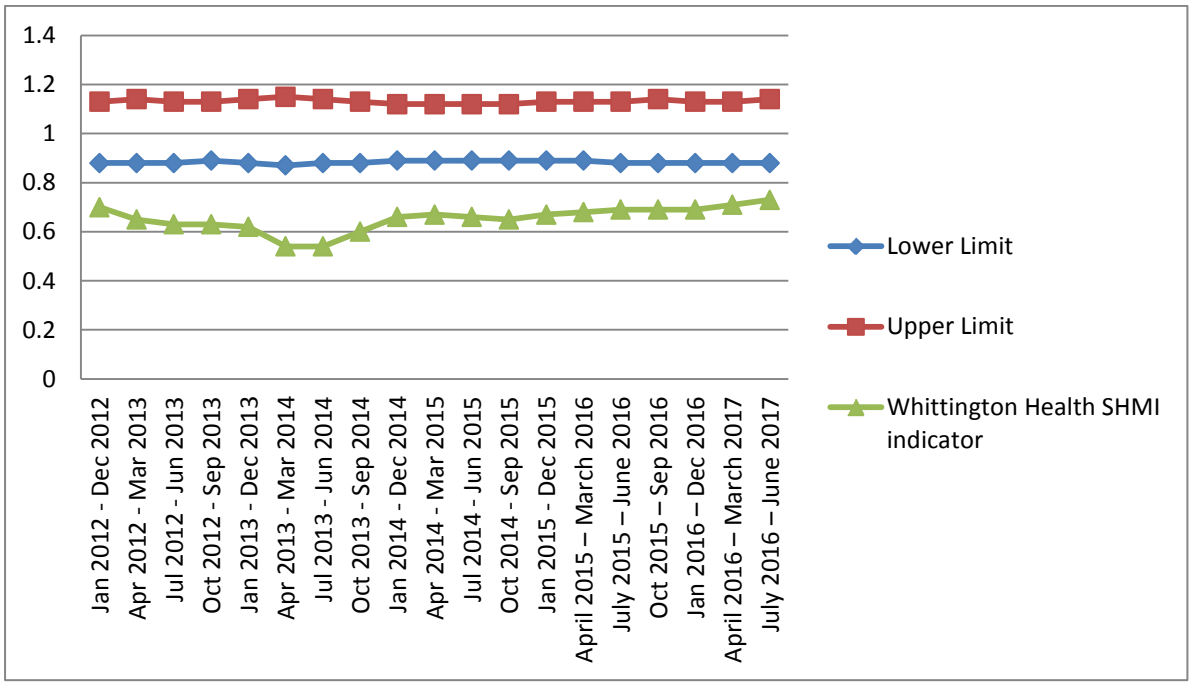
The most recent data available (released in December 2017) covers the period July 2016 – June 2017:

Whittington Health SHMI score	**0.7261**
National standard	**1.00**
Lowest national score	**0.7261 (Whittington Health)**
Highest national score	**1.2277**

Table 1: Whittington Health Summary Hospital-level Mortality Indicator (SHMI) (April 2010 – September 2016)

Data Period	Lower Limit	Upper Limit	Whittington Health SHMI indicator
Jan 2012 - Dec 2012	0.88	1.13	0.7
Apr 2012 - Mar 2013	0.88	1.14	0.65
Jul 2012 - Jun 2013	0.88	1.13	0.63
Oct 2012 - Sep 2013	0.89	1.13	0.63
Jan 2013 - Dec 2013	0.88	1.14	0.62
Apr 2013 - Mar 2014	0.87	1.15	0.54
Jul 2013 - Jun 2014	0.88	1.14	0.54
Oct 2013 - Sep 2014	0.88	1.13	0.6
Jan 2014 - Dec 2014	0.89	1.12	0.66
Apr 2014 - Mar 2015	0.89	1.12	0.67
Jul 2014 - Jun 2015	0.89	1.12	0.66
Oct 2014 - Sep 2015	0.89	1.12	0.65
Jan 2015 - Dec 2015	0.89	1.13	0.67
April 2015 – March 2016	0.89	1.13	0.68
July 2015 – June 2016	0.88	1.13	0.69
Oct 2015 – Sep 2016	0.88	1.14	0.69
Jan 2016 – Dec 2016	0.88	1.13	0.69
April 2016 – March 2017	0.88	1.13	0.71
July 2016 – June 2017	0.88	1.14	0.73

Chart 2: Whittington Health Summary Hospital-level Mortality Indicator (SHMI) (January 2012 – June 2017)



In the above Chart 2 the lower limit (blue diamonds) represents the lower 95% confidence limit from the national expected value; the upper limit (red squares) represents the upper 95% confidence limit from the national expected value.

4. Infection control report

4.1 MRSA Related Issues

There have been two Trust-attributable MRSA bacteraemia since 1 April 2017. In 2016/17 we had two Trust-attributable MRSA bacteraemia.

The first was reported in June 2017 and was referred to in the Quarter 2 2017/18 *Quarterly Safety and Quality Board Report*. It is likely that it was a contamination rather than a real bacteraemia. The Department of Health final review and attribution is still awaited.

The second has been determined as avoidable. This was identified on 5th November 2017. The final Post-Infection Report (PIR) is being completed but it was decided that it was likely to have been cannula related. An action plan is being developed and this will be presented to the Infection Prevention and Control Committee in January 2018.

The Infection Prevention and Control Team (IPCT) continue to monitor, investigate and feedback on MRSA colonisation transmission events on our COOP wards, Orthopaedic Ward and Augmented Care Areas (Critical Care and Neonatal Unit). Table 2 documents MRSA colonisation events. In Quarter 3 2017/18 there have been seven MRSA colonisation acquisition events, with one Trust attributable case.

Table 2: Whittington Health MRSA colonisation acquisition events April 2017-December 2017 (two Trust-attributable cases)

MRSA acquisition April 2017 - March 2018													
	Apr	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Running total**
ITU	0	0	0	0	0	0	0	0	0				0
NICU	0	0	0	0	0	0	0	1	1				2
SCBU	0	0	0	0	0	0	0	0	0				0
Meyrick	0	0	0	1	2	0	0	0	0				3
Cloudesley	0	0	3	0	1	0	0	1	1				6
Bridges - Cavell rehab	0	3	0	0	0	1	1	0	0				5
Coyle #NOF	0	0	0	0	0	2	0	0	0				2
Cavell	0	0	0	1	0	1	0	1	1				4
Totals	0	3	3	2	3	4	1	3	3				22

4.2 *Clostridium difficile* diarrhoea

For 2017-18 there have been ten cases. Consultant-led Post-Infection Reviews have been held on all cases and the reports disseminated to relevant parties. The agreed tolerance for 2017/18 has also been set as 17. The breakdown of cases by ward is shown in table 3.

Table 3: Whittington Health *Clostridium difficile*–associated diarrhoea cases by ward

Date	**No. of Cases**	**Cumulative no. of cases**	**Ward**
April 2017	2	2	Coyle, Cloudesley
May 2017	3	5	Victoria, Coyle, Cloudesley
June 2017	0	5	
July 2017	1	6	Cavell
August 2017	0	6	
September 2017	1	7	Cloudesley
October 2017	3	10	Cloudesley x 3
November 2017	0	10	
December 2017	0	10	

As described in the Quarter 2 2017/18 *Quarterly Safety and Quality Board Report*, Cases 7 (September 2017) to 10 (October 2017) shown in table 3 were all patients on Cloudesley Ward. An outbreak was declared. Following a review, it was found that Case 7 was not a new infection, but was a relapse in a patient who had tested positive for *C. difficile* on admission in August 2017, but as there was 28 days between specimens this is classed as a new infection. Cases 8 and 9 were in a bay together, and as their ribotypes are the same, although this is not certain, it is likely that one case is due to cross-infection from the other. A *Clostridium difficile* outbreak is defined as any situation in which cross-infection from one patient to another has occurred, so this is being identified as an outbreak. Cases 7 and 10 are of different ribotypes to cases 8 and 9, and therefore are not related.

The Infection Prevention and Control (IPC) nurses will continue daily review of all *Clostridium difficile* Toxin (CDT) requested samples daily. The IPC nurses update the JAC electronic prescribing system and the Medway electronic patient record with alerts to highlight patients who have previously been CDT positive.

4.3 MSSA/E*.coli* Bacteraemia Episodes

There have been five Trust-attributable MSSA bacteraemia episodes since 1 April 2017. There are no national or local thresholds for MSSA bacteraemia.

There have been five *E.coli* bacteraemia episodes since 1 April 2017 and short Post-Infection Reviews have been completed on all but the fifth case. We are attempting to reduce the number of *E.coli* bacteraemias by 20% this year to be on target for the national reduction of 50% by 2021. In 2016/17 there were 14 Trust-attributable *E.coli* bacteraemia episodes, therefore we have a threshold of 12 *E.coli* bacteraemia episodes in 2017/18.

4.4 Infection Prevention and Control Training

Infection Prevention and Control mandatory clinical and non-clinical training is now provided predominately via E-learning. As of 15th December 2017, 78% of Whittington Health staff have received IPC training within the last two years; this is a rise of 4% from the last Quarter. The target for IPC training is 90%.

Bespoke clinical and non-clinical face to face IPC training is delivered at least weekly at various sites throughout the ICO by our IPC nursing staff. IPC Link Practitioner study days are held twice a year.

4.5 Other Relevant Healthcare Associated Infection (HCAI) Issues

Carbapenemase Producing Enterobacteriaceae (CPE)

Since the last *Quarterly Safety and Quality Board Report* there have been two new CPE cases at Whittington Health. Both patients were identified as positive for CPE before they were admitted to our Hospital, and this was highlighted in a timely way to clinical staff.

For the year 2017/18 none of the CPE cases are Trust attributable.

Tuberculosis (TB)
In August 2017 a clinical staff member was found to have open respiratory tuberculosis (TB). A root cause analysis investigation into this incident highlighted some areas of learning to mitigate the risk of any future incidents. This includes a revision to the new starter documentation procedure and ongoing training to staff (via Grand Round, Link Nurse teaching as well as ward meetings) highlighting the risks of TB to healthcare workers. Staff are being reminded to be aware of the symptoms in themselves as well as patients and due to TB being so demographically focused on particular risk groups, the trust is also introducing targeted awareness events to specific at risk groups of staff.

5. Sign up to Safety

'Sign up to Safety' is a national three-year patient safety initiative, partly in response to the Francis and Berwick Reports. Its aim is to reduce avoidable harm across the country by half within three years**.** In March 2015 the Trust devised our own local Sign Up to Safety priorities. There have been chosen to provide a strong foundation for the Trust to continually promote quality across the organisation.

Table 4 shows the Sign up to Safety pledges made by the Trust. This year, as in previous years, the quality priorities set for the Trust reflect the Trust's Sign up to Safety pledges; these were developed in consultation with the leads for each of the safety domains.

Table 4: Update on progress against Whittington Health Quality Account priorities and 'Sign up to Safety' pledges for 2017/18 – April – September 2017

Domain	Whittington Health Quality Account priorities and 'Sign up to Safety' pledges for 2017/18	Progress in Quarter 1 and Quarter 2 2017/18
AKI	At least 75% of patients with AKI include an AKI diagnosis in their discharge letter	Insufficient information currently available, data gathering in process
	At least 90% of patients with grade 3 AKI are seen by Critical Care Outreach Team within 24 hours.	Q1 96% Q2 97%
	90% of patients that develop grade 3 AKI have a medicine safety review within 24 hours	Q1 50% Q2 40%
Sepsis	We will achieve the national CQUIN for sepsis (**90% of eligible patients in ED screened for sepsis**) with a particular focus on sepsis developing during inpatient stay.	Q1 97% Q2 91%

<table>
<tr><td></td><td>We will work in partnership with local CCG's to raise patient awareness of sepsis including the distribution of "Could it be sepsis" leaflets distributed to relevant local healthcare provider centres.</td><td>• Sepsis awareness day attended by 263 community and Hospital staff.
• All community nurses now receive sepsis awareness training in their induction.
• 'Could it be sepsis' leaflets distributed to 26 community sites (the Trust has 46 community sites in total).</td></tr>
<tr><td rowspan="2">Falls</td><td rowspan="2">We will introduce StopFalls bundles across the trust, and achieve 80% compliance with falls assessment documentation on the Acute Admissions Unit (AAU) and Care Of Older People wards (COOP)</td><td><u>AAU</u>
Q3 100%
<u>COOP</u>
Q2 62%
<u>Victoria Ward</u>
Q3 55%</td></tr>
<tr><td>We will reduce the number of avoidable falls resulting in SERIOUS HARM to patients year on year</td><td>2014/15: 11
2015/16: 6
2016/17: 6
2017/18 (to Q3): 4</td></tr>
<tr><td rowspan="2">Pressure Ulcers</td><td>To achieve a year on year reduction in all grades of pressure ulcers across the ICO</td><td><table><tr><th>Q1+Q2</th><th>Community</th><th>Acute</th><th>% Improve-ment</th></tr><tr><td>Grade 4</td><td>1</td><td>0</td><td>67</td></tr><tr><td>Grade 3</td><td>9</td><td>4</td><td>20</td></tr><tr><td>Grade 2</td><td>10</td><td>13</td><td>12</td></tr></table></td></tr>
<tr><td>We are developing a cross borough target on the 'React to Red Initiative'</td><td>• Awareness events through attendance at Islington carer hub and Islington Adult Safeguarding Group.
• Training session provided to Islington GPs on PU recognition.
• Article published in Islington newsletter.
• Information distribution to pharmacists, care agencies, practice nurses and GPs, including on the GP portal for Islington.</td></tr>
</table>

LD	75% of patients who present to the Emergency Department with learning disabilities are given a priority assessment (i.e. seen in **<2 hours**)	73.3%
	We will introduce a care pathway for mothers with learning disabilities in the hospital	LD draft protocol in final stages and on target to be approved, ratified and in circulation by 31/03/2018
	All children and young people entering CAMHS for a choice appointment will be screened for Learning Disabilities	Q1 - 100% Q2 – 100% Q3 – 100%

5.1 Sign up to Safety progress update – Learning disabilities

- **Target 1**: **75% of patients who present to the Emergency Department with learning disabilities (LD) are given a priority assessment (i.e. seen in <2 hours)**

This was a new target set for 2017/18; previous 2015/16 and 2016/17 we had a target of 75% of inpatients with LD to meet their LD specialist nurse on admission, which we achieved.

Between Apr and Dec 2017 71% of patients who presented to ED with a known LD were given a priority assessment and fast tracked to see a doctor in less than 2 hours. Progress against this has been achieved through continued response to LD alerts from ED staff and small badges (stickers) are in use to identify LD patients to be fast tracked. We are aiming to meet the 75% target by April 2018.

- **Target 2: We will introduce a care pathway for mothers with learning disabilities in the hospital**

The Trust's LD Specialist Nurse and the Children's Safeguarding Lead for Maternity have developed a pathway through a series of listening events and feedback from patients in line with guidance from the 2015 paper '*Hidden Voices of Maternity - Parents with Learning Disabilities Speaks Out'*. The draft pathway will now be circulated for final comments and is on target to be approved, ratified and in circulation by 31 March 2018.

- **Target 3**: **All children and young people entering CAMHS for a choice appointment will be screened for Learning Disabilities.**

This was a new target introduced for 2017/18. We are currently meeting this target and 100% of children and young people who are entering the Trust's Children and Adult Mental Health Service (CAMHS) are being screened for learning disabilities. This target is being achieved through sustained compliance with the eligibility assessment for Global Learning Disabilities (ICD10).

6. References

1. NHS Digital Indicator Portal, (September 2017, NHS Digital), available from https://indicators.hscic.gov.uk/webview/
2. QI Life Platform, UCL Partners, available from https://uclpartners.com/what-we-do/improvement-and-capability/life-qi-platform/
3. *'NHS Hidden Voices of Maternity - Parents with Learning Disabilities Speaks Out'* (August 2015, Change and PEN), *available from* http://patientexperiencenetwork.org/wp-content/uploads/2015/10/Hidden-Voices-of-Maternity-Executive-Summary-FINAL-260815.pdf

Whittington Health
NHS Trust

Magdala Avenue
London N19 5NF

Whittington Health Trust Board
31 January 2018

Title:	Learning from death – Quarter 2 2017/18		
Agenda item:	**18/007**	**Paper**	**04**
Action requested:	For information and discussion		
Executive Summary:	This paper has been written to give the Trust Board oversight of the "learning from deaths" reviews that formally commenced in April 2017 in line with new NHS England guidance. There were 80 inpatient deaths (including ED) in Q2 2017/18 62.5% of all inpatient deaths were reviewed in a structured departmental mortality review meeting. In Q2 July to September 2017/18: • 80.2% of all category A deaths were reviewed (desired performance 90%) • 57.5% of all category B deaths were reviewed (desired performance 25%) There was 1 'potentially avoidable' death recorded in this time period. This patient death was reviewed fully as a serious incident. There is no benchmarking of data with other Trusts as we are being encouraged not to compare data. However, at a recent UCLP conference other Trusts noted that they were managing to review between 15-35% of inpatient deaths. A robust methodology to independently and systematically review deaths of inpatients has been developed, but administrative support is required to sustain and improve this. Learning from mortality reviews is valuable to improve safety culture, cross team and organisational working, and to ultimately improve the experience for the patients' family and carers.		
Summary of	To support the areas identified for improvement.		

recommendations:	
Fit with WH strategy:	Working together with families and carers
Reference to related / other documents:	NHS Improvement, "Learning from deaths in the NHS" (March 2017), available from https://improvement.nhs.uk/resources/learning-deaths-nhs/#h2-provider-policies-on-learning-from-deaths
Reference to areas of risk and corporate risks on the Board Assurance Framework:	
Date paper completed:	23/01/18

Author name and title:		**Dr Julie Andrews Associate Medical Director**		**Director name and title:**			
Date paper seen by EC		**Equality Impact Assessment complete?**		**Risk assessment undertaken?**		**Legal advice received?**	

Learning From Death - Trust Board Paper

Dr Julie Andrews, Associate Medical Director (Quality Improvement /Patient Safety) and Learning from Death clinical lead

Covering period 1st July 2017 to 30th September 2017 (Quarter 2 2017-2018)

Introduction/Background

There has been an informal system of departmental mortality review processes at Whittington Health, in line with domain 2 of GMC good medical practice, for many years. Following the launch of the NHS quality board guidance "Learning from Death" this mortality review work needs to occur more formally ensuring as a trust 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 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 of the Trust (the After Death Proforma - 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

In line with the NHS Quality board 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 guidance but gives a clearer pragmatic flowchart about which inpatient/ED deaths to review when time is limited. The policy outlines all "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 A)

The mortality dashboard provided by NHSE is shown in Appendix A and demonstrates both the total number of deaths reviewed plus the death avoidability scores given. There were 80 deaths recorded in Q2 (includes all inpatient deaths, ED deaths and neonatal/IUD above 24 weeks gestation). There was **one potentially avoidable** patient death recorded in Quarter 2 2017/18, (1 potentially avoidable death in Q1). This patient's death was reviewed fully as a serious incident. The SI report describes the care given to a 91-year old patient who died shortly after an unwitnessed fall resulted in a head injury. There was shared learning from the SI related to multiple bed moves and allocation of staff and his family were involved in the process.

30 patient deaths in Q2 (37.5%) were not systemically reviewed in a department mortality review process but the majority (26 out of 30) were "category B" deaths. 4 category A deaths were not reviewed; these were deaths in care of the older person, cardiology (2) and gastroenterology patients.

The dashboard outlines the avoidability of death judgement scores for inpatient/ED deaths in Q2 and this is summarised below, in table 2. There were no deaths in patients with learning disabilities this quarter.

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	0
	5	4
	6	45

	NOT REVIEWED	30 (4A and 26B)

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 (ED/paeds/WH)	Percentage of completed discharge summaries sent to GP within 72 hours	Missed coroners referrals
Desired performance	>90%	>25%	>90%	>90%	0
July	83.4%	50%	24.1%	67.7%	0
August	57.1%	39.2%	35.5%	85.7%	0
September	100%	83.3%	45.5%	71.4%	0

Themes from Mortality Reviews (not exhaustive)

i) Key areas for improvement

a) Minimal/no administrational support for departmental and corporate mortality processes. Mortality teams could potentially increase compliance with current process and 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) Need for more detailed and/or timelier and/or realistic treatment escalation plan completion.

c) Improving documentation of patient management plans including **explicit** discussion with patients and families/carers. This theme has also been identified as an issue in 7/7 services audit.

d) Evidence of unreported medicine safety incidents (low/no harm) in 2 patients in Q2. Reported medicine safety incidents (oxygen prescribing and missed doses of medications) had already been addressed prior to mortality reviews.

e) Evidence of delays in referrals of patients to other teams/investigations/ management whilst inpatients (6 patients). Delays in treatment of sepsis found in 1 mortality review.

f) Continued QI work on falls required to ensure all steps of falls bundle introduced for all patients at very high risk of falls.

g) Non-compliance with completion of after death proforma and discharge summaries. These are vital to improve communication of death to primary care and other relevant teams. These are left to individual teams rather than a ward based compliance system.

h) Need to improve process of mortality reviews in some teams - sharing limited, not timely, not multi-disciplinary or not educationally focused.

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) Improved linking of 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. oxygen therapy, earlier discussions about patient treatment escalation plans and need for earlier referrals to specialist teams.
f) Improved safety culture – linking mortality reviews to guideline refinement (e.g. falls, sepsis), ensuring feedback at patient safety forum, triangulating with complaint/PALS team and legal team to improve learning and feedback to families.
g) Falls QI data shows that falls incidence/occupied bed days has reduced steadily over last 15 months.

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

Recommendation	Key actions	Lead	Date
Surgical ICSU requires urgent admin support for M&M process/QI. Finances not currently agreed.	Business case to be written Clearer idea of surgical data required before case written	Surgical audit lead/surgical ICSU Surgical audit lead	30/11/17
Other teams may require access to administration support for mortality process.	Review of admin support for other teams.	Other Clinical Directors	31/12/17
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 residents).	ReSPECT QI project Involvement – pilot through UCLP	Mortality leads ReSPECT project leads	31/03/18

Recommendation	Key actions	Lead	Date
2) Encourage further family/carer involvement through partnership working.	Specific educational project required in surgery Involvement of families/carers in educational projects through "learning together" project	Surgical ICSU leads	31/03/18
3) Revised QI project around improving ADP compliance to promote better death communication	QI project group formed with key objectives	Dr Restrick	30/04/2018

Summary

Trust board should expect to see quarterly "learning from death" data and a learning based report every other quarter. The next trust board report will contain "learning from death" data only.

We had one potentially avoidable patient death this Quarter from the 62.5% of inpatient deaths that have been systematically reviewed in a mortality review meeting. This potentially avoidable death was reviewed fully as an SI and the learning shared locally, through the patient safety forum and spotlight on safety newsletter.

There is no benchmarking of data with other trusts as we are being encouraged not to compare data but at a recent UCLP conference it is clear that other trusts are not completing as many mortality reviews as Whittington Health with most performing between 15-35% of their mortality reviews.

We have developed a robust methodology to independently and systematically review deaths of inpatients but to improve on this the mortality leads are recommending that the administrational support for the project is approved once a business case is finally written to ensure higher amount of mortality reviews are completed.

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 – NHSE Mortality Dashboard

Learning from Deaths Dashboard

Organisation	**Whittington Health**
Financial Year	**2017-18**
Month	**September**

Learning from Deaths Dashboard

Purpose of the dashboard

This suggested dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by NHS Trusts. Trusts may use this to record relevant incidents of mortality, deaths reviewed and lessons learnt to encourage future learning and the improvement of care.

Guidance on what should be recorded in individual fields is provided below, alongside instructions for completing and updating the dashboard. This guidance on individual fields complements the wider guidance provided in the National Framework on Learning From Deaths and separate methodology guidance on the Structured Judgement Review (SJR) as developed by the Royal College of Physicians (RCP). The dashboard is not prescriptive and Trusts may set their own definitions according to local goals and data availability, although minimum requirements are set out in the framework.

To update this dashboard - enter your data on the "Data" worksheet. The dashboard sheet is automatically updated.

Guidance on individual fields

Field No.	Field	Description of Field
Recording data on structured judgement reviews:		
1	**Total Number of Deaths in scope**	Includes ALL adult inpatient deaths and all adult deaths in the Emergency department. Includes all paediatric inpatient deaths and deaths in the emergency department. Includes all maternity inpatient deaths and deaths in the emergency department. Includes all neonatal deaths and stillbirths registered through the trust. Deaths 30 days post discharge are not included in this review.
2	**Total Number of Deaths Reviewed under the SJR methodology**	This is the total number of deaths for which the care provided to the patient has been reviewed by your Trust. This may be a combination of deaths reviewed under national and local minimum requirements and random sampling of all other deaths in scope.
3	**Total number of deaths considered to have more than a 50% chance of having been avoidable**	The Structured Judgement Review methodology, for use in relation to adult acute inpatient deaths, allows for reviewers to score a death as having a more than 50% chance of having been avoidable when this judgement is made in relation to the care provided by the trust conducting the review. This is the equivalent of a score of 3 or less. If using the RCP SJR then the number of such deaths scored in this way is equivalent to this field If not using RCP SJR, then the method used to judge whether a death was more likely than not to have been avoidable in relation to the care provided by the trust conducting the review (or another provider if appropriate) should be stated here including any definitions used. Note that if you are applying other methodologies to specific groups, such as learning disabilities patients, those methodologies may require a degree of judgement to determine whether the death was more likely than not to be avoidable. It may be appropriate to cross-reference those outputs with the processes for assessing structured judgement reviews, and if appropriate to include those outputs here. If the RCP SJR methodology is being used for structured judgement reviews Trusts are able to include monthly totals of reviewed deaths that were in each category 1 to 6. If the Trust is not using this methodology these fields can be either left blank or edited as appropriate.
Recording data on LeDeR reviews:		
4	**Total Number of Deaths in scope**	This must include all adult inpatient deaths for patients with identified learning disabilities. The total number of deaths in scope defined in this field must be used in all subsequent relevant fields. If a post-discharge period is being included in scope, (eg deaths within 30 days of discharge) then the death should be counted in the month where the death actually occurred rather than time of admittance or discharge.
5	**Total Deaths Reviewed Through the LeDeR Methodology**	Formally, the LeDeR review methodology should be applied to all of the deaths shown as 'in scope'. You should record the total number of deaths reviewed here.
6	**Total Number of deaths considered to have been potentially avoidable**	Record the total number of deaths for which review evidence leads to a conclusion that it is more likely than not that the death was potentially avoidable. This will require that a degree of judgement is applied to the outputs of the LeDeR review, and it may be appropriate to cross-reference these outputs with the processes for assessing structured judgement reviews

How to update the dashboard

To update this dashboard - enter your data on the "Data" worksheet. The dashboard sheet is automatically updated.

To update the dashboard with new data:
1. Enter data for appropriate month(s) in the Data tab. Note that the RCP1 to RCP6 and Trust comparison fields are optional and the dashboard will still function correctly if these fields are left blank.
- In the first 3 columns enter the data for your structured judgement reviews (number of deaths in scope, numbers reviewed, and numbers deemed potentially avoidable)
- You have the option of recording how many of the SJR reviews placed cases in each of the RCP1 to RCP 6 categories.
- For learning disabilities patients, enter the number of deaths in scope, numbers reviewed under the LeDeR methodology, and numbers deemed potentially avoidable

2. Change the month and year on the Front Sheet tab to the most recent month of data.
3. Change the data range on the time series charts as required by using the interactive dropdowns on the Dashboard tab (eg cell V4). Note that the time series charts are not linked to the front sheet selection and are driven entirely by the dropdowns.

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

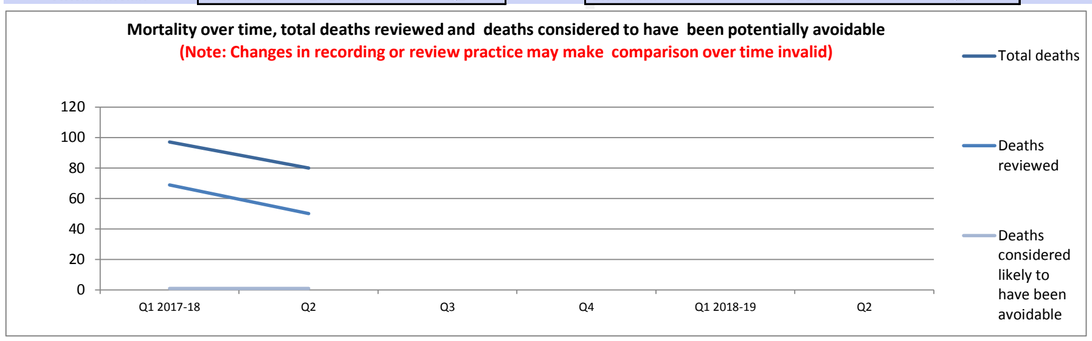
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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
12	35	10	19	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
80	97	50	69	1	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
177	0	119	0	2	0

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



Total Deaths Reviewed by RCP Methodology Score

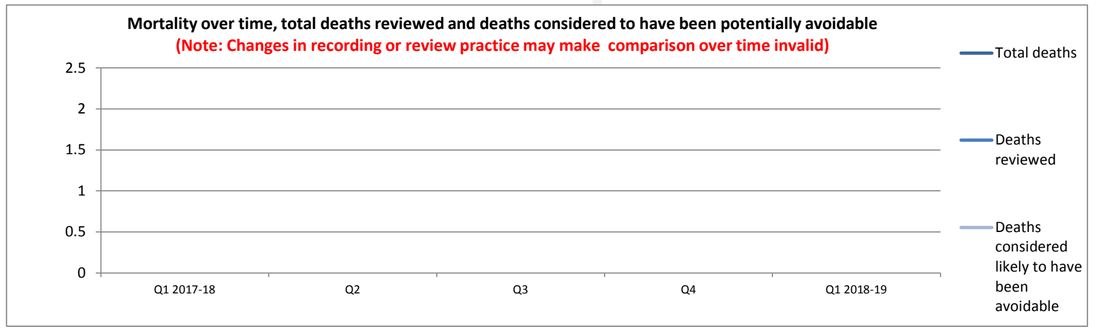
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	10.0%	This Month	9	90.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	2.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	4	8.0%	This Quarter (QTD)	45	90.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	2	1.7%	This Year (YTD)	8	6.7%	This Year (YTD)	14	11.8%	This Year (YTD)	95	79.8%

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

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

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



Trust	Whittington Health
Org Code	
Month	September
Year	2017-18

Financial Year	Month	Total Deaths (not LD)	Total Deaths Reviewed (not LD)	Deaths Avoidable > 50% (not LD)	RCP1	RCP2	RCP3	RCP4	RCP5	RCP6	LD Deaths	LD Deaths Reviewed	LD Deaths Avoidable > 50%
2017-18	April	34	26	0	0	0	0	6	5	15	0	0	0
2017-18	May	32	27	0	0	0	0	0	4	23	2	2	0
2017-18	June	31	16	1	0	0	1	2	1	12	0	0	0
2017-18	July	33	21	0	0	0	0	0	1	20	0	0	0
2017-18	August	35	19	1	0	0	1	0	2	16	0	0	0
2017-18	September	12	10	0	0	0	0	0	1	9	0	0	0
2017-18	October												
2017-18	November												
2017-18	December												
2017-18	January												
2017-18	February												
2017-18	March												
2018-19	April												
2018-19	May												
2018-19	June												
2018-19	July												
2018-19	August												
2018-19	September												
2018-19	October												
2018-19	November												
2018-19	December												
2018-19	January												
2018-19	February												
2018-19	March												
2019-20	April												
2019-20	May												
2019-20	June												
2019-20	July												
2019-20	August												
2019-20	September												
2019-20	October												
2019-20	November												
2019-20	December												
2019-20	January												
2019-20	February												
2019-20	March												
2020-21	April												
2020-21	May												
2020-21	June												
2020-21	July												
2020-21	August												
2020-21	September												
2020-21	October												
2020-21	November												
2020-21	December												
2020-21	January												
2020-21	February												
2020-21	March												
2021-22	April												
2021-22	May												
2021-22	June												
2021-22	July												
2021-22	August												
2021-22	September												
2021-22	October												
2021-22	November												
2021-22	December												
2021-22	January												
2021-22	February												
2021-22	March												
2022-23	April												
2022-23	May												
2022-23	June												

2022-23	July
2022-23	August
2022-23	September
2022-23	October
2022-23	November
2022-23	December
2022-23	January
2022-23	February
2022-23	March
2023-24	April
2023-24	May
2023-24	June
2023-24	July
2023-24	August
2023-24	September
2023-24	October
2023-24	November
2023-24	December
2023-24	January
2023-24	February
2023-24	March
2024-25	April
2024-25	May
2024-25	June
2024-25	July
2024-25	August
2024-25	September
2024-25	October
2024-25	November
2024-25	December
2024-25	January
2024-25	February
2024-25	March
2025-26	April
2025-26	May
2025-26	June
2025-26	July
2025-26	August
2025-26	September
2025-26	October
2025-26	November
2025-26	December
2025-26	January
2025-26	February
2025-26	March
2026-27	April
2026-27	May
2026-27	June
2026-27	July
2026-27	August
2026-27	September
2026-27	October
2026-27	November
2026-27	December
2026-27	January
2026-27	February
2026-27	March

Whittington Health
NHS Trust

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

Magdala Avenue
London N19 5NF

Whittington Health

31 January 2018

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	**18/008**	**Paper**	**5**
Action requested:	For information		
Executive Summary:	This report provides an overview of serious incidents (SI) submitted externally via StEIS (Strategic Executive Information System) during November and December 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:	16/01/2018		

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) from 1st November to 31st December 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 two serious incidents during November, bringing the total of reportable serious incidents to 28 since 1st April 2017. In 2016/17 the Trust decalared 58 serious incidents. No incidents were declared in December 2017.

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
Disruptive/ aggressive/ violent behaviour Ref:24289	Oct 17	Staff member was assaulted by a patient on the ward.
Safeguarding incident Ref:29054	Nov 17	Unexpected death of 23 month old baby. Baby was admitted in cardiac arrest, suffered extensive brain damage due to lack of oxygen. Baby died in ITU 4 days after admission.
Delayed Diagnosis Ref:27362	Nov 17	There was a delay in diagnosing and follow up of chest xrays which showed a new abnormality, possible lung cancer.
Delayed Diagnosis Ref:870	Jan 18	There was a delay in diagnosing pancreatic cancer.
Surgical Evasive Procedure incident (Unexpected Death) Ref: 905	Jan 18	A patient died following an elective surgery for a laparoscopic sub-total colectomy. Patient developed sepsis and deteriorated. On return to theatre patient arrested, CPR was unsuccessful.
Surgical Evasive Procedure incident Ref: 910	Jan 18	A patient deteriorated following an elective surgery for peritonitis, secondary to a bowel perforation. There was a delayed return to theatre.
Patient Fall Ref:1269	Jan 18	Patient fell whilst turning to walk in opposite direction resulting in a fractured neck of femur.

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 – December 2017

STEIS 2017-18 Category	2016/17 Total		April 2017	May 2017	June 2017	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Total 17/18 ytd
Safeguarding	5		0	0	0	0	0	0	0	1	0	1
Attempted self-harm	1		0	0	0	0	0	0	0	0	0	0
Confidential information leak/loss/IG Breach	6		0	0	1	1	0	1	0	0	0	3
Diagnostic Incident including delay	8		0	1	1	1	1	0	1	1	0	6
Disruptive/ aggressive/ violent behaviour	0		0	0	0	0	0	0	1	0	0	1
Failure to source a tier 4 bed for a child	1		0	0	0	0	0	0	0	0	0	0
Failure to meet expected target (12 hr trolley breach)	1		0	0	0	0	0	0	0	0	0	0
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	7		0	1	0	0	0	0	1	0	0	2
Maternity/Obstetric incident mother only	2		0	0	0	0	1	0	0	0	0	1
Medical disposables incident meeting SI criteria	1		0	0	0	0	0	0	0	0	0	0
Medication Incident	0		0	0	0	1	0	0	0	0	0	1
Nasogastric tube	1		0	0	0	0	0	0	0	0	0	0
Slip/Trips/Falls	7		0	1	0	0	2	0	1	0	0	4
Sub Optimal Care	4		0	0	1	0	0	0	0	0	0	1
Treatment Delay	3		1	1	0	0	0	1	0	0	0	3
Unexpected death	10		1	0	1	0	0	0	1	0	0	3
Retained foreign object	1		0	0	0	0	1	0	0	0	0	1
HCAI\Infection Control Incident	0		0	0	0	0	1	0	0	0	0	1
Total	**58**		**2**	**4**	**4**	**3**	**6**	**2**	**5**	**2**	**0**	**28**

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 in November and December 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 nine reports to NELCSU during November and December 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 reports submitted in November and December 2017.

Summary	Actions taken as result of lessons learnt include;
Unexpected death Ref:24271	A patient died following elective surgery for bowel cancer. Following complications during surgery the patient had an iatrogenic oesophageal perforation resulting in sepsis and pneumothorax. They were transferred to a specialist Upper GI centre and subsequently died. • The Trust Lead for Adult Safeguarding continues to provide support and training on the Mental Capacity Act (MCA) and has arranged a teaching session for all surgeons which will include the best Interest meetings guideline and documentation. • To strengthen the informed consent process a standardised colorectal surgery risk stratifications tool is being developed. This will calculate risk for all elective resections and will be included on consent forms. • A list of referral pathways is being populated and will be disseminated to all relevant staff; this will ensure the correct pathways to tertiary centers is followed and treatment delays are minimised. • A guideline on the diagnosis and management of suspected oesophageal perforation is being developed and teaching sessions will be arranged with dissemination of the guideline to all relevant staff (surgeons, anaesthetists and intensive care and ED staff). This will

Summary	Actions taken as result of lessons learnt include;
	also be uploaded to the Trust Intranet site. • To improve the surgical patient ICU documentation, a surgical patient ICU ward round template is being developed. This will need to be completed daily for each surgical patient on Intensive care and will require Consultants to input and sign off daily. • The Trust is currently liasing with colleagues at UCLH to establish if there is scope for developing a channel for urgent bed requests for critical patients.
Delayed Treatment Ref:22420	A patient with a critically ischaemic foot had a forefoot amputation following deterioration of a diabetic foot ulcer. • The Trust has updated the Community Podiatry form which now includes a note clearly indicating that 'All Vascular Podiatry Referrals should be made directly to the hospital team and not by this form'. • To minimise the risk of delays the Central Booking Service will now cascade all referrals of ulcers, straight to podiatry. • A review of records was undertaken in December 2017 for assurance that all community teams have a systematic processes in place to upload significant clinical information for all care episodes. • A review of referrals to community podiatry (over past 6 months) is currently being undertaken to ensure that all vascular referrals have been sent via the correct pathway. • A learning event has been arranged for March 2018 to share the learning from this case with DNs, The Reach Team and Podiatry services.
Information Governance Incident Ref:23561	A ward handover sheet with patient details was found by hospital staff in a public area in the Hospital. • The Trust are in the process of purchasing secure software for electronic mobile devices to replace the hard copy handover sheets. This will be piloted across the trust. An implementation plan is currently being developed for rolling out the 'careflow project' which will include local configuration, process mapping testing and training. • Until the electroinc devices are rolled out on the relevant ward the following steps have been introduced. (i) Hard copy handover sheets are being printed on coloured sheets for easier identification. (ii) Staff members are required to write their name on the top of each sheet. (iii) Confidential waste bins are readily available for disposal of handover sheets at the end of the shift (non-patient areas). This includes the MDT room, staff room, nurses station and managers office. (iv) Signs have been laminated and placed by the disposal bags.
Delayed Diagnosis Ref: 21667	A delay in diagnosing an abnormal MRI scan resulted in a delay in treatment for a spinal cord compression. • Training sessions have been arranged for ED and imaging staff highlighting the potential significance of ongoing neurological abnormalities which should always be reviewed in the context of a 'normal' CT scan. • A review the Standardised Operating Procedures for requesting images out of hours is being undertaken; to clarify if any further improvements to the timeliness and process can be made.

Summary	Actions taken as result of lessons learnt include;
	• Lessons learnt from imaging are regularly being reviewed at meetings by the imaging department which are attended by consultants, trainees and radiographers. • This case has been shared and discussed at the regular A+E teaching sessions for junior doctors, who as part of their induction, receive teaching on the assessment of potential cervical spine injuries.
Patient Fall Ref:20794	A patient had an unwitnessed fall resulting in a fractured skull and intracerebral bleed. The patient subsequently died. • The Trust Falls Group are providing support to embed 'Baywatch', an approach the trust is using to maintain patient safety on wards, especially for those patients deemed as being at high risk of falls. This ensures that if the allocated nurse needs to leave the bay unattended, another member of staff will be asked to be in the bay and on '*Baywatch*' until the nurse returns. • To Improve awareness of the Clinical Guideline – '*Management of Delirium*' a training session is being arranged for ward staff and the site team. • Following review of safer staffing processes an SOP has been developed for the site team to support wards more efficiently, in particular when staffing becomes significantly challenged on the wards. • A review of staffing levels specifically 'specialling' on the elderly medicine wards has been undertaken and an additional HCA assistant has been appointed to the ward. A 6 month staffing review will be undertaken. • A review of handover processes has taken place in relation to patient falls risk assessments to ensure accurate ward to ward handover. The Trust transfer checklist will now incorporate significant risks (including falls risk). • The Trust continues to increase awareness and training in the STOPfalls bundle across the Trust, including lying/standing BP and postural hypotension. A new approach to training has been adopted, previously training was ward based but this has now been taken a step further and quick training on STOPfalls is carried out in the bay itself. This has greatly increased the numbers of agency and MDT staff attending and also improves awareness for patients on the STOPfalls campaign as the training is done in the bay with patients and carers present. • Learning from this incident has also been shared across the Trust via a presentation at the Care of Older People Quality and Safety Meeting and Presentation at Trust falls group, along with discussuions at ward staff meetings.
Infection Control Incident Ref:20792	Staff member diagnosed with probable open pulmonary TB. • Following a review of the new starter screening process, a new starter documentation procedure is now in place and being used by the Occupational Health team. • The Trust continues to provide training to staff (via Grand Round, Link Nurse teaching and Ward meetings) highlighting the risks of TB to Healthcare workers, especially to be aware of the symptoms which may be present in oneself. Due to TB being so demographically focused on particular risk groups, the Trust is also introducing targeted awareness events to specific at risk staff groups.

Summary	Actions taken as result of lessons learnt include;
Never Event - Retained foreign object (tampon) Ref:20098	During a postnatal follow up examination it was identified that a tampon had been left in situ following a perineal suturing /repair procedure. • The maternity unit swab, needle and instrument checklists have been updated to include tampon/s in the counting checks before during and after vaginal birth, perineal repair, postpartum haemorrhage and all other pertinent procedures in maternity. • The maternity unit has introduced the use of Whiteboards to labour rooms to enable real time documentation of any additional items inserted vaginally, including tampons, during all procedures. • The live drills training programme has been updated and now encorporates swab counting, rebriefing, counting in of items such as tampons and use of the whiteboards on the labour ward and birth centre.

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.

This learning is shared externally with our CCGs. The Clinical Commissiong Group (CCG) review all SI reports as part of their process of sign off and closure. The Trust also uploads lesson learned to the STEIS reporting system, which is managed by the North East London Commissioing Support Unit (NELCSU) and CCG.

6. NHS Resolution Early Notification Scheme

The Early Notification Scheme was introduced in April 2017 and requires all trusts to report to NHS Resolution all maternity incidents that occur on or after 1 April 2017 which are likely to result in severe brain injury, as defined below :

Babies born at term (=37 completed weeks of gestation), following labour, with a severe brain injury diagnosed in the first seven days of life, namely babies that have one or more of the following:

- *Diagnosed with grade III hypoxic ischaemic encephalopathy (HIE);*
- *Actively therapeutically cooled;*
- *Have all three of the following signs: decreased central tone; comatose; seizures of any kind.*

The above criteria was identified by the Royal College of Obstetricians and Gynaecologists (RCOG) (Each Baby Counts Programme) as being potential markers for avoidable severe brain injury at birth. Early notification will allow the NHS Roslution (NHSR) to begin their own investigations at a much early stage and focus efforts on those cases where legal and independent expert advice might be warranted.

Reporting of incidents which fall within the defined criteria will be mandatory within 30 days of the incident. It is expected that for such cases an investigation will be carried out by the trust, involving the family and that the necessary steps are taken to comply with the statutory duty of candour.

The NHSR ambition in the first year of the early notification scheme is to achieve 100% reporting of these incidents. They will therefore:

- Cross reference claims reported to to them with national databases to ensure full reporting and will contact trusts if it appears a qualifying incident has occurred and has not been reported to them.
- Encourage full and proper reporting, in line with the Serious Incident investigation framework. Where, in their assessment, investigation processes are not found to be of a reasonable standard may refer such cases to NHS Improvement and in the interests of patient safety, should NHSR identify clusters of cases or other areas of concern, notify their concerns to the CQC.

Since April 2017 we have submitted two notification forms through the Early Notification Scheme.

7. Summary

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

Whittington Health
NHS Trust

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

Magdala Avenue, London
N19 5NF

Whittington Health Trust Board

31 January 2018

Title:	Inpatient Safe Staffing - Nursing and Midwifery – November and December data		
Agenda item:	**18/009**	**Paper**	**6**
Action requested:	For information		
Executive Summary:	This paper summarises the safe staffing position for nursing and midwifery on Whittington hospital wards in November and December 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 increase in shift requests to provide enhanced care to support vulnerable patients in November (n=410) and (n=372) in December compared to October (n=287). In over 95% of cases this relates to providing 1:1 specialing, supported by HCAs. 3. One Registered Mental Health (RMN) nurse was booked for a shift to provide enhanced care for a patient with a mental health condition on Mary Seacole North, in November. 4. There were 16 shifts in November and 33 in December which initially triggered 'Red' prompting a review of available staff. 5. These shifts are regularly reviewed to mitigate any risks to patient safety. The high value in December is partly due to the improvement in the reporting processes and how non-rostered clinical staff are assigned to cover shifts. 6. The Care Hours Per Patient Day (CHPPD) measure during the month increased in November (8.64) and a slight reduction in December (8.40) compared to October (8.13). 7. There is continued use of agency and bank staff to support safe staffing. More work has been undertaken to ensure that these 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 was one Datix report submitted in November on Labour wards and in December on ED Paediatrics where 'staffing' was highlighted as an issue which resulted in "low/minor (minimal harm)."		
Summary of recommendations:	To note the November and December UNIFY return position and processes in place to ensure safe staffing levels in the organisation.		
Fit with WH strategy:	Efficient and effective care; Francis Report recommendations. Cummings recommendations; NICE recommendations.		

Reference to related / other documents:	
Reference to areas of risk and corporate risks on the Board Assurance Framework:	3.4 Staffing ratios versus good practice standards.
Date paper completed:	January 2018

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

Ward Staffing Levels – Nursing and Midwifery

1.0 Purpose

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

1.2 To provide context for the Trust Board on the UNIFY safe staffing submission for the months of November and December 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), Assistant Practitioners (APs) 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. A recent establishment review has been completed, using October 2017 data and is awaiting ratification by the Trust Board in February 2018. Future safe staffing reports will be updated accordingly.

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 manage the safe level of care provided to all inpatients. This measure uses patient count on each ward at midnight (23.59hrs). CHPPD is calculated using the actual hours worked (split by registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight (for November 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 30th November and 1st to 31st December 2017 for Whittington Hospital has been uploaded and submitted on UNIFY, the online collection system used for collating, sharing and reporting NHS and social care data. Patients and the public are able to see how hospitals are performing on this indicator on the NHS Choices website.

Summary of Staffing Parameters

Standard	Measure	Summary
Patient safety is delivered though consistent, appropriate staffing levels for the service.	Unify RN fill rate	*Nov* Day – 81.0% Night – 91.3% *Dec* Day – 80.7% Night – 92.0%
	Care hours per Patient Day - CHPPD	Overall the CHPPD for November and December were 8.64 and 8.40 respectively which was higher than October (8.13)
Staff are supported in their decision making by effective reporting.	Red triggered shifts	16 shifts triggered 'Red' in November and 33 shifts triggered 'Red' in December

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 (defined in hours) 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 November. The number of level 1b patients remains static. 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 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. The staffing levels on all wards are reviewed each morning to ensure staffing levels are safe. Prior to the meeting the Matrons are asked to apply "professional judgement" as a subjective indicator to the objectivity of an "hours short / excess" matrix.

3.2.2 Appendix 1 details a summary of 'actual' versus 'planned' fill rates in November. The average fill rate in November and December respectively were **81.0% and 80.7%** for registered staff and **129.9% and 136.1%** for care staff during the day and **91.3% and 92.0%** for registered staff and **143.9% and 141.6%** for care staff during the night.

3.2.3 The Trust fill rate for November and December are outlined 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
Nov	81.0%	129.9%	91.3%	143.9%
Dec	80.7%	136.1%	92.0%	141.6%

3.2.4 As areas are reviewing their skill mix, Band 4 Assistant Practitioners have been appointed to take on a number of tasks traditionally allocated to registered nurses. As Assistant Practitioners are being appointed into these roles a national steer will be required to decide how their contribution to care is submitted via the Unify report.

4. Care Hours per Patient Day (CHPPD)

Care hours per patient day 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). This indicator does not take into account acuity.

ITU has the most care hours (28.99 and 23.14) as the nurses on this ward deliver more 1:1 care than any other areas, and Coyle ward have the least (5.55 and 6.02) in November and December respectively.

4.1 Across the Trust the average number of hours of Registered Nurse time spent with patients in November and December were calculated at 5.75 and 5.58 hours and 2.89 and 2.82 hours for care staff respectively. This provides an overall average of 8.64 and 8.40 hours of care per patient day. This reduction in CHPPD, in December, is mainly due to seasonal trends as temporary staff are less available to cover shifts.

	CHPPD (November)	**CHPPD (December)**
Registered Nurse	**5.75**	**5.58**
Care Staff	**2.89**	**2.82**
Overall hours	**8.64**	**8.40**

4.2 The table below shows the CHPPD hours for each in patient ward over the last four months and indicates the level of need remained stable overall.

Ward Name	September	October	November	December
Cavell	5.9	5.58	7.01	6.25
Bridges rehab ward	6.44	5.82	6.26	6.20
Cloudesley	5.78	5.90	6.01	6.20
Coyle	5.65	5.67	5.55	6.02
Mercers	6.72	6.79	6.93	6.60
Meyrick	5.71	5.65	6.58	6.19
Montuschi	6.92	6.77	6.81	6.93
Mary Seacole South	7.88	7.86	9.01	7.26
Mary Seacole North	9.16	8.59	9.81	8.21
Nightingale	6.58	6.52	6.75	6.48
Thorogood	7.47	8.02	7.94	6.15
Victoria	5.57	4.61	6.86	6.49
IFOR	10.16	9.50	9.68	10.81
ITU	29.1	30.95	28.99	23.14
NICU	10.42	11.85	11.60	10.70
Maternity	13.14	13.37	12.94	14.42
Total	8.28	8.13	8.64	8.40

4.3 The overall CHPPD is higher in November and slightly lower in December, compared to October with fluctuations in both directions across all cost centres. Human resources and the nursing directorate are ensuring that proactive work is taking place to reduce unfilled shifts and increase recruitment into vacant posts.

Over the last few months there was been lots of work undertaken to make the decision making process relating to staffing more robust. There is now better attendance of senior staff at the meeting, using more meaningful data including patient flows and temporary staffing availability. The introduction of an HCA pool managed by the Site Team has also helped to fill vacant shifts as the staff can be assigned based on greatest requirement.

Furthermore, refining of the process to update the Safecare system when staff are moved from one ward to another for clinical safety has improved during November.

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

5.1 Safe staffing levels are reviewed and managed three times daily and each Friday there is a planning meeting to ensure safe at the weekend staffing. At the daily 08.30 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, with the aim not to allow a ward 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 > 23 hours)', 'amber (hours short > 11.5 hours)' or 'green (<11.5 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. These KPI values continue to be under review.

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 23 hours for more than 30 mins after the review made at the bed meeting. Professional judgement is added to Healthroster by Matron after an assessment and possible redeployments are made.

5.4 There were 16 red flags triggered in November and 33 in December compare to 32 in October. The Deputy Chief Nurse and Heads of Nursing have reviewed the approach to recording red flags to make this process more robust. During December the "professional judgement" tool was introduced and the ability to view the impact will not been seen in its entirely until the software is upgrade at the end of January. There are no concerns, as it is clear that the process is more robust and improving in data quality. This process is under constant review to ensure that all factors are captured. As the paediatric units start to use the same approach to assess their patients, this may have an impact on the numbers reported. Frequency and trends will be regularly reviewed by the Deputy Chief Nurse and will be reported in the board reports.

The table below indicates which wards triggered the 16 red flags during November and 33 in December

Ward	Nov	Dec
Bridges Rehabilitation Unit		1
CAVELL		1
CLOUDESLEY	1	3
COYLE	3	8
MERCERS Ward	3	5
MEYRICK	7	1
MONTUSCHI		4
NIGHTINGALE		3
VICTORIA	2	7
Grand Total	**16**	**33**

6.0 Reported Incidents of Reduced Staffing (Datix Reports)

Staff are encouraged to report, using the Datix system, any incident they believe

may affect safe patient care. During November there were 22 Datix reports submitted relating to staffing, one of the incidences on labour ward relates to a "low/minor (minimal harm)" event. In December there were 23 Datix reports one of which relates to a "low/minor (minimal harm)" in Accident and Emergency (still to be reviewed).

7.0 Additional Staff required to provide 1:1 enhanced care

7.1 In November there were 419 requests for 1:1 enhanced care provision and 388 in December, compared to 287 requests in October. The requests made for this level of care were to ensure the safe management of particularly vulnerable groups of patients. There were 410 HCA shifts, 8 RN and 1 RMN shifts requested in November and 372 HCA shifts, 16 RN shifts requested in December, to provide enhanced care.

7.2 One Registered Mental Health (RMN) nurse was booked for a shift in Mary Seacole North, in November, to provide enhanced care for a patient with a mental health condition.

7.3 There continues to be a high level of need for provision of enhanced care for patients requiring constant supervision. The lead nurse for quality and safety has reviewed this process to 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. This process will be fully rolled out next month.

8.0 Temporary Staff Utilisation

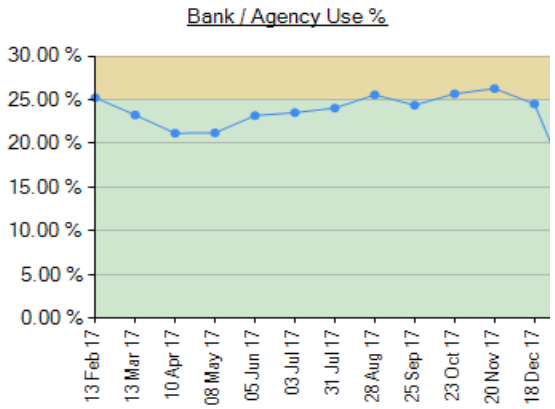
8.1 Temporary staff utilisation (nursing and midwifery) across the hospital is monitored regularly as all requests for temporary staff (agency) on the wards are reviewed by the Head of Nursing/Midwifery followed by a further review and final authorisation by the Deputy Chief Nurse. The authorisation process is currently being reviewed by the Deputy Chief Nurse, Deputy Director of Workforce and Project Management Office to ensure greater rigor and timeliness. During these winter months there has been a drive to release the shifts to Agency earlier in an attempt to improve the fill rates.

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

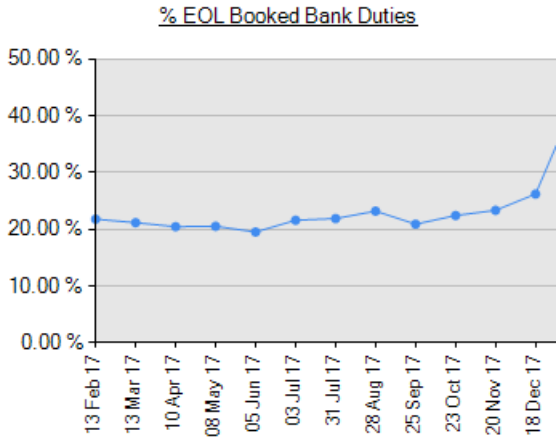
8.2.1 The system in place allows for the most appropriate use of high cost temporary agency staff across the organisation and provides a positive challenge mechanism for all requests.

8.2.2 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.

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.



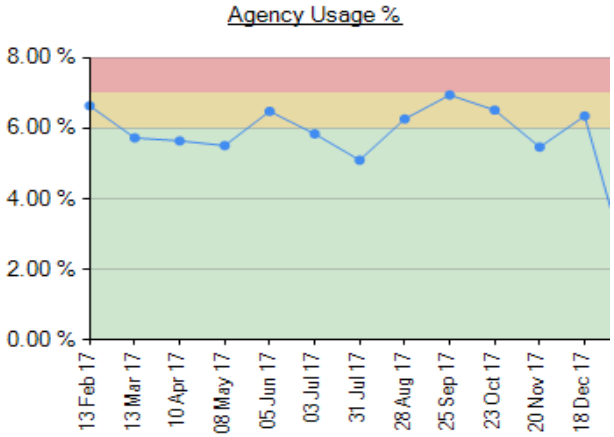
Whilst there is an upward trend in the direct booking process, less than 50% of bank shifts are booked by the staff themselves. This remains an area of service improvement.

9.0 Agency Usage Inpatient Wards (month ending December)

9.1 The utilisation of agency staff across all inpatient wards is monitored using the Healthroster system. The graph below represents total usage of agency staff on inpatient wards for the month ending December (this is cumulative data captured from roster performance reports). Traditionally the use of Agency rises during the winter months as the number of Bank Staff available coincides with the holiday period. This trend was anticipated and an incentive scheme was introduced in order to encourage Bank Staff to book into vacant shifts.

9.2 In the coming months there will be a review of the booking processes by Agencies. In some Trusts the Agencies have direct access to book their staff into vacant shifts. We will be exploring this further to see if this delivers a better fill rate of Agency approved shifts.

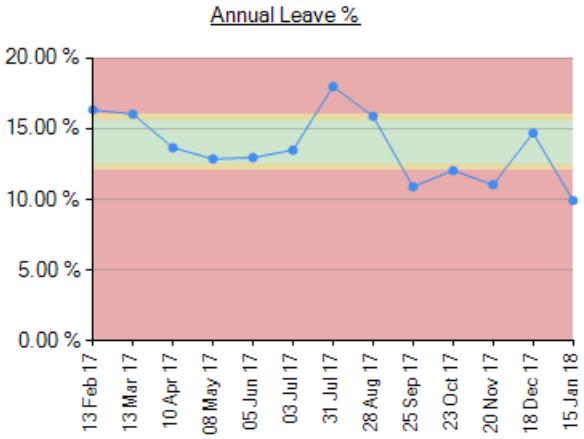
9.3 A key performance indicator (KPI) of less than 6% agency usage (agency shifts compared to total shifts assigned) was set to coincide with the NHS England agency cap. The percentage continues to fluctuate close to the agreed 5% target, less that the agreed KPI.



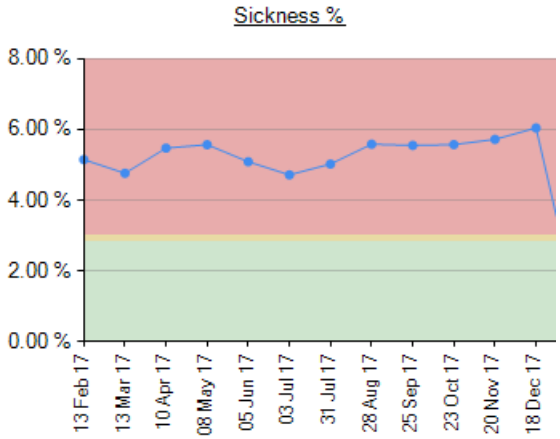
10.0 Absence Management

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.

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. All areas have been appraised of the level of leave still to be taken by staff and this will be actioned to ensure that minimal leave is carried forward into 2018/19



10.3 Sick leave percentage continues to be above the 3% threshold month on month. Heads of Nursing are asked to 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.

Appendix 1

Fill rate data – summary,
November and December 2017

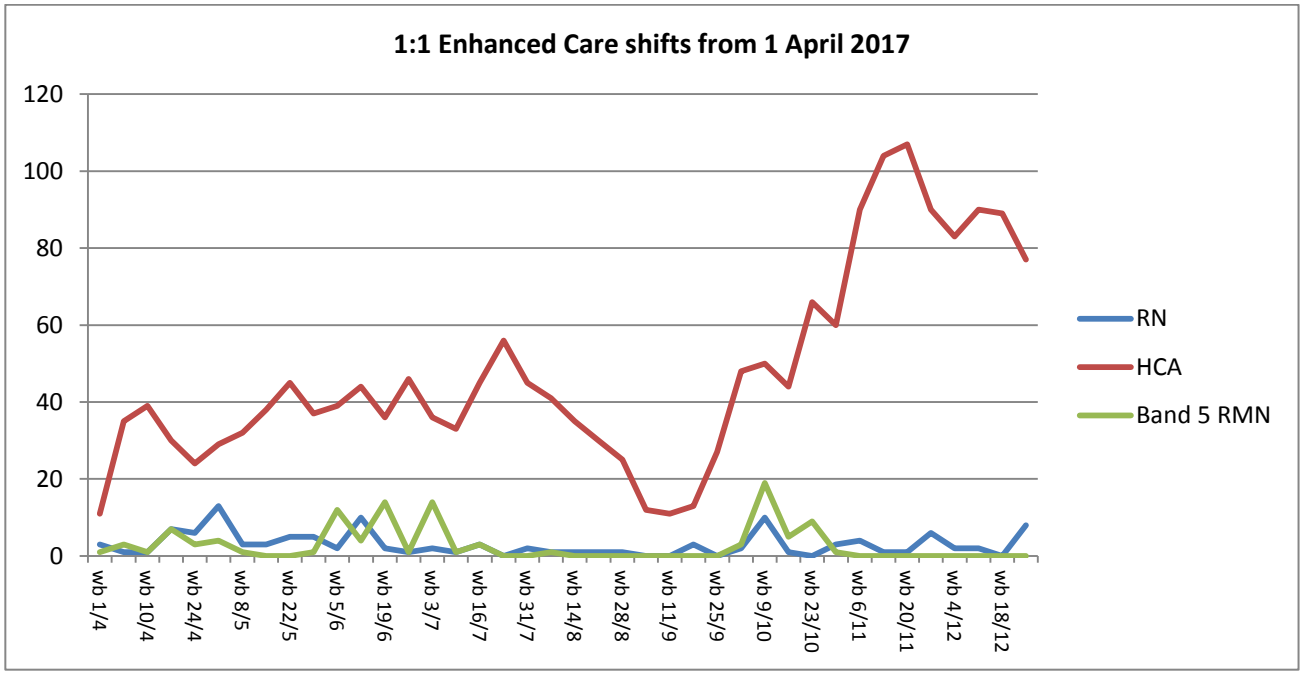
	Day				**Night**				**Average fill rate data- Day**		**Average fill rate data- Night**	
	Registered nurses/ midwives		Care staff		Registered nurses/ midwives		Care staff		Registered nurses/ midwives	Care staff	Registered nurses/ midwives	Care staff
	Planned (hrs)	Actual (hrs)	Planned (hrs)	Actual (hrs)	Planned (hrs)	Actual (hrs)	Planned (hrs)	Actual (hrs)				
Nov	**33515**	**27148**	**11096**	**14414**	**27342**	**24965**	**8198**	**11797**	**81.0%**	**129.9%**	**91.3%**	**143.9%**
Dec	**34647**	**27967**	**11411**	**15533**	**28506**	**26221**	**8384**	**11874**	**80.7%**	**136.1%**	**92.0%**	**141.6%**

The Assistant Practitioners are classified as unregistered (HCAs) and therefore this will increase the HCA fill rate

Care Hours per Patient Day
November and December 2017

	Total Patients at Midnight/Month	CHPPD Registered staff	CHPPD Unregistered staff	Average CHPPD (all staff)
Nov	**9065**	**5.75**	**2.89**	**8.64**
Dec	**9713**	**5.58**	**2.82**	**8.40**

Appendix 2: Enhanced Care requirement to date



Appendix 3: Average fill rate for Registered and Unregistered staff day and night, (November and December)

Nov - 17	Day		Night	
Ward Name	Nurses	Care Staff	Nurses	Care Staff
Cavell	71.0%	141.0%	93.7%	169.2%
Bridges	76.3%	101.7%	98.7%	98.8%
Cloudsley	76.1%	126.7%	100.1%	154.1%
Coyle	73.1%	98.4%	91.2%	100.4%
Mercers	68.1%	138.4%	98.7%	111.4%
Meyrick	72.4%	149.9%	105.9%	184.6%
Montuschi	67.0%	285.1%	107.2%	NA
MSS	63.7%	196.0%	75.4%	272.3%
MSN	73.3%	133.3%	102.8%	250.9%
Nightingale	83.4%	136.3%	77.4%	138.1%
Thorogood	76.6%	38.8%	113.2%	0%
Victoria	88.8%	133.6%	93.0%	133.9%
IFOR	79.9%	100.0%	82.0%	100.0%
ITU	100.0%	0%	100.0%	0%
NICU	75.9%	100.0%	78.3%	100.0%
Maternity	94.4%	120.4%	90.5%	106.6%
Total	**81.0%**	**129.9%**	**91.3%**	**143.9%**

Dec- 17	Day		Night	
Ward Name	Nurses	Care Staff	Nurses	Care Staff
Cavell	68.7%	145.7%	90.6%	159.0%
Bridges	69.0%	120.8%	98.0%	117.4%
Cloudsley	72.0%	143.0%	98.3%	151.3%
Coyle	69.8%	130.6%	92.6%	153.0%
Mercers	64.6%	134.9%	98.5%	96.6%
Meyrick	65.7%	156.2%	97.7%	168.3%
Montuschi	70.5%	281.2%	109.4%	NA
MSS	59.3%	179.1%	77.8%	181.6%
MSN	72.1%	128.2%	100.0%	205.9%
Nightingale	91.5%	121.8%	84.2%	124.8%
Thorogood	79.1%	63.6%	101.6%	0%
Victoria	84.5%	148.9%	99.5%	136.7%
IFOR	83.5%	100.0%	80.6%	100.0%
ITU	100.0%	0%	100.0%	0%
NICU	81.1%	0%	82.9%	0%
Maternity	94.3%	110.7%	90.5%	111.1%
Total	**80.7%**	**136.1%**	**92.0%**	**141.6%**

Whittington Health
NHS Trust

Magdala Avenue
London N19 5NF

Trust Board

31 January 2018

Title:	Financial Performance Report - December (Month 9) 2017/18		
Agenda item:	**18/010**	**Paper**	**7**
Action requested:	To agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends.		
Executive Summary:	The Trust is reporting a year to date position (£0.5m deficit) slightly ahead of plan (£0.6m deficit) at the end of quarter 3. Both income and pay positions improved in month, which has supported the overall position being ahead of plan. As a result of the Month 9 position the Trust is eligible for the full third quarter payment of STF (Sustainability & Transformation Funding). The Trust's assessment at Month 9 is that it will achieve its control total position by year end, which has been increased to a £1.3m surplus following the allocation of additional funding (£0.7m) by NHSI and NHSE to support A&E costs currently being incurred in relation to winter. However, it should be noted that delivery of the Trust's CIP programme is still significantly behind plan (£6.6m adverse) and remains the key risk for the Trust to mitigate in order to achieve its control total.		
Summary of recommendations:	The Board is asked to note: • the financial results for the month of December 2017 • the forecast year end position is achievement of the control total • the risk to delivering the control total position as a result of performance against the Trust's annual CIP programme		
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:	24 January 2018		

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

In-month & Year to Date

The Trust is reporting a £1.0m surplus in Month 9 against a planned deficit of £0.7m. As a result the year to date deficit has reduced to £0.5m and is therefore slightly better than plan, £0.6m deficit, at the end of the third quarter. As a result the Trust is eligible for the full third quarter payment of STF (Sustainability & Transformation Funding), which totals £2m and is reflected within the figures shown below.

Statement of comprehensive income

2017/18, Month 09 (December 2017)

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	20,700	22,626	1,926	195,527	196,614	1,087
Sustainability & Transformation Funding (STF)	*667*	*667*	0	*4,336*	*4,336*	*0*
	21,367	23,293	1,926	199,863	200,950	1,087
Non-NHS Clinical Income	1,817	1,586	(232)	16,532	15,229	(1,303)
Other Non-Patient Income	1,950	2,174	224	17,550	19,228	1,678
Income CIPs	0	0	(0)	(0)	0	0
Total Income	**25,134**	**27,053**	**1,918**	**233,944**	**235,407**	**1,462**
Pay	(18,065)	(17,485)	579	(163,135)	(163,037)	99
Non-Pay	(6,425)	(7,156)	(731)	(59,632)	(61,367)	(1,735)
Total Operating Expenditure	**(24,490)**	**(24,641)**	**(152)**	**(222,767)**	**(224,403)**	**(1,636)**
EBITDA	**645**	**2,412**	**1,767**	**11,177**	**11,004**	**(174)**
Depreciation	(722)	(668)	54	(6,490)	(6,011)	478
Dividends Payable	(345)	(496)	(151)	(3,111)	(3,264)	(153)
Interest Payable	(255)	(232)	23	(2,293)	(2,294)	(1)
Interest Receivable	3	4	1	27	17	(10)
P/L on Disposal of Assets	0	0	0	0	0	0
Total	**(1,319)**	**(1,392)**	**(73)**	**(11,867)**	**(11,553)**	**314**
Net Surplus / (Deficit) - before IFRIC 12 adjustment	**(674)**	**1,020**	**1,694**	**(689)**	**(550)**	**140**
Add back impairments and adjust for IFRS & Donate	(14)	(8)	(6)	(118)	(70)	(47)
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**(661)**	**1,028**	**1,688**	**(572)**	**(479)**	**93**

Both the income and pay positions improved in Month 9, which has supported the overall position being ahead of plan. Originally it was planned that December would be a lower income month, given the reduced number of 'working days', which was the key driver for a planned deficit. However, income performed better than plan, which has led to a favourable variance both in month and for the year to date.

End of Year Forecast

The control total has been increased to a £1.3m surplus following the allocation of additional funding (£0.7m) by NHSI and NHSE to support A&E costs currently being incurred in relation to winter.

Having taken into account the improved income run rate, predicted increase in CIP delivery in quarter 4, the non-recurrent actions taken to date and non-recurrent actions agreed with ICSUs the Trust is forecasting the achievement of the 2017/18 control total which is a material improvement.

CIP performance remains significantly behind plan at Month 9, with delivery of savings recorded as £6.1m against an original target of £12.7m. Delivery against the Trust's CIP programme therefore, remains the key risk for the Trust to mitigate in order to achieve its control total.

Income & Activity

The trust has seen improved income in month, which has led to a position ahead of plan both in month and for the year to date, the cumulative variance being £1.5m favourable.

Points to note:

- Outpatient attendances (controllable income) deteriorated in month, resulting in an adverse variance of £0.1m, and a year to date adverse variance of £1.6m. The largest under-performances were attributable to General Surgery, T&O and Dermatology. To date ICSUs have not met their recovery plan targets for outpatients, and as a result it will prove a challenge to recover the year to date underperformance.

- Elective and Outpatient Procedures continue to over-perform, offset by Day case underperformance, both in month and year to date.

- Non electives continued to improve, again, with an in-month favourable variance of £39K, reducing the overall year to date adverse variance to £994k.

- There is no marginal rate adjustment this month as the Trust is on plan overall for its main contract.

- Other income, overall, is £450k favourable year to date.

Month 09

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	921	28	7,924	8,185	261	5,063	5,796	733	45,894	51,440	5,546
Adult Critical Care	702	455	(246)	6,227	5,463	(764)	580	382	(198)	5,221	4,758	(463)
Community Block	5,858	5,845	(13)	52,754	52,754	(0)	0	0	0	0	0	0
Day Cases	962	937	(24)	10,482	9,938	(543)	1,476	1,230	(246)	15,531	14,022	(1,509)
Diagnostics	186	232	46	2,028	2,114	86	1,838	2,355	517	20,115	21,419	1,304
Direct Access	808	776	(32)	8,831	8,165	(666)	73,832	66,366	(7,466)	807,806	788,940	(18,866)
Elective	614	579	(35)	6,375	6,672	296	97	164	67	1,541	1,733	192
Maternity - Deliveries	1,076	1,111	35	8,740	8,655	(85)	323	329	6	2,627	2,552	(75)
Maternity - Pathways	619	587	(33)	6,775	6,440	(335)	580	574	(6)	6,344	6,105	(239)
Non-Elective	4,068	4,108	39	38,211	37,217	(994)	1,481	1,471	(10)	14,076	14,252	176
OP Attendances - 1st	776	740	(36)	8,454	7,640	(814)	3,740	3,849	109	45,502	42,599	(2,903)
OP Attendances - follow up	686	605	(82)	7,453	6,694	(759)	9,134	9,863	729	107,788	109,780	1,992
Other Acute Income	2,494	3,179	685	20,211	24,153	3,942	9,261	9,653	391	98,749	98,608	(141)
Outpatient Procedures	257	510	252	2,813	3,483	670	1,431	1,961	530	15,718	19,219	3,501
Total SLA	**20,000**	**20,584**	**585**	**187,277**	**187,572**	**295**	**108,837**	**103,993**	**(4,844)**	**1,186,912**	**1,175,427**	**(11,485)**
Marginal Rate	0	0	0	0	0	0						
	20,000	**20,584**	**585**	**187,277**	**187,572**	**295**						
Other Clinical Income	2,975	4,292	1,317	27,803	28,595	793						
Other Non Clinical Income	2,160	2,176	16	18,864	19,239	376						
Total Other	**5,135**	**6,468**	**1,334**	**46,666**	**47,835**	**1,169**	**0**	**0**	**0**	**0**	**0**	**0**
Grand Total	**25,134**	**27,053**	**1,918**	**233,944**	**235,407**	**1,463**	**108,837**	**103,993**	**(4,844)**	**1,186,912**	**1,175,427**	**(11,485)**

In addition to the key points highlighted above, it should also be noted that the Month 9 position (and year to date) includes a positive adjustment for challenges, where a provision has been released following the resolution of issues. Additionally the position also now includes the recognition of audiology new-born screening income, as a review of the contractual position indicates that the Trust is following the correct billing procedure.

Monthly Run Rates – Expenditure

The Trust is reporting an adverse expenditure variance both in month (£0.1m) and year to date (£1.6m). As previously reported the position includes the application of flexibilities as well as the benefit from the removal of booked agency shifts that were unfilled/not utilised.

In run rate the key highlights for pay are:

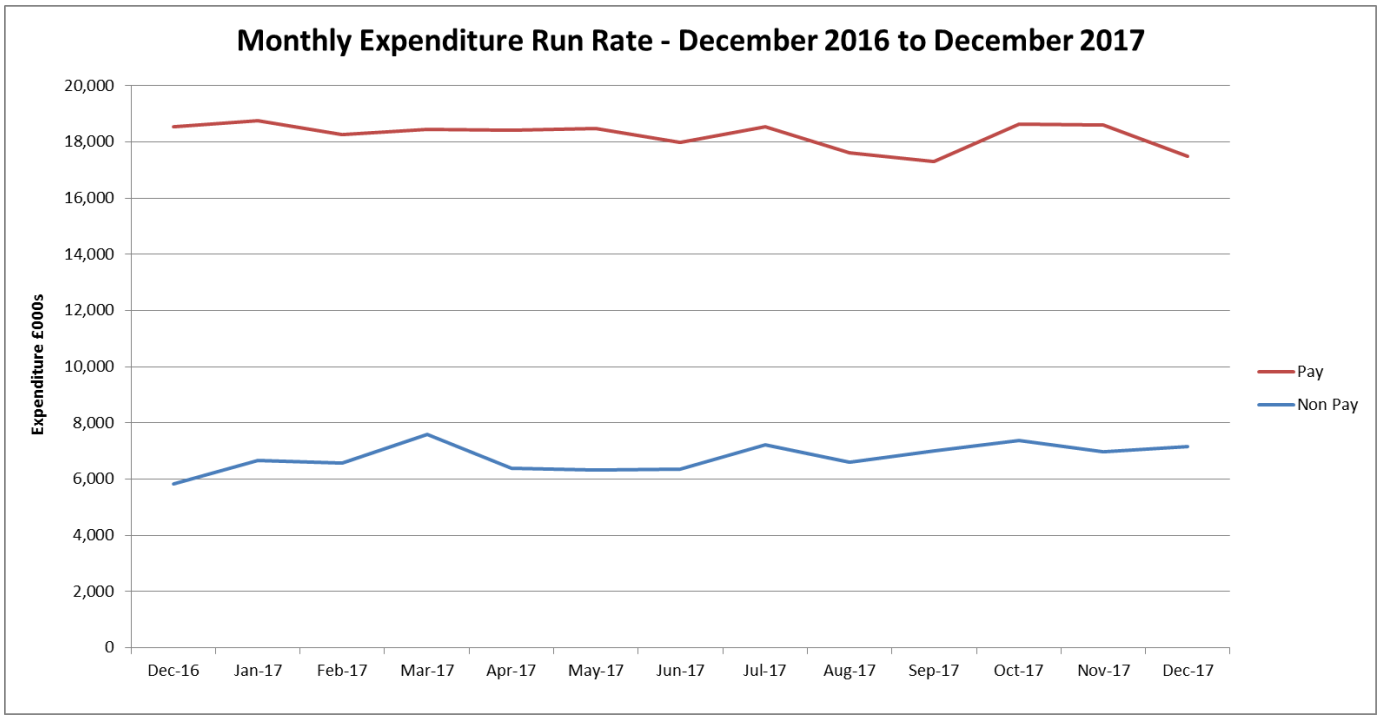
- Total pay expenditure for December was £17.5m, £1.1m lower than the previous month and £0.8m lower than the 12 months rolling average.

- The in month position includes a £0.4m reduction in expenditure following a review of agency shifts for unfilled, etc. The position also benefits from a recharge of staff time associated with capital projects, most notably in relation to IM&T.

- Agency costs this financial year have been averaging at £0.7m per month representing 3.8% of the average monthly pay bill.

Non pay expenditure for December was £7.1m, £0.4m higher than the 12month rolling average. Key drivers for the year to date adverse variance include the underperformance against CIP schemes, together adverse variances under the categories of External Contracts, Staffing & Consultancy (in particular legal fees and dictation services) and Supplies & Services – Clinical.

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



ICSU position

The table below provides an analysis of the expenditure run rates by clinical ICSU for 2017/18. When looking at trend it can be seen that costs are not reducing at the rate required to achieve the Trust's CIP target.

Clinical ICSU Expenditure Run Rates

Pay

	Run Rate - Actual										
	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	2017/18 Month 6 £'000	2017/18 Month 7 £'000	2017/18 Month 8 £'000	2017/18 Month 9 £'000	Average for M1-8	M9 variance from Avg
Children's & Young People	3,896	3,955	3,945	3,941	3,862	3,941	3,804	3,975	3,971	3,915	-56
Clinical Support Services	1,423	1,314	1,423	1,334	1,343	1,382	1,338	1,312	1,336	1,359	23
Emergency & Urgent Care	1,992	1,969	2,036	2,133	2,120	2,091	2,085	2,127	1,697	2,069	372
Integrated Medicine	2,953	2,926	2,820	2,779	2,780	2,963	2,999	2,873	3,127	2,886	-241
Patient Access, Prevention & Planned Care	1,018	1,014	977	943	979	963	969	986	988	981	-7
Surgery & Cancer	3,138	3,006	3,059	3,007	3,197	3,160	3,227	3,083	3,061	3,110	49
Women's Health	1,553	1,571	1,614	1,444	1,456	1,448	1,481	1,518	1,425	1,511	86
Total Pay - ICSUs	15,973	15,757	15,873	15,581	15,737	15,948	15,903	15,874	15,605	15,831	226

Non Pay

	Run Rate - Actual										
	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	2017/18 Month 6 £'000	2017/18 Month 7 £'000	2017/18 Month 8 £'000	2017/18 Month 9 £'000	Average for M1-8	M9 variance from Avg
Children's & Young People	180	219	180	203	227	219	240	234	233	213	-20
Clinical Support Services	1,506	1,563	1,543	1,522	1,602	1,356	1,632	1,450	1,357	1,522	165
Emergency & Urgent Care	223	234	327	277	281	276	252	323	175	274	99
Integrated Medicine	273	277	231	276	282	252	320	289	251	275	24
Patient Access, Prevention & Planned Care	154	134	187	220	201	194	280	309	270	210	-60
Surgery & Cancer	973	836	858	874	874	1,063	832	930	665	905	240
Women's Health	163	197	193	119	112	128	94	132	110	142	32
Total Non Pay - ICSUs	3,472	3,461	3,519	3,490	3,579	3,488	3,650	3,667	3,061	3,541	480

Combined Pay & Non Pay

	Run Rate - Actual										
	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	2017/18 Month 6 £'000	2017/18 Month 7 £'000	2017/18 Month 8 £'000	2017/18 Month 9 £'000	Average for M1-8	M9 variance from Avg
Children's & Young People	4,076	4,174	4,125	4,145	4,088	4,160	4,044	4,209	4,204	4,128	-76
Clinical Support Services	2,929	2,877	2,965	2,856	2,945	2,738	2,970	2,761	2,693	2,880	187
Emergency & Urgent Care	2,215	2,203	2,363	2,410	2,402	2,366	2,337	2,450	1,872	2,343	471
Integrated Medicine	3,226	3,203	3,051	3,055	3,062	3,215	3,319	3,162	3,378	3,162	-216
Patient Access, Prevention & Planned Care	1,172	1,148	1,164	1,163	1,180	1,158	1,249	1,295	1,258	1,191	-67
Surgery & Cancer	4,111	3,843	3,917	3,882	4,071	4,223	4,058	4,013	3,726	4,015	289
Women's Health	1,716	1,768	1,808	1,563	1,568	1,576	1,575	1,650	1,535	1,653	118
Total Spend - ICSUs	19,445	19,217	19,392	19,072	19,316	19,436	19,553	19,540	18,666	19,371	705

Further details of the I&E position for each ICSU, together with Corporate areas and Estates & Facilities can be seen at Appendix 1.

Cost Improvement Programme

Against the Trust's full year target of £17.8m, to date £12.5m 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 and opportunities being proposed and validated to address the gap compared to the target.

Current performance by ICSU is:

Integrated Clinical Service Unit	Against Target		Month 9 - YTD				Year End
	Identified £'000	Gap £'000	Target £'000	Actual £'000	Variance £'000	% achieved	Forecast £'000
Children's services	2,787	278	2,181	731	(1,451)	33.5%	1,191
Clinical Support Services	1,333	1,001	1,661	713	(948)	42.9%	1,033
Emergency & Urgent Care	705	1,452	1,535	440	(1,095)	28.7%	730
Integrated Medicine	1,918	214	1,517	672	(845)	44.3%	943
PPP	674	200	622	626	4	100.7%	875
Surgery	2,161	998	2,248	1,345	(903)	59.8%	2,081
Women's services	990	508	1,066	373	(693)	35.0%	543
Estates & Facilities	836	486	941	392	(549)	41.6%	813
Corporate	1,114	122	880	783	(96)	89.0%	1,064
Total	**12,518**	**5,259**	**12,651**	**6,075**	**(6,576)**	**48.0%**	**9,273**

At Month 9, £6.1m has been recognised as delivered against the CIP programme, which is £6.6m adverse when compared to the Trust's planning submission. It was expected that there would be a step change in delivery of savings from Month 5, but this has not proved to be the case with accelerated delivery now expected in the final quarter. In month £0.9m of schemes was delivered.

The current full-year forecast for delivery is £9.3m, which is £8.5m short of the Trust's full-year CIP target and £8.0m short of its original planning submission. There is a continuing need to offset the shortfall by additional CIPs, other mitigations (both recurrent and non-recurrent) and improved cost control in order to achieve the Trust's forecast year end position.

Statement of Financial Position

	As at 31 December 2017 £000	Plan 31 December 2017 £000	Plan variance 31 December 2017 £000
Property, plant and equipment	209,710	202,403	7,307
Intangible assets	2,613	1,635	978
Trade and other receivables	1,126	851	275
Total Non Current Assets	**213,449**	**204,889**	**8,560**
Inventories	1,591	150	1,441
Trade and other receivables	25,177	27,588	(2,411)
Cash and cash equivalents	6,061	3,730	2,331
Total Current Assets	**32,829**	**31,468**	**1,361**
Total Assets	**246,278**	**236,357**	**9,921**
Trade and other payables	38,309	39,902	(1,593)
Borrowings	2,871	3,832	(961)
Provisions	0	756	(756)
Total Current Liabilities	**41,180**	**44,490**	**(3,310)**
Net Current Assets (Liabilities)	**(8,351)**	**(13,022)**	**4,671**
Total Assets less Current Liabilities	**205,098**	**191,867**	**13,231**
Borrowings	58,768	63,798	(5,030)
Provisions	1,919	1,513	406
Total Non Current Liabilities	**60,687**	**65,311**	**(4,624)**
Total Assets Employed	**144,411**	**126,556**	**17,855**
Public dividend capital	62,404	62,404	0
Retained earnings	(12,038)	(13,924)	1,886
Revaluation reserve	94,045	78,076	15,969
Total Taxpayers' Equity	**144,411**	**126,556**	**17,855**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**

The key highlights for month 9 are:

Property, Plant & Equipment (PPE): The value held at the end of December 2017 is £8.3m above plan, and will remain above plan due to the full valuation exercise undertaken as at 31 March 2017. Additionally, as explained below, the capital programme has accelerated significantly in month 9.

Receivables (Debtors) are currently £2.1m lower than plan. Notable factors within the variance are receipt of the Quarter 2 Sustainability and Transformation Funding, together with reaching settlement arrangements with Camden & Islington NHS Foundation Trust and London Borough of Haringey.

Payables (Creditors) are currently £1.6m lower than plan. The Trust continues to perform well in timely payments to its creditors. Year to date the Trust has averaged 87% payment of creditors within 30 days.

Capital: £4.9m of capital expenditure has been incurred in year to date against a plan of £3.2m (note this includes spend on PFI and finance lease arrangements). Expenditure included the capitalisation of the Trust's bed tender arrangement with Medstrom. It should be noted that the profiling of the Trust's plan requires the increased rate of spend to continue in order to spend the full allocation for the year. Currently, however, the Trust is forecasting an underspend of £0.5m against the capital programme.

Appendix 1 – ICSU I&E Position

	Month 9			Year to date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Children's & Young People						
Income	**1,965**	**2,771**	**806**	**18,190**	**18,837**	**647**
Pay	3,734	3,971	**(237)**	33,687	35,291	**(1,604)**
Non Pay	178	233	**(55)**	1,603	1,937	**(334)**
	1,947	**1,433**	**514**	**17,100**	**18,391**	**(1,291)**
Clinical Support Services						
Income	**1,679**	**1,678**	**(1)**	**16,881**	**16,456**	**(425)**
Pay	1,236	1,336	**(100)**	11,125	12,205	**(1,080)**
Non Pay	1,273	1,357	**(84)**	11,535	13,530	**(1,995)**
	830	**1,015**	**(185)**	**5,779**	**9,279**	**(3,500)**
Emergency & Urgent Care						
Income	**1,298**	**1,435**	**137**	**11,830**	**12,567**	**737**
Pay	1,852	1,697	**155**	16,570	18,250	**(1,680)**
Non Pay	236	175	**61**	2,041	2,368	**(327)**
	790	**437**	**353**	**6,781**	**8,051**	**(1,270)**
Integrated Medicine						
Income	**3,696**	**4,034**	**338**	**34,873**	**33,415**	**(1,458)**
Pay	2,849	3,127	(278)	25,013	26,219	(1,206)
Non Pay	189	251	(62)	1,680	2,453	(773)
	(658)	**(656)**	**(2)**	**(8,180)**	**(4,743)**	**(3,437)**
PPP						
Income	**189**	**182**	**(7)**	**1,788**	**1,521**	**(267)**
Pay	1,048	988	60	9,310	8,837	473
Non Pay	190	270	(80)	1,685	1,949	(264)
	1,049	**1,076**	**(27)**	**9,207**	**9,265**	**(58)**
Surgery						
Income	**4,175**	**3,795**	**(380)**	**40,559**	**39,283**	**(1,276)**
Pay	3,017	3,061	(44)	27,429	27,938	(509)
Non Pay	755	665	90	6,870	7,904	(1,034)
	(403)	**(69)**	**(334)**	**(6,260)**	**(3,441)**	**(2,819)**
Women's						
Income	**2,168**	**2,131**	**(37)**	**22,030**	**21,373**	**(657)**
Pay	1,298	1,425	(127)	12,559	13,511	(952)
Non Pay	99	110	(11)	1,112	1,248	(136)
	(771)	**(596)**	**(175)**	**(8,359)**	**(6,614)**	**(1,745)**
Facilities						
Income	**152**	**212**	**60**	**1,368**	**1,350**	**(18)**
Pay	635	718	**(83)**	5,719	6,317	**(598)**
Non Pay	1,466	1,245	**221**	13,481	13,581	**(100)**
	1,949	**1,751**	**198**	**17,832**	**18,548**	**(716)**
Corporate (Excl Facilities)						
Income	**652**	**645**	**(7)**	**5,364**	**5,903**	**539**
Pay	1,933	1,375	**558**	16,946	15,619	**1,327**
Non Pay	1,575	1,339	**236**	14,276	13,912	**364**
	2,856	**2,069**	**787**	**25,858**	**23,628**	**2,230**

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

Whittington Health NHS

Whittington Health Trust Board
Wednesday 31st January 2018

Title:	Trust Performance report January 2018 (November 17 and December 17 data)		
Agenda item:	**17/132**	**Paper**	**08**
Action requested:	To receive assurance of Trust performance compliance		
Executive Summary:	This report includes narrative for November 2017 and December 2017. **Emergency Department (ED) four hours' wait** Performance against the 95% target increased to 91.3% in November 2017 however performance was challenged in December at 86.5%. This is an increase on performance from the previous year, where performance was 85% for both November and December 2016. In November and December 2017 the Trust saw an extra 300 patients each month compared to the same months in 2016. The Trust reached 100,000 ED attendances over the previous 12 months for the first time in early January 2018. LAS handover times improved in over November 17. This is attributed to the implementation of a new Nurse Led RAT (Rapid assessment and Treatment) Model during daytime hours. LAS handover times rose in December however the data shows that all of the breaches were overnight which suggests that the Trust is maintaining good LAS handover time performance during the day. **Complaints:** The Trust underachieved in November (68.8%) but achieved the standard in December (88.2%) **Cancer:** Underachieving for 62 days target for November 2017 **Community Average Waits:** This is the first time this data is added to the dashboard. It reflects the national waiting time descriptor.		
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:	23rd January 2018		

Author name and title:		**Hester de Graag, Risk and Quality Manager**		**Director name and title:**		**Carol Gillen, Chief Operating Officer**	
Date paper seen		**Equality Impact**	**n/a**	**Risk**	**n/a**	**Legal advice**	**n/a**

by EC		**Assessment complete?**		**assessment undertaken?**		**received?**	

Whittington Health NHS

Integrated Performance Report

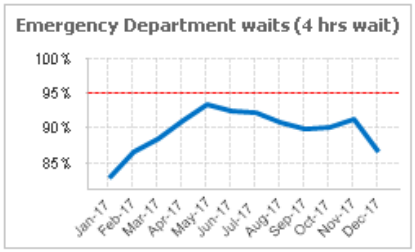
January 2018

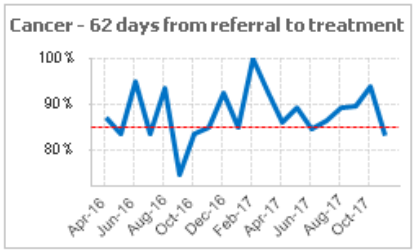
Month 9 (2017 – 2018)

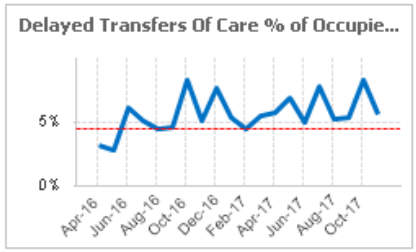
Date & time of production: 24/01/2018 11:14

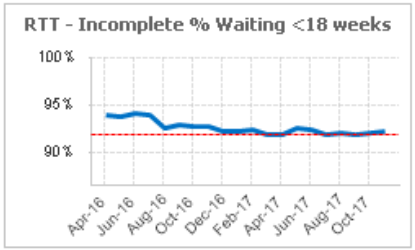
Summary Page - Indicators

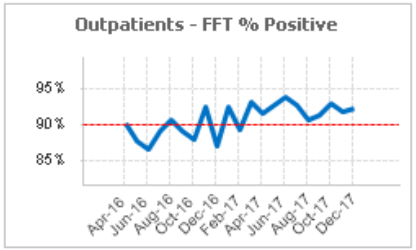
Category	Indicator	17_18 Target	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	2017-2018
ED	Emergency Department waits (4 hrs wait)	>95%	82.9%	86.6%	88.4%	91.1%	93.5%	92.4%	92.3%	90.9%	89.9%	90.1%	91.3%	86.5%	90.9%
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	77	69	72	72	68	63	59	64	72	82	82	81	72
Cancer	Cancer - 14 days to first seen	>93%	94.8%	96.8%	94.6%	93.2%	93.2%	95.3%	95.7%	94.7%	94.3%	93.7%	96.1%		94.5%
Cancer	Cancer - 62 days from referral to treatment	>85%	84.9%	100.0%	92.9%	86.0%	89.1%	84.4%	86.4%	89.4%	89.5%	93.8%	83.1%		87.7%
Admitted	Non Elective Re-admissions within 30 days	<5.5%	4.8%	5.7%	6.3%	6.2%	6.0%	5.8%	6.9%	7.1%	6.5%	7.0%	5.8%	7.4%	6.5%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	5.3%	4.5%	5.5%	5.8%	6.9%	5.0%	7.8%	5.2%	5.3%	8.3%	5.6%		6.2%
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.2%	92.4%	92.0%	92.0%	92.6%	92.4%	92.0%	92.1%	92.0%	92.1%	92.2%	92.1%	92.2%
Outpatients	Outpatients - FFT % Positive	>90%	92.5%	89.4%	93.1%	91.6%	92.8%	93.9%	92.8%	90.8%	91.5%	93.0%	91.9%	92.3%	92.4%
Community	Community - FFT % Positive	>90%	98.0%	96.8%	96.0%	98.5%	94.9%	93.9%	94.8%	96.7%	96.5%	95.3%	94.8%	96.0%	95.6%
Staff	Staff - FFT % Recommend Care	>70%			74.6%			69.0%			69.4%				69.2%

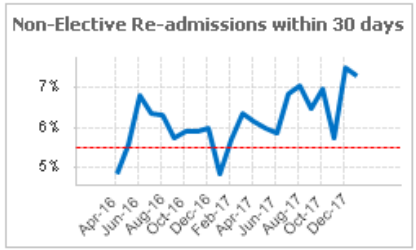












Date & time of production: 24/01/2018 11:143

Safe Services - Indicators and Performance

Category	Indicator	17_18 Target	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-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	1	0	0	1	
Admitted	HCAI C Difficile	<17	0	1	1	2	3	0	1	0	1	3	0	0	10	
All Areas	CAS Alerts Outstanding	0	0	3	0	0	0	0	0	0	0	0	0	0	0	
All Areas	Actual Falls	400	56	45	31	31	44	45	34	31	27	34	28	35	309	
All Areas	Avoidable Grade 3 or 4 Pressure Ulcers	0	2	1	2	2	2	3	2	2	3	3	2		19	
All Areas	Harm Free Care %	>95%	94.3%	92.9%	92.5%	93.2%	93.9%	96.6%	93.5%	93.8%	95.1%	94.1%	93.5%	94.1%	94.2%	
Maternity	Non Elective C-Section % Rate	<15%	20.5%	18.0%	21.4%	19.2%	18.9%	19.7%	22.5%	18.8%	19.8%	20.8%	23.4%	21.7%	20.6%	
All Areas	Medication Errors causing serious harm	0	0	0	0	0	0	0	0	0	0	1	0	0	1	
Admitted	MRSA Bacteraemia Incidences	0	0	1	0	0	0	1	0	0	0	0	1	0	2	
Admitted	Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
All Areas	Proportion of reported Patient Safety Incidents Causing Harm	N/A	21.3%	19.5%	22.4%	18.1%	16.6%	18.3%	17.3%	21.7%	17.1%	16.5%	20.1%	17.2%	18.0%	
All Areas	Serious Incidents	0	4	5	4	2	4	4	3	6	2	5	2	0	28	
Admitted	VTE Risk Assessment %	>95%	96.1%	96.0%	96.5%	95.2%	95.4%	95.6%	95.3%	96.7%	96.0%	95.3%	96.0%		95.7%	

Date & time of production: 24/01/2018 11:143

Safe Services - Commentary

Falls

The number of falls for December 2017 was higher than the expected average. Out of the 35 falls 5 resulted in low harm and 30 in no harm.

Avoidable pressure ulcers

October 2017: 3 pressure ulcers were reported in District Nursing

1 x Grade 3 – Incomplete assessments

1 x Grade 3 - No formal documented assessments completed

1 x Grade 4 - No documents available at the base. Patient's nutritional input had deteriorated and the team did not provide further information for patient or family, no referral to dietician or further monitoring commenced e.g. Food charts.

November 2017: 2 pressure ulcers were reported in District Nursing

1 x Grade 4 – Patient was discharged from Whittington with a Grade 2 sacral pressure ulcer which deteriorated to a Grade 4 whilst under DN team. On discharge the referring ward did not inform the DN's of the Grade 2 pressure ulcer. Delay is completing assessments, no skin inspection completed on first visit. No holistic approach to care. Patient condition, mobility and nutrition were reduced post discharge which was not identified by the DN team.

1 x Grade 3 – Assessments not completed as per DN Standing Operational Procedure.

A new process has been put in place reviewing all grade 3 and 4 pressure ulcers using a panel style approach. The 30% reduction target for community acquired pressure ulcers is on track.

Non Elective C-section rate

21.7% - Slight decrease from previous month (23.4%). The service has seen an increase in induction of labour rates and a proportion of these patients would then go ono to have an emergency section. Working group has been developed to review the induction pathway.

MRSA Bacteraemia
There was 1 new MRSA bacteraemia reported in November 2017. A review (Post Infection Review) was conducted and all actions implemented.

Serious Incidents
2 Serious Incidents were declared in November 2017:

- [IM] 2017.27367 Delayed Diagnosis - possible lesion cancer
- [CS] 2017.20905 Safeguarding Incident- Unexpected death of a 23 week old baby

No Serious Incidents were declared in December 2017.

Caring Services - Indicators and Performance

Category	Indicator	17_18 Target	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	2017-2018	Performance
ED	ED - FFT % Positive	>90%	83.4%	83.9%	83.0%	84.0%	87.4%	84.0%	85.5%	83.0%	80.4%	81.6%	83.3%	83.1%	83.7%	
ED	ED - FFT Response Rate	>15%	14.6%	16.0%	14.6%	16.9%	15.6%	13.8%	13.1%	13.7%	12.6%	13.2%	12.3%	11.5%	13.7%	
Admitted	Inpatients - FFT % Positive	>90%	92.1%	96.1%	94.1%	98.0%	94.2%	97.0%	95.8%	95.2%	97.7%	98.3%	98.3%	97.2%	96.8%	
Admitted	Inpatients - FFT Response Rate	>25%	7.2%	17.1%	26.8%	21.6%	22.7%	19.8%	20.9%	14.9%	16.0%	18.0%	18.2%	16.1%	18.7%	
Maternity	Maternity - FFT % Positive	>90%	88.0%	89.4%	92.4%	93.6%	90.2%	88.1%	92.7%	89.4%	92.4%	94.9%	96.0%	95.9%	93.2%	
Maternity	Maternity - FFT Response Rate	>15%	30.4%	24.0%	27.8%	24.7%	22.2%	20.1%	23.5%	30.1%	18.5%	37.4%	36.2%	49.8%	29.3%	
Outpatients	Outpatients - FFT % Positive	>90%	92.5%	89.4%	93.1%	91.6%	92.8%	93.9%	92.8%	90.8%	91.5%	93.0%	91.9%	92.3%	92.4%	
Outpatients	Outpatients - FFT Responses	400	481	407	551	357	623	537	485	338	433	569	593	336	4271	
Community	Community - FFT % Positive	>90%	98.0%	96.8%	96.0%	98.5%	94.9%	93.9%	94.8%	96.7%	96.5%	95.3%	94.8%	96.0%	95.6%	
Community	Community - FFT Responses	1500	697	1095	1169	725	1192	970	1224	858	940	731	638	605	7883	
Staff	Staff - FFT % Recommend Care	>70%			74.6%			69.0%			69.4%				69.2%	
All Areas	Complaints responded to within 25 working day	>80%	66.7%	90.0%	100.0%	100.0%	83.3%	93.9%	76.0%	81.0%	72.2%	72.7%	68.8%	88.2%	81.8%	
All Areas	Complaints (including complaints against Corporate division)	N/A	22	34	38	22	24	38	32	24	25	26	24	18	233	

Date & time of production: 24/01/2018 11:143

Caring Services - Commentary

FFT

ED continues to be below the 15% response rate and 90% recommend rate KPI. The patient experience team are working with the matron in ED to increase the uptake of FFT in ED and introducing automated SMS FFT alerts for paediatric patients under the age of 12. Currently there are automated SMS alerts for adult patients in ED. Paediatric ED has been identified as an area for improvement as currently FFT is only collected through the paper cards and the response rate in the area is averaging approx. 1-2% (in comparison with adult ED, which averages 15% across November and December). In addition to this action, the Matron has identified leads in the area to improve the pick-up of the paper FFT cards.

Inpatients and Outpatients both have very 'high recommend' rates (98% & 97% for inpatients across November and December; 92% for outpatients across both months). Outpatients were below their target of 400 responses in December, but have tended to be trended significantly above this target in 2017. It is thought the slight drop-off in December (336 responses) is due to services and clinics being closed over the Christmas bank holidays. Actions to improve the response rates on the inpatient wards include increasing the presence of volunteers in the ward areas. In January 2018, 27 new volunteers were inducted, and their allocation/orientation period on the wards is ongoing.

The 'recommend' rate for the Community services remains over 90%, however the number of responses continues to fall, with 638 for November and 605 in December against the KPI of 1,500. The patient experience manager has supported the Podiatry team in setting up SMS links for patients to complete FFTs and is arranging for volunteers to support District Nursing Service inputting FFTs. The patient experience manager will work to identify those areas in the community that need support, and will present an update on this at March's Patient Experience Committee.

Maternity continues to excel. The response rates have risen to 36.2% in November and 49.8% in December, which is well above the 15% KPI. The 'recommend' rate has risen also, with a high of 96% recommending in November, and 95.9% in December. The excellent results in Maternity are a testament to staff engagement in the areas.

Complaints

November 2017:

During November 2017 the Trust closed 24 complaints; 16 required a response with 25 working days, with eight complaints being allocated 40 working days for investigation.

In regard to the 25 working day target, the Trust achieved a performance of 69%, missing its 80% target for the third consecutive month. Four complaints remain outstanding and overdue: three for Integrated Medicine and one for Surgery & Cancer. Three of the eight complaints allocated 40 working days for investigation hit their target, giving the Trust a performance of 37%.
The majority of the complaints were allocated to EUC 25% (6) and IM 25% (6). 37% (9) were designated 'low' risk and 54% (13) were designated 'moderate'.

A review of the complaints for November shows that 'medical care' 29% (7) and 'communication' 29% (7) were the two main issues for complainants; followed by nursing care 12% (3).
In regard to 'medical care', 43% of patients (3) felt that 'inadequate treatment' had been provided with the remaining complainants citing 'poor practice', 'missed diagnosis', 'incorrect treatment' and 'no options offered';
In regard to 'communication', 28% of patients (2) indicated that there was 'poor communication/lack of communication between professionals/staff'; the remaining complainants raised issues relating to 'incorrect details', 'poor verbal communication', 'lack of information to relatives', 'incorrect details', 'language difficulty' and 'poor/inadequate communication with a patient/relative with learning disabilities'.

Finally, in regard to 'nursing care', 67% the issues related to a 'failure to follow prescribed care' (2) and 33% related to a 'poor standard of care' being provided (1).

Of the 20 complaints that have closed, (including those allocated 40 working days), 15% (3) were 'upheld', and 40% (8) were 'partially upheld', meaning that, currently, 55% have been upheld in one form or another.

Caring Services - Commentary

December 2017:

During December 2017 the Trust closed 18 complaints; 17 required a response with 25 working days, with 1 complaint being allocated 40 working days for investigation.

In regard to the 25 working day target, the Trust achieved a performance of 88%, meeting its 80% target for the first time in three months. Two complaints allocated 25 working days remain outstanding and overdue for Surgery & Cancer. The complaint allocated 40 working days hit its target.

The majority of the complaints were allocated to S&C 28% (5), EUC 22% (4) and IM 17% (3). 61% (11) were designated 'low' risk and 39% (7) were designated 'moderate'.

A review of the complaints for December shows that 'medical care' 28% (5) continues to be one of the main issues for patients, in addition to 'attitude' 28% (5) and 'nursing care' 22% (4).

In regard to 'medical care,' 40% of patients (2) felt that there had been 'poor practice' in regard to their care and treatment; 40% (2) felt that 'poor treatment' had been provided.

In regard to 'attitude,' 40% of patients (2) stated that staff had displayed 'inappropriate behaviour' and 40% (2) also stated that staff had been 'rude and/or disrespectful'. Finally, in regard to 'nursing care', issues related equally to 'failure to follow prescribed care'; 'poor continence care/toileting; 'poor pressure area care' and 'poor standard of care'.

Of the 16 complaints that have closed, (including those allocated 40 working days), 44% (7) were 'upheld', and 44% (7) were 'partially upheld', meaning that, currently, 88% have been upheld in one form or another.

Effective Services - Indicators and Performance

Category	Indicator	17_18 Target	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	2017-2018	Performance
Maternity	Breastfeeding Initiated	>90%	93.1%	90.3%	91.6%	90.2%	91.6%	93.3%	94.5%	92.3%	93.2%	91.7%	92.5%	90.7%	92.2%	
Maternity	Smoking at Delivery	<6%	3.6%	5.6%	3.0%	5.4%	3.4%	5.7%	7.5%	4.8%	7.1%	6.2%	6.3%	4.3%	5.6%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	4.8%	5.7%	6.3%	6.1%	6.0%	5.8%	6.9%	7.1%	6.5%	7.0%	5.8%	7.5%	6.5%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	82.2	86.3	61.5	75.1	82.4	70.9	65.8	69.7	31.5				65.7	
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	109.7	31.4	64.4	69.9	71.0	98.1	64.3	75.4	22.1				66.9	
Trust	Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 mont...	1.14			0.71			0.73							0.73	
Admitted	Mortality rate per 1000 admissions in-months	14.4	11.7	9.1	7.9	7.2	7.6	6.5	6.4	7.2	2.6	8.6	8.6	11.7	7.4	
Community	IAPT Moving to Recovery	>50%	50.4%	49.1%	48.4%	50.3%	53.0%	56.4%	52.3%	56.5%	55.1%	50.8%	53.0%		53.5%	
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%									80.0%	90.2%	84.4%	67.8%	79.6%	

Effective Services - Commentary

Smoking at Delivery

Smoking at time of delivery below target for the last 3 months before December 2017 due to:
1) Change in service provision for Camden/Islington, Haringey and our out of area women resulting in challenges in establishing clear referral pathways.
2) Change in referrals process resulting in fewer women getting the help they need to address smoking behaviours.

Actions put in place:

- Backlog of referrals to be addressed urgently.
- Restart referrals via previous process. We have confirmation that Camden/Islington will be picking up the referrals but have no assurance from Haringey as yet.
- Link website established for finding out where local smoking cessation support is available for our out of area women.
- Meeting with Haringey public Health commissioner to help us get this service streamlined.
- Training: Midwives will continue to have updates and newcomers will receive level 1 training from our Camden/Islington smoking cessation providers. We will have a date confirmed for Jan 2018 to train the newcomers.
- Camden/Islington only; help women is via telephone support. This has been shown to be successful elsewhere. Women will be contacted within 24hrs of referral and offered the type of help they want. The smoking cessation clinic was decommissioned as of the end of Sept 2017 for Camden/Islington Services.

December within target at 4.3%

Effective Services - Commentary

Non Elective re-admission within 30 days

The Trust has seen an increase in re-admission rates above the overall average performance. Integrated Medicine ICSU is carrying out 3 audits on readmissions rates, frailty discharges and the use of virtual ward/ambulatory care (results expected in February 2018), overall impact of discharge to assess (ongoing audit) and impact on speech and language services. Results to date have shown when additional resource for speech and language has been made available there is correlation in the reduction of readmissions. Clinician feedback suggests with increased bed pressures there are a high number of "trial" discharges with known risks being undertaken by the MDT. ED is also carrying out an audit looking into re-admission for ED patients.

Referral to District Nursing within 2 hours

The demand increased in December 2017.

Out of the 45 2 hour referrals, 35 were seen on time. Four patients were seen after 2 hours and 6 patients were not seen at the time, as the District Nurse was not given access, i.e. patients were admitted to hospital or patients chose not to be seen by the District Nurse. All 6 patients have been followed up and care has not been compromised.

Responsive Services - Indicators and Performance

Category	Indicator	17_18 Target	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	2017-2018	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	82.9%	86.6%	88.4%	91.1%	93.5%	92.4%	92.3%	90.9%	89.9%	90.1%	91.3%	86.5%	90.9%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	77	69	72	72	68	63	59	64	72	82	82	81	72	
ED	Ambulance handovers waiting more than 30 mins	0	113	68	60	28	14	40	27	23	35	38	15		220	
ED	Ambulance handovers waiting more than 60 mins	0	37	13	3	1	0	7	4	2	1	0	3		18	
ED	12 hour trolley waits in A&E	0	2	3	2	5	4	3	2	4	3	0	0	0	21	
Cancer	Cancer - 14 days to first seen	>93%	94.8%	96.8%	94.6%	93.2%	93.2%	95.3%	95.7%	94.7%	94.3%	93.7%	96.1%		94.5%	
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	93.4%	98.7%	92.9%	96.0%	94.1%	100.0%	100.0%	95.9%	98.1%	98.9%	100.0%		97.8%	
Cancer	Cancer - 62 days from referral to treatment	>85%	84.9%	100.0%	92.9%	86.0%	89.1%	84.4%	86.4%	89.4%	89.5%	93.8%	83.1%		87.7%	
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%		100.0%	
Cancer	Cancer - 62 Day Screening	>90%	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%	99.1%	99.6%	99.2%	99.0%	99.1%	99.1%	99.0%	99.0%	99.1%	99.1%	99.2%	99.1%	99.1%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.2%	92.4%	92.0%	92.0%	92.6%	92.4%	92.0%	92.1%	92.0%	92.1%	92.2%	92.1%	92.2%	
Access	Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	0	0	0	3	1	1	0	0	0	5	

Date & time of production: 24/01/2018 11:143

Cancer Performance - 62D and 2WW by Tumour Group

Cancer - 62D Performance by Tumour Group

		Q4	Q4	Q4	Q1	Q1	Q1	Q2	Q2	Q2	Q3	Q3	Q3		
Indicator	17_18 Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	2017-2018	Performance
Breast	>85%	92.3%	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%		96.7%	
Gynaecological	>85%	40.0%	100.0%	100.0%	100.0%	100.0%	0.0%	50.0%	66.7%	100.0%	100.0%	0.0%		61.1%	
Haematological (Excluding Acute Leukaemia)	>85%		100.0%	100.0%	100.0%	50.0%	100.0%				100.0%			90.0%	
Lower Gastrointestinal	>85%	85.7%		100.0%	100.0%	100.0%		87.5%	50.0%	100.0%	71.4%	76.9%		86.4%	
Lung	>85%	66.7%		66.7%	83.3%		100.0%	100.0%	100.0%	0.0%	100.0%	100.0%		93.9%	
Other	>85%	50.0%													
Skin	>85%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.7%	100.0%		99.0%	
Testicular	>85%				100.0%	100.0%	100.0%		100.0%					100.0%	
Upper Gastrointestinal	>85%			0.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%		75.0%	
Urological (Excluding Testicular)	>85%	85.7%	100.0%	100.0%	54.5%	80.0%	61.5%	57.1%	50.0%	57.1%	94.1%	100.0%		76.3%	

Cancer Performance - 62D and 2WW by Tumour Group

Cancer – 2WW Performance by Tumour Group

Indicator	17_18 Target	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	2017-2018	Performance
Breast	>93%	97.0%	100.0%	95.0%	98.1%	94.8%	98.6%	99.2%	93.9%	98.3%	98.7%	97.3%		97.3%	
Childrens	>93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Gynaecological	>93%	90.0%	95.9%	97.6%	92.6%	97.8%	96.5%	96.2%	100.0%	100.0%	96.5%	100.0%		97.3%	
Haematological	>93%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%	88.9%		97.1%	
Lower Gastrointestinal	>93%	89.4%	94.0%	93.3%	89.2%	87.3%	93.9%	89.3%	88.0%	89.7%	79.5%	93.9%		89.0%	
Lung	>93%	100.0%	88.2%	100.0%	94.4%	100.0%	92.9%	100.0%	100.0%	90.5%	100.0%	83.3%		94.7%	
Other	>93%	80.0%	75.0%	25.0%	80.0%	100.0%								83.3%	
Skin	>93%	97.1%	98.6%	97.3%	100.0%	99.4%	98.6%	99.4%	99.4%	98.7%	97.1%	100.0%		99.0%	
Upper Gastrointestinal	>93%	90.5%	94.4%	78.8%	39.1%	43.3%	77.6%	83.8%	79.5%	57.7%	77.8%	78.8%		69.7%	
Urological	>93%	98.5%	96.8%	98.5%	96.8%	100.0%	95.7%	98.2%	100.0%	95.9%	100.0%	98.5%		98.2%	

Date & time of production: 24/01/2018 11:143

Community Average Waits

Community Average Waits from Referral Received Date to Date First Seen – December 2017

Local Specialty Code	Routine Avg Adjusted Wait (in weeks)	Routine Target	Total Routine Patients 1st Seen	Urgent Avg Adjusted Wait (in weeks)	Urgent Target	Total Urgent Patients 1st Seen
Adult Wheelchair Service	7.0	12	6			0
Adults Speech and Language The...	0.5	12	131	1.7	2	4
Bladder And Bowel Management	15.6	12	109			0
CAMHS	5.9	8	116	Days	5 Days	2
Cardiology Service	2.0	6	27			0
Child Development Services	12.2	18	31			0
Community Children's Nursing	1.0	18	61	1.0	6	7
Community Paediatrics Services	14.8	16	16	3.0	6	17
Community Rehabilitation	3.6	12	240	6.3	2	152
Diabetes Service	4.2	6	34	7.3	2	14
Family Nurse Partnership	4.8	12	12			0
Haematology Service	0.1	-	11			0
Health Visiting	1.9	8	1048	0.4	2	1
Intermediate Care (REACH)	8.0	6	109	1.7	2	16
Looked After Children	4.2	52	25			0
Lymphodema Care	4.7	6	14	5.9	2	3
Musculoskeletal Service - CATS	3.3	18	238	2.6	6	9
Musculoskeletal Service - Routine	4.8	8	1267	3.0	2	74
Nutrition and Dietetics	10.4	8	200	5.6	2	17
Occupational Therapy	9.6	18	20			0
Paediatric Wheelchair Service	6.0	12	1			0
Physiotherapy	8.2	18	58			0
PIPS	3.6	12	16			0
Podiatry (Foot Health)	8.0	8	376	1.7	2	14
Respiratory Service	2.8	6	28	7.2	2	41
School Nursing	2.7	12	56			0
Speech and Language Therapy	9.5	18	101	17.7	6	26
Tissue Viability Service		-	0	1.0	2	77

Date & time of production: 24/01/2018 11:143

Responsive Services - Commentary

Emergency Department (ED) four hours' wait and Ambulance handover time
Performance against the 95% target increased to 91.3% in November 2017 however performance was challenged in December at 86.5%. This is however an increase on performance from the previous year, where performance was 85% for both November and December 2016.

The Trust has seen an increase in the number of attendances and from October 2017 – December 2017 attendances have been over the monthly target of 8285 with October being an especially busy month with 8816 attendances. In November and December 2017 the Trust saw an extra 300 patients each month compared to the same months in 2016. The Trust reached 100,000 ED attendances over the previous 12 months for the first time in early January 2018.

LAS handover times improved over November 17. This is attributed to the implementation of a new Nurse Led RAT (Rapid assessment and Treatment) Model during daytime hours. LAS handover times rose in December however the data shows that all of the breaches were overnight which suggest that the Trust is maintaining good LAS handover time performance during the day.

The median time to treat remained challenged at 82 minutes for November and 81 minutes in December against a target of 60.

12 hour trolley waits in A&E
There were 0 12 hour trolley waits reported in October, November and December which is still a significant improvement from previous months and reflects the ongoing work to streamline the pathway for MH patients as part of the work to embed the recommendations set out by ECIP.

Cancer
The overall cancer indicators are within target except the 62 day standard with a performance of 83.1% against the standard of 85%. Areas of concern are colorectal at 76.9 % and upper GI at 0%. This issue in Endoscopy has been addressed and we expect to see an improvement.
In 2 week wait: The Trust is compliant at 96.08% against the national standard of 93%. However, there are areas of concern in Colorectal with delay in straight to test. A weekly meeting with clinicians and operational lead in endoscopy to monitor action plan which includes an increase in lists (protected) for direct access patients. This should see an improvement in target in March 2018 (April 2018 Performance report)

Community Average Waits
This is the first time this data is added to the dashboard. The format reflects the national waiting time indicator. The report still includes some anomalies, i.e. November referrals included in December data.

Responsive Services - Indicators and Performance

Category	Indicator	17_18 Target	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	2017-2018	Performance
Theatres	Hospital Cancelled Operations	0	15	7	5	6	9	9	2	6	8	15	9		64	
Theatres	Cancelled ops not rebooked < 28 days	0	0	0	0	2	0	0	0	0	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	236	192	255	245	300	210	334	250	252	398	235		2224	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	5.3%	4.5%	5.5%	5.8%	6.9%	5.0%	7.8%	5.2%	5.3%	8.3%	5.6%		6.2%	
Maternity	Women seen by HCP / midwife within 10 weeks	>50%	54.1%	57.5%	50.9%	45.8%	52.8%	48.7%	58.0%	61.4%	59.0%	56.8%	65.2%	64.0%	56.8%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%	97.2%	93.6%	93.3%	97.5%	96.5%	94.7%	94.7%	97.3%	98.8%	95.0%	97.5%		96.6%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	91.3%	93.3%	87.5%	88.6%	93.8%	91.9%	88.7%	89.3%	89.4%	91.6%	89.2%		90.3%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	94.8%	93.3%	90.7%	90.3%	94.1%	96.1%	91.7%	94.6%	94.8%	92.1%	96.4%		93.7%	
Community	Haringey - HR1 % carried out before child aged 15 months					42.9%	36.9%	45.1%	44.6%	41.5%	33.0%	68.4%	68.3%		47.1%	
Community	Haringey - HR2 % carried out before child aged 30 months					37.5%	34.1%	32.7%	48.1%	30.8%	42.2%	44.2%	50.9%		39.7%	
Community	Islington - HR1 % carried out before child aged 15 mths					70.4%	66.8%	70.8%	60.9%	68.4%	73.4%	67.1%	68.6%		68.2%	
Community	Islington - HR2 % carried out before child aged 30 mths					78.0%	75.4%	72.7%	81.5%	72.8%	72.6%	63.7%	75.0%		74.1%	
Community	Haringey - 8wk Review % carried out before child aged 8 weeks				32.1%	20.7%	28.1%	33.7%	42.2%	29.7%	33.8%	30.7%	33.2%		31.7%	
Community	Islington - 8wk Review % carried out before child aged 8 weeks				4.2%	15.5%	29.9%	43.5%	46.4%	48.7%	38.8%	47.3%	52.3%		40.7%	

Date & time of production: 24/01/2018 11:143

Responsive Services - Commentary

Hospital Cancelled operations

In October there were 15 cancelled operation, 11 in Urology (No surgeon available for 8 patient's on flexi list, 1 patient was in another hospital for health reasons and 2 patients were cancelled due to no scope available), T&O cancelled 3 patients due to sickness of surgeon and Gynaecology cancelled 1 as list overran.

In November there were 9 cancelled operations, 2 in Urology due to administrative errors and 7 in Gynaecology 2 due to over ran list and 5 due to administration errors.

New Admission team management is going to be in place from February 2018 to address the administrative issue.

Delayed transfer of care

This indicator has improved its overall performance. Impact of Discharge to Assess, on site social workers from local authorities and overall flow improvements has been positive. The working group between key stakeholders to review capacity and flow improvement has shown successful in December. A MADE (Multi Agency Discharge Event) was held on 28th December 2017. Perfect week is planned for week starting 8th January 2018. MADE will continue to review weekly.

Haringey and Islington New Birth Visits

Islington: 7 (2.85% late)
Islington performance has improved and has achieved 95% target for November.

Haringey: 31 (9.73% late)
Haringey's performance has plateaued between 89-91% from September to November, largely due to HV vacancies and some long term sick leave; recruitment is in place.

Haringey and Islington New Birth Visits cont.

Reasons given for late visits across both boroughs include:
- in hospital (only acceptable exception)
- late notification/incorrect address
- parental preference
- interpreter unavailable
- HV unable to arrange in time (11 NBVs completed on day 15 & 16)

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

1 year review at 15 months: good progress has been made by both boroughs. Haringey has moved from a targeted to universal offer and has seen an improvement from 43% in April to 68% in November; Islington has maintained progress. Both boroughs need to establish targets for 2018/19

2 - 2 1/2 review at 30 months: good improvement in Islington maintaining overall performance at 74%. Haringey has been static due to move from targeted to universal offer; however, improvements made in July 2017 to universal offer should be evident from January 2018.

6-8 week review: both Boroughs have now introduced the 6-8 week assessment and both are making steady and sustained progress. Islington has seen a great improvement from 4.2% in March to 52% in November. Work is in progress to step up Haringey's offer from targeted to universal

Well Led Services - Indicators and Performance

Category	Indicator	17_18 Target	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	2017-2018	Performance
HR	Appraisals % Rate	>90%	72%	75%	80%	80%	79%	79%	78%	78%	75%	71%	69%	71%		
HR	Mandatory Training % Rate	>90%	81%	82%	82%	82%	82%	82%	82%	82%	79%	80%	80%	81%		
HR	Permanent Staffing WTEs Utilised	>90%	87.7%	87.8%	87.8%	88.7%	88.9%	87.4%	86.1%	87.4%	87.3%	87.9%	87.6%	86.3%	87.5%	
HR	Staff FFT % recommended work	>50%			60.5%			54.5%			53.3%				53.8%	
HR	Staff FFT response rate	>20%			24.4%			18.2%			21.6%				19.9%	
HR	Staff sickness absence %	<3.5%	3.8%	3.7%	3.2%	3.4%	3.3%	3.6%	3.3%	3.5%	3.4%	3.7%	3.6%	2.9%	3.4%	
HR	Staff turnover %	<10%	15.3%	15.1%	14.3%	14.8%	14.4%	14.0%	14.7%	15.0%	14.4%	14.1%	14.3%	14.5%	14.5%	
HR	Vacancy % Rate against Establishment	<10%	12.3%	12.2%	12.2%	11.3%	11.1%	12.6%	13.9%	12.6%	12.7%	12.1%	12.4%	13.7%	12.5%	

Average Staff Cost Per Patient

Category	Staff Type	17_18 Target	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Trend
Medical	Average staff cost per patient		94	89	125	107	91	95	96	97	97	95	94	
Nursing	Average staff cost per patient		182	174	237	190	169	169	171	171	164	165	167	
Other	Average staff cost per patient		188	194	256	217	198	194	209	205	209	196	193	

Well Led Services - Commentary

Human Resources

There has been a slight improvement in appraisal compliance to 71% from 69% in December. Sustaining this improvement remains an important priority for each Director and assurance on this will be reinforced through the ICSU quarterly Performance reviews.

Overall vacancy rates increased from 12.4% to 13.7%; however this is likely to be partially due to seasonal factors. The first cohort of international nursing recruits is due to start this month and, this, along with other recruitment improvement measures, is being monitored weekly by the Executive team as they continue focus on reducing nursing vacancy.

Turnover has very slightly increased to 14.5%.

Activity - Indicators and Performance

Category	Indicator	17_18 Target	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Activity
ED	ED Attendances	8285	8254	7430	8527	8285	8699	8239	8537	7853	8051	8816	8549	8582	
ED	ED Admission Rate %		17.2%	17.1%	16.9%	17.2%	17.3%	17.3%	16.4%	17.4%	17.5%	18.0%	18.1%	16.6%	
Community	Community DNA Rate %	<10%	7.6%	7.5%	6.9%	7.1%	7.0%	7.6%	7.3%	7.8%	7.7%	8.1%	8.0%	6.8%	
Community	Community Face to Face Contacts		60467	56369	66464	52666	62912	61529	59794	51845	57405	57507	60419	50126	
Admissions	Elective and Daycase		1879	1686	1850	1618	1790	1931	1904	1830	1828	1907	2004	1584	
Admissions	Emergency Inpatients		2067	1926	2200	2117	2211	2131	2163	2136	2242	2456	2365	2197	
Referrals	GP Referrals to an Acute Service		7098	6567	8314	6304	7615	7064	6912	7240	7122	7936	7871	6112	
Referrals	% of GP Referrals that were completed via ERS		21.5%	20.5%	18.9%	20.5%	19.7%	21.6%	23.1%	28.9%	30.2%	32.3%	34.6%	37.4%	
Referrals	% e-Referral Service (e-RS) Slot Issues	<4%			36.1%	35.1%	32.7%	39.1%	35.7%	25.0%	22.4%	17.3%	14.7%	10.3%	
Maternity	Maternity Births	333	311	274	306	301	329	322	314	319	344	347	337	332	
Maternity	Maternity Bookings	377	364	350	438	345	483	364	380	378	338	420	385	302	
Outpatients	Outpatient DNA Rate % - New	<10%	12.4%	11.8%	12.1%	12.3%	11.9%	11.2%	11.8%	12.6%	11.4%	11.0%	10.2%	11.1%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	12.5%	12.1%	11.9%	11.6%	11.7%	10.2%	11.6%	12.0%	11.1%	10.2%	10.1%	10.8%	
Outpatients	Outpatient New Attendances		8839	8439	9208	7567	9405	9113	8631	8747	8872	9769	10035	7785	
Outpatients	Outpatient FUp Attendances		18671	17070	18970	15644	18621	18989	17819	17398	17424	19460	19171	15254	
Outpatients	Outpatient Procedures		5956	5244	5793	4980	6097	6356	5748	5786	6472	7092	7421	5784	
Theatres	Theatre Utilisation	>85%	72.8%	81.1%	82.7%	84.9%	85.9%	82.7%	83.4%	80.8%	81.2%	86.1%	85.6%	85.7%	

Date & time of production: 24/01/2018 11:143

Average Tariff by Point of Delivery (POD)

Category	Point of Delivery (POD)	17_18 Target	Q4 Jan-17	Q4 Feb-17	Q4 Mar-17	Q1 Apr-17	Q1 May-17	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Trend
Average Tariff	Daycases		682	664	657	739	727	709	699	704	693	687	717	
Average Tariff	Elective		2522	3785	4214	3772	2701	3726	4014	3535	4042	3959	3525	
Average Tariff	Non-Elective		2383	2180	2165	1790	1883	2356	2199	2335	1693	2188	2180	

Activity - Commentary

ERS slot issues
Steadily reducing. Progress is monitered.

Maternity booking and delivery
The maternity unit had 302 bookings in December 17. This is below the KPI, however there has been a reduction in bookings across NCL. In December there were 332 deliveries (women) and 333 births (babies). A delivery figure of 332 is up for December compared to the past two years with less than 300 deliveries in the December month.

DNA
DrDoctor is live within Imaging and CYPS and has shown a reduction in DNA rates since implemented in the Trust. The Trust is working closely with DrDoctor to improve operational reporting after reviewing the current implementation. Once approved by the DrDoctor steering group it will be implemented in Endoscopy, Podiatry and Colposcopy in the next few weeks.

Whittington Health NHS Trust

Trust Board
31st January 2018

Title:	Trust Operational Objectives Update		
Agenda item:	**18/12**	Paper	**09**
Recommendations:	For note		
	This paper provides an update on the progress of the Trust against the operational objectives and the expected position at the end of the year. One target has moved from green to red: This target was to recruit and maintain a substantive workforce to within 13.5% of establishment levels. The current rate is 13.7%. One target was completed (blue): This target was to increase the staff survey response rate. The target was 40%, the Trust achieved 42.4%. One target has moved from red to green: This target was to increase WH market share and identify tenders and contracts to support this objective. In the last quarter 3 bids were successfully submitted. The target to increase the culture of research and development within WH and increase the income from commercial trials by 20% has not been achieved; however two additional commercial trials have been opened. The status of the remaining targets have not changed.		
Reference to related / other documents:	NHSI Operational plan Clinical Strategy		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	BAF 3 BAF 4 BAF 5 BAF 9 BAF15		
Date paper completed:	22/01/18		
Paper previously presented at:			

Author name and title:	**Helen Taylor**	**Director name and title**		**Dr Helen Taylor Acting Director of Strategy**	
Equality Impact Assessment complete?		**Quality Impact Assessment**		**Financial Impact Assessment complete?**	

		complete			

Whittington Health Corporate Objectives 17/18-January 2018 Update

Our Mission
'Helping Local People Live Longer Healthier Lives.'

The Trust vision is to be a national leader in delivering safe, personal, coordinated care to the local community. It is geographically placed in the centre of North Central London (NCL) with a portfolio of services covering the populations of Haringey and Islington but also with some community services in Camden, Enfield, Barnet and Hackney. Externally the developments such as the North Central London (NCL) Sustainability Programme and the Islington and Haringey Wellbeing Programme have a number of strategic priorities which will impact on Whittington Health (WH). This condensed plan summarises the operational objectives that will support WH achieve its clinical strategy and feed into the external developments across Islington, Haringey and NCL.

Deliver high quality, safe care and improved patient experience

Quality of care and patient safety are at the forefront of Whittington Health. The Trust's quality priorities are framed within the context of the 'Sign-up to Safety' initiative, supplemented by a desire to improve patient experience and enhance clinical leadership and engagement.

	in progress and on track
	not met
	completed

Objective	Baseline	Success	Governance/ monitoring	Executive lead	Progress	Expected end of year outcome
Safety Incidents						
Increase reporting of safety incidents as this is a good	**Middle of the pack**	**Top 20% in the NRLS**	**Patient Safety Committee**	**Chief Nurse Medical Director**		

indicator of a strong safety culture			**(PSC) Quality Committee (QC)**			
Achieve the WH Quality targets set out in the quality account.	**Identified in each target plan**	**As identified in each target plan**	**PSC and QC**	**Medical Director**		
Avoidable Mortality						
Establish a trust-wide process for the review of all inpatient deaths	**N/A**	**100%**	**QC**	**Medical Director**		
Quality Improvement						
Address the quality improvement identified in the CQC report	**CQC action plan in place**	**Monitor delivery of actions. Ongoing process including mock inspections completed**	**ICSU Board, ICSU Quarterly review, TMG, QC**	**Chief Nurse**		
Reduce the number of avoidable Falls that result in severe harm	**5**	**<5**	**QC Trust Board**	**Chief Nurse**		
Improve care of people with grade 4 pressure ulcers	**4 in community 0 in hospital**	**<4 in community 0 in hospital**	**QC Trust Board**	**Chief Nurse**		
Ensure there are no 'never events'	**2**	**Zero**	**QC Trust Board**	**Chief Nurse**		
Improve our performance regarding infection control	**2**	**Zero MRSA**	**QC Trust Board**	**Chief Nurse**		
Achieve the 4 hour target for the	**87.36%**	**Implement quality**	**TMG**	**Chief Operating**		**90.45%**

Emergency Department		**improvement plan and trajectory including achievement of 95% by March 2018**	**Trust Board**	**Officer**		
Achieve the cancer access targets Cancer: Urgent referral to first visit Cancer: Diagnosis to first treatment Cancer: Urgent referral to first treatment	 **96.4%** **99.7%** **86.7%**	**Trust compliant with cancer targets.** **93% within 14 days** **96% within 31 days** **85% within 62 days**	**TMG** **Trust Board**	**Chief Operating Officer**		
Achieve the national access standard for : Referral to Treatment (RTT) RTT patients waiting 52 weeks Diagnostic waits Improved Access to Psychological Therapies (IAPT) recovery target	 **Incomplete 93.1%** **0** **99.5%** **50%**	**Trust complaint with the 18 week standard** **Incomplete Threshold 92%** **0** **99%** **50%**	**TMG** **Trust Board**	**Chief Operating Officer**		

Lead the Haringey and Islington Wellbeing Partnership in developing a population based model for Children and Young People in Islington and Haringey	**Plan agreed**	**Service improvement and outcome measures in place**	**ICSU Board TMG Haringey and Islington Wellbeing Partnership Delivery Board**	**Chief operating Officer**		
Work as part of the Haringey and Islington Wellbeing Partnership develop a population based model for Diabetes and CVD in Islington and Haringey	**Plan agreed**	**Service improvement and outcome measures in place**	**ICSU Board TMG Haringey and Islington Wellbeing Partnership Delivery Board**	**Chief Operating Officer**		
Lead the Haringey and Islington Wellbeing Partnership in developing a population based model for Frailty in Islington and Haringey	**Plan agreed**	**Service improvement and outcome measures in place**	**ICSU Board TMG Haringey and Islington Wellbeing Partnership Delivery Board**	**Chief Operating Officer**		
Patient Experience						
We will reduce the amount of time patients wait for booked transport from home to hospital	**Potential 2 hour wait**	**Reduce 15-20 minute wait time**	**QC**	**Chief Nurse**	TBC	
We will reduce outpatient clinic appointment cancellations	**14%**	**<10%**	**QC**	**Chief Nurse**		
We will reduce noise at night for patients	**In patient survey result**	**Improve in patient survey result and additional real time patient feedback**	**QC**	**Chief Nurse**	results in Feb	

We will improve continuity of care when receiving visits from the district nursing team	**TBC**	**TBC**	**QC**	**Chief Nurse**		

Develop and support our people and teams

Our workforce is at the heart of our vision to provide excellent care delivered by expert and caring staff. We are dependent on the creativity and expertise of our staff

Objective	Baseline	Success	Governance/ Monitoring	Executive Lead	Progress	Expected end of year outcome
Workforce development						
Recruit to, and maintain a substantive workforce to within 10% of establishment levels	**16%**	**<13.5%**	**ICSU board, ICSU Quarterly Review, WAC**	**Director of Workforce**		
Reduce and maintain overall turnover to 10.5% or lower	**c14%**	**10.5%**	**ICSU board, ICSU Quarterly Review, WAC**	**Director of Workforce**		
Staff Survey 2017 • Increase response rate • Improvement in key areas through workforce strategy and promotion at ICSU level	**35.9%**	**40%**	**ICSU board, ICSU Quarterly Review, TMG, WAC**	**Director of Workforce Chief Operating Officer**		
Improve the quality of appraisal and achieve the 90% target	**Staff survey results suggest appraisal**	**Improved results in staff survey.**	**ICSU board, ICSU Quarterly Review, TMG, WAC**	**Director of Workforce Chief Operating Officer**		

	not seen as helpful. 80% baseline	**90% staff undergo annual appraisal**				
Tackling bullying and harassment	**30% staff replying reported**	**Improved result in staff survey**	**TMG Trust Board**	**Director of Workforce**		
Deliver the expanding apprenticeship programs throughout the organisation	**33 Apprentices in post**	**HCA appointments are made as apprenticeships**	**WAC**	**Director of Workforce**		
Develop and implement staff survey action plans in each ICSU	**Survey results**	**Action plans in place and implementation measured at each quarterly review**	**ICSU board, ICSU Quarterly Review, WAC**	**Chief Operating Officer**		
Maintain the Mayor of London Charter standard and roll out staff health and wellbeing initiatives	**Charter standard in place**	**Charter standard in place**	**WAC**	**Director of Workforce**		
Annual staff achievement awards in place and established	**N/A**	**Annual awards ceremony**	**Trust Board**	**Chief Nurse**		
Deliver the Quality Improvement strategy through 2017/18	**N/A**	**25% of staff trained**	**TMG**	**Director of Workforce Chief Operating Officer**		

Develop our business to ensure we are clinically and financially sustainable.

A central goal for Whittington Health is to reduce costs whilst continuing to deliver high quality care. This is the second year of the £25m cost reduction plan that is required in order for it to achieve a sustainable position.

Objective	Success	Governance/Monitoring	Executive Lead	Progress	Expected result by the end of the year
Financial objectives					
Ensure the Trust achieves the agreed Control Total for 2017/18 and collects all the STF monies	**Each ICSU and corporate area delivers plans**	**ICSU board, ICSU Quarterly Review, TMG, F&B**	**All**		
Ensure operational excellence in our Community business	**Improved data quality Complete benchmarking Metrics developed SLR data in place and being used**	**ICSU board, ICSU Quarterly Review, TMG, F&B**	**Chief Operating Officer**		
Efficiency Savings					
Deliver the cost reduction of £17.8m	**Each ICSU deliver its CIP programme and a reduces run-rate**	**ICSU board, ICSU Quarterly Review, TOM, Project Management Office (PMO)**	**Chief Operating Officer**		
Reduction in agency spend	**Reduction from £13.197m to NHSI targets**	**ICSU board, ICSU Quarterly Review, F&B**	**All**		

Carter Review					
Review Carter measures and data on model hospital	**Measures agreed for all areas**	**TMG Trust Board**	**All**		
Deliver the Hospital Pharmacy Transformation Programme	**Plan submitted to NHSI**	**ICSU Board, ICSU quarterly review, TMG**	**Chief Operating Officer**		
To improve medical productivity	**100% job plans on Allocate New policy implemented on job planning**	**TMG**	**Medical Director**		
Workforce productivity	**e roster used fully on wards to ensure rosters built on acuity rather than bed numbers**	**TMG**	**Chief Nurse**		
Estates and Capital Plan					
Deliver the Strategic Estates Plan	**Select vehicle and procure for delivery Development plan in place and agreed Business case approved for development Endoscopy improvement project completed**	**Capital Planning Group, F&B TMG Trust Board**	**Chief Financial Officer Director of Strategy**		

New Contracts				Progress	
Increase WH market share and identify tenders and contracts to support this objective.	**Business development plan in place** **Contracts awarded**	**TMG, F&B**	**Chief Financial Officer** **Director of Strategy**		
Develop new funding models for integration and new models through the Wellbeing Partnership	**Design and evaluate new funding models**	**F&BD** **Trust Board**	**Chief Financial Officer**		TBC

Further develop and expand our partnerships and engagement

In order for us to achieve our mission and clinical strategy the most successful model will be local partnership working with a range of agencies. Our locality has a long and strong history of joint working, which we will continue to develop.

Objective	Success	Governance and Monitoring		Progress	Expected by end of year
Develop our partnerships and engagement					
Active membership of the Health and Wellbeing Partnership	**WH is represented at all forums of the Wellbeing Partnership and leads one of the clinical programmes**	**TMG**	**Director of Strategy**		
Actively participate in the North Central London Sustainability and Transformation Plan	**STP supports the principles of population health outlined in the WH**	**TMG**	**Director of Strategy**		

	Clinical Strategy				
Progress work as Digital Exemplar Fast Follower programme	**Plan by end of June Relationship developed with Bristol Hospital Trust**	**TMG**	**Chief Financial Officer**		
Working with Haringey and Islington CHIN developments as part the Health and Wellbeing Partnership and the STP.	**Plans in development WH integral to CHINs developed and alignment of services**	**ICSU Board TMG Haringey and Islington Wellbeing Partnership Delivery Board**	**Medical Director (Integrated Care) Chief Operating Officer Director of Strategy**		
Develop clinical collaborations with UCLH	**Clinical pathways and collaborative working to deliver sustainable services**	**ICSU Board, ICSU Quarterly review, TMG**	**Director of Strategy**		
Further enhance our reputation for excellent multidisciplinary and integrated education and training.	**Implement the Education Strategy and develop operational plan Successfully lead the Nursing Training Superhub for North Central London Extend e training model in ED department that uses the 'Moodle' platform to deliver short courses and learning support courses for targeted sectors of the workforce**	**Education Strategy Group WAC**	**Medical Director**		

Increase the culture of research development within WH	**Open 20% more studies by March 2018** **Open two additional commercial trials** **Increase income from research by 20%**	**ICSU Board Research and Development Office**	**Associate Medical Director and Research Lead**		
Community Engagement				**Progress**	
Ensure community of Islington and Haringey are able to engage with WH	**Revise the Communication and Engagement Strategy Develop a community engagement model and implement a programme of engagement e.g. social media, 'listening events' and a digital community forum for local residents to engage with.**	**TMG Trust Board**	**Director of Communication Director of Strategy**		
Community activation and engagement including embedding co-production into clinical pathway development	**TBC**	**TMG Trust Board**	**Chief Operating Officer Director of Strategy**		

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

Whittington Health
NHS Trust

Magdala Avenue, London
N19 5NF

Whittington Health Trust Board

31 January 2018

Title:	**Fire Safety**		
Agenda item:	**18/013**	**Paper**	**10**
Action requested:	Review		
Executive Summary:	This paper sets out Whittington Health's intent to ensure that its patients, staff and visitors are cared for, work in and visit our premises, confident that the environment is safe in the context of fire safety. The paper identifies improvements required and how they are being delivered, and what work remains. The paper is for information, discussion and support of actions taken		
Summary of recommendations:	To receive the report and support the actions To have an Assurance report six monthly		
Fit with WH strategy:	In line with Trust Clinical and operational strategies		
Reference to related / other documents:	Health Technical Memoranda (HTM) 05 (Fire Safety) and the Regulatory Reform (Fire Safety) Order 2005		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	DATIX Risk 801 Fire Marshals and Warden Provision and Training		
Date paper completed:	24.01.18.		

Author name and title:		**Adrien Cooper Director of Environment**		**Director name and title:**		**Stephen Bloomer, Chief Finance Officer**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

1.0 Purpose

1.1 This paper sets out the Trust's obligations under fire safety, the current position and planned improvements.

2.0 Background

2.1 Whittington Health must ensure that its patients, staff and visitors are cared for, work in and visit our premises, confident that the environment is safe in the context of fire safety.

2.2 Fire Safety law is enshrined in the Regulatory Reform (Fire Safety) Order 2005 (commonly referred to as the RRO), this is translated into Department of Health doctrine in the form of the Health Technical Memoranda (HTM) 05 (Fire Safety). The HTM document provides practical instruction on how fire safety should be proactively managed to protect patients, staff and visitors while using NHS premises. This forms the basis of the Trust's Fire Safety Policy.

2.3 The practical implementation of the Trust's fire policy in terms of our buildings fire safety integrity is the responsibility of the Director of Environment who is the named Responsible Person in terms of the RRO. Most of the day to day fire safety management duties are delegated to the Deputy Director of Facilities as named Fire Safety Manager under HTM 05.

2.4 The Fire Safety Policy is an organisational statutory obligation and every staff member has a responsibility to ensure they proactively minimise the risk of fire by applying their fire safety training in their day to day activities. Fire training forms part of mandatory training.

3.0 The Key Fire Safety roles are:

3.1 Fire Marshals

3.1.1 The Trust aims to have a minimum of one fire marshal per shift within clinical departments, although this is varied in critical areas such as theatres or the intensive care unit. The key duties of the fire marshal are to proactively support and promote fire safety best practice which involves routinely inspecting the ward or department to ensure fire evacuation routes are not impeded, fire doors are not wedged open, or combustible materials are stowed inappropriately. This must be a recorded action.

3.1.2 They are trained in fire evacuation procedures and with the assistance of the fire safety advisor, will produce a local evacuation plan (with the ward or department manager) to direct patients, visitors and colleagues to a position of safety until such time the fire brigade reach site.

3.2 The Fire Safety Advisor (FSA)

3.2.1 The Trust must have a qualified person who provides day to day local advice, mandatory fire training for staff and fire marshal training. Fire risk assessments are often delivered by the fire safety advisor.

3.3 The Authorising Engineer for Fire Safety

3.3.1 This is an important role advocated by the HTM and provides external objectivity, specialist advice and an annual audit. The post holder is normally an external consultant qualified to Chartered Engineer status.

3.4 Fire Risk Assessments (FRA)

3.4.1 A fire risk assessment will assess the physical design appropriateness, building condition, fire safety systems and the operational functionality and safety of the healthcare facility. This is a legal requirement and normally undertaken on a three yearly cycle and updated after a change of use or incident. The assessment will identify any shortfalls and remedial actions.

4.0 Trust Position

4.1 In August 2017 the Director of Environment reported to the Trust Management Group a number of Fire safety improvements required. These are listed below, with the position as of August 2017, improvements made to date and those planned.

4.2 The current trust fire policy required update and improvement

Action taken:

The policy in place at the time was a combined policy and procedural document, it has now been re-written, to separate the policy from the procedures for ease of regular updating. The revised document ultimately defines more clearly the organisation's intent to comply and how it will be achieved. The new policy will formally go to the Trust Health & Safety Committee in February.

The procedural processes have been revised and are complete awaiting ratification at the February Fire Safety Group.

Future actions:

Further fire safety documents will be added, this will form the trust's Fire Management System as advocated in HTM 05. These will include a Whittington Health specific Fire Design Guide for new buildings and refurbishments and Requirements for Contractors. To be completed by June 30th 2018.

4.3 The Fire Safety Group was not delivering against its terms of reference

Action taken:

The Fire Safety Group now meets monthly as a standard frequency, rather than the previous quarterly frequency. The Director of Environment chairs the group and the appointed Authorising Engineer (Fire Safety) is also a full member, and provides external objectivity. The Director of Environment has also secured the regular attendance of London Fire Brigade Healthcare Liaison officer, following the signatory of a Memorandum of Understanding to improve collaborative engagement between the LFB and the organisation.

The meeting is split into two one hour sessions. The first hour is dedicated to user engagement with named Responsible Person's for Fire Safety representing each ICSU. All ICSU's consistently provide representation and have engaged positively to assist in addressing the shortfalls identified, particularly with the immediate need to improve the levels of fire marshals in wards and departments.

Future actions:

The Fire Safety Group will produce regular assurance reports to the Health & Safety Committee, next meeting 26.02.18.

4.4 The Trust did not have an appointed Authorised Engineer (Fire Safety)

Action taken:

The Trust has appointed an experienced Authorising Engineer (Fire Safety) who is assisting the Director of Environment with fast tracking non-compliance remediation.

4.5 The Trust did not have a substantive fire safety advisor.

Action Taken:

The Trust is out to advert for this post and a fire safety consultancy is currently providing support on training and fire risk assessments.

4.6 The Trust did not have enough trained fire marshals (circa forty in August 2017)

Action taken:

Each ICSU has worked with the corporate Health & Safety team to reach a determination of their requirements in terms of numbers of fire marshals per ward and department. Training sessions have now led to one hundred and ten (**110**) fire marshals trained.

The training was redesigned to be delivered in the workplace covering evacuation and general fire safety housekeeping.

Future Action:

The trust is committed to increasing the number of trained marshals to 300 by June 30th 2018.

5.0. Conclusion

The Executive Team have continued to monitor the progress of improvement on a weekly basis via updates from Director of Environment. This will continue until such time that full assurance can be provided that all outstanding actions are completed.

It is recommended that an Assurance Report from the Director of Environment, accompanied by an Annual Audit from the Authorising Engineer for Fire Safety is presented within six months to the Trust Board, then annually thereafter. Both documents are to be approved by Healthcare Liaison officer, LFB.

Emergency Preparedness
Direct Line: 020 7288 3035
www.whittington.nhs.uk

Magdala Avenue
London N19 5NF

Whittington Health Trust Board
31st January 2018

Title:	**EPRR Annual Report**		
Agenda item:	**18/014**	**Paper**	**11**
Action requested:	For information		
Executive Summary:	This paper outlines the progress that the Trust has made over the last 12 months in EPRR arrangements and an update on the plans in place that the Trust is required to prepare for and respond to a wide range of emergencies that could impact on health or patient care. The Trust continues to be represented at appropriate levels in the various London wide EPRR arrangements. • The Trust was inspected by the NHS England assurance team on the 6th and 9th of October 2016. The results and evidence of improvement from the inspection are summarised in this report. • The Trust undertakes various training & exercising initiatives relating to Emergency and Business Continuity and also participates in exercises run by partner organisations, and those on a larger scale run across sector.		
Summary of recommendations:	• Review of EPRR annual report • Review of annual EPRR action plan/programme		
Fit with WH strategy:	Fulfil all relevant legal and contractual EPRR requirements including, the Civil Contingences Act 2004 and NHS England Emergency Preparedness Framework & core standards 2013		
Reference to related / other documents:	EPRR policy, Business Continuity Management Policy.		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	National Risk Register Haringey and Islington Borough Risk Registers Whittington Health NHS Trust Risk Register		
Date paper completed:	11/01/2018		

Author name and title:		**Lee Smith Emergency Planning Officer**		**Director name and title:**		**Carol Gillen Chief Operating Officer**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment**		**Financial Impact Assessment**	

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE
2017/2018 ANNUAL REPORT

1.0 EXECUTIVE SUMMARY

All NHS Organisations are required to prepare for and respond to a wide range of incidents or emergencies that could impact on health or patient care. These could be anything from extreme weather events, infectious disease outbreaks, terrorist attacks to major transport accidents. Furthermore, NHS Organisations must be internally resilient and be able to respond safely to such incidents, or other internal disruptions, whilst maintaining its services to patients.

The Civil Contingencies Act (CCA) 2004 places a number of duties on both Category 1 and 2 responders to ensure they are adequately prepared to respond to an emergency. The Trust is defined as a Category 1 responder under the CCA 2004 and therefore has a legal obligation to comply with a number of statutory duties. The CCA 2004 brings together both Category 1 and 2 responders within a framework to ensure greater consistency and co-operation at the local level.

The Trust continues to be represented and involved at appropriate levels in the various London wide Emergency Preparedness, Resilience and Response (EPRR) arrangements. The Trust undertakes various training and exercising initiatives relating to Emergency and Business Continuity and also participates as appropriate in exercises run by partner organisations, and those on a larger scale run across sector.

2.0 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

The CCA 2004 places duties on all trusts to cooperate and share information with, and to coordinate efforts and work jointly with, partner organisations in Local Resilience Forums to ensure that emergency planning and preparedness is properly coordinated within each area, thus facilitating effective response to Major Incidents, and other emergencies or significant service interruptions.

The NHS England Emergency Preparedness Framework 2015, core standards and a number of significant guidance documents have informed the Trust's emergency planning. Some of these are specifically referred to below in the relevant sections of this report.

It is essential that the Trust Board be kept appropriately informed regarding EPRR, which includes planning for major incidents and emergencies, business continuity issues and any other scenarios with the potential to seriously disrupt the running of the Trust or the delivery of its services.

3.0 RESPONSIBILITY AND ACCOUNTABILITY

The Health and Social Care Act 2012 places upon NHS-funded organisations the duty of Accountable Emergency Officer with regard to emergency preparedness, resilience, and response (EPRR) (Section 46.9). In line with NHS England guidance, Carol Gillen Chief Operating Officer (COO) has been designated to take responsibility for EPRR on behalf of the organisation known as the Accountable Emergency Officer (AEO).. The COO is responsible for ensuring that the Trust has a Major Incident Plan in place based on the duties of the CCA i.e. risk assessment, cooperation with partners, emergency planning, business continuity management, communication with the public and information sharing. This is supported on a day to day management of emergency response by the Emergency and Business Continuity Planning Officer Lee Smith.

4.0 FRAMEWORK FOR EMERGENCY PREPAREDNESS WORK WITHIN WHITTINGTON HEALTH NHS TRUST

The Emergency Management Steering Committee has met throughout the year in order to ensure that the emergency preparedness agenda continues to progress and to facilitate the increasingly requirement to have standardised Trust wide business continuity plans The group is chaired by Carol Gillen and includes senior representatives from each Directorate as well as a number of other key individuals from specific services.

The work of this group is critical to the Trust's ability to respond effectively to any emergency or major incident, and to its ability to continue to deliver agreed levels of services during any crisis. Directors are therefore expected to give the work and requirements of the group high priority, ensure they actively support it, and ensure all within 'their' services comply with its requirements and expectations. The committee reports through to Trust Operating Board (ToB) which in turn reports directly to the Executive Committee (EC).

An EPRR policy and Business Continuity Management (BCM) policy has been written to outline how emergency management will be implemented into the Trust to ensure we are meeting our legal obligations.

5.0 NHS ENGLAND EPRR AND CBRN CORE STANDARDS ANNUAL ASSURANCE

This year Whittington Health was reviewed on the 6th and 9th of October 2017 by the North East North Central NHS England Assurance Team. There was an intense review which focused on business continuity and EPRR. Whittington Health was assessed for compliance against the EPRR Core Standards.

The EPRR Core Standards set out by NHS England enable the Trust to co-ordinate activities and provide a consistent cohesive framework for self-assessment, peer review and assurance processes. There is also core standards related to the response to chemical, biological, radiation, and nuclear (CBRN) incidents.

The core standards have gone through a national review and have not changed from 2016.

This document is Version 5.0. The following addition of a ‘deep dive’ has been made:

• Inclusion of EPRR Governance questions to support the 'deep dive’ for EPRR Assurance 2017-18

Deep Dive Governance Questions 2017

DD2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.
DD3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.
DD4	The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function
DD5	The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/delivery group
DD6	The organisation's Accountable Emergency Officer regularly attends the Local Health Resilience Partnership meetings

The Trust will go through annually an assurance review with NHS England (London) against the core standards, this year that has involved a self-assessment involving RAG rating using Red, Amber Green system – see below.

Red = Not compliant with core standard and no evidence of progress

Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.

Green = fully compliant with core standard.

This was followed by a challenge and review session involving NHS England (London), Clinical Commissioning Group (CCG) and a peer reviewer (Emergency Planning Officer from another Acute Trust) where we went into more detail on each of the core standards and they asked for more evidence to support the RAG rating. This was also carried out in a similar way with the CBRN core standards but was attended by London Ambulance Service instead of the CCG.

The tables below show the results of the 2013, 2014, 2015, 2016 and 2017 EPRR and CBRN core standard assurance illustrating a significant improvement over the 12 months with work on EPRR. NHS England (London) also informed that the Trust that the overall score for this year is “**Substantial**” compliance. This indicates an improvement on last year.

EPRR and CBRN **2017** assurance outcome

NHS England Core Standards	Core Standards total:	Assessment outcome Red	Assessment outcome Amber	Assessment outcome Green
EPRR	52 (1-52)	0	0	52
CBRNE	14(53-66)	0	1	13
Governance Deep Dive Qu	6	0	0	6

EPRR and CBRN **2016** assurance outcome

NHS England Core Standards	Core Standards total:	Assessment outcome Red	Assessment outcome Amber	Assessment outcome Green
EPRR	52 (1-52)	0	3	49
CBRN	14 (53-66)	0	2	12
Business Continuity	6	0	0	6

EPRR and CBRN **2015** assurance outcome

NHS England Core Standards	Core Standards total:	Assessment outcome Red	Assessment outcome Amber	Assessment outcome Green
EPRR	52 (1-52)	0	5	52
CBRN	14 (53-66)	0	4	10
Pandemic Flu	4	0	0	4

EPRR and CBRN **2014** assurance outcome

NHS England Core Standards	Core Standards total:	Assessment outcome Red	Assessment outcome Amber	Assessment outcome Green
EPRR	47	0	4	43
CBRN	14	0	4	10

EPRR and CBRN **2013** assurance outcome

NHS England Core Standards	Core Standards total:	Assessment outcome Red	Assessment outcome Amber	Assessment outcome Green
EPRR	109	3	46	60
CBRN	23	3	8	12

Assurance Review Team Summary 2017

- The Trust now has a permanent EPLO in place, which was based on the recommendations from the NHS Assurance Team in 2015.
- The Trust continues to demonstrate improvements to its preparedness and response since the 2015-16 Assurance process.
- It is recommended that the ELPO engage with the Community and Mental Health Learning Set. The current chair is Katy Tame katy.tame@nhs.net.

Pandemic Flu Feedback

Organization	Patch	Provider/ CCG/ CSU	2016 RAG	2016 Feedback
Whittington	NENC	P	G	A comprehensive plan with detail about actions during the UK response stages. The UK response tables would benefit from including details of who is responsible for the various actions to ensure delivery. You could delete NHS Direct from the table on p46.

Business Continuity Feedback

Organization	Patch	Provider/ CCG/ CSU	2017 RAG	2017 Feedback
Whittington *Business Continuity Planning*	NENC	P	G	The Trust has maintained a robust business continuity management process within the Trust. Work is ongoing to implement formal BC checks as part of procurement/ commissioning processes. Comments from the Business Continuity Plan EPRR feedback: Staff support and wellbeing following the Event. **Good practice.** Information required making a mutual aid request. **Good practice.**

CBRNe/ HAZMAT Assurance Visit

Organization	Patch	Provider/ LAS CSU	2017 RAG	2017 Feedback
Whittington	NENC	P	A	CS-53 -The Trust has scored 1 Amber score from core standards 53-57. The Initial Operational Response requires a clearer algorithm appropriately adapted to an NHS acute setting.

- The Trust has improved since the 2016 Assurance Process. We have reduced the Amber score to one.

Action plans and governance

Within two weeks of the assurance review meeting being held, the Accountable Emergency Officer must submit the following documentation: NHS England (London) also informed that the Trust that the overall score for this year is "**Substantial**" compliance. This indicates an improvement on last year. Areas of good practice identified by NHS England include business Continuity Management.

EPRR and CBRN **2017** overall assurance outcome

- Results of the organisation's final EPRR RAG scores, as agreed at the review meeting
- A resulting action/work plan providing clear actions, timescales and leads on areas where the organisation scored Amber which has been submitted
- A declaration of the Level of Compliance achieved (see below)

To enable a national-level overview of EPRR capability each organisation is asked to provide a single self-assessed Level of Compliance, approved by the AEO. This is intended to summarise whether organisations believe they are fully, substantially, partially or non-compliant against the core standards as a whole. The definitions of each term are detailed below:

Compliance Level	Evaluation and Testing Conclusion
Full	The plans and work programme in place appropriately address the entire core standards that the organisation is expected to achieve.
Substantial	The plans and work programme in place do not appropriately address one or more the core standard themes that the organisation is expected to achieve.
Partial	The plans and work programme in place do not adequately address several core standard themes that the organisation is expected to achieve.
Non-compliant	The plans and work programme in place do not appropriately address multiple core standard themes that the organisation is expected to achieve.

Action plans and governance

Within two weeks of the assurance review meeting being held, the Accountable Emergency Officer must submit the following documentation: NHS England (London) also informed that the Trust that the overall score for this year is "**Substantial**" compliance. The NHS EPRR Assurance Process team for this year concurred that the Trust has achieved "**Substantial**" compliance. This signifies an improvement on last year. Areas of good practice identified by NHS England include Business Continuity Management

6.0 EMERGENCY PLANNING – MAJOR INCIDENT EXERCISING

- On the 21st of November, Whittington Health NHS Trust conducted Exercise Asclepius. Exercise Asclepius was a live simulation that focused on the interoperability between the Metropolitan Police, London Ambulance Service, St John's Ambulance and the NHS. We had representation across the sector with delegates from Local Authorities, Police, LFB, LAS and NHS England present. The exercise tested Whittington Health NHS Trust's capability in response Major Incident Terror scenario.

- On the 15th of November Whittington Health NHS Health participated in the Exercise Eskimo. The exercise was conducted by Public Health England in Conjunction with NHSE NENC EPRR Network Team. The Exercise (Emergo) tested the NENC and Essex Trauma Networks response to a mass casualty terror incident.

- 5th of September Whittington Health NHS Health Trust IM&T staff participated in a table top Exercise Pronesis with the aim of testing the recently updated IM&T Incident Response plan.

- 8th of September Major Incident Emergo event. ED Nurses in charge were trained and tested on how to the pre-hospital and acute phases of responding to a Major Incident. Escalation and response elements of the Major Incident Plan were tested.

6.1 Pre planning - major events

Under emergency management there is also a process to plan for pre identified major events (internally or externally) or upgrades to critical systems. There is a standard template in place which covers:

- Operations
- Logistics
- Communications – internal & external
- Planning – response & recovery

This process has been used for the following events:

- Industrial Action – Health Unions; Junior Doctors; Fire Brigades Union & London Underground
- EPR PAS/ED & BI planned upgrade;
- Medway planned upgrades;
- PACS - imaging planned upgrades;
- JAC updates
- Pathology system planned upgrade;
- Quarterly generator tests;
- Vacuum plant changeover.

- Medical Gasses Maintenance
- Critical Infrastructure updates
- SCBU environmental clean
- Road Works
- Evacuation Matt training on site and in community.

Following each event, a debrief is carried out by the Emergency & Business Continuity Planning Officer with key leads to identify learning in preparation for future major events.

7.0 SERIOUS WEATHER RELATED DISRUPTIONS

There is now a heatwave and cold weather plan for the Trust which follows national guidance. As well as this the advance information and warnings available to the Trust has improved.

The Meteorological Office issues a range of warnings (detailing severity and levels of 'confidence'
In the forecast) which are sent to the Emergency Planning and Business Continuity Officer, Site Managers and silver and gold on call. Thus enabling services to receive (and respond as appropriate to) a range of severe weather related threats and potential service disruptions, without having the receipt of this information delayed by channelling it through one individual or office.

8.0 BUSINESS CONTINUITY MANAGEMENT

The Trust has undertaken initial work on Business Continuity Planning concentrating in the first instance on each Directorate attempting to prioritise services in terms of criticality, and considering the minimum staff levels (and to some extent, skill mix) required to continue delivering these services. However this is still a work in progress as there is variation in the quality and standard of the individual service plans. A new Trust template has been agreed and good progress has been made in completion by the services.

Other significant improvements within this area relate to the following - implementation of:

- Business Continuity Management Policy
- Strategic Business Continuity Plan
- Service/Department Business Continuity Plans

9.0 CBRN RESPONSE PROCEDURES

The CBRN response procedure was updated this summer by the newly established CBRN subcommittee from the Emergency Management steering committee. Training and testing of key staff in the use of the decontamination equipment is carried out monthly lead by CBRN lead in ED and supported by Security. There are some changes with regards to methods of decontamination, the new guidance and DVDs are being produced by NHS England which will be distributed to provider Trusts in due course. The course content for CBRN has changed in 2016; we have increased resilience by adding Paul Abdey Resuscitation Lead to the Training Team, whom qualified in September 2016. We have also increased our resilience and engagement with the EUC by appointing Joanne Poulter to CBRNE/Major Incident link nurse. The aim is book Joanne Poulter onto the CBRNE trainer course in 2018. Whittington Health NHS trust has received 7 new PRPS suits in December and is awaiting the delivery of 17 more in the early part of this year.

10.0 PANDEMIC INFLUENZA PLAN

The pandemic influenza plan has had a complete revision following new guidance and best practice. A new pandemic influenza subcommittee has been established from the Emergency Management Steering Committee to oversee this review. The plan is planned for sign off by the end of December 201. The Plan was reviewed on the 30th of September and was fully compliant with national standards. The plan continues to receive positive feedback from NHS England in 2016. The pharmacy Mass Prophylaxis Plan was reviewed, upgraded and included in the Pharmacy Major Incident Plan on 5th of July 2017.

10.1 Ebola virus disease

Through the pandemic influenza subcommittee there has been a review of the current guidance from Public Health England and NHS England and the Trust viral haemo fever policy to ensure we are following current guidance.

The Trust has been working closely with partners, including Public Health England and NHS England, to review existing preparedness against the following headings:

- Ensuring that updated viral haemorrhagic fever (VHF) algorithm and associated information is cascaded appropriately
- Engaging in multi-agency preparations
- Personal protective equipment (PPE) stock and resupply mechanisms
- Training of staff in the correct use of PPE and any processes in place
- The mechanism and process for identification and isolation of a suspected case

11.0 COOPERATING AND COLLABORATING WITH MUTLI AGENCY PARTNERS

The Accountable Emergency Officer will ensure there is Trust engagement with the Local Health Resilience Partnerships (LHRP). The Trust's Emergency Planning and Business Continuity Officer continued to maintain positive working relationships with NHS England (London). The Trust representatives regularly attend the North East and North Central London NHS EPRR Network Meeting, Network Learning Set and both the Borough Resilience Forum in London Borough of Islington and Haringey.

12.0 SUMMARY

The aim of the Trusts Emergency Preparedness arrangements, including its Emergency and
Major Incident Plan, and associated Business Continuity arrangements, is to mitigate loss once an incident occurs; to (as a minimum) maintain previously agreed essential levels of service; and to return to 'normal' service as soon as possible following an interruption. The work of the Emergency Management steering committee and its representatives over the last year has increased the level of engagement of senior managers around the Trust in these processes, leading to significant progress in some areas.

The Trust continues to update its arrangements and amend them in line with national guidance, external advice and experience. Other supporting arrangements i.e. Evacuation plan and rigorous review of the Business Continuity plans across services will be implemented and actioned accordingly throughout 2018.

13.0 ACTION PLAN 2017/2018

It is anticipated that much of the workload for the Trusts Emergency Management Steering Committee over the coming year 2016 to 2017 will related to the following areas that have been rated Amber in from NHS England in 2016

- Please click here for the full action plan 2018/2019:

Carol Gillen
Chief Operating Officer
(Accountable Emergency Officer & Emergency Planning Liaison Officer)

Lee Smith
Emergency and Business Continuity Planning Officer