Whittington Health NHS

Trust Board Meeting

ITEM: 09

DATE: 27 June 2012

TITLE: **Quality Account 2011/2012**

SPONSOR: Celia Ingham Clark	**REPORT FROM:** Senga Steel and Caroline Allum

PURPOSE OF REPORT: For approval

EXECUTIVE SUMMARY: Health regulation under the Health and Social Care Act mandates all NHS trusts to produce a yearly Quality Account that reports both quality achievements on an annual basis and identifies areas for quality improvement in the coming year. The attached is the final draft of the Quality Account for Whittington Health for the year 2011/2012. Consultation for this year's account included discussions and surveys with staff, commissioners and patient representatives as well as scrutiny of incidents, complaints and performance data. National priorities were also considered in the development of the 'top three' quality goals over the coming year. The Audit Commission has reviewed the account and have asked that we include a 'statement of the responsibilities of the directors' in this year's account, in order to satisfy the DOH requirements. As well as publishing a statement in our QA, approval of the trust board provides assurance that the directors have agreed the content and accuracy of the account. The Quality Account will be published on the DOH website 30th June 2012 and NHS Choices website.

PROPOSED ACTION: *Approval*

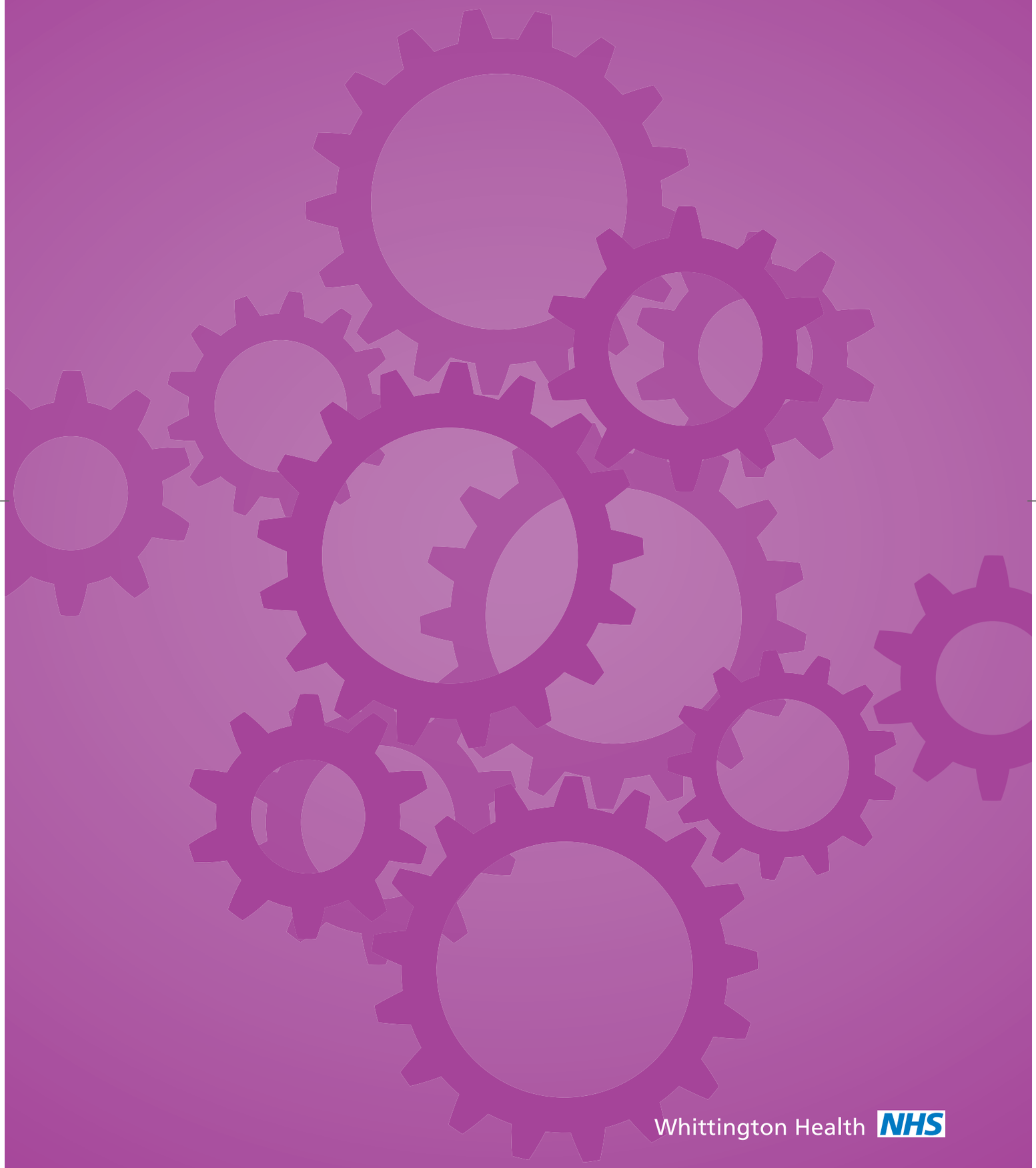
APPENDICES:

DECLARATION
In completing this report, I confirm that the implications associated with the proposed action shown above have been considered – any exceptions are reported in the Supporting Information:

Implications for the NHS Constitution, CQC registration
Financial, regulatory and legal implications of proposed action
Risk management, Annual Plan/IBP
Moving Ahead – how does this report support any of the Trust's 5 Strategic Goals

Supporting Information

Whittington Health
Quality Account 2011-2012



Whittington Health NHS

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Introduction from the Chief Executive

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 regard 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 integrated care organisation (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 provider. 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 compromising 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 Care Quality Commission (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.

Over the last year we have achieved a number of quality improvements that we are proud of. The table below briefly outlines these

Quality improvement

NHS Litigation Authority (NHSLA) level 1	Achieved February 2012
NHSLA level 2 maternity services	Achieved February 2012
MRSA bacteraemia target	Achieved
Clostridium difficile target	Achieved
18 week wait target	Achieved
Reduction in cardiac arrests	Reduced by 50 percent
Mandatory training target March 2012	70 percent of staff by
Summary Hospital Mortality Indicator (SHMI)	Lowest in the country at 67
Finalist in CHKS Quality of Care Award	May 2012

In the CHKS Quality of Care Award, the Whittington Hospital was one of only five in the country to have excelled in all the CHKS quality of care indicators.

The achievement of NHSLA level 1 for Whittington Health as a whole and level 2 for maternity services from our litigation insurers is a key measure of how safe our services are, and provides assurance 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 in 2012 and level 3 as soon as we can.

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.

Data from the NHS Information Centre website regarding the period Oct 2010-Sept 2011 shows that we had significantly low mortality for the following specific conditions:

Condition	Mortality expected	Mortality observed
Chronic obstructive pulmonary disease and bronchiectasis	29.9	19
Congested cardiac failure	37.9	23
Fractured neck of femur	15.4	11
Pneumonia	158.7	112
Septicaemia	27.6	18
Urinary tract infection	33.8	20

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:

Statement of directors' responsibilities in respect of the Quality Account

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

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

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

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

By order of the Board

NB: sign and date in any colour ink except black

Chair

Date

Chief Executive

Date

Priorities for Improvement 2012-2013

New priorities

This year, our quality account priorities were chosen as a result of a number of consultative exercises with external stakeholders, including our commissioners, patient representatives, shadow governors, and GPs as well as asking our staff and reviewing the complaints and incidents that we have received over the last year. We have chosen priorities that are important for our local community and that will have the greatest impact on the health of our local population. As an integrated care organisation, we strive to strengthen our contribution to health promotion and prevention of illness, as well as caring for people when they are unwell. Our priorities this year reflect this aspiration and we have selected quality goals that will enable us to strengthen the integration of services. The Whittington Health quality strategy, also approved this year, includes these goals as high priority areas for service improvement.

Priority One: Effective Care

- **What?**
- To ensure that smoking and alcohol cessation advice and support is available to all who need it.
- **Why?**
- 50 percent of illness is related to behaviour, and lifestyle choices such as smoking and drinking have a significant effect on long term health, on families, society and on the health economy.
- **What does success look like?**
- We want to get details of smoking and alcohol usage from 90 percent of our patients. We then want to make sure that 90 percent of patients with risk factors have a brief intervention to help them make a decision to reduce this harmful lifestyle choice. With smoking, we aim to get 15 percent of smokers to quit with appropriate help. With those who are problem drinkers, we want to alert their GP in 90 percent of cases so that we can work in partnership to reduce this risk behaviour.
- **How will we achieve this goal?**
- The introduction of the electronic patient record will enable us to measure how successful we are in giving this advise to our patients as the smoking status and other health information will form part of this record. This year, both these objectives are part of the CQUINS we have agreed with our commissioners and performance against these goals shall be monitored through our quality committee.

Priority Two: Patient Experience

- **What?**
- Improve the way we communicate and ensure that respect, dignity and compassion are at the heart of our relationships with service users.
- **Why?**
- We want every patient who accesses the services at Whittington Health to have a good experience. We want to be in the top 10 percent in the country for patient experience. We know that there are areas where we do not perform as well as we would like. Surveys of inpatients show that patients feel that nurses and doctors talk in front of patients as though they were not there. We also want patients to feel involved in decisions about treatment, communicate better, and to make sure that the right information is available for patients.
- **What does success look like?**
- We will involve patients in decisions about treatment/care. Hospital staff will be available to talk about worries/concerns; we will ensure privacy when discussing condition/treatment; we will inform patients about side effects of medication; we will inform patients of who to contact if worried about their condition after leaving hospital. We will reduce by 50 percent the percentage of patients who say that doctors or nurses talked in front of them as though they were not there.

- **How will we achieve this goal?**
- The patient experience committee will lead and oversee this work. This group, led by our director of nursing and patient experience reports to our quality committee, which is a sub-committee of the board. National patient surveys and other engagement activities will be used to measure progress against this goal.

Priority Three: Patient Safety

- **What?**
- We will reduce the number of patient falls to achieve the top 10 percent of national benchmarked data.
- **Why?**
- Patient falls are often preventable. They usually affect the most vulnerable of patients and are a cause of patient harm.
- **What does success look like?**
- We will reduce the number of falls by 25 percent on our 2010 baseline across the integrated care organisation.
- **How will we achieve this goal?**
- The number of falls is measured and monitored through our incident reporting system (datix). The number of falls is reported to our quality committee and forms part of the quality dashboard that is reviewed monthly by trust board. There is also falls prevention group that is currently leading on reducing the risk of falling of both patients at hospital and at home .

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".

Statements of assurance from the Trust Board

Review of Services

During 2011–12, the Whittington Health provided 115 NHS Services, and did not sub-contract any services. The Trust has reviewed all data available to it on the quality of care in those NHS Services.

The income generated by the NHS services reviewed in 2011–12 represents 100 percent 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, Patient Advice and Liaison Service (PALS), Litigation and local patient survey findings.

Participation in Clinical Audits 2012

During 2011-2012 **53** national audits and **8** national confidential enquiries covered NHS services that Whittington Health provides.

During 2011-2012 Whittington Health participated in **92 percent** national clinical audits and **100 percent** 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 Whittington Health participated in are listed in the table below. Audits and enquiries in which the Trust did not participate are also listed, along with the reason for not participating.

The national clinical audits and national confidential enquiries that Whittington Health 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 percent if requirement set)
Peri and Neonatal		
Neonatal intensive and special care national neonatal audit programme (NNAP)	Yes	Ongoing submissions
Maternal and Perinatal Mortalities Notifications Maternal and perinatal mortalities notification(MPMN) * replaced CEMACH as of April 2011	Yes	Ongoing submissions
National neonatal audit programme. Standardised electronic neonatal database (SEND)	Yes	Ongoing submissions
Children		
Paediatric pneumonia (British Thoracic Society)(BTS)	No – local data capture	N/A
Paediatric asthma (BTS)	Yes	29 patients
Pain management College of Emergency medicine(CEM)	Yes	50 patients
Paediatric fever (CEM)	Yes	50 patients
Childhood epilepsy Royal College of Paediatrics and Child health (RCPCH)	Yes	Ongoing
Diabetes (RCPCH) National paediatric diabetes audit (NPDA)	Yes	67 patients
Acute Care		
Emergency use of oxygen (BTS)	Yes	157
Adult community acquired pneumonia (BTS)	Yes	Ongoing audit
Non-invasive ventilation (BTS)	Local data captured	50
Pleural procedures (BTS)	Yes	29 patients
Cardiac arrest National Cardiac Arrest Audit (NCAA)	Local data captured	Ongoing submissions
Vital signs in majors (CEM)	Yes	50 patients
Severe sepsis and septic shock (CEM)	Yes	30 patients
Adult critical care (Case mix programme)	Yes	819 admissions
Potential donor audit (NHS Blood and Transplant) submissions		Yes Ongoing
Seizure management National Audit of Seizure Management in Hospitals (NASH)	Yes	30 patients
The National Review of Asthma Deaths (Feb 2012)	Yes	Ongoing audit
Long term conditions		
National Diabetes Inpatient Audit	Yes	Ongoing submissions
Heavy menstrual bleeding (RCOG)	Yes	96 patients
Chronic pain (National Pain Audit)	Yes	Ongoing submissions
Ulcerative colitis and Crohn's disease (UK IBD Audit 3 round audit)	Yes	68 patients
Parkinson's disease National Parkinson's Audit (NPA)	Yes	41 patients
COPD (BTS/Euro)	Yes	60 cases
Adult asthma	Yes	13 patients
Bronchiectasis (BTS)	No - participation planned 2012/13	N/A
National Audit of Dementia (RCP/RCGP) 2012	Yes	40 cases

Elective procedures		
Hip, knee and ankle replacements National Joint Registry (NJR) (Note: Elbow and Shoulder replacement procedures data collected from April 2012)	Yes	Ongoing submissions
Elective surgery (National Patient Reported Outcome Measures Programme)	Yes	Ongoing submissions
Cardiovascular disease		
Acute myocardial infarction and other Acute Coronary Syndrome (Myocardial ischemia National Audit Project)	Yes	Ongoing submissions
Heart failure (Heart Failure Audit)	Yes	Ongoing submissions
Renal disease		
Renal colic (CEM)	Yes	50 patients
Cancer		
Lung cancer (National Lung Cancer Audit)	Yes	Ongoing submissions
Bowel cancer (National Bowel Cancer Audit)	Yes	Approx 90 cases
Trauma		
Hip fracture (Hip Fracture Database)	Yes	Ongoing submissions
Severe trauma (Trauma Audit Research Network)	Yes	Ongoing submissions
Falls and non-hip fractures (National Falls And Bone Health Audit)	Yes	60 patients
Blood transfusion		
Bedside transfusion (National Comparative Audit Blood Transmission)	Yes	36 patients
Medical use of blood (NCABT)	Yes	24 patients
End of Life		
Care of dying in hospital (National Care of the Dying Audit in Hospitals)	Yes	33 patients
National council for palliative care minimum dataset	Yes	247 patients
Infection Control		
4 National Point Prevalence Survey on healthcare associated infection (HAI) and 1 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 audit
National audit on Psychological therapies (NHS Haringey)	Yes	One service submission (356 patients)
NHS Newborn Hearing Screening Programme Audit	Yes	209 patients
Annual audit of Dental Radiographs	Yes	80 (PCT Dental Service) 635 (Haringey and Enfield Service)

Additional

Audit of the open abdomen (NICE)	Yes	14 patients
UKOSS - United Kingdom obstetric surveillance system	Yes	Ongoing submissions
One year multi site audit project on the management of decreased conscious level in children and young people	Yes	10 patients
National study of HIV in pregnancy and childhood	Yes	4 cases
Venous Thromboembolism Risk Assessment (CQUIN)	Yes	Ongoing submissions
Global Trigger Tool Commissioning for Quality and Innovation	Yes	Ongoing submissions
National Confidential Inquiry into Suicide and Homicide by people with mental illnesses	Yes	Ongoing

- Maternal and Perinatal Mortalities Notifications (MPMN) replaced CEMACH as of April 2011. Submissions are 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
Alcohol related liver disease (ARLD)	Participated	Ongoing. 10 patients identified for study inclusion.
Subarachnoid haemorrhage (SAH)	Participated	Ongoing. 12 patients identified for study inclusion

The reports of 21 national clinical audits and national confidential enquiries were reviewed by the provider in 2011-2012 and Whittington Health 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 of the three divisions will have an agreed annual clinical audit (quality improvement) programme which will align the Division's overall audit strategy with the Trust's overall audit strategy and priorities.
- Appropriate priorities are applied to divisional programmes, and capacity is channelled where appropriate away from small ad-hoc audits to major audits vital to safety without losing flexibility or suppressing good local ideas.
- A national audit award category is included in the December 2012 staff Clinical Audit Awards

Examples of actions being taken:

National Confidential Enquiry 'Knowing the Risk' 2011

This national confidential enquiry patient death (NCEPOD) report highlights the process of care for patients aged 16 and over, who underwent inpatient surgery (both elective and emergency), and their outcome at 30 days. The report takes a critical look at areas where the care of patients might have been improved.

Actions ongoing include:

(Lead clinician: Dr A Chekairi, Consultant Anaesthetist):

- Clinical leads of each speciality including anaesthetic department to ensure that if a critical care bed is pre-operatively booked but patient is post-operatively transferred to the ward, a careful explanation must be documented
- Extend the use of cardiac output monitors in high risk cases done under regional anaesthesia (putting local anaesthesia into the area supplied by a nerve)
- Regular auditing of critical care requirement to respond to needs of high risk patients
- Audit patients with unexpectedly poor post operative outcome to improve pre-operative screening and optimisation
- Improved pre-operative optimisation from the time patient is added to operating lists and by involving dieticians pre-operatively
- Involvement of Primary care in pre-operative optimisation
- Produce information leaflets for patients

Ulcerative colitis and Crohn's disease (IBD) UK Audit third round

Whittington Health results were compared against the National Outcomes for the Organisation of Adult Inflammatory bowel disease (IBD) Services in the UK, with excellent results. Whittington Health meets most IBD Service Standards and therefore for our patients is as good as, or better than most Trusts on most audit points.

Areas for improvement include:

(Lead clinician: Dr C Onnie, Consultant Gastroenterologist)

- Development of Shared Care Guidelines with primary care
- To establish an IBD patient database
- Access to IBD Pharmacist, counselling, IBD specialist interest Rheumatology/Ophthalmology/Obstetrics
- Annual IBD service review day
- Better toilet access for IBD patients

TARN (Trauma and Research Network) data

The efficacy and quality of TARN data submissions was reviewed as part of a December 2011 assessment of Whittington Health's current position relative to the Trauma Unit criteria.

Summary

'There is evidence that data collection is now even more effective with data completeness of 96.6 percent for April to September 2011. The Whittington has an exemplary record of collecting TARN data which is used as an example of best practice across London trauma units. The initial investment of dedicated data gathering resource is recognised to have been of significant value in both achieving marked improvements from a weak position in 2010 and supporting local process establishment. The panel are impressed by the further improvements in efficiency and data submission achieved in this financial year and congratulate those clinicians involved. The contribution from information services and the Clinical Governance group is also very much acknowledged'.

Actions/recommendations ongoing include:

(Lead clinician: Mr Robert Pinate, Professional Development Nurse)

- Continued demonstrable improvement in the identification and submission of Lower Injury Severity Score (LSS) patient groups.
- Ensure that the impact of prospective audit in relation to time to CT and time to scanning decision is reflected in future TARN data.
- The hot floor imaging service is noted favourably; however, extension of the audit to include in and out of hours time to report is recommended.

2nd RCP national audit of falls and bone health in older people

Falls and fractures, in people of 65 and over account for over 4 million bed days each year in England alone and cause significant suffering and disability for those affected. Healthcare costs associated with fragility fractures are estimated at £2 billion a year. Injurious falls, including over 70,000 hip fractures annually, are the leading cause of accident-related mortality in older people. Falls often lead to reduced functional ability and increased dependency. An ageing population means rate of falls and fractures are increasing. This was the second national clinical audit of falls and bone health for older people organised by the Royal College of Physicians. The aim was to assess whether patients have risk assessments for falls and osteoporosis and receive appropriate interventions

Actions planned or ongoing include:

(Lead clinician : Dr Rosaire Gray, Consultant Physician)

- Fast tracking from ED to Trauma ward (pilot underway as of March 2012)

- Appointment of orthogeriatrician, a doctor who specialises in bone health in older people
- Introduction of 7 day access to physiotherapy
- Introduction of fractured neck of femur pathway to reduce time spent waiting for surgery for patients.
- Falls nurse specialist/falls coordinator (ED and fracture clinic)

Whittington Health 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.
- Community Champions are identified to lead on these audits.
- Local audits will be agreed by the relevant Divisional Board in addition to the formal committee ratification process.

Examples of actions being taken:

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:

(Lead for actions: Sickle cell lead clinician and Paediatric Haemoglobinopathy clinical nurse specialist).

- 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 pain killing 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, so staff have easy and immediate reference.

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:

(Lead for actions: N Tirlapur,

- Improved awareness of national poisons database (TOXBASE) guidelines. Feedback via audit presentations to doctors in Ed 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:

(Lead for actions: A-Nee Lim, Antimicrobial Pharmacist)

- 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.
- 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 2 trimester onwards are at increased risk of acid reflux due to hormonal and mechanical effects of pregnancy. The danger of this problem to women, is that they could potentially inhale stomach contents and damage their lungs (aspirate). Whilst aspiration is rare, it represents an important cause of maternal death. Risk of aspiration has improved due to better anaesthetic techniques and increased use of regional techniques.'

Actions:

(Lead for actions: Dr T Young and Dr G Panch, Consultant Anaesthetist)

- 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 anaesthetist inserting the epidural. Ranitidine is very effective at treating this condition

Audit of adherence to local guidelines regarding neonatal observations on the postnatal wards.

'Adherence to local clinical management guidelines is a feature of clinical audit (QI) programmes and an important tool for assessing optimum care delivery'.

'This audit was undertaken in order to determine the adherence to local guidelines regarding neonatal observations on the postnatal wards.'

Actions to include:

(Lead for actions: Dr Leith, Consultant Neonatologist)

- A scoring system, designed using local expert consensus, was incorporated into a new observation chart. (Neonatal Early Warning System (NEWS) score). The NEWS observation chart acts as a prompting tool for clinicians, providing early clinical indicators of babies that become unwell. Its ease and comprehensiveness allows it to be successfully and safely used by non-paediatric specialists.
- Re-auditing is an important part of the improvement cycle so that we can continuously improve the standards that we set ourselves. A
- re-audit of this intervention is planned.

Retrospective audit of pregnancies of women with diabetes at the Whittington in 2006-2010.

The aim of this audit was to compare the antenatal care of women with diabetes at the Whittington with Confidential Enquiry Maternal And Child Health (CEMACH), as a National benchmark, and previous audit from 2001-2005. This showed that outcomes for our mothers are better than the national averages reported by CEMACH. We are justifiably proud of this achievement and the benefits it confers to both mothers and babies.

Actions ongoing include:

(Lead for actions: Dr Michela Rossi, Consultant Diabetologist)

- To continue the Diabetes Pre-pregnancy Group information giving sessions which commenced in 2005.
- To continue contact with GP practices regarding Diabetes Pre-pregnancy counselling initiated in 2006.
- To continue with the established one to one Pre-pregnancy counselling sessions with Consultant Diabetologist and Obstetrician.
- To undertake a sub analysis of Emergency Caesarean Section cases.

Participation in clinical research

1 April 2011–31 March 2012

The number of patients receiving NHS services provided or sub-contracted by Whittington Health who were recruited during 2011-12 to participate in research approved by a research ethics committee was 680.

Participation in clinical research demonstrates Whittington Health'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 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 31 March 2011 to 1 April 2012, and approved 34 new projects during the same period.

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

Additionally, in the last three years, 223 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 2011-2012 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 2011-2012 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 following table. 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.

CQUIN scheme	Description	Outcome
VTE assessment: blood clot risk	90 percent of patients assessed for VTE on admission	Achieved
Patient Survey	Improvements in selected survey scores	Partial achievement
Global Trigger Tool	Use of international quality audit tool	Achieved
Enhanced Recovery Programme	Participation in national programme to improve surgical pathways	Achieved
Improved discharging from hospital	More timely discharging of patients	Partial achievement
Discharge Information	Improved quality of discharge letters/summaries	Not achieved
Outpatient letters	Improved quality of OP letters	Not achieved
HfL Dementia Pathway	Implementation of the Dementia pathway	Partial achievement
Readmission rates	Improvements in readmissions for diabetes, COPD and heart failure	Not achieved
Hospital Standardised Mortality Rate	Mortality rates to be better than expected	Achieved
Deaths in low mortality conditions	Mortality rates in selected low risk groups to be better than expected	Achieved
Extend use of SSISS	Extend surgical site infection surveillance	Partial achievement
Nutritional Assessment	Implement nutrition assessment of inpatients	Achieved
Choose and Book	Improve quality of improvement and use of electronic booking	Partial achievement

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

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. This will include children's services.
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 Chronic obstructive pulmonary disease (COPD) Care	
COPD care bundle	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	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.
Safety Thermometer	This involves a series of measures to improve patient safety and benchmark us against other organisations.
Alcohol Screening in the ED	To make sure that patients with alcohol problems are identified and that their General Practitioners are informed, so that they can offer help.
Stop smoking interventions in the Acute Trust	To make sure patients who smoke are identified and offered support to stop smoking.
Dementia screening in >75 yrs for emergency admissions	To make sure we screen patients who are admitted as an emergency for dementia.
NICU inappropriate admissions and follow up care in community	To make sure that babies who have spent time in the Neonatal Intensive Care Unit are followed up appropriately in the community, and that inappropriate admissions are avoided.
Cancer staging	To make sure we record cancer staging for all patients diagnosed with cancer.
Long-term conditions	Extend and improve models of care for patients with long term conditions such as diabetes and COPD.

Statements from the Care Quality Commission

Whittington Health is registered with the Care Quality Commission (CQC) and its current registration status is without conditions.

The CQC has not taken enforcement action against Whittington Health as of 31 March 2012.

Whittington Health has participated in the following special reviews or investigations by the CQC during the reporting period.

March 2012, the CQC national inspection programme for termination of pregnancy (clinical services reviews) relating to the Abortion Act 1967. The Trust was found to be fully compliant with no conditions.

March 2012, inspection by the Mental Health Act Commissioner. The Trust is currently considering the CQC report which has highlighted some issues around administrative processes. An action plan is being developed to address these and the full report will be included in the next Quality Account.

Unannounced Inspections

During April 2011 there was an inspection focused on nutrition and dignity for older people services. The Trust was found to be compliant with some minor concerns which have all been addressed. They were as follows:

- Respecting and involving people who use services. For example: Some staff lacked urgency in their responses to patients' calls/buzzers, and sometimes patients did not feel that they were sufficiently informed about the facilities available on the ward e.g. the presence of a TV lounge, and procedures for using the phone.
- Meeting nutritional needs. For example: There was some inconsistency in the way that staff respond to individual dietary needs, with some people's food preferences not taken into account and although illustrated information booklets are available about food provision at the hospital, these were not widely used, so that people did not always know what options were available to them.

During October 2011 there was an unannounced inspection of the hospital site which included 18 wards/departments, observing how people were being cared for, looking at records of people who use our services, talking to staff, reviewing information from stakeholders and talking to people who use our services.

On 3 February 2012 the CQC confirmed that the services based in the hospital site complied with the essential standards of quality and safety. However, to ensure that the Trust maintains compliance, the CQC has identified six areas where improvements need to be made:

- A need for more training for nursing staff and healthcare assistants in the area of consent, to ensure that they support people in line with their best interests.
- The hospital needs to continue making improvements to managing waiting times in the Ed, and Outpatients departments, and improving the care and support provided by some individual staff members in particular areas.
- Some improvements are needed to facilities on the maternity wards, and outpatient clinics, and in provision of television/radio across all wards, to ensure that patients are provided with a safe and comfortable environment as far as possible.
- There is room for review of the deployment of staff in particular areas to ensure that patient needs are met effectively.
- There is room for improvement in staff appraisals and mandatory training, and management support through provision of regular team meetings to ensure that staff are supported in their work with patients as far as possible.
- Improvements are needed in publicising the Patient Advice and Liaison Service to patients across the hospital and in improving response time to complaints received.

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

Whittington Health submitted records during 2011-2012 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 data that included patients' valid NHS number was:

97.5 percent for admitted patient care (up from 93.5 percent in 2010-2011);

98.4 percent for out patient care (up from 96.2 percent in 2010-2011);

90.2 percent for accident and emergency care (up from 79.4 percent in 2010-2011).

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

100 percent for admitted patient care (100 percent in 2010-2011);

100 percent for out patient care (100 percent in 2010-2011);

99.6 percent for accident and emergency care (up from 98.7 percent in 2010-2011).

Progress with 2011-2012 priorities

Information Governance Toolkit attainment levels

Whittington Health's score for 2011-12 for Information Quality and Records Management, assessed using the Information Governance Toolkit was 69 percent. This translates as a satisfactory rating which has been achieved by demonstrating compliance at Level 2 for all elements of the toolkit.

What does this mean?

This means that Whittington Health has achieved a high standard of governance for the management, protection and quality of patient and staff data across the organisation.

Clinical Coding Error Rate

Whittington Health's Trust was subject to the Payment by Results clinical coding audit during 2011-2012 by the Audit Commission.

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

Main diagnosis code - error rate 7.3 percent (standard is less than 10 percent)

Main procedure code - error rate 9.1 percent (standard is less than 10 percent)

Percent of spells with a different healthcare resource group (HRG) – 6.5 percent (national average = 9.1 percent, standard is less than 10 percent)

What does this mean?

This means that Whittington Health holds accurate data about our service users.

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 herewith 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.

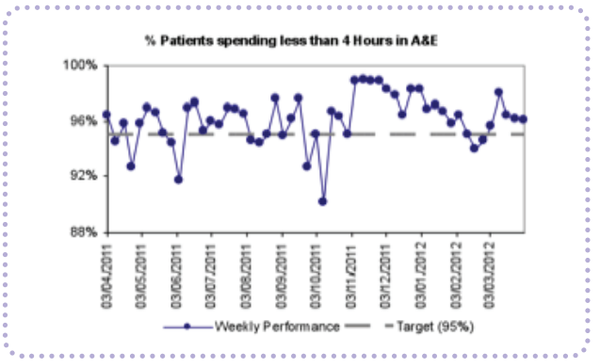
Data is for April 2011 – Feb 2012 unless stated

Goal	Standard/benchmark	Whittington performance
18 week waits for admitted patients to treatment	95 percentile wait to be less than 23 weeks	20.9 weeks
18 week waits for non–admitted patients to treatment	95 percentile wait to be less than 18.3 weeks	14.5 weeks
Outpatient follow up ratio	London median	Action plans in place for performance all specialties; some but not all met the standard in 2011-2012

Operations cancelled for non-clinical reasons	0.8 percent	0.3 percent and all patients offered another date within 28 days
Waits for diagnostic tests	Less than 6 weeks	99.6 percent
Day surgery rate	Audit Commission benchmark	77 percent (best quartile)
Outpatients department (OPD) plan did not attend (DNA) rate (hospital)	8 percent	14.4 percent and action in place to improve
Community Adults' Services DNA rate	8 percent	9.1 percent and action plan in place to improve
Community Children's Services DNA rate	8 percent	14.3 percent and action plan in place to improve
Average length of stay for all acute specialities	6.2 days	6.3 days
Staff sickness absence rate	Local target: 2.5 percent	3.1 percent
Ward cleanliness score	95 percent	96 percent
Elimination of mixed sex accommodation	0 mixed sex breaches	9 breaches
New birth visits (Islington)	95 percent seen within 14 days	70.1 percent
New birth visits (Haringey)	95 percent seen within 28 days	82.0 percent (average monthly performance, Sep-Mar)
Sexual Health services	100 percent offered an appointment within 2 days	100 percent
Cancer waits		
Urgent referral to first visit	Standard is 14 days, target is 93 percent	95.4 percent
Diagnosis to first treatment	Standard is 31 days, target is 96 percent	99.5 percent
Urgent referral to first treatment	Standard is 62 days, target is 85 percent	87.7 percent
Maternity		
Bookings by 12 weeks, 6 days of pregnancy	90 percent	89.4 percent
One to one midwife care in labour	100	100 percent of audited deliveries
Smoking in pregnancy at delivery	<17 percent	8 percent
Rate of breast feeding at birth	>78 percent	89.4 percent
Complaints		
New complaints	no benchmark for ICO	Approx 38 complaints per month (across community and acute services)
Dissatisfied complainants	no benchmark for ICO	7 percent

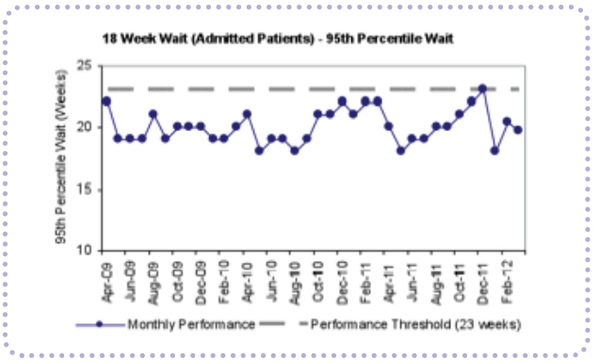
Four Hour Accident and Emergency Wait

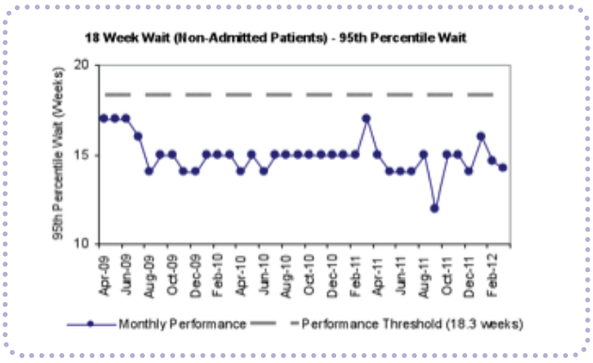
Overall, we have achieved our target for ensuring that people using the Ed do not have to wait longer than four hours. 95 percent of the time, we ensure that patients are seen within this time frame. We plan to work to increase this number in the coming year to further improve the experience of those who use these services. We are also working with colleagues in primary care to signpost people who didn't need emergency hospital services to more appropriate care.



18 week wait

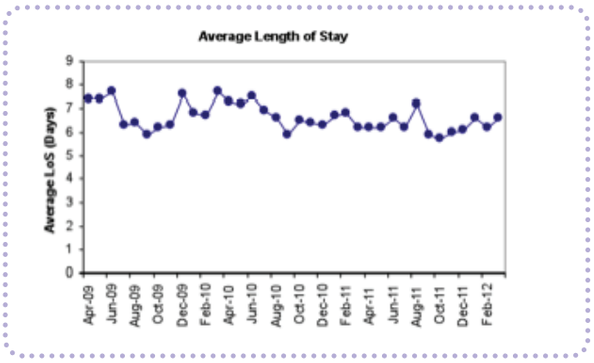
We have achieved our target to see patients within 18 weeks of their referral to the Trust by their General Practitioner.





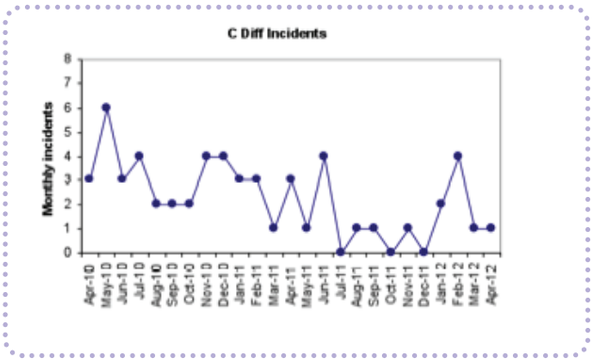
Length of stay

We are working together as an integrated care organisation to ensure that patients remain in hospital for an appropriate time, and that services are in place to ensure appropriate and safe discharge.



Clostridium difficile incidents.

Clostridium difficile can be a serious infection. Over the last year, we have reduced the rate of infection by Clostridium difficile by 54%. We will be working to further reduce the rate of infection in the coming years.



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, since 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 miss-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.

Also as a direct result of patient feedback and adverse outcomes, we made a number of quality improvements in 2011/12. These include an updated

policy and training for checking placement of nasogastric tubes; improved communication process between hospital and community services; updated policy and training about when and how to drain fluid collections in the chest; updated policy and training on the maternity Safe Surgery Checklist.

Revalidation

The General Medical Council (GMC) has introduced a process of revalidation of doctors to check that they are fit to practise. Whittington Health fully subscribes to this and has completed a self-assessment, based on a national format, to assess our readiness to take forward the processes necessary for revalidation. These include effective appraisal and strong quality governance. This self-assessment shows that Whittington Health is ready to make recommendations to the GMC on the revalidation of our doctors. The Organisational Readiness Self Assessment return is included as appendix 1.

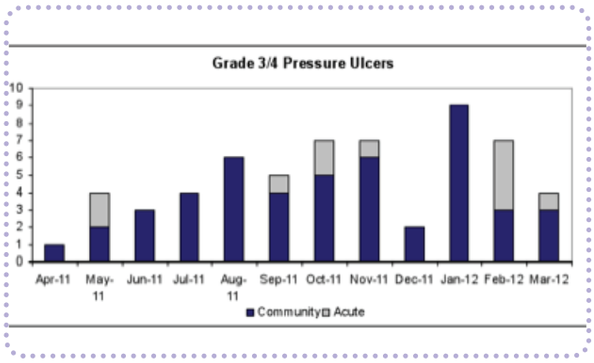
Patient Safety 2010/2011

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. We introduced a new pressure ulcer prevention and management guideline. All patients are now assessed using the same risk assessment tool (Waterlow), whether they are in the hospital or community setting. The grade of a pressure ulcer determines how serious it is in terms of skin damage. Grade 3 and 4 pressure ulceration poses significant harm to patients. These ulcers are difficult to heal and increase the risk of infection for patients and can be painful. To reflect how seriously we respond to pressure ulceration all pressure ulcers are reported as a 'clinical incident', and Grade 3 and 4 as Serious Incidents that require an in-depth and 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. During 2011/2012 we achieved a reduction of 60 percent in Grade 3 and 4 pressure ulcers in hospitalised patients. The graph below shows incidence of grade 3 and 4 pressure ulcers across the ICO over the last year.

We are working to continue to reduce incidence across the organisation as well as 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

The risk of developing a blood clot in hospital is increased in some patients. We have made sure that we assess our patients and prescribe appropriate medication to reduce this risk as much as possible. We have performed well in this area, meaning that patients who are treated at Whittington Health have everything possible done to reduce their risk of this potentially serious complication. The Whittington won an award for excellence in patient safety, awarded by Sunquest at their annual user group 2011-2012 for the innovative use of technology to record these risks.

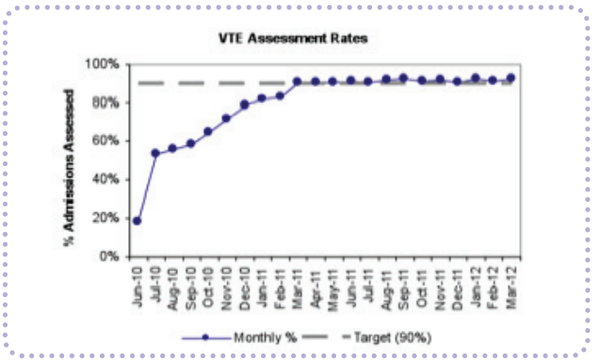
We set a target of 90 percent of patients admitted receiving an assessment to see if they are at risk of blood clots, and if so, of providing them with appropriate preventative treatment.

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.

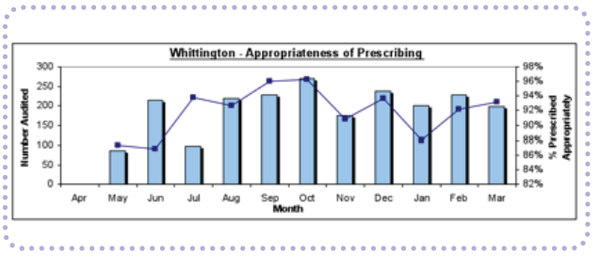
By March 2011, we had achieved our target of 90 percent. Performance in this area has been consistently high throughout 2011 and 2012, with a 95 percent compliance rate for risk assessments being achieved on average throughout the year.

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 blood clot risk, also known as Venous Thrombo-Embolism (VTE) 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 blood clots. 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.

When patients are in hospital, we want to ensure that they get the best care available. By looking at patients' notes and identifying whether we could have done anything better or differently, we can learn as an organisation. This helps us to improve care for our patients, which makes the care we give safer.

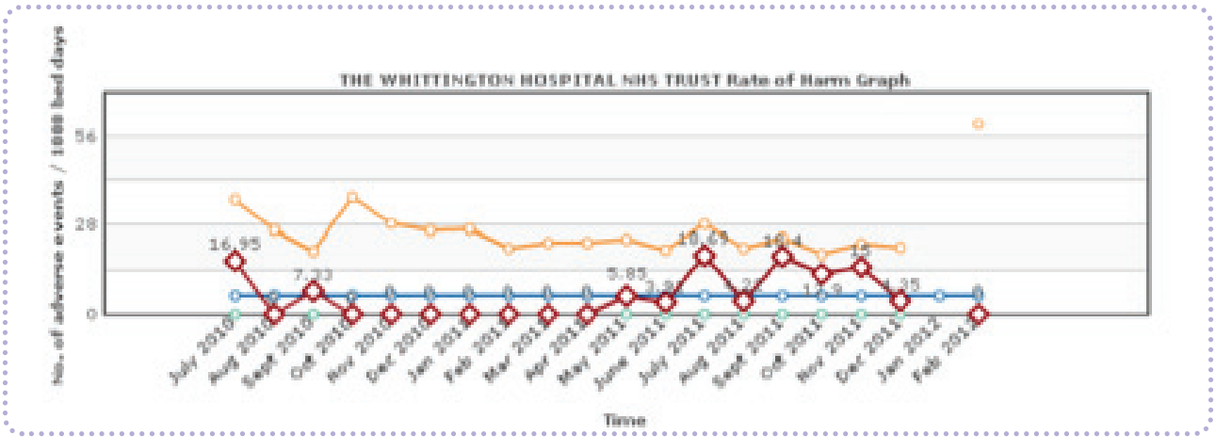
An ongoing mortality audit is now in place for most specialties and is being rolled out to the remaining medical sub-specialties, led by Ihuoma Wamuo, Director of Audit and Effectiveness. In addition the Medical Director continues to review the medical records of patients who die at the Whittington.

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

In addition the health records is audited using the Global Trigger Tool. This audit tool is used to systematically sample recent in-patients records to look at variations in outcomes. For example, it records adverse events such as unplanned return to theatre, unplanned admission to ITU, ward-based cardiac arrest calls. We 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 multidisciplinary reviewers. They work in pairs to review 10 sets of case notes every fortnight. In 2011/12 295 reviews have taken place.



This graph shows the rate of harm identified through the ongoing fortnightly reviews. 16 harm events have been identified within this time period. The list herewith demonstrates triggers found leading to the identification of an adverse event

Trigger type	number
Wound infection	3
Complication of procedure	3
Raised urea/ creatinine (reduced kidney function)	2
ICU/HDU unplanned	1
Procedure change	1
Incomplete/ no observations performed	1
Unplanned readmission	1
Blood transfusion	1
Infection acquired from the hospital environment	1
Blood cultures containing bacteria	1
Pressure ulcer	1

In line with the trigger tool methodology, the three highest triggers will 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 Global Trigger Tool (GTT).

The Trust is reviewing the areas with high adverse events with the aim of implementing change to improve 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 investigated to see if they could have been prevented.

Whilst the number of patient falls causing harm has decreased from 13 in 2009-2010, to ten in 2010-2011, and five resulting in fractures in 2011-2012. This reduction is not yet sufficient. During the last year we introduced "safe ward rounds" whereby all patients on a ward are checked on at least every two hours by the nurse to ensure their comfort and safety.

Simmons House, Child and Adolescent Mental Health Services (CAMHS)

This is our Tier 4 Adolescent Psychiatric in patient and day patient service. Many of the patients self harm and have suicidal thoughts, and can present with risky and challenging behaviour. Every patient has a comprehensive risk assessment on admission and this assessment is regularly updated. This vigilance is important to prevent harm to this vulnerable group of young people and to improve the service that they receive.

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 Simmons House 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 Child and Adolescent Mental Health Service) 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 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.

Clinical Effectiveness 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, Ed, 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.

Lymphoedema is a disabling condition which can lead to inflammation and infection of the skin on the legs 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. We are proud of our achievements and our healing rates have increased from 15 percent to 89 percent and we have reduced our treatment times from 20 weeks to 6 weeks. As a patient this means living with this disabling condition for less time and with a much higher cure rate.

This service was awarded second prize in the Lymphoedema nursing category at the British Journal of Nursing awards in April 2012. The award was for the management and support of people with long term swollen leaking legs in the community.

Changes to the service model in Islington was 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 there would be less complications for patients and better quality of life and better value for money.

Results:

- Healing rates for single treatment episodes have improved from 15 percent at baseline audit to 89 percent
- 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 gathered in 2010-2011, the predicted net prescribing budget saving for 2011-2012 is £99,840

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

To improve our written communication with GPs

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

Results are already being transmitted electronically in this way for Pathology, and approximately 90 percent 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 2012.

Electronic patient discharge letters have been implemented for our in-patients and day case patients.

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.

We have now purchased a unified electronic patient record system which will span acute and community services and interface with primary care

Emis-web, the system used in GP surgeries. This will be implemented in 2013.

To roll out the enhanced recovery programme for patients having operations

Enhanced recovery programmes help our patients get better more quickly and safely following surgery, so they can go home sooner. We started with patients having bowel surgery, and now started to use this approach for patients having hip and knee replacement surgery. For patients having planned colorectal cancer surgery the average length of stay has reduced by 11 days and for patients having hip and knee replacements length of stay has reduced by

two days. Enhanced Recovery has just been introduced into gynaecology.

Dr Martin Kuper, our divisional Medical Director for surgery was awarded NHS London Innovation funding to lead implementation of Enhanced Recovery across North-Central London in 2010-2011; this has been so successful that the project has now received NHS London Innovation Funding to help roll out Enhanced Recovery surgical pathways across London in 2011-2012.

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, and the introduction of the Electronic Patient Record is key. We are working with Clinical Commissioning Group leads towards this end over the year ahead.

The ED already 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

We are focusing on ways to improve the experience of patients in our clinics. We acknowledge that we do not always get it right, and where this has happened we have taken measures to improve. We have used the DVD "The Clinic" to help train outpatient teams in how to improve patient care. We have listened to patients and provided pagers in our most overcrowded clinics so that they can get a coffee and not miss their appointment slot. We have also appointed more cancer clinical nurse specialists to try to provide support and information for patients.

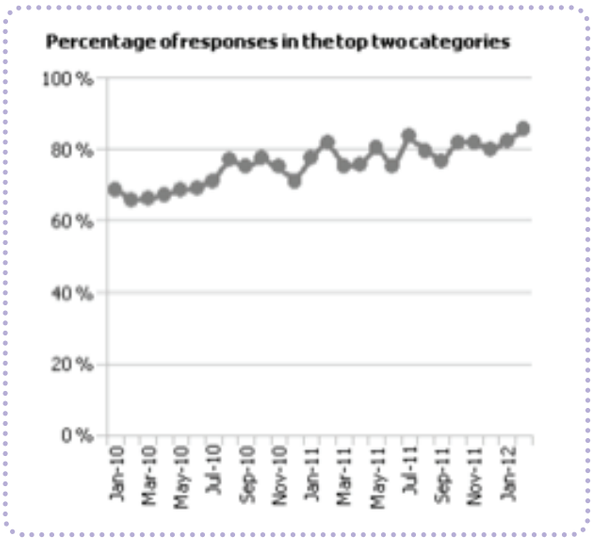
To increase the number of patients who feel involved in their care

The national patient surveys are only conducted once a year and results take some months to come to us. We now capture our own real time patient feedback using electronic surveys via touch screen devices sited throughout the Trust and handheld devices within the inpatients environment. Patients are asked questions that 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. The results are published at Trust Board, and local reports are produced for each area in the trust.

These surveys, coupled with patient interviews, patient stories, 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 – the percentage 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

The Healthcare for London guidance on dementia 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 with older people. We have designated a lead consultant and lead matron to champion this work. Part of the strategy is aimed at improving care of patients with dementia on care of Older People (COOP) wards and specific actions that have been taken include:

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

In addition Susan Tokley, deputy director of nursing, has been successful in securing funding 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

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 2010-2011, 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, as a result of feedback in the national cancer survey in 2010 we have developed an action plan to improve the experience of care within the Trust for patients who have cancer.

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:

How likely is it that you would recommend the Whittington to a friend or colleague? Please choose your 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). We measure this across all areas of the hospital and we are extending this to the community. 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 the results, we try to define any common themes or trends that need addressing. Again this data is shared at both an executive and operational management level.

Review of Quality Performance

Dealing with inequalities within the Whittington Health

Learning Disabilities:

Patients who have a learning disability (LD) often need 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 a 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 a 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.

The community dental service has 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 Photo-symbols, a national group specialising in this area. It was commended by NHS London as an example of good practice in this area.

Work in progress

As part of our work to improve the care of this group of patients with Learning Difficulties 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.

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.

Vulnerable older people

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.

Deprived children

Community dental services established a Parent Dental Advocate training programme 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

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.

Prison population

Whittington Health provides a plain film reporting service for Tuberculosis screening, involving several prisons within the United Kingdom. It also provides dental and medical services at Pentonville.

Improving population health

As an integrated care organisation we are committed to improving the health of our population. We have embarked on an innovative project, with London Deanery support, to engage our local population in a dialogue about their health. Users of our service have been invited to take an on line health risk assessment (www.whittingtonhealth.com). This gives feedback on their health and highlights areas for improvement, signposting the user to relevant local community support services to help them when appropriate.

Equality and diversity

For the last four years, Whittington Health has had 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 Trust is 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 72 percent 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 improvement goals achieved for 2011-2012

- To have a consultant presence on the acute medical unit for 12 hours every day of the week (08.00-20.00) in response to guidance from the Royal College of Physicians. Planned achievement by 1 August 2012.
- To increase the quality, timeliness and accessibility of information given to General Practitioners at the time a patient is discharged from hospital by introducing electronic patient discharge summaries.
- To increase the use of ambulatory care for appropriate patients to avoid unnecessary hospital admissions.

Areas for improvement 2012-2013

- Reduction of emergency readmissions within 30 days by 25 percent.
- Reduction of admissions in patients who have long term conditions.
- To deliver a seven day per week service for inpatients with regard to pharmacy, physiotherapy and occupational therapy.
- To improve the level of satisfaction that patients with long term conditions have with regard to both their secondary and community based care.

Anaesthetics and Critical Care

Quality improvement goals achieved for 2011-2012

- To develop specific anaesthetic outcome measures for patient safety, clinical effectiveness, and productivity.
- To develop a formal report on the quality of the Anaesthetic Service.

Areas for improvement 2012-2013

- To improve the productivity of the clinical service and provide learning opportunities for trainees.
- To introduce an "anaesthetic quality score card" of core outcome indicators and feedback regularly to staff. This will include measures of clinical effectiveness, such as the severity of pain on the first postoperative day, the percentage of patients with hip fractures getting to theatre within 24-48hrs
- To present annual reports on the quality of the Anaesthetic Service to anaesthetic colleagues and to the Divisional Board.

  Launch a pre-assessment service (Pre-Operative Health Evaluation and Optimisation) to improve patient experience and reduce time spent travelling.

  Extend the use of intra-oesophageal doppler to guide intravenous fluid therapy during operations to improve patient outcomes.

Cardiology

Quality improvement goals achieved for 2011/2012

- Awarded the Government's Customer Excellence Service Award (formerly The Charter Mark), having passed the annual "Health Check" in June 2011 for maintaining high quality clinical standards.
- Direct access cardiovascular investigation service: the service remains highly regarded by GPs and by patients and the referrals continue to rise.
- Maintained an outreach Cardiology service supporting the acute medical unit and providing Cardiology input to the wider hospital.
- Introduction of a hyper-acute ACS(acute coronary syndrome) pathway so that patients get directly transferred from the ED to UCLH heart attack centre for high risk patients.
- Community based anticoagulant and stroke prevention services in North Central London. Over 1500 patients who have to take blood thinning drugs to protect their heart and prevent stroke are able to have monitoring and management of their blood clotting in the community.

Areas for improvement 2012-2013

- Aim for compliance with NICE Heart Failure Quality Standards (2011) for high risk patients.
- Two week review for all following hospitalisation with heart failure.
- We aim to demonstrate a further improvement in our services in the 2012 Customer Excellence annual health check.
- Maintaining quality standards for heart failure inpatient care and diagnostics.

Care of Older People

Quality improvement goals achieved for 2011-2012

- Launch a fully integrated care pathway for elderly patients with complex needs.
- Strengthen multi-disciplinary working for all new elderly patient admissions to ensure that their needs are identified and met early on.
- Take an active role in developing and delivering dementia and falls strategies across COOP service.
- Develop Advanced Care Planning to improve patient involvement in decision making.

Areas for improvement 2012-2013

- Improve care of older people with fractured neck of femur in line with NICE and other guidelines aiming to increase expert input, improve care and reduce length of stay.
- Improve care of older people requiring surgery in line with NCEPOD recommendations.
- Aim to reduce in-patient falls by 25 percent.

Community Dental

Quality improvement goals achieved for 2011-2012

- Across community dental services 93 percent of patients said they were involved in their treatment as much as they wanted to be.
- 96 percent 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 percent of patients rated the Islington and Haringey services as excellent, and the remaining 13 percent rated them as good: 0 percent gave a poor rating.
- 76 percent of patients rated the Camden service as excellent, 20 percent good, 3 percent fair and 1 percent poor.
- 100 percent of patients at HMP Holloway seen by the service rated it as excellent. 99 percent of patients accessing the Urgent Dental Service rated it as excellent or good, one percent as poor.

Areas for improvement 2012-2013

- To expand our services for children across Haringey and Enfield, whereby those with high rates of decay are referred for specialist management in our dental services, thus providing 'Care Closer to Home'.

- 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.
- 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.

Diabetes and Endocrinology

Quality improvement goals achieved for 2011-2012

- Reduce amputation of a limb because of diabetes in Islington and Haringey. These are now well below national average rates according to national audit data.
- To achieve better health outcomes for women with pre-pregnancy diabetes. We are now better than the national average reported by CEMACH.
- To improve adherence to national guidance regarding admissions with Diabetic emergencies. These have shown year on year improvements according to local audits.

  77 percent of our Whittington patients with Diabetes received all the key care processes, according to national Diabetic standards. This is against a national average of 50 percent of patients with Diabetes receiving all 9 recommended care processes.
- To increase the numbers of patients with Type 1 Diabetes receiving Insulin pump therapy, in line with 2008 NICE guidance. Improvements show increase from 2.5 percent in March 2010 to 4.8 percent in March 2011 and to 7.5 percent in Feb 2012.
- Co-creating Health team were awarded a national Quality in Care Gold Award for Diabetes in November 2011, for Best Initiative Supporting Self-Care.
- Enhancement of care across primary/secondary care boundaries.
- Improve self-management of Diabetes through increased teaching and support, reducing the need to come to hospital and therefore improve their quality of life.
- Expand our Co-creating Health project, embedding self-management support into local healthcare services for people with long term conditions, including respiratory medicine and musculoskeletal pain.

Areas for improvement 2012-2013

- Ensure there is Diabetes Specialist Nurse support across Whittington Health, providing a seamless service for the local population.
- Continue to contribute to develop local and national audit programme for Diabetes.
- Increase our network links including joining the newly forming insulin pump network.
- Continue to develop and implement improvement projects to support patients' self-management.

Emergency Medicine

Quality improvement goals achieved for 2011-2012

- Implementation of the new Department of Health Performance Indicators for EDs including achieving our target for waiting times for people using our services.
- Development of nursing leadership model to support changes required to implement and meet quality indicators
- Better information to help improve the service for patients and their experience in the department. To improve communication with other groups of staff.

Areas for improvement 2012-2013

- Implementation of seven day Emergency Medicine Consultant working providing Consultant shop floor presence 0800-2000 weekdays and 1200-2000 weekends.
- Multidisciplinary rounds in the ED three times a day to optimise patient care and streamline patient flow.
- Further development of diagnosis specific pathways for patients being managed in Isis ward.
- Development of ambulatory care pathways for patients not requiring hospital admission such as those with blood clots in the legs and cellulites (soft tissue infections).
- Developing closer relationships with community teams to reduce unnecessary admissions and provide care at home where possible.
- Improve information provided to patients, with information boards in the waiting areas and information about performance against quality indicators provided.

Gastroenterology

Quality improvement goals achieved for 2011-2012

- Third endoscopy room has been opened which has increased capacity.
- Outpatient satisfaction survey for endoscopy and outpatients has been completed.

Areas for improvement 2012-2013

- Maintain rapid access to colonoscopy and flexible sigmoidoscopy through public campaign on awareness of bowel cancer symptoms.
- Develop database for Inflammatory Bowel Disease patients (as per national audit).

Imaging

Quality improvement goals achieved for 2011-2012

- Extend same day imaging reporting for the ED to weekends as well as weekdays.
- Improve the efficiency of in-patient transfers to and from the Imaging Department to save patients waiting and improve productivity.

Areas for improvement 2012-2013

- Optimise the use of community resources to ensure patients can be imaged closer to home.
- To make sure patients with a suspected deep vein thrombosis have rapid access to ultrasound scanning appointments.
- To develop acute imaging services which complement new patient pathways.

Infection Prevention and Control

Quality improvement goals achieved for 2011-2012

- We have exceeded our targets to improve orthopaedic surgical site infection. We have met locally set objectives for MRSA bacteraemia, Clostridium difficile.
- Implementation of mandatory surveillance of MSSA Bacteraemia and E.coli in accordance with DH guidance
- Embedded audits of practice into local work programmes to ensure continued improvement in infection rates as measured by national survey.

Areas for improvement 2012-2013

- Develop project to reduce E.coli bloodstream infection rates through Root cause analysis investigations (a tool used to guide rigorous analysis of adverse events).
- To have no avoidable cases of MRSA bacteraemia acquired by patients while in our care.
- To have fewer than 20 cases of Clostridium difficile associated diarrhoea acquired within the organisation.
- To achieve a compliance rate of 95 percent or above for all environment audits.
- To achieve a compliance rate of 95 percent or above for all hand hygiene audits.
- To achieve compliance of over 90 percent in all antimicrobial prescribing targets.
- To ensure more than 90 percent of Whittington Health staff receive infection prevention and control training by end of 2012-2013.

Maternity and Women's Health

Quality improvement goals achieved for 2011-2012

- Increased consultant presence on Labour Ward to 80 hours.
- Working to obtain 40 hour consultant presence on the gynaecological emergency unit. (20 hours achieved).
- Reduced the number of complaints received about our service.
- Expanded Hornsey Rise community clinics in gynaecology.
- Achieved Clinical negligence Scheme for Trusts (CNST Level 2 (indicator of good risk management).
- Ongoing surveys of parents' by Labour ward forum.
- Continued input by the maternity service liaison committee (MSLC) led to two public meetings where women came to discuss their views and opinions of the service. As a result a new community ante natal clinic for Jewish women was established and a 'Shabbos' Room was opened.

Areas for improvement 2012-2013

- Continue to work towards 40 hour consultant presence on gynae emergency unit.
- Daily elective Caesarean section lists separate from labour ward in main theatre.
- More consistent daily ward rounds on antenatal and postnatal wards.
- Improve environment on postnatal ward.
- Enhanced recovery programme in gynaecology.
- Reduce the amount of agency staff used in maternity.
- Improving pathways for gynaecology and sexual health patients
- Reducing caesarean section rate and supporting normal delivery
- Maintain one to one midwife support for every woman in labour.

Michael Palin Centre for Stammering Children

Quality improvement goals achieved for 2011-2012

- International research publications and an international reputation as experts in the field.
- Continuing research into stammering and the impact on the individual and the family.
- Two television programmes 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.

Areas for improvement 2012-2013

- Clinical - providing specialist assessment and therapy services to people who stammer and their families, from the local population and also nationally.
- Research - To conduct clinically based research that will lead to improved services for children and young people who stammer.
- Teaching and Training - to provide training and supervision for students and therapists who work with people who stammer to improve services and access to services at a local level.

Oncology

Quality improvement goals achieved for 2011-2012

- Electronic recording of decisions at multidisciplinary meetings
- Acute Oncology nurse appointed in April 2011.
- Develop the lymphoedema services clinical outcomes measures, with a focus on pain management and improvement.

Areas for improvement 2012-2013

- Develop a drop-in service 9-5 for patients on chemotherapy to avoid ED attendance.
- Develop a 24/7 mobile phone service for all patients on chemotherapy.
- To work with new cancer lead nurse to develop a robust education programme for all nursing staff to manage any patient admitted as an emergency with cancer.
- Improve outpatient area for patients with cancer.

Paediatrics

Quality improvement goals achieved for 2011-2012

- Successfully integrated Child Health Services in Islington and Haringey into Whittington Health.
- Became the leading team in provision of postgraduate training in sector (NCL).
- Established benchmarking for outcomes in General Paediatric conditions-partially met.
- Further improved Neonatal performance and met all of Neonatal toolkit standards.
- Transferred the children's allergy services that could be safely managed in primary care back into local community settings
- Developed the Simmons 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.

Areas for improvement 2012-2013

- Reduce admissions of children to Ifor ward and increase day care visits and use of community referrals.
- Introduction of referral management for acute paediatric referrals. Establishing nurse-led triage of referrals and nurse practitioner led clinics.
- Establishment of bundle tariff for asthma/wheezy child pathway across hospital and community services. This will enable the transformation of patient experience for a child and family. Promoting earlier parental management and care referred back to primary care.
- Length of stay reduction on Neonatal Unit by minimum of five days, improving the family experience and minimising the effects of hospitalisation on the baby and family.
- Joint project with Maternity to achieve a reduced length of stay on the post natal wards by ensuring timely new born back checks through a new pathway using midwifery and neonatal staff.
- Review the transitional care service for babies on the postnatal wards to improve the standard of this care for families.

Palliative care

Quality improvement goals achieved for 2011-2012

- We are 99 percent compliant with communicating with relatives and carers. This was highlighted as positive in the national press.
- Length of time that End of Life Pathway(EOLP) has been in use in hospital: Whittington 84 months (national median 60 months).
- 100 percent of wards are using the EOLP: (national median 90 percent).
- 53 percent of deaths are supported by an End Of Life Pathway (national median 29 percent).

Areas for improvement 2012-2013

- Better access to information relating to death and dying.
- Better access to specialist palliative care services.
- Provision of care of dying continuing education.
- Develop clinical provision/protocols promoting patient privacy, dignity and respect.

Pathology

Quality improvement goals achieved for 2011-2012

- 87 percent of GPs were either very satisfied or satisfied with the direct access to the pathology services, 13 percent were neutral and no GPs reported being unsatisfied or very unsatisfied.
- 97 percent of GPs were either very satisfied or satisfied with the Biochemistry service, three percent were neutral and no GPs reported being unsatisfied or very unsatisfied.
- 96 percent of GPs were either very satisfied or satisfied with the Haematology service, four percent were neutral and no GPs reported being unsatisfied or very unsatisfied.
- 88 percent of GPs were either very satisfied or satisfied with the Histology service, 12 percent were neutral and no GPs reported being unsatisfied or very unsatisfied.
- 95 percent of GPs were either very satisfied or satisfied with the Microbiology service, five percent were neutral and no GPs reported being unsatisfied or very unsatisfied.

Areas for improvement 2012-2013

- Successful formation of Blood Sciences, which includes amalgamation of Biochemistry, Haematology and Serology. A key requirement for this is implementation of the Pathology IT system upgrade and updating Sunquest ICE, a requesting and reporting system for clinicians.
- To move towards providing a quality assured service and improved clinical governance for point of care testing within the hospital and the community.
- Development of Andrology services, to support men's reproductive health .
- Implementing professional guidelines for patient sample and request form identification criteria to improve patient safety by ensuring the right investigation is performed on the right patient.
- Pathology rationalisation of procurement for services and equipment within the NCL sector.
- Development of networked pathology partnerships.

Pharmacy

Quality improvement goals achieved for 2011-2012

- 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 started in March 2012.

Areas for improvement 2012-2013

- There are plans for improvements to our service in outpatients. We bid successfully to work with the Design Council to look at ways of improving the patient experience – improve waiting, the environment, access to information and signposting to health promotion.
- Roll out of electronic prescribing and administration across inpatients and outpatients to improve safety.
- 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

Quality improvement goals achieved for 2011-2012

- COPD mortality three percent at 90 days after acute admission, compared to 9.9 percent in a European Audit (ERS).
- Contribution to integrated respiratory care: NHS Islington COPD LES 2010-2011 won the 2011 national IMPRESS award 'Increasing high value services and reducing low value services
- COPD Discharge bundle introduced October 2011
- Contribution to safer oxygen prescribing and use with pharmacy and London Ambulance Service: 77 percent oxygen now prescribed; when prescribed, target range always used and 94 percent patients receiving oxygen within the target range. 97 percent of patients with COPD now receive controlled oxygen and >100 patients with chronic respiratory failure have a patient specific protocol so they receive only controlled oxygen during hospital transfer.

Areas for improvement 2012-2013

- Evidence based quit smoking interventions offered to all adult respiratory patients admitted to the Whittington who smoke i.e. pharmacotherapy/Nicotine Replacement Therapy and referral to quit smoking service in particular COPD and asthma (currently 69-75 percent for patients with COPD).
- Pulmonary rehabilitation offered to all patients admitted and eligible with COPD (currently 79 percent).
- Work with the ED to reduce delivery of excess oxygen to patients with COPD in ED (currently 11 percent).

Surgery

Quality improvement goals achieved for 2011-2012

- Rolled out enhanced recovery pathway for orthopaedic elective operations.
- Introduced pager system for clinic 4A patients (November 2012).
- Head of Nursing produced information booklets (e-version and hard copy) for the top 20 procedures initially with the clinical nurse specialist leads.
- 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.
- All clinic staff have undertaken "The Clinic" customer care training module in 2011.
- Head of Nursing has led on some local audits and "mystery shopper" spot checks of all Clinical Nurse Specialist contact details and ease of access (cancer and non-cancer clinics) throughout October and November 2011.

Areas for improvement 2012-2013

- Increase consultant presence by separating emergency and planned work to free up consultants to have earlier input in managing emergency patients.
- Improve timely access to call centres to enable people to change appointments.
- Improve risk stratification in bariatric patients and use two consultants operating on high risk patients.
- Involve patients and the public to help us improve patients experience in endoscopy.
- Aim to provide breast clinics 5 days a week.
- Streamline the pathway for urology patients to avoid unnecessary emergency admissions.

Integration of services

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

We also focus on innovation and improvement of services through working together and listening to patients 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.

Over the next year we aim to continue to transform care pathways, to ensure that they are treated in the best place, with the best possible joined up care. We will ensure that all patient information is seamlessly available throughout the organisation with the introduction of electronic patient records, planned for next year.

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

We have 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. Its 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 Hospital 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 now 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 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 ED, 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.

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 over the most recent eight month period.

To date, in the year 2011/12, the Whittington Health Complaints Department received a total of 419 formal complaints of which 274 referred to Whittington Hospital Services and 145 concerned community services of Haringey and Islington. Specific learning and improvements were identified through many of these complaints. Improvements have sometimes been initiated as a direct result of complaints and sometimes are part of the process together with staff identifying potential improvements during service delivery. Complaints are regularly used as part of team meetings across the Trust to ensure all staff learn from mistakes. The following are some of the types of improvements that have occurred at least in part through the investigation of complaints.

Systems have been developed and improved; for example, in the Admissions Department, a new system was developed to ensure that phone messages were checked and responded to on a daily basis; cover arrangements for medical secretaries were clarified; timescales for typing and sending consultant letters was set to one week. New protocols have been developed. In HMP Pentonville, this included rules over where a prisoner might receive an injection. Services have been improved, such as the District Nursing Messaging Service and waiting lists shortened, for example for the dental service in HMP Pentonville. Concerns over attitude and manner of staff have been addressed in a number of ways, resulting in improved performance. This has included staff attending customer care training, and individualised interventions with staff such as discussions and role plays to raise awareness. Communication has also been improved in a number of ways; for example, new leaflets are being developed in maternity to improve information given, information leaflets, including some social services information, have been made more available around the hospital. Name badges are also being reintroduced, following many complaints highlighting

that staff could not always be identified. Quality of care has been improved through complaints also. Where patients are in the hospital for an extended period of time, they are now provided with a specific point of contact, usually the matron, who will visit regularly and coordinate care where necessary. Two hour comfort checks have also been introduced around the hospital to ensure that food and toileting needs are being responded to in a timely fashion.

As well as system wide improvements, there have also been individual quality improvements. This has included individual training needs being identified, for example, within systems for raising safeguarding alerts, consent rules, communication and clinical skills. Other improvements have directly improved the quality of care for one patient, such as a necessary sharps bin being provided to a prisoner and the arranging of immediate appointments for patients whose appointments have been cancelled on more than one occasion.

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 online, 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 us 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 whom 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 was however very positive and has been used to inform this quality account, helping 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 organisations, 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.

Progress against the action points in the alerts are monitored via an overall action plan and reported to Patient Safety Committee every month .The Patient Safety Committee will report the alert fully implemented when all actions are completed.

Safeguarding Children

Whittington Health works hard to ensure that all children both in hospital and at home and other community settings are cared for in a safe, secure and caring environment.

To achieve this, 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 eligible staff employed at the Trust undergo a CRB check prior to employment and those working with children undergo an enhanced level of assessment which is repeated every three years.
- All Trust child protection policies and systems are updated, and are reviewed on a regular basis by the Child Protection Committee. A suite of pan-ICO Child Protection policies will be completed by summer 2012.
- The Trust has a process in place for following up children who miss appointments (at home, clinic or hospital) within any specialty to ensure that their care, and ultimately their health, is not adversely affected in any way.

- Staff undertake relevant safeguarding training, and the content of training is regularly reviewed to ensure that it is up to date. Since becoming an integrated care organisation, we have experienced some challenges in providing assurance about the number of staff who have received appropriate safeguarding training, as we integrate previously independent electronic systems to form an integrated Electronic Staff Record. Regardless of this, our data shows high compliance against our target of training for child protection. These figures below relate to standards set out in the Royal College of Paediatric Child Health intercollegiate document end 2010:
- 75 percent of all staff are up to date on level one training (target is 80 percent) (verified March 2012)
- 30 percent of eligible staff are up to date on level two training (2012). There has been a large increase in the number of staff requiring this level training, and a plan is in place to reach the target of 80 percent (verified March 2012).
- The Trust is continuing to develop robust systems of recording all training undertaken by staff, utilising the Electronic Staff Record (ESR).
- The Trust has a full complement of named professionals who ensure that staff across the integrated care organisation are well trained and supervised on child protection matters and have immediate access to expert advice and a supportive policy framework: .
- There are three Named Nurses for child protection, one in Haringey, one in Islington and one in the hospital.
- There are four Named Doctors; one for the hospital; one in Haringey, one in Islington, one in the ED and one in the neo-natal unit.
- There is one Named Midwife
- 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 Quality 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 and a monthly report on any Serious Case Reviews involving Whittington Health. The last annual report was presented to the board in September 2011, and the Board paper relating to this can be found at www.whittington.nhs.uk under "about us" and "Trust Board".
- The Trust has a robust audit programme to assure the Board that safeguarding systems and processes are working. Performance metrics are reviewed internally at the Trust Quality Committee (a sub-committee of the Trust Board) and externally at the Local Safeguarding Children Boards for Islington and Haringey, which the Director of Operations, Women, Children and Families attends on behalf of the Trust.
- During 2011 Whittington Health has participated in Haringey CQC/ OFSTED, Islington Peer Review of social care and Health and NHS London SIT visits. Action plans have been completed where necessary and positive feedback has been received on our services.
- During February 2012, a CQC/OFSTED inspection of Safeguarding Children services was conducted in the London Borough of Islington, which included Whittington Health. 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.

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 Hospital site who provide some of our adult safeguarding training, and we are guided by their policies for hospital inpatients and Islington residents receiving community services. Having the Islington team on site provides us with easy accessible, speedy advice and support in adult safeguarding matters.

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

Progress in 2011-2012

- 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 and an annual work plan have been set.
- The reporting lines of the committees that monitor and oversee adults at risk has also been updated to ensure that they report appropriately within the trust and are linked to other relevant work streams, including learning disabilities, care of patients with dementia, prison healthcare, victims of violence, DOLS and mental capacity.
- Whittington Health's Safeguarding Adults Policy now matches those of Haringey and Islington boroughs and the pan London policy.

- A policy to assist in recognising when pressure ulcers should also be safeguarding alerts has been approved.
- Whittington Health has senior representation on both Haringey and Islington Adult Safeguarding Boards and input into a number of sub groups.
- Training continues and is delivered via a number of channels including:
- All induction and mandatory training days.
- An e-learning package is available for all clinical staff.
- Uptake of training for 2011/12 was 79 percent against a target of 70 percent.
- An Adult Safeguarding Lead Nurse post has been created for Whittington Health.

National staff survey 2011

On the overall indicator of staff engagement in 2011, the Whittington Health was again in the best 20 percent of all trusts of a similar type. We were also in the best 20 percent for staff recommending the organisation as a place to work, staff motivation and staff ability to contribute towards improvements at work, all of which contribute to the overall staff engagement indicator.

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:

- Local GPs
- North Middlesex University Hospital
- NHS North Central London
- 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 Foundation Trust
- Patient and public 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 an outdated achievement.
- 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:

NHS North Central London (Feedback submitted by Diane CurbishleyDeputy Director of Quality)

NHS North Central London welcomes the opportunity to assure this Quality Account for Whittington Health NHS Trust. In our review, we have taken account of the improvements against 2011-2012 priorities and the priorities identified for 2012/13 and how this plan will support improvements in the quality and safety of care provided to North Central London residents.

NHS North Central London acknowledges the significant number of improvements seen in the areas of quality for 2011-2012, which demonstrate a commitment to continually improving the quality and safety of patient care. In particular we note the reduction in cardiac arrest and the low mortality rate. The focus on reduction of pressure ulcers is also noted as a key area of development over the year and NHS North Central London welcomes the plan to continue this work and to introduce a more focused approach to community acquired pressure ulcers. We would also like to commend the work undertaken to improve the lymphodoema service and the British Journal of Nursing award that work attracted.

We support the priorities identified for 2012/13; smoking cessation, reduction in alcohol related harm, respect, dignity and passion at the heart of care and the continued focus on the reduction of falls, including a community focus and we commend the inclusion of clear measurable outcomes by which to monitor their implementation. We also commend the approach taken to ensure each service has dedicated quality objectives.

In terms of suggested improvements we note:

The Quality Account is a long document, partly due to the inclusion of service line quality objectives and NHS North Central London would support the suggestion by the Trust that a shorter more patient friendly version be published.

The inclusion of patient stories and case studies would add a useful dimension to this account and may be more effective at demonstrating commitment to quality than inclusion of a large amount of detail relating to performance targets.

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

Haringey LINk would like to stress that overall this Quality Account is a very encouraging reflection of the hard work put in by Whittington Health over the past year. We recognise that this year has been a challenging year following the integration of the hospital and community as well as the foundation trust application. These organisational changes have been challenging for staff and we believe that Whittington Health has sought to involve and communicate with employees across Whittington Health. Despite this, we do have concerns that ongoing challenges combined with continuing budget cuts, could result in the focus on quality and safety becoming blurred.

Our relationship with Whittington Health has changed as a result of the organisational changes that they are undergoing. We no longer have observer status with speaking rights on the Whittington Health Board. Currently, this has not affected LINk's ability to ask questions as Whittington Health makes every effort to accommodate our questions and include us on many of their important committees. Therefore, it has been business as usual, but how quickly can that change?

We have targeted key priorities for this year in the hope of making them more robust and encompassing. We should like to comment on the patient experience priority for 2010-2011 and say that it was disappointing to find no evidence of patients' views of the changes made. Another quick observation is the quality performance indicators; although many indicators used to measure performance are positive and action plans are in place for those where risks have been identified, we are concerned at the period of time it takes for an indicator to move from 'risk' to 'non-risk' status.

Priority one – effective care

This has long been an area where improvements can make a huge difference to individuals as well as statistics. Our concern is how information will be gathered from individuals, especially for patients visiting clinicians often, how frequently will they be asked the same questions? Recording answers and making sure these are available to clinicians is of paramount importance here. There is a difference between availability of advice and repeatedly asking the same questions. This is a very fine line that Whittington Health will have to tread.

Priority two – patient experience

We support this wholeheartedly, however patient experience stretches beyond the patients themselves. The patient nucleus of family, friends, and carers should be included in communication plans. Often older people have no family and rely heavily on carers and friends. Not including the patient nucleus can result in conflicting information and less than satisfied patients who rely on more than just clinicians when making decisions. We would like to urge Whittington Health to include the complete patient nucleus in their communication plans.

We end our response by repeating that this is a very good and encouraging account of Whittington Health. Our comments, we hope, will help strengthen next year's work.

Head of LINk Services (Voluntary Action Islington) Islington LINKs representative - Dave Emmett

I note the more structured approach to quality improvement over the last year across the integrated care organisation and I welcome this approach. The governance structures have also been strengthened which is a positive move forward. I also welcome the 'ground up' approach that has been adopted in developing this quality account.

One valuable advancement over the last year has been the inclusion of patient stories to the trust board. This provides a valuable and powerful way to learn from patient experience and brings a real human element to the quality agenda. It would be beneficial too, if patient voices could in some way be reflected in the quality account for coming years to provide further meaning and context to the quality improvements reported.

Independent auditor's limited assurance report to the directors of Whittington Health on the annual quality account

I am required by the Audit Commission to perform an independent assurance engagement in respect of Whittington Health's Quality Account for the year ended 31 March 2012 ("the Quality Account") as part of my work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and the National Health Service (Quality Account) Amendment Regulations 2011 ("the Regulations"). I am required to consider whether the Quality Account includes the matters to be reported on as set out in the Regulations.

Respective responsibilities of Directors and auditors

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

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

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

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

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the Quality Account is not consistent with the requirements set out in the Regulations.

I read the Quality Account and conclude whether it is consistent with the requirements of the Regulation and to consider the implications for my report if I become aware of any inconsistencies.

This report is made solely to the Board of Directors of [trust] in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Assurance work performed

I conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the NHS Quality Accounts Auditor Guidance 2011/12 issued by the Audit Commission on 16 April 2012. My limited assurance procedures included:

- making enquiries of management;
- comparing the content of the Quality Account to the requirements of the Regulations.

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

Limitations

The scope of my assurance work did not include consideration of the accuracy of the reported indicators, the content of the quality account or the underlying data from which it is derived.

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that the Quality Account for the year ended 31 March 2012 is not consistent with the requirements set out in the Regulations.

Signature

Name

District Auditor/Officer of the Audit Commission

Address

Date

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 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