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ISLINGTON

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

# AGENDA FOR THE HEALTH AND CARE SCRUTINY COMMITTEE

Members of the Health and Care Scrutiny Committee are summoned to a meeting, which will be held on **19 July 2016 at 7.30 pm.**

**John Lynch**
**Head of Democratic Services**

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Despatched : 11 July 2016

Membership

**Councillors:**
Councillor Martin Klute (Chair)
Councillor Rakhia Ismail (Vice-Chair)
Councillor Jilani Chowdhury
Councillor Gary Heather
Councillor Michelline Safi Ngongo
Councillor Tim Nicholls
Councillor Una O'Halloran
Councillor Nurullah Turan

**Co-opted Member:**
Bob Dowd, Islington Healthwatch

Substitute Members

**Substitutes:**
Councillor Alice Perry
Councillor Dave Poyser
Councillor Clare Jeapes
Councillor Satnam Gill OBE
Councillor Angela Picknell
Councillor Marian Spall

**Substitutes:**
Olav Ernstzen, Islington Healthwatch
Phillip Watson, Islington Healthwatch

**Quorum: is 4 Councillors**

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|---|---|---|
| **A.** | **Formal Matters** | **Page** |
| 1. | Introductions | |
| | The Chair and Members introduced themselves at the meeting | |
| 2. | Apologies for Absence | |
| 3. | Declaration of Substitute Members | |
| 4. | Declarations of Interest | |
| | None | |
| 5. | Order of business | |
| 6. | Confirmation of minutes of the previous meeting | 1 - 4 |
| 7. | Chair's Report | |
| | The Chair will update the Committee on recent events. | |
| 8. | Public Questions | |
| 9. | Health and Wellbeing Board Update - Verbal | |
| **B.** | **Items for Decision/Discussion** | **Page** |
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The next meeting of the Health and Care Scrutiny Committee will be on 5 September 2016

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

**www.democracy.islington.gov.uk**

London Borough of Islington

**Health and Care Scrutiny Committee - Thursday, 9 June 2016**

Minutes of the meeting of the Health and Care Scrutiny Committee held at on Thursday, 9 June 2016 at 7.30 pm.

| | | |
|---|---|---|
| **Present:** | **Councillors:** | Klute (Chair), Heather, Nicholls, Ngongo, O'Halloran, Turan, Picknell and Ismail |
| **Also Present:** | **Councillors** | Janet Burgess |
| | **Co-opted Member** | Bob Dowd, Islington Healthwatch |

**Councillor Martin Klute in the Chair**

**226** **INTRODUCTIONS (ITEM NO. 1)**
The Chair introduced Members of the Committee

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

**228** **DECLARATION OF SUBSTITUTE MEMBERS (ITEM NO. 3)**
Councillor Angela Picknell stated that she was substituting for Councillor Jilani Chowdhury

**229** **DECLARATIONS OF INTEREST (ITEM NO. 4)**
None

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

**231** **CONFIRMATION OF MINUTES OF THE PREVIOUS MEETING (ITEM NO. 6)**
**RESOLVED:**
That the minutes of the meeting of the Committee held on 16 May be confirmed and the Chair be authorised to sign them

**232** **CHAIR'S REPORT (ITEM NO. 7)**
The Chair stated that the next meeting of the JOHSC would be held the following day at L.B.Islington and a new Chair and Vice Chairs would need to be elected.

The Chair also referred to the fact that Hyde Housing Association would not be present to give evidence that meeting because of outstanding legal issues in relation to some properties with tenants and outlined a statement from Hyde in this regard.

The Chair added that he had also been in correspondence with the Chair of the Whittington Hospital in relation to Governance issues and it is anticipated he would attend the next meeting of the Committee in this regard. The Whittington NHS Trust Quality Account would also be considered at this meeting.

**233** **PUBLIC QUESTIONS (ITEM NO. 8)**
The Chair outlined the procedure for Public questions and filming and recording of meetings

**234** **HEALTH AND WELLBEING BOARD UPDATE (ITEM NO. 9)**

Councillor Janet Burgess, Executive Member Health and Wellbeing was present for discussion of this item and outlined the following main points –

- She was now sitting as an observer on the Whittington Hospital Trust Board and that the last meeting had been a useful one
- The number of consultants in Accident and Emergency at the Whittington Hospital were being increased from 6.5 to 10 and it is hoped that this will increase performance although this would add to the financial pressures on the Trust
- There is concern at the shortage of nursing staff across London and a lack of suitable applicants given the high costs of housing in London Borough of Islington
- The Whittington were carrying out an Estates strategy, however the Trust were engaging with the Defend the Whittington campaign
- The results of the Annual Adults Social care survey had revealed a satisfaction rate of 56% and Councillor Burgess had indicated that she had requested that a comparison be done with other Local Authorities to ascertain if such a comparative low level of satisfaction is common
- There had been no delays in transfer of care at the Whittington in the last 4/5 weeks although there has been a problem at St.Pancras
- Work is continuing to take place on the integrated health and social care programme and pooling of budgets and Islington appeared to be ahead of other boroughs in this
- It is pleasing to note that the payment of the LLW to care staff has resulted in a reduction in staff leaving

The Chair thanked Councillor Burgess for her update

**235** **CAMDEN AND ISLINGTON MENTAL HEALTH TRUST QUALITY ACCOUNT (ITEM NO. 10)**

Taffy Gattawa, Assistant Director Quality and David Barry, Lead Governor Camden and Islington Mental Health Foundation Trust were present for discussion of this item an outlined the report.

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

- In response to a question it was stated that there were dedicated beds for mental health patients with learning disabilities
- Concern was expressed at the fact that BME were not present in higher graded posts and the staff survey had revealed that there had been complaints of bullying and harassment of staff. It was stated that events had been organised for staff in order to learn from their concerns and an Equality Manager had been appointed. However it is important that line management gave opportunities to BME staff and were trained appropriately
- In response to a question as to the fact that there was a high figure of 38% of staff who reported instances of bullying/harassment it was stated that Governors were committed to reducing this figure and ensure that procedures are put in place to deal with this. However it was noted that there had been a number of financial and changing of requirements placed on the Trust which may have contributed at the time to this. A non-Executive Director had been appointed with oversight of this issue
- Reference was made to the high discharge rate and it was stated that female patients were often placed in private facilities and were registered as a discharge even though they may return to the Trust and there would be a strengthening of discharge arrangements

- There had been an increase in patients who could not be discharged as they are homeless and the Trust were in discussions with L.B.'s Islington and Camden on this issue
- The Trust had implementation lead officers for priorities and there is stakeholder engagement to learn from stakeholder experiences
- The Trust met every quarter to monitor progress on priorities
- Training for staff is taking place on the Mental Health Act and other role specific training is also taking place
- Reference was also made to the fact that whilst safeguarding issues had been highlighted there is a need to also identify issues for carers who are often subject to attacks from mental health patients and their views needed to be taken into account and built into the next Quality Account process
- Members expressed the view that the Trust should include how effective the measures to combat bullying/harassment and BME career progression that have been put in place in the next Quality Account presented to the Committee

The Chair thanked Taffy Gatawa and David Barry for attending

**236** **DRUG AND ALCOHOL MISUSE - ANNUAL UPDATE (ITEM NO. 11)**

Charlotte Ashton and Emma Stubbs, Public Health were present for discussion of this item and made a presentation to the Committee.

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

- It is necessary to support clients to sustain their recovery and to support them into treatment services
- There is a need to ensure that substance misuse is not addressed in isolation, with a particular overlap with mental health. There are substantial opportunities for working in a more integrated way across substance misuse and mental health services in order to support a cohort of individuals with overlapping needs
- It is important to ensure that following hospital intervention connection is ongoing to enable clients to access support services
- It is important to ensure that the dangers of substance abuse are made clear and Public Health did get information concerning age of those going to A&E including age, gender and ethnic breakdown and that this information could be circulated to Members
- Those people with substance misuse problems tended to have more than one problem and work is going on with the Mental Health Trust to raise awareness
- Work also is taking place with front line staff and events are held to raise awareness of substance misuse and work took place with Licensing to limit the number of outlets selling alcohol, especially late at night
- There is a high percentage of residents with substance misuse problems that are NEET's
- The Drug and Alcohol budget is a large percentage of the Public Health budget allocation – about 33% but work is taking place to provide savings by working collaboratively
- In response to a question it was stated that there may be a spike in substance misuse problems with legal highs that have now been made illegal

The Chair thanked Charlotte Ashton and Emma Stubbs for their presentation

**237** **WHITTINGTON HOSPITAL GOVERNANCE ARRANGEMENTS - VERBAL (ITEM NO. 12)**

The Chair stated that this item would now be considered at the meeting on 14 July

**238** **SCRUTINY REVIEW - HEALTH IMPLICATIONS OF DAMP PROPERTIES -VERBAL (ITEM NO. 13)**

The Chair stated that Hyde Housing Association had not been willing to attend the meeting that evening given the ongoing legal issues with residents at Alderwick Court as stated earlier in the meeting but he hoped that they would attend the next meeting

**239** **WORK PROGRAMME 2016/17 (ITEM NO. 14)**

**RESOLVED:**

That the work programme be noted

MEETING CLOSED AT 9.25P.M.

Chair

# The Whittington Hospital NHS Trust

## Quality Report

Magdala Avenue
London N19 5NF
020 7272 3070
http://www.whittington.nhs.uk

Date of inspection visit: 8 - 11 December 2015
Date of publication: 08/07/2016

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

## Ratings

| | |
|---|---|
| Overall rating for this trust | Good |
| Are services at this trust safe? | Requires improvement |
| Are services at this trust effective? | Good |
| Are services at this trust caring? | Outstanding |
| Are services at this trust responsive? | Good |
| Are services at this trust well-led? | Good |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Whittington Health was established in April 2011 bringing together Islington and Haringey community services with Whittington Hospital's acute services to form a new Integrated Care Organisation (ICO). Whittington Health provides acute and community services to 500,000 people living in Islington and Haringey as well as other London boroughs including Barnet, Enfield, Camden and Hackney.

The hospital has approximately 320 beds, and is registered across 3 locations registered with CQC: Whittington Hospital (includes community services) , Hanley Primary Care Centre (GP practice and community centre) and St Luke's Hospital (Simmons House) multi-disciplinary MH service for 13-18 year olds with emotional and mental health problems.

We carried out an announced inspection between 8 and 11 December 2015. We also undertook unannounced visits on 14, 15 and 17 December 2015.

We inspected Whittington Health NHS Trust acute hospital, including the right core services: Urgent and Emergency Care, Medicine (including older people's care, Surgery, Critical Care, Maternity and Gynaecology, Services for children, End of life and Outpatients and diagnostic services.

We inspected Whittington Health NHS Trust CAMHS services, Whittington Health community services for adults, children and young people and families, and patients receiving end of life care.

This was the first inspection of Whittington Health NHS Trust under the new methodology. We have rated the trust as good overall, with some individual core services as requires improvement.

In relation to core services most were rated good with critical care and outpatients and diagnostics rated as requires improvement. Community end of life care and community dental services were rated as outstanding.

Our key findings were as follows:

- During our inspection we found staff to be highly committed to the trust and delivering high quality patient care.
- We saw staff provided compassionate and patients were positive about the care they received and felt staff treated them with dignity and respect.
- The trust had vacancies across all staff groups, but was recruiting staff and staffing levels were maintained in services through the use of bank and agency staff.
- Staff were aware of how to recognise if a child or adult was being abused and received good support and training from the trust's safeguarding team.
- The trust had an incident reporting process and staff were reporting incidents and receiving feedback. Learning was shared across ICSU's which encompassed acute and community service.
- The Trust had promoted duty of candour and this was seen to be cascaded through the organisation.
- We observed effective infection prevention and control practices in the majority of areas we inspected.
- Patient care was informed by national guidance and best practice guidelines and staff had access to polices and procedures.
- Patients had their nutritional needs met and received support with eating and drinking.
- There was good team and multidisciplinary working across all staff groups and with clinical commissioning groups, voluntary organisations and social services to deliver effective patient care.
- We found evidence of good compliance with the World Health Organisation (WHO) surgical safety checklist, with good completion of the three compulsory elements: sign in, time out and sign out.
- There were processes in place to ensure staff attended training on the Mental Capacity Act 2005 and the majority of staff demonstrated a good practical understanding of this, with variability in some services,

# Summary of findings

- Staff understood and responded to the needs of the different population groups the trust served and worked hard to meet the needs of individual patients.
- Patients were largely treated in timely manner with the trust meeting national access targets and performing higher than the England average, with the exception of the cancer two week wait standard, although it was noted that improvements were being made against that standard.
- The emergency department (ED) performed better than the average ED in England in the speed of initial assessment, the timeliness of ambulance handover, and the percentage of people staying for more four hours in the department. However, there were times when there were no in-patient beds available and patients remained in ED for a long time.
- The trust had introduced the ambulatory care unit, which engaged stakeholders across the health and social care economy to avoid unnecessary hospital admissions and transfer their ongoing care needs to the most appropriate provider.
- Patient flow out of theatres and critical care, impacted on patient movement and service capacity.
- Executive and non executive members of the trust were visible in most areas, in both acute and community settings.
- The trust had a clear vision and strategy , the development of this into local strategies were in place in some areas, but were still being developed in some cases.
- Staff were positive about how their local and senior managers engaged with them.

We saw several areas of outstanding practice including:

At the Whittington Hospital:

- Whittington Health NHS Trust worked with clinical commissioning groups (CCGs) and other providers to improve the responsiveness of emergency and urgent care services for local people. The Ambulatory Care Centre, which opened in 2014, provided person-centred hospital level treatment without the need for admission.
- Within he Ambulatory Care Centre we observed good multidisciplinary working across hospital services, including diagnostics, care of the elderly physicians, therapists, pharmacists, and medical and surgery specialities to provide effective treatment and care.
- Elderly care pathways had been well thought out and designed to either avoid elderly patients having to go to ED or if they do, making sure that their medical and social care needs are quickly assessed.
- Within the ED there was outstanding work to protect people from abuse. The lead consultant and nurse for safeguarding coordinated weekly meetings attended by relevant trust wide staff to discuss people at risk and to make plans to keep them safe.
- Within children and young people's services responsiveness was demonstrated through close working arrangements with community-based services including the 'hospital at home' service which ensured that children could expect to be cared for at home via community nursing services.
- The trust provided 'Hope courses' for patients who had been on cancer pathways to get together outside of hospital, and hear from motivational speakers including talks on personal wellbeing, nutrition and recovery care.
- At Whittington Health community sites:
- Community teams told us they felt very integrated with the trust hospital services, GPs and nurses. We found examples of shared assessments within community settings, for example joint podiatry and diabetes assessments.
- Within community dental services we received consistently positive responses from patients, some describing the services as "Life changing" and others rating services as five-star on the NHS Choices website.
- Within community end of life care we found the service provided outstanding, effective services to children, young people and their families. We saw examples of very good multidisciplinary working and effective partnerships with the local GPs, other providers and hospices.

# Summary of findings

- Within community end of life care services we observed exemplary care, delivered with respect and dignity. Everyone we spoke with told us they had entirely positive experiences of the service.
- Within community end of life services there was a commitment to offering an equitable service across the three boroughs. Data was collected on the patient's preferred place of death and discussed at a specialist network level.
- The service worked well with the local hospice to make the best use of day care and hospice at home services in response to patient need.
- The children's community palliative care service, Lifeforce, was exceptionally well led. The service was committed, adaptable and flexible to meet the needs of the patients and their families. The term going, 'over and above' was used on many occasions to describe the team's approach to their work.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

Trust wide:

- Review bed capacity to assess capacity across medicine, surgery and critical care to ensure patients are appropriately placed within the correct specialism and enhance hospital flow.

At the Whittington hospital site:

- Within the Emergency Department (ED) there was not sufficient consultant cover and there were vacant middle grade medical posts, covered by locum (temporary) doctors, which poses a risk to delivery of care and training staff.
- Within acute outpatient departments the hospital must improve storage of records and ensure patient's personally identifiable information is kept confidential.
- Within the acute outpatient setting, departments improve disposal of confidential waste bags were left in reception areas overnight.
- Within surgery and theatres review bed capacity to ensure patients are not staying in recovery beds overnight.
- Within critical care the trust must review capacity and outflow of patients. We observed significant issues with the flow of patients out of critical care and found data suggesting 20% of patient bed days were attributed to patients who should have been cared for in a general ward environment. This led to mixed sex accommodation breaches, a high proportion of delayed discharges from critical care and a number of patients discharged home directly from the unit
- Within critical care the service must review governance processes and use of the risk register. We were concerned there was a culture of underreporting incidents and near misses and the importance of proactive incident reporting be promoted.
- Within critical care staff did not challenge visitors entering the unit and we were concerned patients could be at risk if the unit was accessed inappropriately.
- Within maternity services the department must ensure the information captured for the safety thermometer tool is visible and shared with both patients and staff in accessible way.
- Within maternity the service must ensure the safety of women undergoing elective procedures in the second obstetric theatre and agree formal cover arrangements.
- Within palliative care the service did not meet the requirement set by the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care related to number of palliative care consultant working at the hospital.
- Within palliative care services staff were not always aware of patient's wishes in regards to their 'preferred place of death'. They did not always record and analyse if patients were cared for at their 'preferred place of care'.

At CAHMS inpatient services

- Improve ligature risk assessments and the identification of associated risks

# Summary of findings

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

# Summary of findings

## Background to The Whittington Hospital NHS Trust

Whittington Health was established in April 2011 bringing together Islington and Haringey community services with Whittington Hospital's acute services to form a new Integrated Care Organisation (ICO). Whittington Health provides acute and community services to 500,000 people living in Islington and Haringey as well as other London boroughs including Barnet, Enfield, Camden and Hackney.

The hospital has approximately 320 beds, and is registered across 3 locations registered with CQC: Whittington Hospital (includes community services) , Hanley Primary Care Centre (GP practice and community centre) and St Luke's Hospital (Simmons House) multi-disciplinary MH service for 13-18 year olds with emotional and mental health problems.

The health of people in Haringey is varied compared with the England average. Deprivation is higher than average and about 26.8% (14,200) children live in poverty. Life expectancy for both men and women is higher than the England average.

The health of people in Islington is varied compared with the England average. Deprivation is higher than average and about 34.4% (11,500) children live in poverty. Life expectancy for men is lower than the England average.

We inspected Whittington Health NHS Trust acute hospital, including the right core services: Urgent and Emergency Care, Medicine (including older people's care, Surgery, Critical Care, Maternity and Gynaecology, Services for children, End of life and Outpatients and diagnostic services.

We inspected Whittington Health NHS Trust acute hospital, Child and Adolescent Mental Health Services (CAHMS) and community services for adults, children and young people and families, and patients receiving end of life care.

## Our inspection team

Our inspection team was led by

Chair: Alastair Henderson, Chief Executive, Academy of Medical Royal Colleges

Team Leader: Nicola Wise Head of Hospital Inspection Care Quality Commission

The trust was visited by a team of CQC inspectors and assistant inspectors, analysts and a variety of specialists.

There were consultants in emergency medicine, medical care, surgery, paediatrics, cardiology and palliative care medicine and junior doctors. The team also included midwives, as well as nurses with backgrounds in surgery, medicine, paediatrics, neonatal, critical care and palliative care, community services experience and board-level experience, student nurse and two experts by experience.

## How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always inspects the following core services at each inspection

# Summary of findings

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

The trust also provides community services and we inspected

- Community services for adults
- Community services for children, young people and

their families

- Community services for people receiving end of life care
- Community services for inpatients

The trust also provides mental health services and we inspected

- Mental health services for adults

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These organisations included the clinical commissioning groups, Trust Development Authority, Health Education England, General Medical Council, Nursing and Midwifery Council, Royal College of Nursing, NHS Litigation Authority and the local Healthwatch.

As part of this inspection, we visited a number of health centres and community team bases at: St Anne's Hospital, Crouch End Health Centre, Hornsey Central Neighbourhood Health Centre, City Road Health Centre, Holloway Community Health Centre, Hornsey Rise Health Centre, Islington Outlook and the Partnership Primary Care Centre.

We observed how patients were being cared for, spoke with patients, carers and/or family members and reviewed patients' personal care or treatment records. We held focus groups with a range of staff in the hospitals and community services, including doctors, nurses, allied health professionals, administration, senior managers, and other staff. We also interviewed senior members of staff at the trust.

## What people who use the trust's services say

Public Event

To capture the views of local people who use the trust we arranged market-style feedback stands. We received many positive comments about most of the services. Staff were described as caring and supportive.

Friends and Family Test

The percentage of patients who indicated they would recommend the trust met the England average in August 2015, however was consistently below the average between July 2014 and July 2015.

Patient led assessments of the care environment (PLACE)

The trust was above the England average in all measures (food, cleanliness, privacy, dignity and well-being) in 2013, 2014 and 2015.

Healthwatch

Healthwatch Haringey provided feedback from patients and relatives about a range of services including the emergency department, hospital outpatients, and pharmacy. There was a mix of positive and less positive experiences ranging from Reception staff attitude, appointment systems, interpreter services for hearing impaired patients and access to the PALS and complaints service.

Following the PLACE assessment feedback was assessors were impressed by the patient care, cleanliness and hygiene in the hospital. Comments and feedback made last year had been taken on board and there was a great improvement.

Clinical Commissioning Groups (CCGs)

# Summary of findings

Islington and Haringey are the two main local commissioners. They were generally positive about services provided by the trust and believed quality and outcomes were good.

They commented on how the trust worked collaboratively to improve health care across the local health economy and had changed its' organisational structure since the formation of the ICO.

Areas of concern were highlighted as issues with the response time for urgent 2 hour assessment, access times for two week wait cancer assessments, six week diagnostic waiting times. Response rates to for Friends and Family indicators. Appraisals were highlighted as an issue for staff through the staff survey. Benchmarked against other London providers the Trust is in the bottom 50% for staff recommending the Trust as a place to work and also in receiving care.

Overall they described the trust as having "good relationships with commissioners and partners " that actively engaged in discussions about how to improve services.

Royal College of Nursing (RCN)

The RCN described past issues around waiting times in Accident and Emergency and failure to meet targets on patient flow and management. Some members had raised concerns about staffing levels and skill mix in the department as well as some issues around team dynamics, however these had since been resolved.

The RCN highlighted some concerns about the high level of sickness and work-related stress and highlighted the sickness absence policy as an area of concern.

The handling of disciplinary situations and investigations was also raised, feedback stating that a culture of learning and openness would be beneficial.

Overall the RCN described a good working relationship with the trust.

Trust Governors

The trust governors described Whittington Health as an Innovative Trust with an engaged top management team. The governors felt listened to and there was a degree of innovation across the Trust. The Trust did not handle Patient Experience in an integrated and proactive way. The Trust collected only quantitative data about Patient Experience, but there was a need for more in-depth, qualitative study.

Top level management were described as thoughtful and engaged. Issues were raised with interpreting services and the way in which the trust cancels appointments.

## Facts and data about this trust

Whittington Health NHS Trust is a general district hospital and integrated community provider with approximately 23 wards and providers community care services to 500,000 people living in Islington and Haringey as well as other London boroughs. It receives 86 % of referrals for acute services from Haringey and Islington GPs.

The organisation is a teaching institution for undergraduate medical students (as part of University College London Medical School) and nurses and therapists (linked to Middlesex University School of Health and Social Sciences).

Whittington Health NHS trust had a recorded annual income of £295 million (2014/15) and employs in excess of 4,400 staff. The trust recorded a financial deficit of £7.3 million in 2014/2015 and as per many organisations is proposing cuts to its budget, in order to break even over the next 2 to 3 years.

The hospital houses in the region of 320 beds, flexing up to 360 beds during the winter periods and is registered across three site locations with the Care Quality Commission: (includes community services) , Hanley Primary Care Centre (GP practice and community centre) and St Luke's Hospital (Simmons House) multi-disciplinary MH service for 13-18 year olds with emotional and mental health problems.

Whittington Health reports having a slightly less Consultant grade Doctors (36%), compared to the England average of 39%, and less middle grade Doctors (2%) compared to an England average of 9%. Conversely

# Summary of findings

the organisation houses a greater proportion of Registrars (42%) compared tp the England average of 38% and greater junior Doctors (17%) compared to an England average of 15%.

Safe?

- Number of delayed handovers in winter 2014/15 below the median of all Trusts
- The organisation reported one never event reported for misplaced naso or oro-gastric tubes during 2015.
- The ratio of all midwifery staff to births is better than the England average
- There have been no cases of MRSA since February 2015 and cases of Colostrum Difficile has varied over time compared to the England average.

Effective?

- In the Vital Signs in Majors audit 2010/11 the Whittington Hospital scored mostly in the upper England quartile
- Whittington Health scored above the England average for all but two of the indicators in the Heart Failure Audit.
- Performed better than the England average for two out of three nSTEMI indicators in the last two MINAP audits, the trust's performance has improved over time.
- Whittington Health performed well in the Hip fracture audit as 5 indicators were higher than the England average.
- In the bowel cancer audit the trust scored better than the England average and good for case ascertainment and data completeness.
- The lung cancer audit shows the trust as scoring higher than the England average for the two indicators
- The emergency re-admission rates within 2 days of discharge is lower than the England average for non elective admissions. There were no emergency re-admissions for elective admissions
- Unplanned re-attendance rate to A&E within 7 days was worse than the standard for 19 out of the 24 months.
- The trust's performance was also higher compared to the England average for those 19 months. Whittington Health scored similar to other trusts in the A&E survey for questions relating to effectiveness
- Whittington Health performed about the worse than other trusts for six out of the eight standards in the Mental health in the ED CEM audit 2014/15.
- In the national emergency laparotomy audit the trust's self-reported data indicated that the provision of facilities required to perform emergency laparotomy was unavailable for 11 out of the 28 measures reported on.

Caring?

- A&E Friends and Family Test (% recommend) is consistently above the England average.
- The response rate for the friends and family test are higher than the England average.
- In the friends and family test the postnatal ward is the only area to score consistently below the England average

Responsive?

- The percentage of emergency admissions waiting 4-12 hours from the decision to admit to admission below the England average for 49 of the 65 weeks.
- Only one patient who had their operation cancelled was not treated within 28 days, Q1 13/14 to Q1 15/16
- The average length of stay for elective and non elective is lower than the England average
- Since Nov'14 the referral to treatment (RTT) percentage within 18 weeks non-admitted and incomplete pathways (IP) is better than the standard and better than/similar to the England average.
- The percentage of patients (all cancers) waiting less than 31 days and 62 days from urgent GP to first definitive treatment is higher than the England average
- Percentage of patients leaving the A&E department before being seen is regularly higher than the England average. Average total time in A&E is higher than the England average for 25 out of 30 months.

# Summary of findings

- The trust was meeting the 90% standard for percentage of admitted patients treated within 18 weeks of referral (RTT) however it has fallen below the standard after Jun'15. Particular areas of non-compliance are urology and general surgery.
- The percentage of patients (all cancers) seen by a specialist within 2 weeks from urgent GP referral to first definitive treatment is lower than the England average but has shown improvement since Q3 14/15.
- This trust had a high proportion of people waiting 6+ weeks for diagnostic appointments, from May'15 to Aug'15, when compared to the England average.

Well Led?

- Data analysis indicated that the organisation flagged against the Intelligent Monitoring risk for staff turn-over (leavers) rates within nursing and midwifery.
- The volume of written complaints reduced from 460 in 2013/14 to 357 during 2014/15, the lowest figure in the past five-year timescale.
- The trust performed lower than the national average in some areas of the NHS staff survey including: percentage of staff working extra hours, the percentage of staff appraised within the last 12 months and the percentage of staff suffering work related stress in the last 12 months.
- The NHS staff survey indicated there was a higher proportion of staff reporting the experience of harassment, bullying or abuse in the last 12 months, compared to the national average. With a lower proportion of staff believing the trust provided equal opportunities for career progression or promotion, compared to the national average.

# Summary of findings

## Our judgements about each of our five key questions

| | Rating |
|---|---|
| **Are services at this trust safe?**<br>The trust is rated as requires improvement for safety. We found examples of safe care in many of the services we inspected but urgent and emergency services, medical care, maternity and gynaecology, end of life care, outpatients and diagnostics and community adults services were rated as requires improvement.<br><br>For more detailed information please refer to the reports for the acute hospital, community dental, community adults, community children's and child and adult mental health services.<br><br>Incidents<br><br>We found systems for reporting and learning from incidents across services. Staff were aware of how to report patient safety incidents and knew about the trust-wide electronic system for incident reporting. Staff stated they were encouraged to report incidents. Staff told us they received feedback on the incidents they had reported.<br><br>The trust reported a lower number of incidents per 100 admissions compared to the England average.<br><br>We were concerned that the incident reporting culture on the critical care unit was not proactive as we expected more than 69 reported incidents in a twelve month period (other similar sized units reported approximately 25-45 incidents each month).<br><br>Duty of Candour<br><br>The trust had promoted duty of candour and this was seen to be cascaded through the organisation. Staff were aware of the requirements of the duty of candour, including apologising and sharing the details and findings of any investigation. Senior nurses and managers told us that a duty of candour presentation and email was sent to all senior managers describing their responsibilities in this area.<br><br>Infection prevention and control<br><br>The environment in the majority ofareas we inspected was clean and complied with infection prevention and control guidance. The exception to this was where we observed some areas where there were insufficient checks and audits on cleanliness and infection control practices. Where infection control audits demonstrated areas to be lower than the trust standard of 99%, we saw evidence of actions to address this. | **Requires improvement**  |

# Summary of findings

Environment and Equipment

We found evidence within adult community services that staff did not always carry items deemed as essential. We noted of an audit of essential items to be carried by District Nurses (DNs) in November 2015, only three of 14 items that were classed as essential were being carried by all DNs audited. We were informed that some agency staff did not have some basic equipment.

Within the Child and Adolescent Mental Health Services (CAHMS) inpatient unit we observed some blind spots, and ligature points which had not been identified via local risk assessments.

We found evidence of equipment being checked on a daily basis across the organisation, with the exception of maternity services where this was variable.

Records

We observed a mixture of paper and electronic records in use across the organisation. Concerns around the use of temporary records were evident across some services including the Emergency Department (ED) and outpatients.

We reviewed a sample of patient records and found that they were mostly completed in a comprehensive, legible way.

Within outpatients we found inconsistencies in the storage of records. Patients' personally identifiable information was not always kept confidential.

Safeguarding

In line with statutory guidance the trust had named nurses, named doctors and safeguarding teams for child protection and safeguarding vulnerable adults. The Trust had policies and procedures in place in relation to safeguarding adults and children. Safeguarding was embedded as part of mandatory training and induction. Staff were confident in reporting concerns to the relevant teams. Staff were able to explain what constituted a safeguarding concern and the steps required for reporting on these concerns.

Use of the ‘five steps to safer surgery’ procedure

The trust had not fully implemented the five steps of the World Health Organisation (WHO) Surgical Safety Checklist. We found evidence of good compliance with the three compulsory elements: sign in, time out and sign out. We followed the patient pathway through a number of different surgical procedures in main theatres and the Day Surgery Unit. Most of the procedures we witnessed completed the checklist comprehensively.

# Summary of findings

The surgery service audited WHO checklist compliance in September 2015 over a period of 6-8 weeks. The audit found good general compliance with completing the checklist across the service

Staffing

The trust had vacancies across all staff groups, but staffing levels in most clinical areas were maintained at a safe level with the use of bank, agency and locum staff. Where agency staff were used there was an induction programme to help them become familiar with the environment.

Nursing and midwifery staffing levels were reviewed and assessed using the National Safer Nursing Care Tool which conducted every six months. Staff felt that senior managers would listen to their concerns about staffing levels. Safe staffing levels were updated on a constant basis using a safe care e-system.

Areas where we found some specific staffing issues were adult community, children's community, the paediatric Emergency Department (ED) and theatre recovery. We saw evidence of the trust attempting strategies to attract difficult to recruit staff cohorts, for example though the use of pay increases for Health Visitors and rotating staff through challenged areas.

We observed the number of consultants within the ED did not meet the Royal College of Emergency Medicine standards or the London commissioning standards to provide 16 hours consultant cover daily in the ED. Junior doctors in training told us they had concerns about the cover overnight, when consultants were not immediately available.

Assessing and responding to patient risk

The number of ambulance handovers delayed by over 30 minutes during the winter period of November 2013 to March 2014 was one of the lowest in the country, and better than the expected standard.

Within the community setting, services maintained a local database detailing 'patients of concern', these patients were reviewed more regularly by DNs and reviewed by a service manager monthly. Where risks were higher and cases more complex, other services could be called upon.

We observed careful consideration and planning for new patients coming into Simmons House CAHMS service. The unit accepted patients detained under the Mental Health Act. The team considered whether they could safely manage a patient within the unit or whether there was a more appropriate service for them.

# Summary of findings

There was limited assurance about safety of women undergoing elective procedures in the second obstetric theatre.

Mandatory Training

The trust's corporate induction for a new staff was part of mandatory training. It included infection prevention and control, adult safeguarding, adult life support and resuscitation, fire safety, health and safety, duty of candour, mental capacity awareness and equality and diversity. This included two days of lectures and three days of shadowing in their assigned clinical area.

There were some areas of the trust where mandatory training was below the trust's benchmark of 90% compliance across a number of subject areas, with midwifery being an identified area below the target level.

Training in Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) was variable with some services demonstrating compliance, whist others such as adult end of life care and midwifery having proportions of staff not trained.

Safety thermometer

The NHS Safety Thermometer is an improvement tool to measure patient harm and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheters and associated urinary tract infections (UTIs).

We observed safety thermometer data displayed across the core services within the organisation, along with good performance for the months preceding our inspection. Maternity services were the exception where we found the service did collect this information but did but did not use the safety thermometer tool and the information was not visible on ward areas.

Medicines

Medicines including controlled drugs (CDs) were stored and managed appropriately in the majority of areas, however there were some areas where medicines management was poor, for example on Victoria Ward. Due the nature of this ward and the low levels of experience of many of the nursing staff, we found that practices and procedures were not always adhered to.

Within community children's services we observed that although checks showed medicines were stored at the correct temperature, the gauges used appeared to be incorrectly labelled. We were therefore not assured vaccines were always kept at an appropriate temperature.

# Summary of findings

Restraint

Within CAHMS inpatient services staff used the PROACT-SCIP model of restraint. It aimed to support staff to identify patient triggers and recognise early behavioural indicators that could lead to challenging behaviour.

**Are services at this trust effective?**

Good

Overall we rated the effectiveness of the majority of services at the trust as good. Care was evidence-based and the majority of services participated in national and local audits. With the exception of community end of life care, which we rated as outstanding because we found the service provided outstanding, effective services to children, young people and their families.

Feedback from patients and families were positive about the care and resources available to across many of the services.

Within end of life care Lifeforce worked closely with UK charities to take into account the 'Together for Short Lives' eight priorities of care for children with life threatening and life limiting conditions.

Within community end of life services we observed excellent care in the home which provided the family and patients with comfort and reassurance. The team were able to review the patients needs to ensure they could continue with meeting their own particular wishes in the face of great difficulty.

For more detailed information please refer to the reports for the acute hospital, community dental, community adults, community children's and child and adult mental health services.

Evidence based care and treatment

The trust's policies and treatment protocols were based on organisational guidelines from professional organisations such as the National Institute for Health and Care Excellence (NICE) and the Royal Colleges. Staff were able to access guidelines on the intranet.

A central trust team was responsible for arranging an appropriate clinician to review new guidelines and for disseminating them when they were approved.

The ED had performed among the worst 25% of trusts in six of the eight standards in the RCEM Mental Health audit 2014-2015. The department introduced a revised mental health risk assessment form for doctors and nurses, which had improved documentation, but further progress was needed.

Patient outcomes

# Summary of findings

The trust showed no evidence of risk against mortality rates, according to the Intelligent monitoring system.

The trust has mixed results in the national fractured neck of femur audit 2012 -2013. A multi-disciplinary group of staff from orthopaedics and ED worked to improve the outcome for these patients.

The number of day surgery cases was lower than the England average. Approximately 53% of surgery patients were day case. The trust was aware of this and was investigating ways to increase it.

Competent staff

DN compliance with clinical supervision was low. Documentation demonstrated that 10 of 65 were completed for the year. The DN professional development and quality lead indicated that clinical supervision was a 'work in progress.'

Appraisal rates across the organisation were variable, with some areas demonstrating highly trained and appraised staff, with other areas falling significantly below the internal target of 90% of staff having received an appraisals.

Multi-disciplinary working and coordinated care pathways

Multidisciplinary (MDT) working was embedded and effective across the trust. Staff spoke positively about MDT working and we found evidence of good multidisciplinary relationships supporting patients' health and wellbeing. We observed multidisciplinary input in caring for and interacting with patients on the wards.

In the ambulatory care unit we observed good multidisciplinary working across hospital services, including diagnostics, care of the elderly, physicians, therapists, pharmacists, and medical and surgery specialities to provide effective treatment and care.

Community teams told us they felt very integrated with the trust hospital services, GPs and nurses and we saw examples of services which had implemented shared assessments.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

Mental capacity and DoLS training was completed alongside the training for adult safeguarding level two, and was captured as part of mandatory training. The majority of nursing and medical staff we spoke with demonstrated a good understanding of mental capacity and knew about the importance of assessments of people with mental health needs or learning disability.

We found evidence that consent for surgery processes did not follow best practice, with records highlighting that patient consent for

surgery was in some cases being taken on the day of the procedure in the pre-operative admissions unit. This meant that some patients did not have a 'cooling off period' in advance of their surgery, should they wish to reconsider their procedure. This approach is suboptimal, although it is widely recognised as a difficult problem to solve unless the patient is seen on a separate occasion.

Access to information

Staff in the ED and ambulatory care had access to electronic patient information. There was also access to the trust community health records.

Ward staff were able to access patient notes from a locked notes trolley to read and add relevant information. Staff with access to computer workstations were able to access test results electronically.

Within the adult community service staff had to navigate their way around a number of information systems belonging to different care providers, in order to integrate patient care.

Access to information was inconsistent between teams depending on whether staff had tablets, laptops, or paper records.

**Are services at this trust caring?**

**Outstanding** ☆

The trust is rated as outstanding overall for caring. Many of the services we inspected were rated as good, but community end of life care and community dental services were rated as outstanding.

Throughout the inspection and across the trust it was evident that care was patient-centred and staff treated patients with dignity and compassion. Patients we spoke with were positive about their experience and staff caring for them. The trust used a range of mechanisms to obtain feedback from patients including national surveys and the Family and Friends Test (FFT).

For more detailed information please refer to the reports for the acute hospital, community dental, community adults, community children's and child and adult mental health services.

Compassionate care

We found compassionate and respectful care was present in interactions we observed across both acute and community settings. The trust met the England average in the Friends and Family Test for Aug'15, however was consistently below the average before.

# Summary of findings

Within children's community services people we spoke with praised the service they received. Some commented that the care was "life changing" either for them or their children.

In some hospital outpatients clinics we did not find that there was adequate provision to protect a patient's privacy and dignity. For example; not all outpatients departments had suitable rooms for private consultations. In the anti-coagulant clinic patients were seen in a room that was the administration and clinical staff office.

Understanding and involvement of patients and those close to them

Across the organisation staff demonstrated compassion, kindness and respect for the patients and families they worked with.

Patients and relatives told us that doctors and nurses in ED and ambulatory care explained what they were doing and consulted them about treatment. One patient told us she chose to come to Whittington hospital because medical and nursing staff listened to what she said and answered her questions.

In critical care staff took time to get to know the patients and their relatives and made sure patients were comfortable on the unit. Patients and their relatives were involved in decision-making and had opportunities to ask questions about care plans and prognosis. Relatives were encouraged to fill in patient diaries.

Emotional support

We observed an understanding of the emotional impact to the patient of their condition. Patients in the surgery service had access to clinical nurse specialists for cancer support and guidance. Nurses on wards and service leaders told us that the cancer nursing service had transformed the support provided for patients with cancer. The trust had received sponsorship from a local football team to deliver a wellbeing course for patients to participate in after their treatment. The trust also provided 'Hope courses' for patients to get together outside of hospital, and hear from motivational speakers including talks on personal wellbeing, nutrition and recovery care.

There was a trust wide chaplaincy and spiritual support service available. There was no bereavement officer, their duties were performed by the mortuary clerical staff member. They were supported by the mortuary staff.

**Are services at this trust responsive?**

Good

Overall we rated responsiveness of services at this trust as Good. Many of the services were rated as good with the exception of community health for children's, surgery, critical care, and outpatients. Community end of life care was rated as outstanding.

# Summary of findings

Patient flow through surgery and critical care was a significant issue. We heard that some patients remained in recovery area for long periods while waiting for an appropriate bed to become available, some staying in recovery overnight. We saw little evidence of local leadership in recognising and improving these issues.

Surgery wards were used as overflow wards for medical patients and there were considerable numbers of medical patients on surgical wards. This was a regular occurrence despite reorganisation of wards to allocate bigger wards to medical patients.

Within critical care the departmental risk register was sparse and did not reflect all risks we identified during our inspection. We were concerned there was a culture of underreporting incidents and near misses however senior staff did not recognise this.

We found that the trust did not monitor effectively discharge times and obstacles to patients' discharge to ensure prompt response and that patients died in their preferred location. Staff were not always aware of patient's wishes in regards to their 'preferred place of death' and did not always record this information. There was no formal rapid discharge pathway to ensure speedy discharge of patients who wished to die at home or another location.

We rated community end of life care as outstanding because patients and families were able to access 24 hour 7 day per week help and advice for end of life care. There was a commitment to offering an equitable service across the three boroughs. Data was collected on the patient's preferred place of death and discussed at the network MDT meetings. The service worked well with the local hospice to make the best use of day care and hospice at home services in response to patient needs. The team responded to families' needs with their ongoing bereavement work, Memory Day and annual party. The team demonstrated a flexibility of service provision and an attitude of going above and beyond to ensure the patients and families received the best service possible.

Planning and delivering services which meet people's needs

The trust's integrated care approach was designed to meet the wide-ranging needs of patients by providing a variety of services within the acute and community settings to meet the needs of different patient groups. The trust also stated that as an integrated care organisation they aimed to work closely with commissioners on integrated pathways.

Whittington Health NHS Trust worked with clinical commissioning groups (CCGs) and other providers to improve the responsiveness of emergency and urgent care services for local people. The Ambulatory Care Centre, which opened in 2014, was a treatment

initiative providing person-centred hospital level treatment without the need for admission. Elderly care pathways had been well thought out and designed to either avoid elderly patients having to go to ED or, if they do, making sure that their medical and social care needs are quickly assessed.

The nurses and doctors in children's services were highly complimentary about the hospital at home service developed by the trust.

We observed long waiting times in outpatient clinics, which resulted in patients complaining during the time of our inspection.

Meeting people's individual needs

We saw a strong focus on the patients' needs and preferences, and we saw many examples of person-centred care and treatment during our inspection. We found good use of interpreter services within medicine, however this was not as apparent in other areas such as CCU and outpatients.

In CCU staff we met were not aware of support processes for patients with a hearing impairment, learning disability, psychiatric needs or those living with dementia.

Meeting the needs of people in vulnerable circumstances

We observed services to be supportive of older patients they visited and understood the needs of working with this patient group.

Community dental services provided home visits for people who were unable to attend clinic. This included elderly patients with limited mobility and patients who had a physical disability that made it difficult for them to attend the clinic.

We observed that when looked after children moved out of area but were still within easy travelling distance, the Whittington NHS Trust kept them on their caseload instead of transferring care. This helped to ensure continuity of care for vulnerable children.

Access and flow

Healthwatch Haringey informed us of a long-standing concern about the functioning of the hospital's outpatient's appointment system. Patients told us getting through by phone to the trust to cancel or rearrange appointments was difficult, with no facility to leave messages.

We observed that the surgical floor was well managed, at the front end of the patient experience, from admissions through theatres and into recovery. However, post-procedure flow from the recovery

area onto surgical wards was impacted by the limited availability of beds in surgical ward. The surgery service was focused on reducing length of stay for surgery patients by using enhanced recovery pathways.

The 'bed management and transfer policy' identified patients should be admitted to the critical care unit within one hour of the decision to admit being made and the hospital target was to admit 95% of critical care patients within this time frame. Hospital audit data from October 2015 demonstrated 97% of patients were admitted within one hour of the decision to admit to critical care being made and the remaining 3% were admitted within 2 hours.

However, when examining critical care documentation we found ten patients were discharged directly home between 7 October 2015 and 7 December 2015. Staff told us some patients waited for a ward bed for so long that they were ready to go home directly from critical care.

The percentage of patients admitted, transferred or discharged from ED within the national target of four hours was regularly above 95%, and was 94.4% in the six months to September 2015. This was better than the England average and indicated that there was an effective initial assessment.

In information the trust provided prior to our visit, they stated they had responded to an increased demand in a number of ways. In relation to emergency activity, there were a number of initiatives in place to reduce demand. They told us there was an ambulatory care unit in place that worked to prevent emergency admissions and redirected patients away from A&E, as well as other community-based initiatives to help keep people out of hospital.

Learning from complaints and concerns

Information shared with us from external stakeholders indicated concerns in relation to access to the PALS and complaints service, particularly for hearing impaired patients.

The volume of written complaints reduced from 460 in 2013/14 to 357 during 2014/15, the lowest figure in the past five-year timescale.

We found local leadership on complaints responses, whilst the trust complaints staff reviewed comments on NHS choices website and if there was dissatisfaction with the service they responded to the comment by giving details of how to contact PALS.

# Summary of findings

**Are services at this trust well-led?**

Good

The trust is rated overall as Good for well led. Critical care and outpatients and diagnostics were rated as requires improvement, whilst community end of life care was rated as outstanding.

Within surgery we found clinical governance structures beyond incident reporting were not robust. Staff were not able to articulate a clear structure for the escalation of risks, clinical governance or performance information. A number of identified risks remained on corporate risk registers for a long time and were not addressed adequately or in a timely way.

For more detailed information please refer to the reports for the acute hospital, community dental, community adults, community children's and child and adult mental health services.

Service vision and strategy

In 2015 the trust reorganised from three large divisions to seven smaller Integrated Clinical Service Units (ICSUs), led by a clinical director reporting directly to the Chief Executive. Staff of all grades and professions told us they welcomed this change because it had given clinical staff more control over developments in their service. The new ICSU enabled a focus on patient care, working across community services, ambulatory care, acute assessment and ED.

The trust's vision and values around providing integrated patient centred care were reflected by most of the staff that we spoke with and the trust values were included as part of the appraisal process.

We observed examples of strong local leadership, and services were able to articulate individual service strategies and plans, however not all services were able to produce business plans within each ICSU.

Governance, risk management and quality measurement

We found evidence of clear governance and risk management structures in place in the majority of areas, with regular patient safety meetings, monthly senior managers meetings and meetings of the risk board across both acute and community services. Local dashboards provided information on risks, targets, incidents, complaints and infection control. The general managers worked with the trust information team to check the reliability of data about performance. We noted that the Key Performance Indicators were more focused on acute services.

Risk registers were regularly updated and discussed during governance meetings. With the exception of surgery and critical care.

Leadership of this service

# Summary of findings

Staff said they felt well supported in terms of training and development. Staff reported varied levels of visibility of the executive team across the community services.

The trust reorganisation had resulted in some uncertainty, but staff reported that the new ICSU had made the necessary change to systems without disruption to services.

Staff told us that they regularly saw divisional managers and clinical leads on the wards. The Director of Nursing, COO and Chief Executive were visible to staff on the wards.

Culture within the service

Senior managers told us they had been a clinically led integrated care organisation since 2011, which had a philosophy of 'local care for local people'. The culture of the trust was all about integrated care, with learning shared across the integrated ICSUs.

Staff felt informed by their local teams and the executive team about changes within the trust. They received newsletters and emails about any changes.

Many staff commented on the friendliness of the trust and the fact that everyone knew everyone else.

Ward nurses told us that Whittington Hospital was generally a very good place to work. There was recognition that ward staff worked hard, but understood their areas for improvement.

Innovation, improvement and sustainability

The trust set up the Ambulatory Care Centre after piloting a small service and engaging stakeholders internally and externally in planning its development. The service was well known nationally for its innovative approach to providing hospital level care without the need for patients staying overnight.

The Michael Palin Centre was able to rely on a high amount of research from Australia. The Centre for the study of such children is located at the Faculty of Health Sciences at the University of Sydney.

Whittington Health worked well to avoid patients needing to attend. As part of the drive to keep patients out of hospital, the integrated pathways respiratory team has developed a new model across acute, community and primary care. The CORE team is led by two integrated consultants working with respiratory nurse specialists, physiotherapists, clinical psychologies, stop smoking advisors and an integrated specialist registrar.

# Overview of ratings

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Overall | Requires improvement | Good | ☆ Outstanding | Good | Good | Good |

# Outstanding practice and areas for improvement

## Outstanding practice

We saw several areas of outstanding practice including:

At the Whittington Hospital:

- Whittington Health NHS Trust worked with clinical commissioning groups (CCGs) and other providers to improve the responsiveness of emergency and urgent care services for local people. The Ambulatory Care Centre, which opened in 2014, provided person-centred hospital level treatment without the need for admission.
- Within this unit we observed good multidisciplinary working across hospital services, including diagnostics, care of the elderly physicians, therapists, pharmacists, and medical and surgery specialities to provide effective treatment and care.
- Elderly care pathways had been well thought out and designed to either avoid elderly patients having to go to ED or if they do, making sure that their medical and social care needs are quickly assessed.
- Within the ED there was outstanding work to protect people from abuse. The lead consultant and nurse for safeguarding coordinated weekly meetings attended by relevant trust-wide staff to discuss people at risk and to make plans to keep them safe.
- Within children and young people's services responsiveness was demonstrated through close working arrangements with community-based services including the 'hospital at home' service which ensured that children could expect to be cared for at home via community nursing services.
- The trust provided 'Hope courses', for patients who had undergone cancer treatment, to get together outside of hospital, and hear from motivational speakers including talks on personal wellbeing, nutrition and recovery care.
- At Whittington community sites:
- Community teams told us they felt very integrated with the trust hospital services, GPs and nurses. We found examples of shared assessments within community settings, for example joint podiatry and diabetes assessments.
- Within community dental services we received consistently positive responses from patients, some describing the services as "Life changing" and others rating services as five-star on the NHS Choices website.
- Within community end of life care we found the service provided outstanding, effective services to children, young people and their families. We saw examples of very good multidisciplinary working and effective partnerships with the local GPs, other providers and hospices.
- Within community end of life care services we observed exemplary care, delivered with respect and dignity. Everyone we spoke with told us they had entirely positive experiences of the service.
- Within community end of life services there was a commitment to offering an equitable service across the three boroughs. Data was collected on the patient's preferred place of death and discussed at the Great Ormond Street MDT.
- The service worked well with the local hospice to make the best use of day care and hospice at home services in response to patient need.
- The children's community palliative care service, Lifeforce, was exceptionally well led. The service was committed, adaptable and flexible to meet the needs of the patients and their families. The term going, 'over and above' was used on many occasions to describe the team's approach to their work.

# Outstanding practice and areas for improvement

## Areas for improvement

**Action the trust MUST take to improve**

We saw areas of poor practice where the trust needs to make improvements.

Importantly the trust must:

Trust wide:

- Review bed capacity to assess capacity across medicine, surgery and critical care to ensure patients are appropriately placed within the correct specialism and enhance hospital flow.

At the Whittington hospital site:

- Within the Emergency Department (ED) there was not sufficient consultant cover and there were vacant middle grade medical posts, covered by locum (temporary) doctors, which poses a risk to delivery of care and training staff.
- Within acute outpatient departments improve storage of records and ensure patients' personally identifiable information is kept confidential.
- Within acute outpatient departments improve disposal of confidential waste bags left in reception areas overnight.
- Within surgery review local strategy for consent for surgery processes to follow best practice, to allow patients to have a 'cooling off' period in advance of their surgery, should they wish to reconsider their procedure.
- Within surgery and theatres review bed capacity to ensure patients are not staying in recovery beds overnight.
- Within critical care there were significant issues with the flow of patients out of critical care which meant 20% of patient bed days were attributed to level 1 and level 0 patients who should have been cared for in a general ward environment. This led to mixed sex accommodation breaches, a high proportion of delayed discharges from critical care and a number of patients discharged home directly from the unit
- Within critical care review governance processes and local ownership of the risk register. We were concerned there was a culture of underreporting incidents and near misses and the importance of proactive incident reporting be promoted.
- Within critical care staff did not challenge visitors entering the unit and we were concerned patients could be at risk if the unit was accessed inappropriately.
- Within maternity services ensure the information captured for the safety thermometer tool is visible and shared in patient areas, for both patients and staff.
- Within maternity services there was limited assurance about safety of women undergoing elective procedures in the second obstetric theatre. There was routinely insufficient staff presence when cases were conducted, and failure to formally agree for adequate cover by recovery nurses from main theatres meant pregnant women and their families were left without visible staff presence.
- Within palliative care the trust did not meet the requirement set by the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care related to number of palliative care consultant working at the hospital.
- Within palliative care services staff were not always aware of patient's wishes in regards to their 'preferred place of death'. They did not always record and analyse if patients were cared for at their 'preferred place of care'.

At CAHMS inpatient services

- Improve ligature risk assessments and the identification of associated risks

# June 2016 Trust Board Report (May data)

Whittington Health NHS

| Quality | Threshold | Mar-16 | Apr-16 | May-16 |
|---|---|---|---|---|
| Number of Inpatient Deaths | - | 36 | 32 | 23 |
| NHS number completion in SUS (OP & IP) | 99% | 98.5% | 99.0% | arrears |
| NHS number completion in A&E data set | 95% | 96.1% | 95.2% | arrears |

| Quality (Mortality index) | Threshold | Jul 14 - Jun 15 | Oct 14 - Sep 15 | Jan 15 - Dec 15 |
|---|---|---|---|---|
| SHMI | - | 0.66 | 0.65 | 0.67 |

| Quality (Mortality index) | Threshold | Dec-15 | Jan-16 | Feb-16 |
|---|---|---|---|---|
| Hospital Standardised Mortality Ratio (HSMR) | <100 | 70 | 101 | 73 |
| Hospital Standardised Mortality Ratio (HSMR) - weekend | - | 85.9 | 79.3 | 81.0 |
| Hospital Standardised Mortality Ratio (HSMR) - weekday | - | 65.0 | 107.6 | 62.6 |

| Patient Safety | Threshold | Mar-16 | Apr-16 | May-16 |
|---|---|---|---|---|
| Harm Free Care | 95% | 93.6% | 92.2% | 92.7% |
| VTE Risk assessment | 95% | 95.1% | 95.0% | arrears |
| Medication Errors actually causing Serious/Severe Harm | 0 | 0 | 1 | 0 |
| Never Events | 0 | 0 | 0 | 0 |
| CAS Alerts (Central Alerting System) | - | 0 | 0 | 0 |
| Proportion of reported patient safety incidents that are harmful | - | TBC | TBC | TBC |
| Serious Incident reports | - | 2 | 3 | 6 |

***Access Standards***

| Referral to Treatment (in arrears) | Threshold | Feb-16 | Mar-16 | Apr-16 |
|---|---|---|---|---|
| Diagnostic Waits | 99% | 98.8% | 99.4% | 99.6% |
| Referral to Treatment 18 weeks - 52 Week Waits | 0 | 0 | 0 | 0 |

| Efficiency and productivity - Community | Threshold | Mar-16 | Apr-16 | May-16 |
|---|---|---|---|---|
| Service Cancellations - Community | 8% | 6.5% | 7.0% | 5.7% |
| DNA Rates - Community | 10% | 5.6% | 6.0% | 5.8% |
| Community Face to Face Contacts | - | 58,490 | 58,718 | 58,331 |
| Community Appts with no outcome | 0.5% | 0.4% | 2.5% | 5.9% |

| Community Access Standards | Threshold | Mar-16 | Apr-16 | May-16 |
|---|---|---|---|---|
| MSK Waiting Times - Non-Consultant led patients seen in month (% < 6 weeks) | 95% | 49.2% | 41.5% | 39.5% |
| MSK Waits - Consultant led patients seen in month (% < 18 weeks) | 95% | 82.2% | 59.6% | arrears |
| IAPT - patients moving to recovery | 50% | 46.6% | 47.4% | arrears |
| IAPT Waiting Times - patients waiting for treatment (% < 6 weeks) | 75% | 96.8% | 95.7% | arrears |
| GUM - Appointment within 2 days | 98% | 98.7% | 98.7% | 98.5% |

**Efficiency and Productivity**

| Efficiency and productivity - acute | Threshold | Mar-16 | Apr-16 | May-16 |
|---|---|---|---|---|
| First:Follow-up ratio - acute | 2.31 | 1.51 | 1.46 | 1.37 |
| Theatre Utilisation | 95% | 78.3% | 78.2% | 81.1% |
| Hospital Cancellations - acute - First Appointments | 8% | 5.3% | 6.2% | 4.6% |
| Hospital Cancellations - acute - Follow-up Appointments | 8% | 8.1% | 9.0% | 7.2% |
| DNA rates - acute - First appointments | 10% | 12.2% | 12.7% | 12.3% |
| DNA rates - acute - Follow-up appts | 10% | 12.8% | 12.5% | 11.5% |
| Hospital Cancelled Operations | 0 | 3 | 19 | 4 |
| Cancelled ops not rebooked < 28 days | 0 | 0 | 0 | 0 |
| Urgent procedures cancelled | 0 | 0 | 5 | 4 |

# June 2016 Trust Board Report (May data)

Whittington Health NHS

| Patient Experience | Threshold | Mar-16 | Apr-16 | May-16 |
|---|---|---|---|---|
| Patient Satisfaction - Inpatient FFT (% recommendation) | - | 96% | 96% | 95% |
| Patient Satisfaction - ED FFT (% recommendation) | - | 85% | 90% | 92% |
| Patient Satisfaction - Maternity FFT (% recommendation) | - | 88% | 95% | 92% |
| Mixed Sex Accommodation breaches | 0 | 0 | 0 | 0 |
| Complaints | - | 48 | 23 | 23 |
| Complaints responded to within 25 working days* | 80% | - | - | 90% |
| Patient admission to adult facilities for under 16 years of age | - | 0 | 0 | 0 |

| Emergency and Urgent Care | Threshold | Mar-16 | Apr-16 | May-16 |
|---|---|---|---|---|
| Emergency Department waits (4 hrs wait) | 95% | 81.8% | 84.1% | 85.9% |
| ED Indicator - median wait for treatment (minutes) | <60 | 103 | 88 | 88 |
| 30 day Emergency readmissions | - | 189 | 159 | arrears |
| 12 hour trolley waits in A&E | 0 | 0 | 0 | 2 |
| Ambulatory Care (% diverted) | >5% | 3.4% | 2.9% | 2.8% |
| Ambulance Handover (within 30 minutes) | 0 | 21 | 23 | arrears |
| Ambulance Handover (within 60 minutes) | 0 | 0 | 0 | arrears |

| Infection Prevention | Threshold | Mar-16 | Apr-16 | May-16 |
|---|---|---|---|---|
| Hospital acquired MRSA infection | 0 | 0 | 0 | 0 |
| Hospital acquired *C difficile* Infections | 17 (FY) | 0 | 2 | 0 |
| Hospital acquired *E. coli* Infections | - | 1 | 0 | 0 |
| Hospital acquired MSSA Infections | - | 0 | 0 | 0 |
| Ward Cleanliness | - | - | 97% | - |

| Cancer Access Standards (in arrears) | Threshold | Feb-16 | Mar-16 | Apr-16 |
|---|---|---|---|---|
| Cancer - 14 days to first seen | 93% | 99.5% | 98.8% | 97.6% |
| Cancer - 14 days to first seen - breast symptomatic | 93% | 98.3% | 99.4% | 98.1% |
| Cancer - 31 days to first treatment | 96% | 100.0% | 97.7% | 100.0% |
| Cancer - 31 days to subsequent treatment - surgery | 94% | 100.0% | - | - |
| Cancer - 31 days to subsequent treatment - drugs | 98% | 100.0% | 100.0% | 100.0% |
| Cancer - 62 days from referral to treatment | 85% | 81.6% | 88.5% | 88.1% |

**Access Standards (RTT)**

| Referral to Treatment (in arrears) | Threshold | Mar-16 | Apr-16 | May-16 |
|---|---|---|---|---|
| Referral to Treatment 18 weeks - Admitted | 90% | 76.6% | 77.3% | arrears |
| Referral to Treatment 18 weeks - Non-admitted | 95% | 90.8% | 89.2% | arrears |
| Referral to Treatment 18 weeks - Incomplete | 92% | 92.7% | 93.9% | arrears |

| Maternity | Threshold | Mar-16 | Apr-16 | May-16 |
|---|---|---|---|---|
| Women seen by HCP or midwife within 12 weeks and 6 days | 90% | 81.3% | 80.1% | 80.9% |
| New Birth Visits - Haringey | 95% | 85.7% | 88.6% | arrears |
| New Birth Visits - Islington | 95% | 94.7% | 95.1% | arrears |
| Elective Caesarean Section rate | 14.8% | 8.8% | 10.5% | 12.0% |
| Breastfeeding initiated | 90% | 93.0% | 90.9% | 92.1% |
| Smoking at Delivery | <6% | 4.1% | 4.4% | 6.6% |

Meeting threshold

Failed threshold

| | Threshold | Trust Actual | | |
|---|---|---|---|---|
| | | Mar-16 | Apr-16 | May-16 |
| Number of Inpatient Deaths | - | 36 | 32 | 23 |
| Completion of a valid NHS number in SUS (OP & IP) | 99% | 98.5% | 99.0% | arrears |
| Completion of a valid NHS number in A&E data sets | 95% | 96.1% | 95.2% | arrears |

| | Standardised National Average | Trust | | |
|---|---|---|---|---|
| | | Dec-15 | Jan-16 | Feb-16 |
| Hospital Standardised Mortality Ratio | <100 | 70.2 | 100.7 | 73.4 |
| Hospital Standardised Mortality Ratio (HSMR) - weekend | - | 85.9 | 79.3 | 81.0 |
| Hospital Standardised Mortality Ratio (HSMR) - weekday | - | 65.0 | 107.6 | 62.6 |

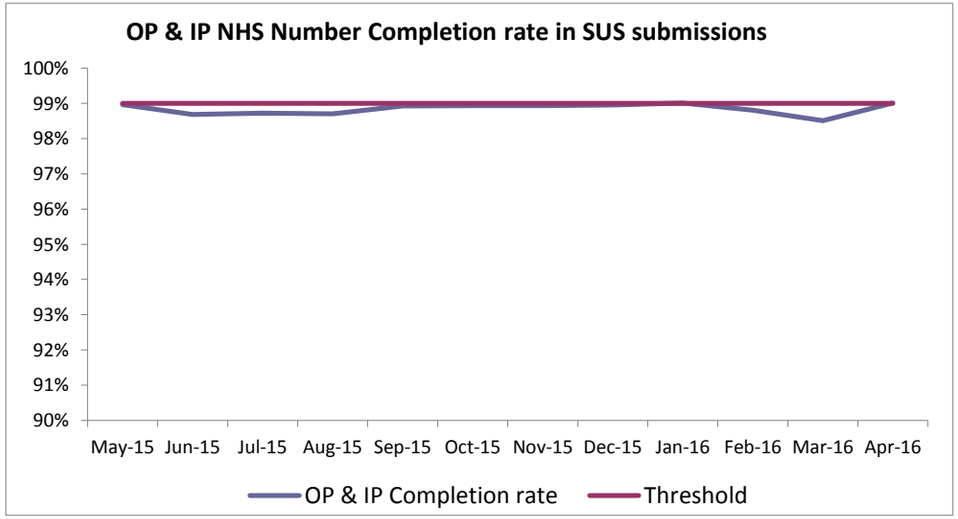
| | | Lower Limit | Upper Limit | RKE SHMI Indicator |
|---|---|---|---|---|
| SHMI | Jan 2015 - Dec 2015 | 0.89 | 1.13 | 0.67 |
| | Oct 2014 - Sep 2015 | 0.89 | 1.12 | 0.65 |
| | Jul 2014 - Jun 2015 | 0.89 | 1.12 | 0.66 |
| | Apr 2015 - Mar 2015 | 0.89 | 1.12 | 0.67 |
| | Jan 2014 - Dec 2014 | 0.89 | 1.12 | 0.66 |
| | Oct 2013 - Sep 2014 | 0.88 | 1.13 | 0.60 |
| | Jul 2013 - Jun 2014 | 0.88 | 1.14 | 0.54 |

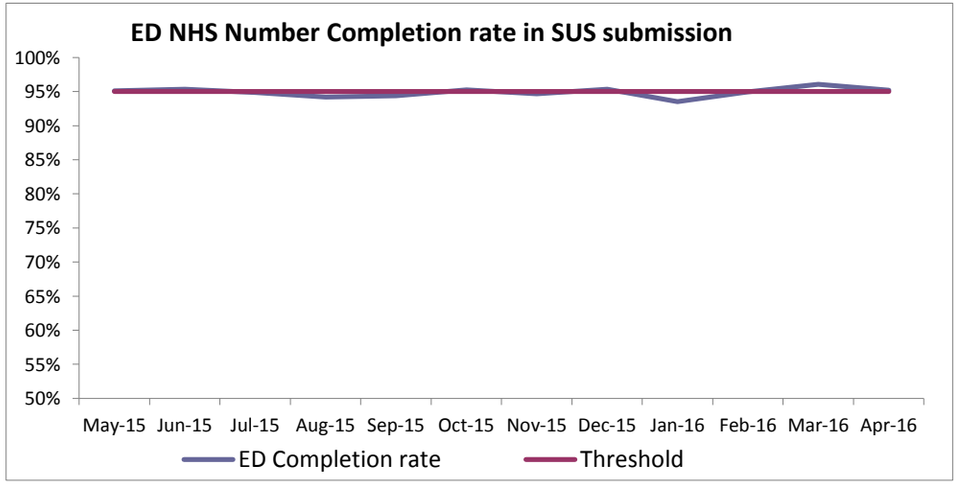
**Commentary**

**Completion of NHS number in SUS**
Within target as expected for June 2016

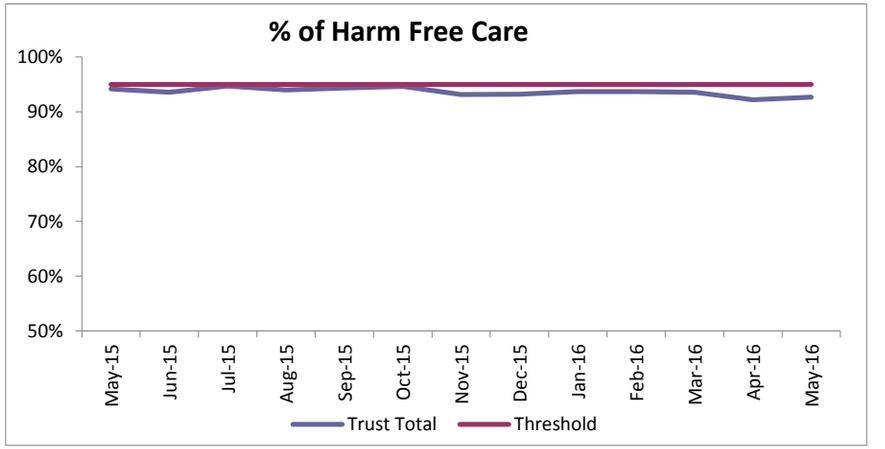
**Completion of NHS number in A&E data set**
Within target as expected for June 2016

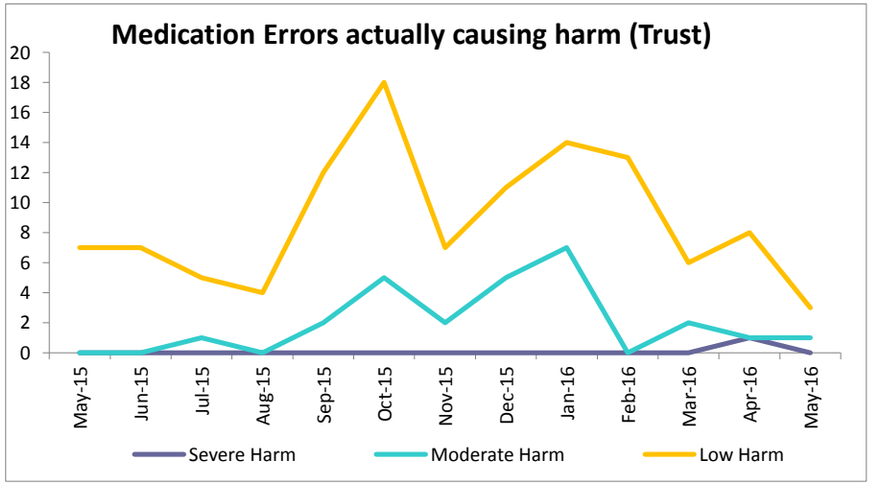
**SHMI and HMSR**
The above metrics are a ration of observed to expected death.
Whittington Health mortality is, again, below the level that is expected for the hospital.
The two different metric employ slightly different methodologies, so result in different values.
Weekend vs weekend mortality rate show extreme variability, because on a monthly basis the numbers are low. No inference can be made from this data.



| | Threshold | Trust Actual Feb-16 | Mar-16 | Apr-16 | May-16 | Trend |
|---|---|---|---|---|---|---|
| Harm Free Care | 95% | 93.7% | 93.6% | 92.2% | 92.7% | |
| Pressure Ulcers (prevalence) | - | 5.33% | 5.59% | 7.19% | 6.35% | |
| Falls (audit) | - | 0.49% | 0.46% | 0.35% | 0.45% | |
| VTE Risk assessment | 95% | 95.3% | 95.1% | 95.0% | arrears | |
| Medication Errors actually causing **Serious** or **Severe** Harm | 0 | 0 | 0 | 1 | 0 | |
| Medication Errors actually causing **Moderate** Harm | - | 0 | 2 | 1 | 1 | |
| Medication Errors actually causing **Low** Harm | - | 13 | 6 | 8 | 3 | |
| Never Events | 0 | 0 | 0 | 0 | 0 | |
| Open CAS Alerts (Central Alerting System) | - | 0 | 0 | 0 | 0 | |
| Proportion of reported patient safety incidents that are harmful | - | TBC | TBC | TBC | TBC | |
| Serious Incidents (Trust Total) | - | 8 | 2 | 3 | 6 | |




**Commentary**

**Harm Free Care and Pressure Ulcer prevalence**

Harm Free Care and the figure for prevalence of pressure ulcers include non-avoidable pressure ulcers. It remains just under 93%.

**Falls (audit)**

**Issue:** The overall numbers of falls recorded in the Nursing Indicators dashboard remain around 20 per month. IT is below the target of 5 falls per 1000 bed days at 2.73 falls.

**Action:** Falls awareness and prevention training session continue to be included in new ward training programme (2pm daily). Business case for care of older persons nurse specialist and increased awareness and recognition of delirium through screening project is in draft format. To be presented at the Investment Group and TMG in July 2016

**Timescale:** Feedback in July 2016

**Medication errors causing harm in April 16**

There were 60 medication incidents reported on Datix in May 2016. This is the second highest monthly total reported in the last 12 months (61 incidents were reported in December 2015)

Twenty nine (48%) of medication incidents were reported by E&UC of which 15 (25% of the total) occurred in patients' homes. The largest reporting group were district nurses (25%), followed by pharmacists (23%), hospital nurses (22%) and medical staff (12%) The incident causing moderate harm concerned a patient discharged without the correct analgesia. The community care team visited and organised an emergency supply of fentanyl patches. This was followed up with the prescriber and ward pharmacy team. All three incidents causing low harm were reported by E&UC: a patient had been given the incorrect dose of oral morphine and two patients had drug doses omitted.

**Proportion of reported patient safety incidents that are harmful**

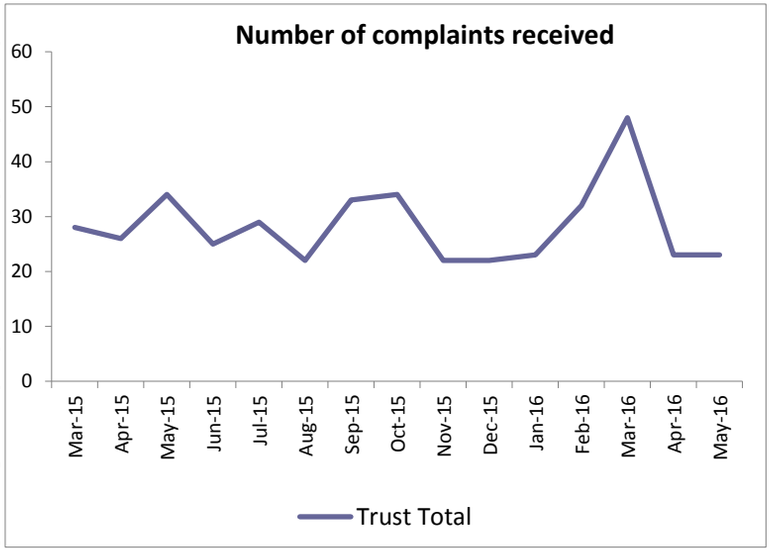
This report is under review due to the review of the Datix system.

**Serious Incidents**

Whittington Health declared 6 SIs in May 2016 including possible delayed diagnosis of leaking abdominal aortic aneurysm, delayed diagnosis of 2 week wait dermatology, 2 Information Governance breaches, one safeguarding children's and an unexpected admission to NICU.

All identified learning form these incidents has been shared with the Services.

| | Threshold | Trust Actual Feb-16 | Mar-16 | Apr-16 | May-16 | Trend |
|---|---|---|---|---|---|---|
| Patient Satisfaction - Inpatient FFT (% recommendation) ** | - | 94% | 96% | 96% | 95% | |
| Patient Satisfaction - Emergency Department FFT (% recommendation) ** | - | 92% | 85% | 90% | 92% | |
| Patient Satisfaction - Maternity FFT (% recommendation) ** | - | 88% | 88% | 95% | 92% | |
| Mixed Sex Accommodation (not Clinically justified) | 0 | 0 | 0 | 0 | 0 | |
| Complaints (**incl Corporate**) | - | 32 | 48 | 23 | 23 | |
| Complaints responded to within 25 working day | 80% | - | - | - | 90.5% | |
| Patient admission to adult facilities for under 16 years of age | - | 0 | 0 | 0 | 0 | |




*'Complaints responded to within 25 working days' now refers to those responses made during reporting month. This is no longer in arrears, but trend data is not available prior to May16

**Commentary**

**Patient Satisfaction (Local standard 90%)**

Please see breakdown of FFT to the left.

**ED:** Similar to last month

**Inpatients:** Lower response rate than last month. Note Coyle ward in high number of negative responses.

**Outpatients:** More responses than in previous months. Positive response rate below 90%. Note high number of negative responses in ophthalmology.

**Community:** Similar to last month. Note Cavell high negative response rate but only 1 negative response.

**Mixed Sex Accommodation**

Achieved

**Complaints**

Target achieved for May 2016. Complaints responded to within 25 working days' now refers to those responses made during reporting month. This is no longer in arrears, but trend data is not

**Emergency Department Friends and Family Test**

Summary

| 2015/16 | Responses | | | | | | |
|---|---|---|---|---|---|---|---|
| Month | Positive | % Positive | Negative | % Negative | Total | Discharges | Response Rate |
| January 2016 | 245 | 94% | 14 | 5% | 260 | 6681 | 4% |
| February 2016 | 361 | 92% | 23 | 6% | 394 | 6480 | 6% |
| March 2016 | 245 | 85% | 29 | 10% | 287 | 7158 | 4% |

| 2016/17 | Responses | | | | | | |
|---|---|---|---|---|---|---|---|
| Month | Positive | % Positive | Negative | % Negative | Total | Discharges | Rate |
| April 2016 | 259 | 90% | 19 | 7% | 288 | 6261 | 5% |
| May 2016 | 298 | 92% | 22 | 7% | 324 | 6742 | 5% |

**Inpatient Friends and Family Test**

Summary

| 2015/16 | Responses | | | | | | |
|---|---|---|---|---|---|---|---|
| Month | Positive | % Positive | Negative | % Negative | Total | Discharges | Response Rate |
| January 2016 | 346 | 95% | 8 | 2% | 366 | 3065 | 12% |
| February 2016 | 357 | 89% | 25 | 6% | 399 | 3168 | 13% |
| March 2016 | 405 | 94% | 12 | 3% | 430 | 3061 | 14% |

| 2016/17 | Responses | | | | | | |
|---|---|---|---|---|---|---|---|
| Month | Positive | % Positive | Negative | % Negative | Total | Discharges | Response Rate |
| April 2016 | 567 | 97% | 6 | 1% | 587 | 3033 | 19% |
| May 2016 | 451 | 94% | 16 | 3% | 482 | 3111 | 15% |

**Outpatient Friends and Family Test**

Summary

| 2015/16 | Responses | | | | |
|---|---|---|---|---|---|
| Month | Positive | % Positive | Negative | % Negative | Total |
| January 2016 | 133 | 94% | 4 | 3% | 141 |
| February 2016 | 60 | 82% | 6 | 8% | 73 |
| March 2016 | 122 | 85% | 8 | 6% | 144 |

| 2016/17 | Responses | | | | |
|---|---|---|---|---|---|
| Month | Positive | % Positive | Negative | % Negative | Total |
| April 2016 | 120 | 90% | 7 | 5% | 133 |
| May 2016 | 150 | 88% | 9 | 5% | 171 |

**Community Services Friends and Family Test**

Summary

| 2015/16 | Responses | | | | |
|---|---|---|---|---|---|
| Month | Positive | % Positive | Negative | % Negative | Total |
| January 2016 | 796 | 98% | 8 | 1% | 812 |
| February 2016 | 947 | 96% | 10 | 1% | 983 |
| March 2016 | 742 | 99% | 4 | 1% | 753 |

| 2016/17 | Responses | | | | |
|---|---|---|---|---|---|
| Month | Positive | % Positive | Negative | % Negative | Total |
| April 2016 | 757 | 97% | 3 | 0% | 778 |
| May 2016 | 733 | 97% | 5 | 1% | 752 |

# Infection Prevention

Whittington Health NHS

| | Threshold | Trust Actual Feb-16 | Mar-16 | Apr-16 | May-16 | Trend |
|---|---|---|---|---|---|---|
| MRSA | 0 | 0 | 0 | 0 | 0 | |
| E. coli Infections* | - | 1 | 1 | 0 | 0 | |
| MSSA Infections | - | 0 | 0 | 0 | 0 | |

| | Threshold | Feb 16 | Mar 16 | Apr 16 | May 16 | 2016/17 Trust YTD |
|---|---|---|---|---|---|---|
| C difficile Infections | 17 (Year) | 0 | 0 | 2 | 0 | 2 |

* E. coli infections are not specified by ward or division

**Ward Cleanliness**

| Audit period | Trust 15/06/15 to 10/07/15 | 01/09/15 to 30/09/15 | 05/10/15 to 03/11/15 | 22/12/15 to 31/01/15 | 16/03/16 to 06/05/16 | Trend |
|---|---|---|---|---|---|---|
| Trust % | 97.9% | 97.7% | 97.8% | 98.6% | 96.9% | |

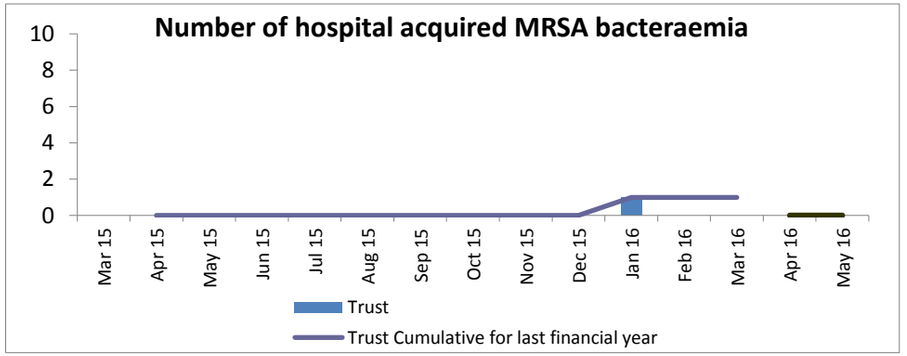
**Commentary**

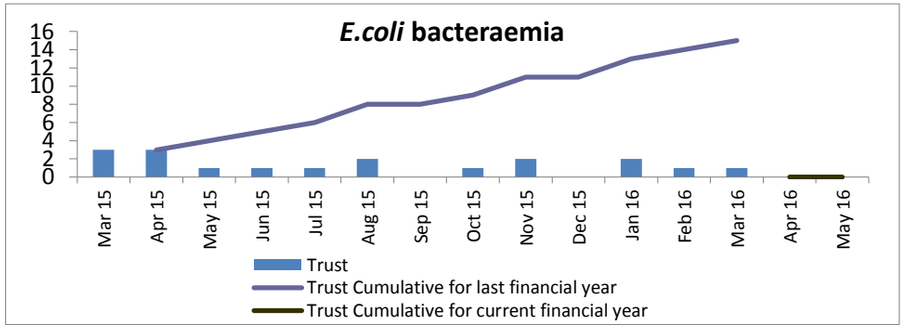
**MRSA and E.coli**
No new bacteraemia

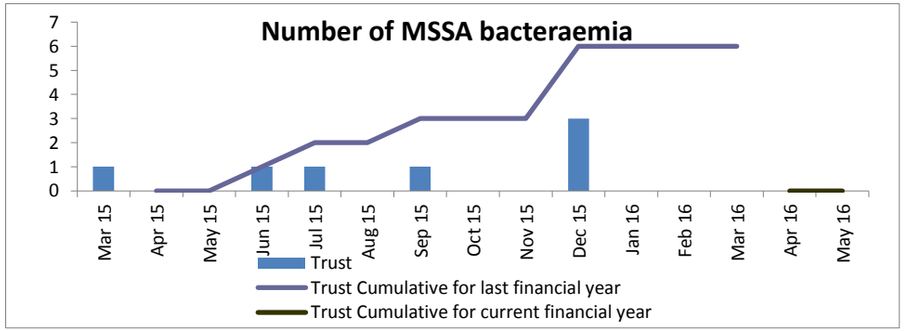
**MSSA**
No new bacteraemia

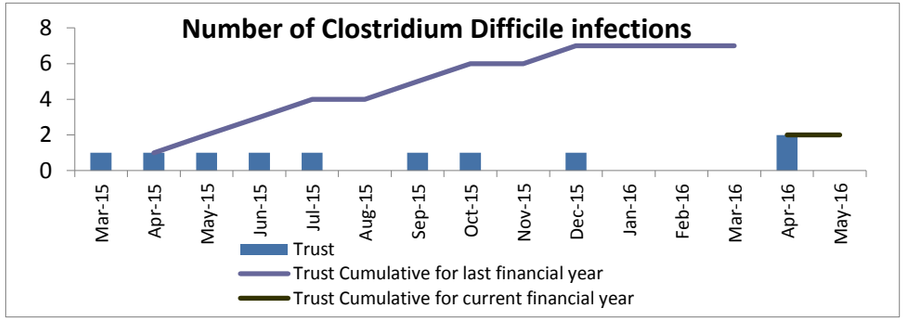
**C difficile**
Two new bacteraemia and all protocols implemented.

**Ward Cleanliness**
**Issue:** Ward Cleanliness figures between March and May 2016 have dropped to 96.9%. The area scoring under 95% are Ante Natal, ED, Clinic 3A, 4A and B and Victoria ward. All other areas score above 95%.
**Action:** A detailed action plan is in place for infection prevention, cleaning standards and audits are being carried out by Estates and matrons to ensure standards are maintained.
**Timescale:** In place.



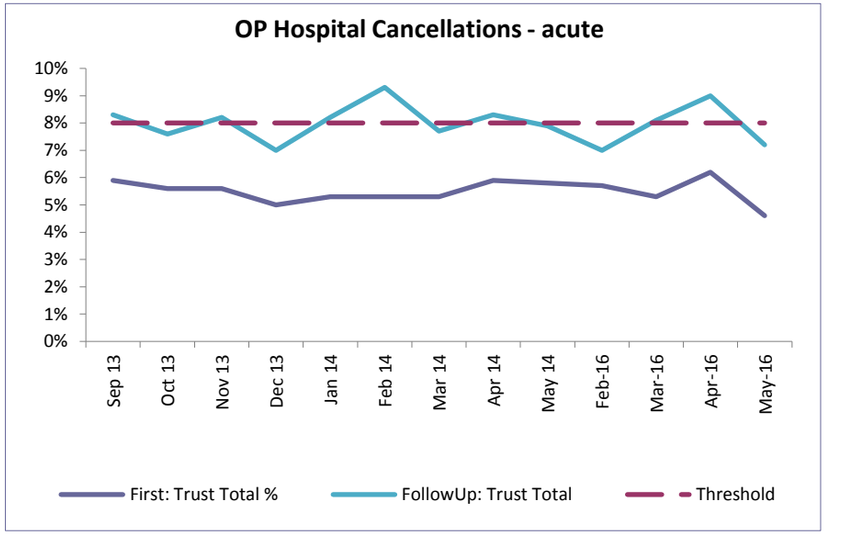



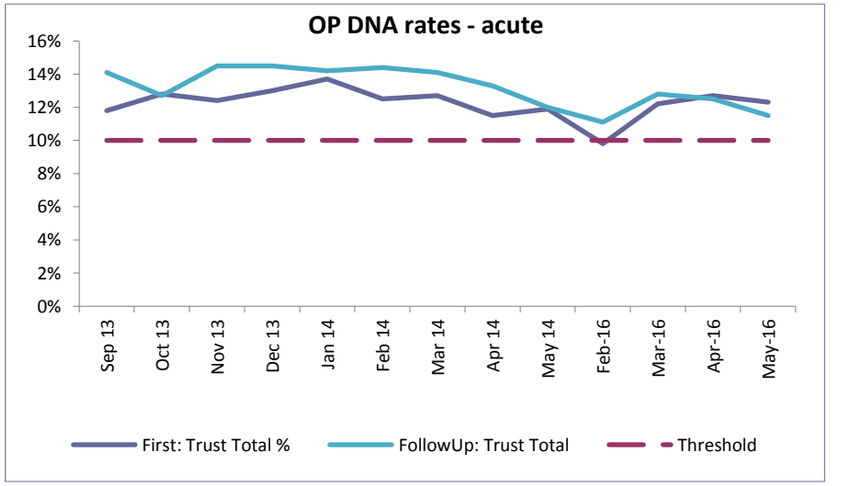



# Efficiency and productivity - acute

Whittington Health NHS

| | Trust | | | | | | |
|---|---|---|---|---|---|---|---|
| | Threshold | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Trend |
| First:Follow-up ratio - acute | 2.31 | 1.56 | 1.44 | 1.51 | 1.46 | 1.37 | |
| Theatre Utilisation | 95% | 81.9% | 81.1% | 78.3% | 78.2% | 81.1% | |
| Hospital Cancellations - acute - First Appointments | <8% | 5.8% | 5.7% | 5.3% | 6.2% | 4.6% | |
| Hospital Cancellations - acute - Follow-up Appointments | <8% | 7.9% | 7.0% | 8.1% | 9.0% | 7.2% | |
| DNA rates - acute - First appointments | 10% | 11.9% | 9.8% | 12.2% | 12.7% | 12.3% | |
| DNA rates - acute - Follow-up appointments | 10% | 12.0% | 11.1% | 12.8% | 12.5% | 11.5% | |
| Hospital Cancelled Operations | 0 | 16 | 3 | 3 | 19 | 4 | |
| Cancelled ops not rebooked < 28 days | 0 | 0 | 0 | 0 | 0 | 0 | |
| Urgent Procedures cancelled | 0 | 0 | 0 | 0 | 5 | 4 | |
| Urgent Procedures cancelled (of these how many cancelled 2nd time) | 0 | 0 | 0 | 0 | 0 | 0 | |




**Commentary**

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**Theatre Utilisation**

Improvement from last month to 81.1% during May 2016, in addition the number of cases being undertaken in theatres has increased due to replacement of vacant surgeons post. Three theatre lists which are not productive and have a low utilisation are stopping from week beginning 4th July 2016. This should improve performance in July 2016. A theatre utilisation dashboard is to be developed with IT to include a range of metrics in line with the Theatre Benchmarking guidelines. This will then be incorporated in the overall Trust dashboard when it is refreshed in the Autumn.

**Hospital Cancellations**

Within target as expected.

**DNA**

Just under target for both first and follow up appointments, but improving as expected.

**Action:** Further improvement to be expected month on month, using NetCall and continuing drive to update the EPR systems with patient details when attending appointments.

**Timescale** expected improve over the next months.

**Hospital Cancelled Operations**

**Issue:** There were 4 reportable cancelled operation of which all were urgent procedures. All were cancelled by the urology service due to no SHO available on the day which was unexpected . All operation were rescheduled within 28 days.

# Efficiency and productivity - Community

Whittington Health NHS

| | Trust | | | | | |
|---|---|---|---|---|---|---|
| | Threshold | Feb-16 | Mar-16 | Apr-16 | May-16 | Trend |
| Service Cancellations - Community | 8% | 6.5% | 6.5% | 7.0% | 5.7% | |
| DNA Rates - Community | 10% | 5.9% | 5.6% | 6.0% | 5.8% | |
| Community Face to Face Contacts | - | 58,307 | 58,490 | 58,718 | 58,331 | |
| Community Appointment with no outcome | 0.5% | 0.9% | 0.4% | 2.5% | 5.9% | |

N.B. From October 2014, figures include Community Dental activity (SCD)

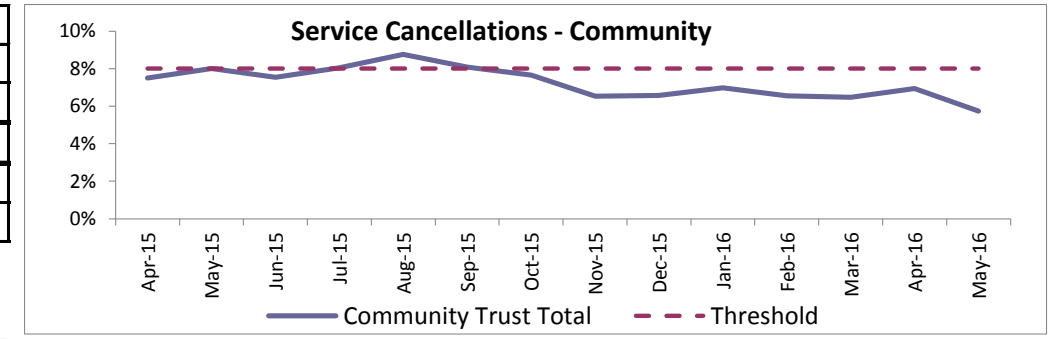
**Commentary**

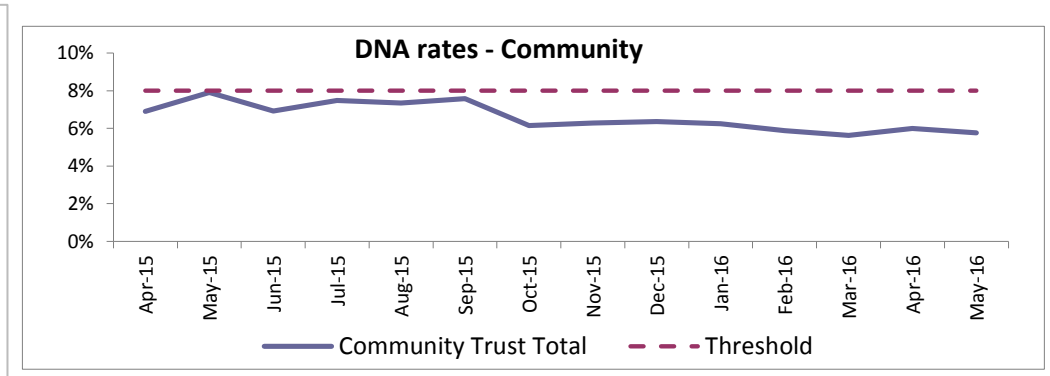
**Service Cancellations - Community**
Achieved

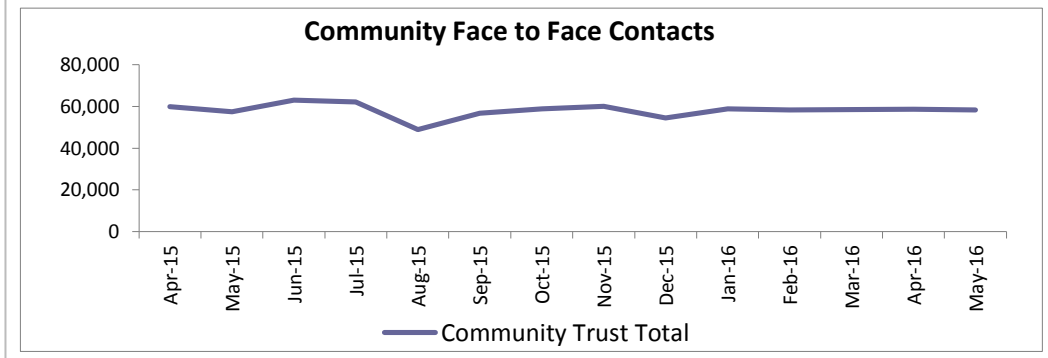
**DNA Rates - Community**
Achieved.

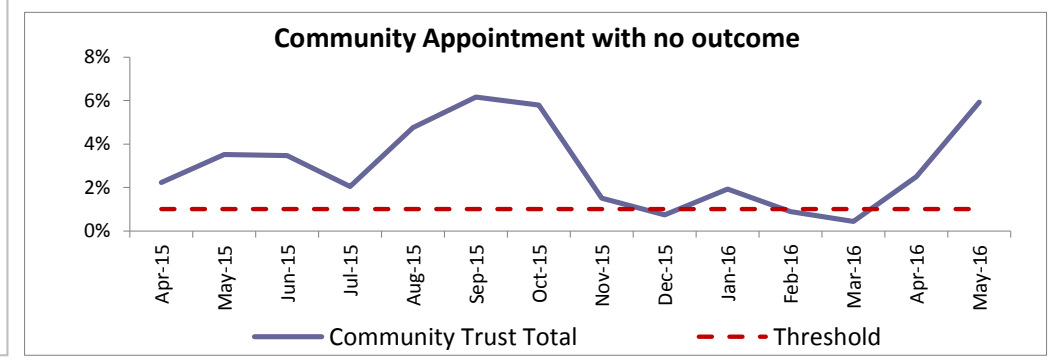
**Community Face to Face Contacts**
All services are monitored against activity targets.

**Community Appointment with no outcome**
Not achieved.
**Issue:** Appointments are not outcomed on the electronic systems for services with high volume appointments. This month DN had more unoutcomed appointments as usual, but all unoutcomed appointments shave now been completed.
**Action:** Electronic reports are in place for Services to monitor their unoutcomed appointments. All appointments are outcomed retrospectively before submission to SUS.
**Timescale:** in place



| | Threshold | Trust Actual Mar-16 | Trust Actual Apr-16 | Trust Actual May-16 | Trust YTD |
|---|---|---|---|---|---|
| District Nursing Wait Time - 2hrs assess (Islington) | - | 83.3% | 66.7% | 60.0% | 66.7% |
| District Nursing Wait Time - 2hrs assess (Haringey) | - | 90.9% | 94.1% | 97.1% | 94.1% |
| District Nursing Wait Time - 48hrs for visit (Islington) | - | 100.0% | 95.3% | 95.0% | 95.3% |
| District Nursing Wait Time - 48hrs for visit (Haringey) | - | 97.7% | 96.3% | 99.1% | 96.3% |
| MSK Waiting Times - Routine MSK (<6 weeks) | 95% | 49.2% | 41.5% | 39.5% | 40.5% |
| MSK Waiting Times - Consultant led (<18 weeks) | 95% | 82.2% | 59.6% | arrears | 59.6% |
| IAPT - patients moving to recovery | 50% | 46.6% | 47.4% | arrears | 47.4% |
| GUM - Appointment within 2 days | 98% | 98.9% | 98.7% | 98.5% | 98.6% |
| Haringey Adults Community Rehabilitation (<6weeks) | 85% | 88.2% | 89.3% | 86.5% | 88.0% |
| Haringey Adults Podiatry (Foot Health) (<6 weeks) | - | 52.4% | 50.2% | 51.3% | 50.8% |
| Islington Community Rehabilitation (<12 weeks) | - | 93.2% | 88.8% | 86.1% | 87.5% |
| Islington Intermediate Care (<6 weeks) | 85% | 72.5% | 74.3% | 73.5% | 73.9% |
| Islington Podiatry (Foot Health) (<6 weeks) | - | 54.6% | 36.0% | 41.9% | 38.7% |
| IAPT Waiting Times - patients waiting for treatment (% < 6 weeks) | 75% | 96.8% | 95.7% | arrears | 95.7% |
| Death in place of choice | 90% | 75.0% | 95.0% | 100.0% | |
| Number of DN teams completing a monthly review of Patients of Concern (POC) (eight teams) | 8 | 8 | 4 | 8 | |
| Number of DN teams completing a monthly caseload review of timely discharge (eight teams) | 8 | 8 | 3 | 8 | |

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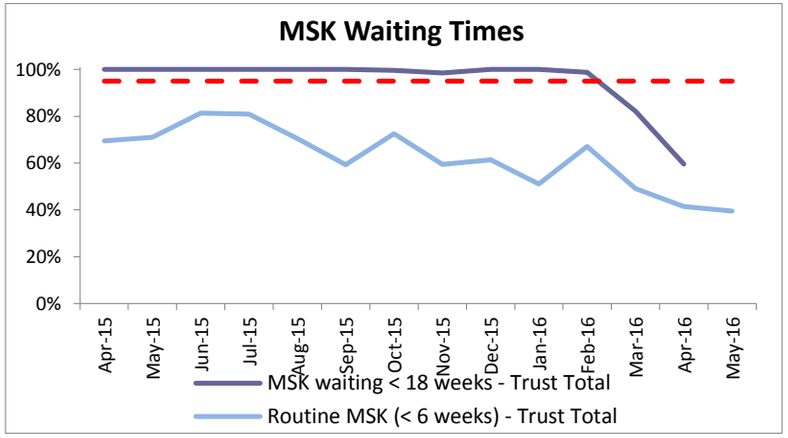


**District Nursing**
Urgent referrals are still called through and recording of these referrals is manual and retrospective. This means that the quality of the data mentioned above is still affected. Failure to respond within the call out time is recorded on Datix as a missed visit incident. There has not been an increase in missed visits. There has also not been a rise in complaints related to urgent wait times. It can be conclude that the quality of care has not been impacted on.
**Issue:** Amending data capture/recording to also reflect urgent requests and visit times .
**Action:** The service's imminent E-community platform will accurately capture when unplanned visits are added to the workload, the urgency, and when they are actioned by a healthcare professional
**Timescale:** Pilot launch scheduled for September 2016.

**Number of DN team reviewing POC and timely discharge**
**Issue:** No issues, targets met
**Action:** Teams will work to maintain the standard achieved
**Timescale:** June 2016

**Death in Place of choice:**
The district nursing teams and their palliative link nurses have worked hard to sensitively address with service users the preferred place of care. For the first time 100% of service users had end of life care in the environment they had chosen which is a remarkable achievement.
**Issue:** No issues, targets met
**Action:** Work with teams to consolidate and encourage good practice.

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**IAPT**
**Issue:** 'Recovery rate showing steady improvement in line with clinical improvement plan. May data submitted to Department of Health now showing recovery rate of 51.64% (target 50%) with reliable improvement - 66.03%
**Action:** all staff now receive their own recovery rates each quarter and have in place individual action plans when these are below 50%.

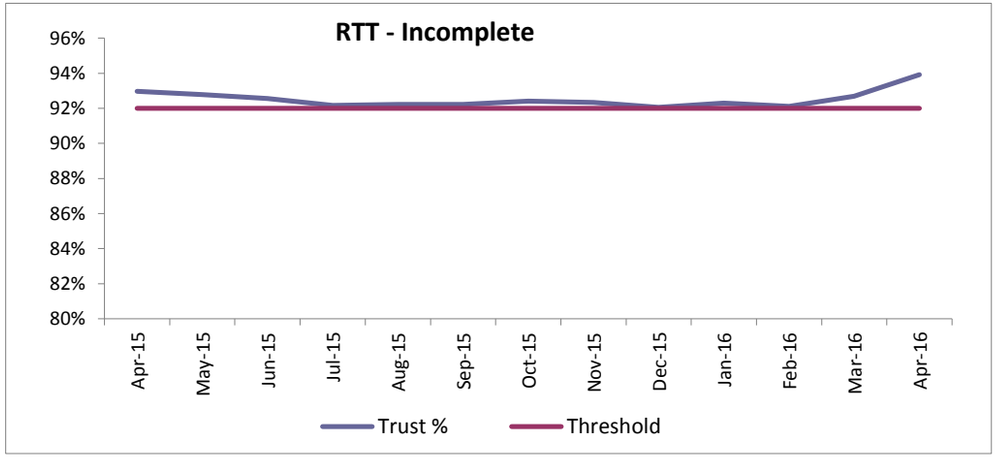
**MSK:**
Actions from April 16:
Continued working with CCG on improving access times. Second Performance Improvement notice meeting held on 31st May. Remedial action plan follow-up papers completed and submitted 10th June 15. This included Self-referral criteria and establishing a group of GPs to review this. Further capacity and demand figures were also provided. Now awaiting CCG response and new meeting date in July 2016.
Recruitment rounds in April complete. Recruitment continues throughout May and June.
**Issue:** Further reduction in both 6 week and 18 weeks waiting times. Focus on clearing backlog impact on increase in waiting times figures. Two locums have now started and the impact on the June figures will be minimal, but improvement to be seen in August, September Trust Dashboard. Average wait remains 6 weeks, which is up from 5 weeks last year in the same period.
**Action:** Further capacity work to be done in the last week of June 2016.
**Timescale:** Next meeting with the CCG in July 2016

**Podiatry**
**Issue:** Vacant posts have resulted in increase in waiting times for new patient as well as routine reviews. Slight improvement seen in waiting times in May 2016.
**Action:** Two locums full time currently in place (started late May '16) to help clear the wait times – and there has been an improvement in wait times since April in Podiatry. Recruited staff are now started to come into post.
**Timescales:** Improvement in waiting times from June 2016, but more noticeable from July 2016 onwards.

# Referral to Treatment (RTT) and Diagnostic waits

Whittington Health NHS

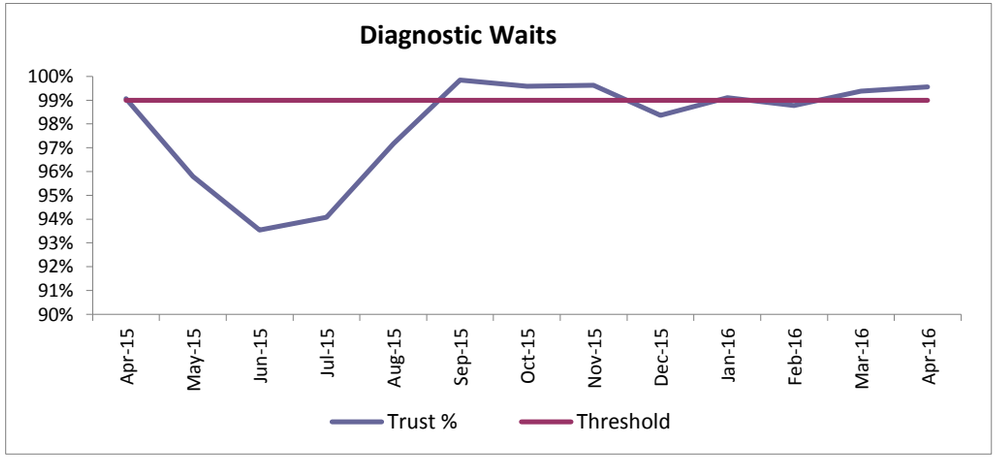
| | Trust | | | | |
|---|---|---|---|---|---|
| | Threshold | Feb-16 | Mar-16 | Apr-16 | Trend |
| Referral to Treatment 18 weeks - Admitted | 90% | 77.4% | 76.6% | 77.3% | |
| Referral to Treatment 18 weeks - Non-admitted | 95% | 91.4% | 90.8% | 89.2% | |
| Referral to Treatment 18 weeks - Incomplete | 92% | 92.1% | 92.7% | 93.9% | |
| Referral to Treatment 18 weeks - 52 Week Waits | 0 | 0 | 0 | 0 | |
| Diagnostic Waits | 99% | 98.8% | 99.4% | 99.6% | |




**Commentary**

**RTT**
National KPI for 18 weeks incomplete achieved.
**Issues:** 18 weeks admitted and non-admitted data reported above is un-validated.
**Action:** Focus on Incomplete RTT data will improve the Admitted and non-Admitted targets.
**Timescale:** Stepped improvement to be seen in the next months.

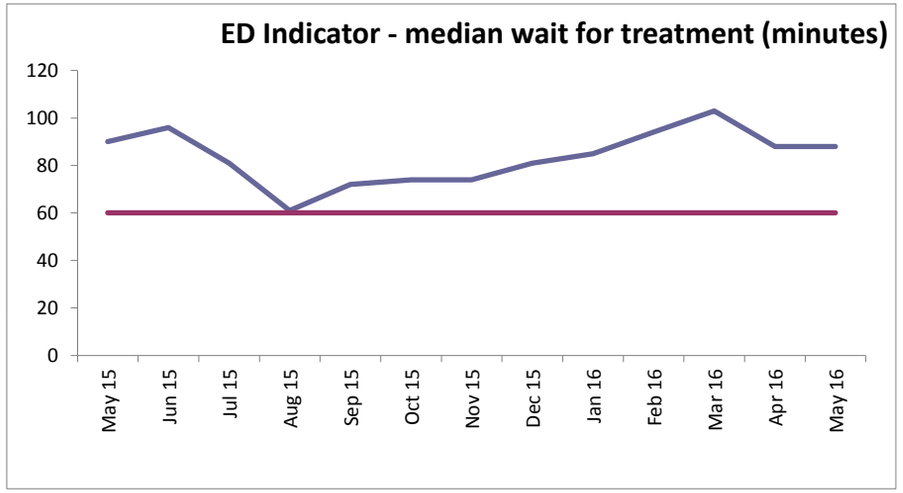
**Diagnostic Waits**
Target achieved as expected.

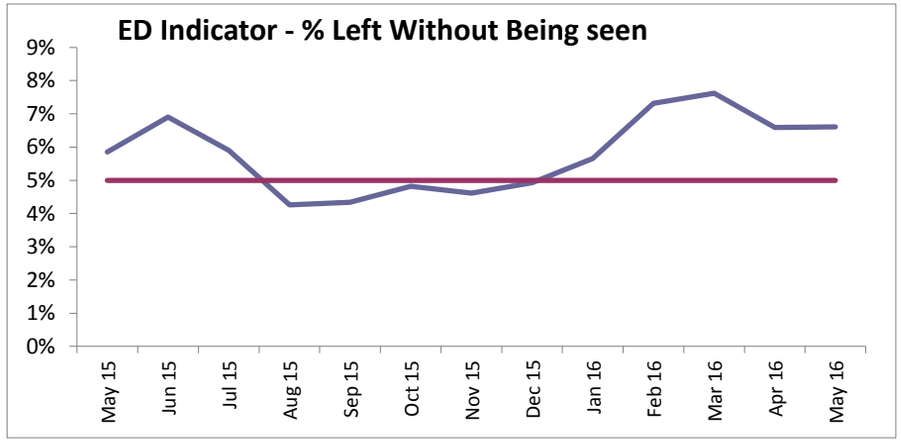


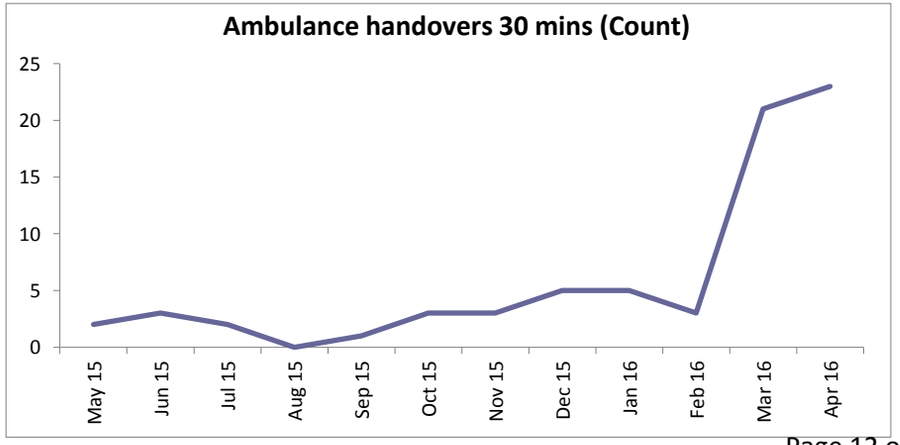
# Emergency Care

Whittington Health NHS

| | Threshold | Trust Actual Apr-16 | Trust Actual May-16 | 2016/17 Trust YTD |
|---|---|---|---|---|
| Emergency Department waits (4 hrs wait) | 95% | 84.1% | 85.9% | 85.0% |
| Emergency Department waits (4 hrs wait) Paeds only | 95% | 93.3% | 95.4% | 94.4% |
| Wait for assessment (minutes - 95th percentile) | <=15 | 19 | 18 | 18 |
| ED Indicator - median wait for treatment (minutes) | 60 | 88 | 88 | 88 |
| Total Time in ED (minutes - 95th percentile) | <=240 | 504 | 462 | 484 |
| ED Indicator - % Left Without Being seen | <=5% | 6.6% | 6.6% | 6.6% |
| 12 hour trolley waits in A&E | 0 | 0 | 2 | 2 |
| Ambulance handovers 30 minutes | 0 | 23 | arrears | 23 |
| Ambulance handovers exceeding 60 minutes | 0 | 0 | arrears | 0 |
| Ambulatory Care (% diverted) | >5% | 2.9% | 2.8% | |




**Commentary**

There has been further improvements seen in May 16, but all but one indicator remain below the threshold. Paediatric 4 hours wait achieved target.

**ED four hour wait** continues to remain a significant challenge across the sector. Lack of available bed are an issue. Following the workshop on the 12th May an in-depth improvement plan has been put in place with the focus on 5 main areas: pre 11 am discharge / criteria led discharge/ reducing LOS over 7 days/ improving speciality response to ED/ bench marking top 10 HRG LOS
the business case for additional consultants was approved at TOB in June 2016.

**Left without being seen** remains above the 5% threshold. It should be noted the patients are taken off our EPR system, but any concerns are followed up by clinical staff contacting the patient's GP.

**12 hour trolley wait -** two informal mental health patients waited in excess of 12 hours for a mental health bed due to non availability of mental health beds.

**Ambulance handovers 30 minutes** have increased significantly this month, due to congestion in ED. It is expect to reduce back to normal levels next month.

The number of patients **diverted to Ambulatory Care** has remained between 2 and 3.5% for the last 18 months. A weekly monitoring plan is in place.

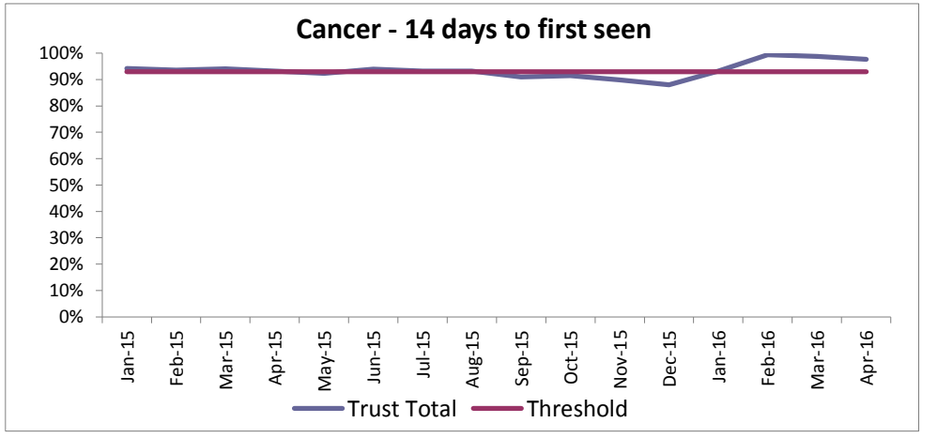
# Cancer

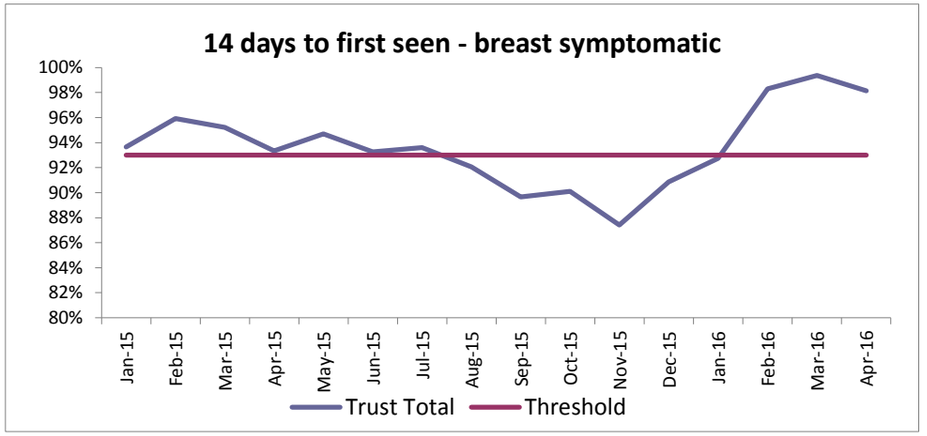
Whittington Health NHS

| | Threshold | Trust Feb-16 | Trust Mar-16 | Trust Apr-16 | Trend | 2016/17 Trust Q1 | Q2 | Q3 | Q4 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|
| Cancer - 14 days to first seen | 93% | 99.5% | 98.8% | 97.6% | | 97.6% | - | - | - | 97.6% |
| Cancer - 14 days to first seen - breast symptomatic | 93% | 98.3% | 99.4% | 98.1% | | 98.1% | - | - | - | 98.1% |
| Cancer - 31 days to first treatment | 96% | 100.0% | 97.7% | 100.0% | | 100.0% | - | - | - | 100.0% |
| Cancer - 31 days to subsequent treatment - surgery | 94% | 100.0% | - | - | | - | - | - | - | - |
| Cancer - 31 days to subsequent treatment - drugs | 98% | 100.0% | 100.0% | 100.0% | | 100.0% | - | - | - | 100.0% |
| Cancer - 62 days from referral to treatment | 85% | 81.6% | 88.5% | 88.1% | | 88.1% | - | - | - | 88.1% |
| Cancer - 62 days from consultant upgrade | - | 50% | 50% | - | | - | - | - | - | - |

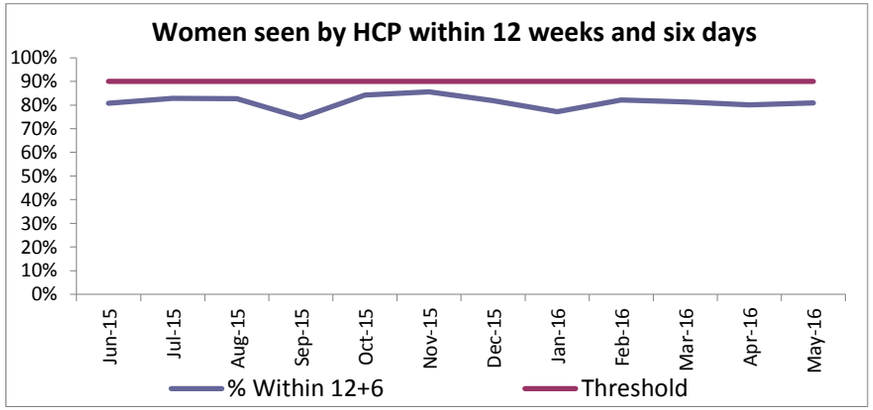
**Commentary**

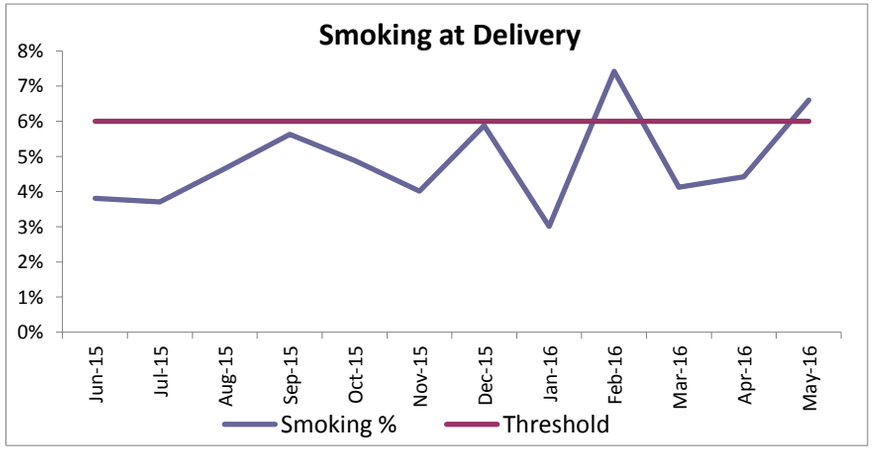
All targets achieved as expected for April 2016.



| | Threshold | Trust Actual Mar-16 | Trust Actual Apr-16 | Trust Actual May-16 | 2016/17 Trust YTD |
|---|---|---|---|---|---|
| Women seen by HCP or midwife within 12 weeks and 6 days | 90% | 81.3% | 80.1% | 80.9% | 80.5% |
| New Birth Visits - Haringey | 95% | 85.7% | 88.6% | Arrears | 88.6% |
| New Birth Visits - Islington | 95% | 94.7% | 95.1% | Arrears | 95.1% |
| Elective Caesarean Section rate | 14.8% | 8.8% | 10.5% | 12.0% | 11.3% |
| Emergency Caesarean Section rate | - | 18.4% | 14.2% | 19.1% | 16.7% |
| Breastfeeding initiated | 90% | 93.0% | 90.9% | 92.1% | 91.5% |
| Smoking at Delivery | <6% | 4.1% | 4.4% | 6.6% | 5.5% |




**Commentary**

**12+6**

**Issue:** Remaining just below target. Issue is with DNA's.
In May 422 bookings were completed , higher than the previous month. 56 referrals were received outside of 12+6 weeks. 37 patients booked outside of 12+6 due to patient choice. 86 DNA.
**Action:** member of bank staff now in place to focus on DNA's. Improvement to be seen in two months.
**Timescale:** August/September 2016

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**New birth visits**

**Issue:** Islington within target and Haringey just below target, correlating with HV workforce.
Reasons for late visits

Islington - 95.1%

Eleven visits were late this month. Five babies were still in hospital when the New Birth visit was due, 5 parents moved their appointment (Patient Choice) and one birth notification cam in late.

Haringey - 88.6%

32 visits were late this month. 12 babies were still in hospital when the New Birth visit was due, 2 parents required Interpreter resulting in a delay in the New birth visit. 13 visits could not be scheduled in time due to parents requesting different times or the Health Visiting Service was not able to contact them in time. One visit was cancelled due to Health & Safety (dangerous dog) and two visits were late due to the family newly moving into the area. Two further visits were late due to re-allocation within the service and administrative complication.
**Action:** Continued workforce plan in place to mitigate. New staff in the process of starting.
**Timescale:** Ongoing

**Smoking at Delivery**

**Issue:** CO screening pilot completed in February and since the pilot was completed the number of patients accessing the cessation services has decreased, the ICSU are doing work around this. The evaluation for the CO screening pilot will be out soon.
**Action:** When we implement CO monitoring for all women in late June or early July, we hope to see a further fall in the number of smokers in pregnancy and at delivery.
**Timescale:** within target next month.

# High Level Workforce Data

Whittington Health NHS

| Metric | Target or Benchmark | Source | Apr-16 | May-16 | Notes and Definitions |
|---|---|---|---|---|---|
| Staff Headcount | Trust Annual Plan | ESR | **4,212** | **4,238** | No. of staff employed at the end of the quarter |
| Staff in Post (FTE) | Trust Annual Plan | ESR | **3,837.16** | **3,857.06** | No. of staff employed at the end of the quarter |
| Establishment (FTE) | Trust Annual Plan | Finance Ledger | **4,401.71** | **4,403.13** | |
| Bank and Agency Use(hours) | | Bank Staff System | **8252.47** | | This equates to around 220 fte |
| Vacancy Rate % | 10% | Calculation | **12.9%** | **12.4%** | The vacancy factor in qualified nursing has reduced from 21% to 14%. There is much focus on substantive and bank recruitment to HCA roles. The vacancy rate for HCAs has fallen from 21% to 17.6%. |
| Annual Turnover % | >13% - red<br>10-12% - amber<br><10% - green | ESR | **14.9%** | **14.9%** | Children's Services and Women's Services remain below 13%. All other ICSU's are above the threshold for turnover - ranging from 15%(Surgery) to 22.1%(OP&LTC). In Corporate areas Finance had the highest turnover with 25.9% |
| Sickness % | > 3.5% - red<br>2.5-3.5% - amber<br><2.5% - green | ESR | **2.9%** | **3.3%** | All areas are below 3.5% with the exception of : Finance 6.7%, Facilities 6.2% and Emergency and Urgent Care 6.7% |
| Appraisal Completion % | 90% | ESR/OLM | **71%** | **69%** | |
| Mandatory Training % | 90% | ESR/OLM | **81%** | **81%** | Percentage of staff compliant for mandatory training. Requirements vary by staff group and roles. |

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Whittington Health NHS

Trust Board 1 June 2016

| | | | |
|---|---|---|---|
| **Title:** | Community Engagement Model | | |
| **Agenda item:** | **16/089** | **Paper** | **09** |
| **Executive Summary:** | The Trust Board has agreed a number of corporate objectives for this year and one of the most important for our future is to develop our community engagement model. This paper proposes our approach to creating an innovative model for Whittington Health over the coming year, resulting in a Community Engagement Strategy coming to the Trust Board for approval in December 2016.<br><br>The shadow governor arrangement ceased in April and the new Whittington Health Forum has been meeting monthly since this time. The key objectives of the forum are to engage fully in the work of the Trust and support the development of our community engagement strategy.<br><br>Membership of the Forum is to be inclusive and to date has initially invited former shadow governors, volunteers, Healthwatch colleagues, community representatives and voluntary sector groups. The invites have been extended to previous members on the members database and a flyer has been published in the local paper.<br><br>Our next steps<br><br>• Meeting with both Islington and Haringey Healthwatch to benefit from their experience of working within the community and engaging with our local communities.<br>• Increasing the range and breadth of the community invited to join the forum.<br>• Web page and email address (whh-r.WhittingtonForum@nhs.net) have been set up.<br>• Co-creating the principles on which the new Forum will operate. The Trust values will be reflected in the manner in which the Forum is both organised and run. These include inclusiveness, openness and transparency.<br>• Approaches to both the Council and to Trust staff will be considered as part of the plan to expand substantially the database of contacts.<br>• During the inaugural meetings of the Forum we will establish a smaller working group to consider the programme of events, the structure, terms of reference and an action plan to sustain and expand the Forum.<br>• Continuing to work through issues such as data protection as we aim to extend and expand the Forum and our use of digital media.<br>• Discussing on a monthly basis at the Forum issues such as | | |

| | |
|---|---|
| | strategic developments across our local area; updating on current issues such as the implementation of the estates strategy and ongoing developments in integrating care.<br><br>The Deputy Chief Executive is leading this project supported by the Chairman of the Trust and some support from the Communications team.<br><br>A volunteer has been recruited two days per week to handle some of the database administration.<br><br>Resources will need reviewing in line with the success of the work of the Forum and a business case will be developed. |
| **Summary of recommendations:** | The Trust Board are asked to consider the following recommendations<br><br>• The Board actively support the development of the Forum<br>• The Board should receive a progress report on the work of the Forum in the Autumn<br>• The Board support the proposed approach to developing our Community Engagement strategy |
| **Fit with WH strategy:** | Aligns with Clinical Strategy, Communication and Engagement Strategy |
| **Reference to related / other documents:** | Whittington Health PPI Toolkit |
| **Reference to areas of risk / BAF:** | Captured on relevant Risk Register |
| **Date paper written:** | 30 June 2016 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Author name and title:** | | **Siobhan Harrington, Deputy CEO/Director of Strategy** | | **Director name and title:** | | **Siobhan Harrington, Deputy CEO/Director of Strategy** | |
| **Date paper seen by TMG** | **5 /7** | **Equality Impact Assessment complete?** | **n/a** | **Quality Impact Assessment complete?** | **n/a** | **Financial Impact Assessment complete?** | **n/a** |

# Whittington Health
# Community Engagement Model
# Update to the Trust Board

1. Introduction.

The Trust Board has agreed a number of corporate objectives for this year and one of the most important for our future is to develop our community engagement model. This paper proposes our approach to creating an innovative model for Whittington Health over the coming year, resulting in a Community Engagement Strategy coming to the Trust Board for approval in December 2016.

Recent reports about NHS care, in particular the Francis Inquiry (2013), have made a call for real patient and public involvement in all that we do and a cultural change across the NHS to ensure greater openness, transparency and a duty of candour to patients.

There are many examples of how we have successfully and at times not so successfully engaged and involved patients and the public in our work. We know that there is more that we can do to ensure the voices of patients, carers and public stakeholders are central to how we work as a Trust.

The duty to involve patients in the development of services and in their individual care and treatment is also central to the NHS Constitution.

The Five Year Forward View (2014) 'sets out how the health services needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill health.' It proposes 'a new relationship with patients and communities'. This paper proposes how we aim to take forward that new relationship with our local communities.

The Trust Clinical Strategy (2015) reaffirms the importance of our relationship with our community and local partners.

This approach will result in a strategy which will build on the previous Stakeholder Engagement Strategy 2014 and the Patient and Public Involvement action plan and toolkit approved at the Board in February this year.

2. Background

Our Patient and Public involvement action plan identified a number of objectives in February that are pertinent to this agenda:

Patients, Families and carers' engagement

- Build a culture that puts our patients and people who use our services at the heart of everything we do
- Ensure patients and their carers are involved at all levels across the organization
- Listen, learn and act on patient feedback to drive continuous improvement
- Enable confidence in our service through an effective and responsive complaints process

Community and other stakeholder engagement

- Engage more effectively with our community through ongoing dialogue with our local population and key stakeholders to ensure their views are listened to and reflected in improved services, their development, future plans and redesign
- Have an ongoing relationship with our stakeholders so they feel involved, considered and can make a difference

In April 2016 the Trust conducted a review of governance arrangements including Board Standing Orders, Board Committees and Terms of Reference.

Alongside this as the Trust Development Authority came together with Monitor to become NHS Improvement, the drive for all Trusts to aspire to Foundation Trust status was slowed with a change in emphasis to 'earned autonomy'.

The Trust had in the past recruited members and contact details have been held on a database. Communication with members has been minimal in recent years. Our shadow governors were largely elected eight years ago for a three year term and had kindly stayed engaged whilst the detail of our journey to Foundation Trust status was not clear. The Trust originally had a number of staff and representative governors who had moved on.

These parallel events, alongside the national policy changes, have led Whittington Health to consider not only the position of our shadow governors and members but also the much broader issues of community and patient engagement. The Director of Nursing and Patient Experience is currently reviewing our approach to patient engagement and improving patient experience.

## 3. Towards a Community Engagement strategy

Following discussion with the shadow governors, it was agreed at the Board to review our community engagement model. This resulted in a commitment to build on the work of the shadow governors to develop an ambitious and effective engagement with both patients and our community. The shadow governor arrangement ceased in April and the new Whittington Health Forum has been meeting monthly since this time.

The key objectives of the forum are to engage fully in the work of the Trust and support the development of our community engagement strategy.

Membership of the Forum is to be inclusive and to date has initially invited former shadow governors, volunteers, Healthwatch colleagues, community representatives and voluntary sector groups. The invites have recently been extended to all previous members on the members database and a flyer has been published in the local paper.

Our next steps include:-

- Meeting with both Islington and Haringey Healthwatch to benefit from their experience of working within the community and engaging with our local communities.
- Increasing the range and breadth of the community invited to join the forum.
- A web page and an email address (whh-tr.WhittingtonForum@nhs.net) have been set up.
- Cocreating the principles on which the new Forum will operate. The Trust values will be reflected in the manner in which the Forum is both organised and run. These include inclusiveness, openness and transparency.
- Approaches to both the Council and to Trust staff will be considered as part of the plan to expand substantially the database of contacts.
- During the inaugural meetings of the Forum we will establish a smaller working group to consider the programme of events, the structure, terms of reference and an action plan to sustain and expand the Forum.
- Continuing to work through issues such as data protection as we aim to extend and expand the Forum and our use of digital media.
- Discussing on a monthly basis at the Forum issues such as strategic developments across our local area; updating on current issues such as the implementation of the estates strategy and ongoing developments in integrating care.

The Deputy Chief Executive is leading this project supported by the Chairman of the Trust and some support from the Communications team.

A volunteer has been recruited two days per week to handle some of the database administration. Resources will need reviewing in line with the success of the work of the Forum and a business case will be developed.

4. What will success look like?

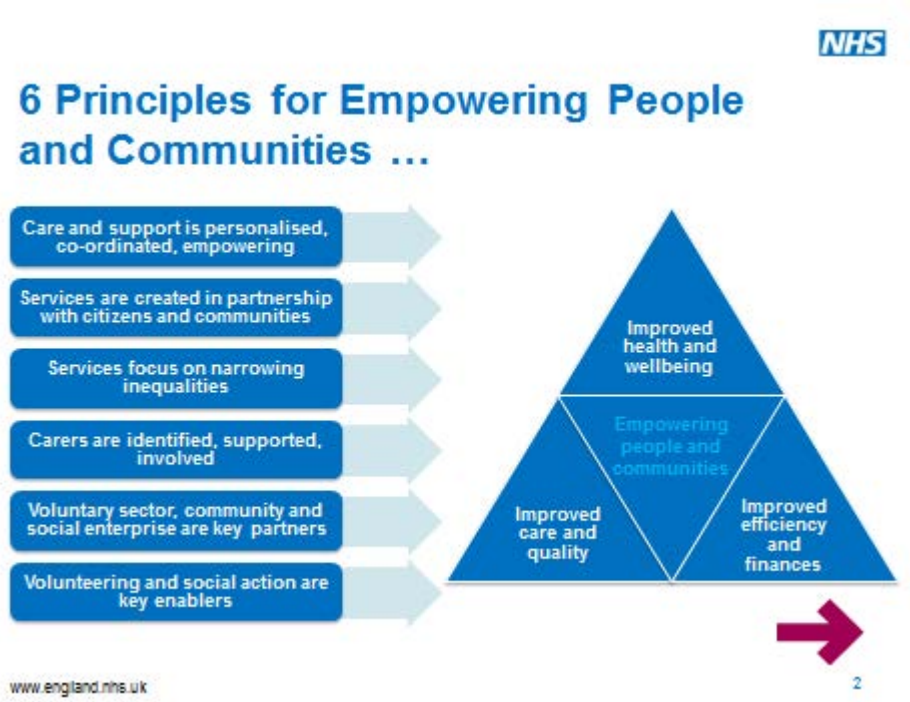
The plan is to engage a substantial number of people in this process who are from our local catchment area.

Trust activities and events will be both developed with and supported by members of our community and Forum members.

A Community Engagement Strategy will be in place. The key elements of the strategy could cover involvement in strategy development and transformation ; assurance; fund raising and open days. We would aim to utilise this engagement in supporting the culture change in cocreating and coproduction which will help us deliver our key strategic goals in relation to prevention and self-management.

We want our strategy to build on those things we do now as well as developing new ways of working too: from involving patients, carers and the public in recruitment, education and training of our workforce, to the design of services.

There are many models of Community engagement and through the development of the strategy there will be more consideration of the models. Patient Voices (2013) promoted by NHS England has published principles of empowering people and communities and we would consider incorporating these into our work.



Digital communication will be the ‘default’ method of communicating with our community although we will engage with people as required to maximise the breadth of engagement across all the community.

## 5. Conclusion

There is a widespread view that Whittington Health has a very strong relationship with its local community. The time is right to confirm this, to build on it and to sustain it.

As an innovative organisation we want to be at the forefront of new models of community involvement and engagement.

The Trust Board are asked to consider the following recommendations:-

1) The Board actively support the development of the Forum.
2) The Board should receive a progress report on the work of the Forum in the Autumn.
3) The Board support the proposed approach to developing our Community Engagement strategy.

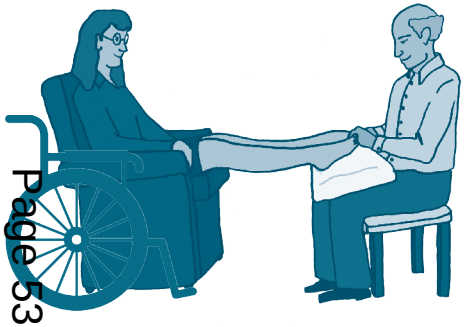
June 2016.

# Having an impact in 2016

healthwatch Islington

healthwatch Network awards
WINNER 2016

The work of our volunteers, and our approach to volunteering, was celebrated as the best in the country at the Healthwatch network awards in June. Our project on mental health services for young adults and our ongoing partnership with 'Help on Your Doorstep' (where staff and volunteers go out door knocking on local housing estates to offer support and learn about residents' needs) were singled out for particular praise.



We worked with Islington Council and two local providers, to reach some 600 people receiving council funded care in their own homes. We provided signposting to those that needed it, helping with enquiries about how individual contributions to the costs of home care were calculated, and giving out complaints information. We also carried out phone interviews, gathering some great feedback on people's experiences of home care which we are publishing and sharing with commissioners this summer.

The work we began nearly two years ago, to increase the use of interpreting services in our GP practices, is beginning to show results. Overall the number of bookings in the last six months has increased, and more practices are offering interpreting. Islington Clinical Commissioning Group have told us that our involvement has really helped them to prioritise this work and expand the monitoring of usage rates. We've also worked directly with community organisations supporting clients who find it difficult to communicate in English, and have produced EasyRead guidance in Arabic, Greek, Spanish and Turkish about getting interpreting support at the doctors.

Our mystery shoppers visited local hospitals and phoned local GP practices, to find out how easy it was for patients on low incomes to receive support under the Healthcare Travel Costs Scheme. Our findings brought about an immediate change of policy at Moorfield's Eye Hospital, and an eventual one at the Whittington. Islington Clinical Commissioning Group also promised to raise awareness of the scheme with GP practices across the borough, and to work with the council to promote it directly to patients likely to be able to benefit.

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# Healthwatch Islington

## Annual Report 15/16 and work plan 16/17

**Health and Care Scrutiny, July 2016**

# 2015/16

- Young adults and mental health,
- Healthcare Travel Costs – removing barriers to access,
- Access to GP services within care homes,
- Experiences of the new extended hours GP service,
- Supporting involvement in the procurement of advocacy services,
- Developed a partnership with nine local community groups to influence CCG commissioning,
- Progressed access to interpreting services,
- Still struggling to improve access for Deaf patients,
- Developing cross-borough working in North East Central London,
- Strengthening our volunteer offer with a bespoke training programme.

# 2016/17

- Home care (user stories),
- Autism (how services make reasonable adjustments)
- Accessible Information Standard,
- Scoping older people and mental health,
- Following up previous work.

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healthwatch Islington

# Annual Report 2015/16

# Contents

# Message from our Chair

Another great year, thanks to all our volunteers and partners.

It's been another great year for Healthwatch Islington. We have continued to extend our reach in to the local community, hearing from more and more people about their experiences of services.

We have hosted stalls all over the borough, worked with a range of partners to reach people who may not speak English and knocked on hundreds of doors to spread the Healthwatch message.

Partners have helped us to collect views on London-wide sexual health services, talk to people about how they manage their own health, and what they need from hospital services.

The achievements of our volunteers were recognised by the Mayor of Islington who presented certificates at our annual event. The teams have influenced the design of mental health services, plans around GP access for care home residents, promotion of the Healthcare Travel Costs Scheme, and new models for delivering GP appointments 7-days a week.

Volunteers' work from previous years means that local GP practices are offering more patients interpreting services, and display clearer information about complaints processes. This report showcases some of their wonderful work.

Our local university London Metropolitan offered us space to run our AGM and we trained and supported health and social care students to facilitate discussions about local services. Our cross-borough work to train volunteers with Disabilities won us two Healthwatch England awards.

We continue to work closely, as a candid friend, with our local council, Clinical Commissioning Group and local GPs. We hope to strengthen these relationships and those with providers as our organisation grows.

Thank you to all our volunteers, staff and partners for what we have achieved so far. We look forward to asserting an even stronger influence in the months ahead.

> **"The achievements of our volunteers were recognised by the Mayor of Islington"**

# The year at a glance

**1,218 Twitter followers engaging with us via social media**

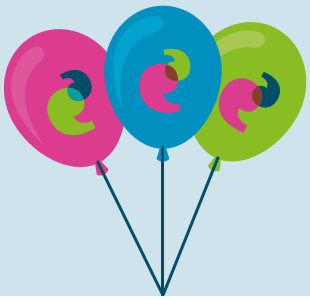
**50 young adults from a range of vulnerable backgrounds gave us their views on mental health, and on the support they would find most useful**

**Our volunteers helped us with everything from data analysis to marketing and promotion**

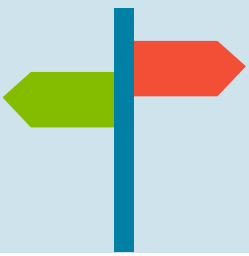
**We've mystery shopped 9 local hospitals and 16 GP centres**

**Our 12 reports championed diverse local groups, from Latin American over 50s to ophthalmology service users**

**From the Whittington to Chapel Market, we've met hundreds of local people at our community events**



**47 of 49 service users expressed satisfaction with our signposting service during this year's evaluation**



**We partnered with 9 local black and minority ethnic organisations to give a voice to less heard members of the community**

# Our priorities for 2015/16

Who we are:

We exist to make health and care services work for the people who use them.

Everything we say and do is informed by our connections to local people. Our sole focus is on understanding the needs, experiences and concerns of people of all ages who use services and to speak out on their behalf.

We are uniquely placed as a national network, with a local Healthwatch in every local authority area in England.

Our role is to ensure that local decision makers and health and care services put the experiences of people at the heart of their work.

We believe that asking people more about their experiences can identify issues that, if addressed, will make services better.

## Young adults and mental health

We trained young adults aged 18 – 32 to carry out peer research around access to mental health services. We gathered and reported the views and experiences of a diverse range of young adults. The findings have been shared with our Health and Well-Being Board who have set up a working group to implement the recommendations.

## Access to services within care homes

We visited people in local homes to hear about their experience in the home and their access to GP services. These findings will feed in to our CCG's overall primary care commissioning plan.

## GP on-line appointments

We used an on-line survey to ask people about their awareness and experience of on-line booking of GP appointments. We used these findings to promote the service to the local community and made recommendations for making the service more accessible.

## Healthcare travel costs

Local volunteers posed as mystery shoppers to find out whether local providers offered access to the Healthcare Travel Costs Scheme. There was good knowledge of the scheme but it was not always easy to access. We have shared good practice amongst providers. Providers are now providing freepost envelopes for patients to make their claim.

## Integrated Care

The borough is developing new models of care to make services more joined up. We interviewed patients to see how the first pilot was working. Feedback was positive and used to inform the model as it is extended across the borough.

## Extended hours GP provision

The borough is developing new models of care to allow 7-day access to a GP. We interviewed patients to see how the pilot was working. Feedback was positive and used to inform the model as it is extended across the borough.

## Advocacy

We trained a group of carers and experts by experience to take part in the procurement process for a range of new advocacy services for the borough. The trained volunteers then took part in assessing the bids put forward by the competing organisations.

## Equality Objectives for Islington CCG

Each year we hold a joint event with Islington Clinical Commissioning Group (CCG) to set Equality Objectives for their work. Knowing that so many people were struggling to access interpreting services in primary care we set this as one of the objectives to help embed our existing work.

## Home care services

We worked with local care providers to contact residents using home care services. A report will follow in 2016/17.

## Work cross-borough

We continued work across North East Central London to offer Enter and View training and visits to people with disabilities. The trained volunteers visited five local Emergency Departments across our 13 boroughs and developed a series of recommendations around accessibility that we will follow up in 2016/17.

Across North Central London we began working together to ensure patient and public views are represented at a regional level.

## Extend our reach into BME communities

(Our work with the Black and Minority Ethnic Community is covered in the next section).

Healthwatch members discuss the year's work priorities at the annual meeting in October 2015.

# Listening to people who use health and care services

## Gathering experiences and understanding people's needs

Healthwatch Islington welcomes the views of anyone living or using services in our borough.

We carry out extensive out-reach with community partners and through information stalls in community settings in order to hear from our local population.

We log and analyse these views, reporting them to providers and commissioners with recommendations for change.

The 2011 census puts the Islington population at around 215,000, a growth of 17% since the previous 2001 census. Islington is a diverse borough with 52% of residents coming from Black and Minority Ethnic Communities.

The census showed that the borough is the country's most densely populated and has high levels of deprivation and of mental health need. The population is fairly young compared to the national average, with large numbers of people in the working age category. There are large numbers of single occupancy households, though housing costs are high.

Of the London boroughs Islington has the highest proportion of residents stating that they are in 'bad' or 'very bad' health (6.4%). Around 8% of residents reported being a provider of unpaid care.

As reaching people who are harder to reach takes more time, we have taken the view that the number of people reached is less significant than the diversity and vulnerability of those contacted.

### General work

- Our Steering Group meetings are open to the public and we encourage participants to give their views and raise questions. We include presentations from local service providers and commissioners in order to give people the opportunity to hold those responsible for services to account.
- Our Annual General Meeting was attended by around 70 people. London Metropolitan University kindly offered us a free space for the event. We trained a group of health and social care students in facilitation skills and they then led workshops on the day to gather people's views on local services.
- We continued to host 2 community stalls each month at various venues around the borough. We did this alongside a range of events on local health and social care policy.

We host an annual stall at the Cally Festival which is attended by over **7,000** people.

Visitors to our stall in King Square Gardens

## Targeted work

Each year we review who we have spoken to and consider who we have not reached. We then tailor our work in the following year. In 2015/16 we wanted to strengthen our work with the following groups.

- Young people (under 21):
  We have been working with the local Youth Health Platform to train young people to gather views from their peers. This work will continue in the coming year.
- Older people (over 65):
  We carried out specific work to gather the views of older people in care homes about GP access.

  We also carried out a focus group with local partners to gather the views of older people who have migrated from Latin America and have made recommendations to health and social care commissioners to make services easier to access. Latin American Women's Rights Service helped us with this work.

## Black and Minority Ethnic Communities

We put together a successful funding proposal for a consortium of 10 organisations working with clients from Black and Minority Ethnic community backgrounds.

The consortium facilitated 27 focus groups attended by over 360 local residents.

The feedback gathered will feed in to the CCG's commissioning intentions. We focused on self-care, primary care access and referral to hospital as these are key issues locally.

> **"Many of the women really appreciated being consulted, as often they don't feel quite understood because of the language and cultural barriers"**
>
> Kurdish and Middle Eastern Women's Organisation

Islington Bangladesh Association hosting a focus group on Caledonian Road

Jannaty hosting a focus group in Finsbury Park

We also work closely with Islington Refugee Forum to find out key themes from our refugee and migrant populations.

**People with disabilities**

- Visual impairment:
  Knowing that our Clinical Commissioning Group are planning to review how eyecare services are commissioned we worked with partners Thomas Pocklington to interview 50 local people about their views on existing services and what will be important to them if services are moved in to the community.
- Autism and Learning Disability:
  We attended several local meetings with families and carers of people with Learning Disabilities and Autism to gather their views on local services. We host a stall at the borough's International Day of Disabled People each year.
- Deaf people:
  Our North East Central London work (picture right) has focussed on access for people with a range of disabilities including people who are Deaf.

**Carers**

Each year we take part in carer's week with local partners Centre 404. This year we attended two events to gather views and experiences of carers.

**Groups which may face socio-economic disadvantages**

We work with partner organisation Help On Your Doorstep to knock on thousands of doors in local estates to reach people who may not find us otherwise.

**Working-age population**

We have found this group difficult to engage as a specific group but reach many working age people when we ask for views on specific services.

In our work on GP on-line booking, 2/3 of those that stated their age were 'working age', for our extended hours GP provision 80% of respondents were 'working age', and for our work on sexual health 100% of respondents were 'working age'.

We also reach the working age population through the door-knocking.


Healthwatch Islington's Emma Whitby congratulates Marlene Daniels on the completion of her mystery shopper training at 'Skilling up for Deaf Inclusion' in May 2015

**People who live outside the area, but use services within the area.**

Anyone who uses services in our area is invited to give a view. However, we will refer them to their Local Healthwatch for signposting queries because their Local Healthwatch will have greater local knowledge.

## What we've learnt from visiting services

Healthwatch has the right to visit services to speak to service users and staff as well as observing how services are delivered. We carry out both announced 'Enter and View' visits and we also mystery shop services by acting as a service user to assess how user-friendly the service is. This year we have undertaken announced visits to the following services:

- Mental health day services as these will be re-commissioned in the coming year. This is the beginning of a larger piece of work to influence the re-commissioning of mental health day services.
- Care home services for older people as we recognise residents as a vulnerable group, we liaise with the Care Quality Commission and the council's contract monitoring team to plan the visits.

Within mental health services we recommended continuing much of the existing good work but exploring ways to incorporate benefits and housing advice services as well as providing cooking classes.

Within the care home services we called for more engagement with relatives and sharing good practice around activities provided.

### Visits to Emergency Departments across North East Central London

We have trained a team of volunteers to Enter and View Emergency Departments. Five visits were made and we recommended auditing patient records to ensure that access needs are recorded, providing more guidance to staff around meeting access needs and video interpreting for people needing sign language interpreters at short notice.

We also visited local GP practices to ask about the new extended hours pilot. We found high levels of satisafaction with this new service. Finally, we visited care homes to discuss residents primary care needs.

### Our Enter and View team

We'd like to thank the volunteers who make up our Enter and View team:

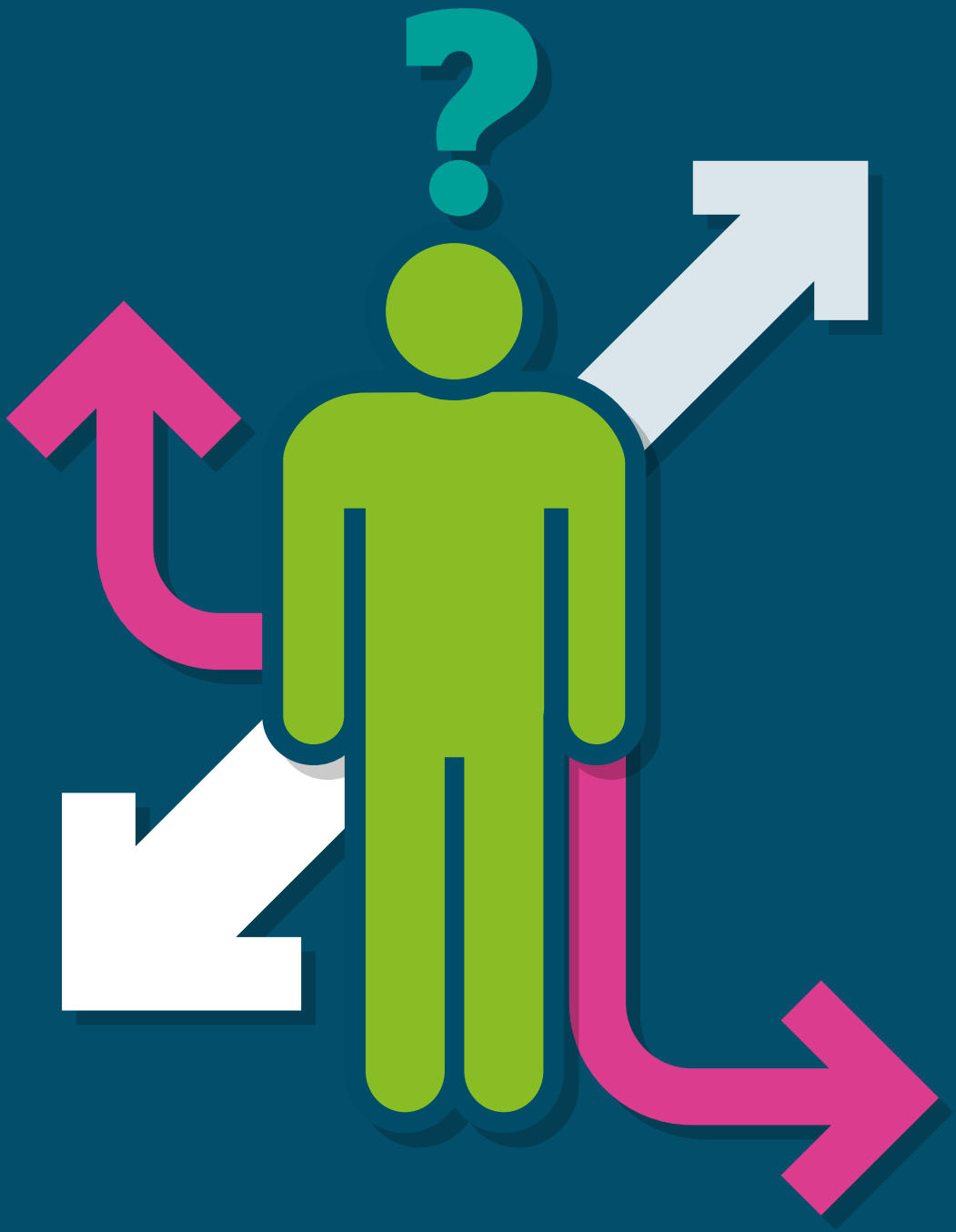
- Mark Austin
- Sue Cartwright
- Jenni Chan
- Viv Duckett
- Olav Ernstzen
- Alison Fletcher
- Lynda Finn
- Frank Jacobs
- Elizabeth Jones
- Rose McDonald
- Helen Mukerjee
- Geraldine Pettersson
- Jane Plimmer
- Natalie Teich
- A representative from a local mental health service user group

### Our mystery shopping team

This year we have carried out mystery shopping to GP services and hospitals to assess the implementation of the Healthcare Travel Costs Scheme, where patients on a range of benefits can have travel costs refunded.

The visits highlighted some good practice from University College Hospital which is now being shared with other local providers and making services more accessible.

# Giving people advice and information



## Helping people get what they need from local health and care services

We want to empower people to get the best from local health and care services.

This year we provided information and support to **229 residents**

We reached over half of these residents through our out-reach work, though many called us.

- Around ¾ of enquiries relate to health and well-being services and ¼ to social care.
- Within health the two most common service areas we provided information on were mental health and GP services.
- Around 14% of queries are from residents querying their entitlements to service. Around 10% relate to making a complaint about services. We work closely with complaints advocacy provider Voiceability to handover these calls.
- We worked with partners through our consortia to signpost an additional 83 people (making 312 in total) who we may not have reached on our own.

> **"You seem to understand what is needed and don't seem to want to rush me off the phone"**
>
> Ms A, local resident

Ms A and her son were living in damp conditions. She needed mental health support and was concerned about her benefits. Healthwatch Islington worked with a range of partners to get her the help she needed.


Healthwatch volunteer Hagir Ahmed (left) promotes our information and advice service.

"They were helpful and phoned around to get the issue with the district nurses sorted out"

Mrs B is a client with reduced mobility and a complex range of well-being needs. She contacted us because she didn't know where else to turn. Healthwatch Islington helped her to get the service that she needed from district nursing staff.

"It is just good to have someone to listen. Thanks again for your input and empathy this was priceless. It's nice to feel supported and listened to - wonderful."

Mr C was in need of advice around benefits and housing. Both of these needs were impacting on his health and well-being. Healthwatch Islington listened to his concerns and signposted him to a local advice service.

**"I really appreciate what you have done."**

Ms D, Islington dental pat

"I really appreciate what you have done."

Ms D was over-charged for her dental care. Thanks to the intervention of Healthwatch Islington she was refunded.

**"You are the phone call I was waiting for."**

Ms E, local resident

Ms E needed help to make a complaint about social care. Healthwatch Islington offered her information on how to make the complaint and where to ask for advocacy support.

**"Thank you very much. I was unaware of the services on offer."**

Mrs F, carer for her elderly husband

Mrs F's husband was in hospital for an operation this year. She has a range of health conditions and was struggling to get to the hospital. Healthwatch Islington helped her to access a reduced rate travel service.

We work with a range of local partners to extend our reach through community meetings, door-knocking and presentations.

We work with a range of local partners to extend the reach of our information service through community meetings, door-knocking and presentations.

# How we have made a difference

## Our reports and recommendations

During the year we produced 12 reports with a series of recommendations on how local services could be improved.

Recommendations included:

- Providing more accessible information on health and care to local communities,
- Bringing mental health services in to the community and linking them with other support services.

Our case studies on pages 19 and 20 demonstrate how this will translate in to improved local services.

## Working with other organisations

We would like to thank all partners for the support in improving access and local services for residents over the last year.

### Islington Clinical Commissioning Group

- We have a really productive relationship with our Clinical Commissioning Group. We have worked together on a number of issues:
- We devised equality objectives for the borough resulting in an increase in the uptake of interpreting services.
- Together we have ensured that patient voices are part of the integrated care work programme, this is particularly important as Islington is a 'Pioneer' borough, developing models for others to emulate.
- We've worked together to extend engagement to a greater number of 'hard to reach' communities.

### Islington Council

- We have worked with Islington Council to engage young people through the Youth Health Platform, to get in touch with home care service users. We sit on the Safeguarding Board and it's Learning and Development sub-group. We have a seat at the Overview Scrutiny Committee and help to provide evidence from local residents to their discussions on local services.

### The Care Quality Commission (CQC)

- We continue to share reports and findings with the commission to inform their inspections.

### Healthwatch England

- We contributed Islington residents' experiences of hospital discharge to the Healthwatch England report 'Safely Home'.

### Local service providers

- Two providers did not provide responses within the 20-day period. Whittington Health and Islington Council – we have looked in to this to improve this in 2016/17.

### Local voluntary sector

- We could not reach so widely in to the community without the support of our voluntary sector partners. They help us to share information, recruit participants, and communicate in a huge number of languages. We have also worked to increase the capacity and confidence of key partners within the sector to signpost their service users to health and care services.

## Involving local people in our work

Local people have been involved in all of the activities listed in this report.

Healthwatch Islington is led and run by volunteers. Our Board of Directors and Steering Group set and manage our work, based on community feedback. Our Steering Group is elected my our members and anyone with an interest in health and care in Islington can become a member.

Teams of volunteers have carried out the visits, mystery shopping and community research described in this report. We follow the principles of Investors in Volunteers and our Recognising Volunteers Policy sets out our commitment to recognise and celebrate volunteers' achievements.

We recruit volunteers through our website, through word of mouth, by working with organisations such as Voluntary Action Islington, and at stalls and events.

In addition to these more generic approaches, we've found it helpful to engage with the community around specific activities, particularly those where we offer training. For example, in October 2015 we offered training in advocacy procurement. Participants helped Islington Council identify an appropriate provider for advocacy services in the borough.

We made sure that the volunteers were empowered to get the most out of the activity. Two of the people undertaking the training went on to join our Enter and View team as a result.

We delivered a similar training package for mental health procurement in February 2016.

**"I attended the procurement panel yesterday for the mental health and wellbeing promotion service. It was a wonderful experience and the marking with the discussions was great. I was nervous at first with the discussion part but I then became comfortable and shared my opinions. Everyone on the panel was so lovely and welcoming it made it a lot easier. Thank you so much for referring me to them.'**

Faiza Al-Abri, volunteer

- Supporting our Health and Wellbeing Board representative to be effective.

Our Chief Executive and Chair represent Healthwatch Islington at the Health and Well-Being Board. The Board meets quarterly. We prepare key information before each meeting and have presented key reports to the Board.

# Our work in focus

# Our work in focus: Mental Health

Islington has high rates of common mental health problems and the highest rates of serious mental illness in London. However, before we got involved, comparatively little was known about our young adults' experiences of mental health services.

22 local organisations highlighted gaps in provision and helped us recruit young adults (18 to 32 years old) for our research. The testimonies we collected were compelling.

We trained **21 young adult volunteers** to interview 50 of their peers from vulnerable backgrounds.

**"I had a flat but I lost it. I was 19 and moved to a flat from leaving care. I wasn't able to look after myself properly and budget, it got to the point where I wasn't even opening letters. I feel I wasn't given the right kind of help."**

Young adult participant

"There is a need for services to be more accessible, meeting people in familiar surroundings. Young people need to know they can talk about anything. Some young people need a service that offers a totally different experience of the health service."

Professional working in the community

**From evidence to influence**

"I can confirm that following our discussion about your report and the emerging recommendations, we will be involving you in developing the specification for the re-commissioning of our Community Development Worker service, which aims to reduce stigma around mental health and increase access to services, particularly from members of excluded communities."

Commissioning Manager, Mental Health, Islington Council, September 2015

- We trained and supported one of our young volunteers to join the procurement panel for the new service.
- We also took our report to the Health and Well-Being Board, emphasising the need for ***more*** services based in the community.

# Our work in focus: Minority Voices

Discussing health issues at IMECE Women's Centre in Newington Green

In May 2015 we wrote a successful funding bid to Islington Clinical Commissioning Group (CCG) on behalf of 'Diverse Communities Health Voice', a partnership between ten community based organisations supporting black and minority ethnic residents in Islington.

Many of the participating organisations had worked with Healthwatch Islington the previous year on a project looking at the health inequalities caused by a lack of access to GP interpreting services. It was the first time many of these organisations had been commissioned.

Healthwatch Islington developed the tools and training sessions for partner organisations. Over 600 residents gave their views.

Healthwatch Islington collated and analysed the wealth of data that partners had provided, then drafted the report on behalf of the partnership. 'Black and minority ethnic groups accessing services in Islington' drew attention to the multiple barriers that these groups faced.

All partners combined the research activity with information provision, in order to empower the individual participants.

> **"Demand to access the advice service increased as a result of this project. Normally after a focus group had taken place, we had to organise a surgery for clients to see one of our advice workers to deal with the queries. We are happy about this. It is really good that we are able to reach people in this way."**
>
> Imece Women's Centre

"I can say that most of the clients that have taken part in the focus groups are now in a better position to understand their rights and entitlements. For example, they now all know that they have a choice about which hospital to go to receive treatment."

Eritrean Community UK

- Recommendations focussed on ensuring patients were made aware of the choices on offer to them, and avoiding assumptions about what patients need. This is now being picked up by our CCG.

# Our work in focus: Ensuring Accessibility


Rose McDonald led this work for Healthwatch Islington

Together with 12 other Local Healthwatch in North East Central London, we developed and delivered accessible Enter and View and Mystery Shopper training to volunteers who had additional communication requirements:

- Deaf or hard of hearing
- Other sensory impairments
- Brain injuries
- People who had suffered a stroke
- Carers of people with communication impairments.

Volunteers visited a number of local hospitals to enable us to understand the barriers to communication they encountered. We shared our findings with the hospitals concerned, and made recommendations for improvements.

Already changes have been made at some of the local hospitals:

- Hospitals have checked staff understand interpreting policies and procedures.
- Communications toolkits have been introduced in reception areas.
- Front-line staff have been trained in communications awareness.
- Development of a top tips video for communicating with Deaf people at one local hospital, which we hope others will adopt.

**"Providers have started to recognise that communications requirements are personal to each individual. This piece of work is just the beginning. Across North East Central London we will continue to work together to improve access for all. By working across 13 boroughs, we have been able to share learning widely."**

Rose McDonald, Enter and View volunteer

# Our plans for next year

## Keep talking to our residents

We will continue to talk to our local community about their health and social care needs using a range of techniques.

## Support statutory partners to meet the Accessible Information Standard

The Accessible Standard, developed by NHS England, tells organisations how they should make sure that patients receive information in formats that they can understand and receive appropriate support to help them to communicate. All health care providers are expected to adhere to the standard. Healthwatch Islington wants to look at progress so far and share good practice.

## Autism and service access

We will assess provision of reasonable adjustments for patients with Autism and share good practice.

## Partner with our local university to inform the Joint Strategic Needs Assessment

We will work with London Metropolitan students to gather research to feed in to the Joint Strategic Needs Assessment.

## Home care experiences

Report on a series of case studies based on interviews with local home care service users.

## Gather views on day services for mental health service users

We will build on the work of the previous year, visiting services and gathering users' views.

## Increase knowledge of our volunteer-base and local residents

We have developed a rolling programme of training for volunteers to help them understand the ever-changing health and care landscape and how we as citizens can engage with services.

## Support a Pan-Islington Patient Group

We will support a borough-wide patient group. Through this group we will gather feedback on the quality of services and on the commissioning intentions of local health partners.

We will be supported by Manor Gardens Health Advocacy Project and Every Voice (Islington's Black and Minority Ethnic Forum) to ensure that this work has a diverse reach.

## Train parents in peer-research

Train parent researchers to carry out peer research (researchers will then carry out work for council's SEN services)

## Gather and report views of extended hours GP practice model (IHUB)

We will carry out further visits to gather experiences of the new model of extended GP opening. Findings will influence the future commissioning of this pilot.

## Audit a new model of maternity support services

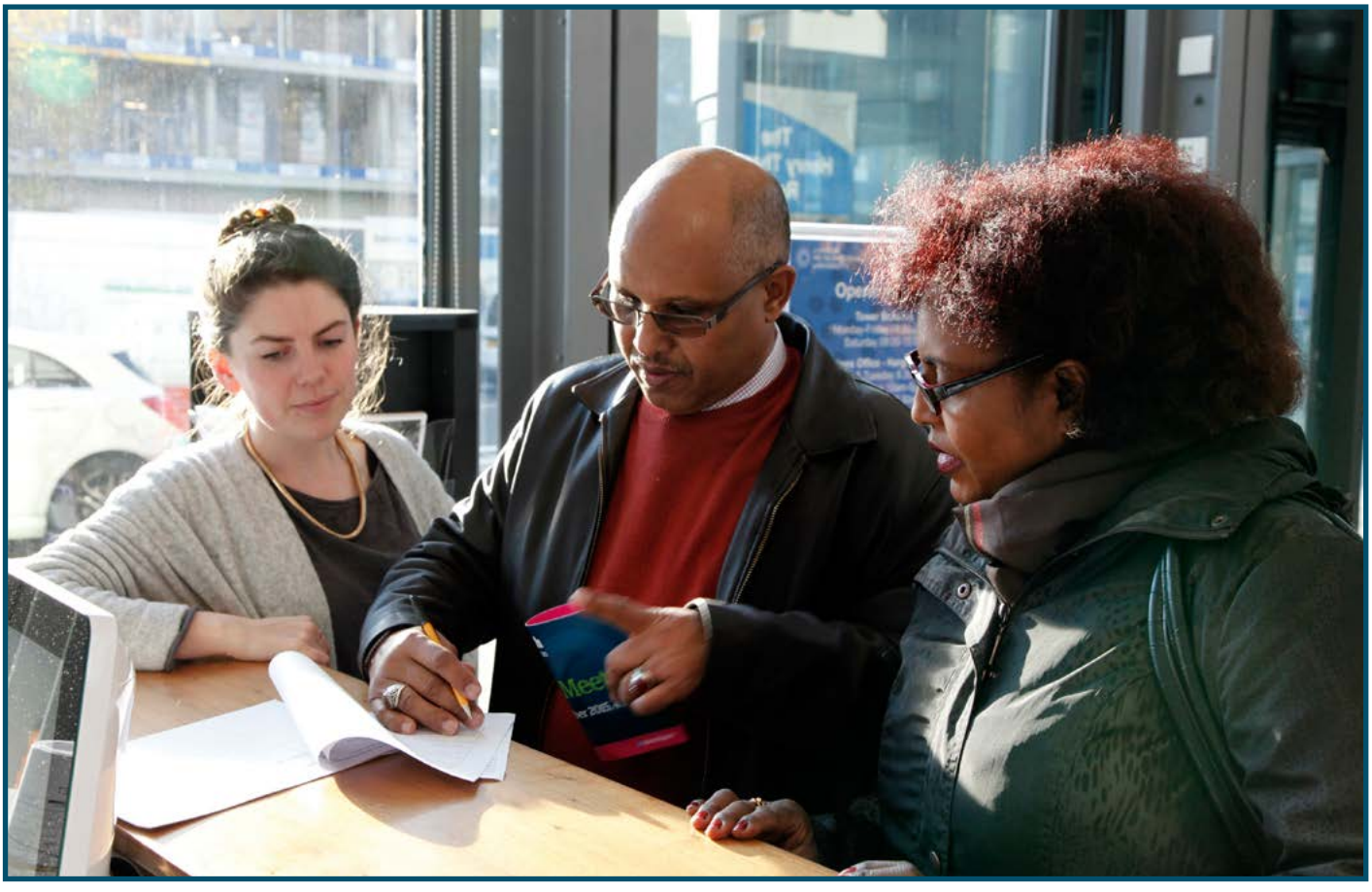
A new service 'Bright Beginnings' will be delivering services to pregnant women and new mothers in the borough. We are working with them to develop an audit tool to measure the effectiveness of the service and the impact on its users over the next three years.

## We will also be doing background research on other issues that have been raised with Healthwatch Islington.

These include:

- Referral pathways for hospital treatment (physical and mental health),
- Alcohol and substance misuse in the over 65s,
- Transfer in and out of borough,
- Personalising maternity services

The register of attendance: Healthwatch members arriving at a meeting.



# Our people

## Decision making

Healthwatch Islington is led by our volunteers and local community. Decision-making by our Steering Group reflects the views of our community. Our work plan brings together community views and local priorities for maximum impact. We take in to account a series of factors including the impact of the issue on vulnerable residents. It is finalised and monitored at a series of public meetings. See web-site for more details.


Decision making reflects the views of the community

## Involving the public and volunteers

The public and volunteers are involved in all aspects of our work. Our Articles of Association, developed by volunteers on our Steering Group, are on our web-site.

Our vision and mission were developed with input from local residents, members and volunteers.

We are a volunteer-led organisation. Our Steering Group (24 seats) is elected by our community members (750 people) with space for some co-options to increase diversity. Membership is open to anyone with an interest in local health and wellbeing services. Individuals and community organisations are represented.

Our work plan is based on feedback from the local community. We develop a list of key themes and then ask members and local voluntary sector partners for their views on these themes.

Any work planning, reports or recommendations we make are discussed and approved by the Steering Group.

The public determine how we will undertake activities and what services to focus on, whether to request information and whether to refer matters elsewhere. Decisions about Enter and View are approved by the Steering Group but made by a specialist team of trained Enter and View volunteers.

Decisions about subcontracting are made by the company directors who are also volunteers from our local community and members of the Steering Group. We follow the principles of Investing in Volunteers and seek feedback from those involved on how we can improve their experience and develop the organisation. Volunteers contribute over 1,200 hours of expertise each year. Without their valuable contribution we would not be able to carry out the work that we do.

# Our finances

[Read & Delete] Below is a table for you to include your basic financial information.

In this table you should include:

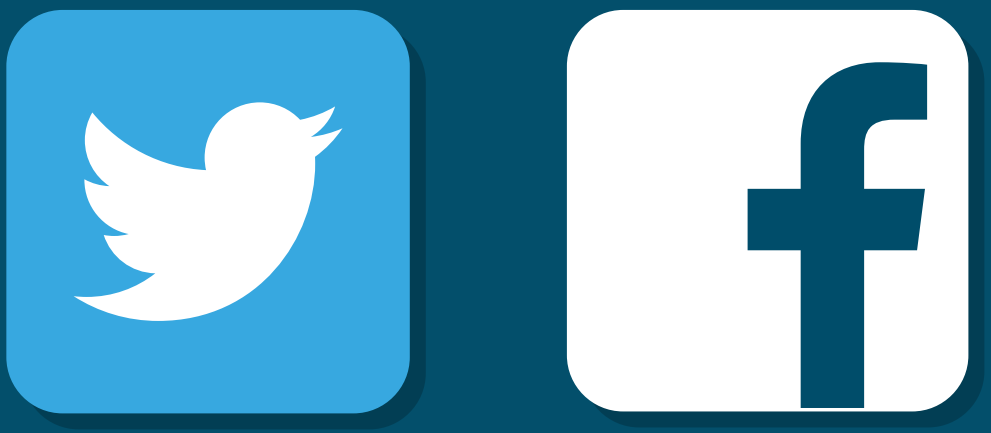
- Funding received from your local authority to deliver local Healthwatch statutory activities.
- A breakdown of how that funding has been spent.

You may also want to include any income generated from other sources.

If you need to, you can add and delete information in this table.

| INCOME | £ |
|---|---|
| Funding received from local authority to deliver local Healthwatch statutory activities | 176,200 |
| Additional income | 64,209 |
| Total income | 240,409 |
| | |
| **EXPENDITURE** | |
| Operational costs | 70,680 |
| Staffing costs | 140,207 |
| Office costs | 29,868 |
| Total expenditure | 240,755 |
| Balance brought forward | -346 (covered by reserves) |

# Contact us



## Get in touch


| | |
|---|---|
| Address: | **Healthwatch Islington**<br>**200a Pentonville Road**<br>**London N1 9JP** |
| Phone number: | **020 7832 5814** |
| Email: | **info@healthwatchislington.co.uk** |
| Website: | **www.healthwatchislington.co.uk** |
| Twitter: | **@hwislington** |


We will be making this annual report publicly available by 30th June 2016 by publishing it on our website and circulating it to Healthwatch England, CQC, NHS England, Clinical Commissioning Group/s, Overview and Scrutiny Committee/s, and our local authority.



The photograph on page 18 was used on the front cover of our report on mental health services for young adults. Image credit: Newscast Online.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format please contact us at the address above.

healthwatch Islington



200a Pentonville Road, London N1 9JP
info@healthwatchislington.co.uk
www.healthwatchislington.co.uk
@hwislington

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**HEALTH SCRUTINY COMMITTEE**
**WORK PROGRAMME 2016/17**

**16 MAY 2016**

1. Membership, Terms of Reference and Dates of Meetings
2. Work Programme 2016/17 and prioritisation of scrutiny topics
3. 111/Out of Hours service specification –update from Chair
4. Islington CCG Annual report
5. Margaret Pyle update – Results of consultation/Progress on transformation
6. Health and Wellbeing Board – update

**09 JUNE 2016**

1. Drug and alcohol misuse – Annual Update
2. Camden and Islington Mental Health Trust Quality Account
3. Scrutiny Review – Health Implications of Damp Properties – witness evidence
4. New Scrutiny topic
5. Work Programme 2016/17
6. Health and Wellbeing Board – update

**19 JULY 2016**

1. NHS Trust – Whittington Hospital – Performance update
2. Scrutiny Review – Health Implications of Damp Properties – Draft recommendations/Hyde Housing Association
3. Work Programme 2016/17
4. Whittington Hospital – Governance arrangements
5. Healthwatch Annual Report
6. Health and Wellbeing Board – update

**05 SEPTEMBER 2016**

1. London Ambulance Service – Performance update
2. Scrutiny Review – Effectiveness of IAP – Presentation and SID
3. Annual Adults Safeguarding report
4. Work Programme 2016/17
5. Health and Wellbeing Board – update
6. Scrutiny Review – Health implications of Damp Properties – Final report
7. NHS Commissioning

**06 OCTOBER 2016**

1. Scrutiny Review – New topic- witness evidence
2. Work Programme 2016/17
3. Presentation Executive Member Health and Wellbeing
4. NHS Annual screening report
5. Healthwatch Work Programme
6. Health and Wellbeing update
7. Performance statistics

**17 NOVEMBER 2016**

1. Scrutiny Review – New Topic – witness evidence
2. Health and Well Being Board – update
3. Work Programme 2016/17

**12 JANUARY 2017**

1. NHS Trust – UCLH – Performance update
2. Scrutiny Review – New topic – Witness evidence
3. Work Programme 2015/16
4. Health and Wellbeing Board – update
5. Scrutiny Review – 12 month progress report – Patient Feedback
6. Performance statistics

**06 MARCH 2017**

1. Scrutiny Review – New topic– witness evidence
2. NHS Trust – Moorfields – Performance update
3. Work Programme 2015/16
4. Health and Wellbeing Board – update
5. Whittington Estates Strategy

**22 MAY 2017**

1. Scrutiny Review – New topic– witness evidence
2. Work Programme 2016/17
3. Health and Wellbeing Board – update
4. Scrutiny Review – Topics 2017/18
5. Membership, Terms of Reference etc.
6. Performance statistics

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