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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 in Committee Room 4, Town Hall, Upper Street, N1 2UD on, **14 September 2017 at 7.30 pm.**

Yinka Owa
Director of Law and Governance

Enquiries to	:	Peter Moore
Tel	:	020 7527 3252
E-mail	:	democracy@islington.gov.uk
Despatched	:	6 September 2017

Membership

Councillors:
Councillor Martin Klute (Chair)
Councillor Jilani Chowdhury
Councillor Gary Heather
Councillor Michelline Safi Ngongo
Councillor Nurullah Turan (Vice-Chair)
Councillor Troy Gallagher
Councillor James Court

Co-opted Member:
Bob Dowd, Islington Healthwatch

Substitute Members

Substitutes:
Councillor Alice Perry
Councillor Clare Jeapes
Councillor Satnam Gill OBE
Councillor Angela Picknell

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

Quorum: is 4 Councillors

A.	**Formal Matters**	**Page**
1.	Introductions	
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4.	Declarations of Interest	

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

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

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

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

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

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

The Chair will update the Committee on recent events.

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The next meeting of the Health and Care Scrutiny Committee will be on 12 October 2017

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

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London Borough of Islington

Health and Care Scrutiny Committee - Thursday, 6 July 2017

Minutes of the meeting of the Health and Care Scrutiny Committee held at Committee Room 4, Town Hall, Upper Street, N1 2UD on Thursday, 6 July 2017 at 7.30 pm.

Present:	**Councillors:**	Klute (Chair), Heather, Ngongo and Turan (Vice-Chair)
Also Present:	**Councillors**	Janet Burgess – Executive Member Health and Social Care
	Co-opted Member	Bob Dowd, Islington Healthwatch

Councillor Martin Klute in the Chair

14 APOLOGIES FOR ABSENCE (ITEM NO. 2)

Councillor Gallagher and Janet Burgess (for lateness)

15 INTRODUCTIONS (ITEM NO. 1)

The Chair introduced Members and officers

16 DECLARATION OF SUBSTITUTE MEMBERS (ITEM NO. 3)

None

17 DECLARATIONS OF INTEREST (ITEM NO. 4)

None

18 ORDER OF BUSINESS (ITEM NO. 5)

The Chair stated the order of business would be as per the agenda

19 MEMBERSHIP, TERMS OF REFERENCE (ITEM NO. 6)

RESOLVED: That the report be noted

20 CONFIRMATION OF MINUTES OF THE PREVIOUS MEETING (ITEM NO. 7)

21 CHAIR'S REPORT (ITEM NO. 8)

The Chair stated that he had met the Camden and Islington Mental Health Trust Chief Executive, together with the Chair of Camden Health Scrutiny Committee to discuss the re-siting of beds from St.Pancras to the Whittington Hospital.

The Chair stated that he felt that this seemed a reasonable proposal but there is the intention to discuss setting up a meeting with L.B.Camden and L.B.Islington scrutiny Committee members to discuss the proposals in more detail in September and that he would keep Members informed. The Chair added that the proposed re-siting of the beds was within the Islington borough boundary.

The Chair also referred to the ongoing negotiations on the re-opening of the LUTS clinic, and that it was likely that the clinic would not reopen for some time and maybe re-provisioned at UCLH. The Chair stated that this was of concern and the JOHSC would be considering this at its meeting the following day.

22 PUBLIC QUESTIONS (ITEM NO. 9)

None

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

Councillor Janet Burgess, Executive Member Health and Social Care was present and outlined the following main issues –

- Islington social workers had assisted in Kensington and Chelsea, following the Grenfell Tower fire
- The Chief Executive at the Whittington Hospital is leaving and a shortlist of replacements is being considered
- The LUTS clinic has still not re-opened
- The Whittington Hospital is the only hospital in the North Central London region to have met it's A&E waiting time targets
- The Whittington has also reduced its dependency on agency staff and both they and Social Services had recruited more permanent members of staff
- Reference was made to the issue of care homes and the recent poor performance of Lennox House, which was run by Care UK. There is a shortage of permanently staff and staff are not properly trained
- Reference was made to a recent Guardian article concerning proposed reductions to health services in London and savings proposed in the region of £182m
- Members expressed the view that the Sustainability Transformation Programme was a method to have budget reductions rather than improve services
- It was stated that the Alcohol summit had been successful and that the substance misuse contract had now been approved

24 SCRUTINY TOPIC 2017/18 (ITEM NO. 11)

RESOLVED: That the scrutiny topic for 2017/18 be Air Quality – Impact on Health and this be submitted to the Policy and Performance Committee for approval

25 CAMDEN AND ISLINGTON NHS TRUST - PERFORMANCE UPDATE (ITEM NO. 12)

Karen Reynolds, Head of Governance and Assurance, Caroline Harris-Birtles, Director of Nursing and David Barry, Governor of Camden and Islington Foundation Trust were present for discussion of this item.

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

- David Barry outlined the role of Governors and that they were involved in the discussions on the redevelopment of the St.Pancras site
- It was stated that the CQC inspection was anticipated in December/January and that action plans were in place to deal with areas of concern from previous inspections. There had been areas of improvement on managing waiting lists, and how to keep patients safe. However, there had been an increase in the number of referrals for the funding that they received
- There had been increased training on safeguarding and how care is planned for patient care
- It was stated that there were 3 key areas of how to plan care for patients including safety, dignity and gaps in care. One of the priorities is also to enable staff, through raising awareness and relevant training to identify, prevent and reduce domestic violence and abuse and in addition there is a need to involve service users and carers in the implementation of the clinical strategy
- It was noted that there are still gaps in relation to dealing with the waiting list and although there had been compliance with the 18 week referral to treatment targets for Improving Access to Psychological Therapies and Early Intervention services it was noted that there are more people on the waiting list than could be dealt with, however consideration is being given to how to manage waiting lists more effectively. In addition, the Government have raised the target for improving access to psychological therapies and this would cause further strain on resources available
- Reference was made to the staff survey and whether there had been any improvement in this area. It was stated that this is not an area that could be responded on in more detail at that meeting as the information was not available however this could be provided following the meeting
- There had been a focus on improving the recruitment of staff and in offering support to staff and training to identify and prevent and reduce domestic violence and abuse. In addition, staff were supported in dealing with any harassment or violence issues and work is going on with patient groups, to get feedback on issues
- There are career progression opportunities for staff and online training and courses are made available to staff
- It was noted that some patients had to wait a long time before being able to access treatment
- In terms of staff turnover it was noted that staff turnover is subject to fluctuation however, this has not risen and there had been improvements in staff retention, although there were some differences in staff turnover in particular areas and the Trust is now less dependent on agency staff
- With the increased awareness around mental health issues and the stigma of mental health being less the service is now dealing with a repressed demand. The Trust did keep performance indicators and statistics and monitor demographics and referrals and the Trust were looking at different ways of working and dealing with primary care. Preventative work is also taking place with Children's Services
- In response to a question with regard to the transition from children's to adults mental health services it was stated that not all children who had received services transferred to adult services and there is no longer a 'cut off' at 18 years of age
- In response to a question it was stated that it was concerning that there potentially could be a large cohort of young people in a few years time needing to access mental health services and that work needed to take place with

commissioners to look at future demand and funding. Commissioners were aware of the challenges facing the service
- It was stated that the Trust felt that it managed its resources effectively and also triaged cases effectively

RESOLVED: That the report be noted and the Trust forward to Members information relating to the latest staff survey report, as referred to above

The Chair thanked David Barry, Karen Reynolds and Caroline Harris-Birtles for attending

26 ANNUAL PUBLIC HEALTH REPORT (ITEM NO. 13)

Julie Billett, Director of Public Health, was present for discussion of this item.

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

- The focus is early intervention and that the report specifically looks at preventative interventions that are supported by evidence of delivering a return on investment to the NHS over the short term. However, whilst many of these interventions described in the report are already being funded across Islington through the Council's public health grant, and with additional funding from NHS commissioners and providers in some cases. To achieve the significant up-scaling of programmes required across the whole system, in order to have a demonstrable impact, further investment into these preventative measures, alongside organisational, cultural and behavioural change is needed
- It was noted however that new investment was not likely given the North Central London Sustainability and Transformation plan and current financial pressures
- It was noted that only 4% of the current health budget is spent on prevention
- Reference was made to air quality in the borough and that poor air quality contributed to about 900 premature deaths per year
- It was noted that it is hoped to join up services to make 'every contact' count in terms of prevention

RESOLVED: That the report be noted

The Chair thanked Julie Billett for attending

27 DRAFT RECOMMENDATIONS - IAPT SCRUTINY REVIEW (ITEM NO. 14)

RESOLVED: That subject to the addition of the words ' and supported' after the word 'encouraged' in the recommendation on Feedback the recommendations and report be approved and the report be submitted to the Executive for consideration

28 WORK PROGRAMME 2017/18 (ITEM NO. 15)

Noted

The meeting ended at 9.35p.m.

Chair

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Whittington Health NHS

Quality Account 2016/17

Contents

1. Statement on quality from the Chief Executive

1.1 Chief Executive's statement

Quality remains our top priority. Our Quality Account describes some of our achievements in the past year and how we aim to continue providing high quality and safe services to help local people live healthier, longer lives. Our commitment to quality is across all our community and hospital services.

The Trust won the CHKS Top Hospitals programme quality of care award 2017. The CHKS Top Hospitals awards celebrate excellence throughout the UK and are given to organisations for their achievements in healthcare quality and improvement.

We received our Care Quality Commission (CQC) full inspection report in July 2016 in which Whittington Health was rated 'Good' overall and 'outstanding' for caring; however within this, the community services were Good to Outstanding, and the hospital 'requires improvement'. Our focus has continued to be on completing actions to improve quality across both the hospital services and community services. These are outlined in this Quality Account.

Over the past year the teams delivering the care to our local community have developed a number of quality initiatives:

- We were one, of only 4, sites selected to pilot a new model of midwife supervision.
- We were shortlisted for the Patient Experience National Network Awards for the Footprints project. This project centred on hearing women's voices to improve care based on human rights principles.
- Our midwives were shortlisted for the British Medical Journal Awards for the Female Genital Mutilation service they run.
- Whittington Health achieved the highest flu vaccine levels in London for which our infection control team were awarded a staff excellence award.
- Our innovative team introduced gentle birth methods, which include reflexology and massage therapy for couples (promoting normality) in midwifery
- 'Excellent'. This was the Peer review classification result of our Paediatric Oncology Shared Care Unit. We are now looking to develop an adolescent service.
- Gold Standard Services. Our Paediatric Mental Health team is one of only two gold standard services in London.
- We are one of the few trusts that meet the Royal College of Paediatrics and Child Health and the NHS acute paediatric standards due to the consultant presence we have in our acute services.
- Self-Management Partnership. We have developed a service user self-management partnership with Tottenham Hotspur.
- Our Tissue Viability Team have led the red pressure reduction campaign in the Trust.
- Further innovation within our Improving Access to Psychological Services led to the development of a new mothers programme.
- Cheryl Hill our imaging manager was a finalist in the Emerging Leader category of the London Leadership Academy Annual leadership Awards.
- We are a pilot site for new pharmacist roles in GP practices and Urgent Care.
- We held 2 Inter-professional Integrated Care Education Days in April and May. These were extremely well received, with excellent feedback from the attendees.
- Advance Care Planning Workshops. We have run 8 events for our local GPs and Care Homes focussing on care of dying patients in the last days of life and supporting professional to look at ways of approaching difficult conversations with patients and their families
- 'Learning Together from Patient Safety Incidents and Complaints'. These inter-professional education events we have developed based on real patient stories, highlighting key learning points for various staff groups. The 10 Learning Together

events this year were attended by WH staff and colleagues working in social care, primary care and the voluntary sector

- 'Islington Integrated Schwartz Rounds'. These are the first Schwartz rounds of this kind to be established. They were set up and run in collaboration with our Community Education Provider Network (CEPN) partners, inviting colleagues from Camden and Islington Mental Health Trust, Islington Clinical Commissioning Group, London Borough of Islington and Whittington Health
- Our 'Outstanding' Care Quality Commission rated community dental service won a tender to deliver services across a further five boroughs in North Central and North West London

This year in June we will be having our first Annual staff awards.

Like many other NHS trusts, we had a challenging winter. The particular pressure for us has been around emergency medical care, especially for frail and elderly patients and those with mental health issues. We reported 87.36% percent performance for the year and have been working very closely with the Emergency Care Improvement Programme (ECIP) identifying and implementing quality improvements to our emergency pathway. One area of focus is to improve the experience of our mental health patients. Working in collaboration with Camden and Islington Foundation Trust and our wider partners we will review and improve the multiagency model of care for our mental health patients in crisis (Section 136 pathway). This will be launched at a workshop in June 2017.

Our excellent Integrated Care Ageing Team (ICAT) has been set up to provide in-reach into care homes in Islington and is looking to work closely with the Care Closer to Home initiatives of the Sustainability and Transformation Plan to continue to support high quality care for the older people we serve.

Within the community we are working to improve our for musculoskeletal services through working with the Haringey and Islington Health and Wellbeing Partnership and piloting new ways of working with Extended Scope Physiotherapists in three GP practices. Within our District Nursing Team we are improving our recruitment and retention through overseas recruitment and have increased the numbers of nurses undertaking the specialist practitioner District Nurse and Specialist Practitioner courses, as well as introduced our new scheduling system e-community which will increase continuity of visits and patient facing time. In addition the workforce model for health visiting and community paediatrics across Haringey and Islington is currently being reviewed with a view to ensuring an effective, sustainable and efficient service is provided to the Children and Young People which we serve.

During the year we continued to make the quality improvements that we pledged to make in our 'Sign up to Safety' commitment. These continue to focus on improving the care of patients with sepsis and acute kidney injury, reducing pressure ulcers both in the hospital and in the community, reducing harm from inpatient falls and improving the care we give to patients who have a learning disability. In the course of this year we have made significant measurable improvements in many of these areas.

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

Simon Pleydell
Chief Executive

1.2 About the Trust

Whittington Health's vision is to be a national leader in delivering safe, personal, coordinated care to the local community. It is geographically placed in the centre of North Central London (NCL) with a portfolio of services covering the populations of Haringey and Islington but also with some community services in Camden, Enfield, Barnet and Hackney. The Trust is an Integrated Care Organisation (ICO) and delivers some of the most innovative models of ambulatory and integrated care in the region e.g. Integrated Respiratory Services, Integrated Care of the Ageing, Integrated Care Hubs and working closely with social care.

Over the last twelve months, the organisation has been working closely with the Haringey and Islington Clinical Commissioning Groups (CCGs), Local Health Authorities (LHAs) and local providers (including Mental Health) in developing the Haringey & Islington Health and Wellbeing Partnership. The objective of this partnership is to work in an integrated and collaborative way to provide high quality health and social care for our local population. This work has been recognised and supported by, and integrated into the North Central London (NCL) Sustainability and Transformation Plan (STP).

As an Integrated Care Organisation (ICO) with community and hospital services across Islington and Haringey, Whittington Health is in a unique and important position to deliver the strategic objectives of the STP. The Trust's mission, documented in our clinical strategy, is to 'help local people live longer, healthier lives'. A key strategic goal is to secure the best possible health and wellbeing for all our community, of which prevention and health promotion is a key objective. An example of this is our CQC rated 'outstanding' community dental services. A key priority next year is embedding our work in co-creating health and shared decision making across our geography and taking a population-based approach to prevention. In addition to prevention, the Trust has led on the development of important service transformation such as our 'outstanding' ambulatory care model, rapid response and frailty units, and integrated care networks, which align directly with intentions to deliver care closer to home.

Within this context, the Trust, like many providers nationally, faces significant financial challenges. The year-end revenue forecast for 2016/17 is a £6.4m deficit, which is in line with the Trust's control total for the year inclusive of Sustainability & Transformation Funding (STF). The underlying, recurrent, position without STF is estimated to be a £15.2m deficit. A central goal for Whittington Health is to reduce costs whilst continuing to deliver high quality care. The Trust identified the need to deliver £25m of improvements when producing its 2016/17 financial plan, which was supported by the development of a 2-year programme. However, as highlighted in this plan, there are risks and challenges associated with our financial position, such as securing a contract for clinical service provision with an income quantum that reflects the level of activity undertaken by the Trust.

1.3 Listening to our staff

This is the sixth year in which Whittington Health, as an Integrated Care Organisation (ICO), has conducted the national staff survey. The survey asks a random sample of the Trust's staff (1,227 people in 2016) a number of questions to see how they respond, giving an insight into the how staff feel about how the Trust is managed, its culture, and the services it provides.

Staff Engagement Indicator

The Care Quality Commission (CQC) report provides an overall indicator of staff engagement for Whittington Health and how it compares with other acute community Trusts. The possible scores range from 1 to 5 (with 1 indicating poor engagement and 5 high engagement).

The Trust's score of 3.83 is above the national average of 3.8 and a local improvement from 3.79 in 2015. The table below illustrates how this score is arrived at and how we were rated under each of the nine staff engagement questions.

Staff Engagement	Whittington Health Scores	National Scores for Acute Community Trusts
Advocacy		
I would recommend WH as a great place to work	3.59	3.50
I am happy with the standard of care provided	3.82	3.73
Care of patients is a top priority for Whittington Health	3.93	3.83
Involvement		
I am able to make suggestions to improve the work of my team / department	3.95	3.84
There are frequent opportunities for me to show initiative in my role	3.89	3.82
I am able to make improvements happen in my area	3.60	3.48
Motivation		
I look forward to going to work	3.60	3.61
I am enthusiastic about my job	3.94	4.00
Time passes quickly when I am working	4.13	4.14
Overall engagement score	**3.83**	**3.80**

Top Ranking Scores

Whittington Health compares most favourably with other acute community Trusts in England in the following areas:

	Indicator	Trust	National
1	Percentage of staff reporting errors, near misses or incidents witnessed in last month	97%	91%
2	Quality of appraisals	3.35 (score)	3.11 (score)
3	Percentage of staff/colleagues reporting most recent experience of violence	78%	67%
4	Percentage of staff agreeing that their roles make a difference to patients / service users	93%	91%
5	Percentage of staff reporting good communication between senior management and staff	36%	32%

It is encouraging to note improvements in areas such as good communication between senior managers and staff and the quality of appraisals, as these were targeted improvement actions from last year's survey. In addition there has been a focus on incident reporting and feedback and this appears to have been reflected in the results.

Bottom Ranking Scores

Where the Trust compares least favourably with other acute community Trusts is set out below.

	Indicator	Trust	National
1	Staff working extra hours	78%	71%
2	Staff suffering work related stress in last 12 months	42%	36%
3	Staff experiencing harassment, bullying or abuse from staff	30%	23%
4	Percentage of staff experiencing discrimination at work in the last 12 months	19%	10%
5	Percentage of staff experiencing harassment, bullying or abuse form patients, relatives or the public in last 12 months	31%	26%

Disappointingly, three of the bottom ranking scores (numbers 1 – 3) appeared in the same category in the Trust's 2015 results and have shown little improvement in year. It is the first time that the percentage of staff experiencing harassment, bullying or abuse from service users has been highlighted as a concern and this will require specific attention this year.

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (KF26)

30% of staff reported experiencing harassment, bullying or abuse from staff in the last twelve months, an increase from 29% in 2015.

Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion (KS21)

79% of staff reported believing that the Trust provides equal opportunities for career progression or promotion, a slight decrease from 80% in 2015.

At the trust Board in April 2017, the Trust agreed a robust action plan to tackle the areas of concern highlighted to us by staff. These actions range from evaluating findings from our Anti Bullying Advisers; tackling specific identified behaviours at a local level; rolling our unconscious bias training to all staff and creating focus groups to understand how we can better focus career management on improving diversity.

Progress on the 2015 Staff Action Plan

A corporate action plan was developed and an accountable executive identified for leading on each of the corporate priorities. The Trust Board approved this action plan in April 2016 with a progress update given in August 2016.

Good progress was made in the development and execution of the staff survey corporate action plan. There was high level engagement in cascading results through Integrated Clinical Service Units (ICSU) and more local service team meetings. Through the Clinical Directors and Human Resources (HR0 Business Partners there was more staff engagement and involvement of staff in the improvement plans at a local level.

Quarterly ICSU performance reviews ensure that local action plans are being delivered. All 31 of the corporate actions were completed by March 2017.

Significant progress has been made in each of these areas. Some of the actions taken included:

- Development of a staff communication and engagement plan;
- Organisational goals and objectives cascaded within service areas and individual objectives aligned;
- Focus on the quality and quantity of annual appraisal;
- Quarterly reporting of all workforce performance indicators to the newly established Workforce Assurance Committee;
- Occupational Health promoted the use of a stress self-assessment questionnaire;
- Bi-annual health and well-being events;
- Introduction of a half-yearly health and safety bulletin for all staff;
- Development of unconscious bias masterclass for all managers;
- Reinforced our organisational values and zero-tolerance of bullying including the introduction of Anti-bullying Adviser role across the Trust; Equality and diversity training introduced as management induction training;
- Mechanisms for staff feedback to those that report an incident reviewed;
- Quarterly analysis of learning from outcomes from reported incidences to all staff.
- Recruitment of the role of ‘Speak Up’ guardian for the Trust

2. Priorities for improvement and statements of assurance from the Board

2.1 Our quality priorities for 2017-18

Our quality priorities are aligned with the Trust's commitment to the 'Sign up to Safety' initiative, which aims to progressively improve quality over a period of three years. Many of the areas chosen for quality improvement in 2016/17 have been retained for the forthcoming year as we continue to consider these important. In addition, we include goals that we believe are important to us as a Trust and to our patients and community.

Goals and targets are developed following extensive consultation with staff and stakeholders. Each target has been developed by clinicians in issue-led quality groups, agreed at the patient safety forum and reviewed at all levels of the Trust, including by the Trust Management Group and Board. Following this, they are considered by our commissioners, local Healthwatch members, and presented to our local councillors.

In developing these priorities, we utilise a range of data and information available to us, such as learning from serious incidents, case note reviews, reviews of mortality and harm, complaints, clinical audits, outcomes from quality panel reviews, patient and staff experience surveys, and best practice guidance such as from NICE and national audits.

Our education quality targets are closely linked to the work we have been involved in with the Community Education Provider Networks where staff across Health, Social care and Primary Care have developed, with Whittington Health, Interprofessional programmes of education. The feedback from the staff and the patient and users has helped further refine what these quality objectives should be.

Our safety and quality priorities for 2017/18 are detailed in the table below:

Domain	Objective
Acute Kidney Injury (AKI) **Acute Kidney Injury is sudden damage to the kidneys that causes them to not work properly. This usually happens as a complication of another serious illness.**	At least 75% of patients with AKI include an AKI diagnosis in their discharge letter
	At least 90% of patients that develop grade 3 AKI have a medicine safety review within 24 hours
	At least 90% of patients with grade 3 AKI are seen by Critical Care Outreach Team within 24 hours.
Sepsis **Sepsis is a rare but serious complication of an infection. Without quick treatment, sepsis can lead to multiple organ failure and death.**	We will achieve the national CQUIN for sepsis with a particular focus on sepsis developing during inpatient stay
	We will work in partnership with local CCG's to raise patient awareness of sepsis including the distribution of "Could it be sepsis" leaflets distributed relevant local healthcare provider centres.

Falls **Anyone can have a fall, but older people are more vulnerable and likely to fall, especially if they have a long-term health condition.**	We will introduce StopFalls bundles across the hospital, and achieve 80% compliance with falls assessment documentation on the Acute Admissions Unit (*AAU)* and *Care Of Older People* wards
	We will reduce the number of avoidable falls resulting in serious harm to patients year on year
Pressure Ulcers **Pressure ulcers are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. They are sometimes known as "bedsores" or "pressure sores".**	To achieve a year on year reduction in all grades of pressure ulcers across the Integrated Care Organisation
	We are developing a cross borough target on the 'React to Red Initiative' with local partners.
Learning disabilities **A learning disability affects the way a person understands information and how they communicate. This means they can have difficulty:** - **understanding new or complex information** - **learning new skills** - **coping independently**	75% of patients who present to the Emergency Department with learning disabilities are given a priority assessment.
	We will introduce a care pathway for mothers with learning disabilities in the hospital All children and young people entering Child and Adult Mental Health Services (CAMHS) for a Choice appointment will be screened for Learning Disabilities
Medication errors Medication errors are patient safety incidents involving medicines in which there has been an error in the process of prescribing, dispensing, preparing, administering,	We will achieve a 10% increase in medication errors reported across the Integrated Care Organisation.
	We will achieve a 10% reduction in medication errors with harm.

monitoring, or providing medicine advice, regardless of whether any harm occurred.	
Research and Education	We will increase by 10 percent the number of National Institute of Health Research (NIHR) programmes in which we participate.
	We will achieve the recruitment target, set by the North Thames CLRN, for patients recruited into NIHR portfolio studies.
	We will continue to provide access to 'learning together from patient safety incidents and complaints workshops' based on real patient stories and aim to deliver 10 structured inter-professional learning events this year.
	100% of students placed at WH will have access to a named educational and clinical supervisor or mentor
	We will expand our portfolio of inter-professional learning opportunities for staff by offering training in Making Every Contact Count and access to the training offered by Haringey and Islington Community Education Provider Networks (CEPNs).
	We will offer upskilling opportunities to health professionals on how to teach and support people to self-manage their long term condition by offering the advanced development programme across Islington and Haringey.
	We will evaluate the access group, currently running in the East of Haringey's Improving Access to Psychological Therapies (IAPT) service, which Turkish patients are offered before the delivery of individual Cognitive Behavioural Therapy (CBT). We aim to establish its effectiveness in improving outcomes, and reducing DNAs and dropouts in this BME community
Patient Experience	We will reduce the amount of time patients wait for booked transport from home to hospital This will be monitored through real time information and contract specification.
	We will reduce outpatient clinic appointment cancellations.
	We will reduce noise at night from other patients. Improvement will be measured via the inpatient and

	outpatient National Survey Picker results and through 'real time' experience surveys (Meridian).
	We will improve continuity of care from District Nurses. This will be monitored through of e-community
	We improve the feedback we receive about our inpatient food. Improvement will be measured via the inpatient and outpatient National Survey Picker results and through 'real time' experience surveys (Meridian).

These patient experience priorities were determined through triangulation of information from complaints, local and national surveys (including FFT) and the very useful feedback from service users via the engagement and workshop event with Islington Healthwatch.

2.2 Statements of assurance from the Trust Board

2.2.1 Subcontracted services

During 2016-17 Whittington Health provided 101 services (41 Acute & 60 community services). Of these services the following are subcontracted:

Organisation details	Service details
Barts Health NHS Trust	Service and Development Support for Immunology/Allergy
Camden and Islington NHS Foundation Trust	Mental Health Services, ILAT contract & Psychology Service
Highgate Therapy Ltd	Psychosexual Services
University College London Hospitals Foundation Trust	South Hub TB Resources
University College London Hospitals Foundation Trust	ENT services
The Royal Free London NHS Foundation Trust	Provision of PET/CT Scans
The Royal Free London NHS Foundation Trust	Ophthalmology Services
Middlesex University	Provision of Moving and Handling Training Sessions

GP sub-contractors; Medical Practices: Morris House Somerset Gardens Tynemouth Road	Primary Care Anticoagulation Service for Haringey CCG
WISH Health Ltd A network of 8 local practices; four in North Islington and four in West Haringey.	Provide primary care services to the Urgent Care Centre at the Whittington Hospital

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

The income generated by the relevant health services reviewed in 2016-17 represents 100% of the total income generated from the provision of relevant health service that Whittington Health provides.

2.2.2 Participation in Clinical Audits 2016-2017

During 2016-17, **41** national clinical audits including **7** national confidential enquiries covered relevant health services that Whittington Health provides.

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

The national clinical audits and national confidential enquiries that Whittington Health was eligible to participate in, and participated in, during 2016/17 are listed below. This includes the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Additionally listed are the non-mandatory national audits to which the Trust also participated during 2016/17.

Title of audit	Management body	Participated in 2016/17	If completed, number of records submitted (as total or % if requirement set)
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	National Institute for Cardiovascular Outcomes Research	✓	92 cases - 100% case ascertainment rate
Adult Asthma	British Thoracic Society	✓	23 cases
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	British Association of Urological Surgeons	✓	16 cases

Bowel Cancer (NBOCAP)	Royal College of Surgeons of England	✓	96 cases
Case Mix Programme (CMP) - Intensive Care Audit	Intensive Care National Audit & Research Centre	✓	804 cases – 100% case ascertainment rate
Child Health Clinical Outcome Review Programme - Chronic Neurodisability	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	1 case – 100% case ascertainment
Child Health Clinical Outcome Review Programme - Young People's Mental Health	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	3 cases - 100% case ascertainment
Diabetes (Paediatric) (NPDA)	Royal College of Paediatrics and Child Health	✓	107 cases
Elective Surgery (National PROMs Programme)	Health and Social Care Information Centre	✓	22 cases
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	Royal College of Physicians (London)	✓	124 cases
Inflammatory Bowel Disease (IBD) programme / IBD Registry	Royal College of Physicians (London)	✓	62 cases
Learning Disability Mortality Review Programme (LeDeR)	University of Bristol	✓	Ongoing
Major Trauma Audit	TARN - University of Manchester	✓	38 cases - 28% case ascertainment rate
Moderate & Acute Severe Asthma - adult and paediatric (care in emergency departments)	Royal College of Emergency Medicine	✓	15 cases
National Audit of Dementia - Dementia care in general hospitals	Royal College of Physicians	✓	44 cases
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre	✓	107 cases
National Comparative Audit of Blood Transfusion programme - Audit of Patient Blood Management in Scheduled Surgery	NHS Blood and Transplant	✓	4 cases

National Diabetes Audit - Adults - National Diabetes Foot Care Audit	Health and Social Care Information Centre, Diabetes UK, HQIP	✓	69 cases
National Diabetes Audit - Adults - National Diabetes Inpatient Audit (NaDia)	Health and Social Care Information Centre	✓	39 cases
National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit	Health and Social Care Information Centre	✓	12 cases – 97% case ascertainment rate
National Diabetes Audit - Adults - National Diabetes Transition	Health and Social Care Information Centre	✓	*No additional data submission is needed*
National Diabetes Audit - Adults - National Core Diabetes Audit	Health and Social Care Information Centre	✓	1827 cases
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	✓	101 cases
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research	✓	150 cases
National Joint Registry (NJR) - Knee and Hip replacements.	National Joint Registry	✓	Ongoing
National Lung Cancer Audit (NLCA)	Royal College of Physicians	✓	60 cases
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Royal College of Paediatrics and Child Health	✓	494 cases
National Prostate Cancer Audit	Royal College of Surgeons	✓	114 cases
Oesophago-gastric Cancer (NAOGC)	Health and Social Care Information Centre	✓	24 cases
Paediatric Pneumonia	British Thoracic Society	✓	Ongoing
Sentinel Stroke National Audit programme (SSNAP)	Royal College of Physicians	✓	Early Supported Discharge – 57 cases Community Rehabilitation Team – 9 cases
Severe Sepsis and Septic Shock (care in emergency departments)	Royal College of Emergency Medicine	✓	27 cases

Maternal, Newborn and Infant Clinical Outcome Review Programme data on 26 cases were submitted to MBRRACE-UK who allocate to the appropriate work stream			
Confidential enquiry into stillbirths, neonatal deaths and serious neonatal morbidity	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
National surveillance of perinatal deaths	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Confidential enquiry into serious maternal morbidity	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
National surveillance and confidential enquiries into maternal deaths	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Perinatal Mortality Surveillance	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Maternal mortality surveillance	MBRRACE-UK, National Perinatal Epidemiology Unit	✓	Ongoing
Medical and Surgical Clinical Outcome Review Programme			
Cancer in Children, Teens and Young Adults	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	Ongoing
Heart Failure	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	Ongoing
Acute Pancreatitis	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	5 cases– 100% case ascertainment
Physical and mental health care of mental health patients in acute hospitals	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	5 cases– 100% case ascertainment
Non-invasive ventilation	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	5 cases – 100% case ascertainment

Mental Health Clinical Outcome Review Programme			
Suicide by children and young people in England(CYP)	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), University of Manchester	✓	If cases identified to WH then participate
Suicide, Homicide & Sudden Unexplained Death	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), University of Manchester	✓	
The management and risk of patients with personality disorder prior to suicide and homicide	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), University of Manchester	✓	
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme			
Pulmonary rehabilitation	Royal College of Physicians / British Thoracic Society	✓	Ongoing
Secondary Care	Royal College of Physicians	✓	Ongoing

Additional (non-mandatory) National Audits undertaken during 2016/17

Title of audit	Management Body	Participated in 2016/17	Status
Minimum Data Sets for Palliative Care	National Council for Palliative Care	✓	Completed
Cardiac Rehabilitation	Health & Social Care Information Centre, British Heart Foundation	✓	Ongoing data collection
Systematic anti-cancer therapy - chemotherapy dataset	National Cancer Intelligence Network	✓	Ongoing data collection

National study of HIV in Pregnancy and Childhood	NSHPC	✓	Ongoing data collection
Society of Acute Medicine Benchmarking Audit	Society of Acute Medicine	✓	Completed
7 Day Services Self-Assessment Tool	NHS England, TDA	✓	Completed
NPDA - PREM audit	Royal College of Paediatrics and Child Health	✓	Completed
London Ambulance Service out of hospital cardiac arrest	London Ambulance Service	✓	Ongoing data collection
UNICEF Baby friendly initiative Mother's audit	UNICEF	✓	Ongoing
Smoking Cessation Audit	British Thoracic Society	✓	Completed
Consultant Sign-off (Emergency Departments)	Royal College of Emergency Medicine	✓	Completed
Sexual Health Screening and risk Assessment	British Association for Sexual Health and HIV	✓	Completed
SAS audit on Gonorrhoea management	British Association for Sexual Health and HIV	✓	Completed
BAD-PRPath NMSC Excision National re-audit	British Association of Dermatologist	✓	Completed
Complex Intra-abdominal Infections	Surgical Infection Society and Infectious Disease Society of America	✓	Completed
National Maternity and Perinatal Audit	Royal College of Obstetricians & Gynaecologists	✓	Ongoing data collection
6th National Audit Project of the Royal College of Anaesthetists - Perioperative Anaphylaxis in the UK	Royal College of Anaesthetists	✓	Ongoing data collection
Testing pulmonary rehabilitation audit dataset and new software	British Thoracic Society	✓	Ongoing data collection
The Right Iliac Fossa Pain Treatment (RIFT) Audit	West Midlands Research Collaborative	✓	Ongoing data collection
ESCP 2017 Snapshot audit - left	European Society of	✓	Ongoing data

colon, sigmoid and rectal resections	Coloproctology		collection
National Complicated Diverticulitis Audit	Yorkshire Surgical Research Collaborative	✓	Ongoing data collection
Closure of Intestinal Stoma	European Society of Coloproctology	✓	Completed
Term Neonatal Hypoglycaemia Admissions Audit	NHS England	✓	Completed

The reports of **11** national clinical audits/ national confidential enquiries were reviewed by the provider in 2016/17.

Whittington Health intends to continue to improve the processes for monitoring the recommendations of National Audits and Confidential Enquires in 2017/18 by ensuring:

- National audit and national confidential enquiries will continue as a key component of the Trust Integrated Clinical Service Units (ICSU) Quality Improvement programmes. Priority will be assigned to all mandatory projects thus maintaining our gold standard 100% participation rate with these studies.
- Monthly compliance with these programmes will be monitored via centralised reporting to each respective ICSU.
- Performance outcome presentations for national audits will be given at senior ICSU and corporate level meetings, including Trust speciality half day audit and quality improvement meetings.
- Optimal clinical and managerial leadership will remain essential to ensure national project completion and reflection.

Examples of results/actions being taken for previous national audits:

National Adult Asthma audit 2016 (BTS)

This annual audit focuses on adult asthma admissions to hospital, management in hospital and discharge arrangements. Results accordingly allow comparison and identification of any substantial change in the deficiencies which have been identified in previous years.

Whittington Health audited and submitted 23 cases for the period of September and October 2016. Results were submitted to National Adult Asthma Audit (BTS).

There are 5 best practice items, as below. From the audit results, we are able to assess our own practice and performance and benchmark ourselves against other NHS organisations:

• Assessment of inhaler technique;

• Review of medications;

• Provision of a written action plan and patient self-management;

• Consideration of triggering and exacerbating factors;

• Appropriate follow up arrangements.

Whittington Health promotes a standard practice of respiratory nurse specialists reviewing all adult patients with asthma, admitted to the hospital. The 5 best practice items are reviewed and actioned by these nurses.

Some key results:

- **Gender:** Of our 23 submissions 57% were male (national results 31%) and 43% were female (national result 69%).
- **Length of patient stay and readmission:** Our average length of stay was 4 days compared to national results of 2 days. Significantly however, we only had 4% (1 patient) readmitted within 3 months, compared to 16% nationally. Additionally, several clinical indicators i.e. number of individuals who were hypoxic on admission, had raised pCO2, were current smokers and had adverse psychological or behavioural factors were higher than national figures, demonstrating that our cohort of patients admitted are more unwell than the national average.
- 87% of our patients had **steroids within four hours** compared to 65% nationally. A total of 39% of our patients received these steroids within 1 hour which is gold standard practice. Nationally this figure was 33%.
- We scored 53% for the provision of a **written action plan**. This appears low at initial glance however 30% of patients already had a written action plan in place. Therefore, in total, 83% of our patients left hospital with a personal asthma action plan. The comparative national result was 41.2%. This result is particularly pleasing as the provision of a 'personal asthma action plan' is one of the key recommendations from the recent National Review of Asthma Deaths report.
- 100% of our patients were **discharged on inhaled steroids**; nationally this figure was 82%.

Our complete results demonstrate that our inpatient respiratory nurse specialists cover all elements that would be expected from an asthma 'care bundle'. For each of the five best practice elements, Whittington Health performed better than the national results.

National audit of Inpatient Falls (Report 2015/16)

The National Audit of Inpatient Falls (NAIF) is a clinically led, web-based audit of inpatient falls prevention care in acute hospitals in England and Wales. NAIF aims to improve inpatient falls prevention through audit and quality improvement.

Round 1 of the National Audit of Inpatient Falls took place in 2015. The first report showed data on nearly 5,000 patients aged 65 years or older across 170 hospitals, and reviewed how well hospital trusts and local health boards prevent inpatient falls in England and Wales, which are set against the NICE guideline (CG161) on falls assessment and prevention.

Our actions:

Whittington Health has a **low rate of falls compared to national figures** however we need to address our care plans to incorporate the 7 key indicators.

Plan: To review our current assessment and risk tool to ensure we incorporate these key indicator recommendations:

- Assessment for the presence or absence of delirium and dementia;
- Measurement of lying and standing blood pressure;
- Medication review
- Visual assessment
- Continence/ toileting care plan
- Appropriate mobility aid within patient reach
- Call bells in sight and reach of patient

National clinical audit of biological therapies 2016

The purpose of the National clinical audit of biological therapies is to measure the efficacy, safety and appropriate use of biological therapies in patients with Inflammatory Bowel Disease in the UK. The audit also aims to capture patients' views on their quality of life at intervals during their treatment.

What do we do well?

- In line with national recommendations, all new patients are being commenced on infliximab biosimilars. We are currently working with patients on established therapies to consider switching to biosimilars.
- Our patients undertake comprehensive pre-screening prior to treatment with biological therapies.
- Our patients have documented follow up within 3 months and at 1 year following initial treatment with biologics. A disease activity index is also recorded in all patients at baseline, 3 months and 1 year as a minimum. These steps will ensure that only appropriately responding patients continue to have treatment.
- Steroid use in all patients is kept to a minimum in line with national recommendations.

Plan for improvement:

- Clinicians will share findings and recommendations of this report at relevant multidisciplinary team, clinical governance and audit meetings.
- An updated record should be kept on all patients on biologics and where possible this should be submitted to the IBD Registry for national analysis.

The reports of **113** local clinical audits were reviewed by the provider in 2016/17.

Whittington Health intends to continue to improve the processes for monitoring the recommendations of local clinical audits in 2017/18 by ensuring:

- All clinical audits are mapped against the Care Quality Commission five areas under Key Lines of Enquiry of Safe, Effective, Caring, Responsive and Well-led.

- Capacity will continue to be channelled where appropriate away from small ad-hoc audits to major, national audits vital to safety without losing flexibility or suppressing good local ideas.
- Usage of the newly published quality improvement project form will be monitored on a regular basis. This will allow review of all QI projects to include clinical audit, Model for Improvement, Lean/6-Sigma and Service Evaluation projects.
- A programme of clinical audit awareness sessions, half-day clinical audit teaching workshops and ad hoc information dates by the Clinical Governance Department will continue throughout the coming year. Additionally, we plan to extend this remit to all quality improvement projects.
- Project actions will continue to be assigned to a senior clinician and managerial representative, if appropriate, with specific time scales for completion.
- Project performance will continue to be monitored on an ongoing basis with regular reporting via the ICSU Quality and Board meetings.

Examples of results and actions being taken for local clinical audit:

An audit cycle: Eye care in Intensive Care Unit

Intensive care unit (ICU) patients are at increased risk of developing exposure keratopathy due to intubation, sedation, paralysis and metabolic disturbance. The factors lead to reduced venous return from the eyes, impairment of the blink reflex, loss of the tone of the orbicularis oculi muscles and dysfunction of the corneal healing. Exposure keratopathy can lead to short and long-term visual impairment.

Objectives (conducted over two phases):

- To ascertain the adherence to nursing eye care guidance and elicit the risk factors and rate of exposure keratopathy in mechanically ventilated ICU patients;
- Modify the current eye care guide if necessary.
- Evaluate the effectiveness of the modified eye care guide.

Conclusion:

Exposure keratopathy is a common but preventable condition in mechanically ventilated patients in ICU with the major risks being lagophthalmos. However, prevention and treatment strategies can be developed to identify the patients at risk, prevent the development of exposure keratopathy and, if exposure keratopathy develops, to treat in accordance with best practice guidance. This audit cycle shows that there was no improvement by substitution of hypromellose with carbomer gel. This audit cycle raised awareness of exposure keratopathy in ICU patients and helped educate ICU nurses and doctors about the risk factors and importance of identify and giving regular eye care to patients at risk of developing exposure keratopathy.

Recommendations:

It is recommended that the Whittington ICU implements a modified eye care guide using lacri-lube as initially agreed and then undertake a related audit to measure the adherence to the modified eye care guide and measure its effectiveness in preventing exposure keratopathy.

Obstetric Weight and Nutrition (OWN) Clinic Audit

The OWN clinic has been set up in line with national guidelines (NICE 2010) on obesity in pregnancy and subsequent management. The audit was undertaken to identify if guidance is being followed and whether women are achieving good outcomes for themselves and their babies. It will help us to improve pathways and identify areas of practice that require improvement.

Improving the health and wellbeing of obese pregnant women prevents morbidity and helps to reduce other complications in pregnancy and birth such as post-partum haemorrhage, infections, potential for c-section. (NICE 2010)

The objectives were to identify if the OWN clinic is used in line with guidance:

- To identify where the problems are with the pathway
- To improve on the areas highlighted in the audit as requiring improvement
- To make recommendations for practice once the audit is completed
- To inform relevant professionals of outcomes of audit.

Conclusions include:

This is the first audit of the OWN clinic since its inception therefore there is no previous data is available for comparison. The results were very encouraging in terms of outcomes for mothers and babies. No babies were admitted to the neonatal unit and only one baby was over 5.0kg. One baby was readmitted postnatally to the paediatric ward for poor feeding.

The significant majority of women who were referred to the OWN clinic were appropriate referrals and all women were offered serial scans as per guidance.

Recommendations:

- All weights at booking must be recorded;
- Subsequent weights at 16 weeks, 28 weeks and at term must be clearly documented in notes;
- Midwives to receive reminder that women should be referred to the OWN clinic if they have a Body Mass Index (BMI) of 35 and over;
- All women with a BMI over 35 must have adequate thromboprophylaxis prescribed and administered. Evidence for this must be recorded in the women's notes including TTAs given;
- Women with BMI>40 should have a manual handling assessment antenatally;
- Re-audit in a year with a larger sample size.

Central line Associated Bloodstream Infections (CLABSI) in Paediatric Oncology patients at the Whittington in 2016

Central line associated bloodstream infections (CLABSIs) are known to be a significant cause of morbidity and mortality in this subset of patients: paediatric oncology. Therefore, it is important that we study the cause and nature of these infections in oncology patients to help inform clinical decisions and hopefully reduce rates of these infections.

The aim of this audit was to study the CLABSIs contracted by 4 of the 25 active oncology patients since January 2016.

We comprehensively examined the notes of the paediatric oncology patients known to have had a CLABSI in order to determine the causative organism, the antibiotic prescribed, the type of central line which the patient had and the patient's neutrophil count preceding the infection.

Conclusion:

- There was a higher incidence of CLABSI in those with Hickman lines compared with Port-a-caths or PICC lines.
- The most commonly isolated organism is Staphylococcus epidermidis and the data suggests patients are most vulnerable to this when neutropenic (low white cell blood count).
- Two patients who had CLABSI were not neutropenic, supporting the use of empiric antibiotics to any febrile oncology patient even if not neutropenic.

Action Plan:

- It is important to enforce strict protocols with regards to central lines in order to prevent these infections. These include meticulous hand hygiene, maximal aseptic technique when accessing the line, adequate patient/ parent education about line care and also optimal line type and site selection.
- Additionally every febrile patient should receive immediate empiric antibiotics even if not neutropenic.
- Finally the line should be removed as soon as it is no longer needed.
- This audit should be repeated annually to ensure the correct precautions are in place and the number of CLABSI are reduced as much as possible.

2.2.3 Participation in Clinical Research

At the time of writing (with 2 weeks until the recruitment upload cut-off), during 2016/17, 357 patients who received their care through Whittington Health were recruited into studies classified by the National Institute of Health Research (NIHR) as part of the NIHR research portfolio, once expected uploads are completed this is expected to rise to in excess of 480.

This compares to 284 patients in 2013/14, 701 in 2014/15 and 720 in 2015/16.

This year's reduction in recruitment can be attributed to a number of factors: the NIHR portfolio has fewer high volume recruiting studies available than in previous years, the mix of studies hosted within the trust has changed - there are more specialities involved though the studies are more specialised, there have been changes within the research delivery team that has meant some specialities have had reduced recruiting potential.

There are currently 48 NIHR portfolio studies in progress and recruiting at Whittington Health compared to 41 studies in 2015/16, 31 studies in 2014/15 and 21 in 2013/14. In addition to the 48 NIHR portfolio studies that are on-going, an additional thirteen non-portfolio studies were commenced so far in 2016/17, an increase of 5 studies on the previous year and puts the number at a similar level to 2014/15 having reduced to just eight studies in 2015/16.These studies are undertaken by nurses, allied health professional and trainee doctors and this year various paediatric and community services have hosted the majority of these studies. The results and impact of these studies are published in peer reviewed publications, at conference presentations and are valuable in their ability to innovate within the trust.

We are a year on from the ratification of the Whittington Health Research Strategy that underpins the clinical strategy and reflects the aim of enabling local people to 'live longer healthier lives'. A key strategic goal is to become a leader of medical, multi-professional education and population based research. We believe we are uniquely placed to take a life course approach to population based research and be at the forefront of the synergy between clinical service, education and clinical research. Progress is being made in our efforts to reach the targets within the strategy including the creation of a Research Assistant post to support one of our clinical academics with the development of paediatric population based research.

Participation in clinical research demonstrates Whittington Health's commitment to improving the quality of care that is delivered to our patients and also to making a contribution to global health improvement. We are committed to increasing the number of studies in which patients can participate, and the specialities that are research active, as we recognise that research active hospitals deliver high quality care. The Trust's research portfolio continues to evolve to reflect the ambitions of our Integrated Care Organisation and also reflects the health issues of our local population. The research portfolio includes CAMHS, dermatology, diabetes & endocrine, emergency medicine (and ICU), gastroenterology, haemoglobinopathies, hepatology, health visiting, IAPT, infectious diseases (TB), microbiology, MSK, oncology, orthopaedics, paediatrics, speech and language therapy, urology, and women's health.

2.2.4 Quality goals agreed with our commissioners for the year ahead (CQUINs)

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

Our CQUINs for 2017-18 are as follows:

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

- Personalised care and support planning

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

https://www.england.nhs.uk/wp-content/uploads/2016/11/cquin-2017-19-guidance.pdf

2.2.5 Progress on our 2016-17 CQUINs

In 2016/17, 1.95% percent of our income was conditional on achieving quality improvement and innovation goals agreed between Whittington Health and our local commissioners through the CQUIN payment framework. These goals were agreed because they all represent areas where improvements result in significant benefits to patient safety and experience. Both Whittington Health and our commissioners believed they were important areas for improvement.

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

Performance against CQUINS - pending end of year formal validation by Clinical Support Unit and Clinical Commissioning Groups

CQUIN scheme	Rationale / Objectives	Estimated Compliance
Staff Health and Wellbeing	To improve the support available for NHS staff to help promote their health and wellbeing in order for them to remain healthy and well.	Compliant
Sepsis	To make sure that the appropriate patients who attend the trust in an emergency are screened for sepsis, and receive the necessary antibiotics	Compliant
Antimicrobial Resistance	To reduce antibiotic consumption, encourage focus on antimicrobial stewardship and ensure antibiotic usage is reviewed within 72 hrs of prescribing.	Partially Compliant
Safe and Timely Discharge	To make sure we discharge patients early in the day, where possible, and that information in the discharge summaries sent to general practitioners is complete and timely.	Compliant
Obesity	To record selected patients BMI during admission, to provide advice and guidance to patients with a BMI >30 and record on discharge summary to GP	Compliant

Domestic Violence Prevention	To encourage the provision of specialist advice, information and support services for patients at risk of domestic violence, and to implement domestic violence screening for all patients in maternity.	Compliant
Nutrition and Hydration	To make sure that all COOP patients have a nutrition and hydration screen within 72hr of admission and that all at risk patients have an appropriate care plan in place.	Compliant
Child Health Information System (CHIS)	To promote the secure and timely transfer of clinical records between providers and the tracking of all HepB and BCG immunisations. This promotes best clinical care for the most vulnerable children which includes looked after children	Compliant
CAMHS	To ensure we improve involvement of carers, that unplanned admissions are appropriate and that we improve physical healthcare	Compliant
Oral Chemotherapy	To ensure that we minimise the amount of Oral Chemotherapy that is prescribed, yet not taken by patients - by reviewing length of prescription courses	Compliant

2.2.6 The Care Quality Commission and Whittington Health 2016/17

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

The CQC has not taken enforcement action against Whittington Health during 2016/17.

The CQC carried out a formal inspection of Whittington Health NHS Trust between 8 – 11 December 2015, with further unannounced inspections taking place on 14, 15 and 17 December.

This was the first inspection under the new CQC guidelines and the inspection team visited:

- **Acute hospital** – including emergency and urgent care, medicine (including older people's care), Surgery, Critical Care, Maternity and Gynaecology, Services for Children, End of Life, Outpatients and diagnostic services
- **Community services** – adults, children and young people, end of life care and CAMHS

The findings were published in July 2016. Whittington Health was rated as 'Good' overall and 'Outstanding' for caring.

	Safe	Effective	Caring	Responsive	Well-led
Whittington Health	**Requires Improvement**	**Good**	**Outstanding**	**Good**	**Good**

Summary of overall key question ratings for each sector

	Safe	Effective	Caring	Responsive	Well-led
Whittington Hospital	**Requires Improvement**	**Good**	**Good**	**Requires Improvement**	**Requires Improvement**
Community Services	**Good**	**Good**	**Outstanding**	**Good**	**Outstanding**

The summary report highlighted many areas of good practice across Whittington Health, including;

- Inspectors found staff to be highly committed to Whittington Health and delivering high-quality patient care
- Our patients were positive about the care they received and felt staff treated them with dignity and respect
- Learning from incidents was shared across the organisation to improve patient safety
- Community end of life care and community dental services were rated as outstanding
- The multi-disciplinary model of the ambulatory care service was commended
- Within ED there was “outstanding work” to protect people from abuse

However the CQC also identified areas for improvement across the ICO and the Trust has developed an action plan for improvement based on the ‘must do’ and ‘should do’ recommendations from the report.

Table outlining the CQC action plan:

CQC Recommendation	What we’ve done
To review our bed capacity and improve flow of patients through the hospital – with a particular focus on surgery and critical care.	We have implemented a new Acute and Emergency Pathway Improvement Plan, which focuses on bed management and patient flow. As a result, we have: • A pre 11.00am discharge campaign aimed at staff and patients, designed to reduce delays which aims to get patients home before lunch. • Increasing the number of nurse-led discharges, using a new set of criteria to make sure patients are ready to go home and have the right support in place. • Implementing best practice from other NHS Trusts to improve bed flow, by introducing ‘Red and Green’ day monitoring to identify any obstacles in patient flow. • We’ve introduced new dedicated cordless phones to help improve our communications between wards. Ward clerks can now be contacted anywhere on the ward – helping to reduce delays with porters and also

	providing a dedicated phone line for patients and family members to contact the ward on.
	Further Actions to Complete: • Recruitment to full establishment is expected to be completed by July 2018. • In order to manage the increase demand and acuity, the organisation is focusing on its Emergency Department (ED) Improvement plan and meeting the recommendations set out by Emergency Care Improvement Programme (ECIP) through; embedding the Frailty Pathway into practice, embedding a Rapid Assessment and Treatment (RAT) model to increase senior leadership and decision making at the ED front door, developing a new nursing model to support quicker London Ambulance Service hand over, the recruitment of additional ED Consultants, increasing criteria lead discharge and pre 11 discharges and working extremely closely with health and social work colleagues to safely support patient discharge. • The organisation was visited by ECIP during February. The visit focused on how on improving flow through medicine and surgery to compliment an earlier ECIP visit to the organisation that focused enhancing the front door flow. • The final report made 3 key recommendations for WH: Develop and implement a local version of the SAFER patient flow bundle, supported by the Red2Green approach Develop, measure and monitor a set of internal professional standards (IPS) for inpatient ward processes (e.g. expected time taken to complete a CT scan, expected time taken for the completion of social care paperwork, etc.) Consider the development of a full capacity protocol to support ambulance handover processes and reduce the risk in ED at times of peak escalation
Increase consultant cover in the Emergency Department	• A recruitment campaign is underway to increase the number of consultants in ED • ED have recruited 4/6 consultants required to achieve full establishment (12 consultants), and further interviews took place in April/ May.
	Further Actions to Complete: • Recruitment to full establishment is expected to be completed by July 2018
Within acute outpatient departments **a. Improve storage of records and ensure patients' personally identifiable information is kept confidential**	• A new health records quality assurance group has been established • Lockable trolleys for patient notes in use • Confidential waste bags kept at manned reception desks and locked away securely at night • Random spot checks now show staff have a good knowledge of patient confidentiality issues and information governance.

b. Improve disposal of confidential waste bags left in reception areas overnight.	Further Actions to Complete: • No further actions to take, however we are continuing to improve our records management and information governance training
Within critical care CQC raised concerns about; • **Underreporting incidents and near misses** • **Tailgating and security of ward** • **Mixed sex breaches and delayed discharges**	• A new Datix system is now in place and went live on 6 June 2016. • New staff training programme was introduced to encourage the reporting of incidents – the number of incidents reported has now increased. • Where specific areas of concern around tailgating were raised, security measures have been increased • Our improvement work on bed management and patient flow is designed to reduce delays in discharge and prevent mixed sex breaches
	Further Actions to Complete: • No further actions to take, however we continue to monitor incidents and a monthly report on mixed sex breaches is shared with our commissioners
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	• The consent process has been reviewed and a pilot is underway way trialling new consent forms
	Further Actions to Complete • Following successful completion of the pilot, the new consent forms will be rolled out across surgery by the end of Quarter 2.
Within maternity services ensure the information captured for the safety thermometer tool is visible and shared in patient areas, for both patients and staff	• The maternity safety thermometer tool is now displayed in all maternity ward areas
	Further Actions to Complete • No further actions to take, the maternity safety thermometer is reviewed monthly
Within maternity services there was limited assurance about safety of women undergoing elective procedures in the second obstetric theatre and concerns about theatre staffing cover.	• Our staffing model has been reviewed and following successful recruitment campaign in March 2017, all posts have now been filled. • We have also increased the promotion of our Enhanced Recovery Programme so women feel more supported during their stay with us
	Further Actions to Complete • No further actions to take, safe staffing levels are monitored daily using our electronic rostering tool

Within palliative care **a. Need to increase palliative care consultant cover within the hospital to meet national guidance** **b. Need to improve the way we record information about whether patients were cared for at their 'preferred place of death'.**	• A business case to increase our consultant cover in line with national standards was approved and work is ongoing to increase consultant cover • An audit of patient notes has shown that we do record patient's preferred place of death • Analysis of the information showed that when possible to do so, patient's wishes are respected. However it is not always clinically safe to discharge patients back home
	Further Actions to Complete To meet NICE guidelines, it is recommended as a minimum, that people have access to 24/7 Specialist Palliative Care (SPC) telephones advice and 9am to 5pm, 7 days a week, face-to-face visiting. We recognise the existing service falls short of this standard, however it is rare that services across London provide this in full. In order to optimise the current service and mitigate the risk of not providing 7 day cover we are working collaboratively with CNWL palliative care services to • Strengthen the governance of both organisations by collaborating on data collection, care pathway, clinical guideline, audit and education. • Share posts including rotational roles for the MDT. • Developing clinical leadership with the team; creation of a new Nurse Consultant post. • Explore options of closer collaboration including formal consolidation of the service. • Introduce training roles within the team to facilitate succession plan
At Simmons House: Improve ligature risk assessments and the identification of associated risks	• A review of all ligature risks was undertaken following the inspection and any required actions have now been completed
	Further Actions to Complete • No further actions to take, a full environmental ligature risk assessment is completed annually at Simmons House
Requirement Notice *: At Simmons House: Sufficient equipment and/or medical devices that are necessary to meet people's needs should be available at all times and devices must be kept in full working order. They should be available when needed and within a reasonable time without posing a risk.	• The Whittington Health Resuscitation Team reviewed the emergency bag and confirmed that all necessary equipment was in place
	Further Actions to Complete • No further actions to take, regular reviews are now carried out to ensure equipment is in full working order
Requirement Notice *: At Simmons House: Oxygen cylinders were stored on top of a tall cupboard in	• There are two oxygen cylinders on site at Simmons House; one on a low shelf and one hanging on the back of the door, within easy reach in case of emergency

the clinic room and were not easily accessible in an emergency situation.	Further Actions to Complete • No further actions to take
Requirement Notice *: In community district nursing, CQC found examples where HCAs were not following trust guidelines with respect to insulin administration. Specific staff are required to be authorised to administer to specific patients only.	• Trust policy states that HCA competency for insulin administration is patient specific. • We carried out an audit to check that all HCAs working in the service had been competency assessed and were working within the policy guidelines. • All HCAs continue to be assessed and we keep a database to show which HCAs can administer insulin and to which patients.
	Further Actions to Complete • No further actions to take, we keep a database to show which HCAs can administer insulin and to which patients.

To ensure continuous quality improvement and shared learning, going forward since the CQC visit, the Trust has an ongoing programme of mock CQC visits across different clinical areas and patient safety huddles.

2.2.7 Quality of Data and Information Governance

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

The Trust monitors the quality of this data through use of quarterly benchmark reports and has developed a Data Quality Dashboard for services to monitor their own data quality on a regular basis.

There is no equivalent system in place yet for community data although the implementation of the Children's and Young Person's mandatory reporting dataset has commenced and data is starting to be published. Whittington Health has been supplying demographic and risk factor information consistently since the service commenced October 2015 while continuing to develop the reporting of the other data items. The overall data quality score for all children's data items reported up to October 2016 was 58% against a national score of 55%; the Trust was ranked 3rd out of the 10 London providers submitting data (the highest score was 63%).

Whittington Health's Integrated Clinical Service Units (ICSUs) have responsibility for data quality within their ICSU. The Trust has a Data Quality Group which includes representation from both the community and acute services and the ICSUs. This group is chaired by the Trust's Chief Operating Officer. This group is responsible for implementing an annual data improvement and assurance plan and measures the Trust's performance against a number of internal and external data sources.

Secondary Uses service

Whittington Health submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number and which included the patient's valid General Medical Practice Code were as follows:

	Percentage of records which included the patient's valid NHS number (%)	Percentage of records which included the patient's valid General Medical Practice Code (%)
Inpatient care	99.32%	97.99%
Outpatient care	99.49%	99.07%
Emergency care	95.86%	97.69%

Information Governance Assessment Report

In 2016/17 Whittington Health continued to work to deliver IG Level 2 compliance with the DoH IG Toolkit (IGT). Whittington Health achieved 74 percent, thus meeting full Level 2 compliance for the first time since becoming an Integrated Care Organisation, and also achieving some requirements at Level 3. This is a huge improvement on previous years' scores and has demonstrated year-on-year improvement in compliance with the standards.

The areas that continues to present a challenge to us is the achievement of the 95 percent target for all staff to have completed IG training annually, and IG serious incidents.

The IG training compliance rates will continue to be regularly monitored by the Information Governance Committee, including methods of increasing compliance. The IG department will continue to target staff with individual emails, Whittington bulletin messages and classroom-based Induction sessions.

As IG awareness increases throughout the organisation, our risk of an IG serious incident reduces correspondingly. However, there is room for improvement in terms of staff awareness of policies and procedures and departments complying with IG guidelines, especially when other pressures are continually increasing. We are confident that through increasing ITG training compliance and increasing general IG knowledge and awareness, the IG-related risks to the Trust will reduce.

Clinical coding audit

Whittington Health was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were the following:

Table of coding accuracy

Area audited	% Diagnoses Coded Correctly		% Procedures Coded Correctly	
	Primary	Secondary	Primary	Secondary
General Medicine	100.00	94.21	100.00	87.88
General Surgery	98.00	97.66	100.00	96.39
Gastroenterology	96.67	96.28	95.24	66.00
Obstetrics	100.00	90.26	100.00	91.03
Accident & Emergency	93.33	92.24	100.00	100.00
Overall	**98.00**	**94.20**	**99.22**	**87.94**

Actions taken to improve data quality

In 2016-17, Whittington Health implemented a number of projects to improve data quality, such as in improving the coding of activity, the systematic use of benchmarking data and other reviews, and developing a programme of audits and action plans to improve data quality.

To improve data quality in 2017/18, Whittington Health will require each Integrated Clinical Service Unit (ISCU) to have a Data Quality Improvement Plan, which will be reported against on a regular basis at the Data Quality Group.

2.3 National Performance Indicators

2.3.1 The Summary Hospital-level Mortality Indicator (SHMI)

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

Most recent performance:

Using the most recent data available, (released Mar17) that covers the period October 2015 to September 2016, the SHMI score for the Whittington is:

Whittington Trust SHMI score: 0.6897

- Lowest National Score: 0.6897 (Whittington Health)
- Highest National Score: 1.1638

Previous Performance:

The data released in March 2016 covered the period October 2014 to September 2015:

Whittington Health SHMI score: 0.6516

- Lowest national score 0.6516 (Whittington Health)
- Highest national score 1.198

The SHMI score represents a comparison against a standardised National Average. The 'national average' therefore is a standardised 100 and values significantly below 100 indicate a lower than expected number of mortalities (and vice versa for values significantly above).

Patients who are coded as receiving palliative care are included in the calculation of the SHMI. The SHMI does not make any adjustment for patients who are coded as receiving palliative care. This is because there is considerable variation between trusts in the coding of palliative care. Whittington Health coding from palliative care indicates that the combined % of deaths with either palliative care diagnostic coding, or under a palliative care specialty is 0.4% for the period Oct15-Sep16 (3 deaths out of 512) and 0.18% for the period of Oct14-Sept 15.

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

Whittington Health is taking the following actions to further improve this score, and so the quality of its services, by:

- Providing regular learning events and resources for all staff to facilitate learning from incidents and findings from unexpected deaths;

- Ensuring that all inpatient deaths are systematically reviewed, and that any failings in care that suggest a death may have been avoidable are identified, systematically shared, learned from, and addressed.

2.3.2 Patient Reported Outcome Measures (PROMs)

The outcomes of these measures are reported one year in arrears. Two years ago no questionnaires were sent out to patient's pre or post operation due to an administrative error. This year Whittington Health participated in the PROMs project, however there was not a sufficiently high response rate to produce any statistically significant results (a minimum of 30 post-operative results for a given procedure are required).Post-operative response rates were also insufficient in 2015/16 (21).

The issue with questionnaires has now resulted in a low linkage performance for this performance measure. Questionnaires are now regularly sent out and chased up by the pre and post operation relevant staff and our return is now improving.

Finally please note that we only started undertaking varicose vein operative procedures at Whittington Health in April 2017, i.e. this year which is why the report is showing as null.

Table 1: Pre-operative participation and linkage

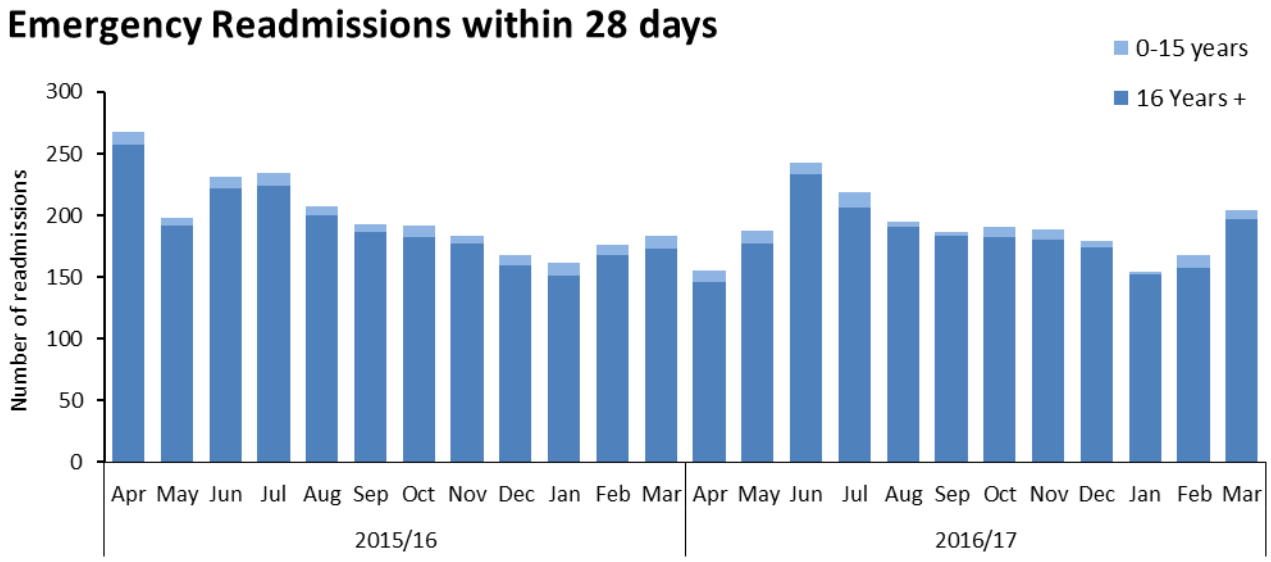
	Eligible hospital procedures	Pre-operative questionnaires completed	Participation Rate (%)	Pre-operative questionnaires linked	Linkage Rate (%)
All Procedures	296	206	69.6	141	74.6
Groin Hernia	139	80	57.6	48	69.6
Hip Replacement	88	64	72.7	52	79.9
Knee Replacement	69	62	89.9	41	71.4
Varicose Vein	*	*	*	*	81.8

Table 2: Post-operative issue and return

	Pre-operative questionnaires completed	Post-operative questionnaires sent out	Issue Rate (%)	Post-operative questionnaires returned	Response Rate (%)
All Procedures	206	52	25.2	22	41.1
Groin Hernia	80	44	55.0	18	48.7
Hip Replacement	64	0	0.0	0	37.4
Knee Replacement	62	8	12.9	4	37.0
Varicose Vein	*	*	*	0	39.1

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

2.3.3 Readmissions



**Data is reported against the month of the emergency readmission*
***Data excludes patients between 0 and 4 years at time of admission*

The Trust considers that this data is as described as it has a robust clinical coding and data quality assurance process, and our readmission data is monitored through the Trust Board or TMG on a monthly basis. National data has not been published beyond 2011/12. Consequently, national comparison is not available and this information is generated locally by the trust.

The Trust intends to take the following actions to improve its readmissions rates:

- Launching a new clinical pathway for non-elective patients over the age of 75 with frailty, to provide early CGA/ geriatrician input in the Acute Admissions Unit for patients who have potential to be discharged ≤ 48 hours

- In 2017 we are introducing ward based Flow Liaison Officers to key wards to support timely and safe patient discharge using both Enhanced Recovery (medicine/ surgery) and Red to Green methodology.

2.3.4 Responsiveness

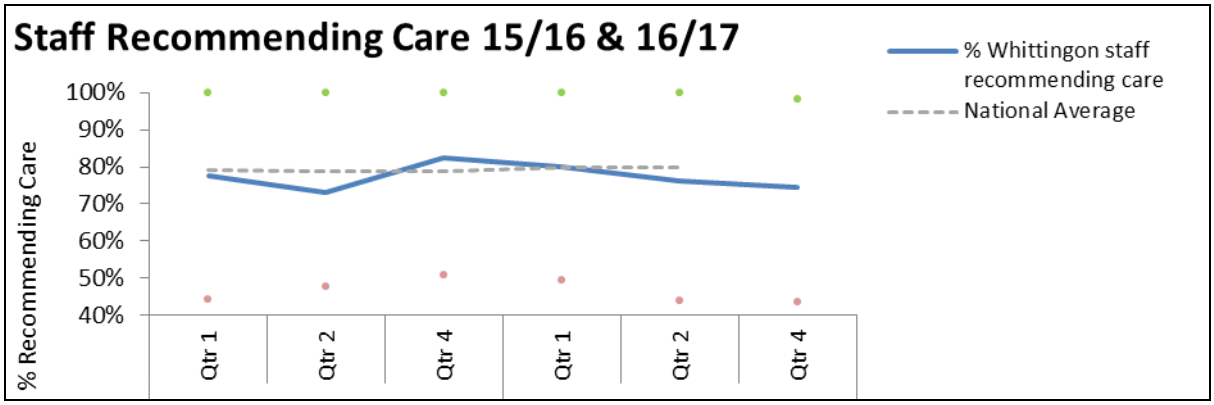
The Responsiveness score for the Trust uses The NHS Outcomes Framework -Patient experience of hospital care. It is based on the average score from a selection of questions from the Inpatient Survey measuring patient experience (score out of 100)

The score for Whittington Health was: **75.2**

2.3.5 Staff Friends and Family Test

FY	Month	% Whittingon staff recommending care	National Average	Highest performing trust	Lowest performing trust
2015/16	Qtr 1	77.5%	79.2%	100.0%	44.3%
	Qtr 2	73.2%	79.0%	100.0%	47.8%
	Qtr 4	82.3%	78.7%	100.0%	50.8%
2016/17	Qtr 1	80.1%	79.9%	100.0%	49.5%
	Qtr 2	76.2%	80.0%	100.0%	43.8%
	Qtr 4	74.6%	79.3%	98.2%	43.6%

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



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

Summary of Quarter 4 Whittington Health Responses

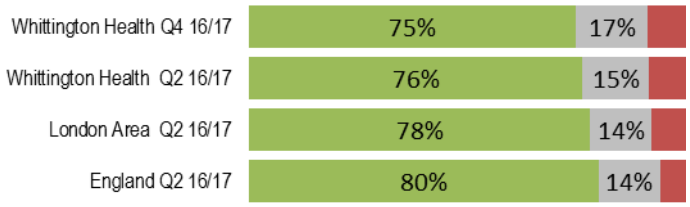
Total Respondents	986	**Response Rate**	24%

	Care	Work
	How likely are you to recommend	How likely are you to recommend
% Recommended	75%	61%
% Did not recommend	9%	23%

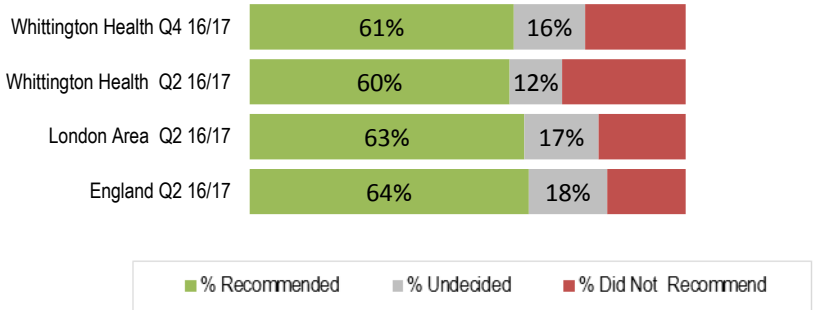
2) Numerator for % recommending: number of *'likely' or 'extremely likely'* responses

Proportion of employees recommending care and workplace

Care



Work



The Trust has high levels of staff engagement and our Family and Friends Test show that staff perception of the Trust's services to be high. We believe that the willingness of staff to recommend the Trust as a place to be treated is a strong and positive indicator of the standard of care provided

2.3.6 Venous Thromboembolism (VTE)

Every year, thousands of people in the UK develop a blood clot in the vein. It is known as the venous thromboembolism (VTE) and is a serious, potentially fatal, medical condition. Here at Whittington health we continue to strive towards ensuring all admitted patients are individually risk assessed and have appropriate thromboprophylaxis prescribed and administered. We have consistently achieved above 95% or above compliance over the past year.

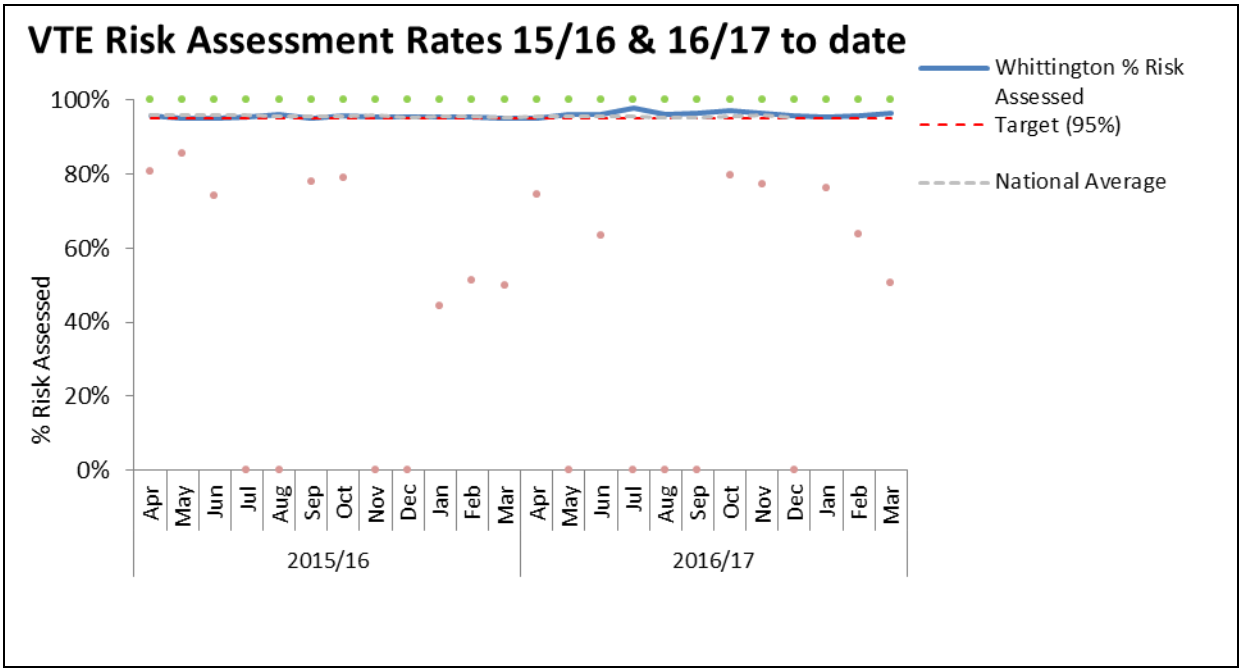
The Trust considers that this data is as described for the following reasons as it is generated via daily, weekly and monthly reports and submitted via the dashboard to executive level.

In 2016-17, the Trust has taken the following actions to improve our approach to VTE:

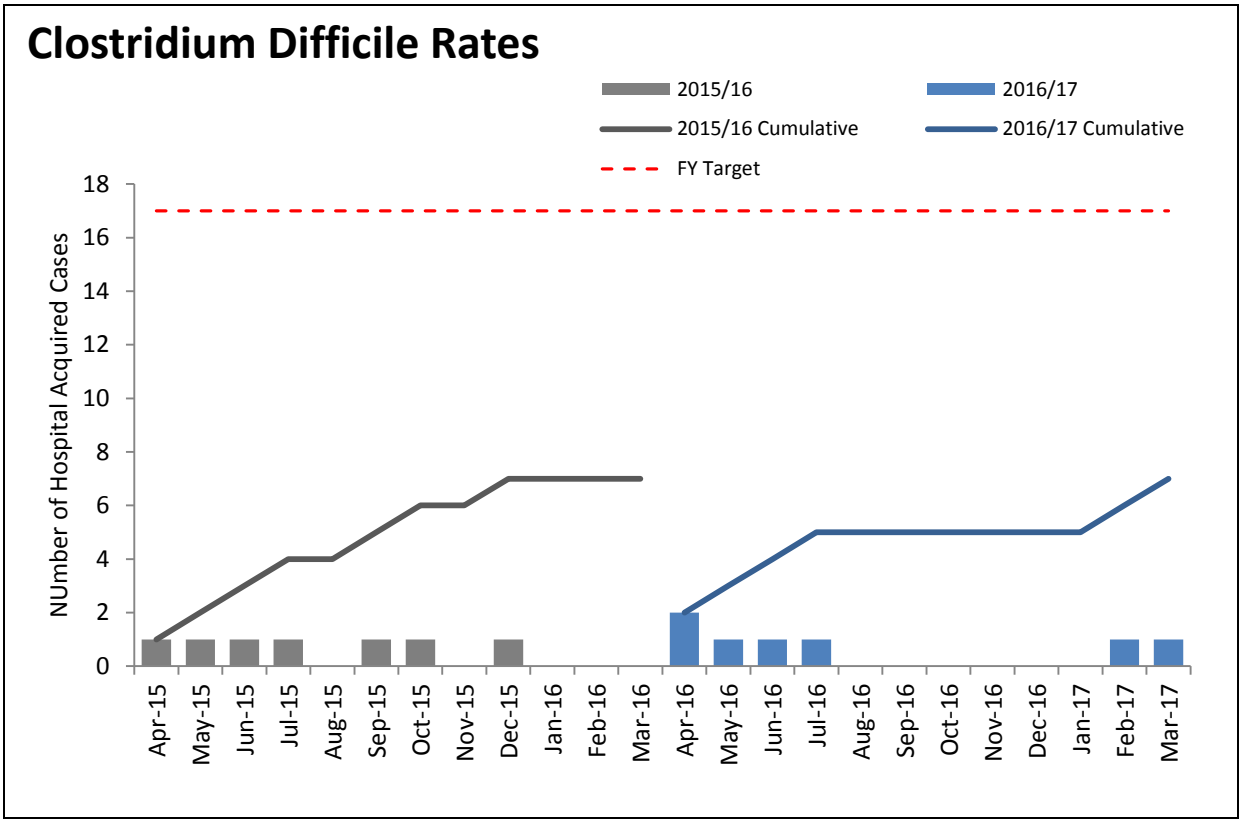
In an effort to continuously improve and review our pathways our medical colleagues undertook audits to ensure VTE compliance is robust and aligned with best patient outcome, for example, two of our doctors undertook an audit of Friday review sheets which is a process for senior clinicians to review and document the weekend plan of care. This identified good compliance across medicine but less so in surgery. Following this review we have introduced a bespoke Friday review sheet across surgery. This document has an

embedded VTE risk assessment, as a prompt mechanism, for clinicians working over the weekend – this ensures continuity of care across the seven days.

Another area of improvement in VTE care over the past year includes improved VTE pathway management. Previously the flow of patients who required further investigation and follow-up was sometimes circuitous with patients going between various health care settings and providers prior to decisions being made. There was also a significant delay in patients being reviewed in the haematology clinic due to work-load pressures. To address this, a regular clinic (initially monthly, now fortnightly) has been created in the Ambulatory care setting (a frequent site of diagnosis of VTE and referrals into haematology). In the initial 6 months this has led to a significant improvement in adherence to the NICE guidelines, improved patient satisfaction and stakeholder engagement. 91% of patients were able to be discharged with a care plan (sent to the patient, primary care and anticoagulation) with the remainder 9% of complex patients then being seen in the general haematology clinic for further follow-up. We are currently reviewing our guidelines on VTE in conjunction with our pharmacy colleagues to further streamline our service and in line with increased use of Direct Oral Anticoagulants (DOACs) in our trust.



2.3.7 Clostridium Difficile



*The Whittington Health NHS Trust considers that this data is as described as it is collected, downloaded and processed in a robust manner, and reviewed as part of routine board and departmental monitoring of infection control.

Month & Year		Whittington Health			National Total	Trust with lowest incidence	Trust with highest incidence
		Monthly Cases	YTD Cumulative	FY Target			
Apr-15		1	1	17	421	0	19
May-15		1	2	17	476	0	12
Jun-15		1	3	17	425	0	16
Jul-15		1	4	17	466	0	14
Aug-15		0	4	17	436	0	14
Sep-15		1	5	17	454	0	12
Oct-15		1	6	17	463	0	10
Nov-15		0	6	17	436	0	15
Dec-15		1	7	17	409	0	16
Jan-16		0	7	17	419	0	11
Feb-16		0	7	17	401	0	11
Mar-16		0	7	17	358	0	11
Apr-16		2	2	17	357	0	10
May-16		1	3	17	386	0	14
Jun-16		1	4	17	359	0	11
Jul-16		1	5	17	390	0	10
Aug-16		0	5	17	427	0	14
Sep-16		0	5	17	433	0	12

Oct-16		0	5	17	401	0	11
Nov-16		0	5	17	411	0	11
Dec-16		0	5	17	369	0	14
Jan-17		0	5	17	414	0	15
Feb-17		1	6	17	325	0	11
Mar-17		1	7	17	*national Data not yet published		

During 2016/17 we had seven *Clostridium difficile* cases attributable to Whittington Health. The following paragraphs outline the actions we have taken to reduce the number of *Clostridium difficile* cases that are attributable to Whittington Health.

Consultant led post infection review meetings (PIR) were held on all cases and the reports disseminated to relevant parties both internally and externally. Our agreed ceiling trajectory for 2016/17 was set at 17 cases and we reported six cases at year end.

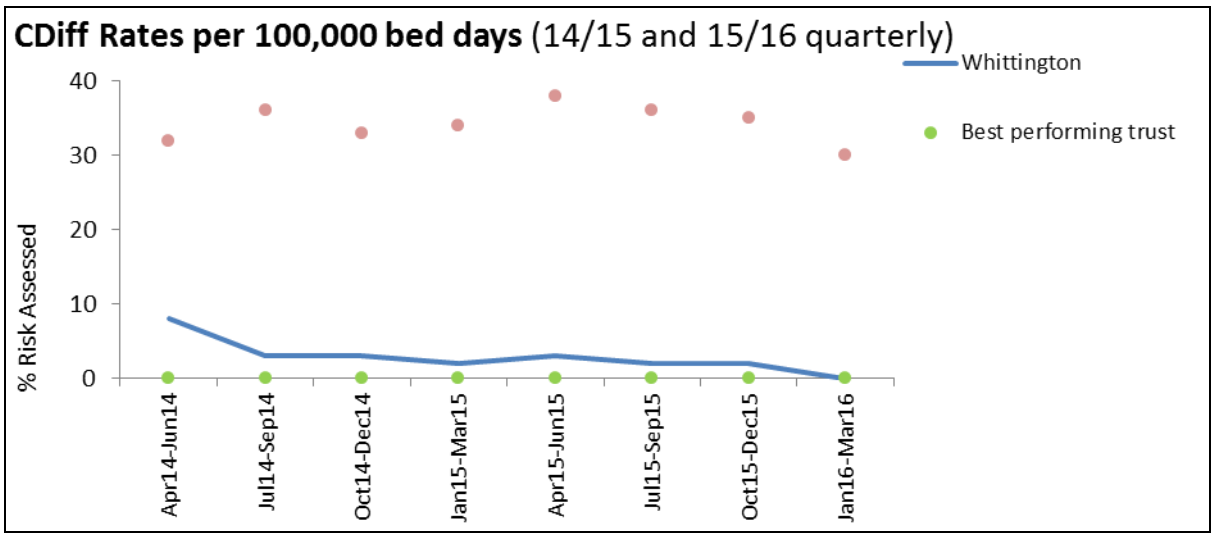
Each patient case of attributable *Clostridium difficile* was thoroughly investigated with a full Consultant-led post-infection review focusing on all aspects of the patient pathway from admission to diagnosis. All cases were deemed unavoidable with no lapses in care.

Infection Prevention and Control alerts are already placed on our Medway electronic patient records system for patients diagnosed with healthcare associated infections but it is apparent that these are not always reviewed prior to bed placement. A further alert has been introduced to the JAC electronic prescribing system to improve staff awareness and aid the correct bed placement of the patient in order to reduce the risk of cross contamination.

We purchased additional patient equipment to aid with the management of infectious / potentially infectious patients. Twenty two electronic blood pressure fixed monitors for our cubicles and 10 isolation carts to be used for cohort / individual bedside isolation.

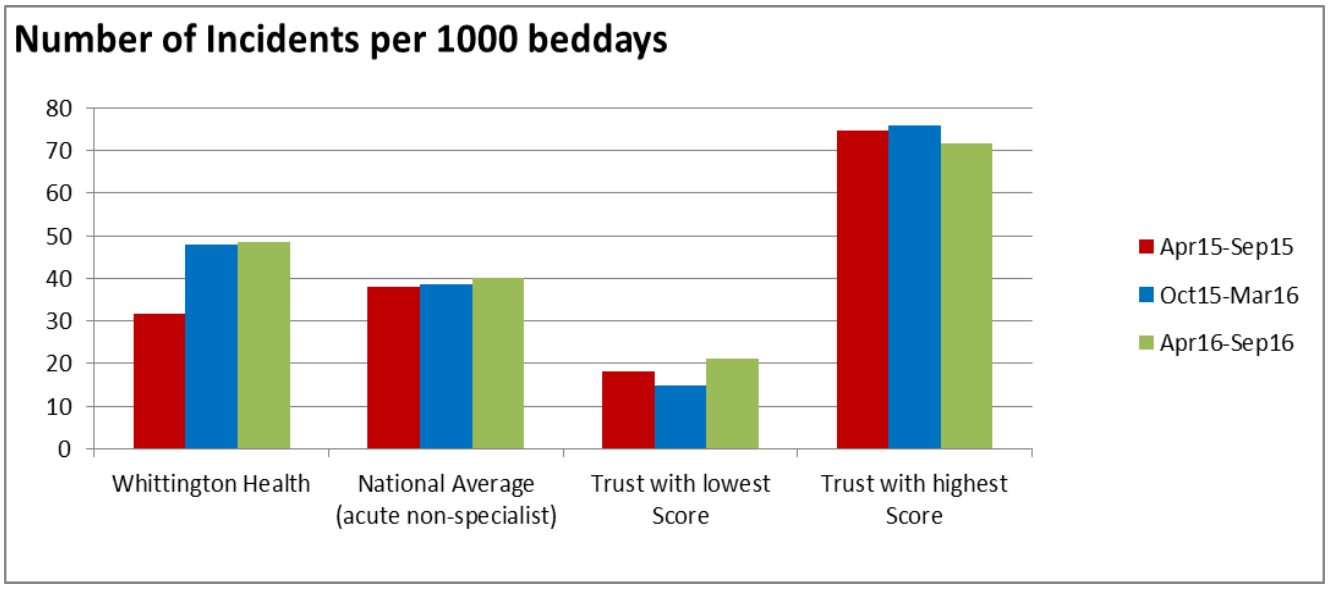
Education sessions specifically on *Clostridium difficile* continue on our acute wards.

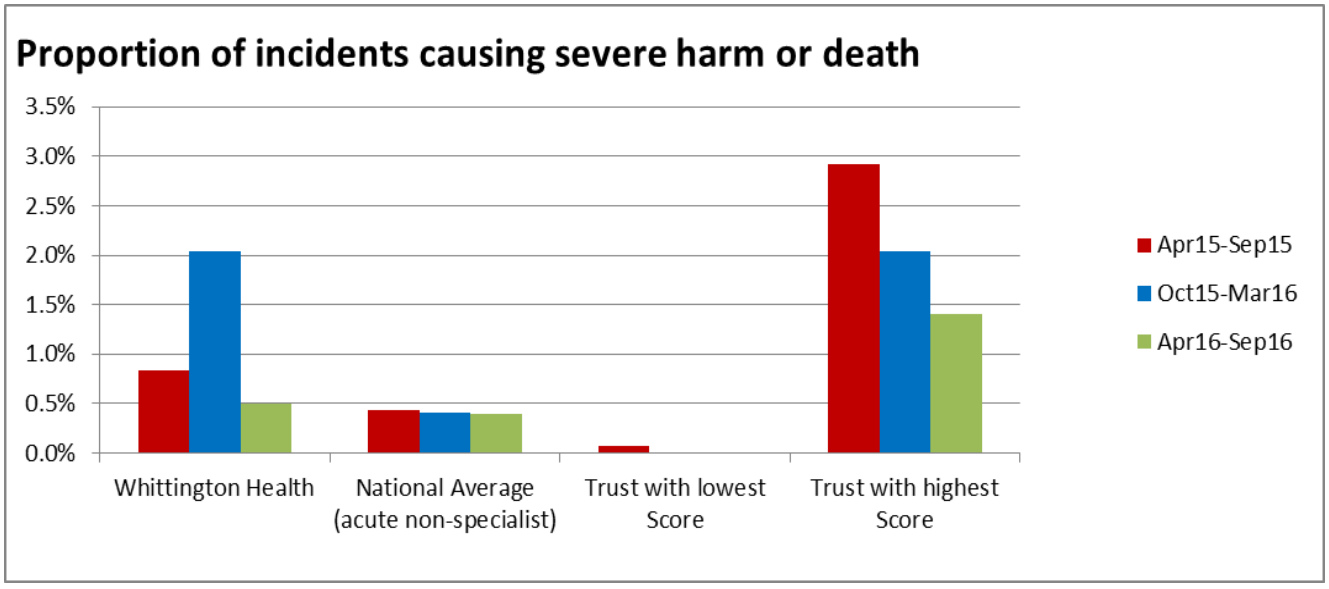
Below identifies our CDiff rates per 100,000 bed days. These national figures are only available up to end of March 16. The data in the CDiff rates discussed in this paper are for 16/17 and are in the graph above.



2.3.8 Patient safety incidents

		Apr15-Sep15	Oct15-Mar16	Apr16-Sept16
Number of Incidents	Whittington Health	1559	2506	2362
	National Total (acute non-specialist trusts)	632050	655193	





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

In April 2015 to September 2015 Whittington Health was an average reporter of patient safety incidents to the National Reporting and Learning System (NRLS). Between October 2015 and March 2016 there was a significant increase in reporting to NRLS such that Whittington Health is now in the top quartile of trusts reporting patient safety incidents. Whittington Health remained in the top quartile of trusts reporting safety incidents for April

2016 to September 2016. Whittington Health has reported 8% more incidents during October 2016 to March 2017.

This has been celebrated by the Trust in recognition that organisations that have high reporting numbers have been shown to be those with an established strong patient safety culture. At the time of reporting approximately 2.7% of the reports within the April 2016 to September 2016 NRLS data had not been validated.

Whittington Health appears to have a higher proportion of incidents causing severe harm or death compared to the national average for acute non-specialist trusts. This has, however, decreased in the last reporting period from 13% to 4.6%.

The Trust intends to or has taken the following actions to improve:

- Each patient safety incident (reported on Datix) that is believed to be associated with severe harm or death is reviewed within 72 hours by the ICSU clinical staff and immediate mitigating steps are put in place.
- These 72 hour reports are reviewed at the Serious Incident Executive Approval Group Panel weekly by the Medical Director, Chief Operating Officer and Director of Nursing (or representatives). Any further key learning messages relevant to staff are sent out via Trust-wide email at this stage. Full root cause analysis investigations are undertaken for all severe harm and death incidents with action plans created, reviewed and shared with relevant parties.
- Learning from incidents are shared through multiple outlets including patient cases on Moodle (interactive e-learning platform), messages of the week sent out via ICSU leads, Spotlight on Safety newsletter, Medicine Safety newsletter, Maternal Cats Eyes newsletter, learning site on intranet, patient safety forum and at team departmental and ward-based meetings.
- The Trust recognises the need to ensure that there is more complete ICSU sign-off prior to uploading data to the NRLS website.

During 16/17 unfortunately the Trust had 2 never events. One was a retained foreign object post-procedure and the other was a misplaced naso-gastric tube. Both of these events were fully investigated and root cause analysis conducted. The learning was disseminated across the organisation.

2.3.9 Friends and Family Test

Our goal is to provide our patients with the best possible experience by increasing the number of patients who respond and the percentage of patients who would recommend our Trust to friends and family if they needed similar care or treatment.

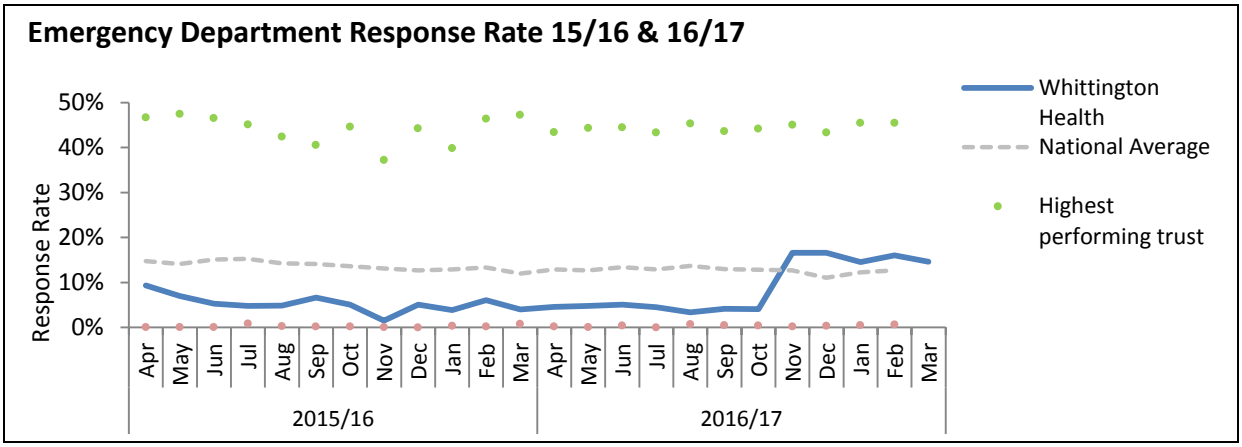
We know that treating our patients with compassion, kindness, dignity and respect has a positive effect on recovery and clinical outcomes. To improve their experience in our hospital and Community, we need to listen to our patients, their families and carers, and respond to their feedback. The Friends and Family Test (FFT) is one key indicator of patient satisfaction. Through our real time patient experience trackers, this test asks patients whether they would be happy to recommend our Trust to friends and family if they needed similar treatment.

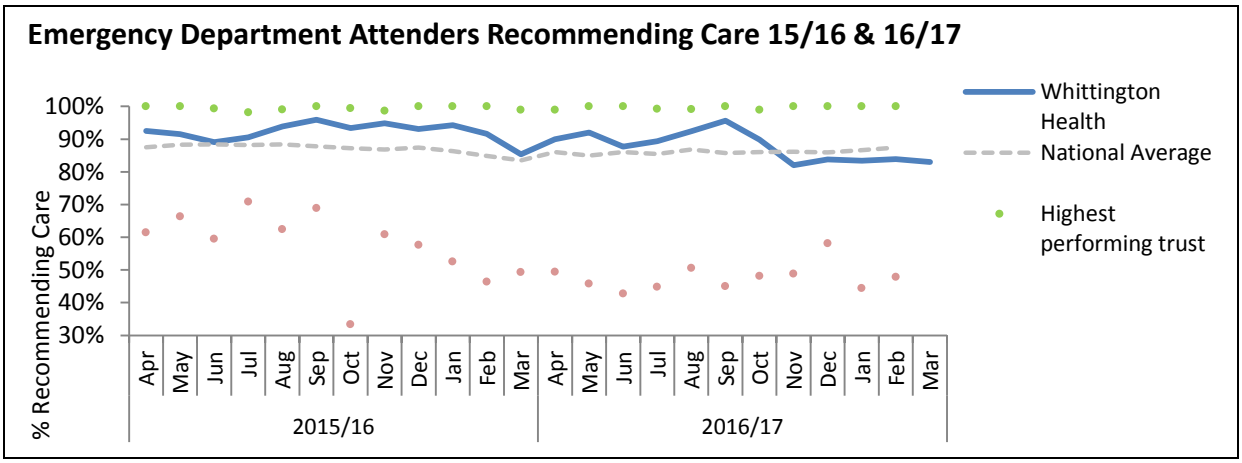
In 2016/17 we achieved our goal of increasing the percentage of inpatients and A&E patients who would recommend our Trust to friends and family, exceeding our target for both and improving on our performance last year.

For patients reporting a positive experience, interaction with staff is the most significant factor. When patients report a negative experience, the cause is usually due to ineffective systems and processes. We continue to take steps to improve our systems and processes to ensure that waiting and delays are kept to a minimum and, where they are unavoidable, patients are kept informed and the environment and staff are as welcoming and supportive as possible. We have achieved our goal through a number of improvements we made that were designed to ensure our services are caring, putting the individual at the centre of their own care, and treating them as we would like our own friends and family to be treated, while also enabling us to achieve our targets for 2015/16. These are described below.

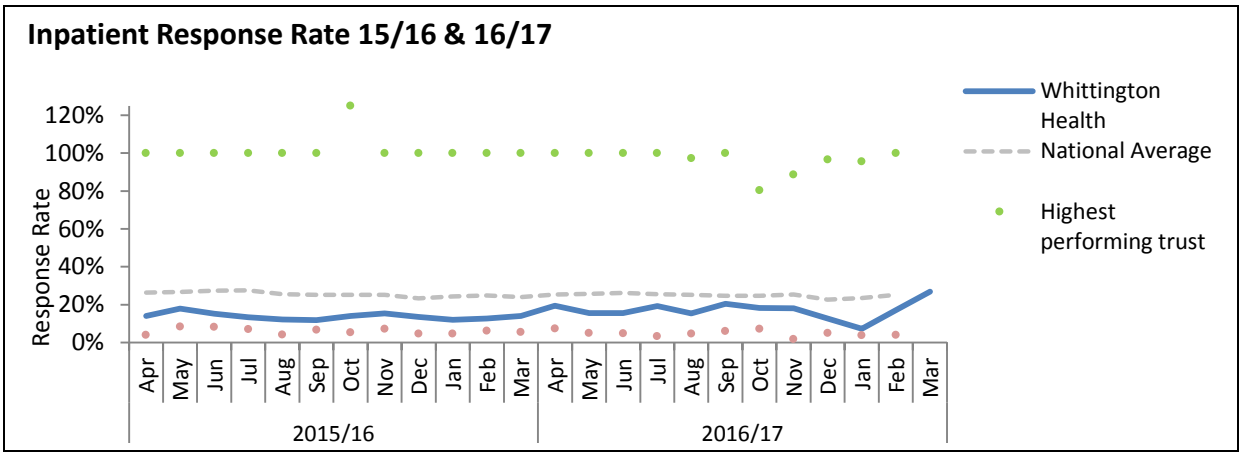
We have identified further improvements in our quality targets for next year which will continue to improve patient experience across Whittington Health.

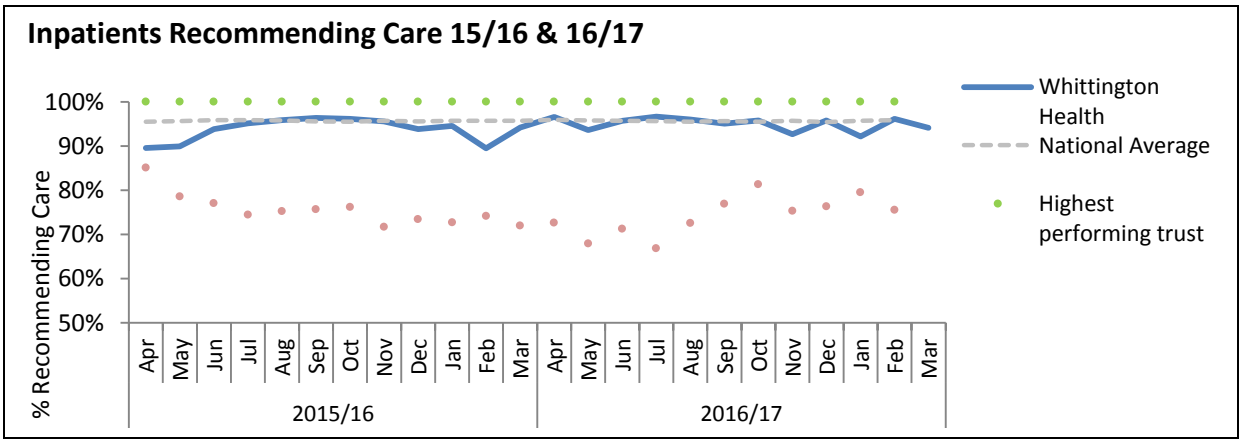
Friends and Family Tests in the Emergency Department





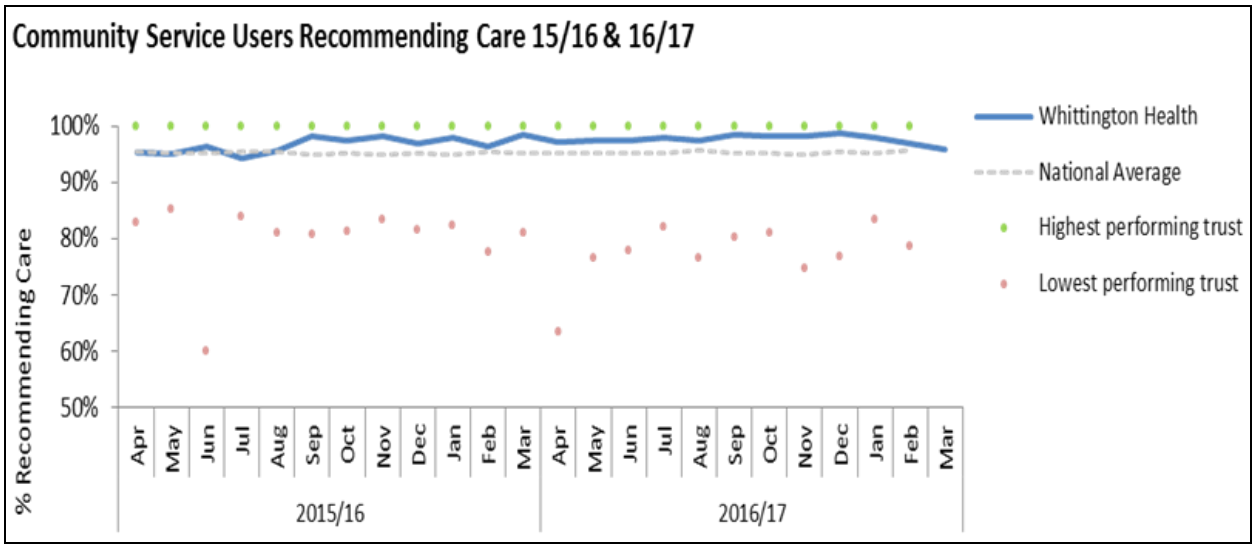
Friends and Family Tests Inpatient Results

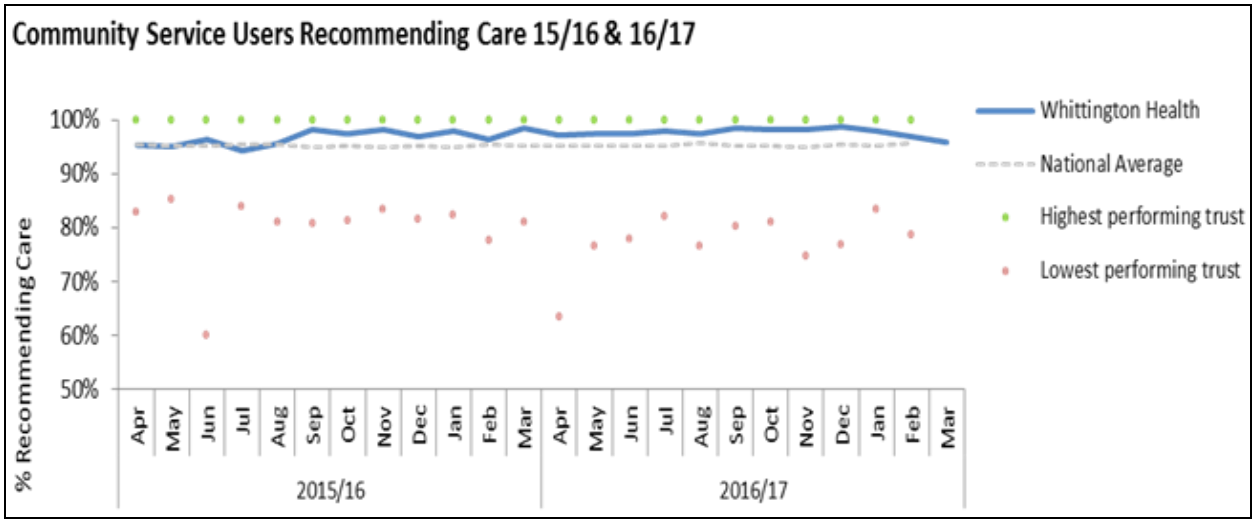




*The Whittington Health NHS Trust considers that this data is as described as it is collected, downloaded and processed in a robust manner, and checked and signed off routinely.

Friends and Family Test- Community Services Results.





While there have been consistently positive Friends and Family Test (FFT) responses for adult community services, the overall response rate has remained low. This includes the highest volume community service District Nursing (DN) . The nature of the patient group and one to one visiting makes introducing new ways of collecting feedback such as text messaging challenging. A sample of patients receive the FFT questionnaire via post and the DNs ask the patents to complete a survey on the DN iPad when they visit.

A 'You Said, We Did' approach is being rolled out and these improvements will be detailed in the service leaflet. In 2017/18 the service will be engaging one of the local voluntary sector organisations to visit patients for structured feedback.

We are pleased that the response rate for other adult community services such as Musculoskeletal, podiatry and 'Improving Access to Psychological Therapies' are increasing. In 2017/18 the services will be introducing text messaging and FFT emails to help improve response rates.

2.3.10 Duty of Candour

As soon as is reasonably practicable after becoming aware that a notifiable safety incident has occurred, the clinician in charge initiates a "being open discussion" with the patient and family or relatives acting on behalf of the patient.

Whittington Health clinicians actively encourage service users and relatives to ask questions and contribute to the Terms of Reference of serious incident investigations.

Duty of Candour meetings take place whilst the patient is an in-patient, i.e. at the "bedside" or when a patient is back at home following discharge or via community based care.

If an incident results in moderate harm or above, a Duty of Candour Lead is identified and appointed by the service, unit or department. The Duty of Candour Lead sends a written apology which clearly states:

- Whittington Health is sorry for the suffering and distress resulting from the incident;
- Whittington Health considers the safety of patients to be a top priority and compliance with the Duty of Candour is customary practice;
- A detailed inquiry into what happened and why, which will include investigation of the patient's concerns will be carried out;

- The patient or next of kin is contacted once again when the investigation has been completed and offered the opportunity to discuss the findings and receive a copy of the inquiry outcome.

Patients are encouraged to provide feedback about how Whittington Health is embracing candour and what improvements could be made to the Duty of Candour approach.

Our Board is responsible for ensuring that a culture of openness, trust, service improvement and sharing of learning is present within the organisation. It has overall responsibility for ensuring that the Trust's duties with regard to the management of Serious Incidents are appropriately discharged, including ensuring compliance with the Duty of Candour. The Board receives assurance of compliance through the Quality Committee.

Duty of Candour Key Performance Indicators are reported quarterly and monitored by the Clinical Quality Review Group in order to provide assurance to partner Clinical Commissioning Groups on Whittington Health compliance with the statutory Duty of Candour.

3. Quality in 2016/17

3.1 Progress against our 2016/17 quality priorities

In 2016/17 we reaffirmed our commitment to our Sign up to Safety pledges by aligning them with our quality priorities. The Sign up to Safety initiative aims to progressively improve quality in the chosen areas over a period of three years; 2016/17 was the second year of the campaign. The views were considered by the Quality Committee and ratified by the Trust Board following consultation with stakeholders.

The table below lists the 2016/17 quality priorities.

Trust Strategic Goals	Quality Priorities
To secure the best possible health and wellbeing for all our community	**1. Learning Disabilities** a) We will develop and implement 'Always Events' for patients with Learning Disabilities in a relevant clinical setting.
	b) We will aim for 75 percent of inpatients with learning disabilities to meet the Learning Disability specialist nurse during their admission.
	c) We will aim for 75 percent of **relevant** staff who work in our Emergency Department to have specific training in the care of patients with Learning Disabilities.
To integrate/co-ordinate care in person-centred teams	**2 Falls** a) We will reduce the number of inpatient falls that result in severe/moderate harm by 25 percent. Target = 4 falls of severe harm.
To deliver consistent high quality, safe services	**3 Sepsis** We will achieve the targets of the new and expanded national sepsis CQUIN in 2016/17:

	a) 90% of eligible **patients in ED** screened for sepsis (CQUIN)
	b) 90% of eligible **inpatients** screened for sepsis (CQUIN)
	c) 90% of **ED patients** diagnosed with sepsis, receive antibiotics within 60mins of arrival in ED and day 3 review (CQUIN)
	d) 90% of **inpatients** diagnosed with severe sepsis administered antimicrobials within 90 minutes and day 3 review (CQUIN)
To support our patients/users in being active partners in their care	**4. Pressure Ulcers** a) We will implement our 'React to Red' pressure ulcer prevention campaign
	b) We will have no avoidable grade four pressure ulcers.
	c) We will reduce the number of avoidable grade three pressure ulcers in the acute setting by 25 percent. Target based on average from 2014-16 = 6 Grade 3
	d) We will reduce the number of avoidable grade three pressure ulcers in the community by 25 percent. Target = 28
To be recognised as a leader in the fields of medical and multi-professional education, and population-based clinical research.	**5. Research and Education** a) We will increase by 10 percent the number of National Institute of Health Research (NIHR) programmes in which we participate
	b) We will launch and publish a newsletter to promote our research and education activities and engagement programmes. We will publish this at least four times a year.
To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population	**6. Patient Experience** a) We will improve the response rate of Family and Friends Test responses by 20 percent in the year. We will document and report our actions from patients' and carers' feedback within our Quarterly Patient Experience Report to the Quality Committee. Target for 2016/17= 25,063 responses
	b) We will develop our Patient and Carer Experience Strategy.
	c) We will revise our Communication and Engagement Strategy.
	d) We will establish a Community Forum which reflects the diverse community we serve.

	e) We will host a minimum of four engagement events and report to our Board on how we have improved opportunities for our patients, carers, public and stakeholders to engage and inform our strategic plans to help local people live longer healthier lives.

3.1.1 Priority 1: Learning disabilities

Always Events®, initially conceived in the US by the Picker Institute and now led by the Institute for Healthcare Improvement (IHI), are defined as those aspects of the care experience that should always occur when patients, their family members or other care partners, and service users interact with health care professionals and the health care delivery system.

Always Events® must meet four criteria:

1. Important: Patients, their family members or other care partners, and service users have identified the event as fundamental to improving their experience of care, and they predict that the event will have a meaningful impact when successfully implemented.

2. Evidence-based: The event is known to contribute to the optimal care of and respect for patients, care partners, and service users (either through research or quality improvement measurement over time)

3. Measurable: The event is specific enough that it is possible to determine whether or not the process or behaviours occur reliably. This requirement is necessary to ensure that Always Events® are not merely aspirational, but also quantifiable.

4. Affordable and Sustainable: The event should be achievable and sustainable without substantial renovations, capital expenditures, or the purchase of new equipment or technology. This specification encourages organisations to focus on leveraging opportunities to improve the care experience through improvements in relationship-based care and in care processes.

For 2016/17, we focused on making a referral to the learning disability nurse an ‘always event’ for all patients with a registered learning disability. As part of this project we introduced an electronic referral system to the learning disability nurse. In addition to increasing the number of referrals, this new system will allow us to identify areas of inappropriate referral for targeted training (e.g. service users with a mental health condition, autism or dementia referred to learning disability nurse).

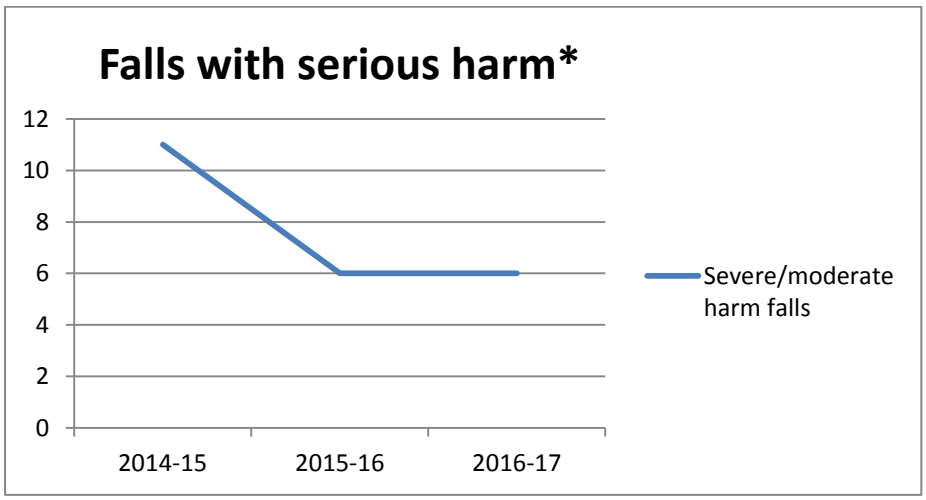
During 2016/17, the trust achieved its target for 75% of inpatients with a registered learning disability to be seen by the learning disability nurse. The electronic referral system has contributed to this achievement.

With regard to training, the trust has developed an e-learning module for learning disability awareness, which is provided in addition to face-to-face training across the Trust. The Trust has not yet reached its target of ensuring 75% of patient-facing staff in the Emergency Department have up to date training in learning disability, however training sessions are ongoing.

3.1.2 Priority 2: Falls

As part of Sign up to Safety, we pledged to reduce the number of inpatient falls that result in serious harm, to ensure that every patient has a falls risk assessment and to implement the 'falls care bundle' for high risk patients in acute settings. In 2015/16, we reduced the number of inpatient falls that resulted in serious harm (i.e. harm that met the criteria for a serious incident investigation) by 45%. In 2016/17, Whittington Health pledged to reduce the number of these inpatient falls by a further 25%, a target of 4 falls.

Unfortunately, we did not achieve our target in 2016/17, however during the year we developed a new 'falls bundle' which provides more comprehensive risk assessments and care plans for our patients, in line with the recommendations of the Royal College of Physicians. We ran a multi-disciplinary programme of education to raise awareness around the needs of patients with delirium and dementia, and added a delirium screening tool for inpatients on admission. In addition, there have been widely attended learning events on falls and more rapid feedback of learning from falls incidents. We have also been selected as one of only twenty trusts to participate in the NHSi falls collaborative. The project focuses on using the newly developed falls bundle to reduce falls on Mary Seacole North and South wards our acute admission wards.



*serious harm was defined as falls meeting the criteria for a serious incident investigation

3.1.3 Priority 3: Sepsis

Sepsis is diagnosed in approximately 260,000 patients in NHS England each year and is responsible for an estimated 44,000 deaths annually, including 1,000 paediatric deaths. Recognising sepsis early and commencing “sepsis 6” interventions rapidly, as well as escalating treatment plans for those with severe sepsis, is paramount in attempting to reduce these mortality figures.

Early recognition and rapid management of sepsis is a key patient safety objective for Whittington Health and monitored through our local Trust ‘Sign up to Safety’ priorities and the Trust’s quality priorities for 2016/17. In addition, it is also a national CQUIN.

Sepsis Quality Account, CQUIN and the ‘Sign up to Safety’ performance data

Whittington Health achieved the Quality Account priority to meet the national CQUIN in 2016/17 for all patients being admitted through the emergency department with sepsis. The national sepsis CQUIN data for Quarter 2 of 2016/17 showed this Trust as being one of the top 5 performing Trusts in England for meeting the sepsis CQUIN quality standards for both emergency admissions and inpatients. The Associate Medical Director for Patient Safety received a letter of congratulations from NHS England in recognition of this important achievement.

Adult patients diagnosed with sepsis are staying on average 1.5 days less in 2016/17 compared to 2015/16 which is probably relates to successful initiation of early management.

55% of adult patients diagnosed with sepsis in our Emergency department are arriving with a pre-hospital alert for sepsis (up from 10% in 2014/2015) which is a surrogate indicator of our integrated educational campaign to ensure all local healthcare providers think “could it be sepsis?”

There is further improvement required for patients developing sepsis during their inpatient stay with on average 80% of patients receiving antimicrobials within the hour against the desired objective of 90%.

Whittington Health performance against the sepsis national CQUIN

	Percentage of patients finally diagnosed with sepsis with completed sepsis pathways in notes	Percentage of patients with sepsis 6 care bundle completed within the hour from diagnosis	Percentage of patients with (sepsis receiving antimicrobials within 60 minutes of arrival to hospital (and have a 72 hour antimicrobials review from 2016/17)	Percentage of patients with sepsis diagnosed within hospital receiving antimicrobials within 90 minutes of diagnosis
CQUIN objective	>90%	n/a	>90%	>90%
Sign up for safety objective	n/a	n/a	>90%	>90%
Quality account objective	>90%	n/a	>90%	>90%
Internal objective	>90%	>90%	>90%	>90%
Q1 2015/16	46.0%	66%	55%	n/a
Q2 2015/16	46.9%	68%	59.4%	n/a
Q3 2015/16	45.6%	72%	67.4%	n/a
Q4 2015/16	63%	80%	78.2%	n/a
Q1 2016/17	66%	82%	82.2%	83%
Q2 2016/17			93%	88%
Q3 2016/17			93%	71%
Q4 2016/17				

3.1.4 Priority 4: Pressure Ulcers

In 2016/17, Whittington Health pledged to have

- No avoidable Grade 4 pressure ulcers across the ICO
- 25% decrease in Grade 3 pressure ulcers in community
- 25% decrease in Grade 3 pressure ulcers for inpatients

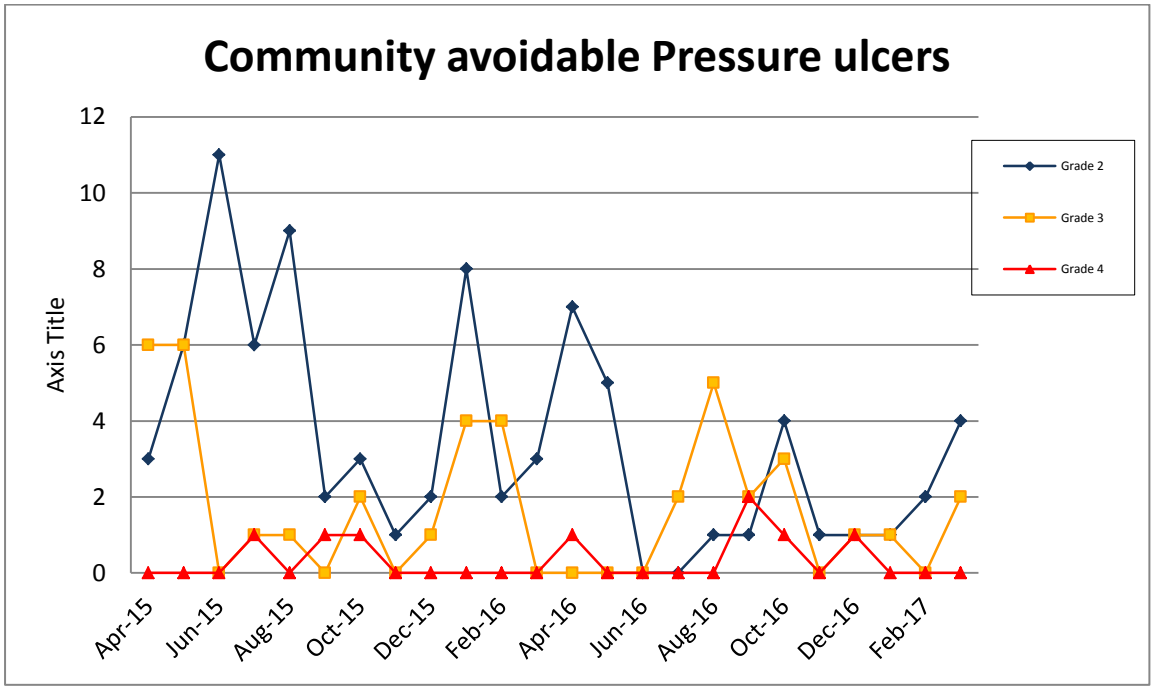
During 2016/17, Whittington Health launched the 'React to Red' campaign to raise awareness with staff, patients and carers on pressure ulcer prevention.

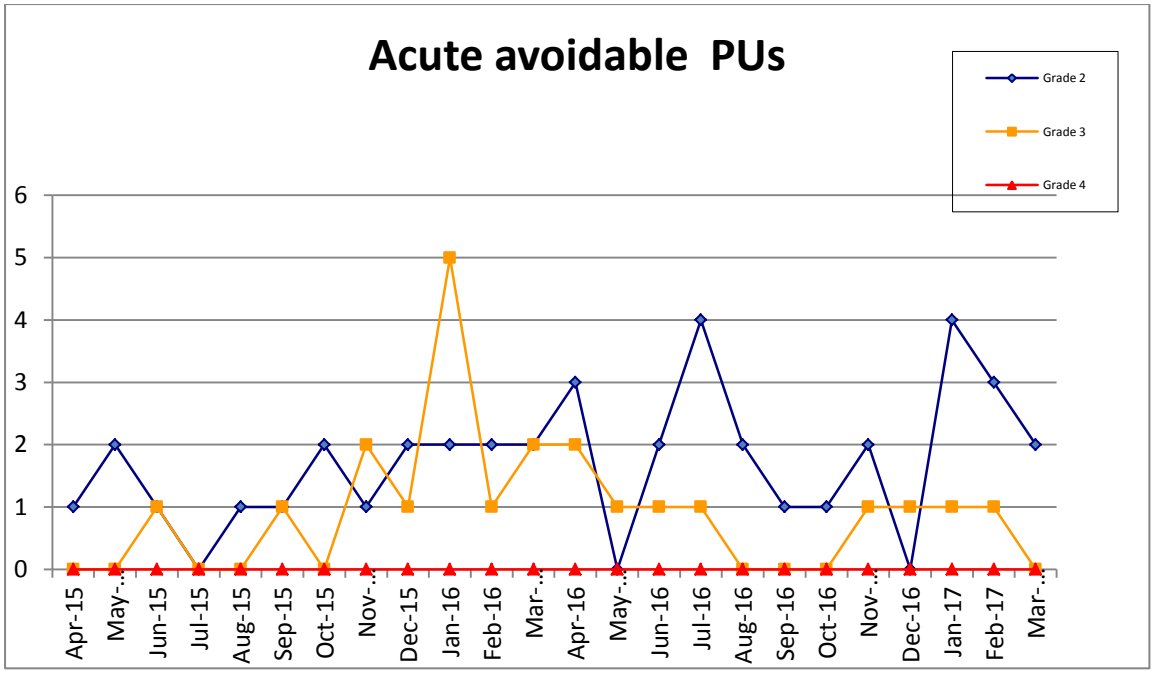
As part of this campaign, Whittington revised internal documents, introduced a new leg ulcer management pathway and developed a pressure ulcer prevention e-learning programme, to make pressure ulcer assessment, management and prevention easier for staff.

The second major component of the React to Red campaign focused on patients, carers and families. Whittington designed a key factsheet for patients and carers to support self-care and pressure ulcer prevention. Whittington also developed a pressure ulcer prevention carer's bundle, which is a comprehensive pack provided at discharge to anyone at risk of pressure ulcers.

We achieved our target to reduce avoidable grade 3 pressure ulcers in the community, with a reduction of 60% since 2015/16. However there were 5 avoidable grade 4 pressure ulcers reported in the community in 2016/17. In the acute setting, there were no avoidable grade 4 pressure ulcers reported and 8 avoidable grade 3 pressure ulcers since 2016/17. While this represents a decrease of 38% since 2016/17, this is still above the number reported in 2014/15.

The 'React to Red' campaign is ongoing to promote pressure ulcer prevention across the organisation.





3.1.5 Priority 5: Research and Education

Research

There are currently 48 NIHR portfolio studies in progress and recruiting at Whittington Health compared to 41 studies in 2015/16, 31 studies in 2014/15 and 21 in 2013/14. In addition to the 48 NIHR portfolio studies that are on-going, an additional thirteen non-portfolio studies were commenced so far in 2016/17, an increase of 5 studies on the previous year and puts the number at a similar level to 2014/15 having reduced to just eight studies in 2015/16. These studies are undertaken by nurses, allied health professional and trainee doctors and this year various paediatric and community services have hosted the majority of these studies. The results and impact of these studies are published in peer reviewed publications, at conference presentations and are valuable in their ability to innovate within the trust.

We are a year on from the ratification of the Whittington Health Research Strategy that underpins the clinical strategy and reflects the aim of enabling local people to 'live longer healthier lives'. A key strategic goal is to become a leader of medical, multi-professional education and population based research. We believe we are uniquely placed to take a life course approach to population based research and be at the forefront of the synergy between clinical service, education and clinical research. Progress is being made in our efforts to reach the targets within the strategy including the creation of a Research Assistant post to support one of our clinical academics with the development of paediatric population based research.

Participation in clinical research demonstrates Whittington Health's commitment to improving the quality of care that is delivered to our patients and also to making a contribution to global health improvement. We are committed to increasing the number of studies in which patients can participate, and the specialities that are research active, as we recognise that research active hospitals deliver high quality care. The Trust's research portfolio continues to evolve to reflect the ambitions of our ICO and also reflects the health issues of our local population. The research portfolio includes CAMHS, dermatology, diabetes & endocrine, emergency medicine (and ICU), gastroenterology, haemoglobinopathies, hepatology, health visiting,

IAPT, infectious diseases (TB), microbiology, MSK, oncology, orthopaedics, paediatrics, speech and language therapy, urology, and women's health.

Education

Whittington Health continues to have a reputation for excellent education.

Education Training Events
Over the last year, we have hosted a wide range of education and training events. These included 2 Inter-professional Integrated Care Education Days in April and May. These were extremely well received, with excellent feedback from the attendees. The theme of the first day was 'innovation and education'. As part of the programme, attendees had an opportunity to hear more about patient self-management and have been introduced to some of the tools for collaborative consultation. Day two focused on 'how to design an integrated service'. Attendees had an opportunity to hear about some of the innovative integrated care services set-up in NCEL area. There was a practical exercise in the afternoon, which encouraged attendees to explore and talk about opportunities and challenges them, as future leaders of the NHS, may face when thinking of joining up services in their local area. We had some really engaging speakers from clinical, academic and management realms, mainly from the Whittington but also some were external speakers. The attendees included specialist nurses, staff from the charity sector, Darzi fellows and specialty trainees from a range of specialities across London. The days were a very successful and we will be running these again in 2017.

Other events included 8 Advance Care Planning Workshops, led by WH clinicians, for our local GPs and Care Homes focussing on care of dying patients in the last days of life and supporting professional to look at ways of approaching difficult conversations with patients and their families.

Further developments have included learning events called 'Learning Together from Patient Safety Incidents and Complaints'. These inter-professional education afternoons are based on real patient stories, highlighting key learning points for various staff groups. So far, we have run 10 Learning Together events, attended by WH staff and colleagues working in social care, GP and voluntary sector. Feedback collected after each workshop suggested that attendees valued the opportunity to learn with and from each other. They reported increased confidence to discuss patient safety issues with their immediate colleagues and other teams and have been able to successfully apply some of the skills and knowledge gained at the workshop to change their way working. A poster about this work was presented at the UCLP Education Conference in December.

We have hosted two simulation training sessions for Core Medical trainees (CMTs), completing their rotations in North Central and East London geography, titled 'Acute Care at the Interface of Mental and Physical Health'. This interactive training was led by experienced clinicians and educators from Camden and Islington Mental Health, with support from UCLP Medical Education Simulation Fellows. The training provided an opportunity to further-develop knowledge, skills and confidence in supporting patients with both mental and physical health problems and increase understanding of services available to support patients with complex mental and physical health problems. The simulation training sessions were designed to address a number of CMT curriculum competencies for example Alcohol and substance misuse, Aggressive/disturbed behaviour, Suicidal ideation or Psychiatry and

Legal framework for practice. Both training sessions were extremely well received in their evaluations. As a result of this training, we have developed and piloted psychiatry simulation sessions for Foundation trainees at the Whittington.

In collaboration with our Community Education Provider Network (CEPN) partners, we have established the 'Islington Integrated Schwartz Rounds' – the first of its kind, inviting colleagues from Camden and Islington Mental Health Trust, Islington Clinical Commissioning Group, London Borough of Islington and Whittington Health. All rounds are held in various venues across Islington so easily accessible to colleagues working in the community and general practice. Schwartz Rounds are a multidisciplinary forum designed for staff to come together once a month to discuss and reflect on the emotional and social challenges associated with working in healthcare. Rounds provide a confidential space to reflect in and share experiences.

'The Art of Emergency Care', brought to the organisation by Kerry Wykes (Matron in our Emergency Medicine Department), is a highly innovative project, which was facilitated by MSc Applied Theatre Studies students from Royal Central School of Speech and Drama and multi-disciplinary staff working in the Emergency Department. The devising workshops explored patient and staff experience through theatre techniques and subsequent performances of the theatre pieces allowed for discussion, reflection and learning for larger groups of healthcare staff. Participants felt that, despite the pressure they are facing at work, this project allowed them to focus on what they can do to improve care, versus the system having to change.

WH hosted their first women only conference for female medical students and doctors on completing their clinical placements at WH.

We ran courses specifically designed for doctors training in different specialities and in general medicine. These included a new course we developed called "A Beginner's Guide to being a Specialist Registrar in Diabetes and Endocrinology". This was designed for junior doctors newly starting in specialist training, which can be a time of great challenge. We had very practical teaching, full of practical tips, from specialist nurses, dieticians and consultants. The junior doctors highly rated the course and have asked us to run it again. We are plan to run another course in 2017 but this time will be opening it to the wider team including nurses, dieticians, podiatrists, pharmacists and trainee GPs as well.

In February 2017, Whittington Health hosted the Clinical Examination for the Membership of the Royal College of Physicians (UK). This exam is designed to test the clinical knowledge and skill of trainee doctors who hope to enter higher specialist training to become a consultant. We are incredibly grateful to all the patients who came along for the doctors. It was a great success and the external examiners commented that the Whittington is always the gold standard exam that other centres try to aim for.

In September 2016, we re-launched the Whittington Grand Round. This is a weekly presentation chaired by Professor John Yudkin, Dr Michael Kelsey or Dr Rodric Jenkin. These presentations have covered research (e.g. using mathematical modelling in the breast cancer clinic), international health (e.g. compassionate communities in Kerala), social issues (e.g. caring for vulnerable pregnant women) and major medical problems (e.g. the rise of Hepatitis C and its treatment). We have opened the Grand Round up to all members of staff across all specialities and to local GPs.

GMC National Training Survey for Doctors in Training 2016

Whittington Health had some outstanding feedback in the GMC survey of doctors in training, with some specialties receiving the highest rating in the country. This is a national survey, sent to all doctors in training, and it asks them about the hospital where they are working and the support and education that they receive there.

Paediatrics training achieved the highest rating for: handover, workload, access to educational resources, local teaching and regional teaching. There was also good feedback in all the other areas, but not quite sufficient to reach the highest rating.

The Core Medical Training programme achieved the highest rating for: reporting systems, adequate experience, supportive environment and access to educational resources. There were good feedback in the other areas, but not quite sufficient to reach the highest rating.

Across the different areas surveyed, access to educational resources and reporting systems are the most highly rated reflecting the excellent work of the library and Richard Peacock the librarian.

Advanced Trauma & Life Support Course
The Whittington runs a successful, internationally recognised Advanced Trauma & Life Support Course, twice per year, for all doctors involved in the management of trauma patients. We have achieved a 100% pass rate for the last two courses and in the feedback the participants scored the last course highly across most categories with an average score of 91%. The Royal of College of Surgeons of England has congratulated us on this high performance.

WH Education structures, access and innovation.
All universities and other institutions of education now have in place IT learning platforms as an essential adjunct to learning and development, used by students and learners as a daily and routine resource. These platforms tend to be described as “virtual learning platforms” (VLP) and form an accessible IT driven platform for accessing lecture and workshop resources, virtual learning packages, reading and textbook resources, exercises, virtual laboratory and simulation classes, portfolio development to name a few functions. In summary VLPs are now an essential component of contemporary high quality education provision.

Within the health service, NHS driven educational provision has not routinely bought into the use of learning platforms such as Moodle. This is an anomaly as, without exception, all younger practitioners of the (regulated) degree entry professions will have experienced undergraduate (and increasingly, postgraduate) learning support through a VLP of some type. As an organisation that invests in workforce development, education and training in order to better deliver high quality healthcare services, we aim to use the best available resources and technology to enhance the training and support of our collective workforce.

During 2016, we successfully introduced a bespoke online platform for Whittington Health Education that is accessible for the workforce in general, and specifically for the continuing education and training of our multi-professional workforce.

We are currently running a broad scope of modules and courses on this platform; for example, Doctors Induction for A&E, GP Training packages, Grand Rounds, electrocardiogram interpretation for new A&E staff; induction for Nurses in A&E; treating minor injuries in A&E and others currently in development. New course development, education needs-based development, and delivery of in-house education and training are embedded within Whittington Health and the new platform will be a quality and accessibility adjunct to this delivery function.

In addition, we have instigated a "user and innovation group" comprising a cross sectional group of instructors and users who provide steer, strategy advice and innovation for the deployment of this education platform to ensure continued progressing and innovation for our education delivery activities.

The Whittington Health Education Conference
This successful event was held in March 2016, with the theme of "Building a Vision for Integrated Education - Showcasing innovation in education, learning & training at Whittington Health". The conference was attended by a multidisciplinary audience with many high quality abstracts submitted. For the first time, these abstracts were published in a peer reviewed journal, further providing quality dissemination for the education and workforce development activities of the Trust (Pharmacy Education, 2016; 16 (1): 52-63).

Community Simulation Hub.
The Community Simulation Hub project is a fully developed a simulation hub that brings health and care practitioners together for education and training. The training design puts patients, service users and their lifestyles at the heart of meeting their care needs. The Hub acts as a simulation centre for integrated and interprofessional training, with observation rooms and fully equipped learning environments to enable feedback of simulated practice in action to review and discuss for practitioner development. Training courses include

- Transition to Parenthood
- Making Every Contact Count
- Protecting Vulnerable Adults
- Chaperoning

And more are in development. This is a unique training environment and fully meets the integrated education and training mission of Whittington Health.

3.1.6 Priority 6: Patient Experience

Patients are at the heart of everything we do here at Whittington Health. We know that in order to improve the experience of patients in our hospital and community we need to listen to them, their families and carers, and respond to their feedback.

Throughout 2016/17, we have worked to improve our systems for collecting feedback and to enable us to capture the views of a more diverse patient population.

There are many ways in which we gather feedback, some examples are:

- National patient surveys, such as the cancer and inpatient surveys;
- Real-time patient experience trackers which ask specific questions including friends and family test, in specific areas of the hospital, such as A&E and outpatients and in

our community services and homes visited by our district nursing and health visiting teams
- Individual ad hoc surveys and questionnaires to support specific projects;
- Feedback received directly from patients in the form of complaints, letters, comments on Twitter, phone calls or comments to PALS, our patient advice and liaison service; Surveys looking at specific aspects of care or the environment such as PLACE;
- Ratings and comments left by patients on NHS choices.

This feedback is regularly triangulated by our patient experience team to paint a picture of what our patients are telling us and of where they think we need to improve.

We know from our work that for patients reporting a positive experience, interaction with staff is the most significant factor. When patients report a negative experience, the cause is usually due to ineffective systems and processes. The improvement programmes and strategies across the trust are supporting improvements across these areas.

We know it is not enough to just listen to our patients and the public; we want to actively involve them in helping us improve.

In 2016/17 we achieved our goal of increasing the percentage of inpatients and A&E patients who would recommend our Trust to friends and family, exceeding our target for both and improving on our performance last year. We also succeeded in increasing the number of response rates to our Friends and Family Test by over 20%.

In addition we developed a Community Forum which currently has 5000 members and we held 4 community meetings throughout the year. This engagement work will be extended in 17/18 as we develop a 3 year Patient and Carer Experience strategy. Through working with our local community and partners to we ensure that we develop a strategy that is ambitious and details annual improvement milestones.

We plan to review and strengthen our complaints processes still further in 2017/18. The primary objective is to resolve peoples' concerns as quickly and effectively as possible. Often this will be best achieved by the Patients Advice and Liaison Service (PALS); whether it is getting a cancelled appointment rescheduled or providing an immediate apology for a poor experience, PALS excel in this type of resolution. The complaints service will then be able to focus on concerns and complaints that require a formal investigation and response. We will review the process for sharing learning from complaints and look to join this up more effectively with learning from claims and patient safety incidents.

3.2 Local performance indicators

Performance figures are for full year of activity (16/17) unless otherwise stated

This section includes non-statutory indicators as part of the Quality Account.

Goal	Standard/benchmark	Whittington performance	
		16/17*	15/16
ED 4 hour waits	95% to be seen in 4 hours	**87.36%**	91.1%
RTT 18 Week Waits: Incomplete Pathways	92% of patients to be waiting within 18 weeks	**93.1%**	92.4%
RTT patients waiting 52 weeks	No patients to wait more than 52 weeks for treatment	**0**	0
Waits for diagnostic tests	99% waiting less than 6 weeks	**99.5%**	97.7%
Cancer: Urgent referral to first visit	93% seen within 14 days	**96.4%**	93.1%
Cancer: Diagnosis to first treatment	96% treated within 31 days	**99.7%**	99.5%
Cancer: Urgent referral to first treatment	85% treated within 62 days	**86.7%**	88.8%
Improved Access to Psychological Therapies (IAPT)	75% of referrals treated within 6 weeks	**94.6%**	94.5%

The Trust met its waiting time targets; however the emergency department waiting times need to be improved.

Within the operational plan the Trust identified that it will expand its programme of improvement for the Emergency Department. There are a number of plans in progress to recover both Emergency Department (ED) performance and flow across the acute admitted pathway, including but not exclusively:

- Front-door streaming: To ensure timely and appropriate care, in the right place by the right team and to maximise use of Ambulatory Care through appropriate diversion of acute medical assessment and paediatric patients, and transfer of medical clerking to the in-patient setting
- Revision and recruitment of ED workforce in order to facilitate rapid assessment treatment (RAT) and reduction in median Time To Treat and meet the ED standards by:
- Increasing the number of consultants by 6 WTE over the next 18 months. This will mean we will have consultant cover form 8-10pm from August 2017 when three of the new posts will be filled and we will be working further toward meeting the London ED standards over the next 8 months as we recruit the additional three posts.
- Developing the new Urgent Care Pharmacists roles with Health Education England
- Developing enhanced roles for nurses and health care assistants within the ED department.
- Improved speciality response/ agreements: To prevent unnecessary delays in decision making and/ transfer of care

- Development of Demand and Capacity tool/ Escalation Cards: To allow early warning of approaching problems and implementation of escalation plan
- Enhancement of Frailty Pathway: To ensure early Frailty Team input to enable appropriate management/ discharge support, to achieve Length of Stay (LoS) and readmission reduction
- Senior Clinician Review by noon: To ensure appropriate management to progress recovery and discharge
- Pre-11a.m. and Criteria Led Discharge: Ongoing promotion and training
- Advance Discharge to Assess model: To ensure patients are discharged when medically fit
- Enhanced Site Team and processes: To proactively manage flow/ discharge planning and timely communication
- Staff engagement: enhanced recovery workshops to support the streamlining of discharge
- Emergency Care Improvement Programme (ECIP): implement the findings of the 2 day review lead by Vince Connolly of the front door, ED, clinical decision unit, ambulatory care and acute admission unit once published.
- System wide improvement: working with Haringey and Islington and the wider STP urgent care pathway to develop system wide processes to improve the performance of ED.

4. Who has been involved in developing the Quality Account

We have worked with many internal and external stakeholders in the development of this year's Quality Account.

Internally, clinical and operational teams have been at the forefront of developing the Account, from frontline staff to management level. Clinical and operational leads were crucial in ensuring the Quality Account is detailed and provides accurate information. Clinical and corporate divisions worked together to produce the Quality Account. The Information, Clinical Governance and Risk Management teams have all had significant input into developing the Account. Externally, our Quality Account has been seen by our local CCGs, local Health Watch, JHOSC and our designated external auditors

5. Statements from external stakeholders

Healthwatch Islington Feedback

We welcomed the Trust's involvement of Healthwatch members in discussions around Quality Objectives. There are some positive examples of patient engagement within the organisation (the setting up of a Young People's Forum, involving Healthwatch members in PLACE assessments). A more systematic approach to this engagement would help to embed involvement across the organisation. We will support this engagement where we can. In Healthwatch's conversations with residents the hard work of staff, noted in this report, is also praised and we feed this in to the Patient Experience Committee.

The report highlights the good work of the Community Dental Service. Healthwatch Islington's Autism report also highlights the very positive patient experience of users of this service and the skills and kindness of the staff working there. We know that the Trust is doing a lot of work to ensure robust implementation of the Accessible Information Standard and we hope to start seeing the results of this, in particular for Deaf patients who have found patient letters difficult to understand, and in improved communication with patients with a range of disabilities.

For other community services, waiting times remain an issue and we hope that the Trust can bring these down, thus improving patient experience. The Trust has stated that they 'are currently redesigning the service and also the way appointments are being booked. One of the plans around appointments is to book them from health centre receptions for all patients needing appointments within 6 weeks. This ensures that clients who have the highest foot risk statuses will receive appointments on the day of being seen… The aim is to start this from April [2017]'. The Trust assured us that they did not foresee a negative impact of this policy on patients who need less regular appointments. We look forward to hearing about how this develops.

Healthwatch Haringey Feedback

Healthwatch Haringey
14 Turnpike Lane
London
N8 0PT
Tel: 020 8888 0579
Email: info@healthwatchharingey.org.uk
Web: www.healthwatchharingey.org.uk

healthwatch Haringey

Dr Helen Taylor
Whittington Hospital
Magdala Avenue
London
N19 5NF

19th May 2017

Dear Helen,

WHITTINGTON NHS TRUST QUALITY ACCOUNT 2017/18

Apologies for the delay in replying; the Healthwatch Haringey Statement is below:

We note and congratulate The Trust on winning a number of national awards for the quality of their services and service innovation in 2016/17. The Trust should also be commended on the local teams developing a number of quality initiatives in the delivery of the care to our local community.

We agree with the priorities identified for 2017/18 and the inclusion of Patient Experience in those priorities. The criteria identified in the Patient Experience category are generally process measures rather than outcome targets measuring improvements in patient experience and we would be happy to work with The Trust in developing some appropriate and achievable targets in this area.

The Trust has improved on a number of measures in the staff survey but we note that there are issues relating to bullying and harassment that need to be addressed. As noted in the Quality Account, patient experience is closely linked with the quality of the interaction with staff and therefore staff morale and motivation is a significant measure. It is interesting to note that although the percentage of staff recommending care is on a par with the national figures it has decreased in 2016/17 from 80.1% to 74.6% which is a reversal of the upward trend in 2015/16. Although staffing indicators are not included in the priorities for 2017/18 they should be the focus of attention to ensure that morale and motivation remain high.

The Patient Experience Forum was a new development in 2016/17 and although all innovations in this area are to be welcomed there is a need to develop a more systematic approach to patient engagement in the coming year. We look forward to being involved in this process and the development of the new three year Patient Engagement Strategy.

Kind regards,

Mike Wilson
Director

Delivered by Public Voice

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VAT registration number: 260 9682 81

Joint Health Overview and Scrutiny Committee Statement

Response from Islington Health and Care Scrutiny Committee and the North Central London (Barnet, Camden, Enfield, Haringey and Islington) Joint Health Overview and Scrutiny Committee received 24/05/17

The Islington Health and Care Scrutiny Committee and the North Central London Joint Health Overview and Scrutiny Committee welcomed the opportunity to review and comment on the detailed draft Quality Account. We have some comments on specific aspects of the report:

The CQC report in July 2016 identified the Whittington's Community Services as being Good or Outstanding and we felt that the Whittington should be commended on achieving this rating. The CQC report however highlighted that under the heading of 'Safe' that both Whittington Health and Hospital requires improvement, whilst Whittington Hospital was graded as requires improvement under 3 out of the 5 areas. We felt the plan to improve was useful but it wasn't clear if this was based on the 'must do's' or on both the 'must do's' and 'should do's'? In addition, the Islington Health and Care Scrutiny Committee requested the Whittington action plan in response to the CQC inspection, and once it was received was strongly of the view that it was far too lengthy, contained too many actions, and the committee felt there was a significant risk that effective response to the inspection outcomes could be lost through attempting to pursue too many different improvement goals. A shorter, more succinct and targeted action plan would be more likely to achieve better results. Whilst not directly related to the quality account the committee considers that the action plan, which presumably is intended to be one of the main drivers towards quality improvement over the next year, could in its present form adversely affect ambitions to achieve improvements to overall quality at the hospital.

We felt that whilst the quality priorities for 2017/18 are clearly laid out, it wasn't clear whether these were identical to last year's priorities or whether some had been added as we didn't get a clear understanding from the introduction what the Trust's previous quality priorities were.

We felt that the safety priorities were good, however we would have hoped for a higher compliance target to have been set within the documentation of falls within the AAU and Older Peoples wards.

We welcomed all the ideas to improve experience such as 'reducing noise levels at night' under Patient Experience but we would have liked to have seen further information on how this would be achieved.

In addition, we would have liked to have seen further clarity on the following:

- Within the more in depth look at how the Whittington Hospital is looking to improve, Graph 2.3.3 shows Emergency re admissions. The younger age range 0-16 is consistently higher than the older age range – we would like to understand why. We would have also liked to have seen further information about what actions are being put in place to reduce the re admission rate for 0-15yr olds? (page 35)

- Graph for VTE risk assessment (page 38): it was not clear what the lilac dots represent.

- Table of Whittington Health performance against the sepsis national CQUIN (page 49). The majority of the table indicates red or amber with the 'Percentage of patients with sepsis diagnosed within hospital receiving antimicrobials within 90 minutes of diagnosis' column indicating that the latest figure in Q3 2016/17 is 71% when the target is 90%. This figure is decreasing: it was not clear why.

NHS Islington Clinical Commissioning Group

Commissioners' Statement for 16/17 Quality Accounts

NHS Islington Clinical Commissioning Group (CCG) is responsible for the commissioning of Health services from Whittington Health NHS Trust on behalf of the population of Islington and all associate CCGs. In its capacity as lead co-ordinating commissioner NHS Islington CCG welcomes the opportunity to provide a statement for the 2016/17 quality account.

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

We commend the Trust on its overall rating of "good" by the Care Quality Commission (CQC) in July 2016 and the "outstanding" rating given to Community end of life care and community dental services. We note efforts made by the Trust during 2016/17 to robustly address the CQC's recommendations. We also commend improvements in the reduction of sepsis during 2016/17 which we hope will continue in 2017/18.

The Trust has proactively engaged with Islington CCG to ensure that commissioner's views have been considered and incorporated and we strongly support the eight quality priorities chosen by the organisation for 2017/18. We are encouraged by the Trust's plans to reduce the number of inpatient falls and pressure ulcers and hope to see significant improvements in outcomes concerning skin integrity for patients in community settings.

The CCG notes that during 2016-17, Whittington Hospital NHS Trust took part in 41 national clinical audits including 7 national confidential enquiries. The CCG would like to commend the Trust's commitment to an increasingly extensive research programme.

Commissioners fully support the quality priorities identified by the Trust for 2017/18.The CCG would have liked to have seen more emphasis on community care within the Quality Account but note this has been included in the eight priority areas and look forward to working with the Trust collaboratively to improve data quality to demonstrate delivery of high quality care.

We consider this Quality Account represents a fair and balanced overview of the quality of care at Whittington Hospital NHS Trust during 2016/17 and we look forward to the year ahead and working with Whittington Hospital NHS Trust to continually improve the quality and safety of health services for the population they serve.

6. How to provide feedback

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

- By writing to:

  The Communications Department,

  Whittington Health,

  Magdala Avenue,

  London. N19 5NF

- By telephone: 020 7288 5983
- By email: communications.whitthealth@nhs.net

7. Appendix 1: Statement of directors' responsibilities in respect of the Quality Account

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

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

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

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

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

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

The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality stands and prescribed definitions, and is subject to appropriate scrutiny and review; and

The Quality Account has been prepared in accordance with the Department of Health guidance.

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

8. Appendix 2: Independent auditors' Limited Assurance report

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF THE WHITTINGTON HOSPITAL NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required to perform an independent assurance engagement in respect of The Whittington Hospital NHS Trust's Quality Account for the year ended 31 March 2017 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following indicators:

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

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

Respective responsibilities of the Directors and the auditor

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

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

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

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

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

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

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

- Board minutes for the period April 2016 to May 2017;
- papers relating to quality reported to the Board over the period April 2016 to May 2017;
- feedback requested by the Trust in March 2017 but not received in time for audit from the Commissioners;
- feedback from Islington Healthwatch dated May 2017;
- feedback requested by the Trust in March 2017 but not received in time for audit from Haringey Healthwatch;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated February 2017;
- the latest national patient survey dated June 2016;
- the latest national staff survey dated March 2017;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2017;
- the annual governance statement dated May 2017; and
- the Care Quality Commission's Inspection Report dated July 2017.

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

This report, including the conclusion, is made solely to the Board of Directors of The Whittington Hospital NHS Trust.

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

Assurance work performed

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

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

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.
The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.
In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by The Whittington Hospital NHS Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:
 the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

 the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and

 the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
Canary Wharf
London
E14 5GL
30 July 2017

9. Glossary

Abbreviation	Definition
BTS	British Thoracic Society
C Diff	Clostridium Difficile
CCG	Clinical Commissioning Group
CEPN	Community Education and Provider Network
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUINS	Commissioning for Quality and Innovation
DATIX	Name of incident reporting system
DBS	Disclosure and Barring Service
DNA	Did not attend
DoLS	Deprivation of Liberty Safeguards
DTC	Day Treatment Centre
DVT	Deep Vein Thrombosis
ED	Emergency Department
FFT	Friends and Family Test
GMC	General Medical Council
HCAI	Healthcare Associated Infections
ICAM	Integrated Care and Acute Medicine
ICAT	Integrated Community Ageing Team
ICO	Integrated Care Organisation
IG	Information Governance
LoS	Length of Stay
MCA	Mental Capacity Act
MSK	Musculo-Skeletal
NIHR	National Institute of Health Research
NRLS	National Reporting and Learning System
PALS	Patient Advice Liaison Service
PE	Pulmonary Embolism
PROMs	Patient Reported Outcome Measures
RTT	Referral to Treatment
Red to Green	Approach to optimising patient flow. The objective is to change a patient from 'red' (a day where there is little or no value adding care) tor 'green' (a day of value for the patient's progress towards discharge and home).
SAFER patient bundle	SAFER is a practical tool to reduce delays for patients in adult inpatient wards
SCD	Surgery, Cancer and Diagnostics
Section 136	A multiagency model of care for our mental health patients in crisis
SHMI	Summary Hospital Level Mortality Indicator
SI	Serious Incident
TDA	Trust Development Authority

UCLH	University College London Hospitals
UCLP	University College London Partners
VTE	Venous Thromboembolism
WCF	Women's Children & Families
YTD	Year to date

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Healthwatch Islington

Update and work planning

Health and Care Scrutiny, September 2017

Achievements

Autism, reasonable adjustments,

Social worker's phones – a big improvement,

Developed a consultation consortia – and now developing it's scope,

Better links between care homes and allocated GPs,

Better information for podiatry patients – or is it?

Volunteering award.

Current and future work

Mystery shopping for Autism-friendliness

Increasing diversity of the Islington Patient Group,

Community mental health services – supporting engagement,

Considering social isolation,

Influencing ADHD assessment,

Safeguarding – sharing what we know.

Achievements and plans 2016 - 18
…behind the scenes

STP-ACO-CCHIN-IPHR-TCP – re-learning the alphabet!

Investing in Volunteers,

Strengthening links with London Met,

Training parent champions.

healthwatch Islington









Healthwatch Islington

Annual Report 2016/17

Contents

Message from our Board

Olav Ernstzen, Chair of our Board

We are pleased to introduce the 2016 Healthwatch Islington Annual Report. It's been another great year for our volunteers with Faiza Al-Abri being recognised as Islington Young Volunteer of the Year and Healthwatch Islington being presented with a national award for its overall approach to volunteering.

We've spoken to hundreds of local residents about their experiences of local services, focussing particularly on the needs of people with autism, refugee and migrant communities, and older people. We've also delivered projects working with parents and new mums, and supported a borough-wide patient group to have their say.

We've been working closely with our neighbours in Barnet, Camden, Enfield and Haringey to champion residents' views within North London.

We are really proud to say that we've made it easier for local residents to access their social worker. We recommended a series of changes to the council's phone system. The council implemented these changes and greatly valued the feedback from Healthwatch.

"Thank you so much for undertaking the mystery shopping. It is really good to see that there has been improvement after our new implementations. We will be sharing the learning in our service managers meetings and will suggest that they implement similar measures to ensure effective call response to the public."

We've also developed strong links within the voluntary and community sector, helping to strengthen the voices of local people. And we continue to gather the views of local residents to make sure that our work is informed by their ideas.

I would like to take this opportunity to thank our volunteers for their continued hard work. Their contribution is fundamental. We hope you'll enjoy reading the report. If it inspires you to join us, our contact details are on the back page.

Highlights from the year

This year we won national recognition for our approach to volunteering.

Our volunteers help us with everything from mailings to mystery shopping

We've visited 22 local health and care services

Our reports have tackled issues ranging from autism to podiatry

We've spoken to 279 people from marginalised groups about challenges accessing services

You've spoken to loads of local people at our community events

Who we are

Health and social care works best when people are involved in decisions about their treatment and care. But this doesn't always happen. We are here to help ensure that those designing, running and regulating health and social care listen to people's views and act on them.

There is a local Healthwatch in every area of England. We are the independent champion for people using local health and social care services in Islington. We listen to what people like about services and what could be improved and share their views with those with the power to make change happen. We also share them with Healthwatch England, the national body, to help improve the quality of services across the country. People can also speak to us to find information about health and social care services available locally.

Our sole purpose is to help make care better for people.

How do I benefit from what Healthwatch does?

+ You can speak to us about what you think of local services – good or bad.
+ We are interested in everybody's views, from all parts of the community.
+ Where possible, we will let you know when changes are planned to services in your area and help you have a say.
+ You can speak to us to find information about health and social care services available locally.

Why should I get involved?

Speak to HealthwatchIslington about your experiences of any NHS or social care service, and help make them better for you, your neighbours, friends, and family. It's quick and easy to get in touch – you can phone, email, chat online, or meet us in person. Just a few moments of your time could make a big difference.

"I've been waiting for a podiatry appointment for 15 weeks. I should get seen every 10 weeks. "

"There are not enough social workers assigned to people. You want to talk to someone who knows about your situation. Everytime I ring up I'm assigned to the duty social worker - they don't know me."

"There was a long wait to see the paediatrician. The appointment really helped. They were very good at explaining her condition, helping me understand and calming my nerves."

Our Vision

+ Local health and care services which are informed by evidence from the local community, and a community which is informed about local health and care services.

Our board of directors use their expertise to ensure that Healthwatch Islington is fulfilling its legal and statutory obligations.

Our Mission

+ To collect knowledge that reflects the diversity of needs and experiences within the borough and encourages people to feedback their honest views on services,
+ To use the evidence we gather to influence service delivery, provision and commissioning for the benefit of local people, and so that people have a better experience of services.
+ To reach out to and empower our local community to be informed about local services, involved in local services, and exercise choice in taking up services.

Our Board of Directors (from left to right): Jana Witt; Phillip Watson; Shelagh Prosser; Med Buck; Rose McDonald (and not pictured: Olav Ernstzen; Bob Dowd; Clara Boerkamp)

Your views on health and care

Listening to local people's views

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:

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. These have included discussions on Sustainability and Transformation Plans and Whittington Health.
+ Each month we hosted at least two community stalls at various venues around the borough and a stall at Cally Festival which is attended by over 7,000 people.
+ We reached 720 people through our activities and captured their views through focus groups, interviews and on-line.
+ 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.

Targetted work

+ We specifically sought the views of people from Black and Minority Ethnic communities through our work with consortia partners.
+ We carried out specific work on Autism and Learning Disability and engaged Deaf people in our patient group meetings. People with a wide range of disabilities have taken part in our work throughout the year, and we aim to be as accessible as possible.
+ Each year we take part in carer's week with local partner Centre 404. We attended our local Carer's Rights Day to speak to carers. We also engaged carers in our Autism work and through the work of our refugee and migrant community consortia.
+ 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.

Of those who recorded their age, 12% of respondents were 18 or under (the same as recorded in the 2011 census). In particular, we engaged young people in our Autism work and our general out-reach activities.

56% of respondents who recorded their age were of working age. Although this is lower than the 80% recorded in the census, this group were well represented in the discussions around extended GP access and mental health.

Older people were over-represented in our work, 23% of respondents who declared their age were over 65 (as opposed to only 8% in the borough as a whole). We particularly engaged this age group in our work on podiatry, home care and residential care.

What we've learnt from visiting services

Mental health day services

We were approached by residents worried about cuts to mental health day services. We visited the services to gather views on how people benefitted from using them and what they valued. People enjoyed the range of activities and the help offered by staff. They would like to see services open for longer.

These views will now inform the council's consultation on day care provision.

Podiatry

Knowing that waiting times for accessing foot care are at an all-time high, we visited local health centres to talk to users. They talked about the anxiety caused by a confusing appointment system, and frustrations about getting an appointment. In general they praised the care provided.

We are now working with the provider to improve the clarity of appointment letters and the Trust is reviewing its system for allocating appointments so that those patients needing an appointment within six weeks are given a time-slot as they leave their previous appointment.

Reaching your social worker

Although we didn't visit social services, we did mystery shop their telephone services. A local resident had told us about how hard it was to reach her social worker. She was aware that this must also be an issue for other social care users. Following a mystery shopping exercise the council implemented a serious of changes to how calls are handled. We mystery shopped again several months later and saw a marked improvement. See page 15 for our case study on Angela, who raised the alarm.

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

Helping you find the answers

How we have helped the community access the care they need

We want to empower local people to get the best from local health and care services. We work with a range of local partners to extend our reach through community meetings, door-knocking and presentations. The majority of contacts come through our partners.

This year we provided information and support to over 550 residents.

- We provided support to 180 residents directly (of which 94 were referred by partner organisations within the community sector)
- We provided information and advice to a further 279 residents through signposting activity carried out with our voluntary sector partners. We also increased the capacity of these partner organisations to respond to future queries.
- We gave out over 100 'goody bags' of useful information as part of International Women's day events we attended. We also provide information about services and entitlements in all conversations with our local community.
- We had more queries about hospital care and home care services than other services.

Case study

One Islington resident told us she was being treated by the Rheumatology Clinic at Universiy College Hospital for a debilitating back issue. She was having to take monthly injections and have weekly physiotherapy to manage her pain. She was finding it difficult to bathe, get ready in the morning, bend down, and sometimes walk.

The partner organisation who first alerted us to this case reported that she had 'no clue about services that are out there', and that she needed help to arrange an Occupational Therapy assessment for a walk-in shower.

Healthwatch called her to discuss her needs. She said that she suffered from the long term chronic condition Ankylosing Spondylitus. She told us that hot water really helped her condition, but she was often in agony and struggled to get in the bath. We suggested a referral to the Navigator service at Age UK. We also explained that there are multi-disciplinary teams based at GP surgeries in the borough who address people's health and social care needs in a joined up way, with GPs and social care professionals working together.

She became nervous about the idea of social services becoming involved. She explained that her children helped her at home. She felt she might be criticised for this. Healthwatch agreed to talk to her again if she changed her mind. She called back a week later, advising us that she had spoken to her GP and she would now be happy for the referral to be made.

Making a difference together

How your experiences are helping influence change

We spoke with Islington residents with Autism Spectrum Condition, and with their families. We heard from 60 people in total. We were particularly interested in learning whether they thought that more could be done to make health and care services accessible.

+ We have recommended more training and support for professionals, more appropriate and readily available information for families and carers, and adherence to the Accessible Information Standard so that appointments are more accessible.

Working with other organisations

We were successful in achieving additional funding for Diverse Communities Health Voice. Diverse Communities Health Voice is a partnership of 10 Islington based organisations: Arachne Greek Cypriot Women's Group; Community Language Support Services; Eritrean Community UK; IMECE Women's Centre; Islington Bangladesh Association; Islington Somali Community; Jannaty; Kurdish and Middle Eastern Women's Organisation; Latin American Women's Rights Service; and Healthwatch Islington.

+ 207 respondents gave the partnership their views on Pharmacy; Well-being; Accident & Emergency; Interpreting services; and referrals to specialist services.

+ 257 people received information to help them access services including what is on offer in local pharmacy and extended hours GP services.

We share reports and findings with the Care Quality Commission and pass them specific service information to inform their inspection visits. We have shared reports and findings with Healthwatch England, including experiences of dentistry for the Healthwatch England Dentistry report, and experiences of accessing services for the Healthwatch England report on children and young people with autism.

All providers and commissioners responded to our formal requests.

How we've worked with our community.

+ Volunteers have taken part in mystery shopping, Enter and View visits and helped us with interviewing local residents.

+ We provided a training programme for parents of children with special educational needs, equpping them with the skills they need to go out and gather views on services from other parents.

+ We are working with the Bright Beginnings project. This project works with new mums from migrant communities, and gathers their feedback on maternity services.

+ The Chief Executive and Chair of Healthwatch Islington represent us at the Health and Well-Being Board. Both are briefed in advance so as to be able to contribute effectively.


It starts with you

Case Study

Thanks to Angela, phoning the social work team at Islington Council is far less stressful than it used to be.

Angela is disabled and relies on support from social services to provide and coordinate her care. She got in touch last year to tell us it was very hard to get through to her social worker or occupational therapist on the phone, nor was it possible to leave a message.

+ This made it much harder than it should be to cancel or rearrange appointments.
+ She was left on hold for long periods of time.
+ Angela told us that a voicemail service would be welcome, particularly one that people could call in the evening when many phone providers offered free calls.

Sharing your experience with us is quick and easy and, as in Angela's case, it could make a big difference.

Healthwatch decided to investigate further. Our staff and volunteers made nearly 300 phone calls to the social work team, spread across two mystery shopping campaigns.

Like Angela, we found that it was not easy to leave a voicemail message if your social worker was not answering the phone. Instead, you'd be placed in a queue to speak to a member of the business support team. But they did not have the capacity to handle the volume of calls that were being forwarded. We experienced very long waits, and often our calls would not get answered at all. We shared what we learned with the service.

"I waited a long time before, an unacceptable amount of time. Sometimes forty minutes and once it was over an hour."

Having some independent feedback from Healthwatch gave the Adult Social Services team the opportunity to look again at the way they managed phone calls.

They made many of the changes we recommended, and as a result:

+ Far fewer calls go unanswered
+ All staff now have answerphones
+ Recorded messages make it easier to tell that you have reached the right person
+ The wait to speak to the business support team has been greatly reduced

The Adult Social Services team were very happy with the outcome. They are sharing what they've learned with the managers of other services at the council, and suggesting that they make similar changes to improve the way they manage phone calls.

"It's much better now. At least you get through and there is somewhere you can leave a message. If I call after 7 pm, calls are free so it saves us from having to make such expensive calls like before"

Angela Dobson, Healthwatch champion

Our plans for next year

What next?

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

+ We will mystery shop services to see if they are meeting 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. Initially we will develop an Autism-friendly checklist and mystery shop services using these. We will then extend this to cover other disabilities.
+ We will gather views on day services for mental health service users. We will build on our work from this year, visiting services and gathering users' experiences.
+ We will work to ensure that local residents' views influence the development of care closer to home networks.
+ We will continue to seek out opportunities to engage children and young people. This year we are considering school nursing with partners at Whittington Health.
+ We will gather views on re-ablement services for people leaving hospital.
+ 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.
+ Building on our work this year, we will train more parent researchers to carry out peer research and act as role models and champions to other parents.
+ We will audit the Bright Beginnings service for new parents from migrant communities. Now in its second year, Bright Beginnings delivers services to pregnant women and new mothers in the borough. We will work with them to audit the effectiveness of the service and the impact on its users over the next two years.
+ We will work with London Metropolitan students to gather research to feed in to the borough's Joint Strategic Needs Assessment.

We will develop our partnership with our local university.

Our people

Decision making

Healthwatch Islington is led by volunteers and by the 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. It is finalised and monitored at a series of public meetings.

How we involve 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.

Volunteers contribute hundreds of hours of expertise each year. Without their valuable contribution we would not be able to carry out the work that we do.

- 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.

Our finances

Income	£
Funding received from local authority to deliver local Healthwatch statutory activities	165,479
Additional Income	76,695
Total income	242,174
Expenditure	**£**
Operational costs	57,455
Staffing costs	147,819
Office costs	25,555
Total expenditure	230,829
Balance brought forward	11,345

Contact us

Healthwatch Islington

Address: 200a Pentonville Road, 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 on 30 June 2017 by publishing it on our website and sharing it with Healthwatch England, CQC, NHS England, Clinical Commissioning Group/s, Overview and Scrutiny Committee/s, and our local authority.

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.

Heathwatch Islington
200a Pentonville Road
London
N1 9JP

www.healthwatchislington.co.uk
t: 0207 832 5814
e:info@healthwatchislington.co.uk
tw: @HWIslington
fb: facebook.com/HWIslington

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A year in volunteering

This year we won national recognition for our approach to volunteering.

Our volunteers help us with everything from mailings to mystery shopping

You've helped us to visit 22 local health and care services

Your work has informed our reports on local issues ranging from A&E to social services

You've gathered views on extended hours GP services, hospitals, and pharmacies

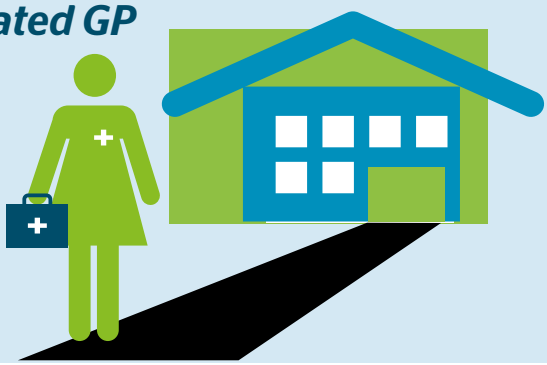
You've met hundreds of local people at our community events

Impact on services

We've made it much easier to reach Islington Council's social work team by phone

We persuaded the CCG to pay for some research into non native English speakers' experience of GP referrals

We've made it easier for care home staff to contact residents' allocated GP



We've helped get free wifi available in more of the borough's care homes

High risk podiatry patients will now be given the date of their next appointment before leaving the clinic

We've helped make access to weekend and evening GP appointments more fair

Work Plan 2016-18

Healthwatch develops a work plan based on conversations with local residents, commissioners and providers. This plan covers 2016 – 18, we review the plan each April.

	What we want to achieve	Actions	Completion date	Progress	RAG
1	To measure and demonstrate influence.	- Follow up previous recommendations from 2015 - 17. - Use log to approach providers/ commissioners. This is to ensure maximum value for any work we carry out.	Ongoing Ongoing	Chasing up recommendations with local partners.	
Gather and report views					
	What we want to achieve	**Actions**			
2a	For views of children and young people to be included in commissioning.	Look for opportunities to work with partner organisations, and ensure that approaches we use are flexible to ensure people of all ages can take part.	Mar-18	This is still fairly ad hoc. We are working with Whittington Health to support their Children and Youn People's Forum to include some more strategic involvement.	

2b	To ensure mental health preventative service specification is informed by user needs	Gather views from users of mental health day services about provision	Mar-18	Spoke to 101 residents at the service and 24 residents who were eligible but may not have used the service.	
2c	To assess person-centred nature of re-ablement services	Speak to users of re-ablement services about their experience	Dec-17	Reviewing methodology with service manager in September as service users are finding it difficult to remember their experience.	
2d	To consider how to reduce isolation for older people	Speak to users of day services and potential users about the offer	Jun-18	Drafted desk-based research on isolation. Liaising with LBI to ensure our work adds value.	
2e	To engage parents	Train parent champions to promote Early Years services and mystery shop those services	Dec-17	First cohort trained, recruiting second cohort at present.	
		Work with Bright Beginnings to champion needs of new parents	Mar-19	Auditing the service, and gathering experiences of new parents.	
2f	Support the Islington Patient Group on behalf of the Clinical Commissioning Group	Deliver two meetings and a series of focus groups	Mar-18	Initial round of activity delivered. Next phase in November.	
2g	Maintain a programme of conversations with community members	Need to monitor more closely to ensure diversity, and strong evidence collection	Ongoing	Focussing on BME residents and parents of children aged 5 and under.	

2h	Engage students from London Metropolitan to support our engagement	Their area of interest is older people - to start September 2017	Ongoing	Recruiting at the moment. First cohort due to join us in November.	
Visit services					
	What we want to achieve	**Actions**			
3a	Assess accessibility for people with Autism	Mystery Shop Accessibility for people with Autism	Dec-17	Working with service users to devise and deliver a mystery shopping programme. Healthwatch Islington is an active member of the Autism Partnership Board and has fed in to their 'reasonable adjustments' work.	
3c	Assess accessibility in line with Accessible Information Standard	Build on the Autism mystery shopping to assess wider accessibility.	Jun-18	To start in Jan 2018	
3d	Support Safeguarding work of LBI	Take an active role in the Safeguarding Board and Safeguarding Reviews where capacity allows.	Mar-18	As well as being an active Safeguarding Board patner our Chief Exective sits on the SAR Board and will chair an initial review this autumn. We are also working with a local befriending organisation to support their volunteers to raise alerts.	
Involve residents in commissioning					
	What we want to achieve	**Actions**			
4a	To influence commissioning	Ensure that all of our work is reported to relevant commissioners and that we are sighted on the STP	Ongoing	All reports are shared with relevant commissioners, CQC, public health. Measuring success proves tricky but we have set aside more time to follow up on recommendations.	

4b	To influence the development of Care Closer to Home Networks	Ensure that residents voices feed in to this planning and that there is service user engagement	Ongoing	Hosted a dicsussion on this and shared information with members. Some engagement had to be postponed due to purdah (back in June).	
Provide information about services					
	What we want to achieve	**Actions**			
5a	Continue to deliver 5-day a week signposting service		Ongoing	Uptake of this service remains constant.	
	Keep our local community informed of policy relating to local services	Community meetings. Key messages for information stalls. Key messages for specific pieces of engagement work.	Ongoing	Web-site, newsletter and Healthwatch meetings create space for this, as well as the Patient Group we administer for the CCG. Topics include Care Closer to Home Networks and changes at Camden and Islington Foundation Trust.	
Deliver a quality experience for our volunteers					
6	Complete Investing in Volunteers Quality Mark	Gather evidence of existing practice, assess this and develop areas which could be improved	Feb-18	Action Plan devised	

ISLINGTON

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

Report of: Executive Member for Health and Social Care

Meeting of	Date	Agenda Item	Ward(s)
Health and Social Care Scrutiny Committee	**14 September 2017**		**All**

Delete as appropriate	~~Exempt~~	Non-exempt

Report: 2016/17 Annual Performance Performance Report

1. Synopsis

1.1. Each year the council agrees a set of performance indicators and targets which, collectively, help us to monitor progress in delivering corporate priorities and working towards our goal of making Islington a fairer place to live and work.

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

1.3. This report sets out progress on corporate performance indicators, related to Health and Social Care, for the year 2016-17 (i.e. 1 April 2016 to 31st March 2017).

2. Recommendations

2.1. To note performance against key performance indicators over 2016/17 falling within the remit of the Health and Social Care Scrutiny Committee.

3. Background

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

4. Adult Social Care

ADULT SOCIAL SERVICES						
Objective	**PI No.**	**Indicator**	**Frequency**	**2016-17 Target**	**2016-17**	**2015-16**
Support older and disabled adults to live independently	ASC1	Delayed transfers of care (delayed days) from hospital per 100,000 population aged 18+ (Q4 target)	Quarterly	700.2	762.7	550.9
	ASC2	Percentage of people who have been discharged from hospital into enablement services that are at home or in a community setting 91 days after their discharge to these services	Quarterly	92%	95.7%	89.2%
	ASC3	Percentage of service users receiving services in the community through Direct Payments	Monthly	35%	30.9%	30.9%
Support those who are no longer able to live independently	ASC4	Number of new permanent admissions to residential and nursing care	Monthly	105	137	133
Carer reported Quality of Life	ASC5	The quality of life for carers as reported in the carer survey.	Every 2 Years	8.0	7.3 out of 12	N/A
*Reduce social isolation faced by vulnerable adults **(E)***	ASC6	The percentage of working age adults known to Adult Social Care feeling that they have adequate or better social contact. **(E)**	Annual (reports May)	70%	70.6%	70.8%

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

(E) = equalities target

Supporting independent living

4.1. Three measures are used to ensure that the Council is providing effective support to enable the most vulnerable to live independently for as long as possible.

4.2. The first, delayed transfers of care from hospital figure for Q4 of 2016/17 was 762.7 which did not meet the target of 700.2 and represents a decrease in performance. This decrease mirrors decreases in performance in London and England generally.

4.3. In Islington, the main reason for NHS delays was access to further non-acute services and for social care delays, access to nursing/residential care. Work is underway with NHS partners to improve discharge processes and ensure that people are not kept in hospital unnecessarily. We are working to ensure that people are supported home as soon as possible with assessments for their social care needs made at home rather than in hospital.

4.4. Delayed Transfers of Care in Islington take place in the context of high levels of deprivation with 11% of the working age population claiming out of work benefits (the 3rd highest in London), 7.8% of the working age population claiming

sickness/disability benefits due to physical and/or mental ill health (the highest in London) and overall, Islington is the 5th most deprived Borough in London. Further information shows that Islington has the second highest prevalence of people with serious mental health conditions in London at 1.5% and in Islington and Haringey, 1.4% of the population have 3 or more long term health conditions, predominantly within the 65+ age group.

4.5. Looking at snapshot data for the number of patients delayed, the total number of people delayed on the 12 snapshot days in 2016/17 amounted to 168 patients, an average of 14 patients per snapshot day. Most patient delays and bed days delayed relate to patients discharged from University College London Hospital and the Whittington, the two main hospitals serving Islington. While the patient numbers are based on a snapshot so don't cover all patients, the snapshot data indicates that a very small proportion of patients experience delays. The London region is commissioning Day of Care Audits, to help understand the reasons why some patients face delays with discharge. Islington is planning to take part in one of these audits to gather intelligence about how services interact with individuals. This and other types of business intelligence will be used to inform actions in 2017/18 and 2018/19 both in Islington and across North Central London.

4.6. Delays at the Whittington, UCLH and St Pancras are monitored daily with a view to finding solutions for patients who are delayed in hospital, with action logs in place and updated regularly.

4.7. Although performance has declined, performance in Islington is still good compared with most other authorities in England.

4.8. The Implementation of a new initiative called the Single Health Resilience Early Warning Database (SHREWD) – an electronic monitoring system which allows key information to be shared electronically between health and social care at the point when a patient is ready for discharge from hospital – has gone well and is now operational. This is a more efficient process than verbal and paper communication between staff involved in a patient's discharge and should help to facilitate the discharge process.

4.9. On discharge from hospital, there has been an improvement in the proportion of people who are supported by our enablement service to return to the community within 91 days. The 2016/17 figure of 95.7% is better than the expected profiled target of 92% for 2016/17. This represents a high level of performance when compared with other local authorities.

4.10. The third measure supporting this objective is the percentage of service users receiving services in the community through Direct Payments. These provide a budget directly to the service user to enable them to 'buy' their own package of support tailored to meet their needs.

4.11. The number of service users receiving Direct Payments at 30.9% is well above average when compared to other London boroughs, based on the 2015/16 benchmarking data. Comparative data for 2016/17 will be available around October 2017. We have developed more focus on the direct payments pathway and the

department is working towards making direct payments our preferred option for delivering services. In addition, service users who go through a reablement service and require ongoing care are offered direct payments rather than brokered service. The majority of our direct payments users are receiving long-term support packages. All staff have targets in their appraisals to promote and implement direct payments.

Admissions into residential or nursing care

4.12 The Council provides residential or nursing care for those who are no longer able to live independently. The aim is to keep this number as low as possible, supporting more people to remain in the community. Due to technical issues, the target for 2016/17 was based on data that suggested better performance than was actually the case. Therefore, the target of 105 actual permanent admissions of clients aged 65+ to nursing and residential care was too ambitious and was not achieved. The target hasn't been achieved but admissions have remained relatively stable with actual admissions in 2015/16 at 133 compared with 137 in 2016/17, despite pressures in the system. These pressures include an ageing population, greater acuity of need and pressures within acute hospitals.

4.13 A range of initiatives are in place to prevent admission to nursing or residential care through the availability of more person-centred services. For example, the proportion of social care clients aged 65+ receiving self-directed support is 99%. Joint work is ongoing at the health and social care interface to ensure that patients are discharged back to their own home. These measures include improvements to the intermediate care pathway and pilot work on Discharge to Assess.

4.14 Currently, around 50% of older adults admitted to permanent nursing and residential care are aged 85 and over with complex needs, including dementia coupled with age-related conditions. While every effort is made to limit the use of permanent nursing and residential care, there are instances where this is the best option for long-term support. Once clients are admitted to permanent nursing or residential care, a great deal of work takes place to ensure the best outcomes for those clients. Work for the High Impact Change Model is already showing success in enhancing health in care homes with the following established:

4.14.1 The Integrated Community Aging Team provides specialist geriatrician and MDT intervention and care planning.

4.14.2 Locality networks and GPs provide integrated multiagency intervention via primary care.

4.14.3 Comprehensive community health services provide intervention to care homes.

4.14.4 A pilot has commenced for an Integrated Urgent Care Professionals advice line. This allows care homes to gain access to advice in order to help prevent unnecessary admissions to hospital.

4.14.5 There is a Care Home Lead Nurse employed by Health and Care who provides care homes with expert support, advice, training and development.

4.15 Nursing and residential care admissions will continue to be monitored in 2017/18 to check progress.

Carer Quality of Life

4.16 The target of 8.0 wasn't achieved but performance remained stable at 7.3 in 2016/17. While comparator data is not yet available for 2016/17, in 2015/16, the comparator average was 7.3.

4.17 The results of the Survey of Adult Carers have been analysed and used to inform work to enhance carer services. Social isolation, for example, was picked up as an area for development as carer satisfaction with access to social contact is low. This is similar to national and comparator results which show that carers can experience isolation as a result of their caring duties.

4.18 Work is ongoing under the provisions of the Care Act 2014 and the Children and Families Act 2014 to ensure the best outcomes for carers and young carers. There is a strong strategic context for services for carers in Islington, with support for carers embedded in the Corporate Plan Towards a Fairer Islington: Our Commitment, in the Joint Health and Wellbeing Strategy 2017-2020 and the Joint Commissioning Strategy.

4.19 This support includes support for carers receiving adult social services, young carers and carers receiving services from the Mental Health Trust. In addition to direct payments, the London Borough of Islington commissions voluntary organisations to provide advice, information, support groups, events, volunteering opportunities for carers, emergency carers cards and the Flexible Breaks fund service. These services also include respite opportunities and a dementia navigator service for carers of older adults.

4.20 The Young Carers' Service (jointly commissioned between Camden and Islington) provides support for carers up to 18 years of age who care for a family member. This support includes assessments, whole family support and outreach services. Other services include interventions to help reduce the caring responsibilities for young carers and carer assessments for young carers transitioning to adult carers.

4.21 Support is also provided for carers of people with long-term mental health conditions. The Mental Health Trust works with carers of people with long-term mental health conditions and when the cared-for person is closed to the Trust, the Trust maintains responsibility for the carer for 12 months while transferring the carer support to social care services.

4.22 For carers of people with learning disabilities support is provided with transition to adult social services and also at the time when the cared-for client is moved to new accommodation or to new services.

4.23 Therefore, a range of services is available for carers.

Reducing social isolation

4.24 This is captured annually in the Adult Social Care Survey and the 2016/17 result is 70.6% which exceeds the target of 70%.

4.25 Reducing social isolation underpins much of the work commissioned by Adult Social Care. We continue to fund day care provision, including lunch clubs across the

borough. These services are provided by a combination of in house services, the voluntary sector and the private sector. Critically, these services support older residents who do not meet the threshold for access to social care which may prevent the need to access statutory services. Additionally, service users who have been assessed as requiring support from social care are also able to access the aforementioned services. In addition to the provision of transport to and from venues, a range of activities on site and the provision of meals, day centres and lunch clubs seek so to reduce social isolation by linking service users to local community groups thereby broadening the number of social contacts for the individual.

5. Public Health 2016/17 Annual Performance

Objective	PI No	Indicator	Frequency	**2016/17 actual performance**	2016/17 Target	On/Off target	**Same period in 2015/16**	Better than last year?
Promote wellbeing in early years	PH1	Proportion of new births that received a health visit within 14 days	Q	**94%**	90%	**On**	New indicator	New indicator
	PH2	a) Proportion of children who have received the first dose of MMR vaccine by 2 years old	Q	**82% (Q4)***	95%	**Off**	92% (Q4)	**Worse**
		b) Proportion of children who have received two doses of MMR vaccine by 5 years old	Q	**72% (Q4)***	95%	**Off**	87% (Q4)	**Worse**
Reduce prevalence of smoking	PH3	a) Number of smokers accessing stop smoking services	Q	**1,645**	1,400	**On**	2,356	**Worse**
		b) Percentage of smokers using stop smoking services who stop smoking (measured at four weeks after quit date)	Q	**46%**	54%	**Off**	48%	**Similar**
Early detection of health risks	PH4	a) Percentage of eligible population (40-74) who have been offered an NHS Health Check	Q	**28%**	20%	**On**	29%	**Similar**
		b) Percentage of those invited who take up the offer of an NHS Health Check	Q	**43%**	66%	**Off**	52%	**Worse**
Tackle mental health issues	PH5	a) Number of people entering treatment with the IAPT service (Improving Access to Psychological Therapies) for depression or anxiety	Q	**5,124**	4,655	**On**	5,357	**Similar**
		b) Percentage of those entering IAPT treatment who recover	Q	**49%* (Q4)**	50%	**Off**	49% (Q4)	**Similar**
Effective treatment for substance misuse	PH6	Percentage of drug users in drug treatment during the year, who successfully complete treatment and do not re-present within 6 months of treatment exit	Q	**17%**	20%	**Off**	18%	**Similar**
	PH7	Percentage of alcohol users who successfully complete their treatment plan	Q	**36%**	42%	**Off**	40%	**Worse**
Improve Sexual Health	PH8	Proportion of adults newly diagnosed with HIV with a late diagnosis (CD4 count less than 350 cells per mm).	Q	**42%**	25%	**Off**	New indicator	New indicator

* Q4 data has been provided as annual 2016/17 data is not available.

Promote wellbeing in early years

5.1 The proportion of new births that receive a face-to-face visit from a health visitor within 14 days has exceeded the annual target. As part of the Council's Early Childhood Transformation plans, throughout 2016/17 the health visiting service has been working closely with Children's Services to develop and implement a new model for an integrated early childhood service. The new service, Bright Start Islington, is due to launch in September 2017 delivering closer integrated working between health visiting and early years' family support, as well as co-location, stronger information sharing arrangements, and a change in cultures and ways of working to support effective collaboration across professional boundaries.

5.2 Quarter 4 saw a decrease in recorded vaccination rates for Measles, Mumps and Rubella (MMR) compared with previous quarters in 2016/17. This was seen among both two year olds (Q1 93%; Q2 92%; Q3 92%; Q4 82%) and five year olds (Q1 89%; Q2 85%; Q3 85%; Q4 72%). This is likely to be associated with data recording, rather than an actual drop off in rates, following the introduction of a new child health information system (CHIS) and data hub arrangements in London. We are working with NHS England, other local authorities and provider partners across North Central London to rectify outstanding CHIS issues and implement action plans to increase childhood immunisation levels.

Reduce prevalence of smoking

5.3 The number of people accessing stop smoking services exceeded the annual target. The percentage of people using the service who successfully quit was below target (54%) at 46%, but was substantially above the Department of Health recommended quit rate of 35%.

5.4 During 2016/17, a major service review and period of engagement with stakeholders, including local smokers, was completed as part of a fundamental redesign of smoking cessation services. A new provider was procured to deliver the new service across Islington from April 2017. The objectives of the service re-design were to provide a more flexible offer to smokers to encourage greater engagement in and uptake of the smoking cessation support, improving outcomes.

Effective detection of health risk

5.5 Invitations to NHS Health Checks exceeded the annual target with over 17,000 residents invited, while uptake was below target at 43% with over 7,300 receiving an NHS Health Check. We continue to work with GPs with a focus on proactive follow up invitations to those who do not take up the offer of an NHS Health Check. In 2016/17, Islington was the fourth highest out of all 152 Local Authorities in England in terms of NHS Health Checks offered, and the twelfth highest in terms of NHS Health Checks delivered.

5.6 In March 2017, Haringey and Islington Councils were successful in a joint bid on behalf of the Haringey and Islington Wellbeing Partnership to the British Heart Foundation for £100,000 to deliver a two-year community blood pressure testing programme. The funding is being used to train a network of community and voluntary sector (VCS) providers across Haringey and Islington to raise awareness of high blood pressure and perform blood pressure testing in a variety of community settings, focussing on high risk and hard to reach groups.

Tackle mental health issues

5.7 Over 5,000 people entered the Improving Access to Psychological Therapy (IAPT) programme in 2016/17, exceeding the annual target. In Q4 2016/17, the percentage of those entering IAPT treatment who recover is just short of the nationally set target (50%), at 49%.

5.8 Islington Council commissions three mental health promotion services with a focus on building resilience and supporting effective signposting into mental health treatment services where required. In 2016/17, 325 staff, residents and volunteers in Islington completed Mental Health First Aid Training; 381 young people participated in mental health and wellbeing workshops and 50 new community Mental Health Champions were recruited.

Effective treatment programmes to tackle substance abuse

5.9 The percentage of drug users in drug treatment during the year who successfully completed treatment and did not re-present within six months of treatment exit is below the annual target (20%) at 17%, but similar to last year's outcome. Islington remains in the top quartile nationally among non-opiate service users successfully completing treatment and not re-presenting within six months.

5.10 The proportion of alcohol users who successfully complete a treatment plan is below the annual target (42%) at 36%. During the year, changes in data recording among one provider in particular led to a reduction in the number of recorded successful alcohol treatment completions.

5.11 The procurement of Islington's adult drug and alcohol recovery service to begin delivery in 2018/19 is well underway. The service specification is based on the feedback gathered through the extensive consultation work undertaken with stakeholders across the borough and was developed alongside drug and alcohol service users.

Improve sexual health

5.12 The proportion of adults newly diagnosed with HIV who are diagnosed at a late stage of infection was above (i.e. off) the annual target of 25%. This measure collects data on all new HIV diagnoses made by Central and North West London NHS Trust's (CNWL) open access sexual health services in Camden and Islington, regardless of service users' usual borough of residence. It is based on relatively small numbers, and is therefore prone to fluctuation on a quarterly basis.

5.13 The higher percentage of late diagnoses recorded is not due to an increase in the number of people with a late diagnosis, but rather is due to a significant drop in newer infections being diagnosed. In January, CNWL published an article in the journal *Nature* highlighting this dramatic drop, which alongside existing initiatives for safer sex and earlier diagnosis and treatment, highlighted the impact of use of anti-HIV Pre-Exposure Prophylaxis (PrEP) among men who have sex with men in reducing new HIV infections.

5.14 CNWL, as the main commissioned provider of open access sexual health services in Islington and Camden, are required to meet a target of offering an HIV test to 97% of sexual health service users at first attendance, with the target uptake rate set at 80%.

CNWL is consistently meeting or exceeding this and there is particularly high uptake among men who have sex with men.

5.15 Data on rates of late HIV diagnosis based on Islington's resident population are only available on an annual basis. The latest available data is for 2013-15, when the rate in Islington was 23.7%. This was an improvement on 2012-14 and the third lowest (best) rate in London.

Report authors:

Name: Michele Chew
Job Title: Head of Quality and Performance, Housing and Adult Social Services
Tel: 020 7527 1168
E-mail: michele.chew@islington.gov.uk

Name: Esther Dickie
Job Title: Project Manager, Public Health
Tel: 020 7527 8766
Email: esther.dickie@islington.gov.uk

Final Report Clearance

Janet Burgess

Signed by ..... Date: 4th September 2017

Received by ..... Date: .....

SCRUTINY REVIEW INTITATION DOCUMENT

Review: The health impacts of poor air quality

Scrutiny Committee: Health Scrutiny Committee

Overall aim: To understand the scale and nature of the negative health and wellbeing impacts of poor air quality in Islington, and the effectiveness of current arrangements and measures for tackling poor air quality and its adverse impacts on health.

Objectives of the review:

- To understand the relationship between poor air quality and health and wellbeing in general, and specifically the impact of poor air quality on Islington residents' health and wellbeing.
- To understand the direct benefits of improving air quality in Islington, including the wider health co-benefits of actions taken to address it including increased physical activity, reduced obesity, reduced social isolation.
- To make recommendations for increasing the impact of local measures to improve health in relation to air quality

Duration: Approx. 6 months

How the review will be conducted:

Scope: The review will look at the issue of poor air quality and its impact on health and wellbeing

Types of evidence to be assessed:

- National and local data on
    a. Scale and location of poor air quality in Islington, including information on the different pollutants, severity etc., as well as the limitations of what is known.
    b. Health and wellbeing impacts of poor air quality, including understanding evidence of causation and association.
    c. Overview of local programmes and interventions to improve air quality in Islington, and information on their impact and effectiveness.
    d. Overview of the health co-benefits of improving air quality, including increased physical activity, reduced prevalence of obesity, reduced social isolation, school absences etc.

- Witness evidence from a range of relevant individuals and organisations

    a. LBI
        i. Public Health (health impacts, effective interventions, JSNA/HWB)
        ii. Clinical Commissioning Managers (interventions, policy initiatives, targeted groups)
        iii. Environmental Health (trends, apportionment, air quality projects, policy)
        iv. Transport Planning (local implementation plan, traffic schemes e.g. Archway, modal shift)
        v. Education (absenteeism due to poor air quality – HeadTeachers; school awareness campaigns incl. school gate engine idling – LBI School Travel Plan Officer/Public Protection
        vi. airTEXT
    b. External partners

i. King's College London (Ian Mudway/Frank Kelly – also from COMEAP)
ii. Imperial College London (Audrey de Nazelle – modal shift & health)
iii. Representatives from Local GP consortia or Health/MedicalCentres
iv. Transport for London (Public Health – Lucy Saunders)
v. Whittington Health (CV & respiratory health overview, ie, Asthma kite mark in schools)
vi. Breathe Easy Groups
vii. Business engagement (ZEN; CRP)
viii. Campaigning organisations – Simon Birkett (Campaign for Clean Air in London); Doctors against Diesel; ClientEarth; Friends of the Earth (Jenny Bates/Quentin Given); Greenpeace (school campaign); Better Archway Forum; Barbecue Action Group

c. Residents
i. Residents – open call for those interested to attend and give evidence
ii. Residents identified via members' casework
iii. Islington HealthWatch

Additional information:
To note the 2013 Regeneration and Environment Scrutiny Committee report on air quality
https://democracy.islington.gov.uk/Data/Regeneration%20and%20Employment%20Review%20Committee/201303051930/Agenda/Air%20Quality%20draft%20report%20including%20amendments%20made%20at%20Committee%20on%205%20March%202013.pdf

ISLINGTON

Air Quality

REPORT OF THE REGENERATION AND EMPLOYMENT REVIEW COMMITTEE

London Borough of Islington
March 2013

CHAIR'S FOREWORD

EXECUTIVE SUMMARY

Air Quality

Aim
The overall aim of the Air Quality Review was to look at the air quality in Islington, consider current work that was being done in Islington and across London and assess the actions that could be taken to improve the air quality in Islington. It was acknowledged that air quality was a regional problem and solutions would involve working with other local authorities and the community and securing funding.

Evidence
The review ran from July 2012 until March 2013 and evidence was received from a variety of sources:

1. Presentations from witnesses - Simon Birkett, Clean Air London, Professor Gary Fuller, King's College, London, Professor Frank Kelly, King's College, London, Iarla Kilbane-Dawe, atmospheric scientist, Lucy Saunders, Public Health Specialist GLA/TfL, Jonathan O'Sullivan, Assistant Director of Public Health, Samantha Heath, London Sustainability Exchange, Elliot Treharne, Air Quality Manager, GLA, Matthew Pencharz - the Mayor's Environment Adviser

2. Presentations from council officers - Paul Clift, Principal Environmental Health Officer, Chair of the Chartered Institute of Environmental Health (CIEH) London Region Pollution Study Group and chair and project manager of the AirTEXT service, Sukky Choongh, Principal Technical Officer, Public Protection, Maxine Williams, Environmental Health Officer, Public Protection, Savva Mina, Service Manager, Environmental Services, Chris Rutherford, Transport Manager, Paul Selby, Career Grade Planner.

3. Visits to Cemex, Air Quality Monitoring Sites, GLA, King's College and a meeting of the Council's Air Quality Consultative Event

4. Written submissions – Client Earth, Lancaster University – Using Trees to Improve Air Quality in Cities, National Institute for Health and Clinical Excellence – Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation

Main Findings
Air pollution is largely an invisible problem which means that often people are not aware it is an issue that needs to be addressed.

Poor air quality has a range of harmful effects on human health. It could exacerbate existing heart and lung conditions. High levels of air pollution leads to increases in hospital admissions for Chronic Obstructive Pulmonary Disease (COPD) and asthma. Older people are more likely to have an existing heart condition or lung disease. Children are more vulnerable to the effects of air pollution because their lungs are still developing, they breathe at a faster rate and spend more time outdoors. They are also nearer the level of exhausts. If children breathed in too much polluted air during the years when their lungs were developing, this could prevent their lungs from ever fully developing. More deprived communities tend to experience higher levels of air pollution because they are closer to the sources of pollution e.g. busy roads). There is a link between deprivation ad heart disease which was aggravated further by air pollution.

Diesel is often presented as a green option however it actually produces 22 times the particulate matter and 4 times the NO2 emissions of petrol.

In 2003 Islington was declared an Air Quality Management Area as air quality targets were not being met. An Air Quality Action Plan was produced and each year progress reports have to be submitted to the GLA and DEFRA. The current position is that Islington does not meet the annual nitrogen oxide roadside data objective but does meet all the other objectives. Neighbouring boroughs also did not meet

the annual nitrogen oxide roadside data objective. Often air pollution in Islington was caused by sources elsewhere in London or even further afield.

Islington's next Air Quality Action Plan would focus on transport, development, energy usage, reducing emissions from businesses and awareness raising initiatives.

The Euro Standards set for vehicle emissions had not been as effective as anticipated as testing in the factory had not involved the starting and stopping that occurs whilst driving around London.

Electric cars, car clubs, cycling and walking should also be encouraged to improve air quality in London. The National Institute for Health and Clinical Excellence (NICE) had published recommendations and guidance on how local authorities could encourage walking and cycling and the health benefits of these.

The London Air Quality Network was founded in 1992/3 to coordinate and support air quality measurements in London. There is a co-ordinated network of continuous monitoring sites within and surrounding London. Fixed long term sites are funded by local authorities, DEFRA and TfL. It was the Europe's largest regional air quality network.

The Mayor's Air Quality Strategy aimed to reduce air pollution and improve the health of Londoners. A commitment has been made to upgrade the bus fleet, create low emissions zones and encourage sustainable travel. There are also non-transport measures which require developers to take appropriate measures when constructing and demolishing buildings and to comply with planning and development new initiatives.

The Mayor's Air Quality Fund (MAQF) and Cleaner Air Boroughs is part of a new approach to support additional local action. The Mayor wants to support boroughs in prioritising air quality and mainstreaming it through their activities (e.g. environment, transport, public health and planning). Funding would only be given to suitable schemes where match funding was provided. In January 2014, the Mayor would be awarding the first of the Cleaner Air Borough awards for exemplar boroughs working in London to improve air quality.

Smoother traffic flow also improved air quality. The GLA is looking to reduce the number of pedestrian crossings in order to do this. At the same time, the quality of the remaining crossings would be improved. Smoother traffic flow could be encouraged through a 20mph limit. Camden High Street is a TfL road where a 20mph limit has been introduced and where the traffic lights have been rephrased to enforce the limit. In future, it could be possible to change the way traffic lights are programmed to link them to monitoring station data and alter the timings accordingly.

There were many schemes taking place across London to improve air quality. These included a freight consolidation on Regents Street which had reduced vehicular movements by 75%, a zero emissions delivery policy in Shoreditch and a low cost cycle track in Camden.

The Council has electric cars, vans, scooters and hybrid cars and vans and had been awarded a bronze membership of FORS – Fleet Operator Recognition Scheme. In addition planning policies were in place to ensure developments kept emissions to a minimum.

The Airtext service provides air pollution, UV, pollen and temperature forecasts for Greater London. It is project managed by Islington Council. It is particularly useful to those who suffered from COPD and enabled them to plan their day accordingly e.g. carry medication, avoid main roads and avoid outdoor exercise where necessary.

The Council had received funding from DEFRA to do business engagement work.

Conclusions

The Air Quality review has concluded that although much work is already done to improve air quality in Islington, further measures are necessary in order to reduce air pollution further. It was acknowledged this would be challenging as the source of much of the air pollution was from outside Islington or was

from traffic passing through Islington but the Council would need to work with other boroughs, TfL and the GLA in order to improve air quality as much as possible.

Recommendations

1. That the Council directly works with the neighbouring boroughs on specific projects to formulate a regional approach to improving air quality and promoting air quality as a health issue to inform residents.

2. That the Council undertakes business engagement to inform businesses of the ways in which they could reduce emissions.

3. That the Council lobbies the Mayor to prioritise Islington bus routes when rolling out the retrofitted buses and includes data to show points where emissions were highest.

4. That the Council carries out a feasibility study on implementing a boroughwide low emission zone, including costings and presents a report to the Committee by September 2013.

5. That the Council's policies give greater priority to air quality in instances where air quality and carbon reduction conflict.

6. That the Council increase planting of trees and plant species which improve air quality.

7. That the Council, when replacing its vehicle fleet, sources vehicles with the highest Euro rating available including electric vehicles where possible.

8. That the Council takes the necessary action to get its bronze membership of the Freight Operator Recognition Scheme (FORS) upgraded to silver and then gold.

9. That the Council includes air quality in procurement criteria. This should include FORS membership.

10. That the Council proactively bids for funding for projects that will deliver improved air quality in Islington.

11. That the Council works with TfL to improve air quality further within the NO2 Focus Areas (Angel to Islington Green and Nag's Head to Archway).

12. That the Council takes the necessary steps to avoid penalties and fines for breaching air quality regulations.

13. That the Council prepares a costed report on providing low cost cycle tracks in the borough to link up with the existing cycle network.

14. That the Council sets up an air quality working group to provide a lead on air quality issues.

15. That the Council's public health team works with the Air Quality Working Group and reports annually to the Health Scrutiny Committee on public health actions to address air quality issues.

16. That the Council applies for a Cleaner Air Borough award.

17. That Members receive a report on air quality midway between Air Quality Action Plans to ensure they are updated on the air quality issues in the borough and that this report be published on the Council's website.

18. That the Council considers establishing a citizen's action network on air quality, to help identify and address specific local air quality problems of concern to Islington's residents.

19. That, noting the successful joint Camden and Islington's air quality summit on 21 November 2011 in Camden, there should be a follow-up event in Islington in autumn 2013.

20. That the Council encourages and provides support to schools in developing walk to school travel plans.

21. That the Council encourages residents to make local journeys by walking and cycling through the provision of a safe, convenient and quieter street environment.

MEMBERSHIP OF THE REGENERATION AND EMPLOYMENT REVIEW COMMITTEE

COUNCILLORS 2012/2013

Councillor Foxsmith (Chair)
Councillor Spall (Vice-Chair)
Councillor Belford
Councillor Wally Burgess
Councillor Charalambous
Councillor Debono
Councillor Hamitouche
Councillor Rupert Perry/Councillor Rakhia Ismail

Acknowledgements: The Committee would like to thank all the witnesses who gave evidence to the review.

Officer Support:
Zoe Crane – Democratic Services
Savva Mina, Paul Clift, Sukky Choongh and Maxine Williams – Environment and Regeneration

1. Introduction

1.1 The London Borough is a densely populated inner city borough. It is recognised as having the least amount of green space per person out of all the London boroughs. The majority of parks and open spaces are located in the north of the borough, whereas the south is predominantly mixed use residential/commercial. The south-east corner of the borough is part of the London congestion charge zone. The main source of pollution is from road traffic as the A1 runs through the heart of the borough and is commonly used as a thoroughfare to travel though the city. Islington is considered a desirable location for developers and is frequented by construction traffic. Planning policies have allowed the authority to place stringent criteria on development in order to ensure emissions to air are not increased. The borough is serviced by 10 London Underground Stations and a number of over ground stations servicing the North London line, Overground, Hertford North to Kings Cross and the East London Line extension.

1.2 Local air quality is managed in accordance with the local air quality framework. The European Union has set legally binding limit values. The National Air Quality Strategy requires all local authorities to review and assess air quality in their areas against set objectives. The air quality objectives are set in the Air Quality Regulations. The review and assessment of air quality is a statutory three year cycle which involves a technical assessment of air quality every three years. Islington is currently on its fifth review.

1.3 The seven air quality pollutants are Benzene, 1, 3-Butadiene, Carbon Monoxide, Lead, Nitrogen Dioxide, Sulphur Dioxide and Particles (PM10 and PM2.5). The pollutants of most concern are Nitrogen Dioxide and particles. PM10 particles are 10 microns in diameter and PM2.5 particles are 2.5 microns in diameter. Particles are mainly produced through the combustion process. Targets are set for pollutants to be at a certain level by a certain date. The pollutants and targets are subject to change over time.

1.4 If one or more of the objectives is not likely to be met, the local authority has to declare an Air Quality Management Area (AQMA) and produce an air quality action plan (AQAP). The first stage review was undertaken in August 2000, in 2001 an AQMA was declared for part of the borough, in 2003 AQMA was declared for the entire borough and an AQAP was published. Progress reports are undertaken each year in between reviews and these have to be submitted to DEFRA and the GLA. The last one had been submitted in 2011 and was published on the Council's website. The current position is that Islington does not meet the annual nitrogen oxide roadside data objective but does meet all the other objectives. Neighbouring boroughs also do not meet the annual nitrogen oxide roadside data objective.
A new action plan will be developed in the near future and the work of the scrutiny review will feed into it.

1.5 The World Health Organisation published Air Quality guidelines in February 2007. Since then there has been much more evidence about the problem of air pollution. The World Health Organisation would be publishing updated guidelines in Spring 2013.

1.6 In urban areas traffic is the main source of 'modern' air pollution – tiny particles and nitrogen dioxide. The collection and monitoring of data from 2000-2012 showed that concentrations of PM10 and NO2 have not decreased during this time. Unleaded petrol has particles that are the same size as those in diesel but there were far fewer particles.

1.7 London and New York are the only Alpha ++ cities in the world. This meant they are the most densely populated, economically active cities. The GDP of the eight inner London boroughs is greater than that of Kuwait, the Czech Republic or New Zealand. 2 million people work in the central London zone and two million people live there. Only 5% of these live and work there which means there are 1.9 million people commuting daily. This contributes to London's air pollution problem. London has half of the UK's air pollution.

1.8 When Londoners were surveyed they frequently put air quality in their list of top ten important issues. However they often did not realise the extent of the problem and the health implications. It was important to remember that being green in relation to climate change did not necessarily

mean being green in relation to air quality. People were more likely to think about transport at times of life change e.g. moving house and could be encouraged to do so (e.g. through estate agents) at these times before habits formed.

2. Findings

Air Pollution Context

2.1 5-9th December 2012 was the 60th anniversary of the Great Smog of 1952. This was caused by burning coal in power stations and people heating their homes with open fires. Levels of smoke and sulphur dioxide rose significantly during this time. Pollution was 100 times higher than the average at that time; hospital admissions rose and there were between 4,000 and 5,000 additional deaths in London.

2.2 By the time of the Great Smog in 1952, London had been very polluted for a century and the smog encouraged politicians to realise that action had to be taken. The Clean Air Act 1956 was introduced. Power stations were moved out of the city and only smokeless fuel could be burned in homes. From the 1970s when oil was discovered in the North Sea, it was used more as a fuel. There is now very little smoke and sulphur dioxide in the air.

2.3 In London there are on average 8-12 days per year when there is visible air pollution in the form of smog. On these days there are higher quantities of particulate matter, nitrogen dioxide and ozone. On most days only invisible air pollution is present and therefore most people do not realise there is a problem.

Heating

2.4 Combined heat and power (CHP) and biomass boilers are increasingly being used in London and they increase air pollution. Biodiesel was used extensively until the subsidy was removed. The London Plan encourages the use of CHP; however, there are more efficient gas heating systems available. There are 23 known biomass boilers in Islington. Some are being well run e.g. at the Angel Centre, the Packington Estate and the Ecology Centre. The newer biomass boilers are better for air quality than the older ones but overall gas boilers are better for air quality than biomass boilers.

2.5 Concerns were raised about people having open fires for aesthetic reasons rather than because this was the only source of heat. This was particularly the case in the south of England at weekends. People were often only unaware that open fires polluted the air they were breathing. Similarly, barbecues caused air pollution.

2.6 20% of particulate matter and 50% of NO2 was caused by buildings. 55,000 homes had been retroffited to improve energy efficiency and public buildings were also being retroffited. Insulating homes would enable people to use less fuel and reduce emissions.

Polluting modes of transport

2.7 80% of particulate matter was caused by transport and diesel produced 22 times the particulate matter (PM) and 4 times the NO2 emissions of petrol. Since 2000, diesel has been promoted to encourage greater fuel efficiency but this has exacerbated the air quality problem. The emissions of petrol cars has improved over time with technology. However, there has been little improvement with diesel cars and emissions were similar today. In 2007 the UK passed the point where half of all vehicles were diesel. Short vehicle journeys contributed to air pollution and those making them should be encouraged not to make them by car.

2.8 Three quarters of PM emissions in London would not be resolvable by taking action in London as the sources were elsewhere. Much of the PM is from as far away as Poland. The only way to control it is at a European level. In the 1990s there was a pact, limits were set that were believed to be achievable (Euro Standards) and power stations were cleaned up. The Euro Standards set for vehicle emissions has not been as effective as anticipated as testing in the factory had not involved the starting and stopping that occurs whilst driving around London. There had been two campaigns to measure this and tens of thousands of car emissions have been measured.

2.9 Buses travelling through Islington are a major source of air pollution and in addition some bus drivers unnecessarily leave their engines on whilst stationery, during particularly during breaks.

Across London 300 hybrid buses have been introduced, there is a hydrogen trial taking place and 1,000 of the oldest buses (Euro 3) are being retroffited. This would reduce bus emissions by 80%. London will have the largest hybrid bus fleet in Europe. Putney was an example of a place where hybrid buses had been introduced due to poor air quality. Due to the size of buses, it is not possible to use petrol to fuel them.

2.10 Taxis over 15 years old are being retired and there is a minimum Euro 5 standard for new taxis. Black taxis are the most polluting vehicles in London. However, it would be possible to reduce particle emissions by 98% if all taxis had a particle filter fitted. These would cost approximately £1700 per taxi. The firm that had made black cabs had gone bust and the Mayor was encouraging potential producers of taxis to make a zero emission taxi. In London, there are currently at least three taxi companies who use Prius or electric vehicles.

Less polluting modes of transport

2.11 Electric cars are commercially available, have zero emissions and many are powered by wind turbines. They have been through the NCAP (New Car Assessment Programme) for safety, have a 75mile range, had 300 miles per gallon and cost £1 to charge. Important technology includes stop start technology, hybrid technology which results in a minimum saving of 15% in fuel and carbon dioxide, retro fit solutions, global positioning systems and fuel monitoring.

2.12 Smiths/Modec electric vehicles are approved for the Government's Plug-In Van Grant of £8,000. Companies purchasing commercial electric vehicles could write down 100% of the capital cost against tax in the first year of ownership. Electric commercial vehicles are exempt from the annual Road Fund and all Smiths vehicles are exempt from the London Congestion Charge, have a 100 mile range, 50mph top speed, zero emissions, a 2 tonne payload and are silent.

2.13 Each car club could reduce the number of cars on the road by up to 5,000 and result in significant carbon dioxide savings each year. Islington had the largest car club in the UK.

2.14 Concerns were raised about cycle routes mainly being along busy roads. If cyclists had to travel on main roads they could reduce the effects of air pollution on their health by avoiding the rush hour and not travelling behind buses. Some facemasks, particularly those containing activated charcoal could prevent some of the inhalation of noxious fumes, however particles are so small they would still be inhaled.

2.15 National Institute for Health and Clinical Excellence (NICE) had published recommendations and guidance on how local authorities could encourage walking and cycling and the physical health benefits of these. They also considered air pollution; the role in which walking and cycling could reduce air pollution emissions as part of their local action plans; balancing the increased exposure against the benefits of active travel and the way in which exposure during walking and cycling could be reduced further by careful route choice.

2.16 Those who cycle could save an average of £700 in commuting costs. Cycling could be incentivised in the work place. The 20mph speed limit would encourage cycling. There is evidence to suggest that face masks did stop some pollution from entering the airways but the smallest, most dangerous particles would still get through.

Studies and work being done across London and elsewhere

2.17 The London Air Quality Network was founded in 1992/3 to coordinate and support air quality measurements in London. There is a coordinated network of continuous monitoring sites within and surrounding London. Fixed long term sites are funded by local authorities, DEFRA and TfL. The network is now Europe's largest regional air quality network with over 100 borough monitoring sites. King's College provides specialist scientific and technical support, collects and quality assures measurements and disseminates data to the public.

2.18 The London Air website had won the Air Quality Bulletin's annual website awards in 2011 and 2012. The website also has a smart phone app and a Google Chrome extension.

2.19 The Mayor of London's Air Quality Strategy 2010 aimed to reduce air pollution and improve the health of Londoners. A commitment has been made to upgrade the bus fleet, create low emission zones and encourage sustainable travel. There are also non-transport measures which require developers to take appropriate measures when constructing and demolishing buildings and to comply with planning and development new initiatives. A further non-transport measure is to raise public awareness.

2.20 The Mayor's Air Quality Fund (MAQF) and Cleaner Air Boroughs is part of a new approach to support additional local action. This complements Londonwide measures delivered by the Mayor. The Mayor wants to support boroughs in prioritising air quality and mainstreaming it through their activities (e.g. environment, transport, public health and planning). To this end additional funding from the MAQF would be linked to signing up to the Cleaner Air Borough criteria. Where funding was provided, match funding would also be required. In January 2014, the Mayor will be awarding the first of the Cleaner Air Borough awards for exemplar boroughs working in London to improve air quality. Boroughs are being seen as laboratories of innovation. Local schemes could have a big impact. It is important they deliver against multiple objectives – air quality, climate change and noise. New ways of thinking are required as exposure reduction is especially important at schools, hospitals and high streets. New ways of working are required; local authorities should work with each other, with Business Improvement Districts, community/residents groups and delivery partners. The old model was top-down delivery led by the Mayor and boroughs and focused on mitigation. The new model sought to empower and raise awareness. There is an increased focus on public health and adaptation. The Cleaner Air Champions have three core roles: 1) to raise awareness; 2) to reduce an individual's air quality footprint and 3) to support adaptation. A pilot scheme is taking place in Hackney, Islington, Redbridge and Havering. There would be 10 champions in each borough. Champions would be recruited from schools, hospitals, community groups, religious groups and businesses. Training and support would be provided by Sustrans. There would be a £10,000 fund to help them have an impact in their community.

2.21 The London Plan requires development proposals to be at least air quality neutral. This is difficult as many new developments are larger than the previous buildings. They therefore required good insulation and the cleanest gas boilers.

2.22 The ClearfLo (Clean Air for London) Project is a collaborative scientific project involving 11 universities. ClearfLo aims to provide long term integrated measurements of the meteorology, composition and particulate loading of London's urban atmosphere, made at street level and at elevated sites, complemented by modelling to improve predictive capability for air quality.

2.23 The Traffic Air Pollution in London is a project which is investigating toxicity and sources of air pollutants, will develop models of exposure to air pollution to include information about concentrations, emissions and time-activity. The effects of long term exposure to traffic pollution will be investigated.

2.24 Exhale (Exploration of Health and Lungs in the Environment) is testing the effect of traffic emissions on children's health by looking for signs of pollution in their saliva, looking at routes to school and estimating exposure. The children being tested live in East London.

2.25 Islington is part of a cluster group consisting of Kensington and Chelsea, the City of London, Westminster and Camden all of which have action plans focussed on transport measures, development, energy usage and raising awareness. The cluster group meets, shares best practice and has a co-ordinated approach. Research is conducted on cost effective actions to cut Central London air pollution.

2.26 TFL have created a green screen of plants on the Edgware Road to find out which plants are the most effective at improving air quality. It is difficult to quantify the benefits of planting trees but this

is encouraged in the action plan. It is recognised that certain types of trees are better than others at improving air quality. There is, however some evidence to show that physical barriers between people and the source of pollution could reduce the effects of air pollution. This may be particularly helpful near schools near busy roads.

2.27 There are ways to reduce vehicle movements. Freight consolidation by the businesses on Regent Street had reduced vehicular movements there by 75%. TNT and Office Depot are two firms the City of London used to delivery supplies by bicycle in order to reduce emissions. There are 13 businesses in central London who undertake zero emission deliveries for little or no extra cost.

2.28 Hackney has set up a zero emission delivery policy in Shoreditch. It might be possible that Islington could join this work programme focussed on Old Street and Tech City.

2.29 Germany has 47 low emission zones. Only vehicles in certain emission categories are permitted to drive in the low emission zones. Stickers specifying the correct emission category for each vehicle have to be bought and displayed before permitted vehicles can drive into the zone.

2.30 The Low Emission Zone in London has been expensive to implement and required heavy infrastructure. It has, however, delivered an improvement in pollution from HGVs.

2.31 Improving public awareness is an important issue. The Mayor of London and Transport for London had run an anti-idling campaign which aimed to improve understanding of the issue and there had also been a radio advertising campaign.

2.32 Under the localism agenda, the NHS would have to report on PM2.5 indicators. Transport providers, health providers and local authorities would all have to work together to improve air quality. A low emission zone across a number of boroughs could work but across one borough would not have as much impact as air flowed across borough boundaries.

2.33 Camden, the City of London, Westminster and Wandsworth are all proactive in working with the GLA. Islington has developed good partnership working with the GLA, particularly through the achievements of the airTEXT service.

2.34 Cycling could be promoted through the implementation of low cost cycle tracks. The cycle lanes are separated from the traffic by measures such as planters and cats eyes rather than kerbs. One is about to be installed in Camden. A 500m track would cost about £53,000 in comparison to the equivalent length expensive track which would cost £500,000. These low cost tracks had been successful in cities abroad particularly in New York and Barcelona.

2.35 TfL are starting to look again at the infrastructure of the 100,000km of quiet roads for cyclists which had made up the TCN programme and how cyclists could be encouraged to use them.

2.36 TFL are looking at fitting catalysts on buses, commissioning new Euro 6 buses or fitting vertical exhausts which would significantly reduce the air pollution from buses at ground level. Buses with vertical exhausts were common in other countries. In New South Wales, Australia they were being phased out due to the Euro Standards but as the Euro Standards had not delivered what they were expected to and the authorities were now regretting phasing the vertical exhausts out. Manufacturers have concerns about vertical exhausts as these would increase the visibility of the emissions from the exhausts when seen against blue sky.

2.37 In San Fransico, Spare the Air days are held. When air pollution levels are high the public is encouraged not to pollute so much that day and people are encouraged to work from home, car share, cycle or walk. This reduces emissions and exposure at the same time. After 20 years of this campaign there has now been a 9% reduction in car use on these days.

2.38 Air pollution in London regularly exceeds twice the World Health Organisation guidelines. London has the worst air pollution in the UK and among the worst in Europe. It was possible that the

government might not meet air quality laws in London until 2025. 2013 would be the EU Year of Air which would aim to highlight the problems of air pollution and air quality.

2.39 In London there is much work being done to reduce PM emissions; however nitrogen dioxide is more of a challenge to address. Nitrogen dioxide is not just a problem in cities. An example of a town with high nitrogen dioxide levels is Bradford on Avon.

2.40 Smoother traffic flow improves air quality. The GLA is looking to reduce the number of pedestrian crossings in order to do this. At the same time, the quality of the remaining crossings would be improved. Smoother traffic flow could be encouraged through a 20mph limit. Camden High Street is a TfL road where a 20mph limit has been introduced and where the traffic lights have been rephased to enforce the limit. In future, it could be possible to change the way traffic lights are programmed to link them to monitoring station data and alter the timings accordingly.

2.41 CMA Spray is a dust suppressant which sticks to the roads. It has been used in Scandinavia for over a decade and could reduce PM by 10-20% on the targeted roads. It is being used by the GLA and it reduces pollution by enough to justify its cost.

In Islington

2.42 In Islington there are two fixed air quality monitoring sites. There is a roadside monitoring site on Holloway Road which monitors carbon monoxide, nitrogen dioxide and particles and there is a background monitoring site at the Arsenal which monitors nitrogen dioxide and particles. The background monitoring site has been moved from the back of a council building on Upper Street in 2007 to the Arsenal when the council moved from the Upper Street building. Since the move, the site had met the annual nitrogen dioxide objective. It was next to the railway line beside the ecology centre. The ecology centre has a biomass boiler and pollution from the burning wood could affect the results. The air quality monitoring stations are unable to decipher the source of the pollutants. The data from the Monitoring Stations is sent directly to Kings College where it is analysed along with data from other boroughs. Trends are identified and comparisons are made with data from other boroughs. The results are published on the London Air Quality Network website. Data from the monitoring sites is available on Islington's website. The Council also has two mobile air quality monitors, however their mobility is limited as they require hard standing and an electricity supply.

2.43 Council wide efforts are being made to improve air quality. The Planning and Development Department encourage car free developments and cycle parking provisions, Fleet and Transport Planning use electric vehicles, Sustainability promote cleaner energy strategies and Construction Impacts manage areas such as dust control.

2.44 The Council works with the Central London Air Quality Cluster Group, Transport for London and the Greater London Authority to improve air quality Londonwide. It is important to have a regional approach to air quality management as many of the sources of pollution in Islington are from outside the borough.

2.45 Each year the Council applies to DEFRA for funding. This year the Council has received funding for business engagement. Work had been done in the borough by City Air and the funding would allow the work to be replicated in other parts of the borough. As part of the business engagement work, businesses could be encouraged to replace their old boilers sooner than they were planning to in order to save energy costs and reduce air pollution.

2.46 Prior Weston Primary School has been part of a GLA funded programme undertaken by the London Sustainability Exchange. The programme is pitched at Key Stage 2 and is cross curricular. Parents, governors and teachers are also involved. Children investigating idling at the school gates had resulted in an 11% reduction of people leaving their engines on.

2.47 Since Islington was declared an Air Quality Management Area (AQMA) in 2003, a number of initiatives had led to improvements in air quality. These included the introduction of the 20mph

zone; parking charge rates being dependent on the vehicle emissions levels; the cycle action plan 2006; the introduction of a green procurement plan and green travel plan; reduced parking provision at council buildings and the use of hybrid council vehicles.

2.48 Islington's updated AQAP had been drafted and planning and transport departments would be consulted before the public consultation. The actions that could be taken to improve air quality are constrained by funding. Some funding is provided by DEFRA and the EU. It is anticipated that the action plan would be finalised by the end of this financial year. The draft updated AQAP focussed on the following five areas:

1) Transport – Driver behaviour could be targeted and driver training could teach drivers about reducing emissions. Car sharing, car clubs and car free days could be encouraged. TfL has an idling vehicles campaign through which £20 fixed penalty notices would be issued when drivers of idling vehicles would not turn off their engines when asked. Low emission zones could be implemented in specific areas of Islington. A best practice guide could be developed for taxi drivers. The council has no control over buses but could encourage the Mayor of London to retrofit the bus fleet with cleaner exhausts.

2) Development – The impacts of new developments would be determined. Developers could be required to submit carbon saving proposals, air quality proposals and mitigation steps that could be taken. Under Section 106, all developments have to comply with the Codes.

3) Energy Usage – The number of gas boilers could be reduced; energy efficiency could be improved; biomass and biodiesel could be controlled as although they were low carbon, they produced nitrogen dioxide and particulates; the uptake of renewable and low emission fuels could be encouraged and advice could be provided on energy saving and fuel use.

4) Reducing Emissions from Businesses – The Council wants to develop a green procurement guide. A bid for funding had been submitted to DEFRA for a business engagement project. If successful the following areas would be targeted: - Angel to Islington Green, Highbury Corner to Archway and possibly the Seven Sisters Road. The Council would like to commission air quality monitoring.

5) Awareness Raising Initiatives – It is important to raise awareness of personal exposure and enable people to reduce their exposure by using less polluted routes. The AirTEXT consortium provides health advice on pollution, UV and pollen levels and temperatures. The Council is interested in working with GPs to help inform patients. Islington has received funding to enable one primary school to be included in the Schools Engagement Project in which 50 schools from across London would try to reduce their emissions.

2.49 Overall, the measures in the 2003 AQAP had significantly reduced the concentration of pollutants. Islington is meeting the target for particulates but not for nitrogen dioxide. It is difficult to specify how much the implemented measures have affected air quality as external activity is also a factor. Modelling is not accurate as it assumes external activity would remain the same. It is also expensive.

2.50 Over the last seven years the Council had had access to funding through the low carbon van procurement programme. £600,000 had been saved buying 10 Smiths vans, 2 Modecs and 2 Ashwood hybrids and £269,000 had been saved in the last vehicle purchases for grounds maintenance (21 Ashwood hybrids). Lifecycle costs made the use of sustainable vehicles possible; however, cost would be the biggest barrier to having a completely green fleet. The Council's fuel costs are approximately £2m per year. The council has a 15 year contract for vehicles which would end in June 2013. After this time there would be a potential reduction in vehicles.

2.51 The Council had been awarded a bronze membership of FORS – Fleet Operator Recognition Scheme. It is hoped that in time the Council could upgrade to a gold membership.

2.52 The council has electric cars, van and scooters and hybrid cars and vans. Islington has an award winning green fleet. Diesel vehicles are used where appropriate due to cost constraints but filters are fitted and engines are downsized wherever possible. If new diesel vehicles have to be purchased they should meet Euro 6 standards wherever possible. Drivers are trained to make their vehicle run as efficiently as possible so that fewer emissions are produced.

2.53 The London Plan is used to make decisions on planning applications. Islington's existing and emerging planning policies includes a range of policies which influence air quality. These cover development in locations of poor quality, impacts of new development on air quality, urban greening and sustainable transport.

2.54 Policy DM34 (part E) states that "Developments in locations of poor air quality should be designed to mitigate the impact of poor air quality to within acceptable limits. Where adequate mitigation is not provided and/or is not practical planning permission may be refused."

2.55 Policy DM34 (part F) states that "Developments should not cause significant harm to air quality, cumulatively or individually. Where modelling indicates significant harm would be caused this shall be fully addressed through appropriate mitigation."

2.56 There should be a precautionary approach to the use of biomass on a site by site basis. Where air quality impacts are deemed acceptable – dispersion modelling and best available technology and fuel should be used. Domestic scale and other small biomass boilers are inappropriate in Air Quality Management Areas (AQMAs). Guidance on the use of biomass is due to be published by the Mayor.

2.57 Local authorities should ensure that constructors were not exceeding emission levels. In Islington there was a member of staff who monitored this.

2.58 Strong policies on energy efficiency and CO^2 emissions would lead to reduced NOX emissions from gas heating systems. A policy on supporting decentralised energy networks would lead to air quality benefits. Vegetation cleaned the air and urban greening could reduce street level pollution by up to 30%. Policy DM38 requires developments "to maximise the provision of soft landscaping, including trees, shrubs and other vegetation" and "maximise the provision of green roofs and the greening of vertical surfaces as far as reasonably possible".

2.59 Policies CS10 and DM49 requires all new development to be "car free". Major developments are required to support the provision of car clubs (DM49). Major developments are required to provide a transport assessment/statement and travel plan (DM4).

2.60 The movement of vehicles on Islington's main roads is now faster than previously. In theory this should result in better air quality but if the volume of traffic increases due to the faster journey times more drivers would decide to use these use these roads which would worsen air quality.

2.61 Tiered parking charges which were based on vehicle emission levels have been successful in Islington.

2.62 There is a bus garage in the borough in a densely populated area. Residents who have previously complained about noise from queuing buses no longer did so as they now have secondary glazing. However, the air quality is at the same level.

2.63 Children are educated about the environment in schools but this rarely includes information about air quality. Islington officers are willing to give talks in schools but there has been little interest.

2.64 The air quality team at the Council has secured a small amount of external funding from Defra to develop business engagement and school engagement work. If internal match funding is provided (for example, through Council LiPs funding), the Council could further develop this work area.

Internal match funding of projects is a key requirement of the new Mayor's Air Quality Fund, which could provide up to £400,000 extra funding for boroughs to improve local air quality. Business engagement projects could be used to encourage businesses to take actions e.g. encourage employees to walk more, turn down the heating and apply for grants where appropriate to help them reduce their emissions.

2.65 The council could promote the use of taxis which met the higher Euro standards. It might be possible to look into providing free parking permits for taxis with the appropriate filters who had attended an approved eco driving course. Local authorities could also require TfL to use buses of at least Euro 5 on Islington highways.

2.66 There is a need to reduce the sources of air pollution in the borough. Concern was raised that many of the polluting vehicles on the A1 are just driving though Islington. However the council had no jurisdiction over the A1 as it is a TfL road.

Health implications

2.67 Poor air quality has a range of harmful effects on human health. It is estimated that poor air quality reduces life expectancy by 7-8 months and that in 2008 4,000 people died as a result of poor air quality, however the figures are hard to quantify. Last year's significant rainfall meant air quality was better during this time.

2.68 Only smoking caused more early deaths than air pollution in the UK.

2.69 Outdoor pollutants include particulate matter, nitrogen dioxide, sulphur dioxide and ozone. The health effects are as follows:

- Particulate matter – Fine particles are carried deep into the lungs and cause inflammation. It could exacerbate existing lung and heart diseases.
- Nitrogen dioxide – This gas irritates the airways, increases the severity of respiratory disease symptoms including Chronic Obstructive Pulmonary Disease (COPD) and asthma. It is associated with reduced lung function growth.
- Sulphur dioxide – This gas irritates the airways, aggravates asthma and COPD and heart disease. It could also irritate the eyes.
- Ozone – High concentrations of ozone could aggravate asthma, reduce lung function and cause other breathing problems including chest pain and shortness of breath.

2.70 Indoor air pollutants includes environmental tobacco smoke, allergens, carbon monoxide and radon. The health effects are as follows:

- Environmental tobacco smoke – Environmental tobacco smoke from active and passive smoking are associated with COPD, lung cancer and heart disease. When smoke free legislation is introduced, there is a 20% reduction in hospital admissions due to asthma and this has continued to decrease.
- Allergens – Dust mite excrement and fungal particles could trigger rhinitis and exacerbate other respiratory illnesses such as asthma.
- Carbon monoxide – This is highly toxic to humans and is responsible for about 50 accidental deaths in England and Wales each year.
- Radon – This is a naturally occurring radioactive gas. Health Protection Agency data predicted that no homes in Islington have a probability of more than 1% for exceeding recommended levels.

2.71 There is little evidence that outdoor air pollution causes COPD but it does aggravate it. High levels of air pollution leads to increases in hospital admissions for COPD and asthma increase. Research published in 2010 by the Aphekom group of scientists had shown that living on roads used by 10,000 or more vehicles per day on average could be responsible for 15-30% of all new cases of asthma in children and of COPD (chronic obstructive pulmonary disease) and CHD (coronary heart disease) in adults aged 65 years and older. Older people are more likely to have an existing heart condition or lung disease. Children are more vulnerable to the effects of air

pollution because their lungs are still developing, they breathe at a faster rate and spend more time outdoors. They are also nearer the level of vehicle exhausts.

2.72 The World Health organisation had produced a review on the evidence of the effects of air pollution on children's health and development. Air pollution was highest near busy roads and often schools were located close to these roads. If children breathed in too much polluted air during the years when their lungs were developing, this could prevent their lungs from ever fully developing.

2.73 The health effects of low levels of outdoor air pollution are unlikely to be noticed even by people who are sensitive to air pollution. Moderate levels could have mild effects unlikely to require action but they could be noticed by sensitive people. Where there are high levels of outdoor air pollution sensitive people could notice significant effects and might need to take action to reduce or avoid them. If there are very high levels of outdoor pollution the effects on sensitive people could worsen.

2.74 There is now more health evidence to show that small particles enter the deeper part of the lungs. Tests have been conducted by putting volunteers into exposure chambers such as a diesel exhaust chamber or ozone/NO2 chamber where conditions are closely controlled. Tiny diesel particles cause lung inflammation. White blood cells are unable to deal with the foreign entity.

2.75 In December 2010 the Committee on the medical effects of air pollutants published a report entitled The Mortality Effects of Long Term Exposure to Particulate Air Pollution in the UK. The survey stated that according to 2008 data the equivalent of 29,000 premature deaths were due to breathing tiny particles released into the air. The average loss of life was 6 months (although the actual amount varied between individuals from a few days to many years).

2.76 For each 10µg/m³ increase in small particulate matter there is a 6% increase in all-cause death rates. In the UK, 29,000 people die early every year due to air pollution. In London, 4,300 die every year. Average life expectancy was reduced by 7-8 months but in the worst affected areas it could be as high as 9 years. Air pollution contributes to 7.9% of deaths in Islington each year. Vulnerable people are most at risk. If a person has an illness they were 7.9% more likely to die of that illness than if they lived in a place with no air pollution. For those with respiratory allergies, pollution worsened the allergic reaction.

2.77 Air pollution could cause nuisance affecting quality of life, particularly smoke from outdoor fires, dust from construction sites and odours.

2.78 The impact of air pollution on health had an impact on NHS resources. There were significant costs associated with more GP and hospital visits, hospital admissions and medication costs.

2.79 The benefits of cycling, walking or running outweigh the effect of air pollution on the body. Where possible, however, routes should be altered to minimise hazards. Quieter roads generally had less polluted air. Where possible, children should be walked to school away from main roads. If people were in better health, air pollution would have less of an impact. Promoting physical activity and exercise is vital.

2.80 The health impacts of the transport system in London relate mostly to motorised road transport. People being physically inactive results in obesity, cancer, heart disease and diabetes. Air pollution affects lung disease and child development. Road Traffic Collisions could cause mental health problems, death and injuries. Poor accessibility to the existing transport system could create social isolation and community breakdown.

2.81 Physical inactivity cost UK society £9.8bn per year, air pollution cost £10.6bn per year and road collisions cost £8.7bn per year. Each of these main transport impacts on health has a much greater effect on the poorest people than the richest.

2.82 In an urban environment, it is vital to reduce particulate matter and oxides of nitrogen. This was to ensure that lung related diseases caused by fine particles were reduced.

2.83 The current understanding is that PM had health implications 200 times greater than NOx. However it is difficult to fully understand the health implications because most polluting sources release a range of different pollutants.

2.84 From April 2013 public health would move into the local authority. This would create new opportunities for integrating the approach to tackling air quality in the borough. The Public Health Outcomes Framework would contain an air quality indictor. It is not yet known how this would be measured. The Health and Wellbeing Strategy would focus on actions the borough could take to improve health.

2.85 There are many things which make a street healthy. These include clean air, people feeling relaxed and safe, not too much noise, people choosing to walk and cycle, places to stop, pedestrians from all walks of life and shade and shelter. These things also make a street liveable, good for the local economy and good for the environment. Living Streets had access to research which showed that improving the environment for pedestrians and cyclists improved trade on shopping streets.

2.86 Air pollution affected different groups in different ways. More deprived communities tend to experience higher levels of air pollution because they are closer to the sources of pollution (e.g. busy roads). There is a strong association between COPD and deprivation, reflecting the greater prevalence of smoking among deprived communities. There is a well established link between deprivation and heart disease, a condition aggravated by air pollution. Deprivation is not independently associated with self-reported asthma, however active smoking is associated with wheezy symptoms and active and passive smoking with the use of medical services. Compared to the England average, the rate of Ambulatory Care Sensitive admissions (which included COPD and asthma) is significantly higher among the most deprived 20% of Islington's population and significantly lower for the least deprived 20%. Living near busy roads could be responsible for some 15-30% of all new cases of asthma in children.

2.87 There are a number of local, regional and national policies to address air quality. These include Islington's Air Quality Supplementary Planning Document, Islington's Evidence Hub, Public Health Outcomes Framework, Mayor's Air Quality Strategy and the UK Air Quality Strategy.

Key public health actions include:

- Providing an evidence base to support policies, programmes and actions to reduce air pollution.
- Management of the local Air Quality Management Area.
- Implementing air quality measures through the Core Strategy and Sustainability strategies.
- Providing advice on mitigating harmful effects when pollution levels are high, especially among people who are more sensitive to air pollution.
- Reducing emissions by promoting alternatives to traffic including walking and cycling.
- Behaviour change programmes to reduce the prevalence of lung and heart diseases which are exacerbated by air pollution, particularly smoking.
- Earlier diagnosis of long-term conditions to improve their management and delay or prevent their progression.

2.88 The Airtext service provides air pollution, UV, pollen and temperature forecasts for Greater London. It is project managed by Islington Council. It is particularly useful to those who suffered from COPD and enabled them to plan their day accordingly e.g. carry medication, avoid main roads and avoid outdoor exercise where necessary.

7. CONCLUSION

The Air Quality review has concluded that although much work is already done to improve air quality in Islington, further measures are necessary in order to reduce air pollution further. It was acknowledged this would be challenging as the source of much of the air pollution was from outside Islington or was from traffic passing through Islington.

The review included much evidence to show that much co-ordinated work was taking place with neighbouring boroughs, Transport for London (TfL) and the Greater London Authority (GLA). It is hoped that through the implementation of the recommendations, there would be more co-ordinated work in the future and that Islington submits innovative schemes to the Mayor which are granted funding from the Mayor's Air Quality Fund.

APPENDIX A

SCRUTINY REVIEW INITIATION DOCUMENT (SID)

Review: Air Quality

Scrutiny Review Committee: Regeneration and Employment Review Committee

Director leading the Review: Jan Hart

Lead Officer: Savva Mina/Paul Clift

Overall aims:

To explore the causes and effects of air quality and ensure that Islington's contributions to reducing air pollution are maximised and are favourable compared to the efforts other London Boroughs.

To look at national air quality standards and see how Islington's air quality compares.

To ascertain how well Islington is working with partners to secure funding and wins through partnership working.

Objectives of the review:

To look at

- Islington's role in Air Quality including how we monitor AQ
- The state of Air Quality nationally, in London and in Islington and how Islington compares
- Actions taken by Islington to reduce air pollution and assess their success
- AQ and heath and health inequalities in Islington
- Islington's partnership working
-
- Islington's AQ enforcement

leading to recommendations to help improve air quality in Islington.

How is the review to be carried out:

The review will focus on

1. State of Air Quality
    - Major pollutants and causes
    - nationally, London, Islington and how we compare
    - how it's managed
    - our role as a local authority and that of other regulators
    -
2. How Air Quality is monitored
    - Nationally / locally

3. Our Current actions to improve air quality
    Focus on the more important

4. Our Partnership working
    - Airtext
    - Chair of pollution Study group
    - Summit with Camden

5. Defra grant work

6. Education /advice/ profile of AQ
    - meetings
    - website
    - publicity

7. Pollution Control
    - idling engines
    - industrial pollution : part Bs
    - complaints – smoke and bonfires
    - CIMO
    - Enforcement
    - Smoke control areas
    -

8. AQ health and Health inequalities

9. Future initiatives
    - New Action plan
    - LES Strategy

Three types of evidence will be assessed by the review:

1. **Documentary submissions including:**
    - Statistics on number of industrial polluting premises in Islington
    - Complaint and enforcement information
    - Information following presentation on Air Quality to the Health Scrutiny Committee
2. **Witness evidence**
    - Officer presentations - Planning and AQ, Fleet manager and AQ, Pollution Manager and Team
    - Presentation by External speakers on AQ and health
3. **Visits**
    - Visit to Monitoring Stations
    - Visit to an industrial polluting premises
    - Invitation to Pollution Study Day

Programme	
Key output:	To be submitted to Committee on:
1. Scrutiny Initiation Document	**17 July 2012**
2. Timetable	**11 Sept 2012, 15 Nov 2012, 17 Dec 2012, 29 Jan 2013**
3. Interim Report	**5 March 2013**
4. Final Report	**23 April 2013**

APPENDIX B

List of witnesses, visits and documentary evidence

Witnesses
Simon Birkett, Clean Air London
Kate Calvert, Better Archway Forum
Paul Clift, Principal Environmental Health Officer, Islington Council, Chair of the Chartered Institute of Environmental Health (CIEH) London Region Pollution Study Group and chair and project manager of the AirTEXT service.
Sukky Choongh, Principal Technical Officer, Public Protection, Islington Council
Professor Gary Fuller, King's College, London
Professor Frank Kelly, King's College, London
Iarla Kilbane-Dawe, atmospheric scientist
Savva Mina, Service Manager, Environmental Services, Islington Council
Caroline Russell, Living Streets
Chris Rutherford, Transport Manager, Islington Council
Paul Selby, Career Grade Planner
Maxine Williams, Environmental Health Officer, Public Protection, Islington Council
Lucy Saunders, Public Health Specialist GLA/TfL, Jonathan O'Sullivan, Assistant Director of Public Health, Samantha Heath, London Sustainability Exchange, Elliot Treharne, Air Quality Manager, GLA, Matthew Pencharz - the Mayor's Environment Adviser

Visits
Cemex
Air Quality Monitoring Sites
GLA
King's College
A meeting of the Council's Air Quality Consultative Event

Documentary evidence
Client Earth
Lancaster University – Using Trees to Improve Air Quality in Cities

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