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ISLINGTON

Governance and Human Resources
Town Hall, Upper Street, London, N1 2UD

AGENDA FOR THE HEALTH AND CARE SCRUTINY COMMITTEE

Members of the Health and Care Scrutiny Committee are summoned to a meeting, which will be held on, **12 July 2018 at 7.30 pm.**

PLEASE NOTE THAT THERE WILL BE A PRE-MEETING AT 7.00 PM PRIOR TO THE MEETING

Yinka Owa
Director of Law and Governance

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Despatched	:	4th. July 2018

Membership

Councillors:
Councillor Osh Gantly (Chair)
Councillor Nurullah Turan (Vice-Chair)
Councillor Martin Klute
Councillor Jilani Chowdhury
Councillor Tricia Clarke
Councillor Sara Hyde
Councillor Anjna Khurana
Councillor Kadeema Woodbyrne

Substitute Members

Substitutes:
Councillor Satnam Gill OBE
Councillor Mouna Hamitouche MBE
Councillor Angela Picknell

Co-opted Member:

Janna Witt – Islington Healthwatch

Substitutes:

To be notified

Quorum: is 4 Councillors

A.	**Formal Matters**	**Page**
1.	Introductions	
2.	Apologies for Absence	
3.	Declaration of Substitute Members	
4.	Declarations of Interest	

If you have a **Disclosable Pecuniary Interest*** in an item of business:

- if it is not yet on the council's register, you **must** declare both the existence and details of it at the start of the meeting or when it becomes apparent;
- you may **choose** to declare a Disclosable Pecuniary Interest that is already in the register in the interests of openness and transparency.

In both the above cases, you **must** leave the room without participating in discussion of the item.
If you have a **personal** interest in an item of business **and** you intend to speak or vote on the item you **must** declare both the existence and details of it at the start of the meeting or when it becomes apparent but you **may** participate in the discussion and vote on the item.

***(a)Employment, etc -** Any employment, office, trade, profession or vocation carried on for profit or gain.
(b)Sponsorship - Any payment or other financial benefit in respect of your expenses in carrying out
duties as a member, or of your election; including from a trade union.
(c)Contracts - Any current contract for goods, services or works, between you or your partner (or a body
in which one of you has a beneficial interest) and the council.
(d)Land - Any beneficial interest in land which is within the council's area.
(e)Licences- Any licence to occupy land in the council's area for a month or longer.
(f)Corporate tenancies - Any tenancy between the council and a body in which you or your partner have
a beneficial interest.
(g)Securities - Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

This applies to **all** members present at the meeting.

5.	Order of business	
6.	Confirmation of minutes of the previous meeting	1 - 8
7.	Chair's Report	

The Chair will update the Committee on recent events.

8.	Public Questions For members of the public to ask questions relating to any subject on the meeting agenda under Procedure Rule 70.5. Alternatively, the Chair may opt to accept questions from the public during the discussion on each agenda item.	
9.	Health and Wellbeing Board Update	
B.	**Items for Decision/Discussion**	**Page**
10.	Whittington Trust - Performance update	9 - 82
11.	Scrutiny Review - 12 month update - Health Implications of Damp Properties	83 - 94
12.	Scrutiny Review - Approval of SID/Witness evidence To follow	
13.	Quarter 4 Performance Update	95 - 104
14.	Work Programme 2018/19	105 - 106

The next meeting of the Health and Care Scrutiny Committee will be on 2 October 2018

Please note all committee agendas, reports and minutes are available on the council's website:

www.democracy.islington.gov.uk

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London Borough of Islington

Health and Care Scrutiny Committee - Thursday, 14 June 2018

Minutes of the meeting of the Health and Care Scrutiny Committee held on Thursday, 14 June 2018 at 7.30 pm.

Present:	**Councillors:**	Gantly (Chair), Turan (Vice-Chair), Klute, Clarke, Hyde, Khurana and Woodbyrne
Also Present:	**Councillors**	Janet Burgess and Una O'Halloran
	Co-opted Member	Shelagh Prosser - Healthwatch

Councillor Osh Gantly in the Chair

97 **INTRODUCTIONS (ITEM NO. 1)**

98 **APOLOGIES FOR ABSENCE (ITEM NO. 2)**
Councillor Jilani Chowdhury

99 **DECLARATION OF SUBSTITUTE MEMBERS (ITEM NO. 3)**
It was noted that Sheelagh Prosser was deputising for Jana Witt – Islington Healthwatch

100 **DECLARATIONS OF INTEREST (ITEM NO. 4)**
The Chair stated that she wished it to be recorded that in connection with her employment with the NHS, she had undertaken some work at Moorfields NHS Trust Sheelagh Prosser, Healthwatch stated that she had also undertaken some part time work at Moorfields NHS Trust

101 **ORDER OF BUSINESS (ITEM NO. 5)**
The Chair stated that the order of business would be as per the agenda

102 **CONFIRMATION OF MINUTES OF THE PREVIOUS MEETING (ITEM NO. 6)**
RESOLVED:
That, subject to the following amendment,
Minute 95 – Whittington Estates Strategy – the deletion of the word discuss in the resolution and the insertion of the word write
the minutes of the meeting of the Committee held on 01 March 2018 be confirmed and the Chair be authorised to sign them

103 **MATTERS ARISING FROM THE MINUTES (ITEM NO.)**
A Member enquired whether the letter referred to in Minute 95 to local MP's had had a response as yet.

It was stated that the letter had been sent, however a reply is still awaited

104 **MEMBERSHIP, TERMS OF REFERENCE ETC. (ITEM NO. 7)**
RESOLVED:
That the report be noted

105 **CHAIR'S REPORT (ITEM NO. 8)**
The Chair welcomed the new Members of the Committee and officers to the meeting.

The Chair added that Sheelagh Prosser was deputising that evening for the Healthwatch representative on the Committee, Jana Witt

106 PUBLIC QUESTIONS (ITEM NO. 9)

The Chair outlined the procedure for dealing with Public questions and filming and recording at meetings

107 HEALTH AND WELLBEING BOARD UPDATE (ITEM NO. 10)

Councillor Janet Burgess, Executive Member Health and Social Care, was present and gave an update to the Committee, during which the following main points were made –

- It was noted that a member of the voluntary sector, from the Manor Gardens Community Centre would be joining the membership of the Health and Wellbeing Board and that this was welcomed
- Members expressed their condolences on the recent death of a carer in Islington who had been murdered by a client and expressed regret at this shocking incident
- It was noted that Stacy Street was closing and residents moved to St.Ann's. Residents would be given support to manage this change. Care plans would be maintained and it was felt that the new provision would be an improvement on existing services
- There is to be a consultation shortly commencing on mental health day services and details of this could be submitted to Health and Care Scrutiny Committee at a later date

108 CAMDEN AND ISLINGTON PERFORMANCE UPDATE - PRESENTATION (ITEM NO. 11)

Andy Rogers, Chief Operating Officer and Simon Africanus Rowe, Patient Experience Lead, Camden and Islington Mental Health Foundation Trust were present and outlined the report, during which the following main points were made-

- The focus has been on patient safety and quality of care and as a result of consultation with all stakeholders, including patients, a list of 9 priorities were identified
- There have been 3 key areas where significant achievements have been made and with regard to patient safety a comprehensive risk assessment had been introduced. Staff had been upskilled, and staff trained to a level that is more than satisfactory. In addition, poor health outcomes for people with serious mental illnesses has been reduced and the Trust has promoted safe and therapeutic ward environments by preventing violence
- In addition, physical as well as mental health was assessed, as it is known that psychosis often develops at an early age, and the Trust has introduced a holistic health care package In addition there is now more communication with GP's
- Work is also being carried out with those patients that present at A&E and how families and patients can be made comfortable when presenting there. Service users and staff have been engaged in suicide prevention strategies
- There have also been efforts to engage with other services and staff to develop an information strategy, and the Trust has worked with stakeholder and the NICE guidelines have provided a framework for this. In terms of patient experience progress has been made. However there are sometimes difficulties if there is no next of kin listed
- With regard to clinical effectiveness the Trust is looking at working holistically with patients, and has developed an integrated practice unit, where

signposting, mental health screening etc can take place. In addition care plans can be reviewed and assessed to get a suitable care plan in place

- In relation to safeguarding, the Trust has identified approaches that can be used to identify risk and take appropriate measures under the Mental Health Act
- The overall CQC rating for the Trust is good, and it has taken a great deal of work for the Trust to achieve this rating
- The Trust has also instituted a Recovery college, and this is doing well and serves service, users, staff and the public. A Women's Psychiatric Intensive Care Unit has been introduced
- As previously stated the Trust has identified 9 priorities, which all involved have signed up for and service users and carers are essential to this
- A Member referred to the improvement of health and wellbeing of NHS staff, and that in quarter 4 this had not been met. The Trust responded that there had been an improvement, however staff, because of the challenging nature of the job that they did, suffer a lot of stress. The Trust recognised that there was still more to do
- Reference was also made to the prevention of ill health by risky behaviours by tobacco and alcohol targets were not met in quarters 3 and 4 and it was stated that the Trust had decided to integrate physical and mental health. It was recognised that this is an ongoing issue, but the Trust felt confident that this was a reporting issue primarily, and internal monitoring is taking place. However it is recognised that this is an area that the Trust need to focus on. This is particularly important given vulnerable patients
- Discussion took place as to talking therapies for those patients at medium risk and that there is a disparity in these services being accessed by BME groups
- It was noted that BME groups tended to present later and at a more acute stage, and tended to suffer from poorer mental health. BME groups are less likely to access IAPT services, however the Trust felt that their services are accessible to all communities and work is taking place between the CCG and GP's, to identify and refer on patients with mental health issues
- Members expressed the view that strategies for BME to access services should be looked at further
- Reference was made to the fact that the management profile of the Trust needed to be more ethnically diverse, and that more work needs to be done on this
- A Member referred to the number of deaths and the Trust stated that any death is unfortunate, but in their view these were not disproportionate, and in addition Islington has one of the highest rates of mental health problems in England
- A Member referred to the use of volunteers and peer support workers and that peer support workers did often take up posts at the Trust. The Trust stated that they would provide details of the peer support programme to Members
- In response to a question it was also stated that there is a BME service user group
- The Trust recognised that better communication with families is needed with families after serious incidents occur, and this is a priority for the Trust. Where such incidents do occur the Trust need to be honest and discuss this with the family,in order to learn lessons for the future
- A Member congratulated the Trust on the removal of ligature points
- Reference was made to the staff survey and that 32% of staff had identified problems of bullying/harassment. The Trust responded that the CQC had identified that the Trust had a high level of agency staff, and the Trust recognised this needed to be addressed. However there are areas where staff morale can be improved by simple remedial measures, such as repairs to the

building and general tidying up. In addition, mandatory training for staff will be taking place

- The Trust are clear that they will deal with any issues of bullying/harassment, however it is recognised that some staff felt that the Trust did not take this seriously enough. The Trust has put in place the ability for staff to talk to guardians and senior staff in confidence and there is a BME member of staff who can be talked to. Some staff had been trained to be bullying/harassment champions
- The Trust stated that they felt that the issue of bullying/harassment is mainly a historical one, and a number of BME staff, who had been employed for a long time, had not yet recognised the changes that have taken place
- In response to a question as to bullying of staff by patients and families, the Trust stated that it would not tolerate this and having a mental health issue did not excuse this. Staff training has also taken place on how to deal with patients and the public, and the Trust were looking to develop pathways to support staff
- In response to questions from the Chair, it was stated that in relation to Police powers to remove people with severe mental health problems from the street, The Trust had capital growth to develop facilities on site in a few years time. In addition, mandatory training had been introduced and such training had achieved over target levels. The Trust were also improving recruitment, however the vacancy on acute wards needed to be improved, but it had to be recognised these were difficult places to work for staff

RESOLVED:
That the Trust circulate details of the peer support worker system to Members of the Committee

The Chair thanked Andy Rogers and Simon Africanus Rowe for their presentation

109 **MOORFIELDS NHS TRUST - PERFORMANCE UPDATE (ITEM NO. 12)**

Ian Tombleson and Tim Withers, Moorfields NHS Trust were present and made a presentation to the Committee.

During consideration of the report the following main points were made –

- Around 250 staff work at Moorfields NHS Trust and the Trust ranks first in staff satisfaction and the quality of work and care they are able to deliver. Staff motivation at work and staff satisfaction with resourcing and support are also at high levels where the Trust requires improvement. In January 2017, the Trust rating placed them in the top third of acute Trusts
- The turnover of the Trust is £224 m, there were 730,000 patient contacts in 2016/17, across 32 sites. The Trust saw more than 586000 oupatients

- The CQC action plan had 78 recommendations and the action plan is progressing well with 82% of actions complete
- The Trust has a 5 year quality strategy with the ambition to deliver outstanding patient care
- In terms of compliance with key national targets, in A&E there is a 98-99% compliance of meeting the 4 hour target, compliance against the national target on incomplete patient pathway, however the cancer target was narrowly missed 95.7% as against 96% target. Six week diagnostic tests were 100% and on infection control there were no cases year on year of MRSA or C difficile
- The CQC patient experience quality results were good both in the children's and young person's survey and A&E. The Families and Friends test continues to be very good and the main feedback relates to the length of patient journeys in clinic. There has been a launch of a Patient Participation Survey, in December 2017 which has more activities with patients participating and signposting and recruiting
- It had been a solid year financially, with a net surplus of £5.7m and satisfactory delivery against CIP's and commercial performance
- The use of resources rating remains I (the best), however expectations for 2018/18 continue to be tough
- It was noted that the Trust are looking to improve IT systems, in order to improve efficiency
- It was stated that the Trust recognised that they needed to improve the stress placed on staff, which is often linked to increased workload
- Reference was made to the Trust moving to the St.Pancras site and that this is progressing well, and it is hoped to go out to public consultation later in the year
- It was noted that work is being carried out to reduce waiting times and in response to a question it was stated that staggered arrival times had worked well at the Trust's network sites. However at the City Road site there was still work needed to be done to improve the situation
- A Member enquired about the CQC findings in relation to patient safety and th WHO surgical checklist. The Trust responded that some staff had been doing their jobs for a number of years, and did not fully appreciate the need for this, however the checklist had meant that there is more team working nd improvements had been made
- In response to a question it was stated that the Trust had a very good safety record, however the City Road site is an old building with narrow corridors and it is challenging. The Trust is constantly looking at ways that this could be improved

The Chair thanked Ian Tombleson and Tim Withers for attending and for their presentation

110 **NEW SCRUTINY TOPIC APPROVAL - VERBAL (ITEM NO. 13)**

The Chair stated that it would be necessary for the Committee to select a topic/s for scrutiny in the forthcoming year.

Following discussion it was –

RESOLVED:

(a) That approval be given to a mini scrutiny review on GP surgeries and the main scrutiny review topic be chosen from the following -

Body dysmorphia/eating disorders- possible link with mental health
Child Obesity
Mental Health – also link with mental health of care leavers
Care staff pay and conditions

(b) That the Chair be requested to contact Members following the meeting, taking into account their views for the main topics listed above, and select one for the main scrutiny topic
(c) That the final topics be submitted to Policy and Performance Committee for consideration

111 CHILD OBESITY (ITEM NO. 14)

Julie Billett, Director of Public Health and Julie Edgecombe, Assistant Public Health Strategist outlined the report for the Committee, during which the following main points were made –

- The Council takes a holistic, whole system approach to tackling obesity which includes creating an environment that supports good health and wellbeing, by improving the food environment, improving the food offer and promoting physical activity
- The Council has long term multi sectoral partnerships to promote this and encourages settings such as workplaces, schools and children's centres to promote good health
- It also supports families and children to maintain a healthy weight, which included a Families for Life programme, health living nurse and a psychology service for children with complex needs
- It was noted that 2.52% of reception children had severe obesity, similar to the England average, while 5.9% of year 6 pupils had severe obesity, which is higher than the England average of 4.07%
- Families for Life is a universal healthy lifestyle programme for families with a child aged 2-11 years. Activities include 4 or 6 week programme focusing on healthy eating, active games and cook and eat activities. 21 programmes ran in 2017/18 and 98 unique families were reached
- An early years and primary parent champion offer to increase referrals into the programme and allow for parent champions to support sessions
- From April 2019, these programmes will be delivered by Islington's School Improvement service
- In relation to the Healthy Living service, which is a weight management service for 5-16 year olds, overweight children are offered one to one support including home visits if needed
- In 2016/17 1038 children were identified as overweight and obese by the National Child Measurement Programme (NCMP), and of these 613 were identified as very overweight
- The Healthy Living Service delivered by Whittington Health, provides follow up support to those children identified via NCMP, and also takes referrals from GP's, school nurses and other professionals
- Vacancies within the service and the numbers of overweight children exceeding service capacity, meant that the service has had to target its resources to focus on supporting those children who are very overweight
- Future models for the delivery of tier 2 weight management services are being developed. Since the enhanced tier 2 weight management service was introduced in 2017, public health has commissioned an enhanced weight management service to help develop and evaluate the type of weight management intervention that best supports children with co-morbidities, and

/or complex needs. This involves working collaboratively with CAMHS, dieticians and community paediatricians via a MST

- Since launch in October 2017, there have been 16 referrals to the pilot service with 9 children/families seen to date
- With a small amount of financial support from Islington CCG the pilot has extended to run until March 2019, to help build up evidence and develop the model
- Discussions are ongoing with the CCG regarding funding beyond April 2019, but this service could be aligned to the CAMHS transformation work locally
- Update on Local Government Declaration on sugar reduction and healthier eating pledges – this was signed by Haringey and Islington Health and Wellbeing Board in October 2017. The summary of pledges and activity include –
  Tackle advertising and sponsorship – draft policy agreed and need to clarify policy in relation to alcohol and there is a process in place for agreeing corporate leadership
  Improve the food controlled or influenced by the Council – Develop a food standards policy (to be completed by Sept 2018) and pilot healthy vending machines in progress with local key employers/organisations
  Reduce prominence of sugary drinks and promote free drinking water – pledge to align work across Islington on plastic waste, includes Refilll Islington and installation of water fountains in public places. It was noted that funding from the Mayor was available to assist in this. Refill Islington will launch in July and a day of action has taken place to get businesses signed up and so far 40 businesses have done this
  Support businesses and organisations to improve their food offer
  Public events – work with Greenspace team to the Councils' event application procedure\; safer food is embedded and the provider must be rated 3 or higher as part of events policy and must provide a range of healthy offerings e.g. the caterers must have a Healthy Catering commitment
  Raise public awareness
- Members were of the view that the launch of the Public awareness campaign could be done at full Council and the Executive Member Health and Social Care stated that she would investigate the possibility of this
- It was noted that the Family Centre is shared across Camden and Islington and there is funding of £40000 available and this funds for 6 months, 3 full time psychologists and an assistant psychologist and is good value. There is a long list of families, and the intention is to build capacity by involving other organisations and services interlinked to provide an evidence base
- Members expressed concern at the increase in child obesity between reception and year 6, and it was stated that family influence plays a big part in diet, even though primary schools have the free school meals offer
- The view was expressed that there is a link between deprivation and obesity for a number of reasons, and residents relationship with food needs to be examined
- In relation to the sugar tax this has proved successful although manufacturers have now reduced sugar in their products to such an extent that the funding is only likely to be for one year
- Reference was made to the fact that families did not tend to eat together, as in the past, and community centres and cookery classes etc should be promoted to encourage healthy eating habits. Community kitchens and food co-ops need to be supported

The Chair thanked Julie Billett and Julie Edgecombe for their presentation

112 WORK PROGRAMME 2018/19 (ITEM NO. 15)

RESOLVED:
That the report be noted

MEETING CLOSED AT 10.25p.m.

Chair

Whittington Health
NHS Trust

Quality Account 2017/18

Contents

Part 1: Statement on Quality from the Chief Executive

I am very pleased to introduce the 2017/18 Quality Account for Whittington Health Integrated Care Organisation, my first as its Chief Executive. It has been a good year for the Trust and we were delighted that in February 2018, the Care Quality Commission improved the rating of the hospital from 'Requires Improvement' to 'Good', recognising the hard work of all our staff. This finding means that both our community health services and hospital services are now rated as 'Good' overall, with our Integrated Care Organisation rated as 'Outstanding' for caring. This is a testament to the dedication and commitment of our staff and something we are very proud of. We are a good organisation with outstanding staff.

The inspection highlighted areas of good and outstanding practice, as well as identifying areas for our further development, especially within our critical care unit and children and young people's community health services. The CQC found clear evidence of improvements since 2015, particularly in the hospital outpatient department in relation to information governance, team working and leadership and in the critical care unit for patient safety. The inspectors also commended the outpatient department for the outstanding practice seen in the hospital one-stop breast and skin cancer clinics. We are fully aware of the quality improvements we need to make and are confident in our ambition that we will become an outstanding organisation recognised as such by our public, staff and regulators.

In June 2017 the Trust won the CHKS Top Hospital Award for the best performing Trust for '**Quality of Care**' across the UK. The CHKS Top Hospitals Awards celebrate excellence throughout the UK and are given to organisations for their achievements in healthcare quality and improvement.

Other achievements for the Trust in 2017/18 have included:

- Placed second in London (behind only the Royal Marsden NHS Trust) and 35th overall in the UK in the National Cancer Patient Experience Survey
- Simmons House Inpatient CAMHs Unit rated as Excellent by the Quality Network for Inpatient CAMHS
- Recognition from the Medical Director for Clinical Effectiveness at NHS England (National team) for the greatest improvements in timely identification and timely treatment of sepsis
- Highest quartile for reporting incidents on the National Reporting Learning System (NRLS) which demonstrates a strong culture of openness and reporting to continuously improve patient safety
- Shortlisted for the 2018 HSJ Value awards for Clinical Support Services, for improving the pharmacy outpatient service through design
- Shortlisted for the 2018 HSJ Value awards for Community Health Service Redesign, for the implementation of the eCommunity paperless system across all of our district nursing teams
- The Trust had the second highest uptake of flu vaccine by our staff across London

In the year ahead, it is a priority of mine to support continuous improvement by taking a whole organisational approach to how we undertake Quality Improvement. The Trust has ensured strong leadership in this area with a dedicated Associate Medical Director for

Quality Improvement. We are working with UCL Partners to develop our quality improvement framework and delivery plan. Our approach is to '**make quality everyone's business'**, encouraging all staff to access the training and get involved in quality improvement projects. One example of this quality improvement work is our clinical collaboration with University College London Hospitals NHS Foundation Trust. This year we expanded our successful 'Hospital at Home' service and now also run a 'Virtual Ward' across our local populations and both hospitals, which enables the prompt discharge of medically optimised patients with high levels of health care support in their own home.

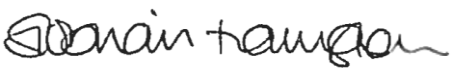
Like many other NHS trusts, we had a challenging winter. The particular pressure for us was consistently delivering the NHS constitution 4 hour emergency department standard over the winter period. We saw a record number of visitors come to our emergency department this year, over 100,000. These pressures within the emergency and urgent care pathway continued to be a challenge throughout 2017/18 and have been felt across the whole of London. However, the Trust reported 89.4% performance for the year against the target of 95% for 4 hour waits – an improvement on 2016/17 and within the top quartile across London. Patient safety remains our top priority and our teams have worked hard to ensure that despite increasing pressures, patient care has not been compromised.

As an Integrated Care Organisation making sure we deliver the right services for our local population is vital. We are fully committed to working closely within the Haringey and Islington Wellbeing Partnership (emerging Integrated Care System) which is focusing on bringing together health and social care services to support people living with long term conditions whether they are frail and elderly or the young.

We are also a committed partner within the North London Partners in Health and Care (NLHCP STP). Together with our CCGs and other stakeholders, we share a vision of improving our population's health and wellbeing. We want to deliver services that enable better independence and health for our diverse population. We are signed up to work with the NLHCP to reorganise services where necessary, improve public health and achieve financial balance in the face of rising demand across north central London.

The world in which we work is challenging with increasing numbers of our population needing our services, restricted financial resources and limited recruitment potential. However, quality, safety and experience remain our top priorities and over the last 12 months there are many examples (many described in this Quality Account) of where we have kept this focus. The achievements we have made over the year are outstanding and a credit to all our staff and our many hundreds of volunteers.

I confirm that this Quality Account will be discussed at the Trust Board, and I declare that to the best of my knowledge the information contained in this Quality Account is accurate.



Siobhan Harrington, Chief Executive

Part 2: Priorities for Improvement and Statements of Assurance from the Board

As an integrated care organisation (ICO) with community and hospital services across Islington and Haringey, Whittington Health is in a unique position to deliver the strategic objectives of the North Central London (NCL) Sustainability and Transformation Plan (STP), that is, working in an integrated and collaborative way to provide high quality health and social care for our local population.

Our Trust's mission, embedded within our clinical strategy and quality account, is to 'help local people live longer, healthier lives'. A key strategic goal is to provide the best possible health and wellbeing for all our community, of which prevention and health promotion are key objectives. These objectives are rooted in our 2017-18 quality priorities.

Priorities for improvement 2018/19

This section of the Quality Account is forward looking and details the quality priorities that the Trust has agreed for 2018/19. The rationale for including these priorities is based on factors such as data from the previous year, clinical or public request, and an ambition to be one of the leading Health Care Trusts.

Our quality priorities for 2018/19 are aligned to the Trust's commitment to improve quality and safety for patients over the coming year. A number of areas chosen as quality improvement priorities last year have been retained for the forthcoming year for one of three reasons:

- the 2017/18 targets were not met,
- we have made significant improvements in certain areas and wish to continue this progress,
- we consider certain areas as highly important to the trust.

We have also introduced new priorities that we believe are important to our patients and the community that we serve.

Our consultation process

Our quality priorities have been developed following consultation with staff and stakeholders and are based on both national and local priority areas.

We have utilised a range of data and information, such as learning from serious incidents, reviews of mortality and harm, complaints, clinical audits, patient and staff experience surveys, and best practice guidance from sources such as the National Institute for Health and Care Excellence (NICE) and national audit data, to help establish what our 2018/19 priorities should be.

As part of our consultation process, external stakeholders, patients, and staff have been invited to share their views on our proposed quality priorities. A meeting was held with Healthwatch Islington and Haringey in February 2018 to establish further priorities that are important to our consumers and feedback on our draft quality domains.

Further to this, each priority has been refined and agreed by clinicians and managers who will have direct ownership and approved at the relevant Trust committees. The quality account, including the 2018/19 priorities, have been shared with our commissioners and external auditors, whose comments can be seen within the appendices.

Priority 1: Improving Patient Experience

Our Patient Experience Quality Priorities for 2018/19 are below. Progress against these priorities is monitored at the patient experience committee and escalated to the quality committee as required.

Domain	Rationale	Top 10 Priorities
Communication (Trust wide)	Better access to information has been highlighted by patients and is a top PALS/complaints concern	1. Development of a Patient Experience Strategy in consultation with patients and families 2. We will complete a trust wide review of patient information quality and availability and aim to improve information in accessible formats
Food (Hospital)	National in-patient survey results, 2017/18 food priority not met	3. We will better our 'quality of food' score from the 2017 National inpatient survey, which is based on patient feedback 4. We will ensure a full range of food choices are available on all hospital wards
Hospital Transport (Trust wide)	Highlighted by patients and families as a top priority	5. We will ensure 95% of patients arrive 15 minutes prior to their appointment 6. We will ensure 95% of patients are picked up within one hour of their appointment ending 7. We will complete a survey of patients using hospital transport to establish if providing a 'call ahead' has improved patient experience.
Outpatient cancellations (Trust wide)	Patient experiences, resource inefficiencies, Target not achieved in 2017/18, outpatient transformation project taking place	8. We will reduce outpatient clinic cancellations by 3% from our 2017/18 monthly average.
Improve District Nurse continuity of care (Community)	Issue raised in patient feedback, learning from incidents and complaints, build on 2017/18 progress	9. We will improve the continuity of care from district nursing with a particular focus on patients of concern (palliative care patients, those in receipt of continuing healthcare funding, safeguarding concerns and patients with pressure ulcers)
Podiatry (Trust wide)	Highlighted by healthwatch as an area requiring improvement	10. In podiatry we will achieve a 50% increase in Friends and Family Test response rates, whilst maintaining the trust 90% recommendation rate for the service

Our progress on achieving our patient experience priorities will be measured by completing a gap analysis of patient information, analysing local and national patient survey results, and scrutinising board performance and e-community quarterly reports.

Priority 2: Improving Patient Safety

Our Patient Safety Quality Priorities for 2018/19 are below. Progress against these priorities is monitored at the patient safety committee and escalated to the quality committee as required.

Domain	Rationale	Top 10 Priorities
Falls (Hospital)	National and local priority, learning from serious incidents, building on improvement work in 2017/18	1. We will equal or reduce the number of avoidable falls in the hospital resulting in serious harm to patients compared to 2017/18 2. We will increase compliance with our STOPfalls bundle to 85% in our acute assessment units and care of older people wards 3. We will develop a mandatory training package for falls prevention
Acute Kidney Injury (Hospital)	National and local priority, target partially achieved in 2017/18, ongoing priority for the trust	4. The Critical Care Outreach Team will review 90% of patients with a grade 3 AKI within 24 hours of detection 5. We will increase our medicine safety reviews for grade 3 AKI patients within 24 hours from 53% to 75% by March 2019
Pressure Ulcers (Trust wide)	National and local priority, learning from incidents and complaints, target not achieved in 2017/18, trust KPI	6. We will reduce the number of avoidable grade 4 pressure ulcers from 5 in the community and continue to maintain 0 within the hospital
Care of Older People (Hospital)	Care of patients with dementia highlighted by Healthwatch as a priority area, national audit data, national campaign, learning from incidents	7. We will promote John's campaign – '*for the right to stay with people with dementia'* – whilst patients with dementia our in our care 8. We will develop a frailty pathway that will prioritise the care of patients over 75 who have been diagnosed with frailty
Mental Health and Learning Disabilities (Trust wide)	Experience of people with mental health in ED highlighted as an area for improvement by CQC, improving experiences for patients with LD and autism a priority for the trust and highlighted by Healthwatch	9. Within our emergency department we will see 75% of patients with an autism spectrum condition or a learning disability in under two hours 10. We will increase the number of people with learning disabilities involved in trust activities e.g. volunteering, hospital guides

Our progress on achieving our patient safety priorities will be measured through falls serious incident reporting and quarterly compliance audits, CCOT and Tissue Viability performance data, a frailty pathway timeline and monthly 'John's Campaign' progress updates.

Priority 3: Improving Clinical Effectiveness

Our Efficiency, Research and Education Quality Priorities for 2018/19 are below. Progress against the patient flow action is monitored through ICSU performance and trust performance reports, clinical research and education are monitored by their respective committees.

Domain	Rationale	Top 10 Priorities
Patient Flow (Hospital)	Delayed transfers of care from the Critical Care Unit to step-down wards highlighted as an area for improvement by the CQC, performance against national target, trust priority	1. We will achieve the national target of 95% of critical care unit ward-able patients being stepped down within 4 hours 2. We will develop a criteria-led discharge process at point of triage within the emergency department 3. We will establish robust pathways between the Emergency Department and specialist onsite assessment units (GAU, AEC, EPU) and aim to stream 3% of presenting patients 4. We will introduce the delirium rapid assessment test - 4AT - and TIME (trigger, investigate, manage, engage) bundle for delirium identification and streaming on the AAU for patients over 65
Clinical Research (Trust wide)	Representative of our patient population (significant Sickle Cell and Thalassemia population), secured funding for haematology research	5. We will increase the number of haematology patients involved in clinical research 6. We will increase the number of clinical specialities and the number of nurses, midwives and AHPs undertaking research in 2018/19 compared to the previous year. 7. We will exceed the 724 patients recruited into research trials during 2017/18
Education and learning (Trust wide)	Importance of sharing learning across the trust, emphasis on looking at themes emerging for pro-active learning, learning from incidents, complaints and claims, build on progress from 2017/18	8. We will increase the number of 'Learning Together' interprofessional workshops from 7 in 2017/18 to 10 in 2018/19 9. Increase teaching satisfaction from 60% to 75% for all medical student placements and increase overall satisfaction for nursing and midwifery courses. 10. We will increase the content available on the Whittington Moodle (electronic platform for education) and aim to develop a minimum of 5 new educational modules.

Our progress on achieving our clinical effectiveness priorities will be measured through monthly research recruitment data, quarterly AHP, Nursing and Midwifery Education reports to ICSU boards, ED performance data, and Quality Improvement project status updates at the two monthly QI group.

Statements of Assurance from the Board

Whittington Health provided 101 different types of health service (41 acute and 60 community services) in 2017/18. Of these services the following were subcontracted:

Organisation details	Service details
Barts Health NHS trust	Service and development support for immunology/allergy
Camden and Islington NHS foundation trust	Mental health services, ILAT contract and psychological service
Highgate therapy LTD	Psychosexual services
UCLH foundation trust	South Hub TB resources
UCLH foundation trust	ENT services
The Royal Free London NHS foundation trust	Provision of PET/CT Scans
The Royal Free London NHS foundation trust	Ophthalmology services
Middlesex University	Provision of Moving and Handling Training Sessions
GP subcontractors – Medical practices Morris House Somerset Gardens Tynemouth road	Primary care anticoagulation service for Haringey CCG
WISH Health Ltd A network of 8 local practices – four in north Islington and four in west Haringey	Primary care services to the urgent care centre at the Whittington hospital

The Trust has reviewed all data available to them on the quality of care in these relevant health services through the quarterly performance review of the ICSU and contract management processes.

The income generated by the relevant health services reviewed in 2017-18 represents 100% of the total income generated from the provision of relevant health services that Whittington Health provides.

A declaration of interest has been made by each of the outgoing and incoming Executive Directors for Integrated medicine in their roles as General Practitioners at one of the eight local practices linked with WISH Health Ltd.

Participation in Clinical Audits 2017-2018

During 2017/18, 51 national clinical audits including 11 national confidential enquiries covered relevant health services that Whittington Health provides.

During that period, Whittington Health participated in 100% national clinical audits and 100% of national confidential enquiries of those it was eligible to participate in.

The national clinical audits and national confidential enquiries that Whittington Health was eligible to participate in, and participated in, during 2017/18 are listed below. This includes the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Additionally listed are the 20 non-mandatory national audits, in which the Trust also participated during 2017/18.

Title of audit	Management body	Participated in 2017/18	If completed, number of records submitted (as total or % if requirement set)
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	British Association of Urological Surgeons	✓	29 cases
Case Mix Programme (CMP) - Intensive Care Audit	Intensive Care National Audit & Research Centre	✓	706 cases – 100% case ascertainment rate
Elective Surgery (National PROMs Programme)	NHS Digital	✓	150 cases
Falls and Fragility Fractures Audit programme (FFFAP) – Inpatient Falls	Royal College of Physicians of London	✓	30 cases 100% case ascertainment rate
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	Royal College of Physicians of London	✓	130 cases
Fractured Neck of Femur (care in emergency departments)	Royal College of Emergency Medicine	✓	50 cases
Inflammatory Bowel Disease (IBD) programme / IBD Registry	IBD Registry Limited	✓	68 cases
Learning Disability Mortality Review Programme (LeDeR)	University of Bristol's Norah Fry Centre for Disability Studies	✓	4 cases
Major Trauma Audit	Trauma Audit & Research Network	✓	69 cases - 35-41.1% case ascertainment rate
Myocardial Ischaemia National Audit Project (MINAP)	National Institute for Cardiovascular Outcomes Research	✓	78 cases

National Audit of Breast Cancer in Older People	Royal College of Surgeons	✓	On going
National Audit of Dementia 2017: Delirium Spotlight Audit	Royal College of Psychiatrists	✓	20 cases - 100% case ascertainment rate
National Audit of Intermediate Care	NHS Benchmarking Network	✓	Islington Teams: 48 cases Haringey Teams: 176 cases Total: 224 cases
National Bariatric Surgery Registry	British Obesity and Metabolic Surgery Society	✓	217 cases
Bowel Cancer (NBOCAP)	NHS Digital	✓	62 cases
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre	✓	81 cases
National Comparative Audit of Blood Transfusion programme – re-audit of 2016 red cell and platelet transfusion in adult haematology	NHS Blood and Transplant	✓	4 cases - 100% case ascertainment rate
National Diabetes Audit - Adults - National Diabetes Foot Care Audit	NHS Digital	✓	146 cases - 100% case ascertainment rate
National Diabetes Audit - Adults - National Diabetes Inpatient Audit (NaDia)	NHS Digital	✓	56 cases
National Diabetes Audit - Adults - National Core Diabetes Audit	NHS Digital	✓	1825 cases - 100% case ascertainment rate
National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit	NHS Digital	✓	25 cases – 93% case ascertainment rate
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	✓	102 cases
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research	✓	96 cases
National Joint Registry (NJR) - Knee and Hip replacements.	Healthcare Quality Improvement Partnership	✓	Ongoing
National Lung Cancer Audit (NLCA)	Royal College of Physicians	✓	81 cases

National Maternity and Perinatal Audit	Royal College of Obstetricians and Gynaecologists	✓	3741 cases
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Royal College of Paediatrics and Child Health	✓	505 cases
National Oesophago-gastric Cancer (NAOGC)	NHS Digital	✓	13 cases – 100% case ascertainment rate
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health	✓	101 cases – 100% case ascertainment rate
National Prostate Cancer Audit	Royal College of Surgeons	✓	105 cases
Pain in Children (care in emergency departments)	Royal College of Emergency Medicine	✓	50 cases
Procedural Sedation in Adults (care in emergency departments)	Royal College of Emergency Medicine	✓	50 cases
Sentinel Stroke National Audit programme (SSNAP)	Royal College of Physicians	✓	45 cases
UK Parkinson's Audit	Parkinson's UK	✓	20 cases + 10 Prem (Patient Reported Experience Measures) cases
Maternal, Newborn and Infant Clinical Outcome Review Programme data on 16 cases were submitted to MBRRACE-UK who allocate to the appropriate work stream			
Perinatal Mortality Surveillance	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Perinatal mortality and morbidity confidential enquiries	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Maternal Mortality surveillance and mortality confidential enquiries	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Maternal confidential enquiries	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Medical, Surgical and Child Health Clinical Outcome Review Programme			
Child Health Clinical Outcome Review Programme - Chronic Neurodisability	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	1 case – 100% case ascertainment

Child Health Clinical Outcome Review Programme - Young People's Mental Health	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	3 cases - 100% case ascertainment
Non-invasive ventilation	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	5 cases – 100% case ascertainment
Acute Heart Failure	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	3 cases – 100% case ascertainment
Cancer in Children, Teens and Young Adults	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	No applicable cases. Organisational questionnaire submitted
Perioperative Diabetes	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	4 cases– 100% case ascertainment
Pulmonary Embolism	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	Study commenced February 2018
Mental Health Clinical Outcome Review Programme			
Suicide by children and young people in England (CYP)	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), University of Manchester	✓	If cases identified to WH then participate - none to date
Suicide, Homicide & Sudden Unexplained Death	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), University of Manchester	✓	
Safer Care for Patients with Personality Disorder	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), University of Manchester	✓	
The Assessment of Risk and Safety in Mental Health Services	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), University of Manchester	✓	
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme			
Pulmonary rehabilitation	Royal College of Physicians	✓	36 cases
Secondary Care Continuous Audit	Royal College of Physicians	✓	147 cases

Additional (non-mandatory) National Audits undertaken during 2017/18

Title of audit	Management Body	Participated in 2017/18	Status
Cardiac Rehabilitation	Health & Social Care Information Centre, British Heart Foundation	✓	Ongoing data collection
Systematic anti-cancer therapy - chemotherapy dataset	National Cancer Intelligence Network	✓	Ongoing data collection
National study of HIV in Pregnancy and Childhood	NSHPC	✓	Ongoing data collection
7 Day Services Self-Assessment Tool	NHS England, TDA	✓	Completed
London Ambulance Service out of hospital cardiac arrest	London Ambulance Service	✓	Completed
UNICEF Baby friendly initiative Mother's audit	UNICEF	✓	Completed
6th National Audit Project of the Royal College of Anaesthetists - Perioperative Anaphylaxis in the UK	Royal College of Anaesthetists	✓	Completed
The Right Iliac Fossa Pain Treatment (RIFT) Audit	West Midlands Research Collaborative	✓	Completed
ESCP 2017 Snapshot audit - left colon, sigmoid and rectal resections	European Society of Coloproctology	✓	Completed
National Complicated Diverticulitis Audit	Yorkshire Surgical Research Collaborative	✓	Ongoing data collection
Intraoperative Oxygenation in patients undergoing major surgery	Pan London Audit Network	✓	Completed
National Adult Bronchoscopy	British Thoracic Society	✓	Completed
Physiotherapy Hip Fracture Sprint Audit (PHFSA) as part of NHFS	CSP/RCP	✓	Completed
National Adult Bronchiectasis Audit	British Thoracic Society	✓	Completed

UNICEF Baby friendly initiative Stage 2 and 3	UNICEF Baby Friendly Initiative	✓	Ongoing data collection
Improving the assessment of wounds	NHS England / CQUIN	✓	Ongoing data collection
BLISS Family Friendly audit	BLISS Charter	✓	Ongoing data collection
IMAGINE: Ileus Management International An international, observational study of postoperative ileus and provision of management after colorectal surgery	EuroSurg Collaborative	✓	Ongoing data collection
Use of Gabapentinoids in UK perioperative pain management – The "GABACUTE" study.	Trainee Audit & Research Network for trainees interested in Pain Medicine	✓	Ongoing data collection
National clinical audit on the management of bullous pemphigoid	British Association of Dermatologists	✓	Ongoing data collection

Whittington Health intends to continue to improve the processes for monitoring the recommendations of National Audits and Confidential Enquires in 2018/19 by ensuring:

- National audit and national confidential enquiries continue as the key component of the Trust's Integrated Clinical Service Units (ICSU) Quality Improvement programme
- Performance outcomes are discussed appropriately and cascaded to all staff grades
- Optimal clinical and managerial leadership is in place to support national project completion
- Learning from excellence is strengthened
- Increased encouragement of patient and carer participation in Trust groups

The reports of 19 **national clinical audits/national confidential enquiries** were reviewed by the provider in 2017/18 and examples of how Whittington Health has taken actions to improve the quality of the healthcare provided can be seen below.

National Audit of Dementia – Care in General Hospitals

This national audit is overseen by the Royal College of Psychiatrists and measures the performance of general hospitals against criteria relating to care delivery which are known to impact upon people with dementia, whilst a patient in a hospital.

Assessment: *The overall score for this section was 93.2% (national average 83.7%)*

The Hospital scored higher than the national average in initial screening for delirium (68%), clinical assessment (100%) and symptoms of delirium summarised for discharge (100%). A specific care plan is to be developed for patients with delirium and work is being undertaken with the mental health liaison team to incorporate learning into the existing falls training.

Information and Communication: *The overall score for this section was 61.8% (national average 64.8%)*

In order to improve communication and information on dementia, the Trust is introducing the '*This is Me'* form, which enables information to be collected and recorded on the patient. John's Campaign (http://johnscampaign.org.uk/#/about) which provides support for people with dementia, their family and carers is also being promoted trust wide as part of our Quality Account priorities for 2018/19. Dementia awareness has been incorporated into the Trust's current falls training also.

Staffing and Training: All clinical staff should access dementia training within the Trust and this can be supported by the re-introduction of the Dementia Champion Scheme. Out of hours support for staff needs to be improved by ensuring that site managers are trained to provide face-to-face and online support. Furthermore, ward teaching materials should be available in staff areas.

Nutrition: *The overall score for this section was 67.5% (national average 83.8%)*

The national audit highlighted nutrition as an area for improvement. Following the audit results, the trust has implemented changes to ensure that there is finger food available on the wards and to further ensure that this is highlighted in the nursing staff food training days. The introduction of John's Campaign will additionally support the improvement of nutrition, for this cohort of patients.

Discharge: *The overall score for this section was 89.7% (national average 72.7%)*

It is essential that all staff are trained in the principles of the Mental Capacity Act, to include the appropriate use of best interests decision making, the use of Lasting Power of Attorney and Advance Decision Making.

Governance: *The overall score for this section was 34.4% (national average 65.1%)*

It was agreed that all clinical staff should access dementia training which would be achieved through re-introducing the Dementia Champion Scheme. In order to improve the environment and activities on the ward, work is being undertaken with the multi-disciplinary staff team to facilitate this. Carers should also be encouraged to respond to surveys so that valuable support may be provided.

Asthma (paediatric and adult) - Care in the Emergency Department

This audit amalgamates Royal College of Emergency Medicine's previously audited adult and paediatric asthma audit topics.

Aims and objectives

- To benchmark current performance in Emergency Departments (ED) against the national standards of best practice
- To allow comparison nationally and between peers
- To identify areas in need of improvement

Our key successes

- The recording of vital signs, supported by the Asthma nurse holding regular teaching sessions for staff
- A proforma is utilised to promote assessment, discharge/admission criteria and medication dosing
- For paediatric patients, there is also a discharge bundle and information packs

Further improvements are being made for paediatric patients, as follows:

- The introduction of an asthma pathway from community to Emergency Department, ward and back home.

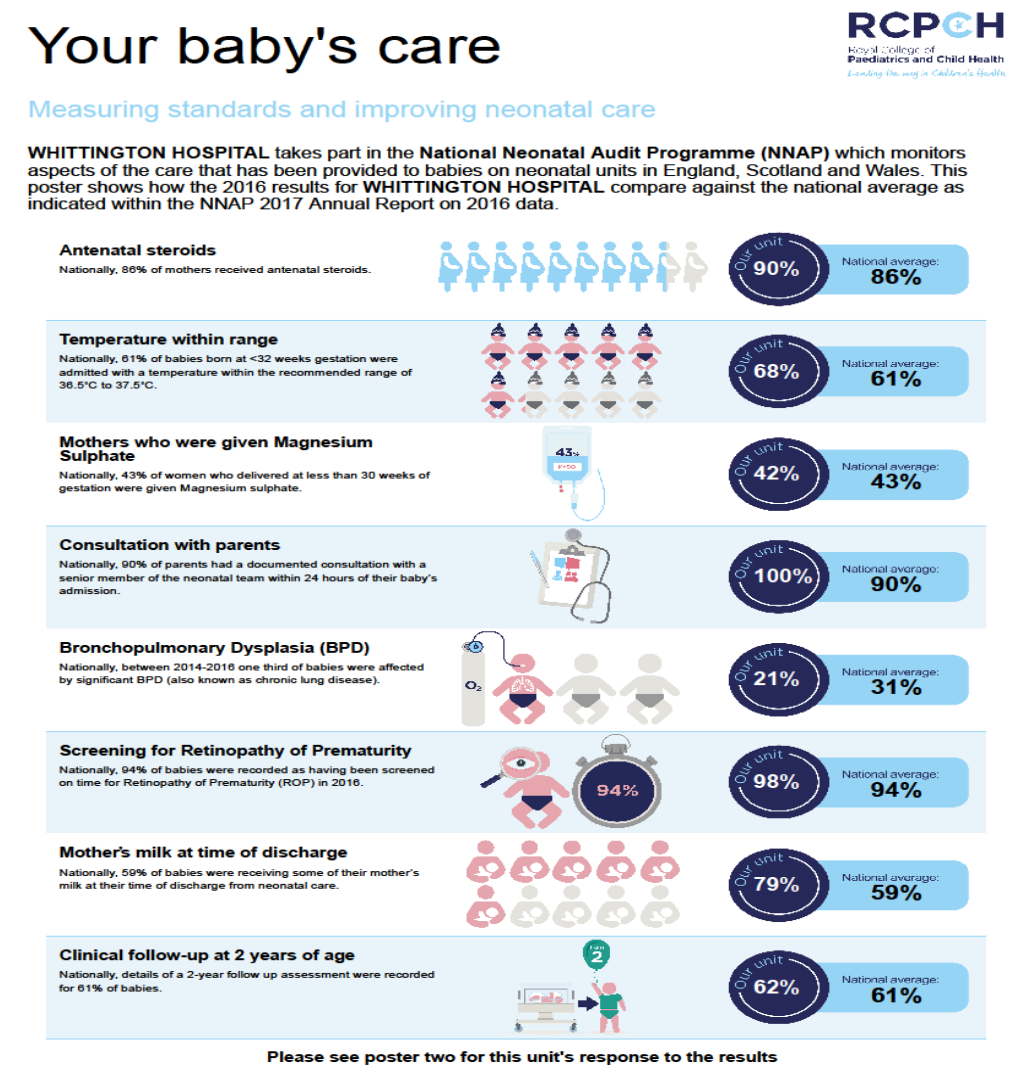
As part of the work to further improve care in ED, the following are either in place or undergoing improvement:

- ED asthma proforma, to improve recording of observations, aid the correct diagnosis and help the patient receive the appropriate medication in the required timeframe;
- There is a Wheeze asthma discharge bundle, that all patients should receive;
- Regular education of staff is ongoing;
- Work is underway with Haringey and Islington regarding ways to ensure that patients discharged from ED always receive their 48 hour follow up;
- A risk assessment tool is in place in the Emergency Department which aims to identify children who are repeat attenders to ED with wheeze and to ensure that they are booked into an appropriate follow up.

Neonatal Intensive and Special Care (NNAP)

NNAP monitors aspects of the care that has been provided to babies on neonatal units in England, Scotland and Wales. Each year, approximately 95,000 babies born will be admitted to a neonatal unit which specialises in looking after babies who are born too early, with a low birth weight or who have a medical condition requiring specialist treatment.

At the Whittington Hospital, 6 out of 8 standards audited achieved above the national average.



Your baby's care

RCPCH Royal College of Paediatrics and Child Health

Measuring standards and improving neonatal care

WHITTINGTON HOSPITAL takes part in the **National Neonatal Audit Programme (NNAP)** which monitors aspects of the care that has been provided to babies on neonatal units in England, Scotland and Wales. This poster shows how the 2016 results for **WHITTINGTON HOSPITAL** compare against the national average as indicated within the NNAP 2017 Annual Report on 2016 data.

Antenatal steroids
Nationally, 86% of mothers received antenatal steroids.
Our unit 90% | National average: 86%

Temperature within range
Nationally, 61% of babies born at <32 weeks gestation were admitted with a temperature within the recommended range of 36.5°C to 37.5°C.
Our unit 68% | National average: 61%

Mothers who were given Magnesium Sulphate
Nationally, 43% of women who delivered at less than 30 weeks of gestation were given Magnesium sulphate.
Our unit 42% | National average: 43%

Consultation with parents
Nationally, 90% of parents had a documented consultation with a senior member of the neonatal team within 24 hours of their baby's admission.
Our unit 100% | National average: 90%

Bronchopulmonary Dysplasia (BPD)
Nationally, between 2014-2016 one third of babies were affected by significant BPD (also known as chronic lung disease).
Our unit 21% | National average: 31%

Screening for Retinopathy of Prematurity
Nationally, 94% of babies were recorded as having been screened on time for Retinopathy of Prematurity (ROP) in 2016.
Our unit 98% | National average: 94%

Mother's milk at time of discharge
Nationally, 59% of babies were receiving some of their mother's milk at their time of discharge from neonatal care.
Our unit 79% | National average: 59%

Clinical follow-up at 2 years of age
Nationally, details of a 2-year follow up assessment were recorded for 61% of babies.
Our unit 62% | National average: 61%

Please see poster two for this unit's response to the results

Actions taken:

- A patient pathway coordinator was appointed to support the clinical follow-up at 2 years of age;
- Magnesium Sulphate and Antenatal Steroids are now maternity targets;
- Neonatal staff continue to encourage the expressing of milk post discharge;
- Data is now collected from the Badger programme on the proportion of babies born <32 weeks who develop Bronchopulmonary Dysplasia. To encourage this further, the results of the audit have been disseminated to staff.

Whittington Health intends to continue to improve the processes for monitoring the recommendations of **local clinical audits** in 2018/19 by ensuring:

- Reactive audits, vital to patient safety, will be the local priority on the Trust Integrated Clinical Service Units (ICSU) Quality Improvement programmes;
- Project proposals will be subject to a weekly quality review, prior to formal registration, in order to prevent duplication and to ensure alignment to local speciality priorities;
- Re-launch of the Trust Clinical Audit Registration form. A new, succinct version will facilitate the registration of projects;
- Demonstrable improvements to patient care and/or service provision will be identified monthly, to support Trust Learning from Excellence initiatives;
- Multidisciplinary Quality Improvement sessions will continue to include reflective learning on local clinical audit findings;
- Clinical speciality performance in relation to local clinical audit will continue to be monitored on an ongoing basis, with regular reporting via the ICSU Board meetings.

The reports of 89 **local clinical audits** were reviewed by the provider in 2017/18 and examples of how Whittington Health has taken actions to improve the quality of the healthcare provided is detailed below.

Attention deficit hyperactivity disorder (ADHD) Pathway - From Referral to Diagnosis

The paediatric ADHD service has been running for many years, initially as part of the Neurodevelopmental clinic at The Whittington Hospital, and more recently (since 2011) as a dedicated ADHD Service in Community Paediatrics at The Northern Health Centre.

This project was a re-audit to examine the timeframe of the ADHD pathway from referral to diagnosis and timeliness of feedback to parents. This would determine whether the pathway adheres to advice provided by NICE and to identify further areas for improvement.

The audit identified 15 children referred to the ADHD and Behaviour clinic that were eligible for the pathway. Of these, eleven completed the pathway and four were still in progress at the time of the audit. Of the eleven, two received a diagnosis of ADHD.

Results:

- Varied compliance to NICE guidance
- 100% of referrals to parent training for those who received a diagnosis.
- Compliance was reasonable for the number of children for whom an examination was documented. However, only 27% had a documented neurological examination. Compliance was below standard for the documentation of duration of symptoms, assessment of carer's health, documentation of the young person's views, documentation of dietary history and documentation of advice given about local support.

Actions:

- To reduce the time between 'first appointment to feedback' to a more acceptable wait - as no standard exists; a reasonable time would be 100% within 8 weeks with 80% within 6 weeks. An additional health care professional has been made available to the clinic who can help complete school observations. Administrative support is also

now available to assist with outstanding questionnaires and school liaison.

- The assessment proforma has been amended to include;
  - full examination, neurological assessment and growth measurements;
  - parent/ carer mental health status;
  - dietary history;
  - young person's views (where applicable).
- A post-diagnostic plan proforma has now been implemented

HIV testing in Pneumonia

Identification of HIV cases is of high importance for both the care of the affected individual, and for prevention of onward transmission. While there are a range of medical and social factors that are highlighted in both Trust and British HIV Association guidance as indications for testing, perhaps the most frequent and readily identifiable of these in acute medical admissions is bacterial pneumonia. The aim of the audit project was to determine the rate of HIV test ordering in adult admissions aged 16-75 with a primary diagnosis of pneumonia over a 3 month period, to be achieved through review of HIV test orders and results for patients recorded as having pneumonia as their primary diagnosis.

According to the Trust and The British HIV Association (BHIVA) guidelines, 100% of patients in this group should have been offered HIV testing, however this only occurred in 27% of our patients.

Actions taken:

- Introduction of clinician prompts to Anglia ICE requests for blood cultures, pneumococcal antigen tests and the community-acquired pneumonia bundle to consider requesting a HIV test;
- Provision of education sessions on the importance of HIV testing in acute medicine, including current Trust and National Guidelines through Junior Doctor Teaching.

Protected Meal Times (PMT) – Re-audit

In June 2004, Whittington Hospital introduced protected mealtimes (PMT), an intervention developed to address the common clinical problem of malnutrition in the hospital setting.

This re-audit was to assess if our hospital wards are compliant with the Trust 'Protected Meal Times' Policy ensuring that patients;

- Are provided with sufficient time during meal times for eating and drinking
- Are not disturbed with routine ward activity such as ward rounds
- Are documented as on the red tray system, if assistance with meals is required
- Have easy access to their meals
- Are provided with a safe and clean environment for their meal time

The audit demonstrated an improvement in PMT in the following areas:

- PMT lasted a full hour on 54% of all wards, a significant increase compared to 33% in May 2016.
- The number of individual patients being interrupted during PMT has decreased from 9% in May 2016 to 5%.
- Staff assisting with the meal service has increased to 50% - significantly higher than

38% of staff in May 2016.

- There has been an increase in the provision of hand-wipes, from 55% in May 2017 to 67%. However, only 8% of patients are actively given the opportunity and assistance to use them.
- The percentage of wards with red tray system awareness and appropriate implementation has decreased from 91% in May 2016 to 83%
- The number of patients unable to access their meals has increased from 0.5% in May 2016 to 2%

What actions have we taken?

- All results have been discussed with our cohort of senior nurses, to ensure that patients using the red tray system receive the help they need and have access to their meals.
- Infection Control Team liaison to consider the implementation of signage to promote handwashing/ use of hand wipes.
- Ward wide promotion of the importance of protected meal times is underway to include; laminated posters to be placed around the wards and not just at the entrance, with further information to be provided to visitors. Nursing induction will ensure the tenets of protected meal times are communicated clearly to all new staff.

Participating in Clinical Research

Involvement in clinical research demonstrates the trust's commitment to improving the quality of care we offer to the local community as well as contributing to the evidence base of healthcare both nationally and internationally.

Our participation in research helps to ensure that our clinical staff stay abreast of the latest treatment possibilities and active participation in research leads to better patient outcomes.

We are three years on from the ratification of the Whittington Health Research strategy that underpins the clinical strategy and reflects the aim of enabling local people to 'live longer healthier lives'. A key strategic goal is to become a leader of medical, multi-professional education and population based research.

Participation in clinical research demonstrates Whittington Health's commitment to improving the quality of care that is delivered to our patients and also to making a contribution to global health improvement. We are committed to increasing the quality of studies in which patients can participate (not simply the number), and the range of specialties that are research active, as we recognise that research active hospitals deliver high quality care.

The trust's research portfolio continues to evolve to reflect the ambitions of our integrated care organisation and also reflects the health issues of our local population. The research portfolio includes anesthesia, CAMHS, dermatology, diabetes and endocrine, emergency medicine (and ICU), gastroenterology, haemoglobinopathies, hepatology, health visiting, IAPT, infectious diseases (TB), microbiology, MSK, oncology, orthopaedics, paediatrics, speech and language therapy, surgery, urology, and women's health.

In 2017/18, 724 patients who received their care through Whittington Health were recruited into studies classified by the National Institute of Health Research (NIHR) as part of the NIHR research portfolio. This is the highest number recruited for five years and represents an increase of 209 patients compared to last year.

There are currently 39 NIHR portfolio studies in progress and recruiting at Whittington Health compared to 48 and 41 studies in 2016/17 and 2015/16 respectively. Whilst this is a reduction in the number of studies we have improved our recruitment to time and target (RTT) metrics in line with the NIHR High Level Objectives. Resultantly there is improved quality in the delivery of studies despite the total number of studies reducing.

Portfolio adopted studies are mainly, but not solely, consultant led and are supported by the trust's growing research delivery team to facilitate patient recruitment. In addition to the NIHR portfolio studies that are on-going, an additional 20 non-portfolio studies have been commenced so far in 2017/18, an increase of seven studies on the previous year which demonstrates an increase in locally lead and locally focused research. Most non-portfolio research studies are undertaken by nurses, allied health professionals, and trainee doctors and the impact of these studies are frequently published in peer reviewed publications, at conference presentations, and are valuable in their ability to innovate within the trust.

CQUIN Payment Framework

A proportion of Whittington Health's income is conditional on achieving quality improvement and innovation goals between Whittington Health and our local CCGs through the Commissioning for Quality and Innovation payment framework.

Our CQUINs for 2017-19 are:

- Improvement of Staff Health and Wellbeing
- Reducing the impact of Serious Infections (AMR and Sepsis)
- Improving services for people with mental health needs who present to ED
- Transitions our of Children and Young People's mental health services
- Offering advice and guidance
- NHS e-Referrals
- Supporting proactive and Safe Discharge
- Improving the assessments of wounds
- Personalised care and support planning

Further details of the agreed goals for 2017-19 are available electronically at:

https://www.england.nhs.uk/wp-content/uploads/2018/04/cquin-guidance-2018-19.pdf

In 2017/18, 2.5 percent of our income was conditional on achieving quality improvement and innovation goals agreed between Whittington Health and our local commissioners through the CQUIN payment framework. These goals were agreed because they all represent areas where improvements result in significant benefits to patient safety and experience. Both Whittington Health and our commissioners believed they were important areas for improvement.

There is a full CQUIN team responsible for the achievement of CQUINs with an operational lead and a clinical lead. There is also a clinical lead and operational lead for each individual CQUIN.

2018-19 CQUIN progress

	Achieved
	Not achieved
	No requirement
	Awaiting confirmation

CQUIN Scheme	Rationale/Objectives	Compliance			
Improvement of Staff Health and Wellbeing	To improve the support available for NHS staff to help promote their health and wellbeing in order for them to remain healthy and well.	Q1	Q2	Q3	Q4
Reducing the Impact of Serious Infections (AMR and Sepsis)	To make sure that the appropriate patients who attend the trust in an emergency are screened for sepsis, and receive the necessary antibiotics To reduce antibiotic consumption, encourage focus on antimicrobial stewardship and ensure antibiotic usage is reviewed within 72 hrs of prescribing.	Q1	Q2	Q3	Q4
Improving Services for People with Mental Health who present to ED		Q1	Q2	Q3	Q4
Transitions out of Children and Young Peoples Mental Health Services	To improve the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services.	Q1	Q2	Q3	Q4
Offering Advice and Guidance	Improve GP to access consultant advice prior to referring patients in to secondary care.	Q1	Q2	Q3	Q4
NHS e-Referrals	All providers publish all of their services and make all first outpatient appointment slots available on e-referral service by 31 March 2018.	Q1	Q2	Q3	Q4
Supporting Proactive and Safe Discharge	Enabling patients to get back to their usual place of residence in a timely and safe way.	Q1	Q2	Q3	Q4
Improving the Assessments of Wounds	To increase the number of full wound assessments for wounds which have failed to heal after 4 weeks	Q1	Q2	Q3	Q4
Personalised Care and Support Planning	To identify the groups of patients who would benefit most from the delivery of personalised care and support planning and provide this support to them.	Q1	Q2	Q3	Q4
Improving Haemoglobinopathy Pathways through ODN Networks	To improve appropriate and cost-effective access to appropriate treatment for haemoglobinopathy patients by developing ODNs and ensuring compliance with ODN guidance through MDT review of individual patients' notes.	Q1	Q2	Q3	Q4
Nationally Standardised Dose Banding for Adult Intravenous Anticancer Therapy (SACT)	To ensure that we minimise the amount of Oral Chemotherapy that is prescribed, yet not taken by patients - by reviewing length of prescription courses	Q1	Q2	Q3	Q4

Registration with the Care Quality Commission (CQC)

Whittington health is required to register with the CQC at our hospital and all of our community sites and our current registration status is 'registered without conditions'.

The CQC has not taken enforcement action against Whittington Health during 2017/18.

Between 31st October and 2nd November 2017 the CQC inspected four core services; Outpatients, Critical Care, Community Children's and Young people's services and Simmons House (Children and Adolescent Mental Health Service). Following this a series of interviews and focus groups were held as part of the trust-wide Well-Led CQC inspection process. The findings identified that the trust's senior management team had the right skills and abilities to run a service providing high-quality sustainable care and therefore rated the trust Good for being Well-Led.

The inspection highlighted numerous areas of good and outstanding practice and found clear evidence of improvements since 2015. In particular, the outpatient department improved in three of the five domains and achieved an overall rating of good. It was clear that significant improvements had been made in relation to information governance, team working and leadership. The inspectors commended the outpatient department for the outstanding practice seen in the hospital one-stop breast and skin cancer clinics. The critical care unit also was deemed to have improved and achieved a rating of good in the domain of safety. Other highlighted areas of good practice include:

- Leaders and staff shared a common vision on supporting their local community
- Patient outcomes in critical care were in-line with or better than national averages
- Improvements in how the critical care team manage and learn from incidents
- Multidisciplinary and joint working for children, young people and their families
- Medicines management systems with medicines appropriately prescribed, administered, recorded and stored

The outcome of the improvements made by the trust and seen by the CQC is that the rating for the Hospital has increased from 'Requires Improvement' to 'Good' following the last inspection. The Whittington Health Trust, encompassing our community services and their individual ratings, maintains a rating of 'good' from the 2015 inspection.

The Deputy Chief Inspector of Hospitals, CQC, Ellen Armistead, said: *"While we have highlighted areas that need some improvement many of the services were rated as Good or Outstanding and staff should be proud of those services."*

The trust was issued with four regulatory actions that it must address and improve with priority. These are listed below alongside the actions that the trust has taken to reduce these risks.

"Must do" actions from the CQC:	Trust response
Critical Care – reduce length of time patients are delayed waiting for discharge from CCU	The trust has made this one of its Quality Account priorities for 2018/19 and we are aiming to meet the national target of 95% of ward-able patients being stepped down from CC within 4 hours. The focus is on embedding the FLOW improvement process throughout the hospital in order to improve capacity so that patients are not delayed in critical care. Our acute assessment units, care of elderly wards, general surgery and general medicine wards have been assigned dedicated FLOW co-ordinators to support with patient discharging by unblocking /escalating delays.
Critical Care – ensure equipment is safely maintained and ensure local oversight of risk is appropriate	Critical care have introduced a local servicing log of equipment on the unit in addition to the log kept by medical physics. CC staff now monitor the equipment service dates on a monthly basis and any delays are escalated to Medical Physics. Introducing this additional local oversite measure has created a more robust equipment maintenance and safety checking system and expedites early escalation to medical physics in the event of delays.
Critical care – ensure patients receive safe care and treatment in line with the faculty of intensive care medicine (FICM) core standards	The parenteral nutrition (PN) policy has been reviewed and updated to provide clearer guidance for CC staff on the expectations regarding the use of PN both in and out of hours to ensure the trust complies with FICM standards.
Simmons House – ensure ligature risk assessments are up to date and accurately identify all ligature anchor points on the unit. This must be supported by information in patient risk assessments	The Ligature risk assessment has been reviewed and updated to ensure that all ward areas are included. A targeted assessment has been completed of Simmons House to ensure all ligature anchor points have been included in the ligature risk assessment register. A revised process has been designed to ensure that all patient ligature risks are assessed and documented and nursing care plans have been introduced for all patients who have been risk assessed as at risk of harm from ligature anchor points at Simmons house.

CQC Ratings for services inspected October-November 2017

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
Community	Good → ← Feb 2018	Good → ← Feb 2018	Outstanding → ← Feb 2018	Good → ← Feb 2018	Outstanding → ← Feb 2018	Good → ← Feb 2018
Mental health	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018
Overall trust	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Outstanding → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018

Ratings for The Whittington Hospital

Critical care	Good ↑ Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018	Requires improvement → ← Feb 2018	Requires improvement → ← Feb 2018
Outpatients	Good ↑ Feb 2018	Not rated	Good → ← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
Overall*	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018

Ratings for community health services

Community health services for children and young people	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018
Overall*	Good → ← Feb 2018	Good → ← Feb 2018	Outstanding → ← Feb 2018	Good → ← Feb 2018	Outstanding → ← Feb 2018	Good → ← Feb 2018

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018
Overall	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018

Secondary Uses Service

Whittington Health submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and which included the patient's valid General Medical Practice Code were as follows:

	Percentage of records which included the patient's valid NHS number (%)	Percentage of records which included the patient's valid General Medical Practice Code (%)
Inpatient care	97.80%	99.90%
Outpatient care	98.30%	100%
Emergency care	92.60%	99.90%

Information Governance (IG) Assessment Report

Reliable information is essential for the safe, effective and efficient operation of the organisation. This applies to all areas of the Trust's activity from the delivery of clinical services to performance management, financial management and internal and external accountability. Understanding the quality of our data means we can accurately measure our performance and ensure healthcare improvements.

In 2017/18 Whittington Health continued work to improve IG level two compliance with the Department of Health IG Toolkit. The trust achieved 77% compliance which demonstrates improvement on previous years' scores and shows a year-on-year improvement in compliance with the standards. The area that presents the greatest challenge is achieving the 95% target for all staff to complete IG training annually.

Assessment	Overall Score	Self-assessed Grade
Version 15 (2017-2018)	77%	Satisfactory
Version 14 (2016-2017)	74%	Satisfactory
Version 13 (2015-2016)	65%	Not Satisfactory
Version 12 (2014-2015)	59%	Not Satisfactory

The IG department will continue to target staff with individual emails, Whittington bulletin messages and classroom-based induction sessions in order to increase annual IG staff training compliance. As IG awareness increases throughout the organisation, our risk of an IG serious incident reduces. However, there is room for improvement in terms of staff awareness of policies and procedures and departments complying with IG guidelines, especially when other pressures are continually increasing. We are confident that through increasing IG training compliance and increasing general IG knowledge and awareness, the IG related risks to the Trust will reduce.

Data Quality

The trust monitors the quality of data through the use of quarterly benchmarking reports.

In order to improve data quality in 2018-19 the trust is taking the following actions:

- Introduction of data quality dashboards for services to individually monitor their own data quality as required.
- Strengthening the trust Data Quality Group and ensuring representation from each of the seven Integrated Clinical Service Units (ICSUs). This group is responsible for implementing the annual data improvement and assurance plan and measures the trust's performance against a number of internal and external data sources.
- Taking measures to improve the coding of activity
- Systematic benchmarking of data
- Running a programme of audits and actions plans

Whittington Health has been supplying demographic and risk factor information consistently since the service commenced in October 2015.

Clinical Coding Audit

Whittington Health was subject to the Payment by Results clinical coding audit during the 2017/18 reporting period. Trusts are required to meet 95% accuracy for primary procedure and diagnostic codes, and 90% accuracy for secondary codes.

The error rates reported in the latest (November) published audit for diagnosis coding and clinical treatment coding are:

Area audited	% Diagnoses Coded Correctly		% Procedures Coded Correctly	
	Primary	Secondary	Primary	Secondary
General Surgery 100	100.00	92.17	100.0	90.84
Trauma & Orthopaedic 110	95.24	94.51	93.75	92.63
General Medicine 300	93.48	95.56	92.31	100.00
Gynaecology 502	84.00	89.74	100.00	96.97
Overall	**95.50**	**93.97**	**97.90**	**92.98**

The trust is taking a number of actions in 2018-19 to improve our clinical coding performance including:

- Acting on feedback from the national audit and coding some care as 'palliative' where this was previously not included
- Having access to more information from clinicians through more detailed recording, death certificates and access to new information (via ICE).

Learning from Deaths

During the period 1 April 2017 to 31 March 2018, 421 Whittington Health patients died whilst in hospital. This includes deaths in our emergency department but excludes deaths 30 days post discharge. This figure also includes intra-uterine deaths greater than 24 weeks gestation. The following number of deaths occurred in each quarter of 2017/18:

- 99 in the first quarter (April-June 2017)
- 80 in the second quarter (July-Sept 2017)
- 155 in the third quarter (October-Dec 2017)
- 155 in the fourth quarter (Jan – March 2018)

By the 31st March 2017, mortality reviews using either case note reviews, structured judgement reviews or Root Cause Analysis (RCA) Serious Incident (SI) methodology had been completed for approximately 70% of deaths occurring in Quarter one to three. Quarter four reviews are still in progress and figures were not available at the date of submission.

The number of deaths in each quarter for which a case record review, structured judgement review or RCA SI methodology was carried out was:

- 69/99 deaths in the first quarter
- 50/80 deaths in the second quarter
- 103/154 deaths in the third quarter

Two patient deaths, representing 0.9% of the patient deaths reviewed during the reporting period April to December 2017 i.e. quarters 1-3, were judged to be more likely than not due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- One representing 0.45% for the first quarter:
- One representing 0.45% for the second quarter
- Zero representing 0% for the third quarter

These numbers have been estimated using the structured judgement mortality review form or equivalent methodology recommended by the Royal College of physicians or by RCA methodology when a serious incident has been declared.

Key learning identified from the review of the death where it was likely that problems in care contributed to the patient's death include;

- Ensuring there are more robust mechanisms in place to ensure that when VTE prophylaxis is suspended in patients (for clinical reasons) that it is restarted as soon as possible.
- Ensuring all patient deaths that involve a possible/probable medical treatment omission are discussed with families/carers as part of our Duty of Candour processes and with the Coroner's office.
- Our trust based pulmonary embolism guidelines could be made easier to read for users by adding in an algorithm and highlighting two other sections.

Actions taken in response to the findings include;

- Presentation of the patient case as an educational case to a wide audience.
- Re-issued the trust guidelines following a lengthy consultation and education period
- Shared the results of the investigation with the family and Coroner
- Enhanced education of issuing medical cause of death certificates
- Enhanced knowledge of the VTE guidelines by clinical teams
- Improved processes of maximising learning from all deaths

There were 0 case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period.

Patient Reported Outcome Measures (PROMs)

The outcomes of these measures are reported one year in arrears. Whittington Health NHS Trust considers that this data is as described because it is produced by a recognised national agency and adheres to a documented and consistent methodology.

Whittington Health participated in the PROMs project during 2017/18, although at the time of review, there were not sufficient numbers of responses to produce any statistically significant results (a minimum of 30 post-operative results for a given procedure are required). In 2016/17 there were also insufficient response numbers at the time of reporting, however subsequent publications eventually showed 226 responses from 572 eligible hospital procedures which demonstrated post-operative health gains in line with national averages.

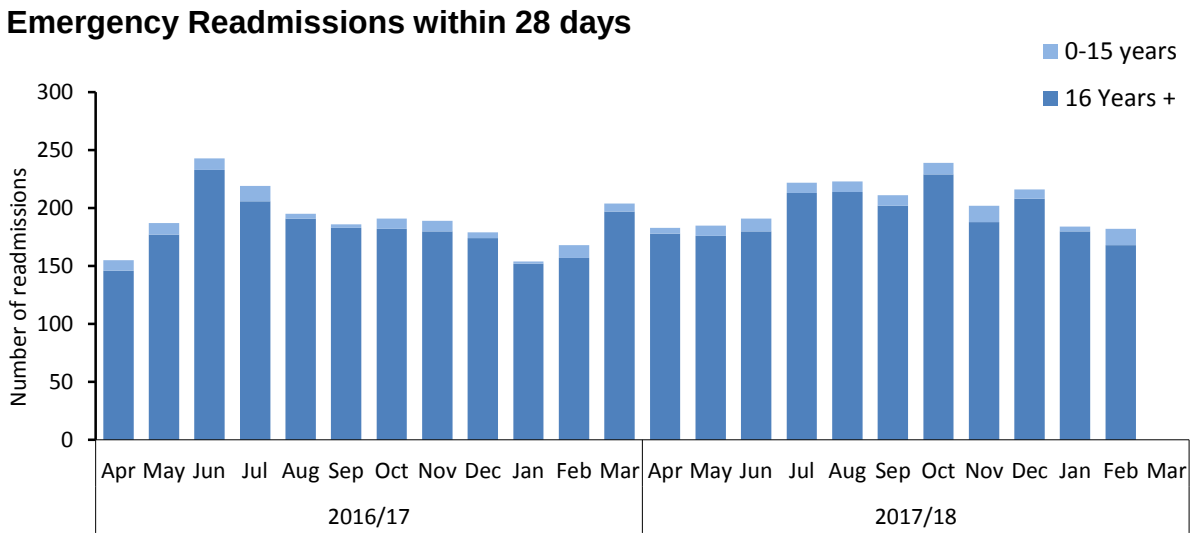
Table 1: Pre-operative participation and linkage

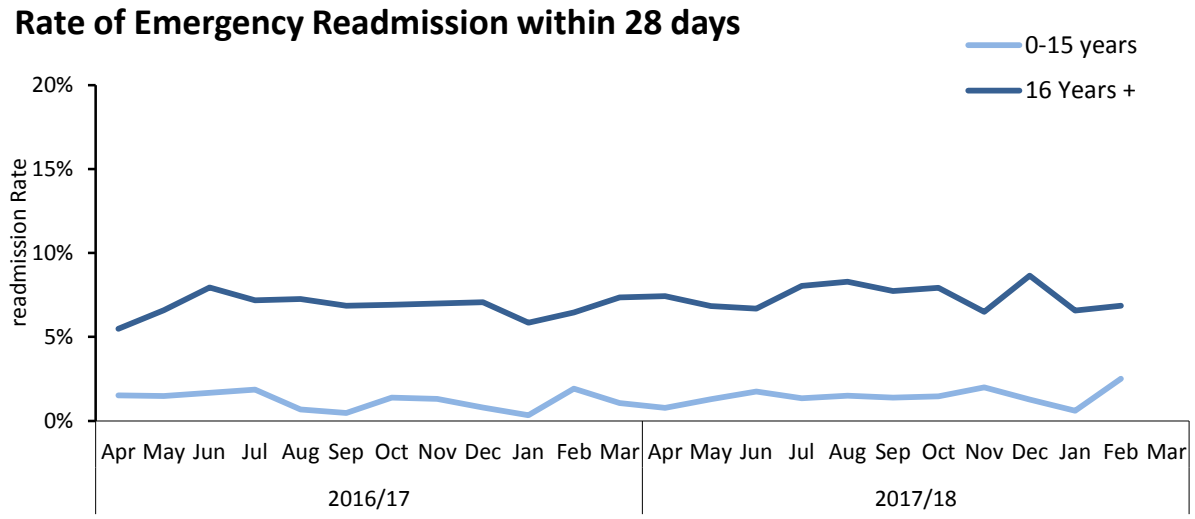
	Eligible hospital procedures	Pre-operative questionnaires completed	Participation Rate	Pre-operative questionnaires linked	Linkage Rate	National Linkage Rate
All Procedures (apr17-Sep17)	161	41	25.5%	21	51.2%	70.9%
Groin Hernia (apr17-Sep17)	152	41	27.0%	21	51.2%	67.8%
Varicose Vein (apr17-Sep17)	*	*	*	*	*	81.3%
Hip Replacement	Data not available					
Knee Replacement	Data not available					

Table 2: Post-operative issue and return

	Pre-operative questionnaires completed	Post-operative questionnaires sent out	Issue Rate	Post-operative questionnaires returned	Response Rate	National Response Rate
All Procedures (apr17-Sep17)	41	20	48.8%	8	40.0%	29.4%
Groin Hernia (apr17-Sep17)	41	20	48.8%	8	40.0%	30.5%
Varicose Vein (apr17-Sep17)	*	*	*	0	*	25.7%
Hip Replacement			Data not available			
Knee Replacement			Data not available			

Percentage of patients 0-15 and 16+ readmitted within 28 days of discharge





*Data excludes patients between 0 and 4 years at time of admission

Whittington Health NHS Trust considers that this data is as described because it has been produced specifically in line with stated requirements, reviewed thoroughly and compared closely to the metric that is used for routine board and departmental monitoring of readmissions.

The Trust has outlined the following actions to improve its readmissions rates in 2018-19:

- Launching a new clinical pathway for non-elective patients over the age of 75 with frailty that provides early geriatrician input within the Acute Admissions Unit for patients who have potential to be discharged within 48 hours
- In 2018/19 we are continuing to support and up-skill the ward based FLOW Liaison Officers who support timely and safe patient discharge using both Enhanced Recovery (medicine/ surgery) and Red to Green methodologies.

The trust's Responsiveness to the Personal Needs of its Patients

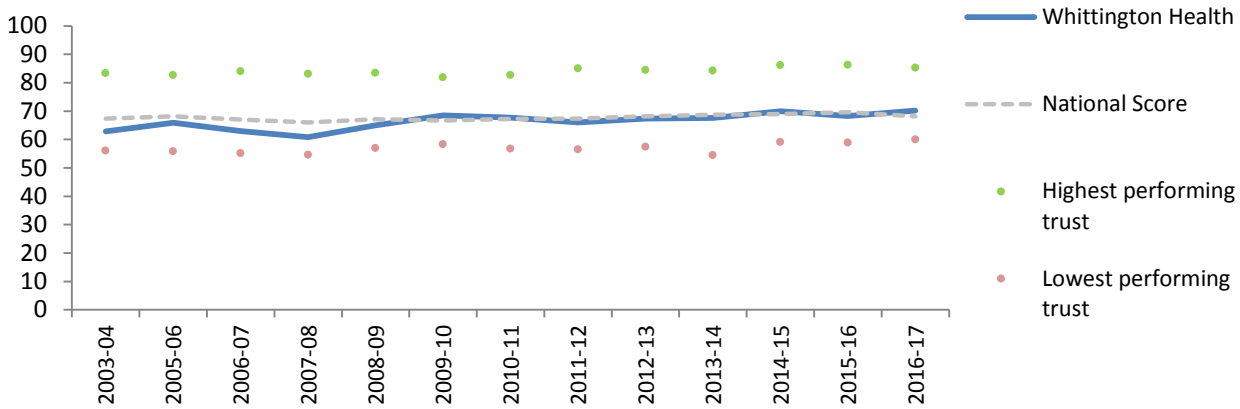
Whittington Health's responsiveness to the personal needs of its inpatients, based on the national inpatient survey, are displayed below. A trust's responsiveness is the weighted average score from five questions (score out of 100) and a higher score is indicative of better performance.

Year	Whittington Health	National Score	Highest performing trust	Lowest performing trust
2003-04	63	67	83	56
2005-06	66	68	83	56
2006-07	63	67	84	55
2007-08	61	66	83	55
2008-09	65	67	83	57
2009-10	69	67	82	58
2010-11	68	67	83	57
2011-12	66	67	85	57
2012-13	67	68	84	57
2013-14	68	69	84	54
2014-15	70	69	86	59
2015-16	68	70	86	59
2016-17	70	68	85	60

In order to improve our responsiveness to the personal needs of our patients in 2018-19 we are:

- Undertaking an action planning workshop which will include representatives from the inpatient wards and estates and facilities
- Highlighting these results at the Patient Experience and Quality Committees
- Making food, transport and communication a quality priority for 2018-19.

Responsiveness to the Personal Needs of Patients



The Whittington Health performance score was two percent higher than the national average in 2016/17 and has achieved a two percent increase compared to the trust's score in 2015/16. This is indicative of a trust that listens to its patients and responds to their needs.

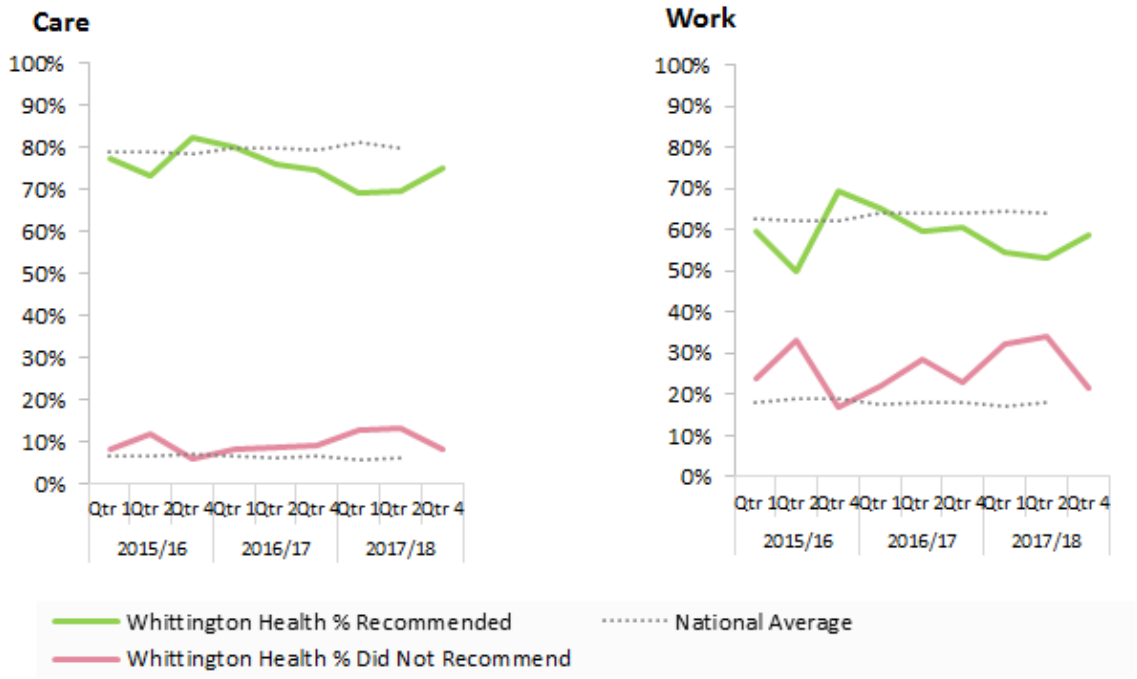
Whittington Health NHS Trust considers that this data is as described because it has been sourced from a recognised national agency in NHS Digital and adheres to a documented and consistent methodology.

Staff Friends and Family Tests

FY	Month	% Whittington staff recommending care	National Average	Highest performing trust	Lowest performing trust
2015/16	Qtr 1	77.5%	79.2%	100.0%	44.3%
	Qtr 2	73.2%	79.0%	100.0%	47.8%
	Qtr 4	82.3%	78.7%	100.0%	50.8%
2016/17	Qtr 1	80.1%	79.9%	100.0%	49.5%
	Qtr 2	76.2%	80.0%	100.0%	43.8%
	Qtr 4	74.6%	79.3%	98.2%	43.6%
2017/18	Qtr 1	69.0%	81.3%	99.6%	54.9%
	Qtr 2	69.4%	79.9%	100.0%	42.9%
	Qtr 4	75.0%			

Note: Staff Friends and Family Test is not conducted in Q3 due to the national staff survey taking place

Whittington Health recommendations compared with national average



The Whittington Health NHS Trust considers that this data is as described because it is collected, downloaded and processed in a robust manner, and checked and signed off routinely.

Listening to Our Staff

Whittington Health conducted its seventh national staff survey as an integrated care organisation (ICO). The survey was distributed to all staff who met the criteria, rather than a sample, and achieved a response rate of 42.4% which is an increase of over 6% from last year's 36% response rate. The survey asks members of staff a number of questions on their jobs, managers, health and wellbeing, development, the organisation, and background information for equality monitoring purposes. The purpose is to give staff a voice and provide managers with an insight into morale, culture and perception of service delivery, appraisals and support for development.

Staff Engagement Indicator

The CQC indicator score for staff engagement for Whittington Health is 3.81 (with 1 being poor and 5 being high engagement). This is considered "average" and is very slightly higher (not a statistically significant difference) compared with other similar organisations of a similar type.

Staff Engagement	Whittington Health Scores	National Scores: Acute Community Trusts
Advocacy	**3.75**	**3.75**
I would recommend WH as a great place to work	59%	59%
I am happy with the standard of care provided	71%	69%
Care of patients is a top priority for Whittington Health	77%	75%
Involvement	**3.87**	**3.89**
I am able to make suggestions to improve the work of my team / department	77%	75%
There are frequent opportunities for me to show initiative in my role	75%	73%
I am able to make improvements happen in my area	58%	56%
Motivation	**3.94**	**3.91**
I look forward to going to work	59%	57%
I am enthusiastic about my job	74%	73%
Time passes quickly when I am working	80%	77%
Overall Engagement Score	**3.81**	**3.78**

Top Ranking Scores

For each of the 32 Key Findings, the combined acute and community trusts in England were placed in order from 1 (the top ranking score) to 43 (the bottom ranking score). Whittington Health NHS Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1:

	Indicator	Trust	National
1	Quality of appraisals	3.27	3.11
2	Percentage of staff experiencing physical violence from patients and public	11%	14%
3	Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	27%	29%
4	Staff motivation at work	3.94	3.91
5	Percentage of staff / colleagues *reporting* most recent experience of harassment, bullying or abuse	49%	47%

Improvement work throughout the trust has resulted in 'staff motivation at work' appearing in the top five and a positive decrease in staff suffering physical violence from patients, relatives or the public which scored as one of the bottom ranking findings in 2016/17. It is encouraging that staff feel more able to report harassment, bullying or abuse: the rate of reporting has increased by 2% and is 2% above the average. This remains a focus for the trust moving forwards.

Bottom Ranking Scores

	Indicator	Trust	National
1	Percentage of staff feeling unwell due to work related stress in the last 12 months	45%	38%
2	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	31%	24%
3	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	73%	85%
4	Percentage of staff reporting errors, near misses or incidents witnessed in the last month	87%	91%
5	Percentage of staff experiencing discrimination at work in the last 12 months	19%	10%

The trust is particularly concerned with the percentage of staff experiencing discrimination or harassment, bullying or abuse from other staff and feeling unwell due to work related stress. As a result the Trust has launched an anti-bullying scheme and begun training a cohort of advisors to support staff who report experiencing bullying. The Trust has also invested in qualifying in-house mediators, training a pool of internal mediators, and launched a mediation service for staff to access.

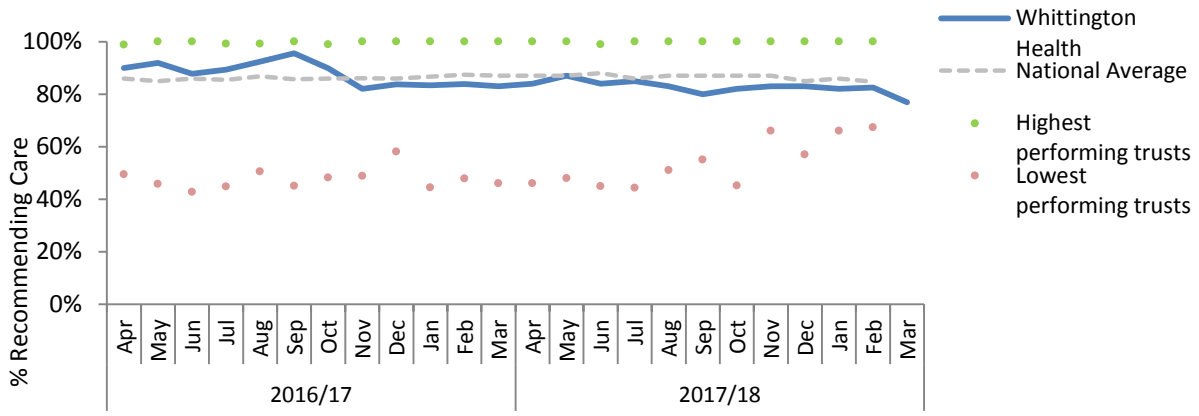
The trust is taking a number of further actions to improve local performance and achieve greater staff satisfaction in 2018-19 following the results of this survey including:

- Local staff recognition arrangements including employee of the month
- Annual Staff Awards ceremony
- Promotion of a Stop/Start service improvement scheme
- Making sure all staff have up to date Personal Development Plans
- Mandating appraisal training for appraisees and appraisers
- Focusing any health and wellbeing events on mental health, stress management and managing work life balance
- Tackling specific identified bullying hotspots in ICSUs
- Providing unconscious bias masterclass training
- Focus groups to understand the reasons behind reported discrimination
- Robust integration of exit interviews to identify themes and 'learning from' opportunities.
- Joining the 'Inclusion Labs' project to help improve our inclusion performance and increasing the Inclusion Team support available.

Patient Friends and Family Tests

Whittington Health NHS Trust is dedicated to giving patients the best possible experience whilst accessing our services. A key aspect towards improving patient care and experience is by listening to the thoughts and views of our patients and service users. We know that improving patient experience and treating our patients with compassion, dignity and respect, has a positive effect on recovery and clinical outcomes. We are dedicated to providing patients with the opportunity to feedback, and to using this feedback to improve patient experience and care. The patient Friends and Family Test (FFT) is used trust wide to determine the percentage of patients that would recommend Whittington Health NHS trust to their friends and family if they needed similar treatment.

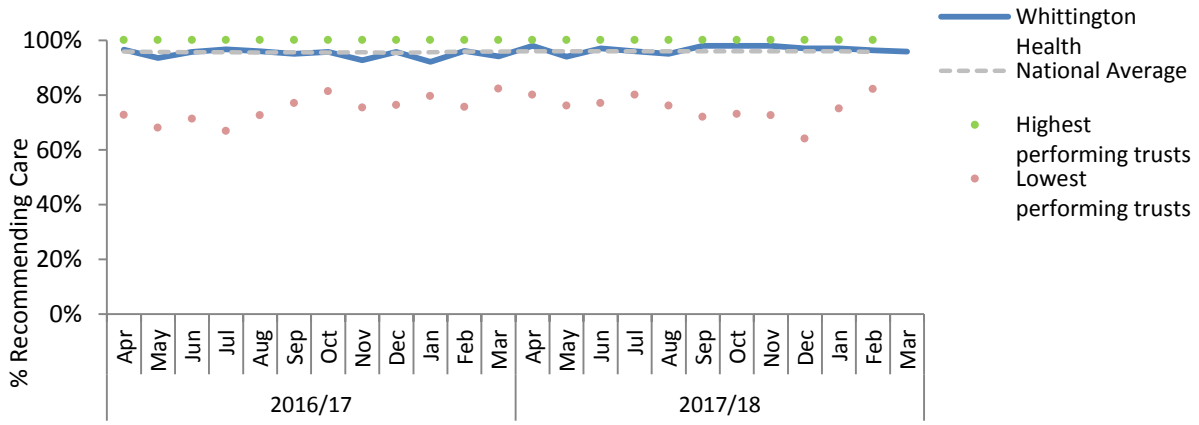
Emergency Department Attenders Recommending Care 16/17 & 17/18



We are constantly aiming to improve our recommendation rate and within the Emergency department we:

- Delivered customer care training for all ED reception staff and new starters
- Conducted regular quality checks by matrons
- Increased consultant establishment and clinical presence
- Sent all Band 6 ED nurses on a leadership study day focussing on standards, communication and developing a culture of quality and safe care.

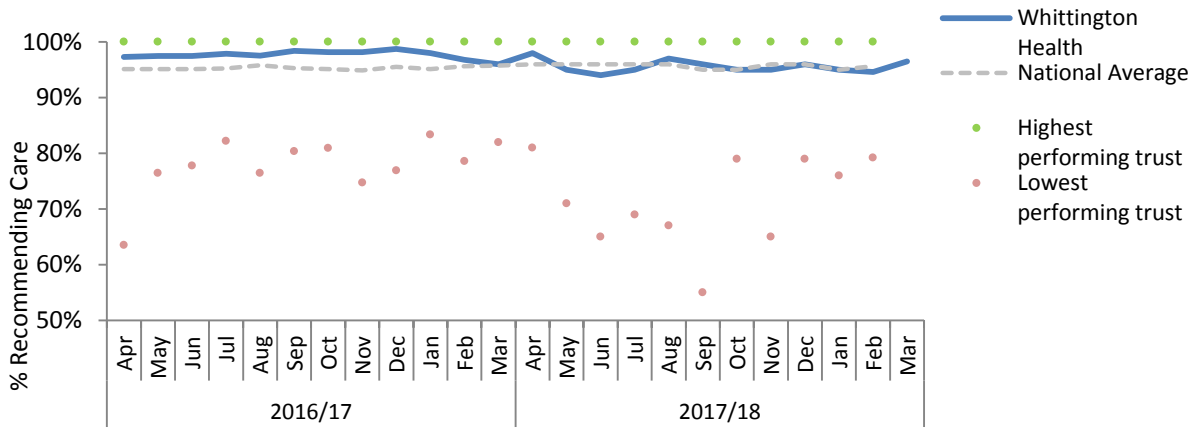
Inpatients Recommending Care 16/17 & 17/18



Within inpatients we have tried to improve response rates and recommendation rates by:

- Writing a “Big Four” each week which is where four key messages are relayed to staff each morning and afternoon at the beginning of their shift. These messages include trust wide updates and themes from compliments, complaints, incidents and feedback from users.
- Day Treatment Centre nurses contacting patients the day after their procedure as a “welfare check” and to answer any questions that they may have. Patients are have found this both helpful and supportive.
- Working with the facilities department to install portable heaters in response to patient feedback
- Creating a new room for visitors on one of our busiest wards. This was in response to patient feedback regarding patients not feeling as though they had enough privacy.

Community Service Users Recommending Care 16/17 & 17/18



The recommendation rate for patients in 2017/18 has frequently exceeded the national average and at times has been close to the rates of the highest performing trusts. For patients reporting a positive experience, interaction with staff is the most significant factor. When patients report a negative experience, the cause is most commonly due to system and process inefficiencies.

In 2016/17 the trust successfully met its target to increase the number of patient responses collected through the FFT method by 20%. Despite this the response rates remained below the national average. In 2017/18 we again achieved an increase in the number of responses we received however did not consistently achieve above the national average.

Emergency Department Response Rate (average per month)	
2016/17	9.08%
2017/18	13.74%
Community Responses (Total)	
2016/17	8,986
2017/18	10,694
In-Patient Response Rate (average per month)	
2016/17	17.12%
2017/18	18.30%

We are taking the following actions in 2018-19 to further increase our response rates:

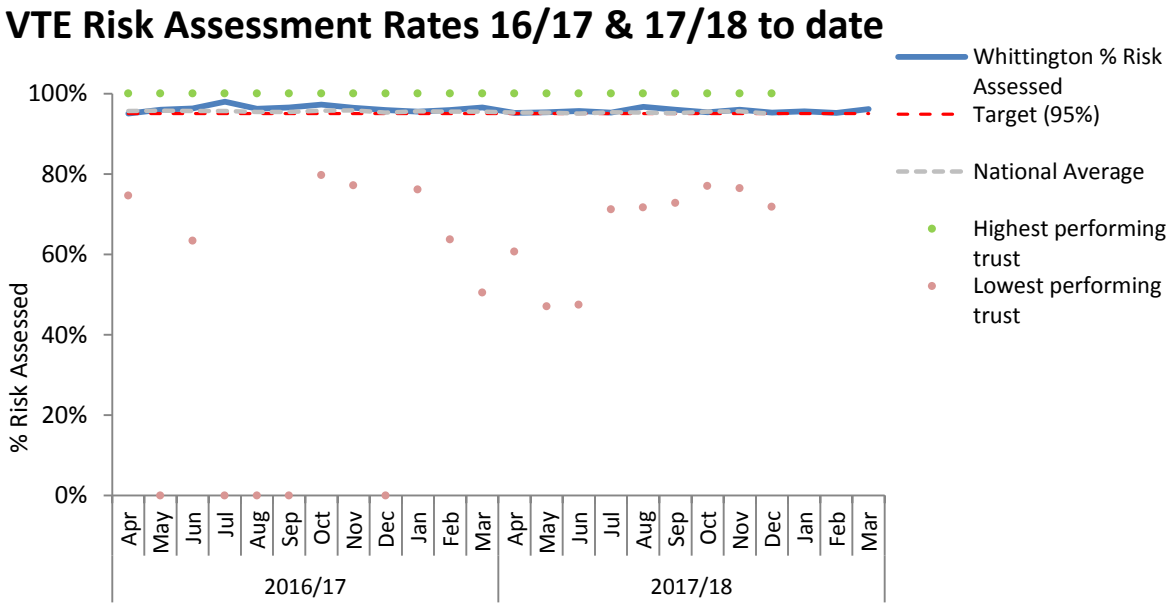
- Recruiting more volunteer ward befrienders to support with collecting FFT,
- Supporting Endoscopy and the Day Treatment Centre with iPads for collecting FFTs,
- Sending themed analysis sent to each ward manager to improve awareness of responses

Replicating the highly successful SMS FFT links in the musculoskeletal physiotherapy department in Podiatry services

Venous Thromboembolism (VTE)

Every year, thousands of people in the UK develop a blood clot within a vein. This is known as a venous thromboembolism (VTE) and is a serious, potentially fatal, medical condition. At Whittington Health we strive towards ensuring all admitted patients are individually risk assessed and have appropriate thromboprophylaxis prescribed and administered. In 2017/18 we consistently achieved above 95% compliance for VTE risk assessment.

In an effort to continuously improve, our medical colleagues undertake regular audits to ensure VTE compliance is robust and aligned with best patient outcomes.



The Trust considers that this data is as described as it is generated via daily, weekly and monthly reports and is submitted via a dashboard to executive level for assurance.

The trust is taking the following actions in 2018-19 to further improve our VTE rates:

- Introduction of a new 0.5 WTE specialist nurse to improve ward assessments and also to improve links with our ambulatory care department (where most outpatient VTE are diagnosed and managed)

- A review of all guidelines in line with recent NICE changes
- Further improve links and shared learning with other departments, including acute care and surgery, to enforce a consistent approach to VTE assessment and management

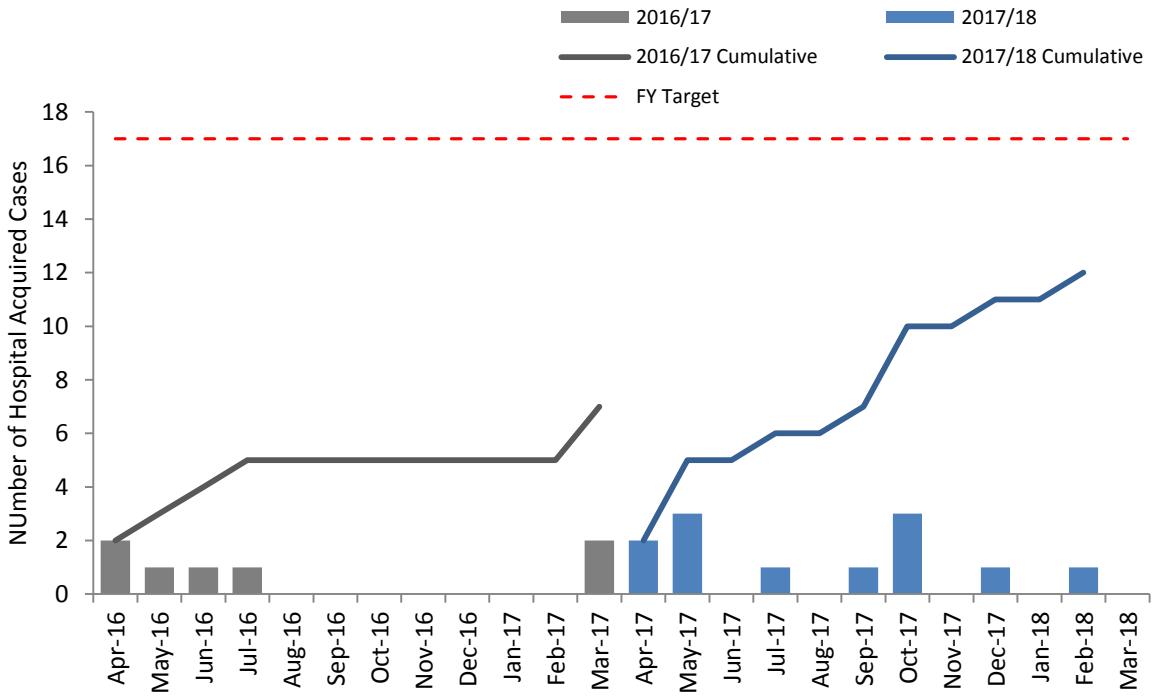
Clostridium Difficile

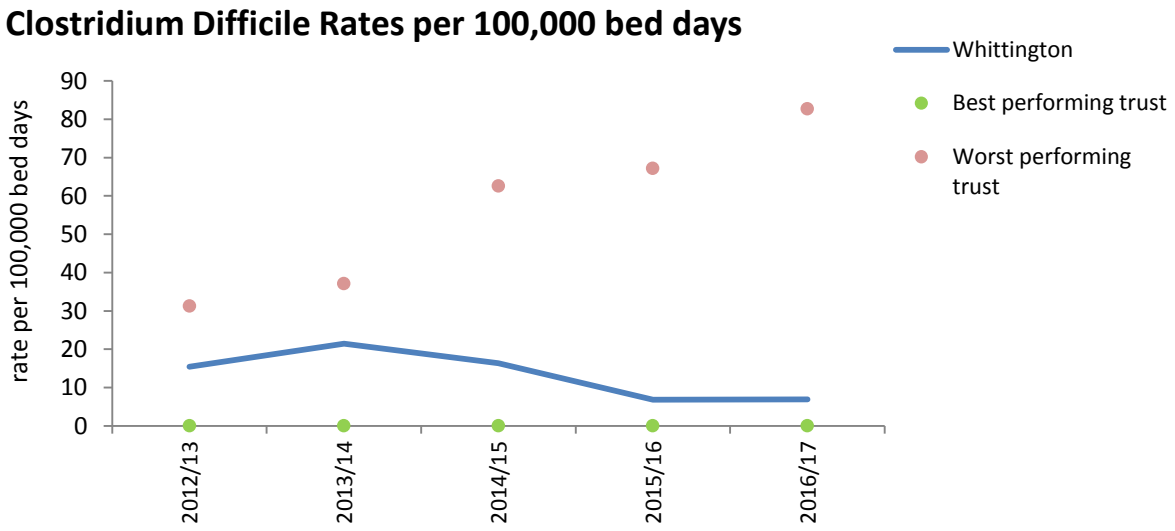
During 2017/18 there have been 11 *Clostridium difficile* infection cases attributable to Whittington Health. For the eleven cases, all but two were unavoidable. Our agreed ceiling trajectory for 2017/18 was set at 17 cases. We have taken a number of actions to reduce the number of *Clostridium difficile* cases that are attributable to Whittington Health including:

- Each patient case of attributable *Clostridium difficile* was thoroughly investigated with a full consultant-led post-infection review focusing on all aspects of the patient pathway from admission to diagnosis. Most cases were deemed as unavoidable.
- There were two cases found on the same ward at the same time which came back as the same ribotype and therefore likely due to cross infection. An action plan was devised and is being reviewed at every Infection Prevention and Control Committee meeting.
- Education sessions specifically on *Clostridium difficile* continue on our acute wards as well as during induction and update teaching sessions.

For 2018/19 our ceiling trajectory has been set at 16.

Clostridium Difficile Rates





Although the Trust has been below the national trajectory for Clostridium difficile infection (CDI) cases for the last three years, the Infection Prevention and Control Team are determined to continue reducing current numbers by:

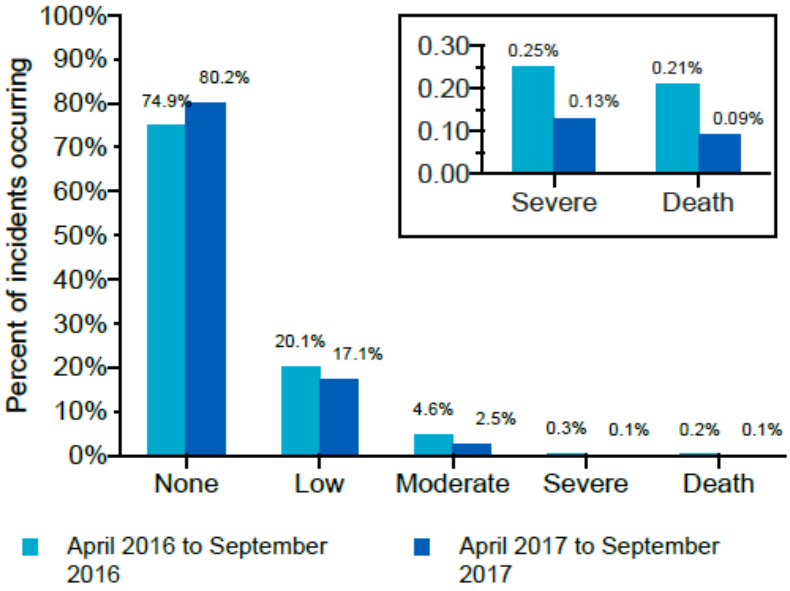
- Continuing post infection reviews (PIR) for all Trust attributable cases and creating action plans for each individual case. These action plans are presented to the Infection Prevention & Control Committee (IPCC) and reviewed at each meeting.
- Completing High Impact Intervention #7 audits on all CDI cases, which look at the compliance with hand hygiene principles by staff.

Patient Safety Incidents

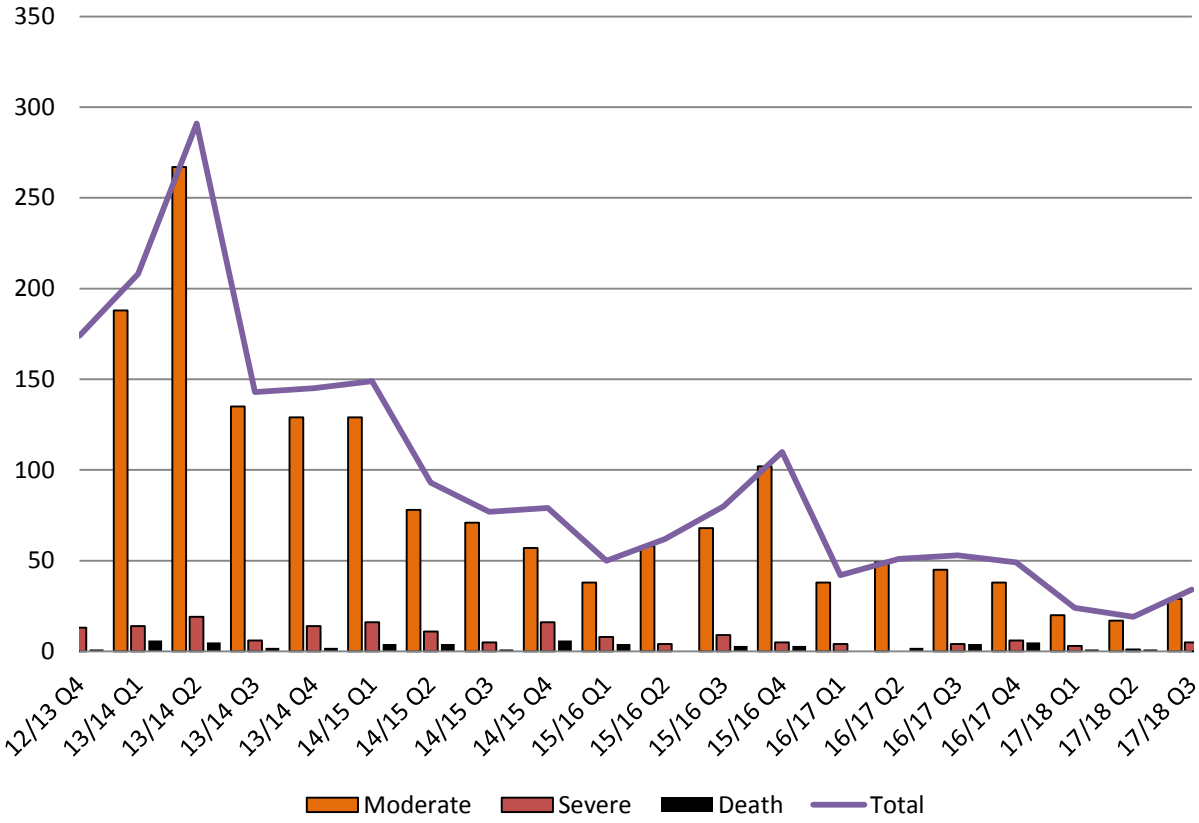
Whittington Health NHS Trust actively encourages incident reporting to strengthen a culture of openness and transparency which is closely linked with high quality and safe healthcare. The latest NHS Improvement report shows that we have a very good reporting culture within the organisation, placing us in the top quarter for incident reporting across the country.

Historically, it appeared that the Whittington Health NHS Trust had a higher proportion of incidents causing moderate-severe harm or death compared to the national average for acute non-specialist trusts. However, as the chart below demonstrates, there has been a significant change in the reporting culture in recent years and the classification process for grading the harm of incidents has been aligned with other NHS organisations.

Incident Harm Grading Chart

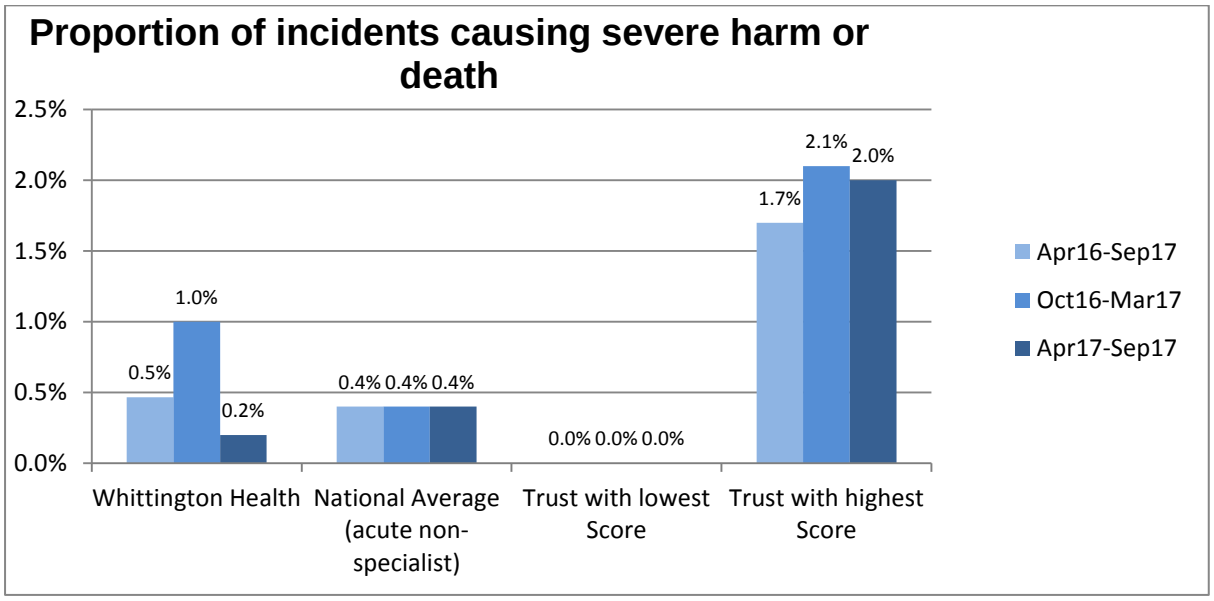


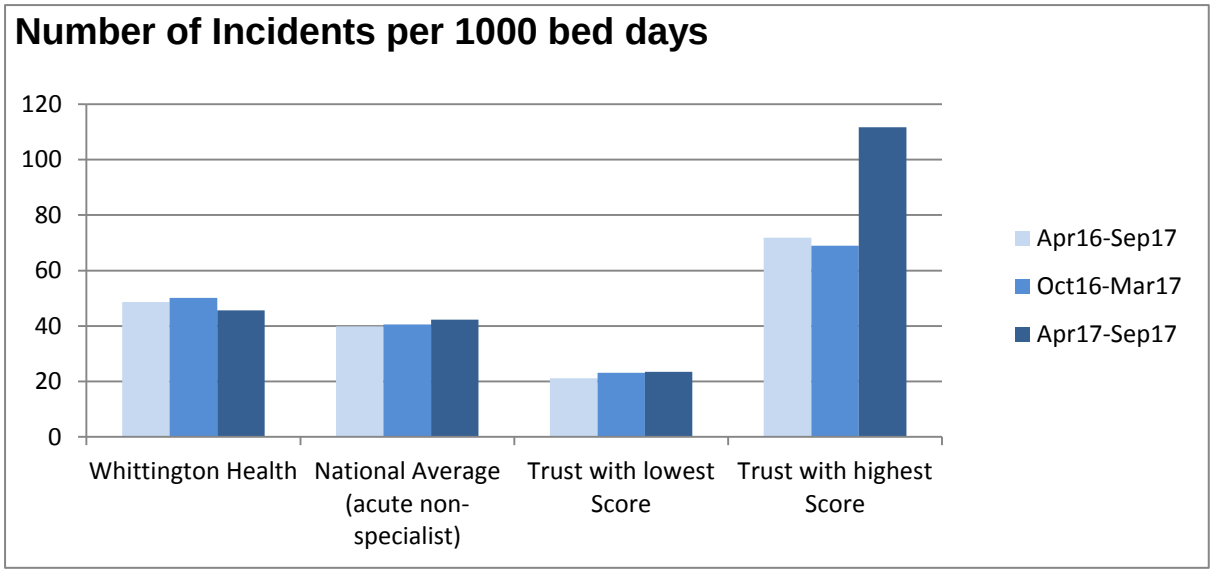
Incidents reported to NRLS (Moderate,Severe and Death caused by the Incident)



In 2017/18 there were a total of 38 serious incident investigations declared within the trust compared to 58 in 2016/17. During 2017/18 unfortunately the trust recorded one never event. This was related to a retained foreign object during a perineal tear repair in Maternity.

This event has been fully investigated and a root cause analysis conducted. The learning from the incident was disseminated across the organisation.





The trust is taking a number of actions in 2018-19 to improve patient safety, including:

- Promoting a culture of openness and transparency with incidents and near misses
- Encouraging shared learning from incidents and aiming to run 10 learning together patient safety workshops in 2018-19
- Improving datix usability and incident grading training
- Expanding the readership and circulation of the two monthly Patient Safety Newsletter
- Focusing on trend analysis in ICSU data/incident reporting

Since 2014 there has been a statutory duty of candour to be open and transparent with patients and families about patient safety incidents which have caused moderate harm or above. The trust complies with its statutory obligations but also strives to apply being open principles for low harm patient safety incidents which do not meet the statutory criteria.

Central Alerting System (CAS) Alerts

Patient safety alerts are issued via the CAS, which is a web-based cascading system for issuing alerts, important public health messages and other safety information and guidance to the NHS and other organisations. The Whittington Health NHS Trust uses a cascade system to ensure that all relevant staff are informed of any alerts that affect their areas. In 2017/18 all CAS alerts were responded to within the predetermined timeframe for the alert and are a standing agenda item at the trust's Patient Safety Committee.

Seven Day Service Standards

The aim of seven day services is to ensure that patients receive the same high quality of care, irrespective of the day that they arrive into hospital. These standards have been identified as the most likely to have the greatest impact on reducing variation in mortality risk.

The four priority clinical standards for seven day hospital services are:

- time to consultant review (standard 2),
- access to diagnostic tests (standard 5),
- access to consultant-directed interventions (standard 6), and
  on-going review by consultants twice daily for high dependency patients and daily for others (standard 8)

Standard		Data (March 2017)
2	Patients don't wait longer than 14 hours to initial consultant review	68%
5	Patients get access to diagnostic tests with a 24-hour turnaround time - for urgent requests, this drops to 12 hours and for critical patients, one hour.	94%
6	Patients get access to specialist, consultant-directed interventions	100%
8	Patients with high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds	91%

The data above is completed as a retrospective audit every six months with the results being submitted to NHS England. The most recent data of patients admitted during a seven day period in March 2017 is presented.

The results show that 68% of patients are seen by a consultant (standard two) within 14 hours of admission, which is similar to performance in the previous reporting period. For access to diagnostic tests (standard 5) the trust performs highly across the seven day period and has made further improvements to 24 hour CT scanning accessibility; however there remains some limited access to MRI, ultrasound and echocardiography at weekends. Access to specialist, consultant directed interventions (standard 6) is above London and National averages and specialist consultant reviews of high dependency patients (standard 8) are 100% and 91% for the last two reporting periods from September 2016 and March 2017 respectively.

Part 3: Review of Quality Performance

This section provides details on how the trust has performed against its 2017/18 quality account priorities. The results presented relate to the period April 2017 to March 2018 or the most recent available period.

Priority not achieved
Priority achieved

Priority 1: Improving Patient Experience

We aim to put the patient, carer and our staff at the heart of all we do in delivering excellent experiences. Through the Patient Experience Committee we have monitored and reported progress to achieving our priorities. The committee reports quarterly to the Quality committee which is a sub-committee of the trust board.

What were our aims for 2017/18?

- We will reduce the amount of time patients wait for booked transport from home to hospital

Priority 1

In order to achieve this priority we call all patients one day prior to their appointment date to confirm transport arrangements. We have also introduced an additional call from the driver of the transport when they are en route to the pickup. This gives the patient a more precise pick up time enabling them to get ready as close to the appointment time as possible.

We introduced these additional calls as we had been told about a patient's experience of the transport service – "further to a long wait, the driver happened to arrive whilst I was in the bathroom and I was unable to get to the door before the driver had left and I therefore missed my appointment".

Although this service improvement has been positively welcomed by patients we have been unable to gather sufficient data to determine if this has resulted in a reduction in the time patients have had to wait for transport and therefore cannot say that we have met this priority. Because of this we have set a specific target for 2018/19 to gather this information so that we can improve the hospital transport service.

What were our aims for 2017/18?	
• We will reduce outpatient clinic appointment cancellations	
Priority 2	Despite increased monitoring of demand and capacity across outpatients which has enabled us to be more responsive to service changes, and better management of staff sickness and absence, we have been unable to demonstrate a reduction in outpatient clinic cancellations and this remains at 13.03% for the year. However, in February 2018 the Trust launched an Outpatient Transformation programme, which aims to improve the productivity and efficiency across all outpatient services. The programme is working to develop a number of 'pilot' initiatives which will be tested, refined and rolled out. Key workstreams include: increasing clinic utilisation by proactively targeting DNAs, patient and Trust cancellations; and the systematic review of all clinic templates – which should provide increased transparency, predictability and capacity. Future improvements to further reduce cancellations include introducing an electronic referral system in October 2018 which will improve clinic planning and filling.

What were our aims for 2017/18?	
• We will reduce noise at night for patients	
Priority 3	In order to achieve this priority the trust set up a working group which included representatives from a number of clinical areas that met several times throughout the year to discuss the best possible strategy for achieving a reduction in noise at night. We also set up a patient focus group where we were told "I would have been able to rest much more had I been provided with ear plugs, eye masks and if the lighting had been minimised". The working group introduced the following actions to reduce noise at night: • night-time walkabouts to identify the main sources of noise • a sleepover on Ifor ward involving young people who reviewed noise and completed questionnaires regarding their experience • offering ear plugs and eye masks to all inpatients • provision of headphones to patients with TVs or other devices as necessary • introduction of desk lights at the nursing stations to reduce lighting • introduction of noise monitors in some areas to improve staff awareness of the noise levels • posters displayed to raise awareness with patients and staff of the importance of reducing noise with staff and patients. The results of the national inpatient survey 2017 show that the trust performed significantly better than the average (i.e. other trusts who were surveyed by Picker) with regards to the question 'bothered by noise at night from staff'. The trust also significantly improved on the question 'bothered by noise at night from other patients' compared to the previous year. The working group is continuing to ensure that the actions are rolled out trust wide and that we can continue improving in 2018/19.

What were our aims for 2017/18?	
• We will improve continuity of care from district nurses	
Priority 4	For patients in the community receiving district nursing care we know that consistently seeing the same nurse has a positive effect on patient care and experience. For this reason we prioritised improving continuity of care from district nurses in 2017/18. A number of steps have been taken to ensure that the quality of care is consistent and minimises unwarranted variations for those patients who see a number of different healthcare professionals. This includes clearly documented care plans, the provision of ipads for temporary staff so that they have access to patient records and handovers with the team leaders. We also introduced e-community software which enables senior staff allocating district nursing shifts to easily identify the last nurse who saw the patient and prioritise the booking of that nurse. The system enables automated allocation to ensure continuity of staff and also raises alerts if the skill of the nurse allocated does not match the needs of the patient. In March 2018 a patient presented their experience of the service to the trust board. The patient provided a positive example of how minimising unwarranted variations in care resulted in a very good experience notwithstanding the variety of healthcare professionals involved. Herman said “although I was visited by a variety of healthcare professionals they were well informed about my care”.

What were our aims for 2017/18?

- We will improve the feedback we receive about inpatient food

Priority 5

Quality food whilst an inpatient is important not only for patient satisfaction but also for nutritional value whilst unwell or recovering from illness. In order to improve the quality of food that the trust provides we set up a working group with representation from clinical areas, catering and nutrition and dietetics.

In October 2017, the patient experience team worked with the dieticians to record a video collecting patient feedback on the Trust's food service. Six inpatients discussed their feedback with the team.

Gladys was very happy with the choice of food and the quality "I think it is absolutely lovely, I really enjoy it and I have what I like. And I am a fussy eater!.....they always have a nice choice, and if they cannot offer one meal they will try to make you something else that is nice to compensate for this".

Gordon found the taste of the food good overall and was happy that staff prepared him adequately in advance of meals.

Susan thought that "the choice of food is excellent…….plenty to choose from'. She reported that she had always received the food that she had ordered, and that the dietician team had helped her in ordering extra items. Susan felt that the "food is fantastic, especially when you think about what all of the staff are catering for".

The actions the group took to improve food included:

- Plated food trials on three wards. Local survey feedback has been positive and the trust is developing a business case to deliver this to some inpatient wards permanently. A full comparative analysis is underway.
- Hand wipes taken round to patients at mealtimes that can be given straight from the packet
- Volunteers have received training to support patient mealtimes
- Menu cards have been improved to ensure patients are aware that different portion sizes are available
- Ensuring that menu booklets with the full range of choice are easily accessible to patients and visitors
- The clinical lead dietician has delivered informative and interactive training to staff to support delivery of mealtimes

Despite these improvements the results of the national inpatient survey 2017 showed that the trust performed significantly worse than average (i.e. other trusts that were surveyed by Picker) with regards to the questions 'food was fair or poor' and 'not always offered a choice of food'. Improving food continues to be a priority for the trust and that is why we are continuing to make this a priority in 2018/19.

Priority 2: Improving Patient Safety

Reducing Falls

What were our aims for 2016/17?

- We will introduce StopFalls bundles across the hospital, and achieve 80% compliance with falls assessment documentation on the Acute Admissions Unit (*AAU)* and *Care Of Older People* wards *(COOP)*

- We will reduce the number of avoidable falls resulting in serious harm to patients year on year

Progress to date

Throughout 2017/18, we introduced the STOPfalls campaign to reduce the number of falls, in particular falls with harm, across the hospital. The STOPfalls bundle was developed in line with the Royal College of physicians guidelines and included:

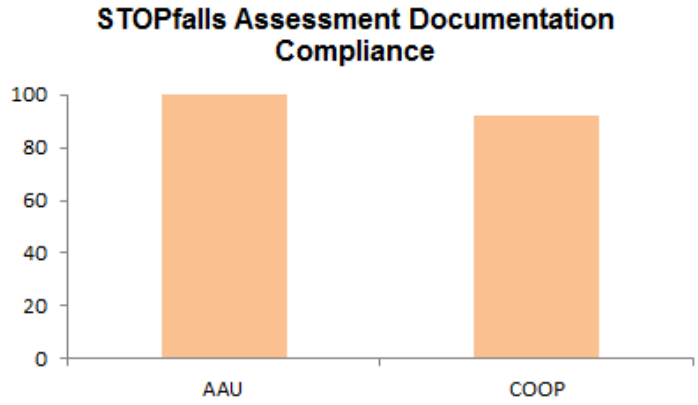
- Multifactorial risk assessment tool
- 'High Risk of Falls' sign for bed space
- Falls risk sign for walking aids
- Falls risk sticker in patient notes
- Falls risk bracelet for patients
- Yellow magnets on whiteboards to indicate falls risk

Whittington Health was one of twenty trusts participating in the National Falls Collaborative with NHSi and through the use of quality improvement methodology implemented a series of changes designed to embed the STOPfalls bundle in practice.

The first critical step in the STOPfalls bundle is the identification of patients that are at high risk of falls through a multifactorial risk assessment tool. This provides a systematic way for staff to check a patient's risk of falls and gives prompts to staff to address the specific needs of patients to reduce the likelihood of a fall. The target set in 2017/18 therefore focused on the completion of the falls risk assessment documentation. For 2018/19, this target has expanded to incorporate the other aspects of the STOPfalls bundle.

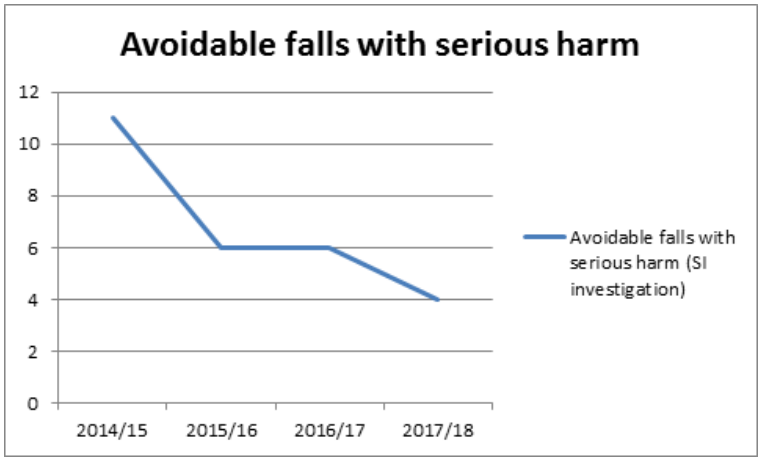
Priority 1

The falls assessment documentation has been audited on a quarterly basis in 2017/18 and has shown 100% compliance on the Acute Assessment Units and an increase from 82% in quarter one to 87% in quarter three on the care of the older people wards.



Since 2014/15 we have had a continuous goal of achieving a year on year reduction in the number of avoidable serious harm falls. We define 'avoidable' falls as those where processes designed to stop falls were not followed; a root cause analysis investigation is completed for each serious harm to identify if any system failures or human error contributed to the fall and what learning we can share across the trust to prevent reoccurrence. Unfortunately, despite all the efforts of hospital staff, carers and patients some falls are unavoidable. This is primarily due to the constant need to balance a patient's falls risk against their right to privacy and dignity, and their need to be mobile and independent to aid recovery.

The trend has shown sustained improvement from 11 incidents in 2014/15 to six in both 2015/16 and 2016/17. This year there were seven serious harm falls reported publicly as Serious Incidents. Following investigation in three of these incidents no care or service delivery problems were identified; the fall was found to have been unavoidable. As a result the number of avoidable falls with serious harm in 2017/18 fell to four.



One of the reasons falls with harm have declined this year is because of the introduction of our STOPfalls improvement project. The introduction of a multifaceted bundle of falls prevention measures has been introduced on the care of older people wards and acute assessment units and includes:

- Ward-based training provided to all staff on the Stop Falls bundle
- STOPfalls assessment tool embedded within the standardised patient admission booklet
- "Baywatch" initiative introduced. "Baywatch" is an MDT approach to maintaining patient safety through a card tag system which supports constant bay supervision. If the named nurse needs to leave the bay unattended, another staff member will be asked to be on "Baywatch" until the nurse returns; this can include doctors, nursing staff, porters, domestics and operations staff.
- "Grab bags" in use in toilets which are single-use bags consisting of toileting essentials for patients. This was introduced as a result of falls reported where patients were left unattended in the bathroom in order for staff to search for these toileting items (i.e. wipes, pads)
- Falls discussed as part of Board Rounds (yellow magnets indicate high risk)
- Regular staff meetings with the senior ward leadership team to raise awareness of STOPfalls

Priority 2

Pressure Ulcers

What were our aims for 2017/18?

- To achieve a year on year reduction in all grades of pressure ulcers across the ICO
- To develop a cross borough target on the 'React to Red Initiative'

Progress to date

Avoidable pressure ulcers are a key indicator of the quality and experience of patient care and are associated with longer stays in hospital and can lead to serious life-threatening complications, particularly in vulnerable patients. Despite progress since 2012 in the management of pressure ulcers they remain a significant healthcare problem and 700,000 people are affected by pressure ulcers each year (NHS Improvement, 2016).

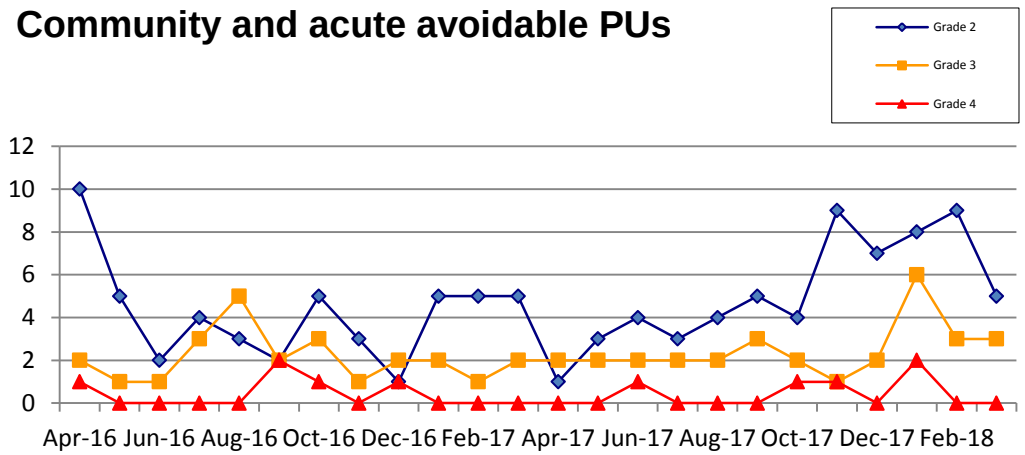
Reported pressure ulcers are classified as either avoidable or unavoidable. These incidents are assessed by the Tissue Viability Nursing team to confirm whether the pressure ulcer was classified correctly.

Priority 1

In order to achieve an annual reduction in pressure ulcers the trust has:

- introduced visual beside aids to assist staff in ensuring patients at risk are turned regularly
- increased senior nurse reviews to particularly focus on pressure ulcer prevention and management
- raised the profile of our tissue viability nursing team with ward staff
- carried out a 72 hour review of care for all avoidable pressure ulcers
- improved multidisciplinary team awareness of pressure care prevention and monitoring
- dedicated time on the morning ward round to ensure we are clearly documenting location and stage of any pressure injuries

We are incredibly proud that for the third year running we have not reported any avoidable grade four pressure ulcers within the hospital. We recognise the continued vigilance, management and escalation of pressure ulcers by staff on a daily basis to achieve this outcome. Within district nursing services we have reported five avoidable grade four pressure ulcers which is the same as in 2016/17.



Despite the improvements that we have implemented and the continued hard work of staff 2017/18 has seen a 25% increase in grade three and 21% increase in grade two pressure ulcers across the trust. It is for this reason that we are keeping this as a quality priority for 2018/19 as we are determined to reduce the number of avoidable pressure ulcers reported.

Priority 2

As part of our commitment to reducing avoidable pressure ulcers, providing education and raising awareness are essential. Consequently, the trust aimed to deliver a react to red initiative across Islington and Haringey.

We can confidently say that we have achieved this target by:

- raising awareness at an Islington carers hub meeting
- raising awareness at a GP training session
- uploading educational information onto the local GP portal
- raising awareness through the adult safeguarding group Islington
- publishing an article in the local Islington newsletter
- distributing information leaflets to pharmacists, care agencies, practice nurses and GPs

Learning Disabilities

What were our aims for 2017/18?

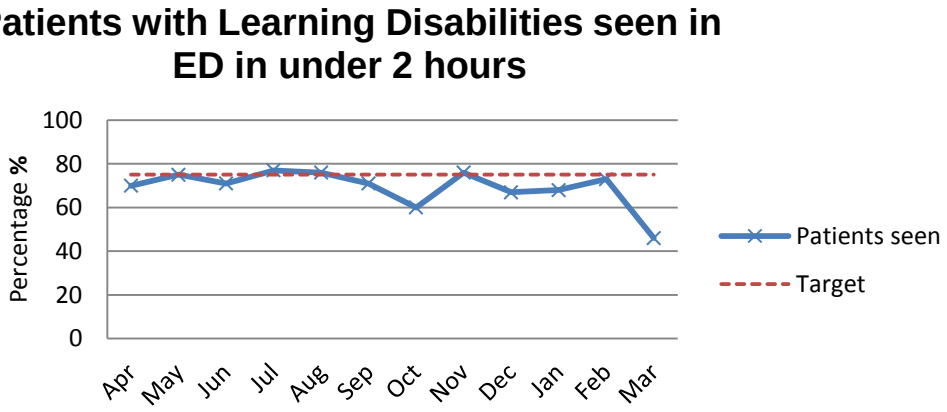
- 75% of patients who present to the Emergency Department with learning disabilities are given a priority assessment (i.e. seen in under two hours)
- To introduce a care pathway for mothers with learning disabilities in the hospital
- All children and young people entering CAMHS for a choice appointment will be screened for Learning Disabilities

Progress update

Priority 1

In conjunction with our stakeholders in 2017/18 we agreed to make reasonable adjustments for patients attending the emergency department with learning disabilities. We have introduced an alert on Medway to highlight to staff when a patient with LD attends the ED. Staff are then able to prioritise the patient and aim to see them within two hours.

The ED has been successful in seeing 68% of patients with learning disabilities in under two hours; however we have not been able to meet our target of 75 percent.



We recognise the importance of making reasonable adjustments for our patients and that is why we are continuing to prioritise triaging patients with learning disabilities that present to the emergency department in 2018/19. We can attribute the unusual reduction in performance in March 2017 to the leaving of our LD nurse specialist. We are currently recruiting into this vacant role.

Priority 2

In line with guidance from the 2015 paper 'Hidden voices of maternity – Parents with learning disabilities speak out' and following a series of listening events and feedback from patients we aimed to establish a care pathway for mothers with learning disabilities.

This pathway and protocol have now successfully been approved and the next steps are to embed it into practice.

Priority 3

In 2017/18 we have screened all children and young people for learning disabilities that have entered our Children and Adolescent Mental Health Service.

Medicines Safety

What were our aims for 2017/18?

- We will achieve a 10% increase in medication errors reported across the Integrated Care Organisation
- We will achieve a 10% reduction in medication errors with harm

Progress update

Priority 1

In 2017/18 we aimed to increase our reporting of medication incidents. High levels of reporting allow for better trend identification and learning and infers an open and transparent organisational culture. The data from the year shows that whilst we have not achieved our 10% increase in reporting we have achieved an impressive 5% compared to the number reported in 2016/17. Despite not achieving our aim the trust continues to be within the top quartile of incident reporting rates nationally.

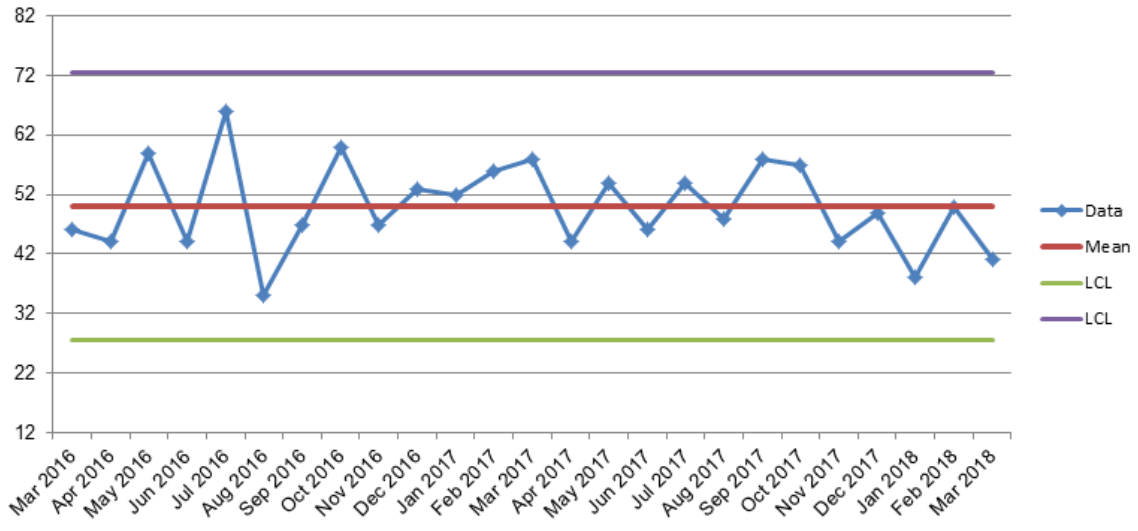
Priority 2

Medication incidents as a percentage of total patient safety incidents reported nationally in 2017/18 was 10.8%. Within the Whittington Health NHS trust, medication incidents accounted for 10.4% which is in line with national figures.

From April 2017 to September 2017, 10.6% of all our incidents were medication related

Reducing medication errors was given priority by the trust in 2017/18 and we set ourselves an aim of 10% for the year. Unfortunately we have been unable to reduce medication errors with harm despite the hard work that has gone into achieving this priority. The data for 2017/18 shows an increase of 2% in low, moderate and severe errors when combined. It is important to note that whilst a number of incidents are described as causing harm, it is often inadvertent harm, i.e. an allergic reaction from a medicine where this was not previously known results in harm, but may not have been avoidable. When looking at the harm severity individually the trust did not report any severe harm medication incidents.

Medication incidents between March 2016 and March 2018



Sepsis

What were our aims for 2017/18?

1. To achieve the national CQUIN for sepsis (90% of eligible patients in the emergency department (ED) screened for sepsis) with a particular focus on sepsis developing during inpatient stay

2. 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.

Progress update

The trust acknowledges sepsis as a potentially life threatening condition, triggered by infection. The UK Sepsis Trust estimates sepsis kills 40,000 people every year. Caught early, outcomes are excellent and therefore screening patients early for signs of sepsis is critical.

Priority 1

In 2017/18 we screened 93.5% of eligible patients in the emergency department for sepsis. This marks a continued improvement throughout the year from 88% in quarter one, to 95% in quarter four. Sepsis screening on the wards has also improved and between July 2017 and March 2018 we achieved over 95% screening of patients. Another achievement that the trust is particularly proud of is that between October and December 2017 and January and March 2018, 100% and 98% of patients with sepsis received antimicrobials within one hour of recognition, respectively, against a target of 90%.

These successes have been achieved by providing specific feedback to the emergency department on all patients that were either missed at the screening stage or did not receive antimicrobials within the target timeframe to ensure lessons are learnt and further improvements can be made.

Following the excellent outcomes achieved in sepsis recognition and management we received the following letter of congratulations:

I am delighted to inform you that you are one of the trusts which has seen the greatest improvements in timely identification and timely treatment of sepsis from the data we have received on the CQUIN.

I would like to congratulate you and your colleagues for all the hard work and dedication you have shown, which has enabled these improvements in sepsis recognition and treatment to take place. Please pass my thanks on to the staff concerned for their achievements in improving the care for patients with sepsis.

Celia Ingham Clark
Medical Director for Clinical Effectiveness
NHS England

Priority 2

We have also been successful in meeting our 2017/18 priority to raise awareness of sepsis. We achieved this by providing training to local GPs, mandating training for community nurses and introducing training programmes across all Haringey and Islington nursing homes. We are also additionally working with the Haringey Quality and Patient Safety Manager to establish a GP sepsis link from each GP surgery.

We were delighted that 263 members of our community and hospital staff attended our sepsis awareness day which highlighted the importance of early recognition of the signs of sepsis and showcased the improvements we had made as a trust managing sepsis.

Pre-hospital sepsis alerts have consistently achieved over 50% between October and December 2017 which is a significant improvement compared to the 10% we achieved in 2014/15. This important recognition process highlights the work we have done in the community in promoting sepsis awareness and early identification of symptoms.

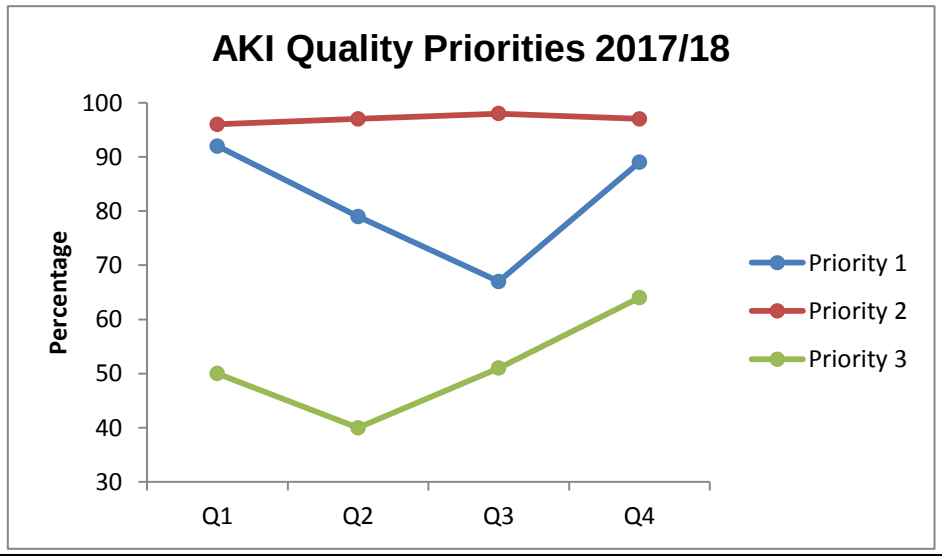
Acute Kidney Injury (AKI)

What were our aims for 2017/18?

1. At least 75% of patients with AKI include an AKI diagnosis in their discharge letter
2. At least 90% of patients with grade 3 AKI are seen by Critical Care Outreach Team (CCOT) within 24 hours.
3. 90% of patients that develop grade 3 AKI have a medicine safety review within 24 hours

Progress update

In the UK up to 100,000 deaths in hospital are associated with Acute Kidney Injury. 'Think Kidneys', the NHS national campaign focusing on prevention and management of AKI estimate that up to 30% could be prevented with the right care and treatment (thinkkidneys.nhs.uk 2018). In 2017/18 the trust continued to prioritise AKI recognition and management and set three ambitious targets to improve patient safety.



Priority 1	In 2016/17 57% of inpatients diagnosed with an AKI had an accurate discharge letter detailing this information. In 2017/18 we set a target of 75% and at year end have achieved an average of 82% based on quarterly audits of discharge letters against clinical notes and test results. This is a significant 25% improvement and highlights the importance we have placed on improving communication between hospital and community services and the need for accurate discharge summaries. Work is ongoing to further improve the accuracy of our AKI reporting and documentation and in 2018/19 we are aiming to achieve 90%.
Priority 2	Timely reviews of patients diagnosed with a grade three acute kidney injury by the CCOT are known to reduce the risk of patient deterioration and the need for subsequent care. The CCOT are alerted to all grade three AKI diagnoses and aim to review these patients within 24 hours. Through the introduction of improved AKI alerting systems and earlier recognition of grade three AKIs we have been able to exceed our 2017/18 target of 90% of patients seen within 24 hours. We have consistently achieved above 95% and have averaged 97% for the year. In the previous year the trust averaged 80%of reviews within 24 hours and this clearly demonstrates the quality work the trust has undertaken to improve patient safety with AKI.
Priority 3	Medicine safety reviews are a key part of medicines management and help to ensure that patients are prescribed the most appropriate medications for their AKI diagnosis. Aiming to do this within 24 hours helps to ensure patients are getting the most effective treatment as early as possible. In 2017/18 we set ourselves an ambitious target of reviewing the medication of 75% of patients diagnosed with a grade three AKI within 24 hours. Whilst we have successfully improved from an annual average of 10% in 2016/17 to 45% in 2017/18 we unfortunately did not meet our annual quality priority target. The second half of 2017/18 has seen a very positive trajectory and in the last four months of the year we have consistently achieved above 55%. We are confident that we can continue this sustained improvement into 2018/19 and have identified further areas that we can streamline to improve the number and efficiency of medicines reviews within 24 hours to further improve patient safety. In light of the patient safety implications involved with this we are continuing to prioritise medicine safety reviews in AKI in 2018/19.

Priority 3: Improving Clinical Effectiveness (Research & Education)

Clinical effectiveness can be measured using various methods including clinical audit, to ensure high quality patient care and outcomes.

Research

What were our aims for 2017/18?
• We will increase by 10% the number of national Institute of health research (NIHR) programmes in which we participate • We will achieve the recruitment target, set by the north Thames CLRN, for patients recruited into NIHR portfolio studies.

Progress to date	
Priority 1	In 2017/18 we did not achieve our target of increasing the number of NIHR research studies compared to the year before (39 compared to 48). However, working with the North Thames Clinical Research Network we have improved our recruitment to time and target metrics in line with the NIHR High Level Objectives which has improved the overall quality of studies (and number of patients recruited).
Priority 2	In 2017/18 the research delivery far exceeded the North Thames CLRN recruitment target, the target was set at 474 patients and we recruited 724 patients.

Education

What were our aims for 2017/18?
• We will continue to provide access to 'learning together from patient safety incidents and complaints workshops' based on real patient stories and aim to deliver 10 structured inter-professional learning events in 2017/18 • 100% of students placed at WH will have access to a named educational and clinical supervisor or mentor • We will expand our portfolio of inter-professional learning opportunities for staff by offering training in making every contact count and access to the training offered by Haringey and Islington community education provider networks • We will offer upskilling opportunities to health professionals on how to teach and support people to self-manage their long term condition by offering the advanced development programme across Islington and Haringey

- We will evaluate the access group, currently running in the East of Haringey's improving access to psychological therapies service, which Turkish patients are offered before the delivery of individual CBT. We aim to establish its effectiveness in improving outcomes, and reducing DNAs and dropouts in this BME community

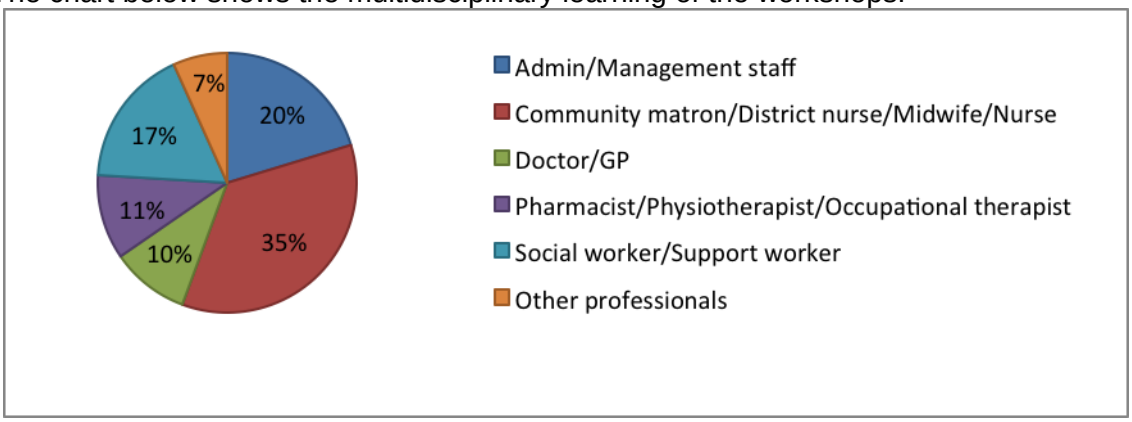
Progress to date

Priority 1

In 2017/18 the trust ran seven half day 'Learning together' workshops based on real patient stories from serious incidents that have happened at Whittington Health. Each workshop discussed a number of key themes and focused on shared learning and quality improvement.

Themes including adult safeguarding, cross-organisational working, discharge planning, end of life, handover, information sharing, learning disability, mental and physical health, pressure ulcers, sepsis and team working were explored. All workshops were facilitated by Whittington Health staff (from various professional backgrounds) and opened up to colleagues working in health, social care and charity sectors in Camden, Haringey and Islington. In total, the workshops were attended by 290 professionals from various backgrounds, with an average attendance of 40 people per workshop. Learning materials from all sessions have been made available on Whittington Moodle to share learning within Whittington Health and with other local health and social care colleagues such as district nurses, GPs or social workers.

The chart below shows the multidisciplinary learning of the workshops.



Priority 2

The trust has made it a requirement for all students to have a learning portfolio in which to keep a log of education and training activities and reflective practice throughout their undergraduate training. As part of this process, all students must have access to a named mentor or supervisor.

In 2017/18 there were approximately 800 medical students, 550 nursing students and 190 midwifery students completing their clinical placements at the Whittington Health NHS trust. Over the last year every student has been given access to 'NHS ePortfolio' or a 'Practice Assessment Document' and has been allocated a named mentor or educational/clinical supervisor.

Priority 3	Education and training activities offered via Haringey and Islington Community Education Provider Networks have focused on the development and delivery of sustainability and transformation plans. The focus remained on recruitment, retention and continuing professional development of staff working across health and social care. New networks such as the North London Partners Quality Improvement network and Trainee and Newly Qualified Professionals network have been established to support workforce development across North Central London. Furthermore, in 2017/18 we ran four pilot simulation based MECC sessions with a view to continue running these in the future.
Priority 4	"The Advanced Development Programme (ADP) – Communication Skills for Supporting Self-Management & Behaviour Change" is a training programme for health professionals from multi-disciplinary backgrounds open to anyone who works with people with long term conditions in Islington or Haringey. The course provides strategies and skills to support people with long-term conditions to optimally self-manage. It draws on best practice from clinical communication skills, motivational interviewing and Cognitive Behavioural Therapy (CBT) approaches. During 2017/18, 67 participants started and 63 completed the course across Islington and Haringey. Overall the feedback from participants was positive; 85% of participants reported in the training questionnaire that they felt 'more' or 'much more' confident/ knowledgeable/important/likely' following the course. Participant feedback includes: • *Thank you for an incredibly informative and well delivered session!* • *Given me more insight into how and why it's so beneficial to get the patient on board with changing their own lifestyle.* • *I have started communicating the skills I have learnt during these sessions to my colleagues as I feel they are incredibly beneficial.* • *I found the advice regarding open ended questions the most helpful and made the biggest difference within my practice.* • *I am more focussed on patient centred goals, rather than what I think should be the goals.* • *Getting patients to explain their own ideas rather than enforcing my ideas.* Due to the success achieved this year we are planning to deliver another six ADP courses to Islington and Haringey professionals in 2018/19.

Priority 5

This priority aimed to discover whether attending the Turkish language Access Group prior to intervention led to benefits in terms of therapeutic outcomes and engagement. In assessing the impact of the course, the project used a number of quantitative variables which showed no difference between people who attended the group prior to intervention, and those who received only an intervention, suggesting the group does not lead to improvements in these areas.

A number of reasons have been identified which may explain the feedback, including confusion about the purpose of the group (29% of respondents reported that the group was not helpful as it did not improve their symptoms. However, this is not what the group aimed to do; rather it aimed to enable clients to benefit more from their intervention). However, despite this 79% of respondents indicated that the group was helpful to them.

These results suggest several future directions for the Turkish language Access Group. Firstly, the purpose of the group needs to be clearly explained, and participants' expectations discussed at the beginning of the first session. Secondly, it could be useful to consider the mix of diagnoses present in a group. Although practical considerations limit the ability to have diagnosis specific groups (and the evidence base does not indicate it is desirable), it may be useful to note if one person has a very different need to others.

Part 4: Other Information

Local Performance Indicators

Goal	Standard/benchmark	Whittington Performance	
		17/18	*16/17*
ED 4 hour waits	95% to be seen in 4 hours	**89.43%**	87.4%
RTT 18 Week Waits: Incomplete Pathways	92% of patients to be waiting within 18 weeks	**92.2%**	93.0%
RTT patients waiting 52 weeks	No patients to wait more than 52 weeks for treatment	**5**	0
Waits for diagnostic tests	99% waiting less than 6 weeks	**99.1%**	99.5%
Cancer: Urgent referral to first visit	93% seen within 14 days	**94.7%**	96.2%
Cancer: Diagnosis to first treatment	96% treated within 31 days	**100.0%**	100.0%
Cancer: Urgent referral to first treatment	85% treated within 62 days	**88.1%**	87.4%
Improved Access to Psychological Therapies (IAPT)	75% of referrals treated within 6 weeks	**95.8%**	94.5%

The Whittington Health NHS Trust considers that this data is as described because it is collected, downloaded and processed in a robust manner, and checked and signed off routinely.

In 2017/18 the trust has performed well compared to benchmarking for local performance indicators and has exceeded standards for Cancer, IAPT, diagnostic test and RTT 18 week waits. However, there are two areas where the trust has not met these standards and is taking the following actions to achieve the 'ED 4 hour wait' and 'RTT patients waiting 52 weeks' goals.

Examples of actions include:

- Establishing better and more robust pathways between the emergency department triage service and specialist inpatient assessment units.
- Revision and recruitment of the emergency department workforce in order to facilitate rapid assessment treatment (RAT) criteria led discharges
- Developing enhanced roles for nurses and health care assistants within the emergency department.
- Establishing a Frailty Pathway that enables early frailty team input to optimise management/ discharge support and reduce Length of Stay (LoS) and readmission rates
- Training and promotion of a pre-11 a.m. discharge culture
- System wide improvement: working with Haringey and Islington and the wider Sustainability and Transformation Programmes to improve the performance of ED.

Summary Hospital-Level Mortality Indicator (SHMI)

The SHMI is the ratio between the actual number of patients who die following admission to hospital and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI score represents a comparison against a standardised National Average. The 'national average' therefore is a standardised 100 and values significantly below 100 indicate a lower than expected number of mortalities (and vice versa for values significantly above).

Patients who are coded as receiving palliative care are included in the calculation of the SHMI. The SHMI does not make any adjustment for patients who are coded as receiving palliative care. This is because there is considerable variation between trusts in the coding of palliative care.

Using the most recent data published in March 2018 which covers the period from October 2016 to September 2017, the SHMI score for the Whittington is 0.727

Lowest National Score: 0.727 (Whittington Health NHS Trust)
Highest National Score: 1.247

The Whittington Health NHS Trust considers that this data is as described as it is produced by a recognised national agency and adheres to a documented and consistent methodology.

Whittington Health is taking the following actions to further improve this score and the quality of its services, by:
• Providing regular learning events and resources for all staff to facilitate learning from incidents and findings from unexpected deaths;
• Ensuring that all inpatient deaths are systematically reviewed, and that any failings in care that suggest a death may have been avoidable are identified, systematically shared, learned from, and addressed

Annex 1: Statements from external stakeholders

Statements from Commissioners and local Healthwatch organisations

Healthwatch Islington feedback

"Healthwatch Islington hosted a meeting with Whittington colleagues about the Quality Account objectives. We discussed progress from last year and areas of focus for the year ahead.

We are liaising with the Trust around community services, waiting times continue to be long and administration of appointments could be improved. We hope to work with the Trust on improving this in the year ahead.

We welcome the Trust's work to develop their Patient Experience Strategy".

Best wishes

Emma Whitby, Chief Executive

healthwatch Islington

Healthwatch Haringey feedback

We agree with the patient experience priorities for 2018/19, subject to the comment below, and note that they have been identified in consultation with patient representatives.

An area of concern which has been highlighted in performance reports but not referenced in the Quality Account relates to the Memory Clinic and the very significant gap between the target and actual waiting times. We would like to see this identified as a priority for improvement in 2018/19.

We look forward to working with the patient experience committee to monitor progress against the targets and working in partnership with the Trust over the coming year.

Mike Wilson

Director

healthwatch Haringey

Commissioner feedback

Commissioners' Statement for 17/18 Quality Account

NHS Islington Clinical Commissioning Group (CCG) is responsible for the commissioning of health services from Whittington Health NHS Trust on behalf of the population of Islington and all associate CCGs. In its capacity as lead co-ordinating commissioner NHS Islington CCG welcomes the opportunity to provide a statement for the Trust 2017/18 quality account.

The Trust has engaged with the CCG to ensure that commissioner's views were considered. We are pleased that our comments were incorporated in the final draft. The CCG notes the inclusion of; further distinction between acute and community services, further detail on infection control, evidence of reflection on previous achievement and further information on how progress against the accounts will be measured in the 2018/19 Quality Account.

The CCG can confirm that the Quality Account complies with the prescribed information, form and content as set out by the Department of Health. The information provided within the account has been checked against data sources made available as part of existing contract/performance monitoring discussions and the data presented within the account is accurate in relation to the services provided.

Between 31st October and 2nd November 2017 the CQC inspected four core services at the Trust. These had been rated "requiring improvement" in the previous CQC inspection in 2015. The outcome of the improvements made by the trust were seen by the CQC when re inspection took place, resulting in the rating for the hospital changing from 'Requires Improvement' to 'Good'. The Trust maintain an overall rating of 'good' from the 2015 inspection.

The CCG note efforts made by the Trust during 2017/18 to robustly address the CQC recommendations. In addition the improvements in the reduction of sepsis during 2017/18 are commendable and commissioners hope this will continue in 2018/19.

Islington CCG fully support the quality priorities identified by the Trust and acknowledge the fourteen priorities for the 2018/19 Quality Account. The CCG look forward to working with the Trust collaboratively to improve the delivery of high quality care. The Fourteen Priorities are:

Priority 1: Improving Patient Experience

1. Communication (Trust wide)
2. Food (Hospital)
3. Hospital Transport (Trust wide)
4. Outpatient cancellations (Trust wide)
5. Improve District Nurse continuity of care (Community)
6. Podiatry (Trust wide)

Priority 2: Improving Patient Safety

1. Falls (Hospital)
2. Acute Kidney Injury (Hospital)
3. Pressure Ulcers (Trust wide)
4. Care of Older People (Hospital)
5. Mental Health and Learning Disabilities (Trust wide)

Priority 3: Improving Clinical Effectiveness

1. Patient Flow (Hospital)
2. Clinical Research (Trust wide)
3. Education and learning (Trust wide)

The Trust has achieved significant success in their CQUIN targets. Improvements embedded have led to significant benefits to patient safety and patient experience and this is noted in the Quality Account.

We consider this Quality Account represents a fair and balanced overview of the quality of care at Whittington Health NHS Trust during 2017/18. We look forward to the year ahead and working with the Trust to continually improve the quality and safety of health services for the population they serve.

Tony Hoolaghan
Chief Operating Officer
NHS Islington Clinical Commissioning Group

How to provide feedback

If you would like to comment on our Quality Account or have suggestions for future content, please contact us either:

By writing to:

The Communications Department,
Whittington Health,
Magdala Avenue,
London. N19 5NF

By telephone:

020 7288 5983

By email:

communications.whitthealth@nhs.net

Publication:

The Whittington Health NHS Trust 2017-18 Quality Account will be published on the NHS Choices website on the 29th June 2018.

https://www.nhs.uk/pages/home.aspx

Accessible in other formats:

This document can be made available in other languages or formats, such as Braille or Large Print.

Please call **020 7288 3131** to request a copy.

Annex 2: Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance in the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amended Regulations 2011.

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

The Quality Account presents a balanced picture of the Trust's performance over the period covered, in particular, the assurance relating to consistency of the Quality Report with internal and external sources of information including:

- Board minutes;
- Papers relating to the Quality Account reported to the Board;
- Feedback from Healthwatch;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- the latest national patient survey;
- the latest national staff survey;
- the Head of Internal Audit's annual opinion over the trust's control environment;
- feedback from Commissioners;
- the annual governance statement; and
- CQC Intelligent Monitoring reports.

The performance information reported in the Quality Account is reliable and accurate.

There are proper internal controls over the collection and reporting of the measures of performance reported in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.

The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and The Quality Account has been prepared in accordance with the Department of Health guidance.

The directors confirm that to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

Siobhan Harrington
Chief Executive

Steve Hitchins
Chairman

Annex 3: Independent Auditors' Limited Assurance Report to the Directors of the Whittington Health NHS Trust on the Annual Quality Account

We are required to perform an independent assurance engagement in respect of Whittington Health NHS Trust's ("the Trust") Quality Account for the year ended 31 March 2018 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following indicators:

- The percentage of patients risk-assessed for venous thromboembolism; and
- The rate of clostridium difficile infections.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of the Directors and the auditor

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in

accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2017 to May 2018;
- papers relating to quality reported to the Board over the period April 2017 to May 2018;
- feedback from the Commissioners, NHS Islington CCG dated 31 May 2018;
- feedback from Islington Healthwatch dated 8 May 2018;
- feedback from Haringey Healthwatch dated 24 May 2018;
- quarterly report on complaints to the Quality Committee covering the period April 2017 to March 2018 - the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009 for 2017-18 has not been completed;
- the Picker inpatient survey 2017 dated January 2018;
- the national NHS Staff Survey 2017;
- the Head of Internal Audit's annual opinion over the Trust's control environment for 2017/18;
- the annual governance statement dated 25 May 2018; and
- the Care Quality Commission's Inspection Report dated February 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of the Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and the Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and

- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by the Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
Canary Wharf
London
E14 5GL

25 June 2018

ISLINGTON
Housing and Adult Social Services
7 Newington Barrow Way, London N1 2RY

Report of: **Service Director – Housing Property Services**

Meeting of:	Date	Ward(s)
Health & Care Scrutiny Committee	12 July 2018	All

SUBJECT: Health Implications of Damp Properties – 12 months' service update to the report of the Health and Care Scrutiny Committee

1. Synopsis

1.1 On 24 November 2016 the Executive received a report from the Health and Care Scrutiny Committee regarding the health implications of damp properties. Subsequently, on 27th April 2017, the Executive agreed its response to the recommendations set out in the scrutiny report. This report updates the Health & Care Scrutiny Committee on progress with the recommendations agreed by the Executive.

2. Recommendations

2.1 To note the progress made set out in paragraph 4 of this report.

3. Background

3.1 In June 2015 the Health and Care Scrutiny Committee commissioned a review of the Health Implications of Damp Properties within the borough.

3.2 The review ran from July 2015 until September 2016 and evidence was received from a variety of sources.

3.3 Presentations from Council Officers

Baljinder Heer-Matiana, Senior Public Health Strategist; Damian Dempsey, Group Leader – Quantity Surveyors and Ellis Turner, Environmental Health Manager-Residential

3.4 Documentary evidence

Information from the Office of Deputy Prime Minister 2006 Housing, Health and Safety Policing system.

3.5 Information from witnesses

Katie White of Andover TRA, Jan Manderson of Girdlestone TRA, John Venning of Partners, Stephen Filis of Anthea Lettings and James Stone of Hyde HA.

The outcome of the scrutiny review was 12 recommendations (see Page 2 of the report dated September 2016).

4. Recommendations and Service Update

4.1 Recommendation 1 - Rehousing of tenants

Where there are damp issues in a property, and tenants can evidence related health issues, the Council is to presume that the damp is the cause of the health problems, and where tenants wish to be rehoused, the Council and Partners for improvement (PFI) are to progress rehousing. RSL's and private landlords are also to be encouraged to adopt the same policy.

4.1.1 Response to Recommendation 1

Under the Housing Act 1996 a local authority must have an allocation scheme which shows how accommodation in the borough is allocated. By law the scheme must ensure that key groups are given 'reasonable preference', this includes people who are homeless, need to move on medical grounds or people living in unsatisfactory housing. Before changing its allocation scheme an authority must consult with residents, local Registered Providers (housing associations) and must carry out an equality impact assessment.

Islington's current scheme was agreed by the Executive in July 2013.

The council's current housing allocation scheme already provides for giving additional priority for residents living in accommodation which has an impact on their health, including because of dampness. An extract from the scheme is below:

The council may give points if it considers that an applicant or a member of their household's accommodation is unsuitable because of a medical condition.

Medical priority will be awarded according to the extent to which the health of one of more members of the applicant's household is affected by their housing conditions and the expected benefits of providing alternative housing. **No medical points will be given if there is a medical condition but the accommodation is suitable**.

A household will be assessed together and one award made for the whole household. The number of medical points you will be given depends on the household's health and the severity of the conditions in their home. There are three categories of medical points:

Category A – this gives the maximum 150 points, an award will be made:

In exceptional circumstances for households where a member of the household has an immediately life-threatening or progressive condition which is seriously affected by their current accommodation

Category B – is an award of 80 points and is for households where a member of the households' current housing conditions are having a major adverse effect on their medical condition. It will not apply where the effect of the housing conditions on health is moderate, slight or variable.

Category C – awards 40 points and is for households where a member of the household's current housing conditions are having a moderate or variable effect on their medical condition. It will not apply where the effect of the housing conditions on health is slight.

4.1.1a **Service Update – May 2018 to Recommendation 1**

Islington's Housing Allocations Scheme was refreshed in March 2018 and continues to be applied consistently for vulnerable residents. This encompasses those who are able to evidence health problems as a consequence of damp within their homes.

Practically, this would entail the provision of medical evidence that highlights the effect of damp on the residents' health. This evidence would then be considered by the Council's medical officer who would make a recommendation about the need for alternative accommodation on the basis of the effect and impact of the residents' deterioration in health.

In these circumstances as noted in the previous report, medical priority points may be awarded;

- according to the extent to which the health of one of more members of the applicant's household is affected by their housing condition;
- and the expected benefits of providing alternative housing.

Within this context, a household would be assessed collectively and one award made for the whole household. Additionally, the number of medical points awarded would depend on the household's health and the severity of the conditions in their home. The aforementioned approach would also apply to properties managed by Partners for Improvement on behalf of the Council.

RSL's and private landlords would typically have their own policies and procedures with respect to disrepair to their properties. Residents of these properties who may approach the Council seeking housing assistance would be supported by housing officers to engage proactively with their landlord to either expedite resolving the damp issue and or negotiate a possible move to another property within their stock. However, we are cognisant of the challenges likely to be raised by RSL and private sector landlords during these negotiations. To that end, the Council's positive relationships with RSL's and private landlords is critical to the success of negotiations related requests for alternative housing within their respective portfolios.

4.1.2 Partners follow the same policy as the council in allocations.

4.2 Recommendation 2 - Building/Fabric issues

That the repairs department, when investigating complaints about damp, should consistently eliminate roof leaks, rising damp, plumbing issues, ventilation issues, cold bridging, lack of insulation on and any building fabric issues as causes of damp, before raising 'lifestyle' issues with residents. Many residents report a presumption on the part of Council surveyors that all damp issues are due to 'lifesyle', where in fact the issues are often building related.

4.2.1 **Response to Recommendation 2**

We have reviewed our processes when diagnosing damp and mould to ensure that there is no presumption that all damp issues are due to residents' behaviours. Surveyors undertake full inspections to the internal & external elements to all reported properties. Repairs are raised and completed where necessary. Before any other possible contributing factors are considered we will ensure the property is free of all internal and external leaks.

4.2.1a **Service Update – May 2018 to Recommendation 2**

The repairs team revised the procedure outlining how its diagnostic surveyors should respond to reports of damp and mould in council homes. The process now sets out more clearly that surveyors must consider and exclude any potential maintenance or building defect that could be a contributory factor to the damp and mould problem. Any identified maintenance issue must be dealt with first before the surveyor will consider any contributory factors related to day to day activities of the household which result in condensation being generated. As part of the process diagnostic surveyors will issue residents affected by damp and mould with the new 'Tips for tackling damp and mould problems' leaflet. In addition to the implemented procedural changes, more members of the surveying team are being recruited on a permanent basis with less reliance on temporary staff. It is hoped this will help reduce the staff turnover rate within this team and enable the service to investment in the team's training with increased focus on strengthening customer care and communication skills. Between April 2017 and March 2018 the repairs service completed 1816 survey inspections in response to reports of damp or mould with repairs orders raised as a result of these inspections and, where applicable, advice given to residents on the treatment of mould and management of condensation. During the same period, the repairs service installed 19 specialist ventilation systems to help tackle the most complex condensation and mould cases linked to the insufficient movement of air through the home. These systems have helped alleviate problems in the homes where they have been installed but they are relatively expensive to install at around £2,000 per unit plus the additional cost of their ongoing maintenance. In addition some residents have refused to consider these systems because they require ducting to be installed within the home which some residents find unsightly.

4.2.2 Partners repair supervisors and surveyors all receive training to ensure that they correctly diagnose the causes of damp and specify appropriate remedial works. This includes specifying work to remedy excessive condensation caused by the design of the dwelling e.g. very cold rear additions. If we think that the condensation is caused by the tenant not heating and ventilating their home adequately then we will work with them and assist them to take appropriate measures to reduce condensation. If we identify that fuel poverty might be an issue that a particular resident is facing, we will make a referral to the SHINE team.

4.2.2a **Partners Update – May 2018 to Recommendation 2**

The works includes thermal insulation or upgrading the central heating system.

4.3 Recommendation 3 - Experienced Damp Surveyor

An experienced damp surveyor to be employed by the Council and PFI to investigate and resolve damp problems (The Committee heard that the response of officers to complaints of damp is prone to inconsistency, and also repeat visits, for no apparent reason. Surveyor's knowledge of damp-related issues is found to be variable).

4.3.1 **Response to Recommendation 3**

All surveyors' reports are being reviewed to ensure that the level of reporting and diagnosis is at the expected standard and we are addressing the repairs in the property.

4.3.1a **Service Update – May 2018 to Recommendation 3**

The repairs team strongly believes a more effective and customer focussed response to reports of damp and mould is achieved by ensuring sufficient levels of diagnostic and investigatory skill and

technical knowledge of the causes and remedies for damp and mould by each diagnostic surveyor in the team, rather than attempting to recruit a surveyor who solely deals with these reports. Technical staff within the repairs team continue to develop their technical knowledge on the issue of diagnosing and resolving damp and condensation cases which has included key staff attending a specialist damp diagnosis training course during 2017 and 2018. A senior member of the surveying team has also delivered training to other colleagues in the wider repairs service on the topic of dampness and mould to raise their awareness and understanding of the issue, its possible causes and solutions. The surveying team continually review the potential that new damp diagnostic methods, tools and technology bring and if these are considered to be both beneficial and cost effective they have started using them within the service, for example, the increased use of thermal imaging to help identify leaks more quickly and accurately and with less inconvenience to affected residents. When necessary, the manager of the surveying team has involved the council's insurance provider and specialist damp consultants in the investigation of complex structural and damp cases.

4.3.2 Partners repair supervisors and surveyors have all received damp training from a damp specialist to ensure that they correctly diagnose the causes of damp and specify appropriate remedial works. More complex damp jobs are referred to an independent damp specialist (not a damp proofing contractor) to provide a full damp report which specifies the remedial work.

4.4 Recommendation 4 - Hyde Damp and Condensation Survey proforma

That following the Council's Condensation Protocol discussion document, this proforma be adopted by the Council's housing department and other RSL's, as a basic structure for investigating damp (Prof forma attached as Appendix to the report).

4.4.1 **Response to Recommendation 4**

We currently have a damp proforma that has been specifically tailored to Islington Council properties. We will review the Hyde proforma to see if there are any useful additions that can be added to our current proforma.

4.4.1a **Service Update – May 2018 to Recommendation 4**

The Diagnostic Surveying team have considered the Hyde proforma document as part of a recent review of the Damp Inspection Report which is completed by council surveyors when undertaking survey inspections following reports of damp or mould. Where appropriate, examples of good practice have been incorporated into the council's Damp Inspection Report.

4.4.2 Partners already uses a proforma for investigating damp but will review the Council's proposed proforma to see what improvements can be made.

4.4.2a **Service Update – May 2018 to Recommendation 4**

Partners has not adopted the proforma but has developed a process map/procedures to track complex damp jobs.

4.5 Recommendation 5 - Systematic response by Council officers

That the Executive consider working in partnership with housing associations which are undertaking Council, PFI, and RSL surveyors, as well as adopting the standardised pro-forma under recommendation 4 above, should be consistent in their reporting their findings to residents. Residents report inefficiencies, with surveyors adopting different responses

and strategies, and recommending different courses of action for similar types of damp problems.

4.5.1 **Response to Recommendation 5**

We are currently looking at options to arrange workshops with other Islington Council surveying departments. This will enable ideas and strategies being discussed to combat common damp issues within our housing stock. We will reissue the damp and condensation procedure to all staff.

4.5.1a **Service Update – May 2018 to Recommendation 5**

The council's diagnostic surveying team intends, during the summer of 2018, to facilitate a benchmarking meeting on the topic of responding effectively to cases of damp and mould with the objective of sharing good practice on this issue with other social landlords delivering services locally. In addition, the Head of Repairs and Maintenance and the manager of the diagnostic surveying team attended a workshop on the topic of legal disrepair which focussed extensively on management of cases linked to dampness and condensation which was held at Haringey Council during January 2018. This event was well attended and learning taken from this event has been incorporated into local service provision.

4.6 Recommendation 6 - Database of damp properties

The Council and PFI are to set up and maintain a database of properties across the borough that have known damp issues.

4.6.1 **Response to Recommendation 6**

We have a database that we use to ensure that damp and mould is regularly monitored. This is regularly discussed and reviewed during surveyors meetings and Diagnostic team meetings to ensure that we maintain service delivery to our residents.

4.6.1a **Service Update – May 2018 to Recommendation 6**

The council already has a database, Oneserve, which is used to record and process repairs diagnostic surveys as well as repair jobs to all directly managed council homes. The service is currently working with Shared Digital to set up a new reporting system which will enable more detailed and effective interrogation of data held on the Oneserve database. It is anticipated that the use of these new business intelligence tools will enable the council to more accurately identify estates where there are increased levels of reports of damp and mould problems.

4.6.2 Partners track all major damp jobs and keeps a separate record of all completed major damp works.

4.7 Recommendation 7 - Help On Your Doorstep database

Help on Your Doorstep have offered to share with the Council information on residents they have contacted with damp issues. Repairs department to take up this offer to help establish more accurately the extent of damp problems (Any personal information to be shared only with residents consent).

4.7.1 **Response to Recommendation 7**

We have contacted Help On Your Doorstep and will be arranging a meeting with the Operations Manager Denise Ward to discuss a way that we can work in partnership to support Islington Council's residents.

4.7.1a **Service Update – May 2018 to Recommendation 7**

The council has contacted Help on Your Doorstep to reconfirm the most effective process for them to follow to signpost or refer details of residents experiencing problems with damp and mould in their homes. We have also asked them to share details, where appropriate, with recent reports they have received from residents about this problem to enable the council to cross reference this data with our own records. The Diagnostic Surveying team has also asked a member of Help on Your Doorstep team to attend one of their future team meetings to discuss how they can work together more successfully in future.

4.8 Recommendation 8 - Legal issues accessing leasehold properties

That the Council and PFI take robust legal steps to access all leasehold properties, where the damp issues appear to emanate from leasehold properties adjoining council tenancies. Also, that legal advice be taken on the scope and options to access leaseholder properties, and the advice be circulated to all officers involved in damp investigations.

4.8.1 **Response to Recommendation 8**

Area Housing Office staff work in tandem with Housing Property Services to ensure that we follow our procedure for repairs access arrangements for leasehold properties.

4.8.1a **Service Update – May 2018 to Recommendation 8**

The council has robust procedures in place guiding staff on the process to follow in order to gain access to tenanted or leasehold properties from which it is suspected a leak is causing damage to a neighbouring property which in the case of small leaks may present itself in the affected property as an area of dampness or mould. The initial stages of the process are to attempt to make contact with the leaseholder, or their sub-tenant, by telephone, email or letter and visiting the property in person to request access. The experience of the diagnostic surveying team is that in the majority of cases access is provided by the leaseholder on initial request with a small minority of cases requiring more formal action. During 2017/18 the council's Legal Services section received a total of 7 instructions from Housing to pursue access injunctions against council leaseholders. Only 2 of these resulted in orders being granted by the court as the other 5 leaseholders provided access to the council prior to court proceedings being necessary. Reasons for requesting these access injunctions will include, but are not limited to, requiring access for the inspection and remedy of possible water leaks between neighbouring properties.

4.8.2 Partners Housing Manager will discuss this issue with their solicitor and produce a guidance note for their staff.

4.8.2a **Partners Update – May 2018 to Recommendation 8**

Partners Housing Manager has confirmed we have the right to force entry and carry out a repair that the leaseholder has not dealt with, e.g. to resolve a leak that is affecting another flat and to recover costs. Forced entry would be carried out in accordance with our no access procedures.

4.9 Recommendation 9 - External or Internal Wall insulation:

The Council, PFI and RSL'S should carry out external or internal wall insulation, wherever feasible and cost effective on all Council and RSL estates within the borough. There should be a presumption that insulation works form a part of any major works undertaken. The success of the recent external wall insulation work at Holly Park Estate in saving energy costs and reducing dampness problems for residents, is evidence of the effectiveness of this strategy.

4.9.1 **Response to Recommendation 9**

In the Council's stock 99% of cavity walls have been insulated with only a few of unusual design, where it is not technically feasible to insulate, remaining untreated. Current building regulations ensure that new buildings are built to high standards of thermal efficiency.

The Council recognises the idea that solid-walled buildings should receive insulation wherever possible. External wall insulation (EWI) has been fitted at Neptune House and Holly Park using grant funding and the proposed scheme to fit EWI to a further 304 flats in four blocks, including three high rise blocks, is funded through a mixture of corporate capital and Section 106 Carbon Offset contributions. We are currently drawing up a possible programme for EWI to medium rise stock in case further Section 106 funding becomes available.

We do not generally use Internal Wall Insulation (IWI) because, as well as the disruption to residents and loss of room size, IWI can pose risks to the fabric of buildings, including potentially increasing the risk of interstitial condensation. However where EWI is not possible, for instance in 'stepped' properties with balconies forming roofs, and there are no other alternatives, we do consider IWI. This is the case on the Andover Estate, where significant internal insulation works are being undertaken. In this case the insulation is required to resolve a cold-bridging problem where a balcony forms the roof of a flat below.

4.9.1a **Service Update – May 2018 to Recommendation 9**

The council has continued to look for opportunities to carry out insulation works. A contract has recently been awarded for the insulation of cavities at 1-40 Besant Court which has recently been discovered to have a cavity wall, having previously been believed to be solid.

The council has also continued to investigate programmes of external wall insulation (EWI) in our own stock. The proposed scheme to install EWI at 304 flats in four blocks mentioned in the previous report was put out to tender in spring of 2017. Extensive analysis of the council's medium-rise blocks was also undertaken to identify those most in need of EWI with damp reports being one of the criteria.

However, following the tragic fire at Grenfell Tower, in which it is believed that the external cladding was a factor in the spread of fire, the contract for the 304 flats was not awarded and all future EWI work is currently on hold. Although none of Islington's proposed EWI schemes were using similar cladding material as Grenfell Tower, it was deemed unwise to continue with this kind of work before the outcome of the public enquiry and revisions to the building regulations arising from the tragedy. The council will reconsider the programme of EWI in solid wall properties to reduce the risk of fuel poverty and incidences of damp once we have the full outcomes of these processes and have the maximum knowledge to ensure that this can be done without compromising fire safety. It is worth noting that a full review has been carried out confirming that the materials used in previous EWI works do not pose a risk.

4.9.2 Partners do fit thermal insulation boards to the internal face of external walls when the design of a dwelling is contributing to excessive condensation e.g. very cold rear additions with three external walls. External cladding is not always considered appropriate for street properties in Islington.

4.9.2a **Partners Update – May 2018 to Recommendation 9**

The works also includes additional insulation to flat roofs.

4.10 Recommendation 10 - Improvement grants

Publicity be made available to private sector landlords on grants available for improvements to insulation for properties.

4.10.1 **Response to Recommendation 10**

Environmental Health currently only offer one grant to landlords for empty properties. This grant funding is extremely limited and operates on a first come first served basis. We do not have any other grants for private landlords for insulation or dampness.

4.10.1a **Service Update – May 2018 to Recommendation 10**

Environmental Health continue to offer private landlords for empty properties and limited funding is still operating on a first come first served basis. There are currently no other grants for private landlords for insulation or dampness.

4.10.2 In 2015, Partners worked with the Seasonal Health & Affordable Warmth Team (SHINE) to deliver thermal improvement works funded by grants. This was to address affordable warmth and damp issues. Eligibility for grant funding was based on vulnerability. SHINE identified suitable dwellings for improvement works and delivered a limited programme.

4.11 Recommendation 11 - Clear information leaflets

Leaflets should be issued to residents on how to report and to deal with damp issues. This should also include advice on how to operate heating systems to maximum effectiveness and to deal with any condensation issues. Leaflets should also be made available to GP surgeries across the borough, and with GP's being made aware of the existence of the leaflets, and asked to distribute them to tenants that present with damp related health problems.

4.11.1 **Response to Recommendation 11**

Council surveyors issue leaflets to our residents when carrying out inspections for damp and mould. The leaflets are also distributed from Area Housing Offices and is available on the council website. These leaflets were reviewed during 2016 and now include information for residents on the effective use of their heating systems and tips on how to prevent and reduce condensation in the home. We are currently investigating having the leaflet distributed from local GPs' surgeries.

4.11.1a **Service Update – May 2018 to Recommendation 11**

All GP surgeries within the borough were sent a supply of the 'Tips for tackling damp and mould' leaflet to enable them to issue these to patients attending their surgery due to heath issues which they attribute to damp or mould problems in their home. Along with these leaflets, GPs were also reminded about the council SHINE service and how to refer patients that could benefit from this service. The leaflet continues to be issued by diagnostic surveyors when visiting council tenants

reporting damp and mould problems and is available to access and download from the council's website. Hard copies are available from local area housing offices.

4.11.2 Partners have leaflets advising residents how to manage condensation and the leaflet is regularly reviewed to ensure effective communication. They also provide advice on how to use heating systems efficiently and have the manuals for newly installed boilers on their website.

4.11.2a **Partners Update – May 2018 to Recommendation 11**

The leaflet is sent to residents by the Repairs Team when they identify any condensation issues, the leaflet is also posted on our website and advice on condensation has featured in resident newsletters.

4.12 Recommendation 12 - GP information programme

Public Health and Environmental Health are to work with the CCG to disseminate information to the Borough's GP's on the extent and issues with damp properties and their perceived interaction with health issues, and to request GP's to return data to the CCG when they are seen by patients with health issues that appear to be related to living in a damp property.

4.12.1 **Response to Recommendation 12**

Environmental Health have dialogue with colleagues in Public Health and various commissioners in CCG. Officers from the SHINE team and newly created posts of senior practitioners both sit in the many different Multi-Disciplinary Team case conferences that sit to unpick some of the most complex patients' cases.

Both the SHINE team and the senior practitioners try ensure that the housing condition question is raised and where appropriate a referral is made through SHINE to Environmental Health for further investigation.

4.12.1a **Service Update – May 2018 to Recommendation 12**

Environmental Health continue to be a key partner in the SHINE network and investigate referrals from GPs and other colleagues in health and social care.

E.g. Both the SHINE team and the senior practitioners continue to sit in the many different Multi-Disciplinary Team case conferences and ensure that the housing condition question is raised and where appropriate a referral is to Environmental Health for further investigation

5. Implications

5.1 Financial implications:

It is not possible to precisely quantify the financial implications of these recommendations at this stage however the following can be said.

If implemented recommendations 2 - 8 and 10 -12 are either already current practice or primarily involve a change/improvement in administrative practices/processes and as such are unlikely to generate a significant additional cost, but conversely recommendations 1 and 9 could potentially generate a very significant additional cost to the HRA.

Hence, it is important that these recommendations be considered against the backdrop of the HRA needing to deliver a package of savings totalling £18m over the next 4 years in order to mitigate against the loss of income arising from the 1% rent reduction.

Therefore a decision to proceed, with in particular recommendations 1 & 9, will mean either diverting capital resources that have been allocated to other projects or reducing the housing management or repairs service to compensate for any increased costs.

5.2 Legal Implications:

There are no specific legal implications on this report. Where required, legal advice and support will be provided to Housing Services in respect of the implementation of the recommendations in particular recommendation 8.

5.3 Resident Impact Assessment:

The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

Where the proposals in this report may have equalities implications and other implications for residents. Resident Impact Assessments (including assessment of equalities implications) will be undertaken as part of the process of developing and implementing policies and actions arising from this report.

5.4 Environmental Impact Assessment:

Although there may be some environmental impact from works to reduce damp in properties (e.g. resource use, waste generation), the works have a long-term positive environmental impact as they can lengthen the lifespan of buildings, avoiding the need for early demolition and replacement or keeping the dwelling empty. Works that involve improving levels of insulation also reduce the energy consumption of the dwellings being treated.

6. Conclusion and reasons for recommendations

6.1 This report details the Service Updates to the recommendations of the Health and Care Scrutiny Committee.

Final report clearance:

Signed by:

Simon Kwong
Service Director - Housing Property Services Date: May 2018

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ISLINGTON

Chief Executive's Department
Town Hall, Upper Street, London N1 2UD

Report of: Executive Member for Health and Social Care

Meeting of	Date	Agenda Item	Ward(s)
Health and Social Care Scrutiny Committee	**12 July 2018**		**All**

Delete as appropriate	~~Exempt~~	Non-exempt

Report: Q4 2017/18 Performance Report

1. Synopsis

1.1. Each year the Council agrees a set of performance indicators and targets which, enables the monitoring of progress in delivering corporate priorities and working towards the goal of making Islington a fairer place to live and work.

1.2. Progress is reported on a quarterly basis through the Council's Scrutiny function to challenge performance where necessary and to ensure accountability to residents.

1.3. This report provides an overview of progress at the end of quarter four 2017/18 (1 April 2017 to 31 March 2018) against corporate performance indicators related to Health and Social Care.

2. Recommendations

2.1. To note progress at the end of quarter four against key performance indicators falling within the remit of the Health and Social Care Scrutiny Committee.

3. Background

3.1. The Council routinely monitors a wide range of performance measures to ensure that the services it delivers are effective, respond to the needs of residents and offer good quality and value for money. As part of this process, the Council reports regularly on a suite of key performance indicators which collectively provide an indication of progress against the priorities which contribute towards making Islington a fairer place.

4. Implications

4.1 **Financial implications**

There are no financial implications arising as a direct result of this report.

Any plans or strategies derived or agreed in relation to this report should use existing available resources and therefore not create a budget pressure for the Council.

4.2 **Legal implications**

There are no legal implications arising from this report.

4.3 **Environment implications**

There are no significant environmental implications resulting from this report.

4.4 **Resident impact assessment**

The Council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The Council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The Council must have due regard to the need to tackle prejudice and promote understanding.

A Resident Impact Assessment has not been completed because this is a report providing information about performance at the end of quarter three 2017/18.

5. Adult Social Care

ADULT SOCIAL SERVICES									
Objective	**PI No.**	**Indicator**	**Frequency**	Q4 Actual Jan-March 18	Q4 Target Jan-March 18	Target 2017-18	On/Off target	Same period last year	Better than last year?
Support older and disabled adults to live independently	ASC1	Delayed transfers of care (delayed days) from hospital per 100,000 population aged 18+	Q	885.93	N/A	N/A	N/A	776.0	No
	ASC2	Percentage of people who have been discharged from hospital into enablement services that are at home or in a community setting 91 days after their discharge to these services	Q	96.46%	95%	95%	On	95.7%	Yes
	ASC3	Percentage of service users receiving services in the community through Direct Payments	M	32.1%	35%	35%	Off	30.9%	Yes
Support those who are no longer able to live independently	ASC4	Number of new permanent admissions to residential and nursing care	M	127	130	130	On	137	Yes
*Reduce social isolation faced by vulnerable adults **(E)***	ASC5	The percentage of working age adults known to Adult Social Care feeling that they have adequate or better social contact. **(E)**	A	74%	73%	73%	On	70.6%	Yes

Frequency (of data reporting): M = monthly; Q = quarterly; T = termly; A = annual B=Biennial

(E) = equalities target

Supporting independent living

5.1 Delayed transfers of care

Data in this report covers the first quarter of 2018 and shows improvements from the previous reporting period. Whilst the data does indicate that DTOC performance has declined compared to last year, there have been significant pressures across the system which have contributed to this, including in particular challenges in the social care provider market such as embargos on care agencies and closures of residential homes in the latter part of the year which have had an impact. In addition, whilst there is an ongoing improvement plan underway in Islington's in-house reablement service, it has had capacity issues on a number of occasions in the last 6 months and this has impacted the service's ability to support discharges with maximum capacity.

Action has been taken to stabilise the market by reviewing fees, putting intensive support into underperforming sites and in April 2018 there was an expansion in the contracted homecare providers available in the borough. A process has also been established and successfully implemented when it's been necessary to deliver reablement support via external providers

where our in-house service has been at capacity. All of this activity has contributed to supporting to ensure there will be increased capacity in the system to address issues with our DTOC figures going forward. Outlined below are some the key steps taken to ensure improvements and build on progress to date.

5.2 A key factor upon our DTOC rates has been the establishment of the D2A Pathway 3, part of our Winter 17/18 D2A pilot (see below). 20 patients were discharged via Pathway 3 throughout the pilot, which resulted in an estimated 691 bed days saved for our acute partners the Whittington and UCLH – an excellent outcome for hospitals and residents. In addition to the patients who were successfully discharged, the work to move patients awaiting a CHC assessment to a dedicated intermediate care facility (where they can be supported by a fully trained CHC Nurse Assessor) is delivering greater benefits than predicted in the Q3 scrutiny report, at an average of 35 bed days saved per patient as opposed to 28.

5.3 Our DTOC rates are also being impacted by the other pathways: the dedicated social work post supporting Pathway 2 is improving discharge times in our intermediate care settings (which in turn improves overall throughput) through innovative joint working practices with Housing. To further increase this impact additional work is underway with the SPOA to ensure screening and triage for the intermediate care facilities becomes a core part of their role.

5.4 Changes to the setup of our hospital social work team is also playing an important role, ensuring social workers are embedded in the acute and working closely with ward staff to facilitate discharges. Improving both DTOC performance and length of stay in hospital for our residents continues to be an absolute priority going forwards both at an operational and strategic level.

5.5 Discharge to home or community setting

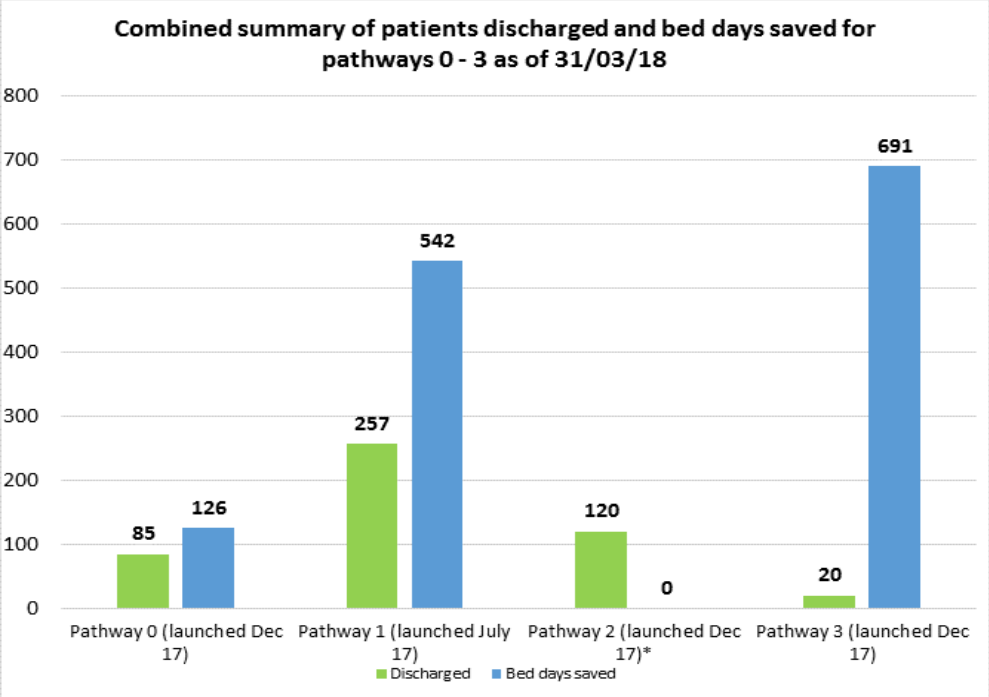
Over winter 2017-18 we successfully established a Discharge to Assess (D2A) pilot between LBI Adult Social Care and our acute health partners UCH and Whittington Hospital, as part of the Wellbeing Partnership between Islington and Haringey. The D2A service supports earlier discharge for medically optimized patients from hospital, and is based upon the 'Medway Model' discharge pathways 1-4:

- Pathway 0 – package restarts
- Pathway 1 – patients returning home with a Reablement support plan
- Pathway 2 – patients requiring ongoing rehabilitation within an intermediate care facility
- Pathway 3 – patients who have triggered the CHC checklist and have ongoing nursing care needs

This was achieved through the creation of the Single Point of Access (SPOA) service, a dedicated team of OTs and PTs who liaise closely with the hospitals and LBI Reablement service. The therapy-based model has supported ongoing improvements for service users within a community setting in regards to regaining mobility and independence, and reduced readmissions to hospitals.

5.6 This pilot continues to be the focal point of our work to support improved hospital discharge. Funding has been confirmed for the project to continue for the next 12 months and fixed term recruitment is underway for the associated posts. The impact of the pilot can be seen in the graph below: the methodology for Pathway 2 bed days is still being agreed, but across

Pathways 0, 1 and 3, LBI have made a total of 1,359 bed day savings as of 31st March 2018. Further qualitative analysis of the pilot is being undertaken at the moment through a service user survey and partner feedback.



5.7 We are continuing to drive this work forwards, both as an active member of North London Partners in Healthcare and also through the Health and Wellbeing Partnership. Areas we're working on to further improve our discharge and admission avoidance offer include:

- Revisiting the Choice Policy across NCL to ensure we have a consistent approach to residential placement, which enshrines the principle of patient choice but also supports effective, timely discharge from the acute in-patient setting.
- Working to scale up our existing single point of access to deliver greater integration with community health partners as well as with LB Haringey.
- Developing a robust admissions avoidance offer with a sustainable social care component to help keep people well in the community wherever possible.
- Continuing to support our in-house reablement service through an improvement and transformation programme to ensure it is able to meet the demand generated through hospital discharge but also to have a meaningful community facing offer.
- Expanding our Pathway 1 and 3 offers to ensure patients with long term needs who have not triggered positive on the Continuing Healthcare Checklist are able to benefit from the D2A approach.

5.8 Direct Payments

Ongoing work around increasing Direct Payments (DPs) now mean that around 30% of all Islington care and support is provided through DPs; this figure has increased by 0.9% since Q3, which represents a good increase over a short period. Feedback from the 2017 service user survey showed that DP recipients felt that they had the most "choice and control over their care and support services" and had the highest percentage of those "extremely" or "very" satisfied with their service, which ties into our corporate value of Empowering service users.

Two key pieces of work are being taken forward to support the uptake of Direct Payments in Islington: the Spark a Solution mapping project, and the Personal Assistants (PA) Pathway proposal. The former has mapped out the entire DP set-up process to identify blockages and recommend areas of improvement. Within this is the PA Pathway proposal – Personal Assistants support better outcomes for service users and cost-effective delivery of services, and the proposed pathway would improve the recruitment, training and support offer for Personal Assistants across the borough.

Admissions into residential or nursing care

5.9 The Council provides residential or nursing care for those who are no longer able to live independently. The aim is to keep this number as low as possible, supporting more people to remain in the community. We have completed this quarter with a final total of 127 individuals admitted to residential or nursing care, successfully within our target of 130.

Reducing social isolation

5.10 Social isolation refers to a lack of contact with family or friends, community involvement or access to services. The next update for this indicator will be available in July 2018. A number of initiatives in the borough are in place to reduce social isolation which were highlighted in the previous Health and Care Scrutiny Report of 14th December 2017.

5.11 Reducing social isolation will be one of the key tenets of the upcoming Front Door project, which will re-envisage how residents first engage with adult social services and how we can support prevention and resilience through signposting or direct referrals to community settings, improving our advice and support services, and embedding a strengths-based approach at the core of all interactions with residents.

5.12 As part of this work we will be seeking to better understand the borough's assets in relation to reducing social isolation for the 18-64 population, especially around what we commission (e.g. day services, befriending services, supported employment services) and the extent to which they meet resident's needs. A mapping exercise has taken place to help better understand what is currently operating and providing outcomes for social isolation in the borough (both commissioned and non-commissioned). Work will now start with the sector to show what we have and what providers can do to help assist and support in providing these outcomes.

5.13 The Social Inclusion Service provided by Royal Mencap provides free and low cost activities for residents with a Learning Disability. These include day trips, sports activities and other group activities. The service also signposts to other services and provides travel training for participants aimed at reducing their social isolation.

6. Public Health

Objective	PI No	Indicator	Frequency	Actual April - Dec	Expected profile	2017/18 annual target	On/Off target	Same period last year	Better than last year?
Promote wellbeing in early years	PH1	Proportion of new births that received a health visit within 14 days	Q	96% (Jan – Mar)[1]	90%	90%	On	94%	Better
	PH2	a) Proportion of children who have received the first dose of MMR vaccine by 2 years old	Q	84% (Oct - Dec)[2]	95%	95%	Off	91.4%	Worse
		b) Proportion of children who have received two doses of MMR vaccine by 5 years old	Q	77% (Oct - Dec)[2]	95%	95%	Off	87%	Worse
Reduce prevalence of smoking	PH3	a) Number of four week smoking quitters	Q	423 (Apr – Dec)[3]	600	800	Off	New measure	
		b) Percentage of smokers using stop smoking services who stop smoking (measured at four weeks after quit date)	Q	46% (Apr – Dec)[3]	50%	50%	Off	46%	Same
Effective detection of health risk	PH4	Percentage of eligible population (40-74) who receive an NHS Health Check	Q	15%	13.2%	13.2%	On	New measure	
Tackle mental health issues	PH5	a) Number of people entering treatment with the IAPT service (Improving Access to Psychological Therapies) for depression or anxiety	Q	5,045	3,492	4,655	On	5,091	Same
		b) Percentage of those entering IAPT treatment who recover	Q	47% (Jan – Mar)[1]	50%	50%	Off	49%	Same
Effective treatment programmes to tackle substance misuse	PH6	Percentage of drug users in drug treatment during the year, who successfully complete treatment and do not re-present within 6 months of treatment exit	Q	17% (Oct – Dec)[2]	20%	20%	Off	18%	Same
		Percentage of alcohol users who successfully complete their treatment plan	Q	40% (Oct – Dec)[2]	42%	42%	Off	35%	Same
Improve sexual health	PH7	Number of Long Acting Reversible Contraception (LARC) prescriptions in local integrated sexual health services	Q	942 (Jul - Mar)	780	780	On	New measure	

[1] Cumulative data is not available
[2] Q4 and cumulative data not available
[3] Q4 data is not yet available

Promote wellbeing in early years

6.1 Health Visiting continues to perform well on timely delivery of new birth visits within 14 days. The local rate of 96% compares favourably with London* (93%) and England* (88%)
The provider has made considerable improvements to data quality and reliability over the last year such that they are now able to report with confidence their performance on four of the five nationally reported mandated health checks, and reported rates are rising. This improvement work is continuing.

6.2 Engagement of the Health Visiting service with the wider agenda of early years transformation to fully integrate services has improved markedly since the appointment of a new manager in February. The organisational changes required will still take time to enact, but these are now on course for co-location in September of this year, a crucial step in the path to integrated services for children under 5 and their families.

6.2 Measles, Mumps and Rubella immunisation rates for two and five year olds remain low relative to the target although similar to London rates. As reported previously, there have been substantial changes to the data recording of immunisations, with a complete reconfiguration across London introduced in late 2016/17. Public health is working closely with primary care commissioners in Islington to look at ways to increase the recording/rates among GPs practices in Islington.

Reduce prevalence of smoking

6.3 Due to the time lag in smoking quitting data, Q4 data is not yet available. In Q3, performance was below target with 154 people accessing the service successfully quitting, against a quarterly target of 200. The number of four quitter has increased since quarter 2, and it is expected that the number of four week quitters will continue to increase quarter on quarter, based on the providers delivery plans.

6.4 The quit rate was slightly below the 50% target at 46%, although the proportion successfully quitting has improved compared to last year, and is significantly higher than the Department of Health recommended minimum quit rate of 35%.

6.5. Commissioners are working with the service to increase the number of smoking quits. The provision of specialist support has increased, including out-of-hours services and drop-in mobile van sessions. A successful outreach campaign to mosques and high street shops took place in Q4. The service is also training staff from the Octopus (typo) Communities Network to deliver stop smoking support to local residents. Plans are in place to work with several large local employers to provide stop smoking support to staff. Finally, a dedicated member of staff is now working with GPs and community pharmacies to improve stop smoking performance in these settings.

Effective detection of health risk

6.5 In 2017/18, over 7,500 residents received an NHS Health Check. As well as delivering the service through GP practices in Islington, 1,200 NHS Health Checks have been delivered through a community outreach programme. Over half of NHS Health Checks delivered through the community programme have been to people living in the most deprived areas in Islington or from Black and South Asian ethnic groups - the two groups at greatest risk from cardiovascular disease.

Tackle mental health issues

6.6 In 2017/18, over 5,000 people entered the Improving Access to Psychological Therapy (IAPT) programme, with performance exceeding the annual target. In Q4, the percentage of those entering IAPT treatment who recover is just short of the nationally set target (50%), at 47%.

6.7 Islington's Mental Health Promotion projects continue to perform well. In 2017/18 the Direct Action Project delivered 37 workshops and creative programmes with young people and /or staff who work with young people. The Wellbeing Service reached 4,115 people through awareness and outreach activities and recruited eight new champions. 750 people were trained in Mental Health First Aid and Mental Health awareness. In addition, five "Mental health in the workplace for line managers" courses were held in 2017/18. Public Health convened a successful suicide prevention stakeholder workshop on 28th February, together with Islington Clinical Commissioning Group, CIFT and Manor Gardens Welfare Trust. The workshop was well attended with representation across a wide range of services and agencies. The focus of the workshop was on men as a high risk group for suicide.

Effective treatment programmes to tackle substance misuse

6.8 Q4 data are not yet available. In Q3, the percentage of drug users in drug treatment during the year who successfully completed treatment and who did not re-present within six months of treatment exit is just below the quarterly target (20%) at 17%. Islington saw a slight fall in this indicator. Treatment services undertook a significant data cleaning exercise in the latter half of the year, as part of the mobilisation of the new integrated drug and alcohol service in the borough, and this is likely to have impacted negatively on performance.

6.9 Q4 data are not yet available. In Q3, alcohol successful completions saw a small percentage increase. The proportion of alcohol users successfully completing treatment was just below target (42%) at 40%. Better Lives, the new Islington Integrated Drug and Alcohol Recovery Service, started on 1st April 2018. Camden and Islington NHS Foundation Trust are working in partnership with Blenheim CDP and Westminster Drug Project to deliver an innovative service with the following aims at its core: co-production, working with peer mentors, increasing the number of clients who experience recovery, supporting families, ensuring the service is accessible to those in need of support and partnership working. Service providers are working very positively with users, staff, commissioners, and other local agencies and services that work with this client group, as part of the mobilisation of the new service and to support the embedding of the new model.

Improve sexual health

6.10 Full year data shows that performance (942) has exceeded the annual target (780) for the number of women prescribed long acting reversible contraception in 2017/18. Long-acting reversible contraception, such as the contraceptive implant, is more effective than user dependent methods (such as the pill or condoms) in reducing unplanned pregnancies. Commissioners have been working closely with CNWL, the service provider, to fully mobilise the new service model, including the implementation of a pan-London e-service for people who are asymptomatic. The first phase of this new e-service service launched in North Central London in February 2018 with the second phase, SMART kits (off line kits available for users to pick up and to use within clinics), will take place from 21st May 2018.

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Final Report Clearance

Signed by 00/00/2018

Received by …… ……
Date

HEALTH AND CARE SCRUTINY COMMITTEE – WORK PROGRAMME 2018/19

14 JUNE 2018

1. Camden and Islington Mental Health Trust - Performance update
2. New Scrutiny Topic – Decision on topics- Main review/mini review
3. Health and Wellbeing Board update
4. Work Programme 2017/18
5. Child Obesity
6. Membership, Terms of Reference
7. Moorfields NHS Trust – Performance update

12 JULY 2018

1. NHS Whittington Trust – Performance update
2. Scrutiny Review – GP Surgeries – Approval of SID/witness evidence
3. Health and Wellbeing update
4. Quarter 4 performance report
5. Work Programme 2018/19
6. Scrutiny Review – Health Implications of Damp Properties – 12 month progress report

02 OCTOBER 2018

1. Health and Wellbeing update
2. Work Programme 2018/19
3. Scrutiny topics – witness evidence
4. Whittington Estates strategy – update
5. London Ambulance Service – Performance update
6. IAPT Scrutiny Review – 12 month progress update
7. Healthwatch Annual Report/Work Programme
8. Walk in Centres

15 NOVEMBER 2018

1. Scrutiny topic – GP surgeries - witness evidence
2. Health and Wellbeing Update
3. Work Programme 2018/19
4. Presentation Executive Member Health and Social Care
5. Public Health/Performance Annual Report 2017/18/Performance update Quarters 1 and 2
6. Local Account
7. Alcohol and Drug Abuse update

28 JANUARY 2019

1.Scrutiny topics – witness evidence
2 Health and Wellbeing update
3. Work Programme 2018/19

07 MARCH 2019

1. Moorfields NHS Trust - Performance update
2. Scrutiny Reviews – Draft recommendations – GP surgeries
3. Health and Wellbeing update
4. Work Programme 2018/19

01 APRIL 2019

1. Scrutiny Review - GP surgeries - Final Report
2. Scrutiny Review - Health Implications of Poor Air Quality – 12 month progress report
3. Health and Wellbeing update
4. Work Programme 2019/20

02 MAY 2019

To be notified

FORTHCOMING MEETING JUNE/JULY

Scrutiny review – Draft recommendations/Final report
Performance report – Quarters 3 and 4