Whittington Health *NHS*

The Whittington Health NHS Trust

Quality Account 2011 – 2012

(DRAFT)

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Introduction from the Chief Executive

Integrated Care Organisation – Whittington Health NHS

Purpose of the Quality Account

Whittington Health's Quality Account forms part of the Trust's annual report to the public. It describes our key achievements with regards to the quality of patient care for 2011 – 2012, as well as areas where we need to focus our improvement work. It also sets out three key quality priorities for the year ahead.

The development of our Quality Account has involved identifying and sharing information across the ICO, particularly with our consultants, nurses, therapists, quality teams, governors and non-executive directors. We have also sought information from our colleagues in local community services, and other local NHS acute trusts.

Quality Vision for Whittington Health

In 2011 Whittington Hospital merged with the provider services of Haringey and Islington to form one of the first integrated care organisations in the UK bringing together both acute and community health services for the benefit of the local population. Whittington Health will work in partnership with the local community, local authorities, general practitioners, schools and service users to deliver the overall objectives of this new health industry. In order to achieve this we will work to deliver the following objectives:

Developing integrated models of care
Ensuring an approach to care that supports the ethos of 'no decision about me without me'
Efficient and effective services
Improving the health of local people
Changing the way we work

We believe that the three critical success factors to this are to deliver: effective care, safe patient care and a positive patient experience, and under each of these categories we have set ourselves key aims, which help support these. These are set out in our Quality Strategy, also agreed this year. We will also continue to push forward with the priorities identified in last year's Quality Account, where some have been achieved, but need to be sustained, and in others where we have achieved some improvement, but still require more work. This account therefore includes information relating to last year's performance against national and local quality measures, which have helped us to identify our priorities for going forward.

Whittington Health recognises that we are living in a changing health care climate, and as with all NHS Trusts, we have faced, and will continue to face, challenges, particularly financial, which make it all the more important to keep safe, high quality patient care as our focus, and to ensure that savings are made by driving up efficiency and cutting waste, rather than by impacting on patient experience or outcomes

Key Quality Achievements and Developments

Two key achievements this year have provided the foundations on which we can continue to build and deliver the vision for Whittington Health. In October 2011 we were visited and inspected by the CQC, which is responsible for ensuring that registered health services are providing essential standards of quality and safety. The CQC team visited 18 services across the ICO and spoke to many service users, staff and relatives. The findings from their visit were very positive, and no significant concerns were identified. Some areas of improvement were suggested and we have taken note of these and include them in this quality account and our quality strategy as key objectives for the coming year. INCLUDE THESE LATERSS

In February 2012 we achieved NHSLA level 1 from our litigation insurers following a two day inspection. Obtaining this standard is a key measure of how safe our services are and provides assurance to our insurers that the key governance arrangements are in place that ensure safety and high quality services. We are proud of these achievements, and will focus now on obtaining NHSLA level 2 by June 2012 and level 3 as soon as we can.

We have also met our Department of Health target for minimum numbers of key **health care associated infections**. For MRSA Bacteraemia the target was to have no more than () cases attributable to the Trust, and we had (). For *clostridium difficile* our target was no more than () cases for the year, and we had (). Add figures for 2011/12

The opening of a new Primary Care Led Urgent Care Centre signalled another significant step in improving services for our local community. The service is delivered by Whittington Health working closely with WISH Ltd. who provide senior General Practitioners from 8 local practices for 12 hours per day. Many people attend their local ED with Primary Care problems that are best managed by a GP. The first year has been very successful:

- Around 3500 patients are seen in the UCC each month
- In Dec 2011 96% of adults were seen and assessed within 20 minutes and 87% children within 20 minutes
- A dedicated primary Care support officer is available to assist patients to register with a local GP

- During November and December no patient was in the UCC for over 4 hours in total
- 94% of patients were satisfied with the care they received

I am also delighted that the national Standardised Hospital Mortality Index continues to show that the Whittington Health is one of the safest hospitals in the country. Our rate is 67 for the 12 month period to February 2012 (latest published data), significantly better than the expected average value of 100.

Trust Board Endorsement

I confirm that this Quality Account has been discussed at, and endorsed by the Trust Board.

Chief Executive's signature

I declare that to the best of my knowledge the information contained in this Quality Account is accurate.

Signature: CEO Date:

Priorities for Improvement

New priorities

NB Metrics for all need to be discussed and priorities selected

Priority One: Effective Care

- **Ensure that smoking cessation advice and support is available to all who need it as well as support and advice to reduce the harm caused by alcohol abuse**

Priority Two: Patient Experience

- **Improve the way we communicate and ensure that respect, dignity and compassion are at the heart of our relationships with service users**

Priority Three: Patient Safety

- **We will reduce the number of patient falls and the harm associated with patient falls by 25% (approve metic) to achieve the top decile of national benchmarked data**

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METRIC
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Progress with 2010 – 2011 Priorities

Although the Trust has agreed the above three new priorities, they will not be at the expense of continuing to deliver improvements on the priorities we set ourselves last year. Progress and ongoing work in these areas is described in section three, under "Review of quality performance".

Statement of Assurance from the Trust Board

Review of Services

During 2011 – 12 the Whittington Health provided (ADD) NHS Services, and sub contracted no services. The Trust has reviewed all data available to it on the quality of care in those NHS Services. (ANITA GARRICK)

The income generated by the NHS services reviewed in 2011 – 12 represents 100% of the total income of the Whittington Health.

The Trust Board receives, reviews and acts on quality data on a regular basis, as key quality indicators are included in the Trust's Performance Dashboard. The Board also receives regular full Patient Feedback Reports, including information on complaints, PALS, Litigation and local patient survey findings.

Participation in Clinical Audits 2012

During 2011/2012 **??** national audits and **??** national confidential enquiries covered NHS services that *The Whittington Health NHS Trust* provides

During 2011/2012 *The Whittington Health NHS Trust* participated in **??% (??/??)** national clinical audits and **100%** national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Whittington Health NHS Trust was eligible to participate in during 2010/2011 are listed in the table below.

The national clinical audits and national confidential enquiries that The Whittington Health NHS Trust participated in are listed in the table below. Reasons for non-participation are also included.

The national clinical audits and national confidential enquiries that The Whittington Health NHS Trust participated in and for which data collection was completed during 2011/2012 are included below, listed alongside are the number of cases submitted to each audit or enquiry or the percentage of the number of registered cases required by the terms of that audit or enquiry.

Title (source)	Participation during 2011/2012	If data collection completed, cases submitted (as total or % if requirement set)
Peri and Neonatal		
Neonatal intensive and special care (NNAP)	? Yes	Ongoing
Perinatal mortality (MBRRACE-UK)	?Yes	Ongoing
Children		
Paediatric pneumonia (BTS)	?No – local audit	Anas – CHECK

	instead?	
Paediatric asthma (BTS)	Yes	
Pain management (CEM)	? Yes	Anas – CHECK
Paediatric fever (CEM)	? Yes	
Childhood epilepsy (RCPCH)	Yes	Ongoing
Diabetes (RCPCH, NPDA))	Yes	
Acute Care		
Emergency use of oxygen (BTS)	Yes	
Adult community acquired pneumonia (BTS)	?Yes	
Non-invasive ventilation (BTS)	Yes	
Pleural procedures (BTS)		
Cardiac arrest (NCAA)	Local data captured	
Vital signs in majors (CEM)	?Yes	
Severe sepsis and septic shock (CEM)	?Yes	
Adult critical care (Case mix programme)	Yes	
Potential donor audit (NHS Blood & Transplant	Yes	
Seizure management (NASH)	Yes	30 patients
National audit of renal failure in Intensive Care	Yes	
Long term conditions		
National Diabetes Inpatient Audit 2011)	Yes	
Heavy menstrual bleeding (RCOG)	Yes	
Chronic pain (National Pain Audit)	Yes	
Ulcerative colitis and Crohn's disease (UK IBD Audit 3rd round audit)	Yes	
Parkinson's disease (NPA)	Yes	
COPD (BTS/Euro)	Yes	
Adult asthma	Yes	
Bronchiectasis (BTS)	Yes	
National Audit of Dementia (RCP/RCGP)	Yes	
Elective procedures		
Hip, knee and ankle replacements (NJR)	Yes	
Elective surgery (National PROMs Programme)	Yes	
Peripheral vascular surgery (VSGI database)	? Yes Check	
Carotid interventions (Carotid Interventions Audit)	?Yes Check	

Cardiovascular disease		
Acute myocardial infarction and other ACS (MINAP)	Yes	Ongoing submissions
Heart failure (Heart Failure Audit)	Yes	Ongoing submissions
Renal disease		
Renal colic (CEM)?	?Yes	
Cancer		
Lung cancer (NLCA)	Yes	
Bowel cancer (NBCOP)	Yes	
Trauma		
Hip fracture (NHFD)	Yes	
Severe trauma (TARN)	Yes	
Falls and non-hip fractures (National Falls And Bone Health Audit)	Yes. Date?	
Blood transfusion		
Bedside transfusion (NCABT)	Yes	
Medical use of blood (NCABT)	Yes	
End of Life		
Care of dying in hospital (NCDAH)	Yes	
Infection Control		
4th National Point Prevalence Survey on healthcare associated infection (HAI) and 1st National Point Prevalence Survey on antimicrobial prescribing quality indicators.	Yes	300 patients met the criteria for inclusion and were included in the survey.
Community		
National audit of Intermediate Care 2012	Yes	Ongoing
National Falls and Bone Health Audit	Yes	Check all
National audit on Psychological therapies	Yes	"
CQC National Stroke Audit	Yes	"
MS NSF measuring success audit	Yes	"
NHS Newborn Hearing Screening Programme Audit	Yes	"

Annual audit of Dental Radiographs	Yes	“
Additional		
Ongoing audit of the open abdomen (NICE)	Yes	14 patients
Diverticular disease national audit	Yes	Ongoing
National colonoscopy audit	Yes	
UKOSS - United Kingdom obstetric surveillance system	Yes	
One year multi site audit project on the management of decreased conscious level in children and young people	Yes	
Venous Thromboembolism Risk Assessment (CQUIN)	Yes	
Global Trigger Tool CQUIN	Yes	

National Confidential Inquiry into Suicide and Homicide by people with mental illnesses	Yes	Ongoing

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Eligibility and participation:

Title	Participation 2011/2012	Percentage of cases submitted
Peri-operative care (report published)	Participated	100 percent
Surgery in Children (report published)	Participated	100 percent
Cardiac arrest procedures	Participated	100 percent
Bariatric surgery	Participated	100 percent
ARLD (Alcohol related liver disease)	Participated	Ongoing. 10 patients identified for study inclusion.

Centre for Maternal and Child Enquiries (CEMACH)
CEMACE no longer exists, as of April 2011. We report maternal deaths to MPMN but they only collect minimal data and will not be publishing the triennial reports we are used to receiving.

Title	Participation 2010/2011	% cases submitted
Perinatal mortality		
Maternal death		

The reports of **?** national clinical audits and national confidential enquiries were reviewed by the provider in 2011/2012 and *The Whittington Health NHS Trust* intends to take the following actions to improve the quality of healthcare provided.

Whittington Health intends to improve the processes for monitoring the recommendations of National Audits and Confidential Enquires 2012/2013 by ensuring:

- The results, recommendations and associated action plans of national audits are presented to the Clinical Audit and Effectiveness Committee which reports through to the Quality sub-Committee of the Trust Board.
- Each division has an annual clinical audit plan that includes both local and national audits
- An award specifically for national audit is included in the Clinical Audit Award submissions 2012.

IBD national, NCEPOD x 2, ?COPD Euro, ?Falls, ?dementia, Bowel ca, Lung Ca, ITU Casemix, NJR, NASH, Neonatal national project see Roly B email, ? Colonoscopy

Examples of actions being taken: Add in April

The reports of **??** local clinical audits were reviewed by the provider in 2011/2012 and The Whittington Health NHS Trust intends to take the following actions to improve the quality of healthcare provided.

The Whittington Health NHS Trust intends to improve further the processes for monitoring the recommendations of local audits for 2012/2013 by ensuring: -

- The Clinical Audit and Effectiveness Committee continue to receive Clinical Audit lead summary presentations at bi-monthly meetings.
- The audit actions are assigned to a lead clinician with specific time scales for completion.
- Re-audits are planned and completed to ensure sustained improvements can be demonstrated.
- Add community champions identified etc

Examples of actions being taken: **Complete in April (SIX EXAMPLES)**

Paediatric sickle cell pain management audit
'Acute pain is the most common reason for hospital admission in sickle cell; Increased frequency of pain is associated with early death in sickle cell patients'

Actions ongoing include: -

- Score pain at initial clerking then hourly until pain settles.
- Make pain score one of the routine observations on the doctors ward round
- Recommend non-histamine releasing opiates in place of codeine and morphine. (Better side effect profile in relation to their analgesic properties)
- Educate junior doctors at induction to ensure local sickle cell disease in childhood guideline is followed accurately from day one.
- Pain score card attached to ID badges.

Management of Tricyclic Antidepressant Overdoses
'Tricyclic antidepressants (TCAs) remain one of the commonest causes of death from drug overdose, with over 200 deaths/year. TCAs are still widely prescribed in spite of their risks.'

Actions ongoing include: -

- Improved awareness of TOXBASE guidelines. Feedback via audit presentations to doctors in Emergency Department and Department of Medicine.
- TCA use should be routinely reviewed when discharging patients after a TCA overdose by both medical and psychiatry teams.
- Feedback to Pharmacy to consider 'red-flag' system when prescribing TCAs in future planned electronic prescribing.
- Improved communication is needed with primary care to encourage safer anti-depressant prescribing in the community via audit result feedback to Medicine and Liaison Psychiatry departments.

Audit of staff knowledge on penicillin allergy.
'The National Patient Safety Agency (NPSA) reported that patients who are allergic to certain medicines are more vulnerable to patient safety incidents than other groups of patients. Local systems have been developed to ensure the safe use of antibiotics in penicillin allergic patients.'

Actions undertaken or ongoing:

- develop antibiotic guides, which uses the 'traffic light system' to highlight antibiotics containing penicillin;
- provide staff with Penicillin Allergy 'FACT: Penicillins can kill' cards;
- provide posters for clinical areas;

- introduce yellow penicillin cautionary labels that are affixed onto medicine packs to alert staff and patients to products containing penicillin; and
- implement an electronic prescribing and dispensing system that utilises a record of patient's allergy status to provide alerts when medicines are prescribed or dispensed.

Antacid prophylaxis in obstetric patients

'All women from 2nd trimester onwards are at increased risk of acid reflux due to hormonal & mechanical effects of pregnancy. Whilst aspiration is rare, it represents an important cause of maternal death. Risk of aspiration has improved due to better anaesthetic techniques & increased use of regional techniques.'

Actions:

- All patients who receive opioids for pain relief in labour should be started on regular ranitidine by the obstetric team.
- All patients who have an epidural sited during labour should be prescribed regular ranitidine by the anesthetist inserting the epidural.

Research

April 1st 2011 - 31st March 2012

The number of patients receiving NHS services provided or sub-contracted by Whittington Health that were recruited during 2011-12 to participate in research approved by a research ethics committee was **(ADD SS)**

Participation in clinical research demonstrates Whittington's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stays abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes and better health for the population. The Whittington was involved in conducting 138 clinical research studies across 28 specialities during March 31st 2011 to April 1st 2012 and approved 34 new projects during the same period. Over the same period, mortality amenable to healthcare/mortality rate from causes considered preventable in [medical specialty] changed from the previous year by [insert percentage].?

There were 85 clinical staff participating in research approved by a research ethics committee at the trust during the reporting period.

As well, in the last three years, 223 SS to check with RP publications have resulted from our involvement in clinical research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS. The trust's strategic aim includes improving the health of the local population and this cannot occur without research with and for our local population. We have

research programmes in clinical specialities that reflect the health concerns of the local population including cancer, haemoglobinopathies, critical care, infection, women's health, continence science and speech and language therapy.

Goals agreed with our commissioners (CQUINS)

A proportion of The Whittington Health NHS Trust's income in 2011-12 was conditional on achieving quality improvement and innovation goals agreed between Whittington Health and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2011-12 and for the following 12 month period are available on request from the Planning and Programmes Team, via the hospital switchboard.

These goals were agreed as they all represent areas where improvements result in significant benefits to patient safety and experience, and which both the Whittington Health and our commissioners believed were important areas to improve in.

A preliminary assessment of the outcome of these improvement schemes is shown in the table below. The full analysis of achievement against each scheme's objectives is still being carried out and a final report will be published in the Summer. ANITA GARRICK TO PROVIDE. THIS NEEDS TO FOLLOW SPECIFIC FORMAT

SARAH-IS THIS IS CORRECT FORMAT?

The CQUIN schemes for 2012-2013 have been agreed with our commissioners. Very briefly, they are:

Hospital-Based:

CQUIN scheme	Rationale / Objectives
Venous Thrombo-embolism (VTE) - Risk assessment - Appropriate Prophylaxis	VTE is a significant cause of mortality, long-term disability and chronic ill health.
Patient Experience - Composite indicator score on inpatient survey	The indicator incorporates questions which are known to be important to patients and where past data indicates significant room for improvement across England.
Enhanced Recovery Programme - Reporting on the national database - Surgery on day of admission - Goal directed fluid therapy for colorectal surgery - Reduction in length of stay	To improve the quality of patient care through the implementation and development of enhanced recovery schemes. The adoption of enhanced recovery models of care is proven to reduce length of stay, enhance the patient experience and improve clinical outcomes for some surgical procedures.
Improvement in COPD Care - COPD care bundle - Smoking cessation	COPD bundle: To improve long term prognosis and progression of the disease, to improve quality of life, reduced exacerbations, reduced hospital admissions and re-admissions. Smoking cessation: Up to one in five deaths in London is

	due to smoking yet there are cost effective interventions that can be used in hospitals to reduce that mortality, improve health and prevent admissions
Discharge Planning - Additional information on discharge summaries - Electronic submission - Planning proactive discharge - Timeliness and content of discharge letters	To improve information to GPs, to enhance patient care and to improve the use of resources
Out of Intensive Care Unit Cardiac Arrests - Decrease the number of Out of Intensive Care Arrest Calls - Completed sets of 6 vital signs - Increase the number of patients admitted to Critical Care in under 60 minutes	Department of Health and NICE evidence shows that reducing out-of-ICU cardiac arrests is a marker of good clinical care of acutely unwell patients

Community-Based:

CQUIN scheme	Rationale / Objectives
Long-term conditions	Extend and improve models of care for patients with long term conditions such as diabetes and COPD
Care closer to home	To design and implement new models of care to reduce hospital care
VTE - Risk assessment - Appropriate Prophylaxis	VTE is a significant cause of mortality, long-term disability and chronic ill health.

Statements from the Care Quality Commission (CQC)

STATEMENT NEEDED FOR THIS YEAR

Data Quality

Statement on relevance of Data Quality and actions to improve our Data Quality

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 to internal and external accountability. Understanding the quality of our data means we can make the most of it.

The Trust's operational divisions have responsibility for data quality in their areas. The Trust has a Data Quality Group, which includes representation from each division, and this group is responsible for implementing an annual data improvement

plan, and measuring how well the Trust is performing, against a number of external sources.

NHS Number and General Medical Practice Code Validity
The Whittington Hospital NHS Trust submitted records during 2011-12 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published date that included patient's valid NHS number was: -

97.5% for admitted patient care (up from 93.5% in 2010/11);
98.4% for out patient care (up from 96.2% in 2010/11);
90.2% for accident and emergency care (up from 79.4% in 2010/11).

The percentage of records in the published date that included the patient's valid General Medical Practice Code was:

100% for admitted patient care (100% in 2010/11);
100% for out patient care (100% in 2010/11);
99.6% for accident and emergency care (up from 98.7% in 2010/11).

Progress with 2011/12 Priorities

Information Governance Toolkit attainment levels (Anita)

The Whittington Health NHS Trust's score for 201-12 for Information Quality and Records Management, assessed using the Information Governance Toolkit was (ADD ANITA)

The grading system has changed from a traffic light rating system to satisfactory/not satisfactory. To achieve satisfactory, trusts must achieve level two for all 45 key requirements. We are still working on the following four requirements: -

- Letting people know how we protect their information
- Completing the project to anonymize patient level data when not used for direct clinical care
- Improving NHS Number completeness (see above)
- Ensuring that all staff are trained in protecting confidential information (75% of staff received training during 2010-11)TO UPDATE

Clinical Coding Error Rate

The Whittington Health NHS Trust was not subject to the Payment by Results clinical coding audit during 2011-12 by the Audit Commission. (check SS??)

The clinical coding error rate for 2011/2012 was as follows:

Main diagnosis code - error rate (ADD-AG) Main procedure code - error rate (ADD) % of spells with a different healthcare resource group (HRG) - ADD (i.e. only half the coding errors involved changing the HRG)

Standard is to be 90% accurate.

Review of Quality Performance

Patient experience remains at the very heart of our quality agenda. Work will continue throughout the year ahead, particularly around obtaining and acting upon real patient feedback. Listed below are priority progress updates from last year including a specific section on the patient experience

Whittington Hospital performance against key goals

The Trust Board receives a monthly report (the "Dashboard") on all **performance indicators**. This report is part of the Trust Board papers and is published on the Trust's website.

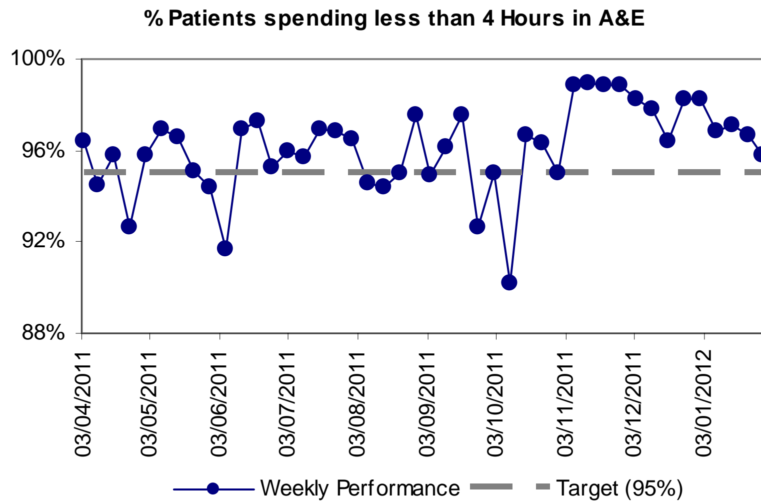
Data is for Apr 2011 – Jan 2012 unless stated

Goal	Standard/benchmark	Whittington performance
18 week waits for admitted patients to treatment, as of Jan 2012	95th percentile wait to be less than 23 weeks	20.4 weeks
18 week waits for non – admitted patients to treatment, as of Jan 2012	95th percentile wait to be less than 18.3 weeks	14.5 weeks
Outpatient follow up ratio	London median performance	Action plans in place for all specialties
Operations cancelled for non-clinical reasons	0.8%	0.4% *and* all patients offered another date within 28 days
Waits for diagnostic tests	Less than 6 weeks	99.5%
Day surgery rate	Audit Commission benchmark	76% (best quartile)
OPD DNA rate for new patients (hospital)	8%	12.3% and action plan in place to improve

OPD DNA rate for follow up patients (hospital)	8%	14.7% and action plan in place to improve
Community Adults' Services DNA rate	8%	9.0% and action plan in place to improve
Community Children's Services DNA rate	8%	14.4% and action plan in place to improve
Average length of stay for all acute specialities	-	6.2 days (unchanged over last two years)
Staff sickness absence rate	Local target: 2.5%	3.1%
Ward cleanliness score	95%	96%
Elimination of mixed sex accommodation	0 mixed sex breaches	9 breaches
New Birth Visits (Islington)	95% seen within 14 days	72.9%
New Birth Visits (Haringey)	95% seen within 28 days	81.3% (Dec data)
Sexual Health services	100% offered an appointment within 2 days	100%
Cancer waits (all data April 2011 – Dec 2011)		
Urgent referral to first visit	Standard is 14 days, target is 93%	95.7%
Diagnosis to first treatment	Standard is 31 days, target is 96%	99.4%
Urgent referral to first treatment	Standard is 62 days, target is 85%	86.1%
Maternity		
Bookings by 12 weeks, 6 days of pregnancy	90%	89.9%
One to one midwife care in labour	-	100% of audited deliveries
Smoking in pregnancy at delivery	<17%	8%
Rate of breast feeding at birth	>78%	91.3%
Complaints		
New complaints	-	Approx 38 complaints per month (across community and acute services)
Dissatisfied complainants	-	7%

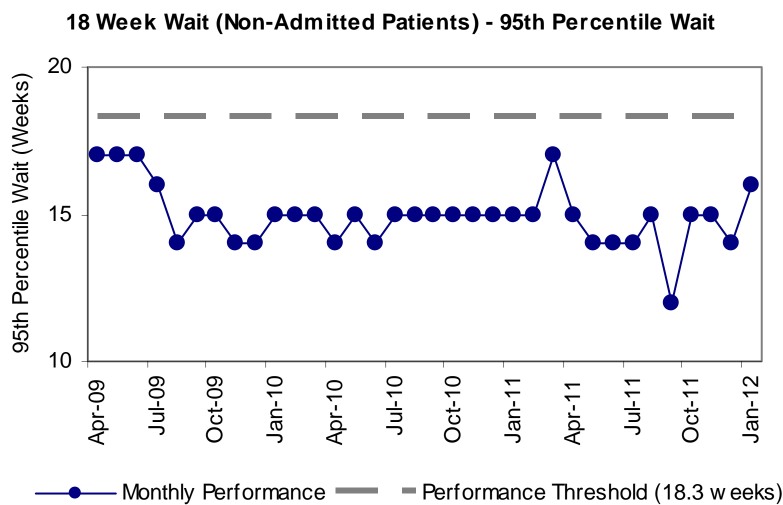
Four Hour A&E Wait

ADD NARRATIVE



18 week wait

ADD NARRATIVE



Length of stay

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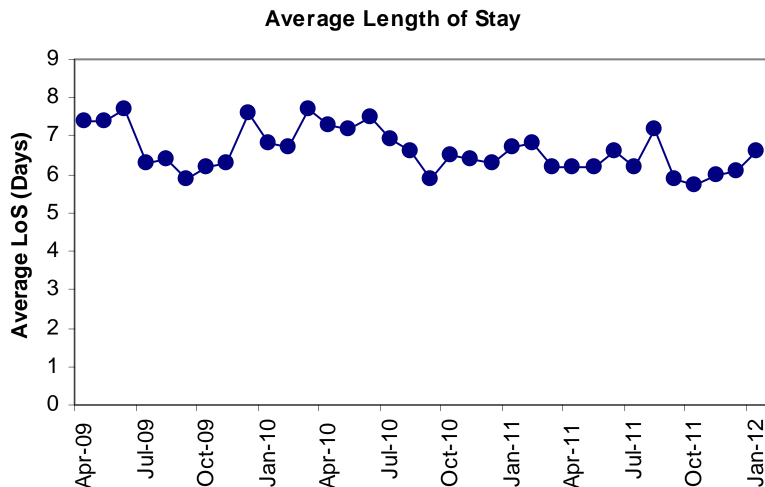


Never events

The National Patient Safety Agency has developed a list of 25 "never events" that are applicable to acute trusts. These are events that should never happen during a healthcare episode as they are all avoidable, and can have serious consequences for the patient if they do occur. Whittington Health has had two "Never Events over the past 12 months, one involved a mis-placed nasogastric tube, and the other a retained swab after surgery. Both have been treated as Serious Incidents. They were fully investigated and actions have been taken to reduce the risk of them happening again.

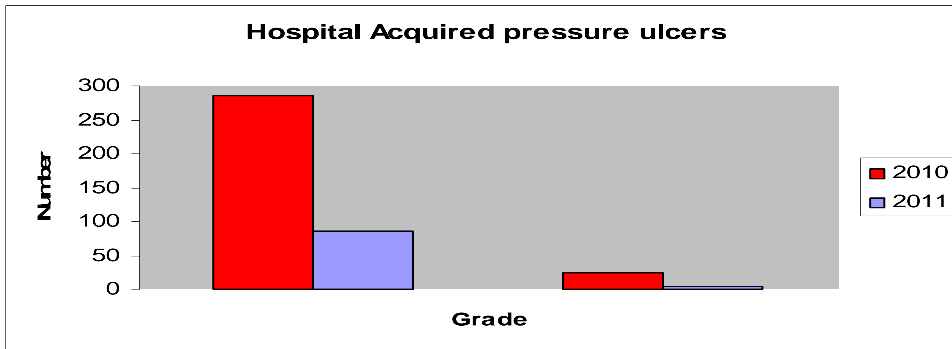
Patient Safety 2010/2011

Progress against Priority One:

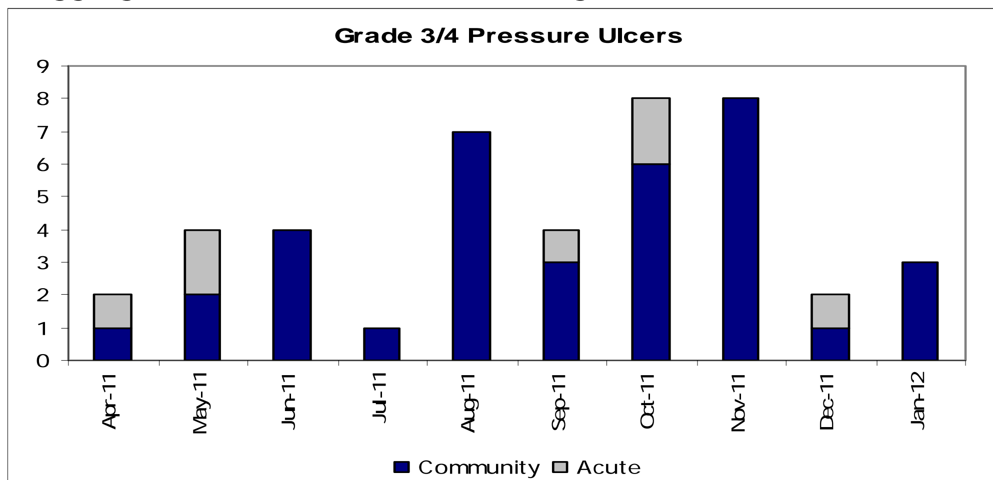
To reduce the number of healthcare attributable pressure ulcers both within the hospital and the community

Over the last year our pressure ulcer prevention team have worked hard to reduce the incidence of pressure ulcers and have achieved this by improving the guidance to health professionals and service users about active prevention and improved compliance with validated assessments of risk. The new Pressure ulcer prevention and management guideline was introduced in (). All patients are now assessed using same risk assessment tool (Waterlow) whether they are in the hospital or community setting. Additionally all pressure ulcers are reported as an 'clinical incident' and Grade 3 & 4 as Serious Incidents that require an in-depth an rigorous investigation and action plan to prevent it happening again. We have introduced a pressure ulcer Serious Incident panel to undertake and oversee this work and ensure that the action plans are completed in a timely manner. A new leaflet has also been developed for those who are at risk of pressure

ulceration giving advice on prevention. The graphs below show the reduction in pressure ulceration that we have achieved for hospitalised patients. Next year, we will hard to continue to reduce incidence in the community setting.



Aggregated incidence across Whittington Health



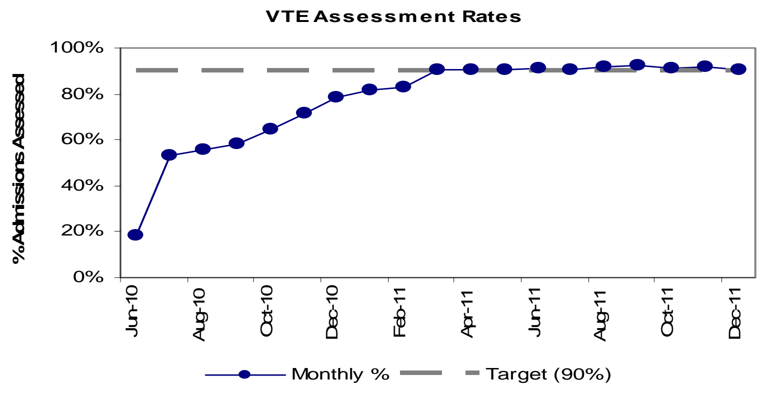
Progress against previous priorities

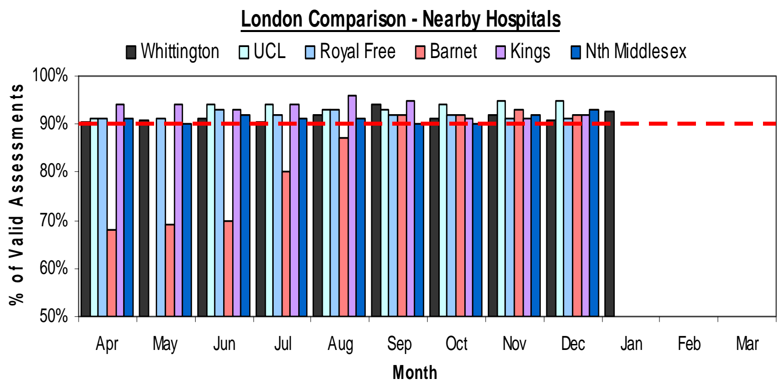
To reduce the risk of patients who are admitted to hospital developing blood clots SS and CA to update

We set a target of 90% of patients admitted receiving an assessment to see if they are at risk of blood clots, and if so, of providing them with appropriate preventative treatment.

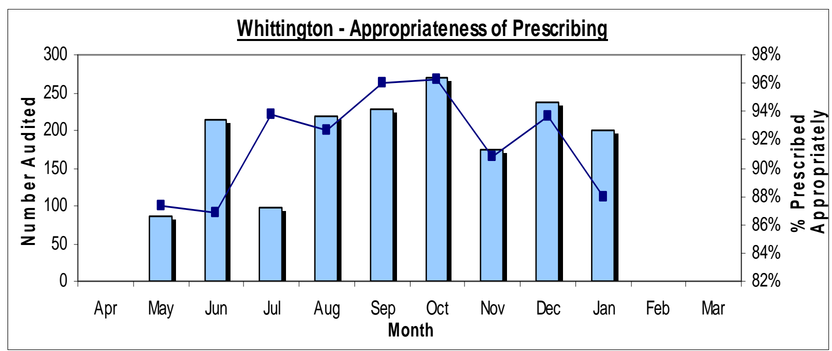
We appointed an experienced nurse specialist to lead this work and have put in place an electronic assessment tool and provided training to all staff in how to use it. A responsible committee has been set up to oversee the work, with a working group meeting fortnightly to ensure progress is made. By March 2011 we had achieved our target of 90%. Performance in this area has been consistently high throughout 2011 with a 95% compliance rate for risk assessments being achieved on average throughout the year. They won an award for excellence in patient safety- awarded by Sunquest at their annual user group 2011/2012
When patients do develop a blood clot, each one is carefully reviewed to find out if they were correctly assessed and treated, and if it could have been prevented, so that we can continue to improve in this area. The graph below shows the improvements we have achieved over the last year in our assessment of VTE risk

and how we compare with other hospitals nearby. The appropriateness of prescribing shows how well we are doing in giving the right treatments to people who are at risk of VTE. This means that in most cases, we do all that is possible to prevent a blood clot from occurring.





Appropriateness of prescribing for VTE prevention



To sample patients health records every month in order to identify ways to reduce risk.

We have been sampling patients' health records every month since 2009 in order to review the care given and identify if we could have done things any differently that would have reduced risk. We do this in two ways as set out below: -

- Health records audit: mortality reviews.
- Lead Celia Ingham Clark, Medical Director.

An ongoing mortality audit is now in place for most specialties and is being rolled out to the remaining medical sub-specialties, led by Ihuoma Wamuo, Director of Audit and Effectiveness. The Medical Director continues to review the medical records of patients who die at the Whittington.

The death reviews audits have led to:

- improved documentation in medical records
- identification of two Adult Safeguarding alerts
- identification of two Serious Incidents not otherwise reported
- many examples of feedback to individual consultants and their teams to promote good practice

- **Health records audit: use of Global Trigger Tool. Lead Ihuoma Wamuo.**

This is an audit tool that is used to systematically sample recent in-patients records to look at variations from good outcomes. For example it records adverse events such as unplanned return to theatre, unplanned admission to ITU, ward-based cardiac arrest calls, INR over 5. It takes approximately 20 minutes to review one set of records. We now use this regularly, reviewing 20 sets of records per month. This allows us to recognise the types of issues and areas where improvements should be made, and so help set our priorities.

The Trust has a trained team of 6 multidisciplinary reviewers. They work in pairs to review 10 sets of case notes every fortnight. Year to date 295 reviews have taken place, with the data being inputted onto the safer care toolkit (NHS Innovations and Improvement database). Below provides a run chart of the median rate of harm for the Trust.

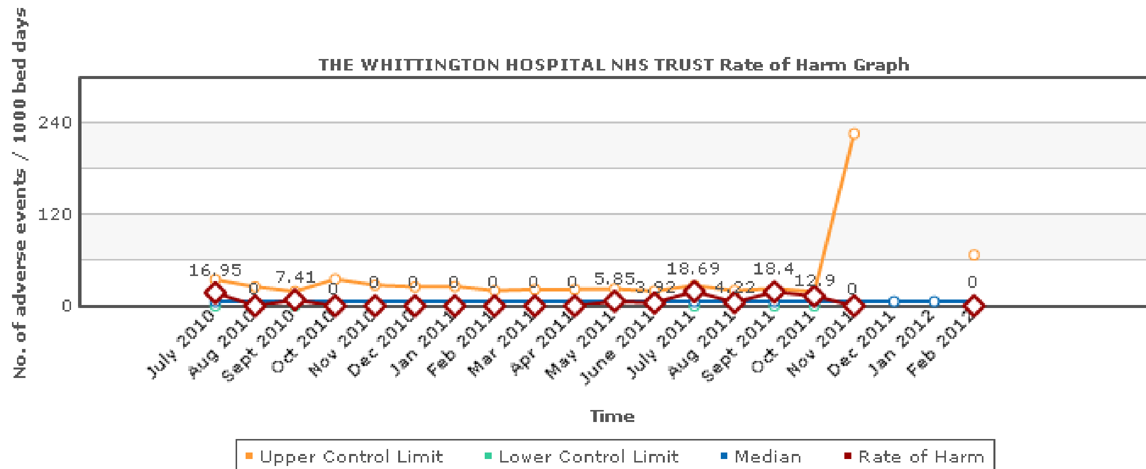


CHART NEEDS CORRECTION

The data above represents the rate of harm identified through the ongoing fortnightly reviews. The Trust has been implementing the GTT since July 2010. **The current rate of harm as expressed through the use of the GTT for Whittington Health is %**

16 harm events have been identified within this time period. The list below demonstrates triggers found leading to the identification of an adverse event

Wound infection 3
Complication of procedure 3
Raised urea/ cretonne 2
ICU/HDU unplanned 1
Procedure change 1
Incomplete/ no obs 1
Readmission 1
Blood transfusion 1
Nosocomial infection 1
Positive blood cultures 1
Leg/ pressure ulcer 1

In line with the trigger tool methodology the three highest triggers, shall be a focus of patient safety initiatives for 2012.

70 triggers have been identified to date, and 35 have been due to readmission within 30 days of discharge. This has been consistently the highest trigger since the implementation of the GTT.

In Summary the Global Trigger Tool has been fully implemented for 16 months. The Trust could review the areas with high adverse events, implement change, to continue to improve our success in improving patient safety throughout the Trust in the coming year.

To reduce the number of falls causing harm to our patients

We have developed a Trust goal to "reduce the likelihood of falls whilst maintaining dignity and independence". In order to achieve this goal a Trust policy has been developed on "Safer handling of the falling and fallen patient". The policy has been supported by the development and implementation of a Falls Risk Assessment tool, so that we can identify those patients most likely to fall, and for those this applies to, an individual targeted Falls Care Plan has been developed and is in use, which sets out the actions needed to reduce the risk of falling. Initially this work was targeted at our older patients, who are often the most likely to fall, but we are now including all patients. All the above work is overseen and steered by a lead consultant and lead matron, who have increased recognition of this important issue by holding staff awareness days. Where falls do occur, they are recorded on the Datix Risk Management System, and are investigated to see if they could have been prevented.

Whilst the number of patient falls causing harm has decreased from 13 in 2009-10, to ten in 2010-11, this reduction is not yet sufficient. We are therefore continuing our work to further improve in this key area, and looking at new prevention methods, including the use of "safe ward rounds" whereby all patients on a ward are checked on at least every two hours.

Simmons House, Child and Adolescent Mental Health Services (CAMHS)
Our Tier 4 Adolescent Psychiatric in patient and day patient service. Many of the patients self harm and have suicidal ideation and can present with risky and challenging behaviour. Every patient has a comprehensive risk assessment on admission and this assessment is regularly updated.

Learning from experience and reflective practice sit at the heart of Simmons House risk management:

- All incidents of self harm of any kind and of any degree are reported to case managers, consultants and lead to a clinical incident form being completed
- All incident forms are reviewed by senior nurses daily, summarised and sent out to senior clinical staff
- All incident forms are discussed monthly at the SH Management Group
- All incident forms are forwarded to the Trust Clinical Governance department for scrutiny
- All incidents are reported to the lead commissioner for Simmons House (Islington CAMHS) quarterly

Within the past 12 months Simmons house conducted a medication errors review within their service, this was reviewed externally with support by a senior nurse from UCLH.

As a result of this review the service has developed and is implementing an action plan with recommendations from the review for the ongoing management of medication errors.

The risk assessment tool (RAT) used at Simmons House has been devised by the clinicians at Simmons House and shared with other services. However the risk assessment tool is not a substitute for regular and ongoing risk assessment; its aim is to capture the detail and background relating to risk.

The unit's philosophy, strategies, structure and daily activity are designed to ensure that the service offered at Simmons House is as safe and effective as possible.

INSERT RUN CHART??? If data makes sense

Clinical Effectiveness 2010/2011

2010/2011

To establish daily consultant ward rounds at weekends and on bank holidays, for all inpatient areas

Daily consultant ward rounds are in place, including weekends and Bank Holidays for the majority of our specialties, including paediatrics, maternity, neonatal care, intensive care, Emergency Department, Medical Admissions Unit and surgery. On the medical wards consultant ward rounds take place five days a week at present, and plans are under way to raise this to include weekends and Bank Holidays this year.

Lymphoedema - leaking legs-DAVID WILLIAMS? UPDATE SC TO CHASE

Lymphoedema is a disabling condition which can lead to cellulitis and erysipelas resulting in frequent admissions to hospital. Leaking legs is a highly distressing and disabling symptom for patients. The management of leaking legs was identified as an area for service improvement though QIPP.

Changes to the service model in Islington were piloted and focussed on a model of initial intensive management by a dedicated team to bring the leaking legs rapidly under control so that once healed, the patient would be able to put on re-useable stockings to maintain therapy and prevent re-leaking. If successful it was anticipated that savings would be made in the prescribing budget through decreased dressing costs as well as improving patient outcomes and quality of life.

Results:

- Healing rates for single treatment episodes have improved from 15% at baseline audit to 89%
- Average treatment times have reduced from 20 weeks at baseline audit to 6 weeks.
- Treatment levels have reduced from 54 treatments at baseline to11 treatments per episode
- Dressing costs have been reduced from £40 per treatment session to £11
- Based on data gather in 10/11 the predicted net prescribing budget saving for 11/12 is £99,840

The data gathered so far provides significant evidence that intensive, specialist intervention is welcomed by patients, key in the effective management of leaking legs and the vast majority of cases can be resolved rapidly through appropriate treatment.

Progress on previous priorities:

To improve our written communication with GPs

The Trust is developing new electronic systems of communication with GPs that will embed results, discharge and outpatient letters directly into the individual patient's health care record.

Results are already being transmitted in this way for Pathology and approximately 90% of Imaging results are also currently delivered electronically. There are some practices in Haringey which lack the computer configuration to currently accept results electronically. We will be contacting those practices with a view to resolving the problems and stopping all hard copy printed results by the end of June 2011.

Electronic patient discharge letters have been implemented for our in-patients and are being introduced in Spring 2012 for day case patients.
WH ICO is committed to sending all communications electronically to GPs and are working with the CCGs and practices to address specific technical and process issues
We have identified a simple and accurate voice recognition system to create a discharge summary and outpatient letter template. The document will give clear headings that are easy to understand for the referring General Practitioner
We are also implementing a computer system (EMIS web) that will allow safer care by letting staff in the Urgent Care Centre have access to important medical information from General Practice

To roll out the enhanced recovery programme for patients having operations

CA CAN YOU UPDATE THIS SECTION?
INCLUDE RUN CHARTS IF WE HAVE THEM? Have emailed martin Kuper 21/2/12

Enhanced recovery programmes help our patients to get better more quickly and safely following surgery, so they can be discharged sooner. We started with patients having bowel surgery, and during the last year have continued to embed the use of the pathway with these patients, so that it is now well established. We have also started to use this approach for patients having hip and knee replacement surgery. We are checking the improvements in care by how soon before their operation patients are admitted, how long they stay in hospital after the operation and if they needed to be re-admitted. For patients having planned colorectal cancer surgery the average length of stay has fallen from 20 days in 2006 to 9 days in 2010 and the death rate after surgery has fallen from 13.1% to none in 2010.LATEST DATA???
We have now implemented Enhanced Recovery for orthopaedic surgery. Length of stay has fallen to on average 5 days from 7.5 days and patients are very happy with the service.

Dr Martin Kuper from the Whittington was awarded NHS London Innovation funding for the Whittington to lead implementation of Enhanced Recovery across North-Central London in 2010/11 and this has been so successful that we have just been awarded a further £150000 of NHS London Innovation Funding to help roll out Enhanced Recovery surgical pathways across London in 2011/12.

To send imaging, endoscopy and pathology reports to consultants electronically, rather than by paper, in order to speed up the process and reduce hospital stays for our patients

This is now an established part of the Hospital users' practice. There are plans to extend this into the Community, but the introduction of an Electronic Patient Record is the key. We are working with Clinical Commissioning Group leads towards this end.
The Emergency Department receives all patient results electronically which is faster and safer than relying on paper systems.

Patient Experience 2010/ 2011

To ensure that all out-patients are welcomed, treated correctly and promptly and given full information about their visit and on-going care

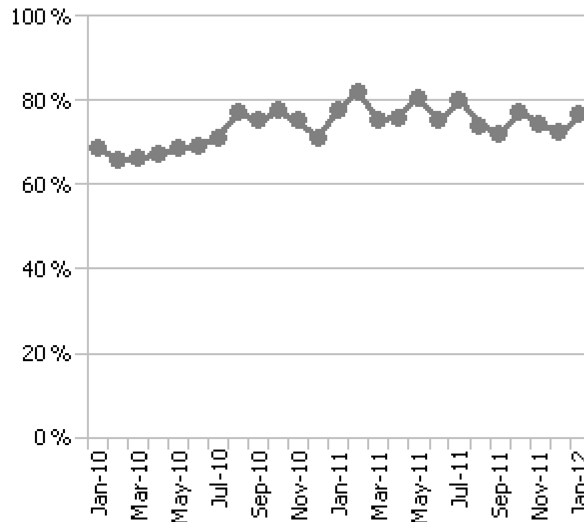
JENNIE WILLIAMS/CA

Progress against previous priorities

To increase the number of patients who feel involved in their care

The national patient surveys are only conducted once a year and results take some months to come to us. This process is always retrospective in nature and the document itself can be unwieldy in its content and composition. We now capture our own real time patient feedback using electronic surveys via touchscreen devices sited throughout the trust and handheld devices within the inpatients environment . Patients are asked multiple questions that both reflect those asked within the CQC patient surveys such as if they agree with the statement 'I was involved as much as I wanted to be in the decisions about my care' and how they rate their care overall. These corporate questions are supplemented by specific questions relevant to the particular area or aligned to a particular initiative. These results are published at a trust level to both Hospital Management and Trust Boards and local reports are produced for each area in the trust. ANY RUN CHART?
These surveys coupled with patient interviews, focus groups and learning from patient complaints ensure that more patients have an active involvement in shaping the attitude and behaviour of the trust.

Local Patient Survey - % of those questioned answering in the top two categories to the statement "I was involved as much as I wanted to be in the decisions about my care"



To implement the Healthcare for London Dementia Care Pathway

CM TO UPDATE

The Healthcare for London guidance advises that an acute trust should have strong clinical leadership, provide basic training for all new nurses and provide specialist training for those nurses working in care of older people areas, as well as following their specific pathways for acute patients. We have therefore designated a lead consultant and lead matron to champion this work. Initial part of strategy is aimed at improving care of patients with dementia on COOP wards and specific actions that have been taken (and are in the process of implementation) include:

- Ensuring training is received by all staff working on COOP wards
- Launch new documentation
- Improve care on COOP wards by rolling out agreed signage by NLHA Dementia Partnership Group
- Updating guideline on management of delirium

In addition Susan Tokley, deputy director of nursing has been successful in securing £200,000 from the Burdett Trust to develop and evaluate a care pathway to improve care and service delivery for those with dementia in hospital and at home.

To introduce a systematic approach to learning from patient feedback JW TO UPDATE

Historically feedback from patients was collected in a variety of separate, disjointed ways across the hospital, which did not allow us to have, or act on, an overall picture. During 2010-11, we established a Patient Experience Steering Committee, chaired by the Trust's chairman, to bring together all the variety of feedback, and work out how best to act on it. This committee has provided a structured mechanism for pulling together patient feedback from a variety of sources, including local patient surveys, national patient surveys, complaints, PALS and risks. This feedback is matched to speciality or specific areas of the hospital, e.g. a ward or clinic, so that it is meaningful to staff at local level. This has allowed themes to be identified and improvement areas to be prioritised. As a result a trust-wide Patient Experience Improvement Plan has been developed and is now being implemented. For example we identified that in the national cancer survey in 2010 our cancer patients were dissatisfied with the care that we provided. As a consequence we have developed an action plan to improve the experience of care within the Trust for this group.

To increase the number of patients who would recommend the Trust to a friend or relation

An integral question within the surveys is the following rateable question.

How likely is it that you would recommend the Whittington to a friend or colleague? Please choose tour rating, with 1 meaning very unlikely to 10 meaning very likely.

The result of the responses from this question creates a unitary measure known as 'the Net Promoter Score' (NPS). This measure is captured from patients using devices across all areas of success and those that require additional support.
We can also now track the NPS over a period of time to evaluate the impact of seasonal pressures or the refurbishment of an environment . We also try to ensure that as part of the operational review of these results that there is a focus upon the detractors in order to define any common themes or trends that need addressing . Again this data is shared at both an executive and operational management level.

Greentrees (Chestnut Ward) one of our community services which focuses on rehabilitation in Haringey has been working on a structured programme with a focus on Dignity and Respect, this has also been linked into the work surrounding the Productive Community Hospital, an NHS Institute for Innovation and Improvement programme with the aim of improving quality, patient outcomes, experience and releasing more time for face to face care.

Review of Quality Performance

Dealing with inequalities within the Whittington Health

Care of patients with a Learning Disability

Introduction

REPORT PROGRESS AGAINST THIS. WE NEED MORE EXAMPLES ON INEQUALITY WORK.SUGGESTIONS PLEASE? TB SERVICE?

Patients who have a learning disability (LD) often need "reasonable adjustments" to be made to enable their care in an acute trust to be safe and a positive experience. It can be very distressing for them if not handled well, and several reports have shown that some patients experience poor standards of care just because of their LD, leading to serious avoidable harm, and even death. The recent Ombudsman's Report entitled "Six lives: the provision of services to people with learning disabilities" provides a summary of their investigation reports into six cases where patients with an LD died whilst in NHS or local authority care.

The report recommended that all organisations review the systems they have in place to meet the needs of people with an LD that use their services. This review was carried out over summer 2010, and was led by the Nurse Consultant in LD from NHS Haringey.

WHO WOULD UPDATE THIS SECTION ask Sue Tokley who.
Next section needs tidying up please

Community Dental: This has included a large scale project with involving learning disabled community groups in Islington and Camden. The aim was to improve access to dental care for LD adults by making information and referral pathways more appropriate to this group. End result was a new service brochure and referral form combined just for this care group: the leaflet featured the local LD community and was facilitated by Photosymbols, national group specialising in this area. It was commended by NHS London an example of good practice in this area.

The community dental service also provides care to the prison population, to those in nursing homes, with complex physical and psychological problems. It has a 90% satisfaction score from its users

Work in progress

As part of our work to improve the care of this group of patients at the Whittington, a strategy was developed and an awareness launch held. Following this, a set of standards was developed based on our own strategy, plus the national must dos, including "Six Lives".

The standards set out how we will raise awareness and train staff about the needs of these patients, particularly around better communication and making reasonable adjustments.

We have been working closely with colleagues in NHS Haringey's LD team for some time, who have kindly provided advice and support, and in November 2010, we were delighted that an acute trust Learning Disabilities nursing post was established for the Whittington Health. The post holder provides expert advice for individual patients and carers, and also provides training and support to our staff.

Next steps

The foundations are now in place and awareness has begun to be raised, but there is still some way to go to ensure that all our staff, including administrative and facilities etc, understand the reasonable adjustments that must be made to ensure that this group of patients are not disadvantaged and that their care is safe. We will continue to work in partnership with our LD colleagues to improve this important area.

Equality and diversity

SC TO CHECK WITH MB IF ACCURATE AND UP TO DATE AND REFLECTS DEVELOPMENTS

Whittington Health has had, for the past 4 years, a single equality scheme (SES) in place.

The main aims of our SES are to:

- ensure that consideration of equalities issues are at the mainstream of thinking and day-to-day practice across the trust
- reduce health inequalities and improve health outcomes for patients
- meet the current legal requirements concerning race, disability, age and gender
- ensure that trust policies and practices do not discriminate
- challenge discrimination against people who work here or use our services
- ensure equal access to services and work to enhance and improve service user choice and control
- provide a coordinated approach to meeting the requirements of forthcoming legislation on: religion/belief and sexual orientation
- raise staff awareness and understanding of these issues.

The hospital is now working towards meeting its requirements under the Equality Act 2010.

In Jan 2012 new goals were agreed by the organisation in order to strengthen the equality agenda. Our equality objectives for 2012 include:

1. Ensure better healthcare outcomes for all regardless of race, gender, sexuality or religion
2. Improve access to healthcare and the experience of services
3. Empower, engage and support our staff
4. Ensure inclusive leadership at all levels of the organisation that reflects the diversity of our community

All staff have access to training on equality and diversity issues and (ADD) of staff have received this training
Additionally all Whittington Health policies are assessed to ensure that they meet the requirements of the equality agenda and that our services do not discriminate against any groups in society

Speciality progress reports

Acute Medicine

Quality achievements 2010/11	1. The Acute Medicine Unit (AMU) expanded from 16 to 34 beds in November 2010. Over 90% of acute medical admissions are now admitted to AMU, (previously 66%) – this gives equality of service access, brings a reduced length of stay in hospital to more patients & reduces unnecessary ward transfers. 2. The AMU was measured against the Royal College of Physicians national benchmark of Dec 2008: of 14 Guideline standards our service met 13 3. In 2010 3416 AMU patients were surveyed, and in all 5 domains – involvement, dignity, cleanliness, confidence, overall 94% of patients rated their care positively. 4. The AMU-based outpatient antibiotics service helped many more patients stay out of hospital while still receiving effective intravenous treatment, saving 247 bed days in a year 5. The system of nurse-led discharge of inpatients at weekends helped many patients to spend less time in hospital, and this saved 154 bed days in 2010.
Areas for improvement 2011/12	1. The Acute Medicine service aims to have a consultant presence on AMU for 12 hours every day Monday-Friday (08.00-20.00) in response to guidance from the Royal College of Physicians. ACTIVELY BEING ADDRESSED- AIM TO HAVE PLAN/TIMESCALE FOR HOW WE WILL HAVE ACHIEVED THIS BY END OF MARCH 2. At weekends, the Division of Medicine aims to have enhanced consultant presence during the day so that not only new patients, but also established inpatients, can receive a consultant-led review seven days a week, again in response to guidance from the Royal College of Physicians. ACTIVELY BEING ADDRESSED- AIM TO HAVE PLAN/TIMESCALE FOR HOW WE WILL HAVE ACHIEVED THIS BY END OF MARCH 3. The Acute Medicine service aims to increase the quality, timeliness and accessibility of information given to General Practitioners at the time a patient is discharged from hospital. ELECTRONIC DISCHARGE SUMMARY PROGRAMME FULLY ROLLED OUT ON MAU **Development area:** To continue to develop the services at Chestnut Ward surrounding Dignity and Respect and Patient

	Experience during a period of change guaranteeing clinical quality whilst the service is commissioned elsewhere. 4.
Suggested areas for improvement 2012/13	1. Reduction of acute emergency 30 day readmissions by 25% 2. Reduction of admissions in Long Term Conditions/ chronic ambulatory care sensitive conditions. Asked for more targets and progress 21/2/12

Anaesthetics

Quality achievements 2010/11	1. Developed staff rotas that are compliant with the European Working Time Directive, without needing to rely on temporary staff 2. Reduced high rates of sick leave
Areas for improvement 2011/12	1. To develop specific anaesthetic outcome measures for patient safety, clinical effectiveness and productivity 2. To develop a formal report on the quality of the Anaesthetic Service
Suggested Areas for improvement 2012/13	1. To continue to improve staff management in line with improving the *productivity of the clinical service* and providing learning opportunities for trainees. 2. To further establish specific anaesthetic outcome measures by introducing an *"anaesthetic quality score card"* of core outcome indicators which is fed back regularly to clinicians and managers. This score card will include *measures of patient safety* such as the relevant DOH Never Events and Royal College of Anaesthetists National Audit project indicators. The DATIX system will be updated for monitoring and reporting these indicators. The scorecard will also include *measures of clinical effectiveness* such as the severity of pain on the first postoperative day for patients having colorectal surgery and elective major joint replacements as well as the percentage of #neck of femur patients getting to theatre within 24-48hrs - factors which influence the LOS of these surgical patients. 3.To present annual reports on the quality of the Anaesthetic Service to anaesthetic colleagues and to the Divisional Board. 4. Enhanced Recovery: We have just introduced Enhanced Recovery into gynaecology and orthopaedic surgery and reduced the mean length of stay by 2 days since April 2011 for hip and knee replacement surgery. 5. Intraoperative Oesophageal Doppler audit: The Whittington led a 3 centre interventional audit on the intraoperative use of the Oesophageal Doppler Monitor. This technology was recommended for wide adoption by the NHS in the 2011/12 Operating Framework and adoption of this and the other high impact technologies recommended will be a requirement for CQUIN 'prequalification' in 2012/13. The Whittington will be in an excellent place to meet these requirements.

Cardiology

Quality achievements 2010/11	ADD
Achievements 2011/12	1.Awarded the Government's Customer Excellence Service Award (formerly The Charter Mark) having passed the annual "Health Check" in June, for maintaining high quality clinical standards for the totality of its services. 2.Running a direct access cardiovascular investigation service for GPs, the service remains highly regarded by GPs and by patients and the referrals continue to rise. 3.Maintaining a responsive high quality electronic-based Cardiology Outreach service (via Anglia Ice) supporting MAU in particular but also providing Cardiology input to the wider hospital. 4.100% compliance with post-acute coronary syndrome (ACS) secondary prevention therapies (MINAP audit 2011) September 2011 5.Introduction of a hyper-acute ACS pathway (direct transfer from ED to UCLH Heart Attack Centre for high risk ACS patients) 6.Community Based Anticoagulant and Stroke Prevention services in North Central London The service has continued to develop

	progressively with over 1,500 patients being managed in the community across PCTs. We have helped Islington develop several community sites in 2011 with our highly regarded educational programme of knowledge based and experiential content. The Clinical Governance Board oversees the dimensions of quality. The service has shown itself to be demonstrably safe and is well regarded by patients, commissioners and anticoagulant practitioners 7.Inpatient HF care is guideline supported shared care (between the admitting physician and the HF team) across the hospital aimed at all patients admitted with heart failure including frequent Consultant led Heart Failure ward rounds, and a weekly MDT. This translates into a high standard of care with >95% patients having undergone echocardiography and electrocardiography at discharge* and excellent prescribing rates for beta-blockers (>90%)*, angiotensin converting enzyme inhibitors (>95%)* and aldosterone inhibitors (>70%)*. These figures exceed all the North Central London Targets. The inpatient mortality for those admitted with CCF is consistently lower than expected, with SHIMI reporting inpatient CCF deaths as 78% of those expected. 8.The National HF Audit data suggest the quality of inpatient care determines immediate, 30 day and annual mortality rates. Whittington figures are consistently lower than the mean national figures: the inpatient mortality is 5.8% (against National 9.8%), 30 day mortality is 7.2% (against National 11%), 1 year mortality 22.3% (against National 30.7%) and the 2 year comparator is 23% (against National 33.7%). * Data source National Heart Failure Target 9.Community based Cardiac Rehabilitation classes that include a gym based fast service for those wishing to return to work for younger and more active patients, and a community based group based rehabilitation program that is inclusive or more complex patients. The latter incorporates upwards of 40% heart failure patients (nationally the figure is below 10%, often <5%). All patients are entered in the National Rehabilitation Audit and Whittington Care Rehabilitation consistently achieves and exceeds all National targets.
Suggested areas for improvement 2012/13	1. We aim to demonstrate a further improvement in our services in the 2012 Customer Excellence annual health check 2.Maintaining quality standards for heart failure inpatient care and diagnostics: 3.Aim for compliance with NICE HF Quality Standards (2011) with emphasis on two week response with a local (Whittington) service for those identified as high risk referrals, maintaining inpatient standards, including early Consultant assessment and current prescribing patterns, and introduce 2 week review for all following hospitalization with HF (NICE Quality standard 2011). 4.Improve compliance with NICE guidelines for management of Transient loss of Consciousness in Adults and Young People

	focusing on initial assessment, appropriate cardiovascular referral and appropriate cardiac investigation (Echo, 24 tapes, Tilt-tests and Carotid Sinus Massage) 5.We will encompass in 2012 the new atrial fibrillation (AF) services which are being led nationally and in London. Our current anticoagulation and stroke preventions services will be further developed together with suitable education and electronic advisory system support (HeartBeat) which is a module in an Electronic Health Record (EHR). The clinical information and advisory system crosses the NHS boundaries. The intent will be to offer and support a "Stroke Prevention Service" which encompasses AF and anticoagulation. 6.We will also be developing our Clinical Governance Board, building on our experience with anticoagulation, so that it will also encompass AF. .

Care of Older People

Quality achievements 2010/11	1. Introduced new integrated Parkinson's outpatient clinic with neurology 2. Piloted daily consultant review of all patients leading to improved clinical care and reducing unnecessary delays in investigations, treatment and ongoing care 3. Established a programme for scrutinising any death under COOP care and feeding back lessons learnt to the whole team to continually improve the service
Areas for improvement/achievements 2011/12	1. To develop a care pathway for complex elderly patients based on a consultant-led service that is fully integrated with community services. IN DEVELOPMENT AS PART OIF AMBULATORY CARE SERVICE, WILL BE READY BY MAY 2. To strengthen multi-disciplinary working for all new elderly patient admissions to ensure that their needs are identified and met early on. THERAPY REORGANISATION UNDERWAY TO BUILD ON SIGNIFICANT PROGRESS MADE SO FAR 3. To take an active role in developing and delivering dementia and falls strategies across COOP service. FALLS TRAINING ROLLED OUT ACROSS ALL WARDS. DEMENTIA TRAINING AND AWARENESS PROGRAMME IN PROGRESS 4. To continue to develop Advanced Care Planning to improve patient involvement in decision making. DEVELOPED LOCAL EXPERTISE< TRAINING

	MATERIAL AND AUDIT SHOWING IMPROVED PRACTICE BUT STILL MASSIVE CHALLENGE: LOTS OF PATIENTS WITH ACP NEEDS> PRIORITY IS TO FIND WAY OF WORKING TO ADDRESS NEED WITH GPS> 5. We have now got falls awareness training up and running and risk assessments and falls care plans are now been done on all adult medical wards. We are feeding back regularly to wards and have take part in the pilot PCP audit of falls in care settings and plan to do regular audits as part of visual leadership programme
Suggested Areas for improvement 2012/13	1. Improve care of older people with fractured neck of femur in line with NICE and other guidelines aiming to increase orthogeriatric input and improve care and reduce LOS 2. Improve Care of older people requiring surgery in line with NCEPOD recommendations 3. Aim to Reduce in-patient falls by 25%

Community Dental

Quality achievements 2011/12	1. Dental Services have achieved consistently high scores for measures of patient experience. For example, across all community dental services, 93% of patients said they were involved in their treatment as much as they wanted to be. Also this year 96% of patients surveyed at our Urgent Dental Service said they would recommend the service to friends and family (4,000 patients attend this service each year). 87% of patients rated the Islington and Haringey services as excellent and the remaining 13% rated them as good, 0% gave a poor rating. 76% of patients rated the Camden service as excellent, 20% good, 3% fair and 1% poor. 100% of patients at HMP Holloway seen by the service rated it as excellent. 99% of patients accessing the Urgent Dental Service rated it as excellent or good, 1% as poor. (against an SLA target of 75% satisfaction) 2. We worked with a number of community groups to improve access to dental care for Learning Disabled adults by making information and referral pathways more appropriate to this group. The result was a new service brochure, which is now accessible on the Whittington

	Health website. Learning disabled users also attended staff training events to tell dentists how their approach to patient care could be improved this was facilitated by Photosymbols, national group specialising in this area. It was commended by NHS London an example of good practice in this area. 3. We developed an Oral Health improvement programme for Older People in nursing homes across Islington and Enfield. This involved training staff to assess the dental needs of their residents, undertake measures to improve oral health including additional fluoride therapy, and arrange for referral to dental services when necessary. The programme has resulted in a measurable increase in access to dental care for residents. 4. In Enfield we established a Parent Dental Advocate training program for parents attending Children's Centres in deprived areas of Enfield. A similar programme titled "Tiny Teeth" targeted under 5s in Haringey, with the aim of raising awareness of oral health in deprived areas, was also established 5. Dental Services won the contract in Islington for providing a Fluoride Varnish Programme in schools and Children's Centres. Islington has one of the highest levels of child tooth decay in London and stark inequalities exist across the borough. Fluoride varnish is proven to be a safe and effective way of preventing tooth decay and reducing inequalities. This year, as part of the programme, we have provided 9,000 fluoride applications to children in the borough.
Areas for improvement 2012/2013	We shall continue to focus on the provision of safe, effective dental care that delivers excellent patient experience. We shall also continue to listen to our local communities for ideas on how we can make improvements to our services. In addition to building on last year's objectives we also plan : 1. To expand our Paediatric Referral scheme across Haringey and Enfield whereby young children with high rates of decay are referred for specialist management in our dental services, thus providing 'Care Closer to Home' and avoiding secondary care activity. 2. To further develop sedation services for patients with special care needs across Haringey and Enfield to reduce the need for General Anaesthetics for dental treatment and to ensure 'Care Closer to Home'.

	3. To improve the quality of dental care for children in Islington by working with our local partners in general dental practice and supporting them with specialist advice, skills and health promotion resources.

Critical Care

Quality achievements 2010/11	1. The outcomes of critical care are assessed as part of an independent national audit called ICNARC. Our critical care unit was rated as one of the top in the country. This was based on the critical care standardised mortality, adjusted for patient risk. Our score was 0.65, which means that the chance of our patients surviving is almost 50% higher than that expected for those types of patients.

Diabetes and Endocrinology

Quality achievements 2010/11	1. Selected to continue into Phase 2 of the Health Foundation's Co-creating Health (CCH) initiative, a national demonstration programme to embed self-management support in health care services. 2. As part of CCH, established clinician training in consultation skills (Advanced Development Programme – ADP) to support patient self-management (feedback excellent – 93% participants implemented ADP skills into daily practice). 3. As part of CCH, established a patient Self-Management Programme for type 2 diabetes (feedback excellent – rated 10/10 by participants). 4. As part of CCH, implemented a service improvement programme in diabetes and endocrinology clinics. This included designing self-management support tools for patients (agenda setting sheets, confidence ruler) and working with the Business Improvement Team to improve the overall patient experience. 5. Written and updated several guidelines for diabetes care both in hospital and in the community (e.g. diabetes and day surgery, diabetic emergencies, insulin infusion). 6. Continued focus on providing excellent patient care, achieving diabetes health targets similar to or better than national QOF data. 7. Continued focus on providing excellent care to patients with diabetes and very complex medical needs, including those with chronic kidney disease, thalassaemia major, foot ulceration and pregnant women with diabetes. For example,

	in 2010, patients in our diabetes thalassaemia clinic achieved better clinical outcome markers (HbA1c, blood pressure, cholesterol) than the national diabetes audit data. 8. Ongoing expansion of the insulin pump service with 5% of our patients with type 1 diabetes now using this treatment. The Whittington was one of three sites participating in a national NHS project to improve uptake of insulin pump therapy, resulting in the launch in late 2010 of an NHS guide to implementation of this technology.
Areas for improvement 2011/12	1. Working within the new Integrated Care Organisation to further enhance care across primary/secondary care boundaries. We are working closely with local GP commissioners in Haringey and Islington to support an integrated care model for patients with diabetes. The underlying ethos aims to encourage self-management both by direct educational work with patients as well as supporting primary care to embed a self-management approach in routine practice. Part of this work is looking at the use of different financial mechanisms of commissioning such as bundled tariffs, which are more appropriate for management of long term conditions. 2. Continuing to provide high quality, patient-centred care. a. National Diabetes Audits published in 2011 have shown annual amputation rate for people with diabetes in Islington and Haringey are below the national average. This is a vast improvement from previous national data for Islington from 2003/4. b. Local audits regarding care for women with prepregnancy diabetes during 2005-10 have shown outcomes are better than national averages reported by CEMACH. c. Yearly local audits regarding admissions with Diabetic Emergencies have shown year on year improvements in adherence to national guidance & continued good outcome data. d. We contributed to the National Diabetes Audit, which defined a bundle of diabetes care, made up of 9 key processes. Nationally only 50% of patients with diabetes receive all 9 care processes. We do not have access to eye screening data, so this had to be excluded. But for the remaining 8 elements, we found that 77% of our Whittington patients with diabetes received all the key care processes, better than both the national average and the highest performing PCT (Gateshead - 68%). e. The numbers of patients with Type 1 diabetes treated with Continuous Subcutaneous Insulin Infusion (insulin pump therapy) in line with 2008 NICE guidance has increased year on year, from 2.5 % in March 2010 to 4.8% in March 2011 and to 7.5% in Feb 2012. Preliminary audit results for patients who have been using this treatment for at least one year show an average fall in HbA1c of 0.8% in the first year, despite a significant reduction in problematic hypoglycaemia. 3. Continue to encourage and implement improvement projects within the Multidisciplinary Diabetes Team to support patient self-management. We have continued our Co-creating Health project, embedding self-management support into local healthcare services for people with a longterm condition. We have been

	spreading this initiative from diabetes into other conditions, including respiratory medicine and musculoskeletal pain. We are currently working with primary care, to enable whole practices to have training in and take part in the Co-creating Health model. The high quality of this work was recognised by our local Co-creating Health team being awarded a national Quality in Care Gold Award for Diabetes in November 2011, for Best Initiative Supporting Self-Care.
Suggested Areas for improvement 2012/13	1 1.Working within the new Integrated Care Organisation to further enhance care across primary/secondary care boundaries. (Establishing the Diabetes Specialist Nurses across Whittington Health as a coherent team, providing seamless care for the local population, with consultant level clinical governance.) 2. Continuing to provide high quality, patient-centred care. (Continue to update and publish diabetes care guidelines; continue to contribute to national diabetes audits and to complete and continue local diabetes care audits; further establish links with national diabetes care initiatives, including joining the newly forming insulin pump network.) 3. Continue to encourage and implement improvement projects within the Multidisciplinary Diabetes Team to support patient self-management. (Run and evaluate Co-creating Health in 3 GP practices in Islington; establish funding mechanisms to sustain the Co-creating Health initiative; establish Quality Assurance for Co-creating Health clinician training, by building on links with University College London.) 2 3

Emergency Medicine

Quality achievements 2010/11	1. Achievement of the Department of Health ED four hour Performance Standard 2. Introduction of regular medical , nursing and bed management rounds in the Emergency Department to ensure safe and streamlined patient flow 3. Development of an Urgent Care Centre for patients with Primary Care conditions & minor injuries 4. Review of ED patients using same day imaging reporting for Emergency Department patients 09.00-17.00 Monday to Friday 5. Introduction of an electronic process for checking of X Ray reports for films performed after hours and at weekends 6. Streamlining of pathways for management and referral of patients with trauma as part of the North East London & Essex Trauma Network 7. Introduction of streamlined patient care pathways within Isis ward (Clinical Decision Unit) 8. VTE assessment for >80% of ED patients admitted via Isis ward

Areas for improvement 2011/12	1. Implementation of the new Department of Health Performance Indicators for Emergency Departments. ongoing progress to achieve targets 2. Development of nursing leadership model to support changes required to implement and meet quality indicators nursing consultation undertaken with change to roles and responsibilities of senior nurses; creation of post for ED Deputy Matron 3. Improve availability of real time departmental information in order to assist with the implementation of the performance indicators and to capture information around patient and staff experience improvement in daily breach report analysis; dissemination of information across relevant specialties 4. Development of pathways for the use of non invasive ventilation within the Emergency Department– NIV machine now in department; programme of staff training ongoing 5. Further develop relationship between ED and inpatient teams to streamline care of the unscheduled patient presenting to the Whittington development of Ambulatory Emergency Care Pathways to streamline care of patients not requiring admission
Suggested Areas for improvement 2012/13	1) Successful Achievement of Department of Health Four Hour Performance standard 2) Ongoing work to achieve Emergency Department Quality Indicators 2) Implementation of seven day EM Consultant working providing Consultant shop floor presence 0800-2000 weekdays & 1200-2000 weekends. 3) Multidisciplinary rounds in the ED three times a day to optimise patient care and streamline patient flow 4) Further development of diagnosis specific pathways for patients being managed in Isis ward. 5) VTE assessment for >80% of ED patients admitted via Isis ward 6) Development of pathway for fast track admission from ED to Mary Seacole for patients requiring admission 7) Development of Ambulatory Care pathways for patients not requiring hospital admission e. g DVT / cellulitis 8) Development of Internal Professional Standards to optimise multidisciplinary team working 9) Developing closer relationships with Community teams to reduce unnecessary admissions and provide care at home where possible 10) Improved information provided to patients with information boards in the ED waiting areas and information about performance against Quality Indicators provided on Trust website and updated regularly

Gastroenterology*

Quality achievements 2010/11	1. Introduction of twice weekly Endoscopic Retrograde Cholangiopancreatography Service October 2010 2. Extension of Straight to Test Colonoscopy for patients with significant lower GI symptoms (in addition to suspected Colorectal Cancer) 3. Extension of Telephone Follow Up Clinic for GI and post-endoscopy patients June 2010 4. Introduction of monthly Dietetic Service for Inflammatory Bowel Disease patients 5. Introduction of gastroscopy-specific patient information leaflet
Areas for improvement 2011	1. Increase endoscopy capacity by opening a third endoscopy room 2. Carry out a regular patient satisfaction survey for endoscopy and outpatients
Suggested Areas for improvement 2012/13	1 2 3

Imaging

Quality achievement(s) during 2010-11	1. Introduction of same day imaging reports for the Emergency Department patients on week days between 09.00 – 17.00 2. Weekend MRI scans now been carried out to reduce outpatient waiting times, and ensure the MRI Scanner asset is used more fully 3. Introduction of radiologist led breast clinic for women under 35, with high level of patient satisfaction Use of Surgical Safety check list for interventional imaging 5. Introduction of emergency interventional imaging 24/7 for life threatening bleeding
Areas for improvement during 2011-12	1. Extend same day imaging reporting for the Emergency Department to weekends as well as week days 2. Improve the efficiency of in-patient transfers to and from the Imaging Department to save patients waiting and improve productivity
Suggested Areas for improvement 2012/13	1 2 3

Infection Prevention and Control

Quality achievement(s) during 2010-11	1. Achieved locally set Trust objectives for episodes of MRSA bacteraemia and *Clostridium difficile.* 2. Recognised as an exemplar in the above - visited by other trusts for advice 3. Continued to provide all trust staff with annual hand hygiene training 4. Carried out regular audits of infection prevention and control practice across the trust, developed ward performance dashboard and acted on results.
Areas for improvement during 2011-12	1. Continue to meet and if possible exceed locally set objectives for MRSA bacteraemia, Clostridium difficile and Surgical site infection rates in Orthopaedic surgery. 2. Implement mandatory surveillance of MSSA Bacteraemia and *E.coli* in accordance with DH guidance 3. Embed audits of practice into local work programmes to ensure continued improvement in HCAI rates as measured by national survey.
Suggested Areas for improvement 2012/13	1. Develop ICO divisional reporting of IPC related issues such as HCAI rates, audit and training of staff. 2. Develop ICO E.coli bloodstream project with an aim to reducing E.coli bloodstream infection rates through Root cause analysis investigations. 3. Move from mandatory IPC training for all to bespoke practical Infection prevention training for staff supplemented by mandatory E-learning based IPC training.

Maternity and Women's Health

Quality achievements 2010/11	1. Increase to 60 hours consultant presence on Labour ward birthing unit 2. Expansion of antenatal clinic 3. Introduction of daily consultant ward rounds on maternity unit 4. Women's Diagnostic Unit open every day from 08.00 – 20.00 5. Implementation of Badger maternity IT system
Areas for improvement/achievements 2011/12	1. Have increased consultant presence on Labour Ward to 80 hrs 2. Working to obtain 40 hr consultant presence on WDU (gynaecological emergency unit) 3. Patient survey- have a reduction in the number of complaints 4. Have expanded Hornsey Rise community clinics in

	gynaecology 5. Gynaecology new patient to follow up ratio is much better 6. About to have clinical negligence scheme for Trusts, level 2 inspection 7. Numerous methods of PPI have been engaged across a variety of community settings. 8. Labour ward forum has users and Neonatal unit undertakes ongoing survey's of parents 9.The maternity service liaison committee (MSLC) was reviewed in 2011 resulting in 2 successful public meetings where women came to discuss their views and opinions of the service This highlighted a need for Jewish patients and as a result a new community ante natal clinic for Jewish women was established and has proved to be very successful and well received 10.Shabbos Room was open in 2011 for any family to use who have relatives in the hospital – this is used regularly 2-3 /week
Suggested Areas for improvement 2012/13	1. Daily elective LSCS lists separate from labour ward in main theatre 2. More consistent daily ward rounds on antenatal and postnatal wards 3. Improve environment on postnatal ward 4. Enhanced recovery program in gynaecology.. 5. Reduce the amount of agency staff used in maternity 6. Developing outpatient Hysteroscopy services 7. Improving pathways for gynae and sexual health patients 8. Reducing caesarean section rate and normalising birth 9. Family Nurse Partnership 10.See 90% of women before the 12+6 week of pregnancy. 11.Maintain 100% target of supporting women 1:1 in labour. 12. Role out of patient screens in all maternity wards 13. Support to produce comprehensive report collating all the different information and ensure we act on it and share learning

Michael Palin Centre for Stammering Children

Quality achievements 2010/11	1.
Achievements 2011/12	International research publications and an international reputation as experts in in the field Continuing research into stammering and the impact on the individual and the family. Two television programs focussing on stammering, one of which was nominated for a BAFTA, the other which resulted in funding and a visit to the House of Commons (more details on their way)
Suggested Areas for improvement 2012/13	

Oncology

Quality achievements 2010/11	1. Awarded Oncology team of the year by British Oncology Association & Pfizer for the Acute Oncology Service 2. Considered a Beacon site for the Acute Oncology service with several trusts and cancer networks visiting our Model of care 3. Developed a "live" alert to notify the acute oncology team of the arrival of a patient with febrile neutropenia to ED 4. Introduced an electronic data capture for MDT recording starting with a successful pilot in the GI MDT
Areas for improvement 2011/12	1. Roll out electronic data capture to all cancer specific MDTs across the Trust 2. Develop a robust cover system for the Oncology consultant 3. Appoint a dedicated CNS for the acute oncology team 4. Improve the out-patient experience for known cancer patients 5. Improve the waiting times for patients attending chemotherapy unit 6. Achievements: Upper GI , Lower GI , Lung & Breast MDT members are using ICE to put cases on MDT. Urology, Dermatology & Gynaecology being set up. 7. Achievement: Acute Oncology nurse appointed in April 2011. 8. Further develop the lymphoedema services clinical outcomes measures with a focus on pain management and improvement.
Suggested Areas for improvement 2012/13	1. Develop a drop in –service 9-5 for patients on chemo to avoid ED attendance 2. Develop a 24/7 mobile phone service for all patients on chemotherapy 3. To work with new Cancer lead nurse to develop a robust education programme for all nursing staff to manage the acutely admitted patient with cancer

	4. Improve OPA area for patients with cancer

Paediatrics

Quality achievements 2010/11	Peer review in 2010 1. Paediatric Sickle Cell Services (jointly with UCLH) *rated excellent* 2. Paediatric Oncology Shared Care Unit multidisciplinary team was rated 81.8% and the unit itself at 95.9% *by an external validator* 3. Paediatric HDU paper validation exercise 4. Safeguarding SITT *'Good, in danger of being too good, needs more evidence* & Ofsted 5. NICU Neonatal Toolkit *meets 80% of standards* 6. PMETB survey *best training department in London for paediatrics* second year running and o*ne of the top large training units in the UK*
Areas for improvement 2011/12	1. Successful Integration of Child Health Services in Islington & Haringey into Whittington Health ICO. Maintaining safeguarding 2. To become the leading team in provision of postgraduate training in sector (NCL) 3. Benchmarking for outcomes in General Paediatric conditions 4. To further improve Neonatal performance and meet all of Neonatal toolkit standards 5. To 'export' the children's allergy services, that can be safely managed in primary care, back into local community settings **6.** To further develop the Simmonds House Your Welcome information pack with the young people who use the services to ensure that the information for young people and their families is accessible.
Suggested Areas for improvement 2012/13	1 Reduce admissions of children to Ifor ward and increase ambulatory unit use and community referrals (10%reduction of workforce required for Ifor Ward) 2. Introduction of referral management for acute paediatric referrals. establishing nurse led triage of referrals and nurse practitioner led clinics 3. Establishment of bundle tariff for asthma/wheezy child pathway across hospital and community services. This will enable the transformation of patient experience for a chid and family. Promoting earlier parental management and care referred bask to primary care. 4.LOS reduction on NNU by minimum of five days, improving the family experience and minimising the effects of hospitalisation on the baby and family. 5.Joint project with Maternity to achieve a reduced LOS on the post natal wards by ensuring timely new born back checks through a new pathway using midwifery and neonatal staff. 6. Review the transitional care service for babies on the post natal wards so improve the standard of this care for families

Palliative care

Quality achievements 2010/11	1. Developed draft strategy for Whittington in response to National end of Life Care Programme 2. Implemented Version 12 National End of Life Pathway. 75% of patients referred to the palliative care team who die in hospital are on the EOL care pathway at time of death. 3. Implemented Anglia ICE as portal for Making referral to inpatient palliative care team Ordering End of Life pathway Ordering referral form for community palliative care teams 4. 4th annual palliative care patient satisfaction survey – rated good/very good/excellent by 100% of respondents in all relevant domains. This reflects a steady improvement over past 4 years (from a high baseline). 5. Collaborated with Network and Trust colleagues in introducing Advance Care Planning policy and documents to the Trust 6. Collaborated in the development of Advance Care training package 7. Facilitated in the acquisition of funds for refurbishment of the mortuary viewing areas 8. 2010 Bereavement audit demonstrates compliance with NICE standards 9. 2010 Time to respond audit 96% of referrals are responded to on same day. 93% seen within 24 hours of referral (82% on the same day) 10. Reduction in %deaths in hospital (for patients referred to the team) from 39% in 2007/8 to 28% in 2009/10
Areas for improvement/ development 2011/12	1. Following a year of working at 50% of nursing establishment, Recruit Band 7 CNS to team and ensure that establishment 100% 2. National end of life audit in progress (April –July 2011) – aim to improve on good performance in last audit. 3. Purchase of NPSA compliant syringe drivers 4. Education across acute/community settings utilising the opportunities presented by the ICO In particular Emergency department liaison & training to facilitate patient choice and avoid unnecessary admissions Roll out ACP training across Whittington Health 5. Integration of hospital and community teams in the context of the ICO 6. Send Gold Standards Framework reminder letter and any documented advance care planning (informal and formal) to GP when patient discharged 7. Achievement: communicating with relatives and carers - which was highlighted in the **national press** we are 99% compliant. 8. Achievement: Anticipatory prescribing for the 5 key symptoms : Whitt 100% (National median 83% IQR 73-92%) 9. Communication with relatives/carers: Whitt 99% (National median

	71% IQR 65-80%) 10. Achievement: Ongoing routine assessment Whitt 93% (National median 76% IQR 69-84%) 11. Achievement: Compliance with completion of Whitt 99% (National median 67% IQR 59-76%) 12. Achievement: length of time that EOLP has been in use in hosptial Whitt 84 months (National median 60 IQR 44-84) 13. Achievement: Total percentage of wards estimated to be using EOLP Whitt 100% (National median 90%) 14. Achievement: total percentage of deaths supported by an End Of Life Pathway: Whitt 37%. (National median 29%) .NB past 3 months average of 53% of all deaths are on EOLP following appointment of full establishment and linking of EOLP to ICE - so way above the national median 15.
Suggested Areas for improvement 2012/13	1 Access to information relating to death and dying 2 Access to specialist pall care services 3 Care of dying continuing education 4 Clinical provision/protocols promoting patient privacy dignity and respect

Pathology

Quality achievement(s) during 2010-11	1. External Inspections: ➢ Histopathology and Microbiology have achieved Clinical Pathology Accreditation (CPA), an external assessment that ensures our pathology department operates safely and follows all relevant guidance ➢ The Human Tissue Authority (HTA) inspection accredited our service with no conditions 2. We achieved the national target of 14 days turn around time to carry out cervical screening, by using "lean methodology" 3. Successfully piloted electronic requesting and reporting of tests results for our GPs, this speeding up the process and enabling patients to be diagnosed more quickly 4. Responded rapidly in 35 cases where patients had large bleeds that required blood transfusions urgently
Area for improvement during 2011-12	1. We will continue to work at improving the quality of patient data received, including developing further electronic requesting and links to laboratories at the Royal Free Hospital 2. We will merge our biochemistry, haematology and serology labs to form one united Blood Sciences Laboratory 3. We will implement the use of one, standardised blood glucose meter across the Trust. This will reduce the reduce of staff making mistakes caused by using different meters in different areas 4. We will work to achieve "point of care" testing accreditation, which means that tests carried out at the patient's bedside will be safer 5. We will improve reporting turn around times in histopathology by

	adopting "lean methodology" 6. We will implement HPV testing in cervical cytology in accordance with national guidance 7. Achievements: 87% of GPs were either very satisfied or satisfied with the direct access service as a whole, 13% were neutral and no GPs reported being unsatisfied or very unsatisfied97% of GPs were either very satisfied or satisfied with the Biochemistry service, 3% were neutral and no GPs reported being unsatisfied or very unsatisfied 8. 96% of GPs were either very satisfied or satisfied with the Haematology service, 4% were neutral and no GPs reported being unsatisfied or very unsatisfied 9. 88% of GPs were either very satisfied or satisfied with the Histology service, 12% were neutral and no GPs reported being unsatisfied or very unsatisfied 10. 95% of GPs were either very satisfied or satisfied with the Microbiology service, 5% were neutral and no GPs reported being unsatisfied or very unsatisfied
Suggested Areas for improvement 2012/13	1 2 3

Pharmacy

Quality achievement(s) during 2010-11	1. Helped improve the discharge process by introducing pharmacists transcribing of "to take away" prescriptions 2. Introduced ward based dispensing, which speeded up receipt of drugs to a ward and therefore to the patient, and provided patients with information and advice on their medication 3. Both the above helped reduce prescribing errors from 12% to less than 1 % 4. Stated work to roll out electronic prescribing – see below
Areas for improvement during 2011-12	1. To roll out electronic prescribing across the Trust, in order to provide the following benefits: - ➢ Prescribers accurately and clearly enter medication orders ➢ System identifies relevant patient details, e.g. drug allergies ➢ Prescription data is stored safely and cannot get lost ➢ The nurses who administer medicines have clear, easy to read prescriptions, thus reducing errors Electronic prescribing for discharge medicines was implemented in January

	2012. The roll out for electronic inpatient prescribing and administration starts in March 2012.
Suggested Areas for improvement 2012/13	1 Outpatients. We have won a bid with the design council to look at way improving the patient experience in outpatients – improve waiting, the environment, access to information and signposting to health promotion. 2 Roll out of electronic prescribing and administration across inpatients and outpatients to improve safety. 3 Support patients in optimising their medications with pharmacists working with social services, supporting patients at home on their discharge, working with the diabetic patients and those with musculoskeletal disorders in the community.

Respiratory

1. Quality achievements 2010/11	1.Use of the Surgical Safety checklist for bronchoscopy 2. Good data completeness in National Lung Cancer Audit and 90% compliance in recent peer review 3. Introduced oxygen section on prescription charts and audit shows 95% of Whittington patients have a prescription within the correct target range (46% nationally) 4. Community Respiratory Service team continuing to save bed days 5. Patient specific protocols in use by London Ambulance Service for 90 Whittington patients with chronic respiratory failure, preventing over oxygenation 6. Achieved London targets for completion TB therapy 7. Ward based non-invasive ventilation service for patients with acute exacerbations of COPD resulted in excellent outcomes – hospital mortality down to 12% and ITU admissions avoided in 93% of patients 8. Excellent access for patients with possible lung cancer against the 2 week target
Areas for improvement 2011/12	1. Improve number of patients who have lung cancer nurse specialist present when given their diagnosis 2. Availability of post discharge pulmonary rehabilitation 3. Ensuring patients admitted with COPD have **all** had best value interventions i.e. smoking cessation and offer of pulmonary rehabilitation 4. Continue to reduce over-oxygenation of emergency admissions with type 2 respiratory failure 5. Establish ultrasound guided pleural aspiration and chest drain insertion service 6. COPD mortality 3% at 90 days compared to 9.9% nationally 2010 ERS Audit. 7. Contribution to integrated respiratory care: NHS Islington COPD LES 2010-11 won the 2011 national IMPRESS award 'Increasing high value services and reducing low value services' 8. COPD Discharge bundle introduced October 2011 9. Contribution to safer oxygen prescribing and use with pharmacy and

	London Ambulance Service (LAS): 77% oxygen now prescribed; when prescribed target range always used and 94% patients receiving oxygen within the target range. 97% of patients with COPD now receive controlled oxygen and >100 patients with chronic respiratory failure have a patient specific protocol (PSP) so they receive only controlled oxygen during hospital transfer by the LAS.
Suggested Areas for improvement 2012/13	1. Evidence based quit smoking interventions offered to all adult respiratory patients admitted to the Whittington who smoke i.e. pharmacotherapy/NRT and referral to quit smoking service in particular COPD and asthma (currently 69-75% for patients with COPD). 2. Pulmonary rehabilitation offered to all patients admitted and eligible with COPD (currently 79%) 3. Work with ED to reduce delivery of excess oxygen to patients with COPD in ED (currently 11%).

Surgery

Quality achievements 2010/11	1. WHO Surgical safety check list for elective and emergency operation 2. Consultant led pre assessment clinic for high risk patients requiring elective operation 3. Use of cardiopulmonary exercise testing for all complex major surgery 4. Daily Surgical handover for Emergency and Elective inpatients. Real time updating of patients conditions on surgical handover database. 5. ITU mortality reduced and ranked in the top 10% best performing units in the country 6. All elective colorectal patients managed on Enhanced Recovery Pathway 7. No deaths for all elective colorectal operations in 2010
Areas for improvement 2011/12 Achievements	1. Rolling out enhanced recovery pathway for orthopaedic elective operations 2. develop a surgical assessment unit 3. Reducing surgical site infections(SSI) 4.Pager system was introduced for clinic 4A patients (November 2012) 5.Head of Nursing is producing information booklets (e-version and hard copy) for the top 20 procedures initially with the clinical nurse specialist leads (completion January 2012) 6.All clinical nurse specialists have been issued with Trust mobile phones and business cards so that there is a clear contact route for all patients through to the CNS lead (mobile phones introduced & business cards issues from 7.All clinic staff have undertaken "The Clinic" customer care training module in 2011. 8.Head of Nursing has led on some local audits and "mystery shopper" spot checks of all CNS contact details and ease of access (cancer and non-cancer

	clinics) throughout October and November 2011
Suggested Areas for improvement 2012/13	1. Outpatient experience: specifically patient experience in outpatients (clinic 4a particular outlier) and cancer service patient experience as confirmed by net promoter scores, cancer survey and peer review feedback 2 Improve quality of patient information provided for surgical procedures- as confirmed by patient feedback, local audit of available information 3.Public and Patient Involvement: To increase the level of engagement in order to maximise the benefits associated with greater PPI 4. Improve fractured neck of femur pathway: To upper quartile. 5. Increase Consultant presence: Currently daily consultant input but needs to meet the requirements which will be set out by NHS London requiring us to have 12/7 coverage in acute services. 6. Improve timely access to call centre to change appointments. This work is being developed further now alongside the UNIPART programme to further define and improve the appointments process, which generate a large proportion of complaints. 7.Ensure high quality assistance in bariatric surgical procedures through use of two consultant operating 8Improve risk stratification in bariatric patients 9. Move all bariatric surgical lists to earlier in the week. 10. Improve cleanliness and Hand Hygiene on wards scoring below the 95% target. 12 Reduce pressure ulcers. Introduction of Safe rounds, including changing the patient's position, if required, during the two hourly review. 13.. improve VTE screening rates for patients admitting non-electively onto wards 14. Implementation of weekly local audits of compliance in terms of the "red tray initiative" identifying patients with increased nutritional and feeding requirements. 15. Reduction of falls: Starting January 2012 all wards will be assessed against the number of completed falls risk assessments within the division. 16. Deteriorating patient project. This is an enhanced quality and patient safety project aimed at reducing avoidable in-patient deaths by 50%. 17. Re-launch of the productive ward series. 18.Development of patient pathway for Bariatric surgery. 19.increase patient and public involvement in Endoscopy 20. Business case for additional surgical and imaging capacity (breast tumour site) to reduce overbooking and increase consultation time and enable clinics every day of the week 21. Redesign of urology patient pathway 22. Reducing 30 day readmissions 23. Establishment of an ambulatory model for patients admitted for potential urological conditions in conjunction between urologists and the Emergency Department

	3

Within Community Services

Whittington Health as an integrated care provider aims to provide high quality services for the population we serve, ensuring we use tax payer's money wisely.

We also focus on innovation and improvement of services through working together and listening to patient and carers. We wish to improve outcomes for the population and intend to do this through working with partners in the delivery of services to patients and improving the pathways of care to ensure a more seamless service. The content of this contribution to the Whittington Health Quality Account 2011/12 has been endorsed by senior leaders within Whittington Health and has also been shared with a number of other partners and community forums to gain feedback on the content and the language used in the development of this account.

Partnership Working

It is vital that we work in partnership with other organisations, patients and our staff, so that good practice is shared, and feedback is listened to and acted on so that we improve.

Other organisations

In view of the work to create Whittington Health, we have obviously worked very closely with our colleagues in both NHS Haringey and Islington Community Services. We have, however, also continued to work collaboratively with colleagues in other hospitals.

We are a member of **UCL Partners**, an Academic Health Science Centre, which is dedicated to achieving better health for our population. It's aim is to harness the best of academic medicine, high class education and clinical practice to deliver significant health improvement. Examples of work undertaken are: developing a new approach to providing an integrated, improved quality cancer service; providing patients with long term conditions with more information, choice and control, so that they have a better experience and reduced hospital visits and developing a set of outcome measures to ensure patient pathways focus on what matters to patients.

Within the UCLP Quality Forum the Whittington is working with the other partner organisations on better prevention and management of deterioration of inpatients

We also work closely with our partners in **local authority social services**. Key areas where joint work is essential is in adult and children's safeguarding. Islington Social Services have a base at the Whittington Health site, making access to advice and support easy and speedy. We also work with the individual patient's borough social services to arrange patient discharges, particularly in complex cases, where support packages in the community are required.

Patients and Public

It is vital that we see patients as partners and listen to and act upon what they tell us about the services we provide. We do this in a number of ways. Firstly we use information gained from participating in national surveys. An example of this is the outpatient survey, which told us that we don't always provide patients with a good experience in this area. As a result we have set up an outpatient improvement programme, with key, measurable objectives. These are reported to our Patient Experience Steering Committee, which was established in September 2010 and is chaired by the assistant director of nursing and patient experience, who also attends the Quality Committee, a subcommittee of the board so there is "ward to board" information on progress. As national surveys like these are only undertaken annually, however, we need to have much more frequent feedback from our patients. This is why we use feedback kiosks in key areas, such as outpatients and the Emergency Department, and hand held patient experience tracking devices on all the wards. They include five key questions and a comments field. This feedback is shared with the relevant staff and also presented and discussed at the Patient Experience Committee, so that we can monitor our progress in key areas, e.g. the cleanliness of the area, being involved in your care and having confidence in the nurses treating you. In 2011 we introduced 'matrons' conversations' as part of our visible leadership programme. Every six weeks senior nurses and other senior staff visit different areas to talk to patients and staff about their experience of Whittington Health and how we can improve. This information is collated and the resultant data has enabled us to focus our improvement work as a result of the themes identified.

CASSIE HAS GIVEN SOMETHING FOR US TO UPDATE THIS SECTION SS TO UPDATE
Feedback from complaints is also used to help us focus on areas where we need to improve. During 2011-12 we have improved how we present complaints reports so that we can see which areas of the hospital are being complained about and what types of subjects. For example lack of information is a common area of concern. We have therefore rethought our approach to this, and have almost completed a review of all written patient information to ensure it is up to date, accurate, written in plain English and readily available. Where patient feedback told us there was a particular information need, for example around MRSA and discharge, we have developed specific information to address this. In addition, a recent publication of the Risk Management newsletter 'CAT'S EYES' highlighted the importance of doctors and nurses writing legibly in patient notes ensuring that they are immediately identifiable. Pharmacy staff are now expected to follow this up, reporting any illegible handwriting.
Furthermore, following a number of complaints about a particular clinical ward, we have assigned a Matron to the area with an emphasis upon improved leadership. No further complaints have been received about that ward subsequently, over the most recent eight month period.

As well as patients, we also seek views from the public, particularly our governors. They provide us with a user perspective from our local population, and actively participate in a number of key forums, including Trust Board, Clinical Governance Committee and Patient Experience Committee.

Staff

Our staff also let us know about the quality of the services we provide, particularly if we get, or could get something wrong that would impact on patient safety. During the last year we have rolled out a new incident reporting system that enables staff to let us know about cases where some aspect of care has gone wrong, or had the potential to go wrong. This is done on line so that our Risk Management Team know about the incident as soon as it is logged, thus enabling appropriate action to be taken. As with complaints, this allows is to identify which areas of the hospital and what types of things we need to improve.

For over a year our Executive Team and other members of the Trust Board including LINK representatives have been carrying out Patient Safety Walkabouts. These involve visiting various wards and departments to ask staff and patients directly for their views on what can be done to improve patient safety. Resulting action plans are monitored by the Executive Committee. The Patient Safety Walkabouts are now being extended to community services.

We have also developed a "discharge alert" process, so that if the hospital sends someone home that staff in the community are concerned about, they can easily raise an alert, so we can investigate and address the issues raised.

We also have a "Whistle Blowing Policy" so that if a staff member has a concern, they can safely report it without fear of come back.

This year, for the first time we undertook a quality survey to provide an opportunity for staff to report any areas of concern and also what has gone well over the last year. We plan to develop the methodology further to ensure that we achieve a representative response rate in coming years. The initial response however was very positive, the results of which have been used to inform this quality account and has helped us identify priorities for the coming year.

Safety Alerts

The Trust receives safety alerts from national external bodies, such as the National Patient Safety Agency (NPSA), which warn us about equipment or drugs that have been shown to be faulty in other organisation, and could therefore potentially harm our patients or staff. A process is in place to ensure that these alerts are acted on, thus reducing the chance of harm.

All alerts are received and recorded by our Risk Management Team, then scrutinised by the Assistant Director of Governance who decides on the appropriate person within the trust to investigate our practice and make any necessary changes. A

designated staff member of the RM team contacts the lead/leads with the alert and deadline for the investigation/changes to be made. The chair of the Patient Safety Committee will intervene and advise the lead should there be a delay in responding.

Progress against the action points in the alerts are monitored via an overall action plan and reported to Patient Safety Committee every month and to Quality Committee twice a year CHECK CURRENT PROCEDURE ask Rekha. The Patient Safety Committee will report the alert fully implemented when all actions are completed.

Safeguarding Children

SS TO ASK JO C TO UPDATE

Whittington Health works hard to ensure that all patients, including children, are cared for in a safe, secure and caring environment. As a result a number of arrangements for safeguarding children are in place. These include:-
Whittington Health meets statutory requirements in relation to Criminal Records Bureau checks. All staff employed at the Trust undergo a CRB check prior to employment and those working with children undergo an enhanced level of assessment.
All Trust child protection policies and systems are up to date and robust and reviewed on a regular basis by the Quality Committee. THIS SECTION NEEDS TO TURN INTO GOOD ENGLISH! As the Trust has a process in place for following up children who miss outpatient appointments within any specialty to ensure that their care, and ultimately their health, is not adversely affected in any way.
A CQC/OFSTED inspection of Safeguarding Children services was conducted in the London Borough of Islington, which included Whittington Health during February 2012. The feedback showed that Whittington Health was contributing well to keeping children safe and to health outcomes for children. We are preparing for an inspection of Haringey children's services later in 2012 .
Staff undertake relevant safeguarding training and the content of training is regularly reviewed to ensure it is up to date. Since becoming an ICO we have experienced some challenges in providing assurance about the number of staff who have received appropriate safeguarding training however, this is largely a result of data quality issues which we will be working to improve in the coming year as a high priority. Integration of previously independent electronic systems to form an integrated electronic staff record have resulted in these challenges. Regardless of this, our data shows high compliance against our target of training for child protection. These figures below relate to standards in the Royal college of Paediatric child health intercollegiate document 2006. This guidance has recently been revised and the new document was
published September 2010.

- ADD THIS of all staff are up to date on level one training (target is 80%) (verified March 2011)
- ADD THIS of eligible staff are up to date on level two training (2011)
- ADD THIS of eligible staff have attended at least one level three education session within the last year (2011)

The Trust is continue to develop robust systems of recording all training

undertaken by staff utilising the Electronic Staff records. There have been additional administrative resources identified to achieve this. The Trust has named professionals who lead on issues in relation to safeguarding. They are clear about their roles, have sufficient time and receive relevant support and training to undertake their roles:

- Named nurse: full time (1wte)
- Named doctor: one designated PA per week. (Plan for further PA to be allocated in the spring to Consultant Neonatologist for safeguarding.)
- Named midwife: 0.25 wte (post holder 1 wte)

UPDATE??

The director of nursing and patient experience is the executive lead for safeguarding children, and chairs the Trust child protection committee, which reports to the (? COMMITTEE) and ultimately to the Trust board.
The Trust board takes the issue of safeguarding extremely seriously and receives an annual report on safeguarding children issues. The last annual report was presented to the board in (?), and the Board paper relating to this can be found at www.whittington.nhs.uk under "about us" and "trust board". The Trust has robust audit programme to assure the board that safeguarding systems and processes are working. This is discussed at the Local Safeguarding Children Board for Islington and Haringey, of which the director of nursing and patient experience is a member.
The Whittington has participated in Haringey Ofsted, Islington Peer Review of social care and Health and SIT visits positive feedback has been received on our services.
The next safeguarding children declaration will be presented as a integrated care organisation declaration.

Safeguarding vulnerable adults

Introduction

As Whittington Health is located in Islington, the organisation comes under the Borough of Islington's Social Services, who are our lead for adult safeguarding. Their Adult Safeguarding team have staff based at the Whittington site, provide adult safeguarding training, and we follow their policies. Having their team on site provides us with easy accessible, speedy advice and support in adult safeguarding matters.

The patients that use the Whittington Health are, however, roughly equally split between Islington and Haringey, and so we also try to ensure that we also work closely with the Borough of Haringey, and NHS Haringey on adult safeguarding issues.

Progress in 2010 -11

UPDATE THIS SECTION who??

- The terms of reference for the Whittington Health's Adults at Risk Steering Committee were updated, to ensure the membership is relevant and clear objectives have been set
- The structure of adults at risk has also been updated to ensure that the committee reports appropriately within the trust and is linked to other relevant work streams including learning disabilities, care of patients with dementia, prison healthcare, victims of violence, DOLS and mental capacity
- The Whittington Health's Safeguarding Adults Policy was updated in December 2010 to reflect the template set by the Borough Islington, which in turn is based on the pan London policy. This has been shared with NHS Haringey's Adult Safeguarding Lead, who has checked it and assured us that it also meets their requirements
- Training continues and is delivered via a number of channels including: -

    - Now included in all induction and mandatory training days (provided by Islington)
    - An e-learning package is about to go live. It is for all clinical staff, but is being aimed at FY1s and FY2s
    - The Adult Safeguarding lead from NHS Haringey is providing training for ED staff
    - It has been agreed to include LD in the audit half-days. These are for all clinical staff, but mainly attended by Drs

Next steps

With the advent of the ICO the various systems, policies and procedures that support adult safeguarding will become integrated, to provide one responsive, unified approach across the acute and community services.

National staff survey 2011

UPDATE THIS-SC TO ASK MB TO UPDATE

On the overall indicator of staff engagement, the Whittington Health was in the best 20% of all trusts of a similar type and for the question on staff recommending the trust as a place to work and for staff satisfaction, we were also in the best 20% ADD MOST RECENT RESULTS.

Who has been involved in developing this Quality Account

A cross section of individuals/teams were invited to have a say in the Quality Account, including: -

- Haringey Community Health Services* thats us isn't it?
- Islington Community Health Services *
- Local GPs
- North Middlesex University Hospital

- NHS Islington
- NHS London
- Local LINKs
- The Trust's senior medical staff, including Divisional Directors, Clinical Directors, Clinical Leads and the Medical Director
- Senior Nursing Team
- Clinical Governance Team
- General Managers
- Members of the Executive Committee, Trust Board, Divisional Boards and Clinical Governance Committee
- Patient Feedback Manager
- UCLH
- UCLP
- Royal Free NHS Trust
- Patient Governors
- Volunteers from NHS Islington

We would like to thank those that chose to contribute.

Our Quality Account in draft format was sent to our Trust Board, Non-Executive Directors and Foundation Trust Shadow Governors for review and comment. As a result of comments received, we have taken the following actions:

- The removal of the use of unnecessary jargon and acronyms;
- The removal of section numbering;
- The removal of a section of the Gastroenterology speciality progress update which referred to a 2009 service introduction.
- Further development of some of the 2009/2010 priority sections.

A number of the comments received related to the structure and length of the Quality Account. Adherence to the Department of Health recommended template precluded specific structural changes. Further advice on this issue was sought from the Department of Health which supported our decision to keep the existing format.

Statements from external stakeholders

Additionally, we asked for external stakeholder comment. Following a comment made by NHS London, an insert was added to the 'Review of Quality Performance' section, reaffirming our commitment to the patient experience.

Statements received from external stakeholders are listed below: I guess all below relate to last year – should remove before circulation and leave blank headings to prompt LINKs etc to add new

FOR UPDATE ONCE COMPLETE

NHS North Central London (Feedback submitted by Alison Pointu, Director of Quality and Safety)

TO BE ADDED

Haringey LINk Feedback submitted by Helena Kania (Haringey LINk Chair).

TO BE ADDED

Head of LINk Services (Voluntary Action Islington)

TO BE ADDED

Part 4 How to provide feedback on this Quality Account

If you would like to comment on this quality account, or have suggestions for the content of next's year's then please let us know. We can be contacted by the following means; -

Communications Office, Whittington Health, Magdala Avenue, London N19 5NF
Telephone 020 7288 5983 or communications@whittington.nhs.uk