NHS
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.

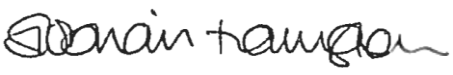
Like many other NHS trusts, we had a challenging winter. The particular pressure for us was consistently delivering the NHS constitution 4 hour emergency department standard over the winter period. We saw a record number of visitors come to our emergency department this year, over 100,000. These pressures 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.

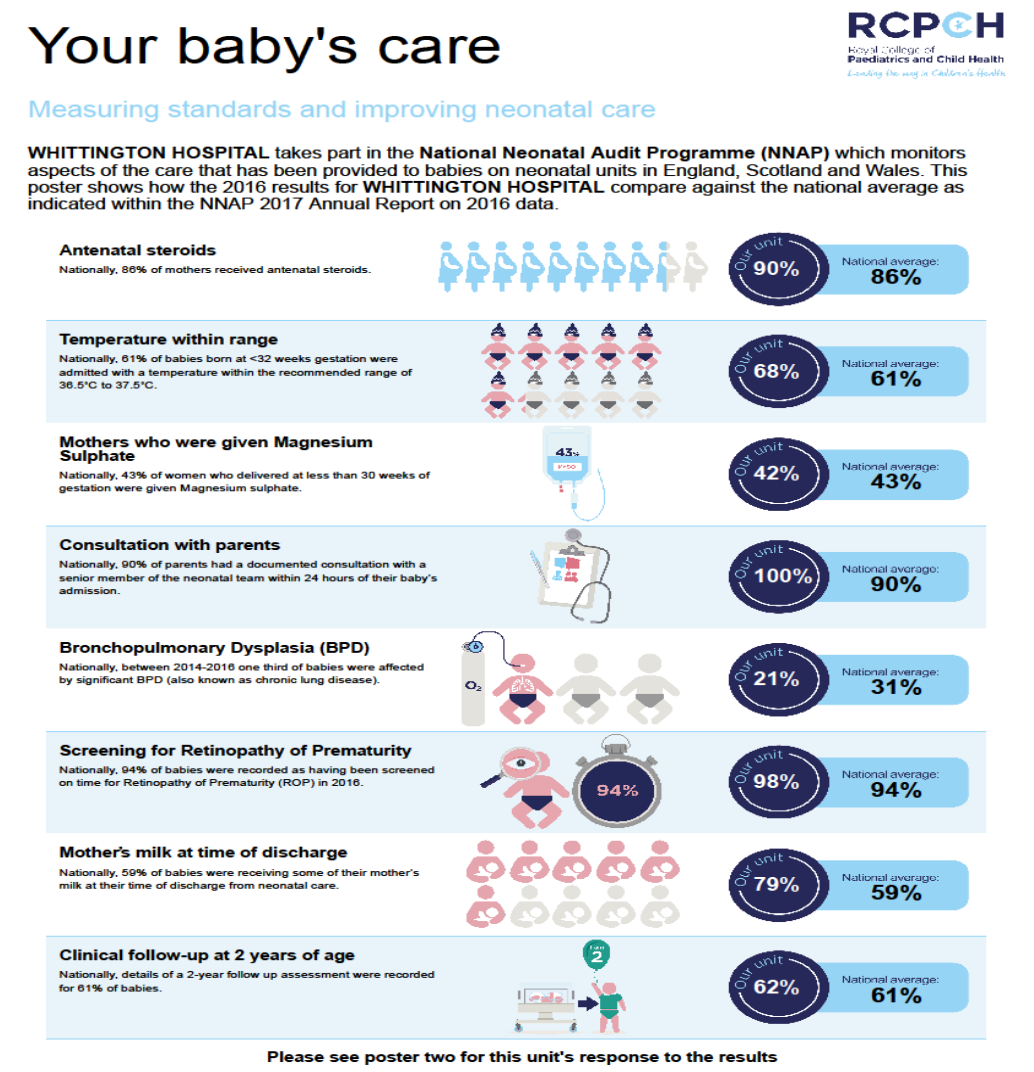
As part of the work to further improve care in ED, the following are either in place or undergoing improvement:

- 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.
94%
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.

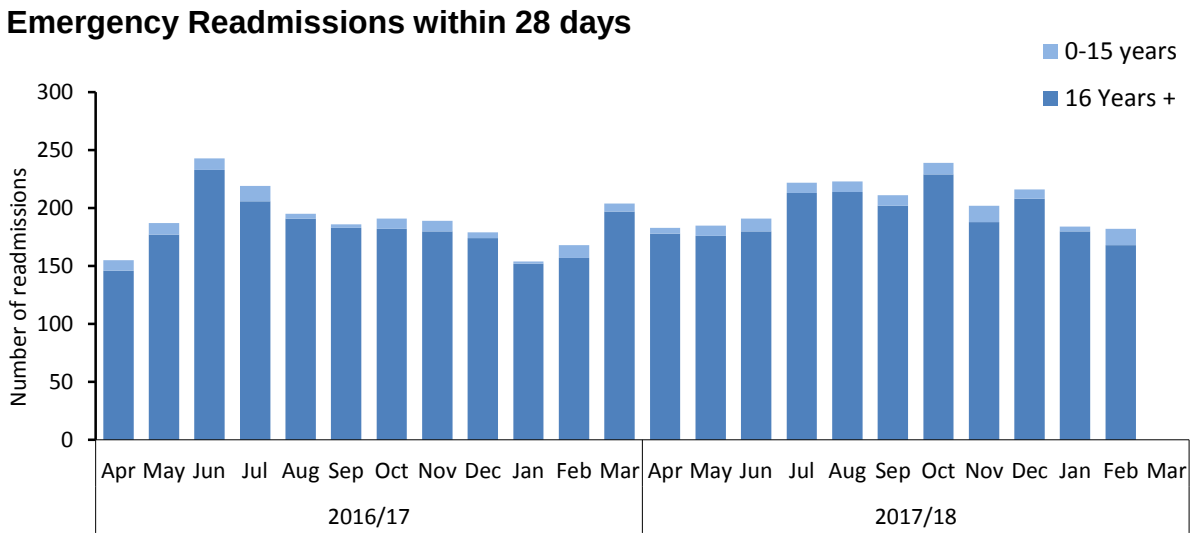
Table 1: Pre-operative participation and linkage

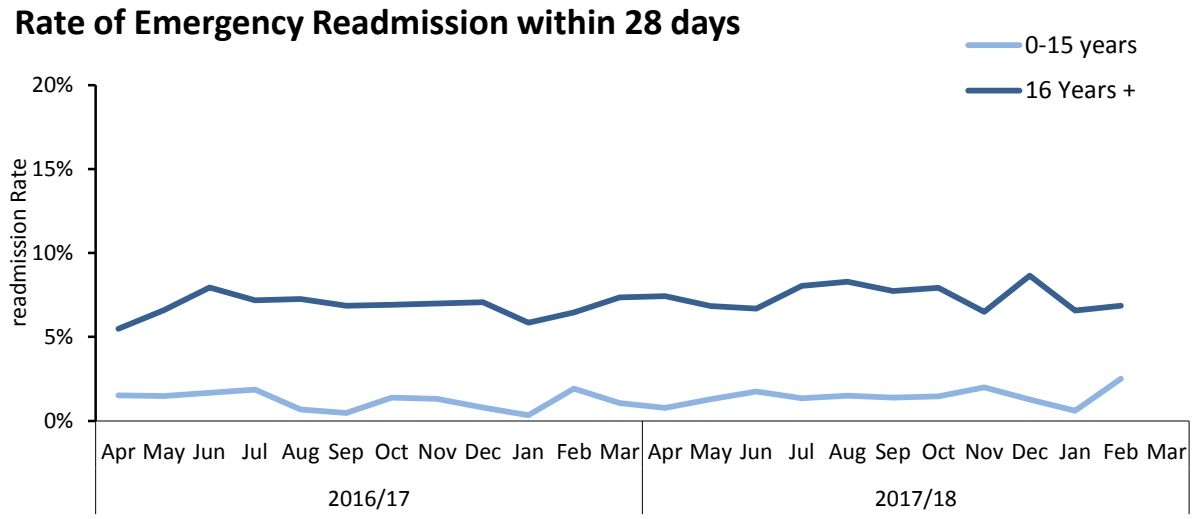
	Eligible hospital procedures	Pre-operative questionnaires completed	Participation Rate	Pre-operative questionnaires linked	Linkage Rate	National Linkage Rate
All Procedures (apr17-Sep17)	161	41	25.5%	21	51.2%	70.9%
Groin Hernia (apr17-Sep17)	152	41	27.0%	21	51.2%	67.8%
Varicose Vein (apr17-Sep17)	*	*	*	*	*	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

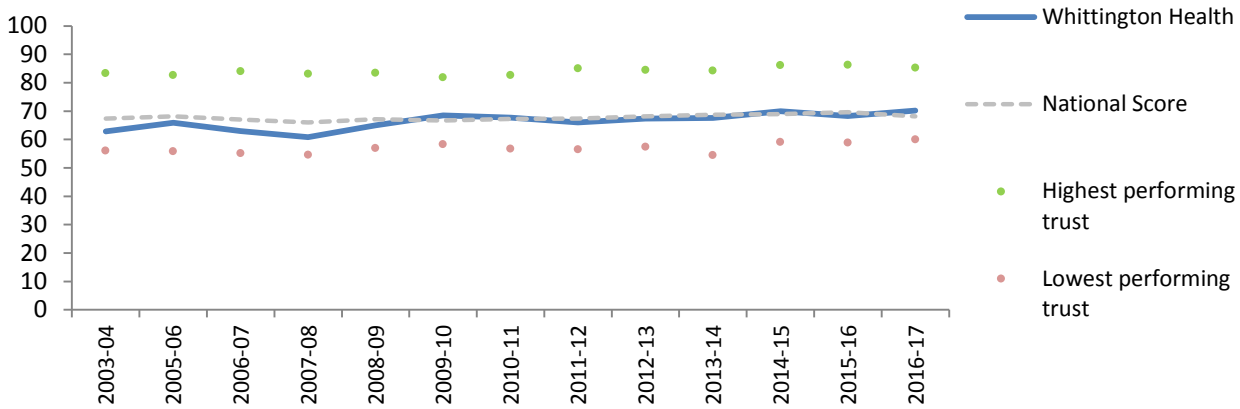
Whittington Health's responsiveness to the personal needs of its inpatients, based on the national inpatient survey, are displayed below. A trust's responsiveness is the weighted average score from five questions (score out of 100) and a higher score is indicative of better performance.

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.

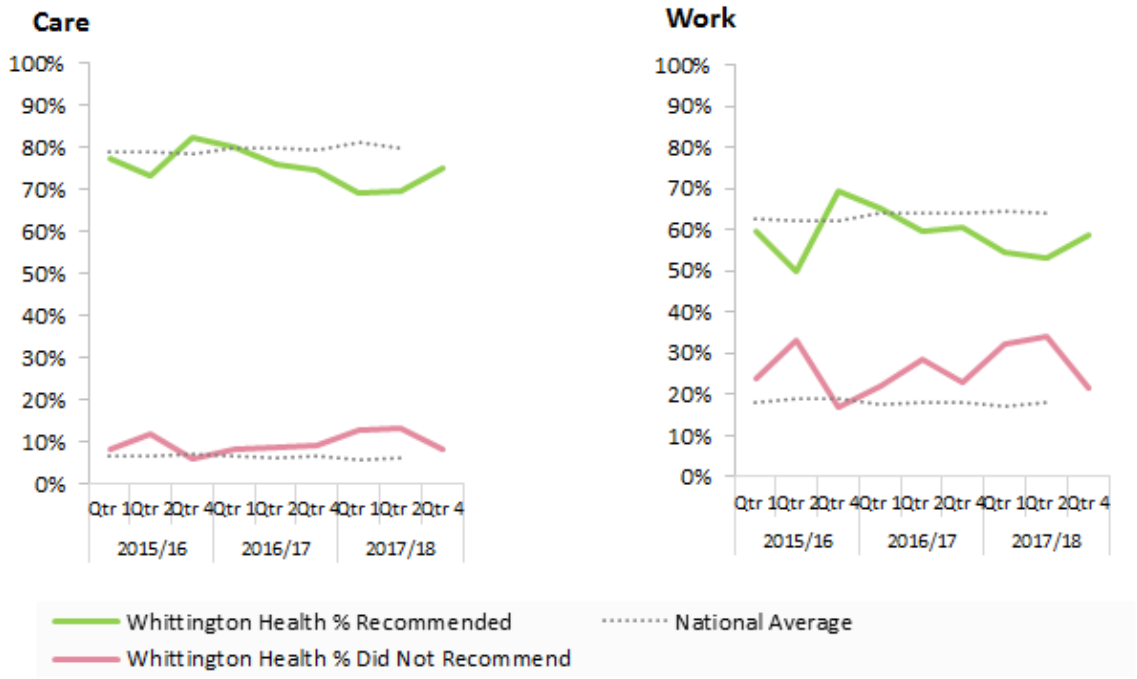
Whittington Health NHS Trust considers that this data is as described because it has been sourced from a recognised national agency in NHS Digital and adheres to a documented and consistent methodology.

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.

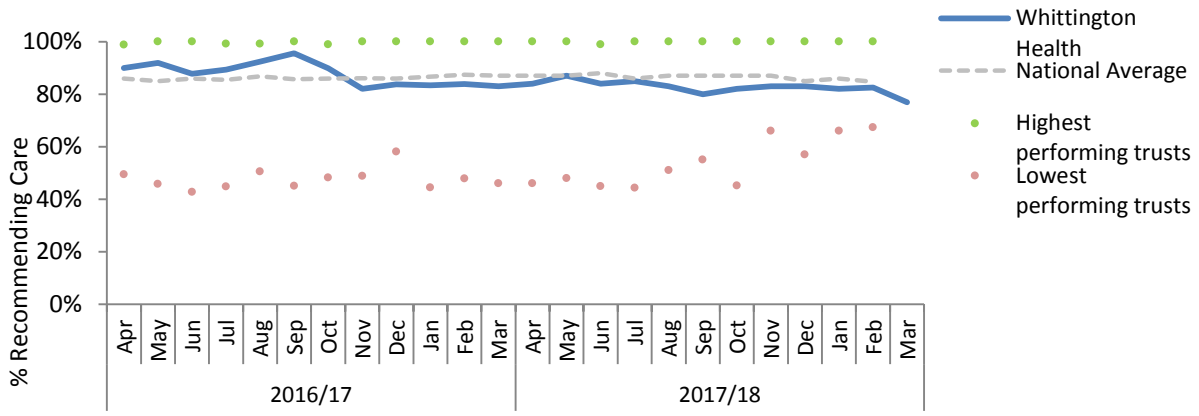
The trust is taking a number of further actions to improve local performance and achieve greater staff satisfaction in 2018-19 following the results of this survey including:

- 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.

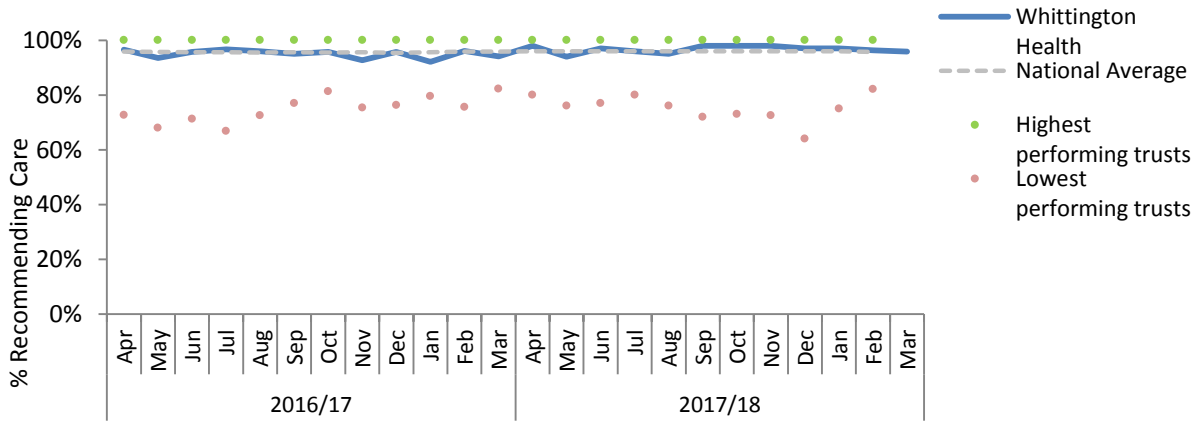
Emergency Department Attenders Recommending Care 16/17 & 17/18



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.

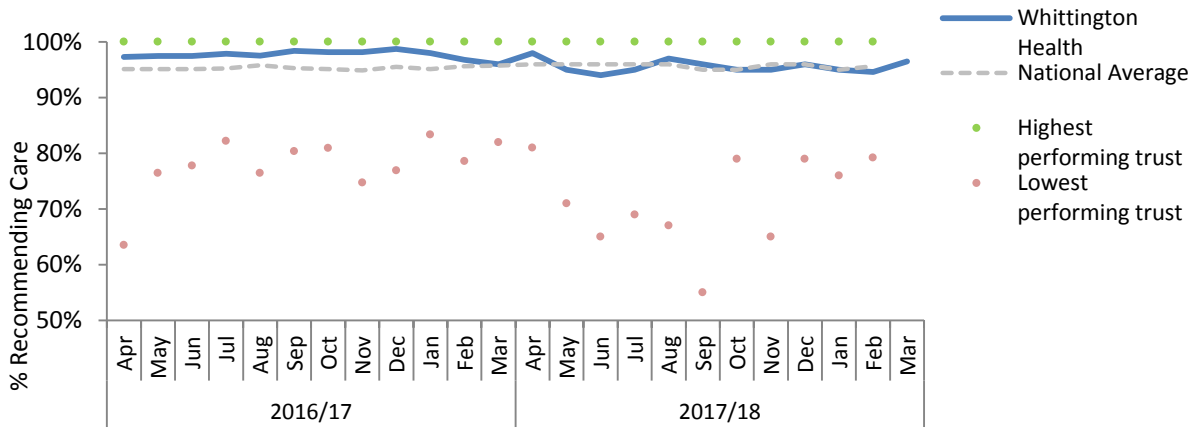
Inpatients Recommending Care 16/17 & 17/18



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:

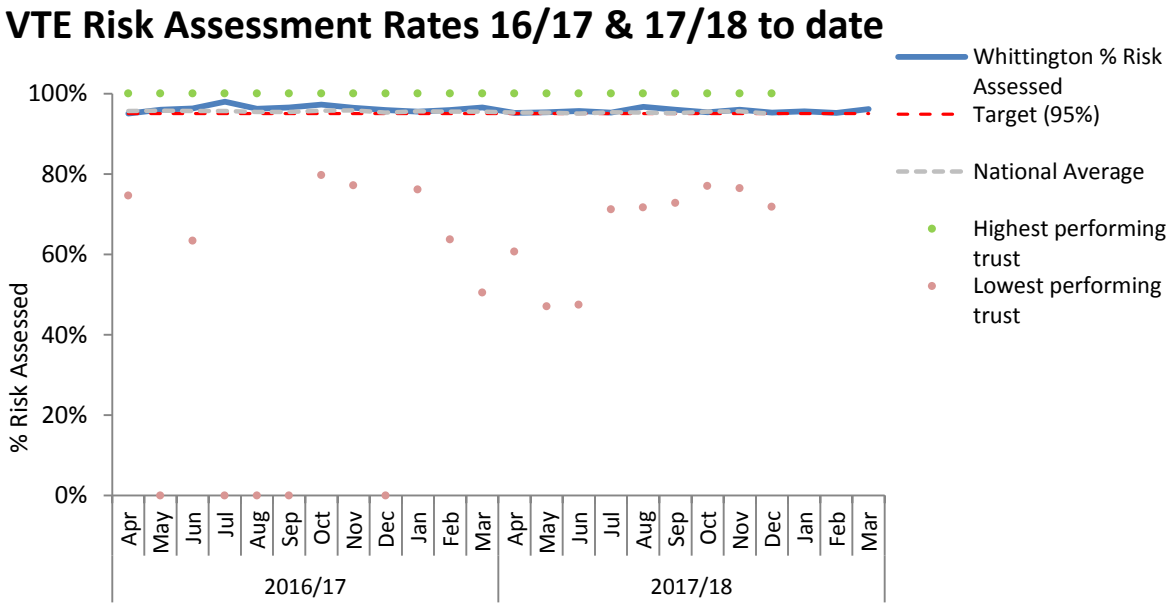
- Recruiting more volunteer ward befrienders to support with collecting FFT,
- Supporting Endoscopy and the Day Treatment Centre with iPads for collecting FFTs,
- Sending themed analysis sent to each ward manager to improve awareness of responses

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

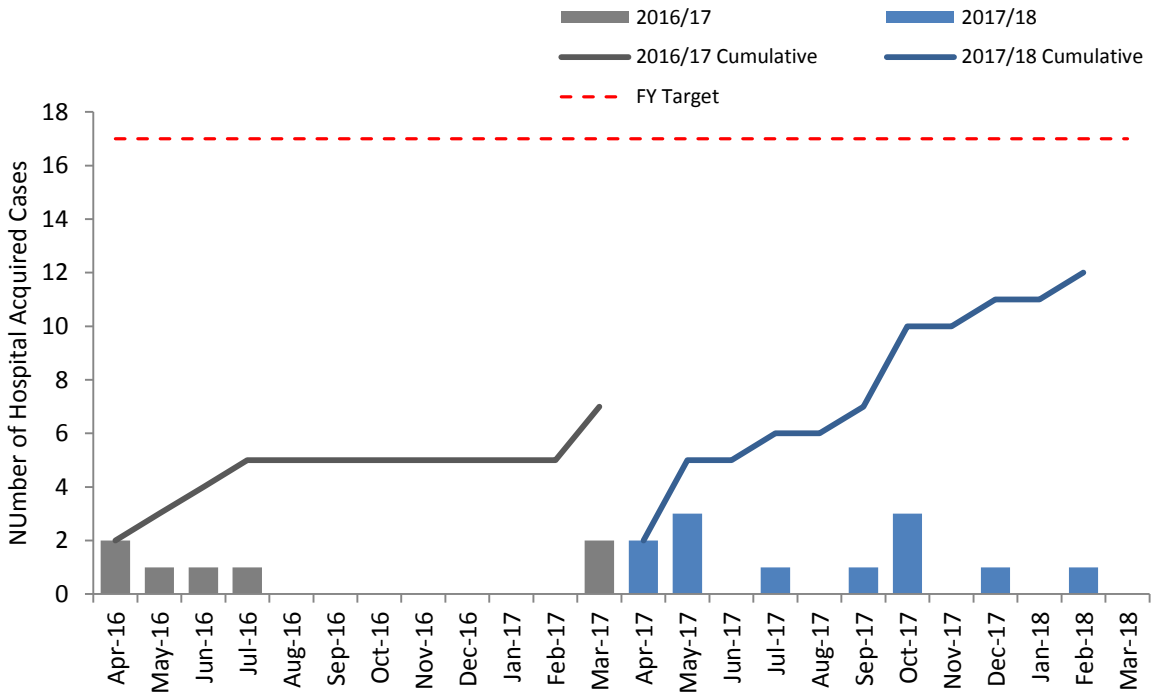
Clostridium Difficile

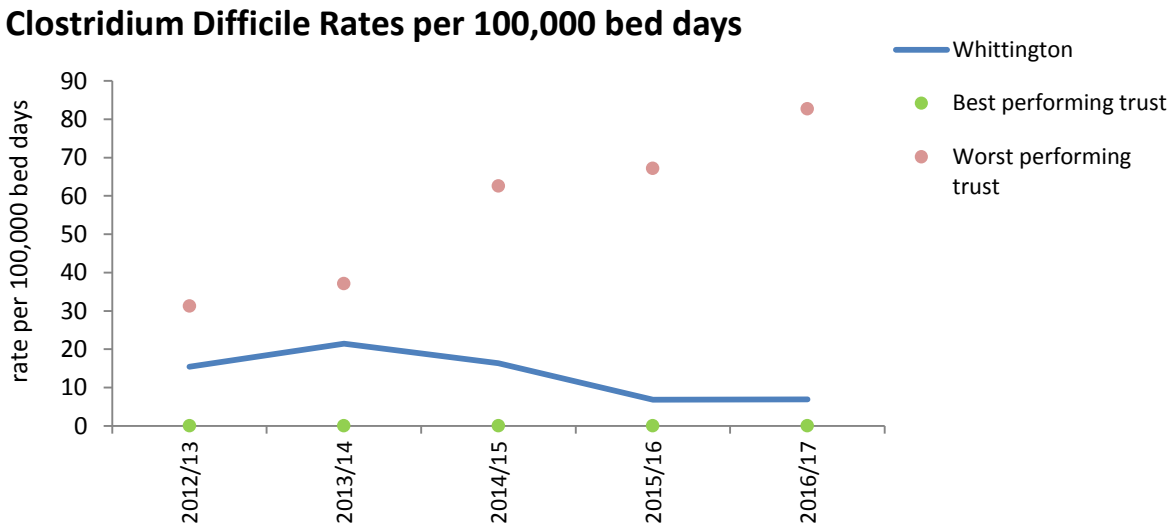
During 2017/18 there have been 11 *Clostridium difficile* infection cases attributable to Whittington Health. For the eleven cases, all but two were unavoidable. Our agreed ceiling trajectory for 2017/18 was set at 17 cases. We have taken a number of actions to reduce the number of *Clostridium difficile*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

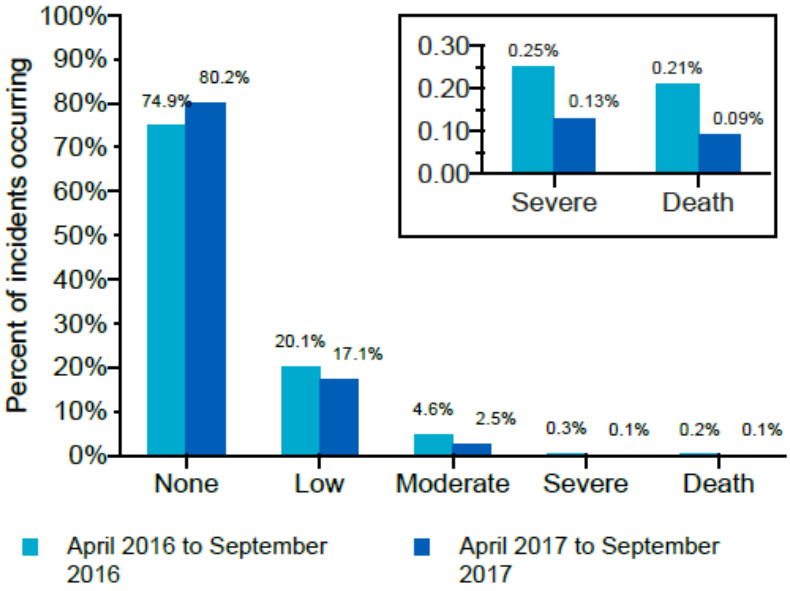
- Continuing post infection reviews (PIR) for all Trust attributable cases and creating action plans for each individual case. These action plans are presented to the Infection Prevention & Control Committee (IPCC) and reviewed at each meeting.
- Completing High Impact Intervention #7 audits on all CDI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

Patient Safety Incidents

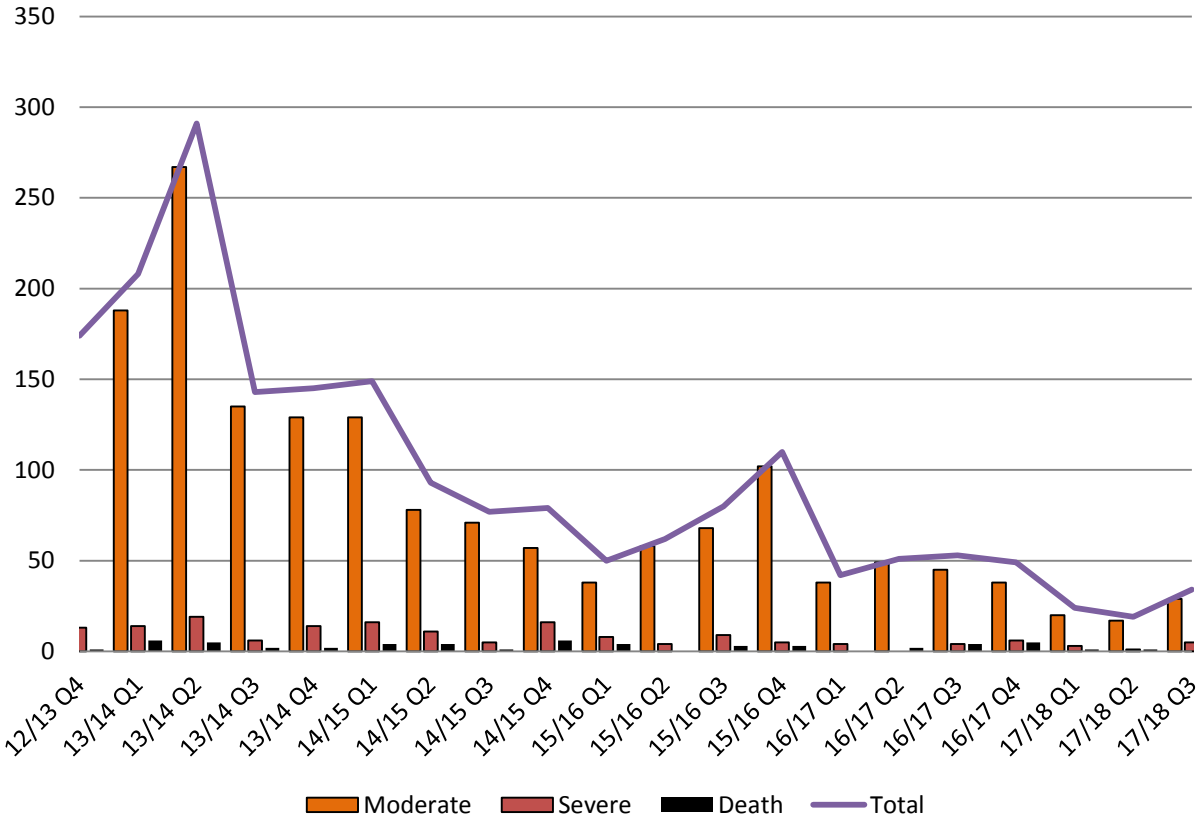
Whittington Health NHS Trust actively encourages incident reporting to strengthen a culture of openness and transparency which is closely linked with high quality and safe healthcare. The latest NHS Improvement report shows that we have a very good reporting culture within the organisation, placing us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

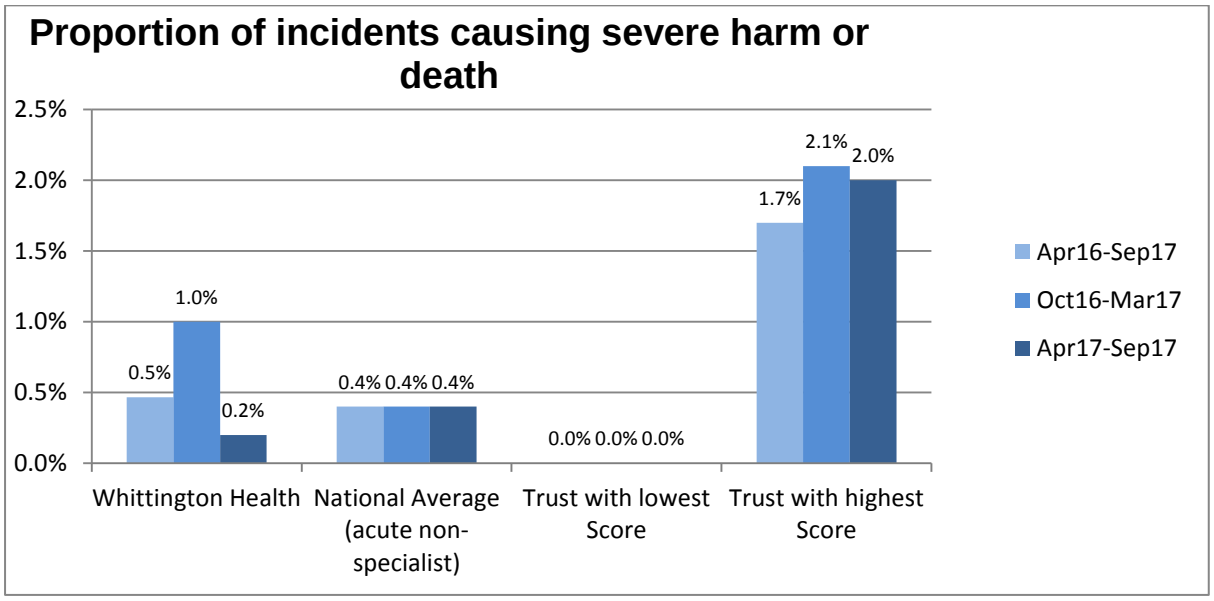


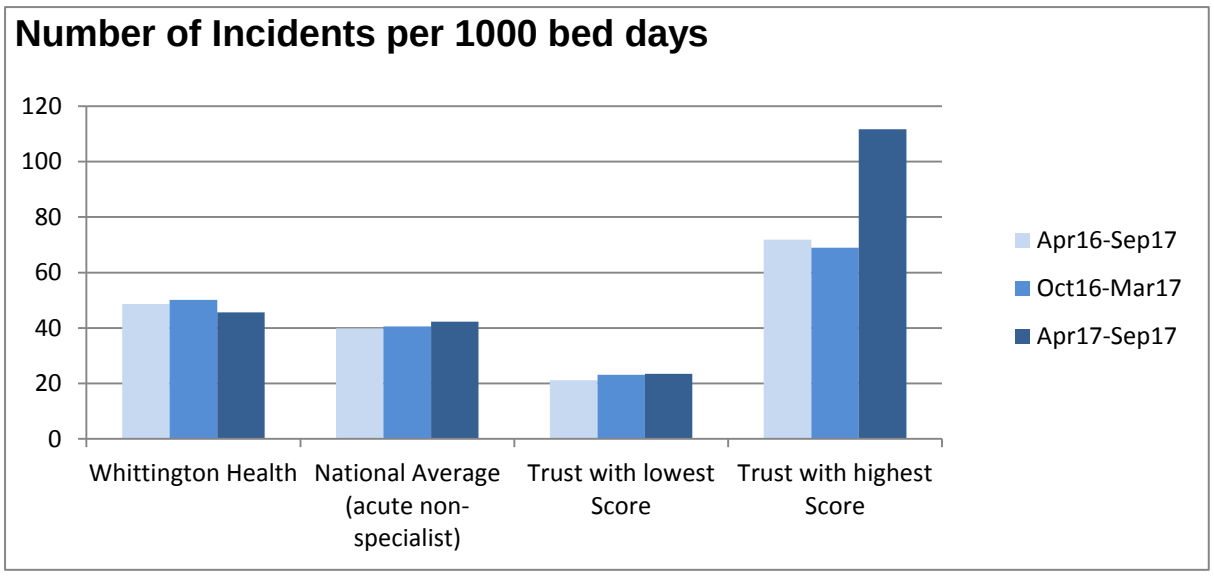
Incidents reported to NRLS (Moderate,Severe and Death caused by the Incident)



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:

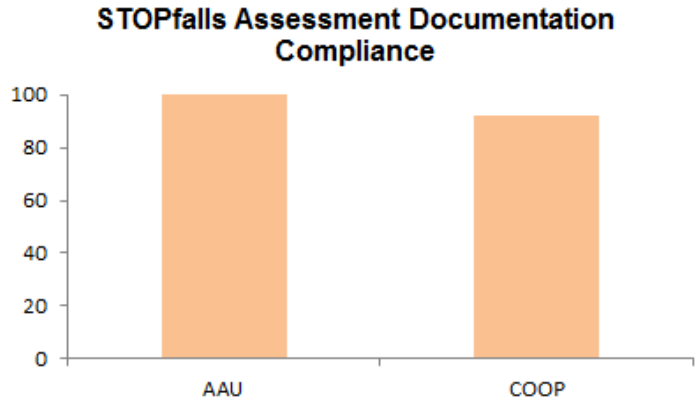
- Multifactorial risk assessment tool
- 'High Risk of Falls' sign for bed space
- Falls risk sign for walking aids
- Falls risk sticker in patient notes
- Falls risk bracelet for patients
- Yellow magnets on whiteboards to indicate falls risk

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.

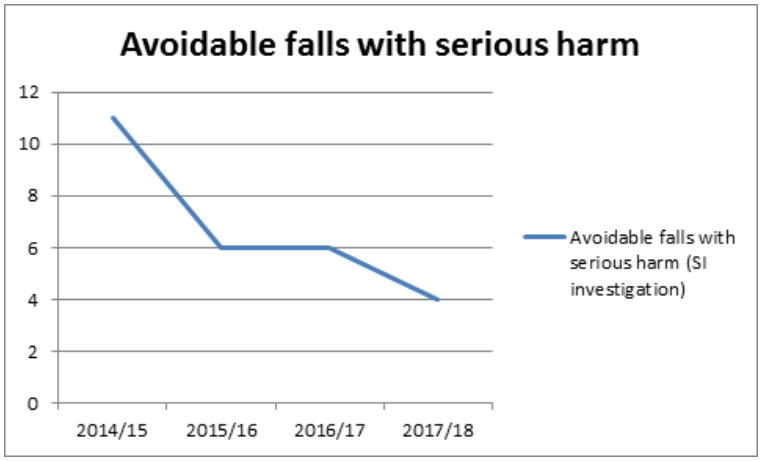
Priority 1

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).

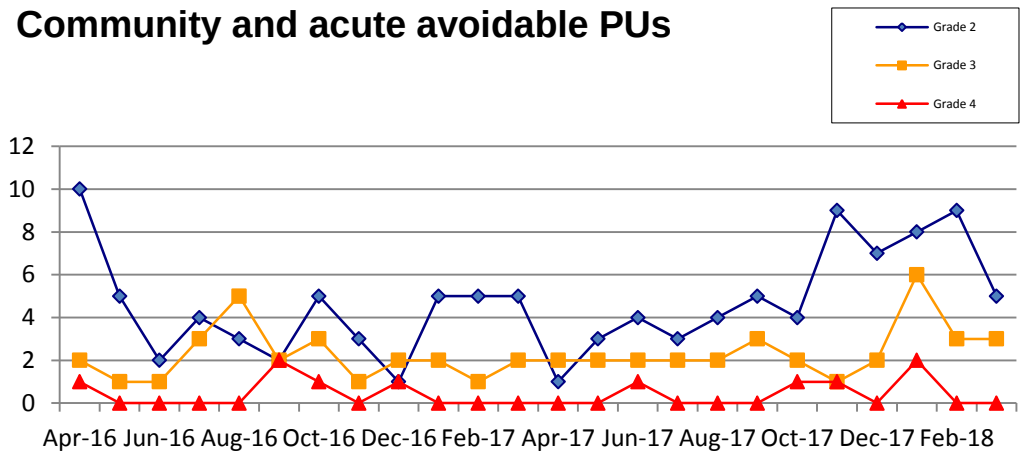
Reported pressure ulcers are classified as either avoidable or unavoidable. These incidents are assessed by the Tissue Viability Nursing team to confirm whether the pressure ulcer was classified correctly.

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?

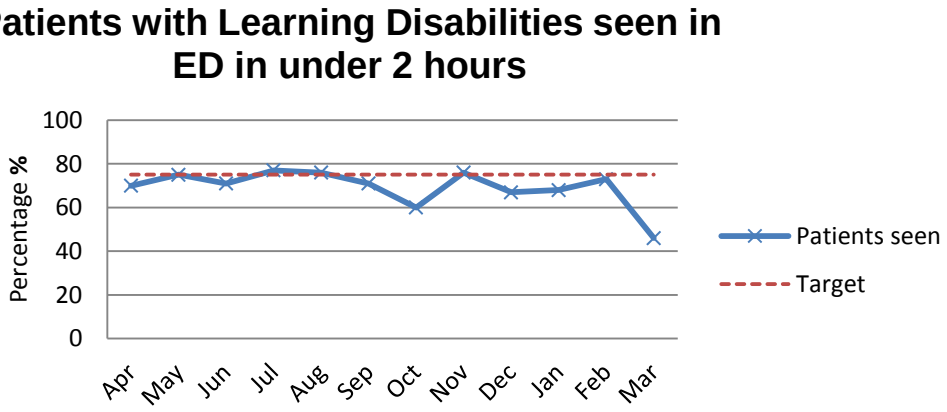
- 75% of patients who present to the Emergency Department with learning disabilities are given a priority assessment (i.e. seen in under two hours)
- To introduce a care pathway for mothers with learning disabilities in the hospital
- All children and young people entering CAMHS for a choice appointment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

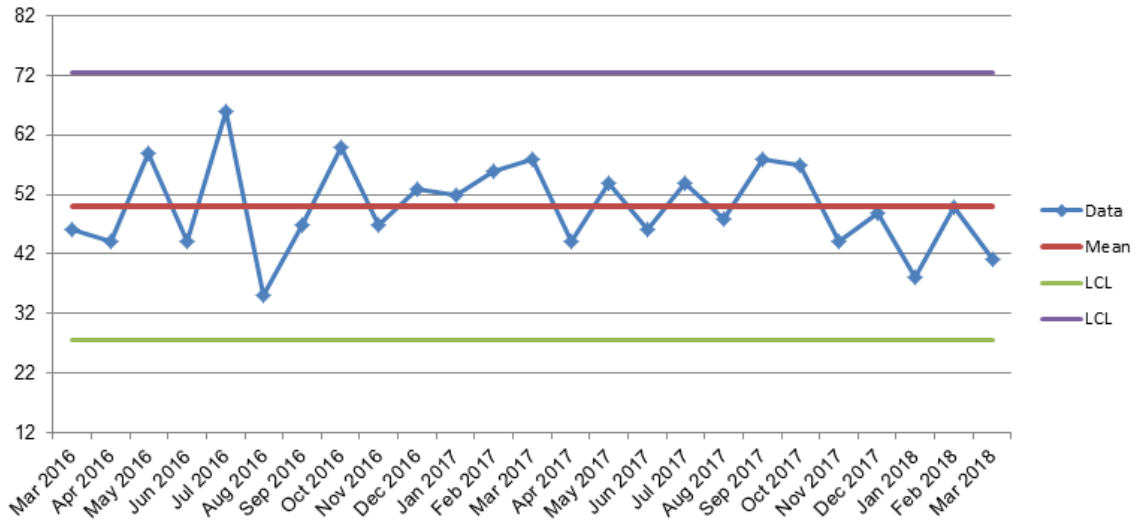
Priority 2

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.

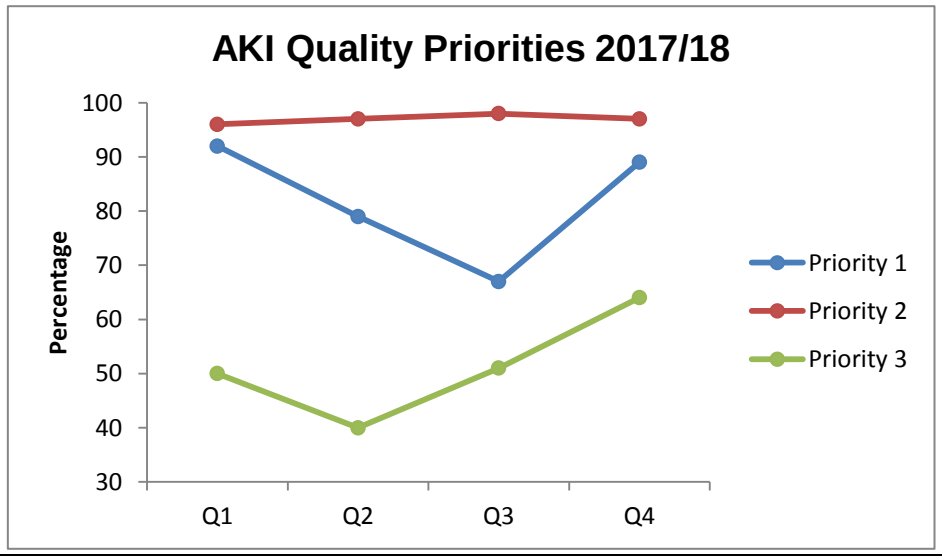
Acute Kidney Injury (AKI)

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

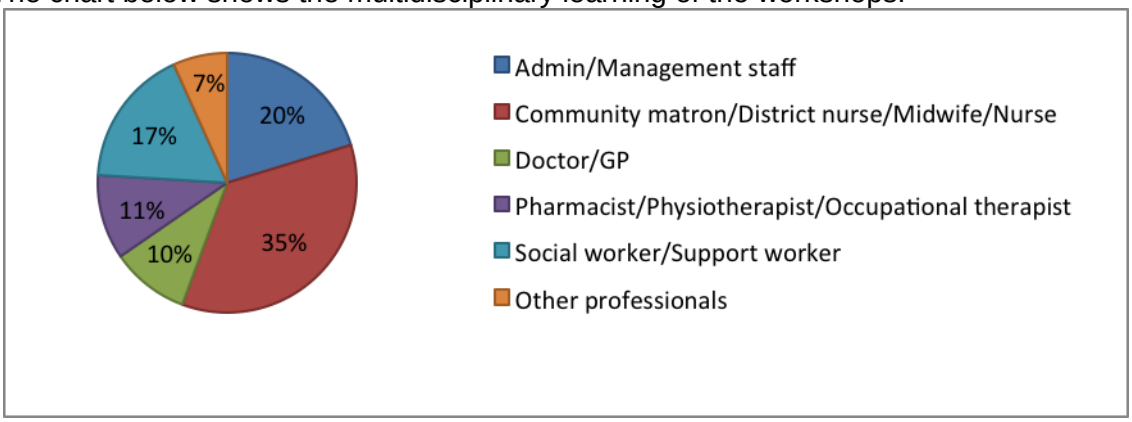
Progress to date

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.

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25 June 2018