Whittington Health NHS

WHITTINGTON HEALTH STRATEGY

2011-2016

November 2011

uclpartners

.... caring for you

Contents

Executive Summary 2
- Our Achievements to Date 2
- Our Five Year Vision 2
- Our Strategic Goals 2
- Organisation Wide Enablers 3
- Our Measure of Success 4

Introduction 5

Context 5
- Trust Profile 5
- National Policy 5
- Our Local Health Economy 6
- Health Care Providers in our Health Economy 6
- Whittington Health Performance 6

Vision 8
- Patient Stories 8

Strategy 10
- Strategic Goals 10
- Delivering Our Strategy 11
- Demonstrating Delivery 13

Organisational Enablers 14
- Process Enablers 14
- Technological and Information Enablers 14
- Organisation Enablers for Integrating Care 15

Our Future Organisation 16
- Our Measure of Success 16

Contact Details 17

Foreword

We are delighted by the unique opportunity that Whittington Health has in providing comprehensive health care to our local population. The strategic direction of the National Health Service is to provide sustainable models of care, able to deliver improvements in outcomes that matter for patients, carers and their families for every pound spent.

Our mission is to provide the best healthcare to our community supporting self-care, in partnership with GPs and educating the next generation of clinicians. Over the next five years our vision is to create an integrated care organisation that is clinically excellent, financially stable, and population focussed, both in what we do and how we do it. We want our patients, carers and families to receive excellent, non-duplicative care that is delivered in the setting most appropriate for them.

Delivering excellent patient care goes hand in hand with valuing our staff. In the annual staff survey, staff said they could influence decision making, that senior managers were 'visible and approachable' and there was excellent communication within the hospital. A culture of full staff engagement is critical as we develop Whittington Health as an integrated care organisation over the next five years and work towards Foundation Trust status in the next two years.

Whittington Health will build upon its good reputation to develop locally based teams that will support delivery of our strategy around the needs of our population. We will organise care to ensure our approach with individuals is proactive and consistent. Each team will include professionals from primary care, community, mental health, social care and secondary care. This will ensure a population based approach and reinforces our commitment to work with other providers across the system for the benefit of patients, carers and their families.

We look forward with enthusiasm to the next five years of Whittington Health to provide a firm foundation for the future of health care for our local population.

Mr Joe Liddane	Dr Yi Mien Koh
SIGNATURE	SIGNATURE
Chairman	Chief Executive

Executive Summary

The need to radically revise how General Practice and hospital care work together to provide comprehensive care to our local population together with the transfer of community services under one board provides a unique opportunity for Whittington Health to deliver improved integrated pathways of care. We are in position to support the financial requirements of the National Health Service to develop a sustainable model of care that delivers improvements in outcomes that matter to patients, carers and their families.

Our Achievements to Date

We have an excellent reputation based on some outstanding achievements. The Whittington has achieved one of the lowest Hospital Standardised Mortality Ratios, demonstrating our commitment to excellent clinical care. We have achieved annual improvements in our Care Quality Commission inpatient survey, underlining our commitment to patient experience. We implemented the "co-creating health" programme across our services, defining our commitment to innovative approaches that change the culture between people with long term conditions and the clinicians who treat them and demonstrating our commitment to patient centred care. Through our work with University College London and Middlesex University we have developed an excellent reputation in the delivery of healthcare education.

Our Five Year Vision

Our mission is to provide the best healthcare to our community. Whittington Health is uniquely positioned as an organisation to build on our partnership with GPs, to offer seamless care across hospital, community and social services that meet the needs of patients, carers and their families. To achieve this ambition, we will collaborate with other healthcare providers, specialist centres and independent and voluntary sectors and local authorities to ensure that the most appropriate care is provided at all times during a patient's journey. We will work with universities to develop new roles, continued education and training programmes to deliver care that focuses on our population. We will innovate to make sure that any change we introduce is better for patients, carers and their families and improves value. We will promote health and support self-care, by providing patients, carers and their families with expert backup whenever it is needed.

"Our five year vision is for Whittington Health to be an outstanding provider of integrated acute and community health care to local people. In partnership with GPs, we aim to deliver excellent outcomes and patient experience whether in the hospital, the community or at home."

Our Strategic Goals

By 2016, our three key goals are to:

1. **Deliver high value care for patients, carers and their families** to ensure we can deliver services that improve outcomes that matter to patients, carers and their families per pound spent.
   To support delivery of this we will:
   a. Provide Care in the Right Place at the Right Time
   b. Promote patient empowerment
   c. Deliver top quartile performance

2. **Improve the health of local people** to improve life expectancy, reduce premature mortality, and contribute to reducing the inequalities in health in our community by identifying people at risk and intervening at an early stage.

3. **Build on our culture of innovation and continuous improvement** to be a more efficient and effective learning organisation and to ensure quality and caring are at the heart of all that we do.

We will deliver our strategic goals in two ways:

1. **Trust wide initiatives will ensure that our three goals are met**
   These initiatives centre around four delivery areas that will ensure we achieve our strategic goals:
   a. Integrated Models of Care
   b. Patient Partnership
   c. Efficient Services
   d. Transforming our culture

2. **Through each of our divisions**
   Supported by trust wide initiatives, each division will deliver specific initiatives that demonstrate tangible benefits for specific patient and population groups. Whittington Health is organised into three divisions that represent integrated teams across acute and community service:
   a. Integrated Care and Acute Medicine
   e.g. by remodelling services for Older People with GPs and Social Care, and Co Creating Health
   b. Surgery, Diagnostics and Cancer
   e.g. by introducing enhanced recovery models across all surgical groups to optimise outcomes and reduce time in hospital
   c. Women, Children and Families
   e.g. by integrating children's services around local GP and practice based multidisciplinary teams, particularly for children with long term conditions

Organisation Wide Enablers

Supporting the delivery of our initiatives, our strategic goals and our vision will require us to ensure that several organisational enablers are in place in the short, medium and long term. These are the focus of operational work and are reflected in our operational and organisational development plans. They include:

1. **Process Enablers**
   The Whittington site will be transformed to reflect the shift of focus from the hospital to being a healthcare provider that focuses on our local population.

   We will maintain 24/7 access to care.

   We will achieve a step change in efficiency by continuing to adjust the way in which we work. We are committed to ensuring that we take a whole pathway approach to care – from prevention and primary care through to acute and rehabilitation. To achieve this, our portfolio of community services will play a fundamental role and strong integration with social care will be essential.

   Process enablers include the following:
   a. Attaining Foundation Trust status
   b. Service Improvements
   c. Clear accountability for staff
   d. Continued Education
   e. Estates management

2. **Technological and Information Enablers**
   We are committed to being at the leading edge providing the technology and information infrastructure that supports a radical transformation in service provision and partnership working.

   We will revolutionise the flow of information across GPs, hospital, social and community care, ensuring high quality, efficient care and information-sharing across all providers.

   There will be easy access to up-to-date patient records and opportunities for accurate risk profiling and predictive modelling to support early intervention when necessary and consistent care. We will ensure that patient confidentiality is respected at all times.

   Information and Technology enablers include:
   a. Information and technology improvements across the health network
   b. Introduction of the electronic patient record to enable the process of transformation

3. **Organisation Enablers for Integrating Care**
   Effective partnership and communication across professional groups and organisations is critical to our success.

   We will work in true joint partnership with primary care and General Practitioners to radically change how we work together to provide comprehensive care to our local population.

   We are committed to working closely with colleagues at UCLH, North Middlesex Hospitals, and Royal Free Hospital; at Barnet, Enfield Haringey, and Camden and Islington Mental Health Trusts; at the Local Authorities in Haringey and Islington; with local voluntary sector organisations; with the London Ambulance Service; and with UCLPartners; and, the Academic Health Science System that we are part of.

   Organisational Enablers for integrating care include:

   a. Commissioning arrangements
   b. Partnership working
   c. Working as part of our local community and our community as part of us
   d. Working in partnership with General Practitioners

Our Measure of Success

We envisage that when we deliver our vision and strategy that will create the following outcomes for each of our major stakeholders:

- **For local residents** success means access to services when you need them; 24 hours a day; 7 days a week; and, support in maintaining a healthy lifestyle.
- **For Whittington Health patients and service users** it means excellent care; co-ordination and communication across services; and, an experience that you would recommend to others. One team caring for you.
- **For local GPs** it means listening and responding to your needs; providing easy access to the most appropriate service; open and easy communication; and, partnership in providing best value local services and helping your patients to live as well and as independently as possible. It means offering a place for learning together with secondary and community colleagues.
- **For Whittington Health staff** it means continually improving and innovating and taking pride in our work. Staff will receive support, training and development to help them achieve their best and deliver innovative and excellent local healthcare.
- **For students and trainees** it means high quality delivery of education and training by committed trainers in an environment that supports the education of tomorrow's healthcare providers.
- **For Commissioners** it means a sustainable, effective organisation for the delivery of heath care that meets the national strategy of the National Health Service locally
- **For the NHS** it means a pioneering model of local provision that is focused on the needs and preferences of the population and patients, and provides high quality services and value for money.

Introduction

Whittington Health is a new organisation that is ambitious and innovative. Our local community is integral to who we are and how we operate as an organisation that delivers health care. We will build on the openness and transparency we have with General Practitioners and community partners. We will meet the health care needs of our local population. We will increasingly over the next five years strive to have General Practice and our local community at the very heart of our organisation.

This strategy has been developed with input from the Trust Board, clinicians and managers within the Trust, and local GPs. It is the first stage in explaining what we hope to achieve as an integrated care organisation. This document forms the basis of our engagement with our local community in considering our strategy. We recognize that one of the keys to our success is working in partnership with our staff, our community, our GPs and other providers. This strategy is what we believe is needed to ensure that the best care for the best value meets local needs. The next five years will be challenging. With our common goals and a clear strategy designed to help us to meet those goals we believe that we will be the preferred organisation to provide health care for our local health care economy.

Context

Trust Profile

- Whittington health was born out of the boroughs of Islington and Haringey community services and an acute hospital trust, The Whittington Hospital.

- We are an integrated care organisation that delivers acute and community services for adults and children, primarily to the residents of Islington and Haringey and also to other London boroughs, including Enfield and Camden.

- Whittington Health community services portfolio also covers Camden (e.g. Speech and Language therapy; tissue viability) and Barnet and Enfield (e.g. IAPT)

- 86% of Whittington Health referrals for acute services are generated from Haringey & Islington GPs

- We serve a catchment population of circa 443,000 people; have a turnover of circa £277m and 4120 staff.

- We have a highly regarded educational role, teaching 200 undergraduate medical students, and providing a range of educational packages for postgraduate doctors and other healthcare professionals.

- We have a strong track record of working well and being networked with our local community and local primary care services through information and technology and through our culture of openness and transparency. The coming together of the community and acute services under one leadership provides a unique opportunity to improve on this.

National Policy

- National policy is designed to promote significant efficiency gains. Whittington Health is positioned to meet this challenge.

- The development of Clinical Commissioning Groups, putting the provision of care into the hands of those closest to the needs of the populations the health service provides for, is a key policy that assists the design our strategy.

- The ‘Any Qualified Provider’ model for service development supports new ways of working to improve patient choice and flexibility in commissioning arrangements that best suit local populations.

- A cornerstone of our strategy that underpins all National Policy is the emphasis on quality and safety in the care we provide at all levels of the health economy.

Our Local Health Economy

- The wider area of London that we serve and the Islington and Haringey communities are diverse in both socio-economic status and ethnicity. Public health profiles for Islington and Haringey when benchmarked nationally show that both areas are challenged by income deprivation, drug misuse, violent crime and child poverty.

- Population growth is set at 9.4% over the next ten years (Islington 11.2% and Haringey 7.1% against national norms).

- Both Islington and Haringey have high international migration figures of which a significant number are asylum seekers and high rates of transition through the boroughs.

- Disease prevalence and health inequalities within Islington and Haringey are above the national average. Our community suffers from obesity, alcohol and smoking related diseases in common with our population profile.

- Our lead commissioner (North Central London NHS) is in the process of developing a commissioning strategy to meet the requirements of our local populations and the challenges faced by our sector to provide the best value for money organisations across a variety of providers.

- The Clinical Commissioning Groups in development are likely to move to three localities in London: North Central, North East, North West and South London

- Recent clinical service commissioning strategy developments have included: the reconfiguration of stroke services; the Urgent Care Centre model implemented at the Whittington Hospital; the development of ambulatory services at Hornsey Central; a tender for re-provision of Haringey rehabilitation and stroke beds; and, emphasis on the reduction of re-admissions to hospital and outpatient follow-ups.

Health Care Providers in our Health Economy

- **University College London Hospitals NHS Foundation Trust** is a large Foundation Trust provider of specialist tertiary services that is building primary care relationships locally with a vision to develop 'hub' and 'spoke', supply chain or lead provider models of care across NCL

- **The Royal Free Hampstead NHS Trust** is a large teaching Trust on target to achieve Foundation Trust by April 2012.

- **The North Middlesex University Hospital Trust** is a large Trust with a strong component of non-elective work from a catchment area from Enfield and East Haringey with some patients from North East London.

- **Barnet and Chase Farm Hospitals NHS Trust** is in a transition phase with Chase Farm Hospital more likely to be part of North Middlesex University Hospital Trust. Barnet Hospital is exploring future sustainable options.

- **Our Community providers** in North Central London include: Central London Community Healthcare NHS Trust in Barnet (Foundation Trust path agreed); Central and North West London Foundation Trust; Camden and Barnet Enfield and Haringey Mental Health Trust (on FT path). Both CLCHT and CNWLFT are ambitious organisations operating with similar community portfolios as Whittington Health.

- **GP Provider Consortia** include Haverstock Health which includes the majority of Camden practices; SIGPAL in South Islington; WISH in West Haringey and North Islington; and, Barndoc across Barnet and Enfield.

Whittington Health Performance

We consistently demonstrate good performance in achieving targets. The Whittington has the best standardised mortality ratio in the country. We compare favourably with our local health economy on major quality factors that determine our success as a health provider, as shown in the table below from the North Central London High Level Quality Review (August 2011).

From this foundation of quality and accomplishment we will build a high achieving open and transparent organisation across all of our services where we will continue to measure and demonstrate our success.

Indicator	Source	WH	RFH	NMH	UCLH	BCF
Acute Bed numbers	Trust	319	647	379	864	874
2009/10 Mortality Rate	Dr Foster (2009-10)	84.15	72.11	94.80	69.89	87.73
3 year Mortality Rate 3 years ending 31 March 2010	Dr Foster (2009-10)	79.33	76.33	110.22	79.33	94.40
MRSA bacteraemia (Q1 2011-12)	Trust	1	1	3	2	4
C. difficile cases (Q1 2011-12)	Trust	7	12	9	13	7
Fractured neck of femur % of patients in surgery within 2 days from admission – Nat. av. = 65.71%	Dr Foster (2009-10)	91.56	69.44	72.73	82.43	71.81
Referral to treatment 18 weeks (Q1 2011-12)	Trust					
Venous Embolism assessment (Q1 2011-12)	Trust					
Workforce (Q1 2011-12)	Various					
Patient experience (Q1 2011-12)	Various					

High Performance	Average or Early Warning	Under Performance

Vision

"Our five year vision is for Whittington Health to be an outstanding provider of integrated acute and community health care to local people. In partnership with GPs, we aim to deliver excellent outcomes and patient experience whether in the hospital, the community or at home."

Patient Stories

The following stories are based on real events for patients, carers and their families. They demonstrate how the Whittington Health will be different in the way it cares for our community. They demonstrate how Whittington Health will make a difference as an integrated care organisation to the quality of health in a financially resourced whole system that is designed to support people when and where they need care.

A child's story

Ben is a three month old boy who has developed severe eczema. After investigation Ben's GP decides that Ben is best cared for using the allergy guidelines developed with Whittington Health.

Ben's GP books him for an assessment at the Whittington Health community clinic so that they might develop a plan for Ben to reduce the possibility that his allergic reactions result in asthma, and to avoid if possible Ben needing emergency attention.

The team make an assessment and a plan following testing which confirms egg and cow's milk allergy. The team support Ben's parents with education and dietary advice. Ben is discharged to his GP with details of how to access support if required concerning his eczema, diet management and family education on food restrictions, including the recognition and early management of asthma.

Ben is managed by his GP with email and telephone support from the community allergy nurse and team and avoids having to attend multiple specialists in different clinics in secondary care.

A patient's story of care at home

Edward and his wife, Georgina are an elderly couple who both have dementia. Their daughter Jessica was their main carer and she does not live with them.

Jessica takes Edward to his GP because he is suffering from a persistent urinary tract infection that had not responded to several courses of oral antibiotics. Edward needs antibiotics through a drip, intravenously as the next stage in his treatment.

Edward's GP decides that the best way to support Edward is to lead his care clinically himself with the Whittington Health practice based multidisciplinary team. He books the nurse-led home care team to visit Edward the next day to make sure that he has antibiotics given to him intravenously for a full course of treatment in his own home. The home care team visit Edward twice a day for seven days until his IV antibiotics are stopped and he no longer needs their care.

Previously the GP would have had to send Edward to the emergency department. He might have stayed for up to ten days in the hospital for a full course of treatment. Edward's wife could not be left alone. She too would have had to be cared for whilst her husband was in hospital.

Now there is a way of continuing Edward's care at home by administering IV antibiotics outside hospital. Hospital admissions may have been avoided and Edward's GP is able to commission a flexible patient-centred service. Alongside the savings to the healthcare system, the patient and family are less anxious as they are supported in their own familiar environment.

A Patient's Emergency Department Story

Bert is a 79 year old man with heart failure. He feels breathless and so he calls for an ambulance.

When he gets to the emergency department Bert is cared for by a nurse who can see from his hospital record that he was sent home from another hospital six days ago following a short stay due to his breathlessness.

The emergency department consultant decides rapidly that Bert's needs are best met by immediate transfer to the care team for older people and ambulatory care, the Whittington Health multidisciplinary team. Bert's problem is not such an acute emergency that he needs to stay in hospital but he does need some specialist attention and support in managing his condition back home in the community with the practice based multidisciplinary team.

The team assesses the type of support Bert has in the community, such as district nursing or social services. Bert is seen rapidly by a clinician who is part of this team who advises on his condition for immediate support and management of his medication. The team devise a plan with Bert for his continued care at home. Bert's GP is involved in Bert's care as part of the practice based multidisciplinary team and the whole team are able to see his care plan by looking at Whittington Health's shared electronic patient record.

For Bert one of the best things about his visit has been that he is able to go home from the hospital without staying overnight. Bert feels confident that he is being cared for both at the hospital and at home when he needs care, and that everyone who should know does know what is happening as his needs change.

Strategy

Whittington Health is committed to achieving three key strategic goals over the next five years. These goals when achieved together will result in a change in culture and quality across our services. Our attainment of these goals will make sure our vision to be an innovative integrated care organisation, integral to the local community whom we serve.

Strategic Goals

4. **Deliver high value care for patients, carers and their families to ensure we can deliver services that improve outcomes that matter to patients, carers and their families per pound spent.** We will be dedicated to organising in ways that deliver positive results for patients, carers and their families. We will reduce waste and make certain of a financially sustainable position for our organisation as a significant part of our health economy, driving through more efficient use of resources. We will transform our services to function with senior leadership seven days a week to ensure the greatest access and support to our population. We will ensure that our administrative offices function and deliver in the most efficient way possible to enable us to focus our investment and support on front line care for patients.

   To support delivery of this we will:

   a. **Provide Care in the Right Place at the Right Time to ensure patients, carers and their families get access to the best care when they need it.**
   By concentrating on the needs and preferences of patients, carers and their families, we intend to ensure the hospital provides services that only the hospital can provide. In turn we will transfer a significant part of the demand for hospital services to more appropriate community and primary care settings (including patients' own homes).

   b. Promote Patient Empowerment for self-management and support for all patients with long term conditions, their carers and families, to help them to manage their condition.
   We will build on the "co-creating health" programme to embed self-management support within mainstream health services across the organisation, and equip patients, carers, their families and clinicians to work in partnership in order to achieve better outcomes. By 2016 all patients will be offered support for self-management, and all clinicians will be trained to facilitate them to do so.

   c. Deliver top quartile performance to ensure all of our services are achieving excellence.
   We will routinely benchmark all that we do with the aim to deliver top quartile performance in clinical quality, patient experience, service efficiency and financial position for every specialty and service that we provide.

5. **Improve the health of local people to improve life expectancy and reduce premature mortality by identifying people at risk and intervening at an early stage.** We will ensure that health promotion and proactive prevention of ill health is embedded as part of each role that our staff perform in caring for our population. We are committed to supporting delivery of healthy lifestyle plans in order to reduce smoking; encourage healthy eating and physical activity; and, to promote better mental health. We are committed to supporting efforts to reduce those health inequalities that exist in our local population. We will work with our GPs and our primary care community to help us deliver these commitments and to support appropriate demand management for our population.

6. **Build on our culture of innovation and continuous improvement to be a more efficient and effective learning organisation and to ensure quality and caring are at the heart of all that we do.** In order to help us achieve our vision, and to meet the challenges of quality improvement in times of financial constraint we will be innovative and we will do things differently to achieve large gains in performance. We recognise that these innovations will come from the staff working within our organisation. We will ensure that leaders support and create a learning culture in their departments and across the health system in order to channel the energy of all staff into innovating whilst maintaining a focus on quality and caring. Our education and development programmes will support this.

Delivering Our Strategy

In order to deliver the strategic goals there are a number of Trust wide strategic initiatives that have been determined.

Integrated models of care	• **Population based, geographic MDTs.** Each team will representatives from across settings as required (primary care, community, mental health, social care and secondary) • **Consistent intermediate care services** that provides both step-up and step-down care, pro-active approach to managing care – preventing admission where possible, and accelerating where necessary • **24/7 access** to the appropriate setting, delivering 7day senior led healthcare provision
Patient partnership	• **Prevention** using each interaction as an opportunity to promote health Every intervention is a health promotion intervention'. • **Patient Experience** ensuring that every patient has an excellent experience, understanding components that matter most to the users and acting to improve them • **Patient Empowerment** supporting self-management, particularly for patients with long term conditions • **Understanding** the population and our patients better, using risk profiling to intervene – in supporting prevention, in proactively managing care, and in evaluating our performance
Efficient services	• **Lean approaches** to delivering services, in and outside of the hospital • **Multi-skilling our workforce** to ensure we can get maximum benefit from each patient interaction and think more creatively about the roles we deploy • **Benchmarking** to ensure we continue to improve
Transforming our Culture	• **Innovation** encouraging staff to lead change, empowering them to think differently about what and how we deliver services and enable them to deliver transformation • **Quality and Caring** ensure that best practice is upheld, that internal processes promote patient need and at all time caring for them in the best way • **Education and Training** pioneer new models to ensure reinforce the behaviours we want to see and support care delivery across settings

Whittington Health has been organised into three integrated divisions to ensure that people are in the right teams to focus on patient pathways.

The divisions are 'Integrated Care and Acute Medicine'; 'Surgery, Cancer and Diagnostics'; and, 'Women, Children and Families'. Each Division is led by a Divisional Medical Director and Director of Operations who report to the Chief Operating Officer.

The division of **Integrated Care and Acute Medicine** has a wide remit of care and service that ensures the needs of patients, carers and families are met in the community, in hospital when appropriate and with care close to and in their own homes in partnership with General Practitioners. Their remit includes innovations in care such as long term condition management and working with patients, carers and families to support them in managing their own conditions, always knowing that there are experts on call to assist when ever and where ever the need arises.

Services in this division include for acute services: the Emergency Department and Urgent Care Centre; clinical site management; the Medical Assessment Unit and acute medical wards; medical outpatients; and, district nursing assessment teams in Islington and Haringey. Rehabilitation includes the care of elderly wards and outpatients; services for inpatient and for the community; Intermediate care; community stroke services; equipment (including seating and mobility in Haringey) and reablement services; the hospital social work team (Whittington, UCLH, St Pancras); and, Discharge planning. For Long term conditions the division includes: outpatient clinical specialities (such as Diabetes, Respiratory, Cardiology and Oncology); access to psychological therapies; community specialist nursing (such as tissue viability); foot health; musculoskeletal services; physiotherapy; nutrition and dietetics; drugs and alcohol; smoking cessation; palliative care; and, chronic pain. The division also includes prison health care as a primary care service; long term conditions; mental health; substance misuse (commissioned from C&IMHT); and, Psychiatric liaison (commissioned from Barnet Enfield Haringey Mental Health Trust). Social care includes: access services across the north and south localities; occupational therapy; the sensory team; Hanley Primary Care Centre; business support; resource team; direct Payments team; and, care practice and policy advisors.

Surgery, Diagnostics & Cancer Services provide diagnostic and surgical care that meets the needs of our local population for all the common conditions that includes cancer care, Bariatric surgery and urgent surgical care where close links with general practice add value to the quality of patient care. This division provides innovative

care that enhances patients' recovery and enables speedy access to a more appropriate home environment with close links to community services such has rehabilitation and physiotherapy.

Services within this division include: surgical specialities (such as Orthopaedics, Urology, emergency surgery; General Surgery, Bariatric Surgery, Breast Surgery and cancer); Oncology; Dermatology; critical care; Imaging; Pathology; Dentistry; and Enhanced Recovery.

Women, Children and Families provide our community with a leading edge maternity service with a midwifery led birthing centre, home births and medicalised births where appropriate with the support of a dedicated team of midwives and doctors that provide an excellent experience for women that enables them to choose the most appropriate place for their care. This division is designed to provide care for women, children and families from pre birth through to end of life care, with a focus on prevention and health promotion, in partnership with general practice and local authorities.

Services within this division include: maternity services delivering 4,200 babies each year, midwifery-led Birthing Unit; delivery suite; induction of labour rooms; theatres; antenatal wards; postnatal beds (including transitional care mother & baby beds); and, a triage area seeing 550 attendances each month. The division includes: a Maternity Day Unit for 3500 high risk attendances each year; a Foetal Medicine Unit (1350 ultrasound scans/year); 23 bedded level 2 neo-natal unit; and, antenatal clinics. In the community the division includes HMP Holloway antenatal and delivery care on site, including specialist obstetric medicine and peri-natal mental health services together with on site acupuncture services. Gynaecology includes in-patient beds, theatres and fertility services. Paediatric services include the paediatric emergency department; an emergency clinic for GP referrals; a 23 bedded in-patients ward which includes HDU beds; paediatric outpatients in the hospital and in the community at the Northern Health Centre; Simmons House for adolescent mental health beds; and, specialist nurses in community (including acute asthma and sickle cell disease).

Divisional Initiatives

Divisional initiatives will follow the strategy described in this document. They will be designed to help the organisation fulfil its strategic goals and vision. Initiatives will build upon existing work and focus on detailed aspects of strategy with the aim of achieving best performance. Examples of initiatives by division are outlined below:

Integrated Care and Acute Medicine

- **Care of Older People:** Remodel services for care of older people with Primary care and Social Care to be more preventative and community based including Dementia and Falls
- **Advanced Care Plans**: Ensure advanced care plans are in place for patients at the end-of-life and accessible to all professionals

Surgery, Diagnostics and Cancer

- **Enhanced Recovery:** Implement the Enhanced Recovery model across all surgical groups
- **Patient Safety, Productivity, Quality and Innovation:** aspiring to upper decile performance in key indicators, including patient experience designed around our population and community integration

Women's, Children's and wellbeing

- **Children's services:** Develop 'Virtual Paediatric Ward', care closer to home for LTCs, cancer, streamline care coordination between GP, Consultant, Ward, Community nursing and therapy teams to reduce duplication.
- **Gynaecology:** Provider of choice for community gynaecology for Haringey and Islington. One stop service; hysteroscopy in the community
- **Maternity services:** improve pathways; best quality performance and patient experience

Demonstrating Delivery

We will develop a core set of indicators to track the delivery of our strategic goals with our public health and primary care partners, other stakeholders and external benchmarkers. We will monitor our progress and demonstrate our delivery of our strategy. These indicators will be embedded in our reporting at all levels of the organisation from the individual services and divisions right up to board level. The indicators are grouped by the three strategic goals below:

Strategic Goal: Deliver high value care for patients, carers and families

Domain	Indicators	Why we selected them
Quality outcomes	▪ Mortality rates ▪ Healthcare acquired infections	Key outcome measures in maintaining quality and safe healthcare provision.
Patient Experience	▪ Net promoter score	Asks the question whether patients, carers and families would recommend us to their family or friends
Clinical Effectiveness	▪ Readmission rates ▪ Emergency Admission rates for long term conditions	Measures whether we have been successful in keeping people out of the hospital care setting through improvements in their health, through more self-care and better access to community and primary care services
Access	▪ 4 hour waits in the A&E Department ▪ 18 week wait from referral to treatment for planned care	Key national measures of timely access to health services and treatment
Efficiency	Upper quartile performance for ▪ Outpatient follow up rates ▪ Day Case rates	Measures how successful we have been in moving care to an ambulatory and community based setting

Strategic Goal: Improve the health of local people

Domain	Indicators	Why we selected them
Health promotion	We will work with our public health and primary care colleagues to develop indicators for this goal together with external benchmarking	These indictors will show the effect of health promotion work such as stopping smoking, or better access to and education for sexual health, or in maternity and children's services for example
Reducing health inequalities	We will work with our public health and primary care colleagues to develop indicators for this goal together with external benchmarking	These indictors will track changes in the health of our population and outline the impact we can make in order to improve and reduce inequalities in outcomes

Strategic Goal: Create a culture of innovation and improvement

Domain	Indicators	Why we selected them
Learning culture	Whittington Health will develop these indicators in partnership with our public health and primary care colleagues together with external benchmarking	These indictors will show how we encourage and embed learning and change into the organisation
A Caring culture	Whittington Health will develop these indicators in partnership with our public health and primary care colleagues together with external benchmarking	These indictors will enable us to monitor our patient centred approach to health care. This will extend beyond clinicians direct contact with patients, carers and families to all roles in the organisation, such as receptionists and other front line staff.

Organisational Enablers

Process Enablers

- **Foundation Trust:** To help deliver this strategy, we will fulfil our ambition to become a Foundation Trust as soon as possible seeking views from patients, members and Governors.
- **Service Improvements:** We will promote clinical audit and participation in research and trials to support continuous improvement as a lean learning organisation.
- **Workforce Strategy:** Our strategy for organisational development will enable our vision to be realised through engaging the 'hearts and minds' of our staff; designing the appropriate shape of the workforce; and, developing skills. Clinical strategy will inform the most appropriate shape for our workforce, promoting a de-layering of management levels and responsibility. We will develop a workforce that is able to understand and promote integrated care to patients, carers, their families and our partners. Our staff will have the skills, knowledge and expertise to enable them to deliver care in the most appropriate way for our population.
- **Clear Accountability:** Teams will have a collective responsibility to ensure patients, carers and families receive high quality care, but at all times there will be clarity on who is accountable for each patient, helping ensure that appropriate services are delivered with no duplication or unnecessary utilisation of services. We will embed this clear accountability in our combined teams across acute, community, primary care and social care.
- **Education:** We will grow our profile as a leading campus for the education and training of medical and clinical staff. We will work with education providers to adapt training methodology and content to reflect the breadth of Whittington Health's services, and to ensure we are educating clinicians with skills to work in tomorrow's world.
- **Estates:** We will ensure the premises from which we deliver care are fit for purpose, and remodel them as required to assist the achievement of this strategy reflecting local population needs.

Technological and Information Enablers

- **Information:** We will revolutionise the flow of information across GPs, hospital, social and community care, ensuring high quality, efficient care and information-sharing across all providers. We will be at the leading edge in the use of technology to support patient care including remote access and assessment for example with tele-medicine.
- **The Electronic Patient Record:** There will be easy access to up-to-date patient records and opportunities for accurate risk profiling and predictive modelling to support proactive and consistent care whilst ensuring that patient confidentiality is respected at all times. The information box below provides a more detailed description.

The Electronic Patient Record (EPR)

– The evidence base for EPR is compelling as a starting point from which to transform the quality and the cost of delivering health care services.

– The investment in information infrastructure will enable the partnership process to function in real-time across our organisation with General Practitioner and other partners.

– We will invest in an EPR solution that will: provide a single integrated patient record across the whole patient pathway; integrate with health and social service partners outside our organisation; improve patient safety, outcomes and experience; and, enable more efficient and effective workflows.

– The implementation of the EPR solution will support the transformation of healthcare delivery across Whittington Health as an integrated care organisation, transcending the current geographical, organisational and cultural boundaries that limit patient care.

– This will encourage primary and secondary care to work together. It is a key enabler in the success of our mission.

Organisation Enablers for Integrating Care

- **Commissioning arrangements:**
  We will work closely with commissioning consortia to agree financial systems that will ensure our reimbursement mechanism is consistent with the model of care we are committed to delivering.

- **Partnership working:**
  Effective partnership and communication across professional groups and organisations will be critical to our success. Partnership working with local GPs is key to being able to deliver our strategy. We are committed to working closely with colleagues at UCLH, North Middlesex Hospitals, and Royal Free Hospital; at Barnet, Enfield Haringey, and Camden and Islington Mental Health Trusts; at the Local Authorities in Haringey and Islington; with the London Ambulance Service; and with UCLPartners; and, the Academic Health Science System.

- **Working as part of our local community, our community becoming a part of us:**
  We will work with local people to deliver different models of care that improve health and support people. As we evolve as an organisation we want our local community to become more integral to our organisation. General Practitioners and others will be true partners in our joint practice of shared care.

Working In Partnership with General Practice

- We recognise that one of the keys to our success as Whittington Health is the continuity and effectiveness of our partnership with General Practitioners.
- We will build upon our good relationship with our GPs to create a cultural change of true joint partnership in the provision of patient care.
- We will work for patients, carers and their families to provide multidisciplinary teams that are built around their GP practices.
- Our mission is to provide the best healthcare to our community supporting self-care, in partnership with GPs and educating the next generation of clinicians.
- We will revolutionise the flow of information across GPs, hospital, social and community care, ensuring high quality, efficient care with information-sharing across all providers, removing all barriers to effective communication between clinicians
- The Whittington Health web site will provide all the information that GP practices need, specific to their practice with links and email, telephone numbers to support GPs in their work
- We will respond to GPs in real-time to support them in the delivery of care for patients, carers and their families.
- We will enable GPs to have access to information easily; to receive timely and clear discharge information about patients; and, to have clear advice on next steps in the patient care
- We will ensure that our contact with GPs is aimed at a grass roots level: to GPs working in their practice with clear information about the relationships, contact details and routes for accessing services and people that relate to that particular practice's requirements.
- For our GPs it means that they will have access to the most appropriate service; open and easy communication with clinicians; and the best value local services.

Our Future Organisation

The Whittington site will be transformed to reflect the shift of focus from the hospital to being a healthcare provider which focuses on its population. We will maintain access to care 24 hours a day and 7 days a week. A step change in efficiency will be achieved by continuing to adjust the way we work. We are committed to ensuring that we take a whole pathway approach to care – from prevention and primary care through to acute and rehabilitation. To achieve this, our portfolio of community services will play a fundamental role, and strong integration with social care will be essential.

Our Measure of Success

We envisage that when we deliver our vision and strategy that will create the following outcomes for each of our major stakeholders:

- **For local residents** success means access to services when you need them; 24 hours a day; 7 days a week; and, support in maintaining a healthy lifestyle.
- **For Whittington Health patients and service users** it means excellent care; co-ordination and communication across services; and, an experience that you would recommend to others. One team caring for you.
- **For local GPs** it means listening and responding to your needs; providing easy access to the most appropriate service; open and easy communication; and, partnership in providing best value local services and helping your patients to live as well and as independently as possible. It means offering a place for learning together with secondary and community colleagues.
- **For Whittington Health staff** it means continually improving and innovating and taking pride in our work. Staff will receive support, training and development to help them achieve their best and deliver innovative and excellent local healthcare.
- **For students and trainees** it means high quality delivery of education and training by committed trainers in an environment that supports the education of tomorrow's healthcare providers.
- **For Commissioners** it means a sustainable, effective organisation for the delivery of heath care that meets the national strategy of the National Health Service locally
- **For the NHS** it means a pioneering model of local provision that is focused on the needs and preferences of the population and patients, and provides high quality services and value for money.

Contact Details

Whittington Health
Magdala Avenue
London
N19 5NF

Telephone and fax

Telephone: 020 7272 3070

Fax: 020 7288 5550

Email communications.whitthealth@nhs.net