Appendix One:

Quality Account 2022/23

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Part 1: Statement on Quality from the Chief Executive

Information to follow

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About the Trust

Whittington Health is one of London's leading integrated care organisations – helping local people to live longer, healthier lives.

We provide hospital and community care services to over half a million people living in Islington and Haringey as well as those living in Barnet, Enfield, Camden and Hackney. Whittington Health provided over 40 acute and 60 community health services in 2021/22. In addition, we provide dental services in 10 London boroughs. Every day, we aim to provide high quality and safe healthcare to people either in our hospital, in their homes or in nearby clinics. We are here to support our patients throughout their healthcare journey – this is what makes us an integrated care organisation.

Our services and our approach are driven by our vision.
We have an excellent reputation for being innovative, responsive, and flexible to the changing clinical needs of the local population. We are treating more patients than ever before and are dedicated to improving services to deliver the best care for our patients, with a clear focus on integrating care for women, children, and the adult frail.

Our vision is: Helping local people live longer, healthier lives.

What we do: Lead the way in the provision of excellent integrated community and hospital services

Our 2019/24 strategy has four main objectives:

What is a Quality Account?

Quality Accounts are annual reports to the public from providers of NHS healthcare that detail information about the quality of services they deliver. They are designed to assure patients, service users, carers, the public and commissioners (purchasers of healthcare), that healthcare providers are regularly scrutinising each and every one of the services they provide to local communities and are concentrating on those areas that require the most improvement or attention.

Quality Accounts are both retrospective and forward looking. They look back on the previous year's information regarding quality of service, explaining where an organisation is doing well and where improvement is needed. They also look forward, explaining the areas that have been identified as priorities for improvement over the coming financial year.

The requirement for external review and assurance by an external auditor, has been removed again for this year by NHS England / Improvement due to COVID-19.

Part 2: Priorities for Improvement and Statements of Assurance from the Board

This section of the Quality Account describes the priorities identified for quality improvement in 2023/24. It also sets out a series of statements of assurance from the Board on key quality activities and provides details of the Trust's performance against core indicators.

The progress made against priority areas for improvement in the quality of health services identified in the 2022/23 Quality Account can be found in 'Part 3: Review of Quality Performance' which starts on page 46.

2.1 Priorities for improvement 2020-23

Our quality priorities are aligned to the Trust's commitment to helping local people live longer, healthier lives and build on factors such as quality performance, clinical or public proposals and our 'Better Never Stops' ambition, to continually improve and provide even better care. The Trust identified 4 key priorities for quality improvement pre pandemic in 2020, with a recognition that embedding change would take up to three years. The Quality Priorities for 2020-24 are set out below, with key targets and milestones to delivery within each year specified.

- Reducing harm from hospital acquired de-conditioning
- Improving communication between clinicians and patients
- Improving care and treatment related to blood transfusion
- Reducing health inequalities in our local population

Our consultation process

Whittington Health recognises that to achieve sustainable improvement, projects need to be long-term and effectively monitored and so priorities were set as part of a four-year improvement plan 2020-24. However, given these were initially developed before the onset of the pandemic, the Trust felt that a

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full review of intelligence, patient feedback and stakeholder consultation was needed to ensure that these priorities were still reflective of the current need.

To this end, the Trust has held several engagement events across the Trust and community sites to gather feedback from people who use our services and staff. This feedback was combined with intelligence from a range of data and information, such as learning from serious incidents, reviews of mortality and harm, complaints, claims, clinical audits, patient and staff experience surveys, and best practice guidance from sources such as the National Institute for Health and Care Excellence (NICE) and national audit data and presented in a meeting with key stakeholders from Healthwatch and the Clinical Commissioning Group to help establish ongoing priorities and any new priorities to be added in 2023-24.

The specific objectives, to achieve the priorities set for 2023/24 have been refined and agreed by clinicians and managers who will have direct ownership and approved at the relevant Trust committees. The quality account, including the 2023/24 objectives, have been shared with our commissioners, whose comments can be seen within the appendices.

Monitoring of progress against priorities

We have developed a robust system to monitor and report on progress against the quality priorities. Each priority has a project work stream (which focus on the key objectives for the year) which is aligned to one of the three pillars of patient safety, patient experience or clinical effectiveness, and reports regularly to the relevant governance group (Patient Safety Group, Patient Experience Group and Clinical Effectiveness Group). The Quality Governance Committee review progress on a quarterly basis and any concerns are escalated to the Quality Assurance Committee, a committee of the Trust Board. Within each priority, key milestones and targets are identified to monitor progress which are reviewed in the context of the wider Quality Account priority ambition.

The key milestones and targets highlighted below, and in the table that follows we have provided a rationale for selecting this area for focus, details of the improvement plans, and detail on the monitoring data and progress indicators.

- Improving communication between clinicians and patients and their carers (Ongoing priority, 4-year improvement plan 2020-24)
- Reducing harm from hospital acquired de-conditioning (Ongoing priority, 4-year improvement plan 2020 – 2024)
- Improving care and treatment related to blood transfusion (Ongoing priority, 4-year improvement plan 2020-24)
- Reducing health inequalities in our local population (Year 3)
    - Including specific projects to Improve care and treatment of patients with sickle cell anaemia & projects to improve care we provide to those with Learning Disabilities by increasing staff knowledge and confidence.

Quality Account Priority	Why are we focusing on this as an area for improvement?	What are we doing to improve?	Goals for 23/24
Reducing and avoiding harm from hospital	Hospital-acquired deconditioning, defined as a loss of independence in	The deconditioning work stream focuses on preventing functional decline in frail patients by:	

acquired de-conditioning	activities of daily living (such as toileting, walking, eating/drinking) affects up to one in three adults over the age of 65. This deconditioning is associated with increased length of hospital stays, increased care or rehabilitation needs on discharge, as well as increased mortality. Hospital-acquired deconditioning is associated with longer stays in hospital, increased rehabilitation or care needs on leaving hospital and an increased risk of mortality. As the Trust provides care to both those in hospital and those within our local communities, this priority will cover both avoiding deconditioning whilst in hospital, as well as avoiding admissions that could results in deconditioning.	Reducing the length of time that patients remain in hospital.	To ensure 100% of patients have documentation of a full pressure ulcer risk assessment within 6 hours of admission, and an action plan to manage risks identified in place within 24 hours of admission. To manage 4 patients per month (2 from Islington borough, 2 from Haringey borough) via the delirium discharge pathway. To reduce medically optimised patients by 50% daily. To implement pathway for 'Trial without Catheter' (TWOC) at home, reducing the length of stay by at least one day.
		Preventing unnecessary hospital admissions through supporting patients to stay well in their home environments.	To utilise up to 28 Virtual Ward daily, including 8 technology enabled virtual ward patients and those on the delirium pathway. For Urgent Response and Recovery Care Group to ensure patients are seen within the national guidance of 2 to 24 hours for >80% of referrals
		Supporting patients in hospital with their eating and drinking, ensuring they have the appropriate choice and support.	For patients with Dementia & Learning Disability who are admitted to hospital to have eating and drinking preferences and information about support required available within 24 hours of their admission. This requires 100% of this cohort to have accurate and up-to-date next of kin and emergency contacts who will be able to supply this information, and for them to be contacted in regard to the individual's care needs within 24 hours of admission.

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Reducing health inequalities in our local population	The NHS Long Term Plan outlined an urgent need to prevent and manage ill health in groups that experience health inequalities. This includes population groups less able or likely to access health services available.	The Health Inequalities work stream focuses on reducing inequalities by:	
		Improving the care we provide to those with Sickle Cell disease.	Deliver training to X% of ED staff to educate on the condition, ensuring unconscious bias does not exist in the treatment of patients with sickle cell anaemia by end of March 2024. Ensure 80% of sickle cell patients receive 1st dose of pain relief within 30mins of attendance to ED by end of March 2024.
		Improving the care we provide to those with Cancer or suspected Cancer, that have been identified as having health inequalities.	To expand on the previous success of Prostate cancer events, we will hold up to 6 specific cancer events by the end of March 2024.
		Improving the care we provide to those with Learning Disabilities	To develop and implement training packages by end of March 2024 for all clinical staff about: 1. Treating and supporting those with Learning Disabilities 2. Treating and supporting those with Autism Success in the project will be measured by implementation of package, uptake of training and reviewing patient experience within these populations to determine whether the training delivered shows a positive impact on experience and care. To improve patient experience by offering 100% of patients with Learning Disabilities access to care bags (including items aimed to improve this patient cohort's comfort within this environment) when attending ED by August 2023.

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Improving access and attendance for appointments	We have received feedback from patient representatives that information around appointments can be confusing and access challenging. This includes comments around wayfinding on hospital sites; difficulties booking transport; as well as poor communication being highlighted as a contributory factor in PALS contact, complaints, and incidents.	The appointment work stream focuses on improving communication, access, and attendance by:	
		Continuing Zesty Patient Portal roll out with further functionality and availability across outpatient services.	For 60% of outpatients to be using Zesty by end of March 2024 For DNA rates reduced in line with booking amendments functionality being introduced by end of March 2024
		The Trust has an external provider for transport. We are working closely with this provider to streamline processes and make access to transport provision as easy as possible for those that require assistance in attending their appointments.	For patients to be able to complete single eligibility criteria for multiple transport requests by end of March 2024. For clear communication and guidelines on how to access Transport to be developed in conjunction with the transport provider, demonstrating an impact of reducing the number of patient complaints relating to Transport being received by March 2024.
		Improving clarity within patient letters and signposting around our sites	For outpatient letters to be reviewed and updated to ensure location correctly matches hospital signage Accessible information for those with Learning Disabilities (in the form of leaflets and videos) is currently in development for the following areas: • Outpatients (generic) • Outpatient check in stations • Going to Emergency Department • Going to Theatres • Having an operation • Having an anaesthetic • Going Home from Hospital • Compliments and Complaints • Appointment letters

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			By the end of March 2024, this accessible information will be fully implemented, and accessible information will be further rolled out to other areas & topics required. Success will be measured via audits of how many information leaflets have been distributed, how often videos have been used, as well as reviewing patient experience feedback to determine the impact on their care and treatment.
		Offering increased options to be able to attend more local sites for outpatient appointments.	To improve uptake and attendance of Woodgreen CDC walk-in and booked appointments through offering a range of patient information (in different languages and different formats such as easy read, Braille, electronic and written formats) and by improving wayfinding to the CDC within the Mall, by end of March 2024. To improve accessibility of booking appointments by introducing an electronic self-booking system for Woodgreen CDC services by end of March 2024. Success will be measured via improvements in patient surveys, uptake of electronic app & booking rates of appointments.

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2.2 Statements of Assurance from the Board

The Trust provides statements of assurance to the Trust Board in relation to:

- Modern slavery
- Safeguarding children and young people
- Mixed gender hospital accommodation

Mixed sex/gender accommodation declaration

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. The Trust are committed to providing every patient with same gender accommodation to help safeguard their privacy and dignity when they are often at their most vulnerable.

Patients who are admitted to hospital or come in for a planned day case will only share the room or ward bay where they sleep, with members of the same gender, and same gender toilets and bathrooms will be close to their bed area.

There are some exceptions to this. Sharing with people of the opposite gender may sometimes be necessary. In addition to clinical need other reasons for exceptions would be in a major incident or to maintain infection prevention and control isolation. This will only happen by exception and will be based on clinical need in areas such as intensive/critical care units, emergency care areas and some high observation bays. In these instances, every effort will be made to rectify the situation as soon as is reasonably practicable and staff will take extra care to ensure that the privacy and dignity of patients and service users is maintained.

Modern Slavery Act

It is our aim to provide care and services that are appropriate and sensitive to all. We always ensure that our services promote equality of opportunity, equality of access, and are non-discriminatory. We are proud of our place in the local community and are keen to embrace the many cultures and traditions that make it so diverse. The diversity of this community is reflected in the ethnic and cultural mix of our staff. By mirroring the diversity that surrounds us, our staff are better placed to understand and provide for the cultural and spiritual needs of patients. In accordance with the Modern Slavery Act 2015, the Trust has made a statement on its website regarding the steps taken to ensure that slavery and human trafficking are not taking place in any part of its own business or any of its supply chains.

Safeguarding Adults and Children Declaration 2022/23

Whittington Health NHS Trust (WH) is committed to achieving and maintaining compliance with national safeguarding children standards and guidance to ensure that children and young people are cared for in a safe, secure and caring environment.

The Chief Nurse holds the position as Executive Lead for safeguarding children and adults and the two Heads of Safeguarding (adult and child) professionally reports to the Chief Nurse.

A Safeguarding Bi-Annual Report is produced which is reviewed by the Trust Board (covers both children and vulnerable adults).

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Whittington Health is an active member of two local safeguarding children's partnerships in Haringey and Islington. The Section 11 audits into safeguarding compliance across the Trust are completed as required.

The Trust is a member of the local safeguarding adults' partnerships in Haringey and Islington and the Safeguarding Adults Partnership Assessment Tool is completed annually for both.

The WH Joint Safeguarding Committee meets quarterly to discuss all matters pertaining to safeguarding, domestic abuse, Prevent, Deprivation of Liberty Safeguards and the Mental Capacity Act and monitors serious case review and Safeguarding Adult Reviews recommendations The committee reviews the Trust's responsibility across children and vulnerable adults.

Subcontracted Services

Whittington Health provided services across acute and community service in 2022/23. Of these services a number were subcontracted.

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

The income generated by the relevant health services reviewed in 2022-23
represents 100% of the total income generated from the provision of relevant health services that Whittington Health provides.

A breakdown of the individual subcontracted services can be found in Appendix 2

Participation in Clinical Audits 2022/2023

During 2022/2023, 53 national clinical audits including 5 national confidential enquiries covered relevant health services that Whittington Health NHS Trust provides.

During that period, Whittington Health participated in 98% of national clinical audits and 100% of national confidential enquiries of those it was eligible to participate in.

The single national audit to which the Trust did not participate: End of Life Care Audit (EoLC), was discussed widely with North Central London EoLC colleagues as well as our full MDT at Whittington Health. Our rationale for non-participation was communicated to HQIP; that the work involved for small teams is significant, and the action plans extensive. The Trust requested consideration to moving the audit to a bi-annual undertaking which will allow our clinical team adequate time to implement the findings of each report.

The national clinical audits and national confidential enquiries that Whittington Health was eligible to participate in, and participated in, during 2022/2023 are detailed in (Appendix 1). This includes the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Additionally listed are the 17 non-mandatory national audits, in which the Trust also participated during 2022/2023 (Appendix 2).

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Whittington Health intends to continue to improve the processes for monitoring the recommendations of National Audits and Confidential Enquiries in 2023/2024 by ensuring:

- National audit and national confidential enquiries will remain the key feature of our Integrated Clinical Service Unit (ICSU) clinical audit and effectiveness programmes.
- Learning from excellence will continue to form an intrinsic part of our work, and innovative ways of promoting and celebrating successes will be considered and shared.
- Patient and carer representation in national clinical audits will continue to be developed and effectiveness monitored.
- Multidisciplinary clinical effectiveness sessions will continue to include reflective learning on national clinical audit findings and quality improvement.
- The Clinical Effectiveness group will continue to ensure actions from national audit reports are scrutinised and monitored at the highest level to provide additional organisational assurance.
- Our new national audit response template will be monitored for assurance.
- Improved collaboration with our Quality Improvement lead will identify appropriate project follow up subsequent to national audit report publication.

The reports of 33 national clinical audits/national confidential enquiries were reviewed by the provider in 2022/2023.

Examples of results and actions being taken for a national clinical audit:

National Paediatric Diabetes Audit

The National Paediatric Diabetes Audit collects information on the care and diabetes outcomes of all children and young people receiving care from paediatric diabetes teams. The primary aim is to provide information that leads to an improved quality of care for those children and young people living with diabetes.

The recent National Paediatric Diabetes Audit Annual Report has identified the following areas for improvement:

The median HbA1c has not improved since the 2019/20 report and the department are continuing to work and improve upon the previously identified actions:

- Team to set higher expectations of families. HbA1c 6.5% (48mmol/mol)
- Continue to focus on education in clinic and patient empowerment – downloading and reviewing data at home.
- Low threshold for elective patient admission.
- Low threshold for social services referral.

There is an identified need to improve access to Continuous Glucose Monitoring. This was escalated to the appropriate operational lead who agreed that for all children who fulfil National Institute for Health and Care Excellence (NICE) criteria to have access to CGM with alarms. The Trust continue to use Freestyle Libre as per NCL Guidance. This has resulted in improvement; however, the Trust are not yet on a par with other units. The Trust expect to improve access to CGM for all. Approval from the operational lead was given to start Freestyle Libre 2 at diagnosis and those who need it outside NCL criteria.

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Structured education reflected by blood ketone testing and sick day rules was previously 90-100% but reduced to 55-65%. This was appropriately discussed at the regular MDT meeting where it was decided to move from group sessions to structured education clinics in order to bridge this gap.

Royal College of Emergency Medicine National Audit on Fractured Neck of Femur

The aim of the Royal College of Emergency Medicine's audit on fractured neck of femur is to improve the care provided to adult patients in the Emergency Department (ED) who had sustained a fractured neck of femur, over a 6-month period of continuous data collection.

The data for this audit was collected during 2020/21, to identify performance in EDs against the following four clinical standards:

1. Pain is assessed immediately upon presentation at hospital.
2. Patients in moderate or severe pain (e.g., pain score 4 to 10) should receive appropriate analgesia within 30 minutes (or in accordance with local guidelines) unless there is a documented reason not to.
3. Patients should have an X-ray at the earliest opportunity.
4. Patients with severe or moderate pain should have documented evidence of re-evaluation and action within 30 minutes of receiving the first dose of analgesic.

Following comprehensive review of our results it was determined that none of the records audited for each standard achieved the gold standard 100% compliance.

Emergency Department staff took the following actions:

- To ensure that pain is assessed immediately upon presentation at hospital (standard 1) triage of these patients will be prioritised. Teaching sessions will further encourage and promote the need for documented pain assessment.
- To improve the compliance to the other audit standards, requirements for this group of patients has been included in departmental teaching. Due to the high turnover of ED staff, this is now a routine feature of emergency medicine teaching sessions.
- A local re-audit is to be undertaken in September 2023 and results will be carefully monitored to ensure continuous improvement, with particular emphasis upon these four key clinical standards.

Local Clinical Audits:

Whittington Health intends to continue to improve the processes for monitoring the recommendations of local clinical audits in 2023/2024 by ensuring:

- Reactive local audits, vital to patient safety, will remain of intrinsic value to audit programmes, with further emphasis upon collaborative working across clinical effectiveness, patient experience, quality improvement and patient safety domains.
- Project proposals will continue to be subject to a centralised and multidisciplinary quality review to prevent duplication and to ensure alignment to speciality priorities.
- Bespoke clinical audit training packages will continue alongside our pre-existing workshops. These sessions will be open to staff of all designations and grades.
- Clinical speciality performance in relation to local clinical audit will continue to be monitored on an ongoing basis, with regular reporting via the ICSU Board meetings.

The reports of 61 local audits were reviewed by the provider in 2022/2023.

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Example of results and actions being taken for a local clinical audit:

Audit of MRI spine requests for cord/cauda equina compression

Cauda equina is a time-sensitive diagnosing that requires urgent surgical intervention to prevent paralysis, sexual dysfunction, and/or loss of bladder or bowel function.

The British Association of Spine Surgeons has recommended 24/7 availability of MRI at the referring hospital for these cases.

The aim of this audit undertaken by the Imaging Department is to assess the time performance, hit rate and number of MRI requests to help guide local departmental policy.

The results demonstrated one breach of the 24-hour target for scanning. Therefore, 98.8% scans performed within 24-hour target.

Action taken: As the results were exceptionally positive, the Clinical Lead amended the number of slots to one MRI Cauda equina saved slot per day (rather than the previous 2 slots).

Assessing the appropriateness of antibiotic prescribing for UTI in adults age 16+

The UK has launched a 20-year vision regarding antimicrobial resistance where the optimal use of antimicrobials and good antimicrobial stewardship across sectors is being promoted. A five-year UK Antimicrobial Resistance national action plan outlined concerns about an observed increase in gram-negative bloodstream infections, including Escherichia coli (*E. Coli)* bloodstream infections. Targeting and improving the diagnosing and treatment of urinary tract infections (UTIs) would help reduce avoidable infection rates, improve patient safety, reduce length of hospital stay, and in turn, release bed capacity.

Aim: To assess current clinical practice and compliance to NICE guidance regarding the diagnosis and treatment of UTI's in patients (16+ years) at Whittington Health NHS Trust.

Results and discussion: 70% of the antibiotic prescriptions complied with all 5 standards, meeting the Commissioning for Quality and Innovation (CQUIN) CCG2 compliance target of 40% minimum. Lower and upper UTI antibiotic prescriptions showed good compliance to standard 1, and acceptable compliance to standards 2, 3 and 4 (see figure below). This indicated satisfactory use of antimicrobials; however, further work could be done to increase compliance to national guidance.

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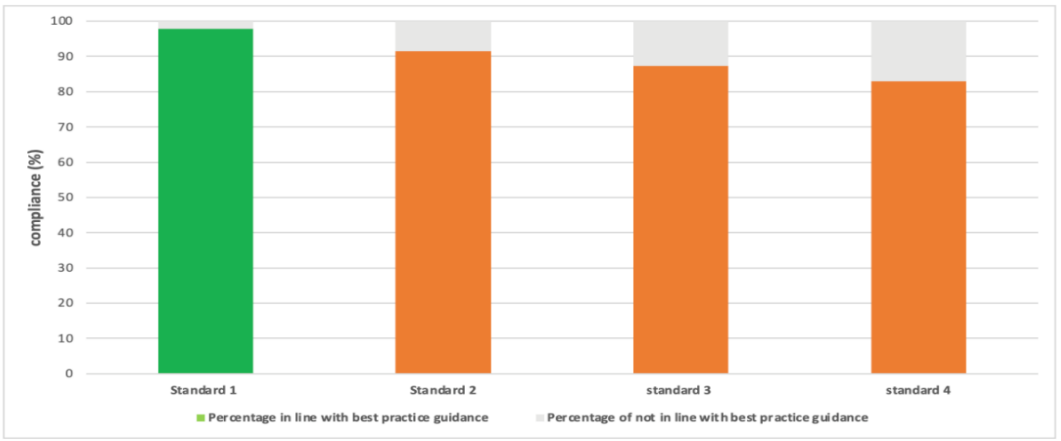
a)



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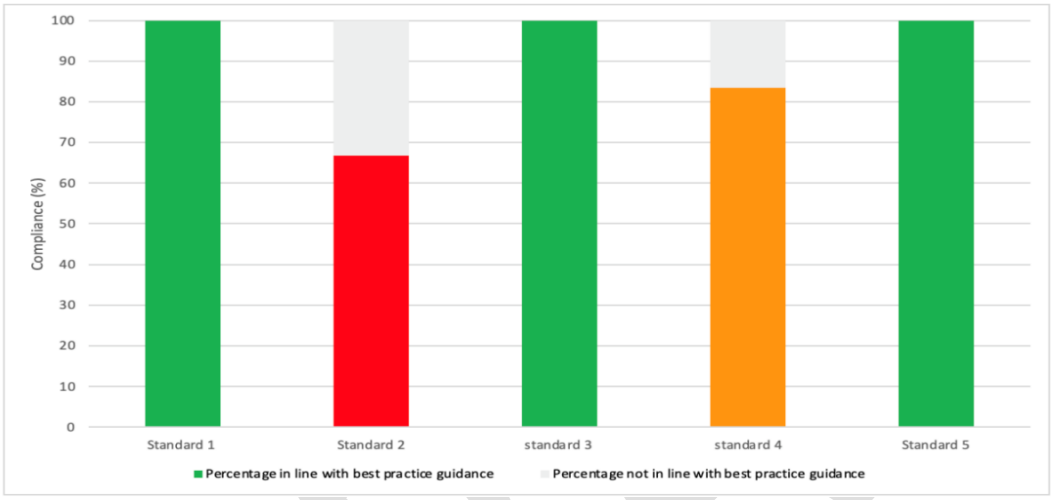

Conclusion

Results demonstrate that 70% of antibiotic prescriptions for UTIs at Whittington Health NHS Trust complied with all 5 standards set out by the CQUIN CCG2 target. However, interventions should be made to further increase and maintain compliance, whilst action must be taken to improve compliance to standard 2 in catheter-associated urinary tract infection (CAUTI) diagnoses.

Recommendations and action plan

- Raising awareness for when it is appropriate to take urinalysis and appropriate antibiotic prescribing by implementing ward-based training sessions.
- Including a 'further details' parameter in the data collection toolkit allowing inclusion of information about inappropriate antibiotic prescriptions.
- To present findings to the pharmacy and microbiology teams. Conduct a re-audit once recommendations have been implemented.

Participating in Clinical Research

Involvement in clinical research demonstrates the Trust's commitment to improving the quality of care we offer to the local community as well as contributing to the evidence base of healthcare both nationally and internationally. Our participation in research helps to ensure that our clinical staff stay

abreast of the latest treatment possibilities and active participation in research leads to better patient outcomes and demonstrates Whittington Health's commitment to improving the quality of care that is delivered to our patients and to global health improvement. The Trust are committed to increasing the quality of studies in which patients can participate (not simply the number), and the range of specialties that are research active as it is recognised that research-active hospitals deliver high quality care.

The research strategy reflects the Trust aim of enabling local people to 'live longer healthier lives' and has been established to benefit patient outcomes, staff recruitment and retention, revenue generation and the Trust's reputation.

A key strategic goal is to become a national leader in integrated care, covering all facets of district general hospital and community health research, and how they relate. The Trust's research portfolio continues to evolve to reflect the ambitions of our integrated care organisation (across hospital and acute, community health services, dental and mental health services).

The research portfolio has reverted to resemble the pre-COVID range of activity. Whilst studies originally classified as COVID-19 Urgent Public Health (UPH) studies remain open, they are no longer prioritised over other studies and as participant numbers for these studies are low, it has been possible to use capacity in other areas. The number of patients receiving relevant health services provided or subcontracted by Whittington Health NHS Trust in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee was 540 at the time of writing (with further data to be uploaded). These patients all participated in studies adopted to the National Institute of Health Research (NIHR) portfolio. This was a decrease to each of the previous 5 years which (had included the highest annual recruitment recorded for the Trust in 2020/21) and reflected the challenges seen in opening new studies and reengaging clinical teams as they returned to pre-pandemic activities. The number of active NIHR Portfolio studies, 47 (30 actively recruiting, 17 in follow-up), has broadly been sustained during this period with Emergency & Integrated Medicine and Surgery & Cancer seeing the most activity (17 and 12 studies respectively) followed by Children & Young People and Women's Health. Acute Patient Access and Support services (having 8 studies each, with one cross divisional study).

Portfolio-adopted studies are mainly, but not solely, consultant led and are supported by the Trust's growing research delivery team to facilitate patient recruitment. In addition to the NIHR portfolio studies, an additional 4 non-portfolio studies commenced in 2022/23, a reduction of one from the previous year which had seen a pleasing increase in non-portfolio studies. There are plans in place to support the growth of locally led and locally focused research as a vital aspect of delivering the research strategy. Most non-portfolio research studies are undertaken by nurses, allied health professionals, and trainee doctors and the impact of these studies are frequently published in peer reviewed publications, at conference presentations, and are valuable in their ability to innovate within the Trust. In addition, small locally funded studies can provide the evidence needed to secure grant funding for larger scale projects and their potential to build capacity and capability to undertake larger research studies should not be underestimated. As a result of hosting two grants the Trust will receive enhanced Research Capability Funding (RCF) in the next financial year which will in part be used to increase and encourage both portfolio and non-portfolio research activity within the Trust.

CQUIN Payment Framework

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

Our CQUINs for 2022-2023 are:

- CCG 1 - Flu Vaccinations for Frontline Healthcare Workers (Target for achievement)
- CCG 2 - Appropriate Antibiotic Prescribing for UTI in Adults (Reporting only)
- CCG 3 - Recording of NEWS2 Score, Escalation and Response Times for Unplanned Critical Care Admissions (Target for achievement)
- CCG 5 - Treatment of Community Acquired Pneumonia in Line with BTS Care Bundle (Reporting only)
- CCG 6 - Anaemia screening and Treatment for Patients Undergoing Major Elective Surgery (Reporting only)
- CCG 7 - Timely Communication of Changes to Medicines to Community Pharmacists via Discharge Medicines Service (Target for achievement)
- CCG 8 - Supporting Patients to Drink, Eat and Mobilise After Surgery (Reporting only)
- CCG 9 - Cirrhosis and Fibrosis Tests for Alcohol Dependent Patients (Reporting only)
- CCG 13 - Malnutrition Screening in the Community (Target for achievement)
- Local Maternity CQUIN - 75% of continuity of carer for women from Black, Asian, Mixed and Minority ethnic communities and from the most deprived groups (Target for achievement)

For 2022/23 the Trust is required to undertake 12 CQUIN Indicators (9 National and 1 Local). However only 5 Indicators are included in the CQUIN payment scheme for 2022/23.

In 2022/23, 1.25% percent of our income was conditional on achieving national quality improvement and innovation goals agreed between Whittington Health and local commissioners through the CQUIN payment framework. These goals were set because they represent areas where improvements result in significant benefits to patient safety and experience.

Further details of the agreed goals for 2022/23 are available electronically at:
https://www.england.nhs.uk/nhs-standard-contract/cquin/2022-23-cquin/

Proposed CQUINs for 2023-2024 are:

- CQUIN01 - Flu Vaccinations for Frontline Healthcare Workers
- CQUIN02 - Supporting Patients to Drink, Eat and Mobilise After Surgery
- CQUIN03 - Prompt Switching of Intravenous to Oral Antibiotic
- CQUIN04 - Compliance with Timed Diagnostic Pathways for Cancer Services
- CQUIN05 - Identification and Response to Frailty in Emergency Departments
- CQUIN06 - Timely Communication of Changes to Medicines to Community Pharmacists via Discharge Medicines Service
- CQUIN07 - Recording of and Response to NEWS2 Score for Unplanned Critical Care Admissions
- CQUIN12 - Assessment and Documentation of Pressure Ulcer Risk
- CQUIN13 - Assessment, diagnosis, and Treatment of Lower Leg Wounds

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- CQUIN16: Reducing the Need for the Use of Restrictive Practices in CYPMHS Inpatient Settings
- Local CQUIN - Core20plus5

There is a CQUIN Project Manager who leads, coordinates, and oversees the CQUIN projects and is responsible for the achievement of CQUINs. There is also a clinical lead and operational lead for each individual CQUIN. CQUIN progress information for 2022/2023 can be found in Appendix 7.

Registration with the Care Quality Commission (CQC)

Whittington Heath is registered with the Care Quality Commission (CQC) without any conditions. The CQC carried out two inspections of the Trust during 2022/2023. One was conducted in Maternity services and the other was a 'mental health act monitoring inspection' of Simmons House our Child Specialist Community Mental Health Service for Children and Young People. The final report for Maternity services was received on the 28th April 2023. Only two domains were inspected during the Maternity inspection, and these were 'Safe' and 'Well-led'. The trust received a rating of requires improvement for 'Safe' and a rating of Good for the 'Well-led' domain which gave Maternity services a rating of 'Requires improvement'. The previous ratings for the other three domains of effective, caring and responsive were not taken into account as they were inspected jointly with Gynaecology services back in 2017. An action plan is being developed to address the findings in the report.

The Mental Health Act (MHA) monitoring report following the inspection' of Simmons House our Child Specialist Community Mental Health Service for Children and Young People, was received on the 30th March 2023. Concerns were raised by the young people to the inspectors about the hot water temperature, medication errors and the anti-barricade doors. An action plan has been developed to address these actions and sent to the CQC.

The table below provides the rating summary table for the CQC's final report published in March 2020 following its previous inspection in December 2019 of four core services (Surgery, Urgent and Emergency Care Services (ED), our Critical Care, Community Health Services for Children Young People and Families and Specialist Community Mental Health Services for Children and Young People). The Trust's current CQC overall rating from that assessment is 'Good' for Whittington Health, with 'Outstanding' ratings for our community health services and performance against the CQC's '*Caring'* domain. The overall rating of the Trust has not changed following the CQC inspection of Maternity services in 2023 and remains 'Good' overall.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires Improvement	Good	Good	Good	Good	Good
Community	Good	Good	Outstanding	Good	Outstanding	Outstanding
Children's mental health services	Requires Improvement	Good	Outstanding	Good	Good	Good
Overall trust	Requires Improvement	Good	Outstanding	Good	Good	Good

The CQC action plan remains a focus for improvement; the actions are monitored by the responsible ICSU at their Quality meetings and through the Trust's Better Never Stops programme.

The CQC have moved to a more risk-based approach for service inspection since the COVID-19 pandemic began, this new approach focusses on reviewing data collected to trigger 'Direct Monitoring Activity' conversations. If there are still concerns or further action required after these conversations are

held, then this would trigger inspection activity. There will be a new assessment framework released by the CQC in 2023 to support this. Regular meetings have been held with our CQC Relationship Manager during 2022/2023. These have mainly focused on the following areas:

- Staff wellbeing and support
- Innovation at Whittington Health NHS Trust
- Elective services provision
- COVID-19 updates on outbreaks
- Serious incident investigations and CQC enquiries
- Victoria Ward
- Outpatients and diagnostic services – Core service focus
- Community nursing – core service focus
- Cancer waiting times – core service focus
- National audit program outlier status
- Maternity staff concerns raised to the CQC
- Pharmacy (direct monitoring activity conversation)

The most recent CQC engagement meeting was held in January 2023 and focused on recent leadership changes at the Trust and the current operational situation with impact on cancer performance and referral to treatment times due to COVID-19 and flu challenges. Our CQC relationship manager was given significant assurance on the areas highlighted at the meeting.

Secondary Uses Service

Whittington Health submitted records during 2021 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episodes Statistics. The percentage of records in the published data which included the patient's valid NHS number, and which included the patient's valid General Medical Practice Code were as follows:

		Percentage of records which included the patient's valid NHS number (%)	Percentage of records which included the patient's valid General Medical Practice Code (%)
2021/22	Inpatient care	99.45%	99.91%
	Outpatient care	99.62%	99.96%
	Emergency care	84.58%	100.00%

Data Item Score Average - April 2021 - December 2021

Information Governance (IG) Assessment Report

Information governance (IG) is to do with the way organisations process or handle information. The Trust takes its requirements to protect confidential data seriously and over the last 5 years have made significant improvements in many areas of information governance, including data quality, subject access requests, freedom of information and records management.

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The Data Security and Protection (DSP) Toolkit is a policy delivery vehicle produced by the Department of Health; hosted and maintained by NHS Digital. It combines the legal framework including the EU General Data Protection Regulations 2016, UKGDPR and the Data Protection Act 2018, the Freedom of Information Act 2000 and central government guidance including the NHS Code of Practice on Confidentiality and the NHS Code of Practice on Records Management. The framework ensures the Trust manages the confidential data it holds safely and within statutory requirements.

During the year the Trust implemented an improvement plan to achieve DSP Toolkit compliance and to improve compliance against other standards. As a result, the Trust hopes to meet the majority of the mandatory assertions with an improvement plan in place for IG training which will likely be below the target of 95%. The Trust's DSP Toolkit submission and former IG Toolkit submissions can be viewed online at www.dsptoolkit.nhs.uk and www.igt.hscic.gov.uk.

All staff are required to undertake IG training. In 2022 the Trust ended the year at 86% of staff being IG training compliant. The compliance rates are regularly monitored by the IG committee, including methods of increasing compliance. The IG department continues to promote requirements to train and targets staff with individual emails includes news features in the weekly electronic staff Noticeboard and manage classroom-based sessions at induction.

Information Governance Reportable Incidents

IG reportable incidents are reported to the Department of Health and Information Commissioner's Office (ICO). Reportable incidents are investigated and reported to the Trust's SIEAG Panel, relevant executive directorate or ICSU and the Caldicott Guardian and the Senior Information Risk Owner (SIRO). The IG committee is chaired by the SIRO who maintains a review of all IG reportable incidents and pro-actively monitors the action plans. The Trust declared two reportable incidents in 2022/23.

Data Quality

The Trust continued to work on a data quality improvement plan with significant improvements noted in the targeted areas. Trust monitors all national data submissions data quality at the point of submission and responds to any issues raised by NHS Digital with any remedial action required. Where system limitations have existed, the Trust continues to work with system suppliers to include fixes in the scheduled system upgrades as part of the supplier contracts. A regular review of the Data Quality Maturity Index (DQMI) scores published by NHS Digital Monthly is done at the Data Quality Group as well as the RIO User Group to highlight specific data quality issues requiring attention and to update on progress on data quality improvement initiatives.

To improve data quality in 2023-24 the trust will continue to embed the following actions:

- Replacing the Data Quality Group with a Data Quality and Business Intelligence Group that will include more stakeholder whose roles are relevant to maintaining data quality.
- Continue to use of data quality dashboards for services to individually monitor their own data quality as required. Plans are underway to improve the current dashboard and develop that in a more user-friendly platform that allows better collaboration.
- Issuing of regular data quality reports to specific services identified as requiring improvements.

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- Continue monitoring data quality for each of the Integrated Clinical Service Units (ICSUs) through the Data Quality and Business Intelligence Group
- Undertake to complete any data quality related actions as stipulated in the Data Quality Improvement Plan (DQIP) requirements of Schedule 6 of the NHS Standard Contract
- Undertake regular internal clinical coding audits.
- Increase the frequency of the external clinical coding audit to every 6 months and produce and monitor action plans.
- Systematic use of benchmarking of data
- Actively engage in any national or NCL-wide data quality improvement initiatives

End of life care

Adult Specialist Palliative Care Service

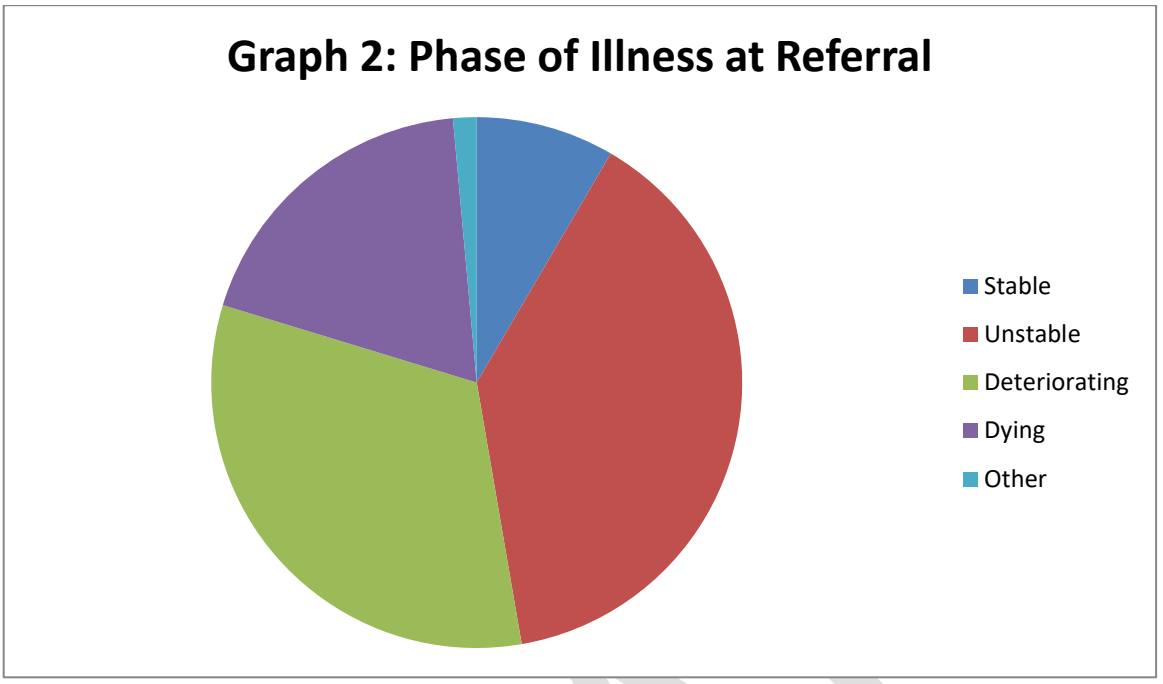
The Whittington Hospital Specialist Palliative Care team (SPCT) is a liaison service providing advice and guidance to the acute hospital teams caring for patients with palliative care needs. We manage physical symptoms, provide psychological support to patients and families, and engage in advance care planning to ensure that patients are discharged to their preferred place of care and die in their preferred place of death. We also provide education for non-specialist clinicians delivering palliative and end of life care.

The team has a visible presence across all hospital adult wards, including ambulatory care and ED. We have robust relationships and maintain regular contact with the Haringey (North London Hospice) and Islington (CNWL) community palliative care teams in order to facilitate joined up care across settings for patients and families.

Activity

At Whittington Health we cared for 503 patients who died during an acute admission in 2022. The SPCT saw over half of these patients. Our referrals were higher in 2022/23 than previous years, totalling 700. This is the highest number of referrals ever received by the service.

As well as increasing numbers of referrals, the complexity of our caseload has increased, particularly the amount of complex family support required. Over 70% of patients referred to SPCT in 2022/23 were in an unstable or deteriorating phase of their illness.



The SPCT proactively supports advance care planning discussions, including recording a patient's preferred place of care and death and whether this is achieved. Where appropriate, this is uploaded into the Pan-London Urgent Care Plan (UCP) so it is visible to all urgent and emergency care staff. In 2022/23, 225 palliative care patients had a UCP of which 104 were created or updated by the SPCT.

Quality and Performance Indicators

The Trust participated in the 2021/22 National Audit of Care at the End of Life (NACEL). This included a case note review (CNR) of all expected hospital deaths in April and May 2021, a hospital overview of governance and staffing (HGS), and a staff reported measure (SRM). The Trust was unable to participate in the Quality Survey designed to be sent to the families and those important to the deceased, as we have no robust mechanism for collecting these contact details. The summary scores for data collected include:

Table 1: Summary scores for data collected in NACEL

Key Theme	Source	National Summary Score	Whittington Hospital Summary Score
Communication with the dying person	CNR	7.9	8.5
Communication with families and others	CNR	7.0	6.9
Involvement in decision making	CNR	9.5	9.8
Individualised plan of care	CNR	7.7	6.8
Governance	HGS	9.7	10

Workforce / Specialist Palliative Care	HGS	8.1	3.1
Staff confidence	SRM	7.5	7.1
Staff support	SRM	6.4	5.3
Care and culture	SRM	7.3	6.9

Whittington Health scores are broadly in line with national performance. As in previous years, the Trust was a significant outlier in terms of specialist palliative care workforce. Since the audit period the SPCT have submitted a successful business case and recruited to a further 0.8WTE Band 7 Clinical Nurse Specialist post. This has enabled us to keep pace with our growing clinical workload and to renew our focus on education of ward staff, in response to our staff reported measure scores which are slightly lower than the national average.

NACEL Staff Survey Results and Education Action Plan

Thirty-three staff members responded to the survey which was circulated to all staff in summer and autumn 2021. The main feedback was that staff wanted more knowledge, education and training regarding palliative and end of life care to improve their confidence in caring for these patients. The survey reflects a time when staff had been engaged in caring for large numbers of patients with COVID-19, which is relevant in interpreting the results. It will be valuable to see results of subsequent surveys in future NACEL audits.

In response to the NACEL staff survey results, the SPCT has expanded its educational offer over the past year. This has been facilitated by an expansion of our Clinical Nurse Specialist team. Prior to the team expansion, we had been very limited in the education we were able to offer due to increasing clinical workload without a corresponding increase in staffing. The team has delivered training in 2022/23 as follows:

- Palliative care for student midwives
- Nursing students shadowing of team
- Syringe driver training on ICU
- Foundation year teaching on palliative and end of life care
- Respiratory team teaching on opioids and breathlessness
- HCSW Introduction to Palliative Care & Recognising Dying
- Nursing study day
- New staff nurse induction

Whittington Health elected not to participate in NACEL 2022/23. Results from the 2021/22 audit were made available informally in February 2022 and formally published in July 2022. It was felt that a further case note review of deaths occurring in April and May 2022, before any action could be taken on the results of the previous audit, would not add useful information and would take a significant amount of palliative care clinician time. This extra time was used to undertake staff training as described above, with our ongoing action plan in Table 2 below. The frequency of the national audit has now been reduced to biannually with the next round of data collection due in 2024.

All clinical staff caring for patients on medical and surgical wards need basic palliative care skills. Palliative and end of life care education ideally needs to be included in the induction and mandatory training programmes for all clinical teams. Over the past year, the SPCT has provided formal training

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at New Nurses Orientation, study days (nurses, HCSWs, student midwives) and for medical and foundation trainees. The team also provides a significant amount of informal training and support (including reflective practice and emotional support) through working with ward staff caring for patients with palliative care needs and attending team Morbidity and Mortality meetings. The team is small and so to ensure all staff receive the training they need to care for patients towards the end of life the SPCT need to work with colleagues such as practice development nurses and ward managers. The team would be happy to work with the Learning and Development Team to agree a programme of mandatory training utilising the eLearning for Health (eLFH) resources for relevant staff if this is agreed.

Below are the main areas that professionals need training in, and how training can be expanded.

Table 2: Areas requiring training, current delivery and how training can be expanded:

Topic	**How provided currently?**	**How could be expanded?**
Principles of PEOLC	Induction for nurses and medical trainees.	Induction and Mandatory training for all relevant clinical staff (could utilise eLFH modules).
Care of the dying patient	Induction for nurses and medical trainees. Study days. Working with palliative care teams on wards.	Induction and Mandatory training for all relevant clinical staff (could utilise eLFH modules).
Symptom control	Induction for nurses and medical trainees. Study days. Working with palliative care teams on wards.	Induction and Mandatory training for all relevant clinical staff (could utilise eLFH modules).
Syringe driver training	Syringe driver training currently available via PDNs. Specialist palliative care teams can support with ad hoc training. Ward managers are responsible for signing off staff competencies.	Ensure ward managers are keeping a record of syringe driver competencies.
Prescribing syringe drivers	Guidelines on intranet, at induction for trainees. 1-2-1 informal training.	
Communication Skills in PEOLC	Study days. Working with palliative care teams on wards	External courses eg Sage & Thyme

Learning from Deaths

Information to follow

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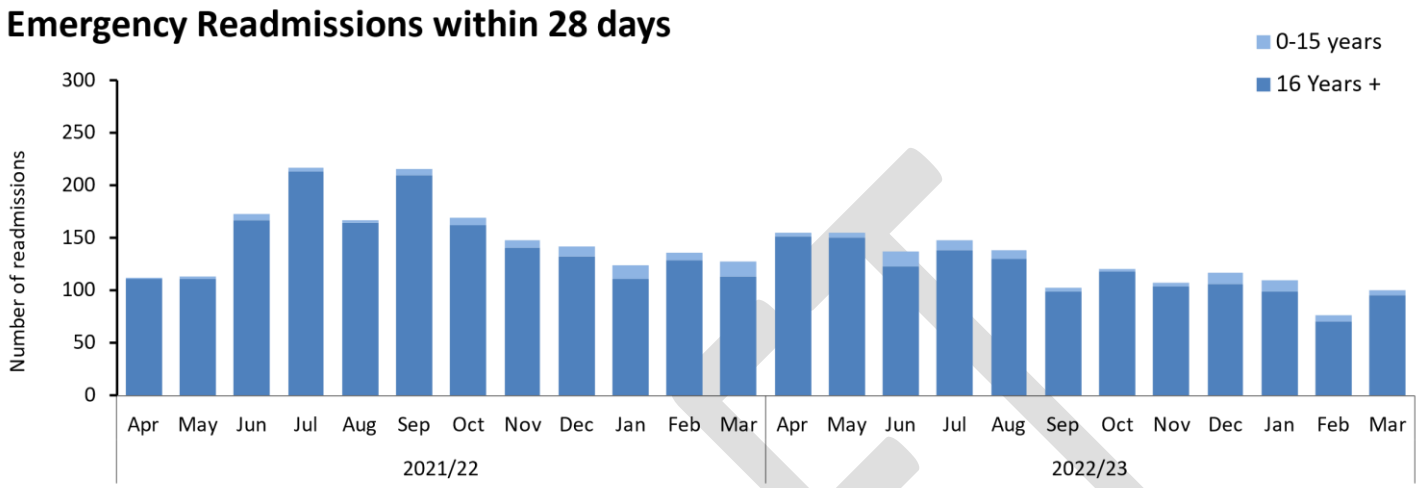
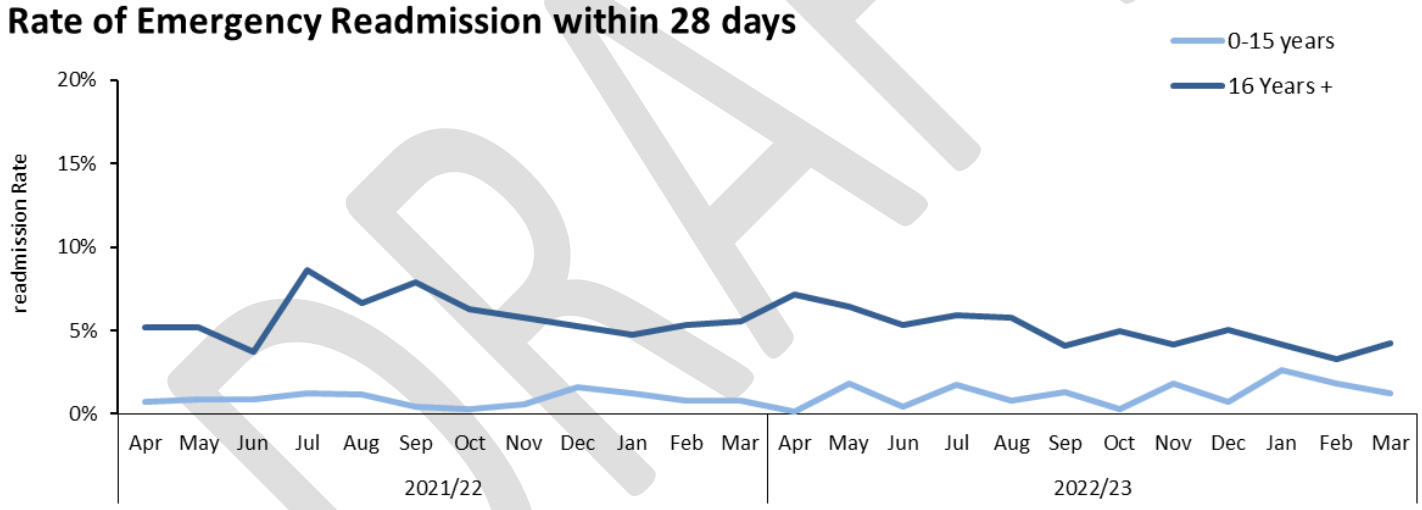
Percentage of patients 0-15 and 16+ readmitted within 28 days of discharge





The Trust reports within stated requirements, the readmission data is reviewed thoroughly and compared closely to the metric that is used for routine board and departmental monitoring of readmissions.

*Data is reported against the month of discharge of the emergency readmission

*Data excludes patients between 0 and 4 years at time of admission or re-admission. Cancer and Maternity admissions and readmissions are excluded. Patients who discharged themselves are also excluded.

National data has not been published beyond 2011/12. Consequently, national comparison is not available, and this information is generated locally by the trust.

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During 2022 the Trust has focussed on scoping and implementing initiatives to improve patient flow within the hospital and ensure safe discharges but, also reduce the numbers of patients requiring potential readmission within 28 days of discharge. Streaming pathways have been implemented and reviewed to try and reduce admissions and reduce waits against the 4 hour target, improving patient experience.

Our 'Multi Agency Discharge Event's' (MADEs) are now part of business as usual. They have regular input from Social Care, Clinicians, District Nursing and GPs to ensure patients are discharged to the most appropriate place for their care in a timely manner. However operational pressures have been experienced nationally which has affected discharge times. The data table that supports the graphs below can be found in Appendix Three.

The trust's Responsiveness to the Personal Needs of its Patients

Learning from National Patient Surveys

The Trust received the results for three national patient experience surveys during 2022/23. These were:

- 2021 Adult Inpatient Survey (published September 2022)
- 2022 Maternity Survey (published January 2023)
- 2021 Cancer Patient Experience Survey (published July 2022)

Adult Inpatient Survey 2021

1250 people, who stayed in hospital for at least one night during November 2021, were invited to take part in the survey. 30% of people responded, with a reduction of 3% response rate in comparison to our previous survey conducted in 2020. This percentage sits below the average response rate for similar organisations of 39%.
The survey, carried out by Picker on behalf of the Trust, used a mixed-mode data collection of both online and paper-based surveys, in addition to using a range of contact for invitation and reminders for completion, via letter and SMS format.
The survey was made available in a range of accessible formats, including Braille, Easy Read, British Sign Language, non-English languages, telephone assisted completes and a screen-reader compatible online questionnaire. In addition to this, a freephone language line service was available to provide translation services.

The representation of our respondents was as follows:

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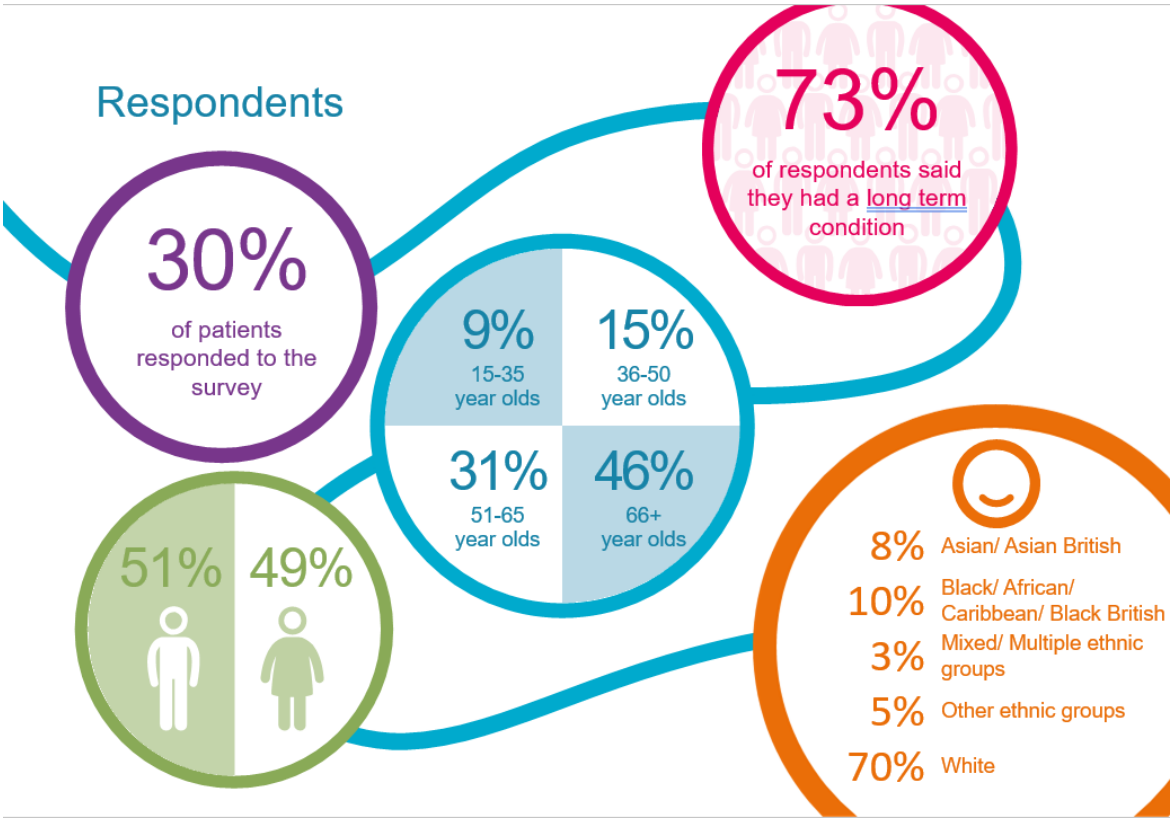

In comparison to the previous year, the following changes were noted within the demographics of respondents:

- An increased percentage response from those with a long-term condition (70% to 73%)
- A closer matched ratio of male to female participants (43/55% to 51/49%)

The key improvements and issues to address are summarised below:

Most improved scores since 2020		
↑	**98%**	Staff helped when needed attention
↑	**96%**	Room or ward very or fairly clean
↑	**91%**	Got enough to drink
↑	**79%**	Staff discussed need for additional equipment or home adaptation after discharge
↑	**98%**	Had confidence and trust in the doctors

Top scores vs the Picker Average			
	Trust Score	**Picker Average**	
☺	**90%**	**87%**	Given information about medicine at discharge

	16%	**13%**	Asked to give views on quality of care during stay
	97%	**95%**	Questions before procedure were answered well
	98%	**98%**	Staff helped when needed attention

Focus on Inpatient views	
77%	Rated overall experience as 7/10 or more
97%	Treated with respect and dignity overall
98%	Had confidence and trust in the doctors

Bottom 5 scores vs the Picker Average		
	52%	Food was very good or fairly good
	56%	Able to get food outside of mealtimes
	64%	Told who to contact if worried after discharge
	39%	Not prevented from sleeping at night
	58%	Staff did not contradict each other about care and treatment

Key successes include people getting help when they needed attention (Q30), increasing from 95% to 98% (above the national average of 97%). We maintained our scores for 98% of respondents having confidence and trust in their doctors (Q17), and 97% for answering questions before procedure well (Q32). These positive results are testament to the hard work and care of our clinical staff, and we will aim to maintain and even exceed these scores in future years.

96% of respondents reported that their room or ward was very or fairly clean (Q8), an increase on the previous score of 95%, in comparison to national results which saw a decrease in positive results since 2020.

When considering discharge from hospital, there was discussion about additional equipment or home adaption (Q37) for 79% of respondents (an increase from 78% in 2020), and their medications (Q41) for 90% of respondents (decreasing from 93% in 2020, remaining above the Picker average of 87%).

Looking at nutrition and hydration questions, there were both positive and negative results. We have increased our score for getting enough to drink (Q15) from 90% to 91%, matching the national average. This coincides with work done with staff to ensure patients are regularly asked whether they would like more to drink, and making water more readily available with the use of water dispensers on wards. However, our food score (Q12) has fallen to 52% from 55%. As the survey was conducted prior to the roll out of fully plated meals in January 2022 across all areas, allowing for increased patient choice at each mealtime, we hope to see a positive change in these scores in future patient surveys.

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We continue to ask patients on their views on the quality of care during their stay, scoring 16%, which is 3% above the Picker average. However, this score has seen a downward trend since 2017 from 22%, showing our need to focus on accessing patient opinion more regularly during their stay. The Patient Experience and Volunteering team are currently working on ways to increase feedback received, and this area will be a goal to look to improve over the next year. The implementation of the Patient Safety Incident Response Framework (PSIRF) will support an increase in accessing patient views, as it has a key focus on engaging those with a lived experience of NHS care as a key part of incident responses and improvement work.

Staff Friends and Family Tests

Listening to Our Staff

This is the twelfth year in which Whittington Health as an Integrated Care Organisation (ICO) has conducted the national staff survey and the fifth year in which the Trust opted to invite all eligible staff to complete it. It is the second year Whittington Health has opted to run the survey online only. This paper summarises the results of the survey, draws out key comparative data and provides details of the proposed steps for updating staff and developing action plans. The 2022 NHS England-commissioned survey was sent to all staff in 124 NHS organisations. In 2022, 432,292 staff nationally responded with a median response rate of 44%.

This is the second year the survey results are aligned to the People Promise. There are seven People Promise elements which replace the old themes in addition to the existing elements of staff engagement and morale. A total of 117 questions were asked in the 2022 survey, of these 97 can be positively scored. Our results include every question where our organisation received at least eleven responses, which is the minimum required.

Of Whittington Health's (WH) 4519 eligible staff, 2019 staff took part in this survey, a response rate of 45% which is 1% below the average response rate for Acute and Acute & Community trusts using Picker. The Trust's response rate dropped by 7% since 2021. This is first time since 2017 that WH has experienced a response rate below 48%.

The purpose is to give staff a voice and provide managers with an insight into morale, staff engagement, wellbeing, culture and perception of service delivery. In 2020 NHS England and NHS Improvement took the decision to combine Acute trusts and combined Acute and Community trusts into one benchmarking group after analysis of the 2019 survey showed no substantial difference in the occupation group profiles or the overall distribution of scores or the survey themes for the two types of organisation. Whittington Health has been part of this newly combined Acute and Acute & Community Trusts group since 2020.

Staff Engagement Indicator

For the 2022 Staff Survey the key findings that make up the engagement score of staff are:

- Staff recommendation of the trust as a place to work or receive treatment (Advocacy)
- Staff motivation at work
- Staff ability to contribute towards improvements at work (Involvement)

Whittington Health's theme score of 6.8 for staff engagement is the national average 6.8 score and a reduction from the previous year which was 6.9.

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Staff Morale Indicator

Whittington Health's theme score of 5.5 for staff morale which is slightly below the national average of 5.7 and a reduction from last year where morale stood at 5.6. The reduction follows a similar trend with other Acute and Acute Community Trusts.

The key findings that make up the Morale score are:

- Staff retention/turnover – thinking about leaving the organisation where the organisation scored 0.4 below average.
- Work pressures where the organisation scored 0.2 below average.
- Stressors – where the organisation scored average, and in line with other organisations.

Whittington Health – 2022 overall results – Themes

In 2022 Whittington Health is not ranked as 'worst' or 'best' in any of the themes. The Trust is slightly above average for one of the themes: We are a team; Average for two themes: We are recognised and rewarded, and We each have a voice that counts. The Trust has scored slightly below average in We are compassionate and inclusive, We are safe and healthy, We are always learning, We work flexibly.

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team
Your org	7.1	5.7	6.6	5.8	5.3	5.9	6.7
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3
Responses	2016	2017	2006	2004	1927	2014	2016

Most improved scores

The table below shows the top five most improved scores for 2022 in comparison to 2021. Note that in the areas of Development and Reasonable Adjustments the organisation is still below the NHS average, with making reasonable adjustments to enable staff with disabilities to carry out their work 8.3% below average.

People Promise element or theme	Question	2021	2022	NHS average
We are safe and healthy: Negative experiences	q11b. In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	36.6%	33.2%	30.6%
Morale: Stressors	q5c. Relationships at work are unstrained	46.4%	48.4%	44.0%
We are always learning: Development	q22e. Able to access the right learning and development opportunities when I need to	52.6%	54.8%	56.4%
We are compassionate and inclusive: Inclusion	q8b. Colleagues are understanding and kind to one another	68.7%	70.7%	69.6%
Not linked to People Promise elements or themes	q30b. Has your employer made reasonable adjustment(s) to enable you to carry out your work?	61.8%	63.4%	71.7%

Most declined scores

The below table indicates the most declined areas in comparison to 2021 and shows the overall NHS average in 2022. Note that despite the decline in these five areas since 2021, apart from the level of pay satisfaction, the Trust remains above NHS average.

People Promise element or theme	Question	2021	2022	NHS Average
We are recognised and rewarded	q4c. Satisfied with level of pay	25.7%	20%	25.1%
Staff Engagement/Advocacy	q23d. If friend/relative needed treatment would be happy with standard of care provided by organisation	67%	62.2%	61.9%
We are compassionate and inclusive: Compassionate Culture	q23b. Organisation acts on concerns raised by patients/service users	74.7%	70.7%	68.3%
We are safe and healthy: Health and safety climate	q11a. Organisation takes positive action on health and well-being	76.5%	70.6%	68.3%
We are safe and healthy: Health and safety climate	q13d. The last time you experienced physical violence at work, did you or a colleague report it?	76.5%	70.6%	68.3%

Highest and lowest scores in comparison to the NHS average

The below table shows the highest scores for WH in comparison to the NHS average scores.
The organisation has scored highly on quality of relationships at work and in two domains around line manager's asking staff opinions before implementing changes and providing clear feedback. The organisation has also scored positively around witnessing errors or near misses that could hurt the patients or service users.

Despite the organisation scoring positively (10% below NHS average) on staff not working additional paid hours, the trust is still 7.4% above NHS average where staff are working additional unpaid hours.

People Promise element or theme	Question	2021	2022	NHS average

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Not themed	q10b. On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?	30.5%	30.5%	40.4%
Morale: Stressors	q5c. Relationships at work are unstrained	46.4%	48.4%	44.0%
We are a team: Line management	q9c. My immediate manager asks for my opinion before making decisions that affect my work.	60.9%	62.1%	56.9%
Not themed	q17. In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users?	N/A	31.8%	35.2%
We are a team: Line management	q9b. My immediate manager gives me clear feedback on my work	64.7%	66.0%	62.1%

The table below shows the bottom five scores for WH in comparison to the NHS average.

The organisation has seen an improvement in some of the bottom scores since 2021, such as the organisation making reasonable adjustments for staff with long term conditions or disabilities, but it is still one of our lowest scored compared to the NHS average. The same applies to career progression, where the organisation has made an improvement of 2% but it is still below NHS average by 7.3%. The organisation has seen a decline and remains in the bottom scores in the areas of working additional unpaid hours, having adequate material to do my work and thinking about leaving.

People Promise element or theme	Question	2021	2022	NHS Overall
Not themed	q10c. On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?	62.5%	63.7%	56.3%
We are safe and healthy: Health and safety climate	q3h. I have adequate materials, supplies and equipment to do my work	47.0%	46.5%	53.5%
Not themed	q.30b Has your employer made reasonable adjustment(s) to enable you to carry out your work?	61.8%	63.4%	71.7%
We are compassionate and inclusive: Diversity and equality	q15. Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	46.3%	48.3%	55.6%
Morale: Thinking about leaving	q24b. I will probably look for a job at a new organisation in the next 12 months.	27.5%	30.5%	23.0%

Progress on the 2021 Staff Action Plan

In response to advice provided by the NHS Co-ordination Centre, the Trust sought to create action plans that focused on a small number of key areas to ensure progress is made and staff are able to experience the changes.

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On receipt of the 2021 survey results the Workforce Directorate provided summaries of Integrated Care Service Units (ICSU) and Directorate results with three suggested focus areas for each ICSU and Directorate and a high-level action plan template.

The themes and templates were shared with all of the leads who were then tasked with cascading downwards, using the '***We Said We Did'*** templates to capture improvement work at team level. In addition to the templates and guides, departments and teams were issued with team coaching guides and action plan to support workshops.

To support managers and ensure staff were included in the process a number of workshops and support was offered by HR and Organisational Development (OD) to 'hot spot' teams. This included attending senior team Away Days, helping managers facilitate workshops to share the data and identify improvement areas.

The scoring matrix from the 2021 staff survey, which illustrates the changes in scores from the 2021 survey can be found in Appendix 4.

Details of the Equality indicators for the staff survey can also be found in Appendix 5.

Patient Feedback: Learning from National Patient Survey Results

2022 Maternity Survey

300 people, aged 16 or older who had a live birth during the month of February 2022, were invited to take part in the survey. 54% of people responded, with a reduction of 7% response rate in comparison to the previous survey conducted in 2021. Although reduced, this response rate is above the average rate for similar organisations (48%).
The survey, conducted by Picker on behalf of the Trust, used a mixed-mode data collection of both online and paper-based surveys, in addition to using a range of contact for invitation and reminders for completion, via letter and SMS format. The online survey was available in nine non-English languages and included accessibility formats.
The representation of our respondents was as follows:

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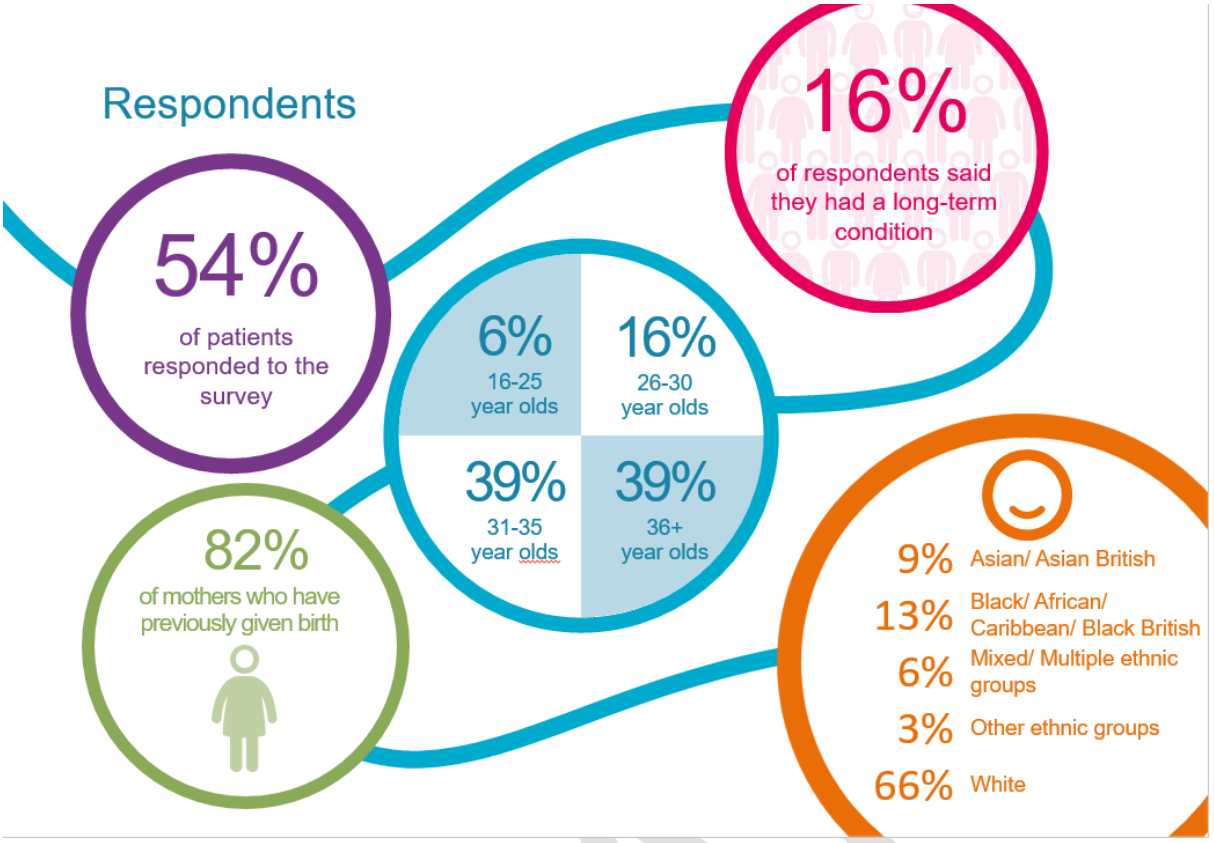

The number of respondents reporting a long-term condition remained static at 16%, as did the percentage of mothers who have previously given birth (82%). The percentage of respondents from ethnic minority groups increased from 29% to 31%.

Key findings, improvements and issues to address are summarised below:

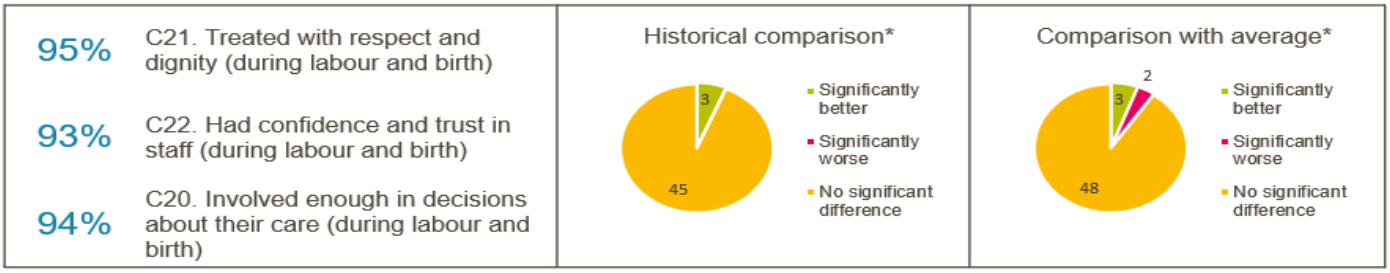

*Chart shows the number of questions that are better, worse, or show no significant difference

Most improved scores since 2021		
↑	**70%**	Saw the midwife as much as they wanted (postnatal)
↑	**71%**	Felt GP talked enough about mental health during postnatal check-up
↑	**69%**	Felt GP talked enough about physical health during postnatal check-up
↑	**84%**	Given enough support for mental health during pregnancy
↑	**72%**	Felt midwives aware of medical history (postnatal)

Top scores vs the Picker Average		
	91%	Found partner was able to stay with them as long as they wanted (in hospital after birth)
	85%	Given enough information about coronavirus restrictions and any implications for maternity care
	70%	Saw the midwife as much as they wanted (postnatal)
	90%	Involved enough in decision to be induced
	81%	Able to ask questions afterwards about labour and birth

Most declined scores		
	73%	Felt they they were given appropriate advice and support at the start of labour
	83%	Given information about changes to mental health after having baby
	93%	Had confidence and trust in staff (during labour and birth)
	80%	Given enough information about their own physical recovery
	94%	Involved enough in decisions about their care (during labour and birth)

Bottom 5 scores vs the Picker Average		
	72%	Provided with relevant information about feeding their baby
	73%	Felt they they were given appropriate advice and support at the start of labour
	63%	Received suppport or advice about feeding their baby during evenings, nights or weekends
	80%	Given enough information about their own physical recovery
	82%	Received help and advice about feeding their baby (first six weeks after birth)

Key highlights to note include the excellent feedback that **91%** felt their partners were able to stay for as long as they wanted (D7), in comparison to a national average of 41%, reflecting the Trust's proactive approach to risk assessing partner visiting during the Covid pandemic to allow this to continue safely. This score was in the top 10 out of 121 Trusts who conducted the survey.

The survey results indicate that further work can be done to improve provision of information, advice and support in maternity services (B16, F15 & F16: feeding information – 63% - 82%; C7: start of labour – 73%, F14: physical recovery – 80%; F12: mental health - 83%). Following the survey, an Ockendon visit took place in June 2022, which found that the service worked closely with the Maternity

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Voices Partnership to drive improvement, including co-design of patient information. Additional quality improvement projects are currently underway looking at improving education and information for maternity service users, which we hope will be reflected in future positive survey results regarding information provision, advice, and support.

National Cancer Patient Experience Survey 2021

228 patients (with a confirmed primary diagnosis of cancer, discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April, May and June 2021) were invited to take part in the survey, and 88 responses (39%) were received.

The survey was conducted in both paper and online form, with respondents from 10 different tumour groups. Age distribution was from 25-85+, with 15% of total respondents from ethnic minority groups.

The executive summary is displayed below:

Questions Above Expected Range	Case Mix Adjusted Scores			
	2021 Score	Lower Expected Range	Upper Expected Range	National Score
Q22. Family and/or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options	86%	64%	85%	75%

Questions Below Expected Range	Case Mix Adjusted Scores			
	2021 Score	Lower Expected Range	Upper Expected Range	National Score
Q6. Diagnostic test staff appeared to completely have all the information they needed about the patient	69%	75%	93%	84%
Q18. Patient found it very or quite easy to contact their main contact person	74%	77%	93%	85%
Q19. Patient found advice from main contact person was very or quite helpful	89%	91%	100%	96%
Q26. Care team reviewed the patient's care plan with them to ensure it was up to date	94%	95%	100%	99%
Q32. Patient's family, or someone close, was definitely able to talk to a member of the team looking after the patient in hospital	35%	42%	79%	61%
Q34. Patient was always able to get help from ward staff when needed	54%	61%	91%	76%
Q35. Patient was always able to discuss worries and fears with hospital staff	44%	50%	84%	67%
Q37. Patient was always treated with respect and dignity while in hospital	68%	78%	100%	89%
Q38. Patient received easily understandable information about what they should or should not do after leaving hospital	70%	77%	100%	89%
Q41_1. Beforehand patient completely had enough understandable information about surgery	78%	80%	99%	89%

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Q42_1. Patient completely had enough understandable information about progress with surgery	65%	74%	95%	85%
Q59. Patient's average rating of care scored from very poor to very good	8.4	8.6	9.2	8.9

To put this into context the results came during a period of extreme challenges for the delivery of patient centered care for Whittington Health cancer patients. Whilst it is accepted that many of the scores are below the lower expected range, Cancer Services valued the opportunity to learn and develop its services to ensure that these concerns are reduced in the future.

In response to the results, an action plan was drawn up to address some of the issues highlighted in the survey. The actions included:

- Building a stronger working relationship with other hospitals in order to enable better understanding of the needs of those with cancer or where cancer may be suspected.
- 'Ten at Ten' sessions were organised from September 2022 onwards giving the opportunity for the clinical nurse specialist (CNS) team to engage with other healthcare professions to support their learning and understanding about issues that might affect cancer patients. These included topics such as neutropenic sepsis and spinal cord compression which may be the cause of an acute admission. The CNSs also provide expert advice and guidance during a hospital admission, as their expertise and good practice is essential to the development of ward staff, which in turn enhances patient care.
- Training for frontline staff, including Ward Clerks and administrative staff around patient engagement. This was delivered by 'Wingfactors' (aviation experts) during Q2 and Q3 of 2022. This helped to promote and improve better communication with patients, their families and carers, especially during periods when a hospital stay was required. During the time of the survey, hospital visiting was very limited due to ongoing Covid-19 restrictions, which created further problems with access to information, especially for a patient's family and carers.
- Work is currently underway to increase the support available in cancer specific outpatient settings using volunteers. This is to improve the patient experience, but also gives the opportunity to engage with the patients to further support the collection of friends & family feedback (FFT)
- Face to face Health and Wellbeing events have also increased during the latter part of 2022. These help to increase engagement with different patient groups. This then supports patients to gain further information and awareness of support mechanisms, which helps to manage some of the concerns and anxieties that occur because of a cancer diagnosis and ongoing treatment. An example of this was the highly successful Prostate Cancer event held in September 2022. This focused on a patient group that had been poorly serviced in relation to ongoing support (men and in particular Black Men who have a disproportionately higher chance of being diagnosed with prostate cancer). The event brought patients and healthcare professionals together, provided access to information, personal testimonies of living with this condition and explored the need for ongoing support.

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Family & Friends Test (FFT)

Response Rates

A total of 29,577 Family & Friends Tests were completed for the year, with an average of 2,465 per month. This is an increase on the previous year's average of 2,067 per month.

August 2022 received the highest volume of submissions, coinciding with focused intervention of Patient Experience team and Maternity services to increase response rates, going from a response rate of 202 in July, up to 517 in August. Whilst this improved rates for that month, the subsequent months did not maintain this rate, dropping to 167 the following month, demonstrating that further work is required to embed the practice of services proactively requesting service user feedback.

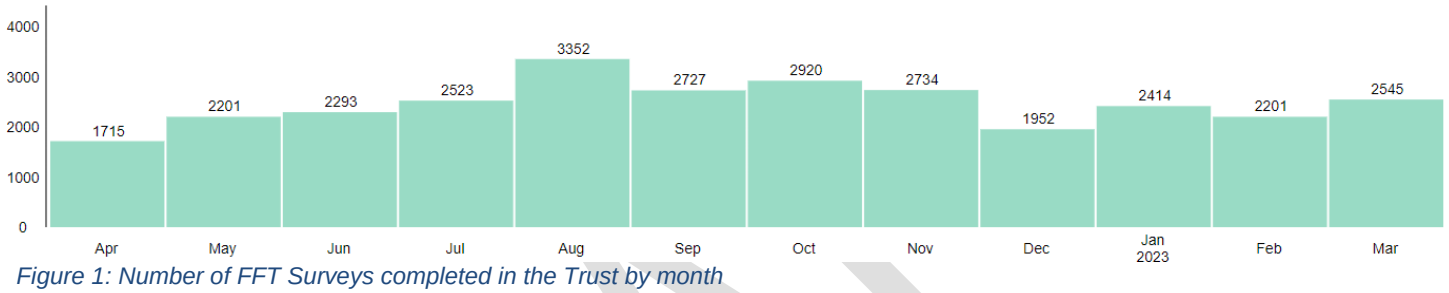


Figure 1: Number of FFT Surveys completed in the Trust by month

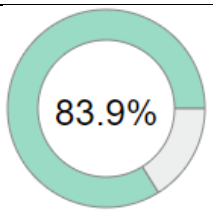
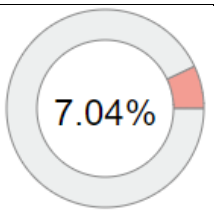
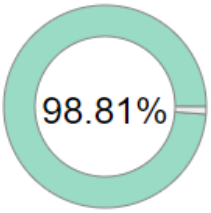
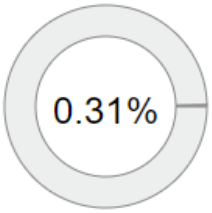
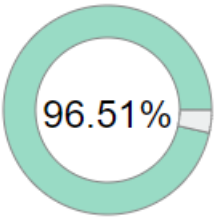
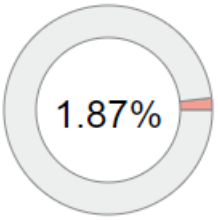
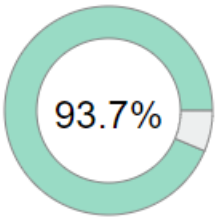
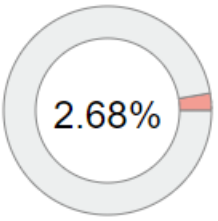
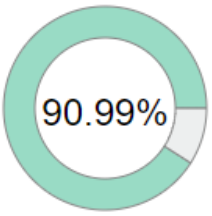
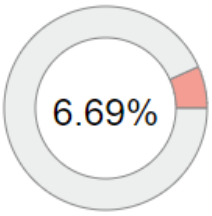
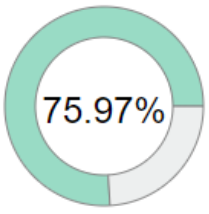
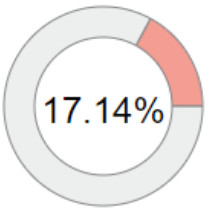
Work has continued within the Patient Experience Team and Voluntary Services to promote and collect FFT responses. This includes the ongoing work of collecting handwriten postcards to upload to the electronic reporting system. A new project was commenced in Quarter 4 of 22/23, with Patient Experience staff and volunteers regularly visting Outpatient waiting areas to promote completion of FFTs, making electronic tablets available for patients to complete.
FFT responses are received from a range of sources, including:

- SMS/text (12,329 responses)
- Smartphone app/tablet/kiosk (7,710 responses)
- Postcards (6,161 responses)
- Online survey after discharge/appointment (1,781 responses)
- Telephone survey after discharge of appointment (5 responses)

QR codes have been introduced across the Trust, enabling patients to provide feedback from their own devices, as well as reducing the need for manual collection and inputting of data. The automated SMS/text message is in place, with the largest number of SMS/text responses being received for the Emergency Department FFT (9,388).

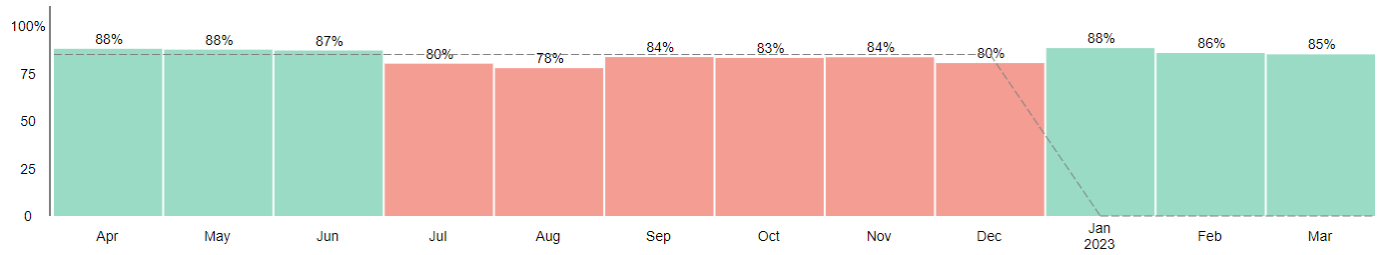
Scoring

The below charts demonstrate the percentages of "very good/good" versus "poor/very poor" responses.

FFT - All	 % very good or good  % poor or very poor
FFT – Birth	 % very good or good  % poor or very poor
FFT - Community	 % very good or good  % poor or very poor
FFT - Inpatient	 % very good or good  % poor or very poor
FFT - Outpatient	 % very good or good  % poor or very poor
FFT – Emergency Department	 % very good or good  % poor or very poor

The overall average has fallen from 89% to 84%, with lowest scoring noted within the Emergency Department and Outpatient FFTs. On further analysis, it is noted that this drop in responses were during Quarter 2 and 3, with an uplift in scoring during Quarter 4, reflecting a proactive response of Patient Experience and individual services to improve based on feedback received.

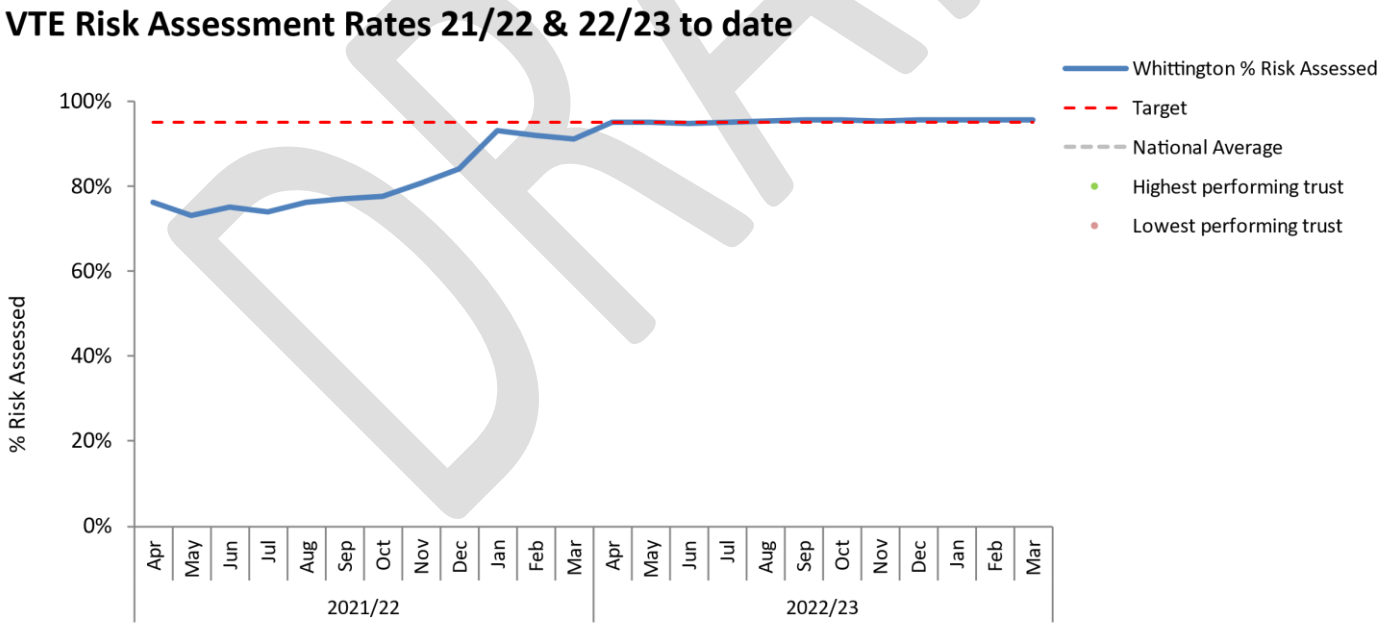
Figure 2: Very good and good responses for all FFTs



The Patient Experience and Engagement Strategy for 2023-2025 has been written and an action plan drawn up. Goals include:

- To expand methods used to receive feedback in order to engage with a wider audience that is representative of the community we serve.
- To increase our Friends and Family Test responses to baseline response rate seen prior to the Covid Pandemic.
- To engage and recruit patient representatives to be present and able to contribute at Trust meetings, playing an active role in improvements and learning from incidents.

Venous Thromboembolism (VTE)



Every year, thousands of people in the UK develop a blood clot within a vein. This is known as a venous thromboembolism (VTE) and is a serious, potentially fatal, medical condition. The Trust

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policy requires all admitted patients are individually risk assessed and have appropriate thromboprophylaxis prescribed and administered.

Since April 2022 the Trust VTE Risk assessment compliance is consistently above 95% as per National Standards.

The following actions have been taken:

- Close co-operation between the VTE pharmacist and Information Technology to switch from a non-mandatory VTE RA on ICE Sunquest to a mandatory VTE RA form on Careflow clinical noting which happened in November 2021.
- A Quality Improvement project has been published internally as an example of successful implementation.
- Subsequent inclusion of the VTE mandatory form into gynaecology, paediatrics and elective surgical proformas to increase compliance rate and maintain a good level of safety in VTE prevention.
- Weekly VTE team meeting established to review actions to be taken to increase VTE RA compliance and policies/guidelines e.g., sub-massive PE, COVID guidelines updates, one-page anticoagulation and PE guidelines.
- A quarterly Thrombosis Committee meeting also established starting from March 2022 with a multidisciplinary representation.
- Weekly MDT meeting to follow up patients who might need bridging plans/haematology reviews.

Root Cause Analysis:

Root cause analysis continue to represent an educational tool for healthcare professionals on VTE thromboprophylaxis and the VTE pharmacist and the team are keen on keep collecting data to prove our Trust standards and implementing a robust reporting system.

- A report system is currently in place for the Trust to be able to provide data on Hospital Acquired Thrombosis (HAT) occurred annually in the Trust.

- Serious Incidents management (Datix) and co-operation with the Patient Safety Pharmacist and Patient Safety Group leads to help increasing awareness of incidents occurring related to anticoagulation.

The team is working towards an application as VTE Exemplar Centre.

Infection prevention and control

A senior lead nurse leads the Trust Infection Prevention and Control (IPC) procedures, in collaboration and under the direction of the Chief Nurse and Director of Allied Health Professionals, who is the Accountable Officer, and Director of Infection Prevention and Control. The Infection Prevention and Control Team (IPCT) provide a full service to hospital, dental, mental health and community services across Whittington Health NHS Trust. Operationally, they are a team of senior IPC nurses, audit person and an information analyst who support national, regional and local reporting on health care acquired infections (HCAI), Trust attributable bacteraemia such as Methicillin Resistant Staphylococcus Aureus

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(MRSA) and Escherichia Coli (E. Coli); Clostridium Difficile infections, HCAI outbreaks; Seasonal respiratory illness e.g., Influenza and Sars-Cov-2 (COVID-19) across the Trust.

The focus is on prevention of infection through surveillance, audit, education, training and reaudit. The table below summarises the numbers of incidents of patients acquiring the main healthcare acquired infections.

Health Care Acquired Infections (HCAI)

Nosocomial or Health Care Acquired Infections (HCAI) are defined as those occurring:

- as a direct result of treatment in, or contact with, a health or social care setting
- because of healthcare delivered in the community healthcare-associated infections
- outside a healthcare setting (for example, in the community) and brought in by patients, staff or visitors and transmitted to others (for example, norovirus).

(NICE Quality Standard- 13 - 2016)

The UK Health Security Agency (UKHSA) monitors the numbers of certain infections that occur in healthcare settings through routine surveillance programmes and advises on how to prevent and control infection in establishments such as hospitals, care homes and schools.

Management of healthcare associated infections

Whittington Health's infection prevention and control policy documents the importance of preventing and reducing rates of HCAI and the surveillance of potential incidents. This remains critical for inpatients who are at risk as they provide essential information on what and where the problems are and how well control measures are working.

Health Care Acquired Infections – COVID-19

2022-23 Covid surveillance continues, anticipating a drop of reported infections in line with August 2022 guidance pausing routine asymptomatic testing in a number of NHS settings (e.g., emergency, trauma). The Trust reports daily on all HCAI COVID-19 infections. There have been 182 definite COVID-19 HCAI cases in the reporting period 2022/23. Wherever known transmission has occurred, appropriate IPC measures are implemented, individual cases are reviewed and when necessary, closure of beds recommended. There is regular updating of the COVID-19 IPC guidance, and this is incorporated within local policies and guidelines to ensure all staff are kept up to date on Department of Health and NHSEI changes.

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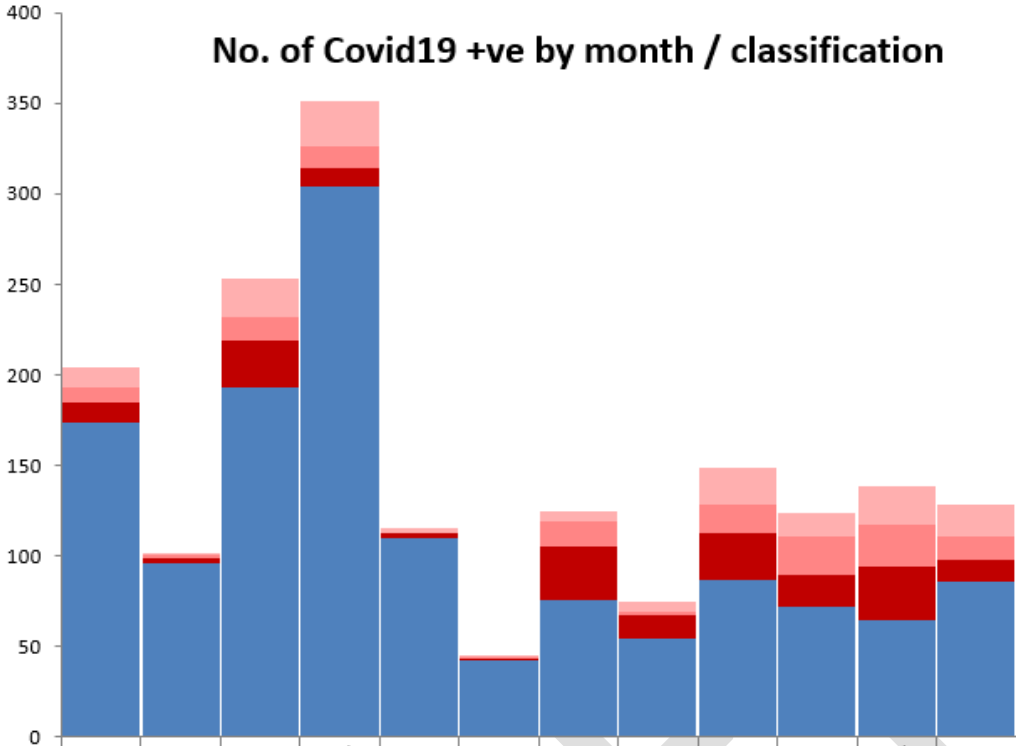

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2022									2023		
Intermediate HAI	11	1	21	25	2	1	6	6	21	13	22	17
Probably HAI	8	2	13	12		1	14	2	15	21	23	13
Definite HAI	11	3	26	10	3	1	29	13	26	18	29	12
Community Acquired	174	96	193	304	110	42	76	54	87	72	65	86

Health Care Acquired Infections – Other infections

The Infection Prevention and Control team continue to support the hospital and community services by performing the post infection reviews which focus on all aspects of the patient journey from pre-admission through to discharge when the patient acquires a HCAI. This includes a multi-disciplinary clinical review of all cases with rapid feedback of good practice and/or any lapse in care identified to prompt ward-level learning; these are reported at the Infection Prevention and Control Committee (IPCC) meeting to ensure Trust-wide sharing and learning and an appropriate platform for escalating outstanding actions.

2022/23 has seen an increase of Clostridium Difficile (C. Diff) cases compared with previous years which may be a threefold consequence of 1) increased use of key antibiotics required during the acute and subsequent phases of the COVID-19 pandemic 2) the altered surveillance definitions of health or community acquisition and 3) C. difficile threshold is calculated during the 12 months ending November 2021 data. If a trust had more than ten cases the threshold will be one less than the count. Up until February 23 Whittington Health reports zero cross infection in relation to this infection. March cases remain outstanding on referencing two sample strains to rule out cross contamination of two cases found in the same ward at the same time.

The table below summarises the numbers of incidents of patients acquiring the main healthcare acquired infections.

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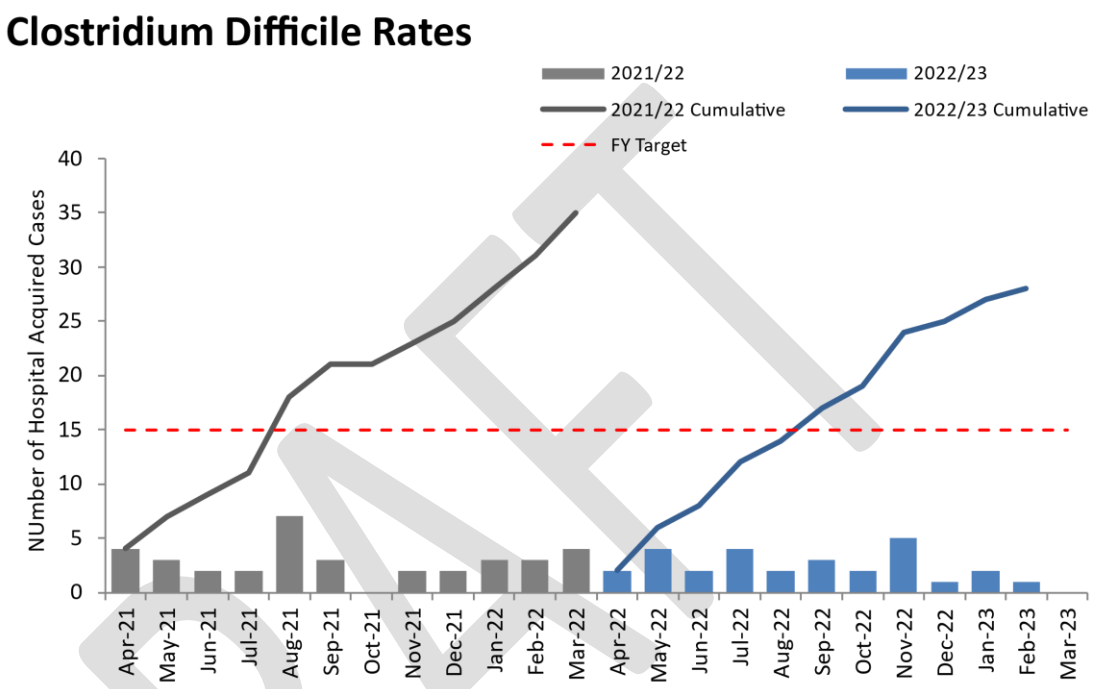
Infection	Outcomes
MRSA (Methicillin Resistant Staphylococcus Aureus)	There is a zero tolerance on MRSA blood stream infections (BSI). Unfortunately, there were two reported case in the reporting year. The first case (February 23) is from an unclear source and a possible contaminant. The second case is probable source to be line related. There is Trust wide learning outcomes identified and dedicated work streams underway through audit and education.
Clostridium Difficile Infections (CDI)	 The UKHSA CDI trajectory recommended for 2022/23 within the Trust was set at 14, Whittington Health reported 21 cases of CDI (Hospital onset, healthcare associated (Day 2 or later since admission HOHA) above the target. All cases were investigated under collaboration with microbiology, pharmacy, IPC, nursing and the medical teams. There have been no lapses in care related to cross-transmission or antibiotic choices until February, March cases investigation continue. Recurring themes from post infection reviews (PIR) were: • Missed opportunity to send stool on time (making a CAI a HAI) • Not isolated ○ as no side room ○ not recognising infectious diarrhoea • Poor documentation ○ not being able to isolate not recorded ○ no pre-admission bowel habit recorded ○ no cause of diarrhoea assessment undertaken IPC are working alongside the EPR program team to ensure documentation on the frontline is intuitive, clear and simple. Rapid patient clinical assessment is essential for providing appropriate IPC management and reducing the spread of infection.

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Infection	Outcomes
E.Coli Bacteraemia	Trusts are required under the NHS Standard Contract 2022/23 to minimise rates of both C. difficile and of Gram-negative bloodstream infections so that they are no higher than the threshold levels set by NHS England and Improvement. There were 17 Trust-attributed E. coli blood stream infections (BSI) this year of a trajectory set at 35. The national objective in line with the UK five-year plan 'Tackling antimicrobial resistance 2019-2024' is to halve healthcare associated Gram-negative BSIs, by March 2024 to which Whittington are on target.
Respiratory other than C19	This winter, there were 36 acquired cases of influenza within the hospital, no HCAI deaths were associated. Currently seeing slight increase in cases of Influenza B which is consistent with seasonal picture. Influenza A and RSV cases occurring in low numbers.
Surgical Site Infections (SSI)	National mandatory SSI reporting is one quarter / one orthopaedic surgical procedure. Whittington opted to report three quarters in 2022/23 on large bowel and repair of neck of femur fracture surgery as follows: • Apr to Jun 22 Large bowel Surgery and repair of neck of femur fracture surgery • Jul to Sep 22 No SSI surveillance undertaken • Oct to Dec 22 Repair of neck of femur fracture surgery – data being finalised • Jan to Mar 23 Repair of neck of femur fracture surgery The Trust reported: • 7 large bowel surgery SSIs • 0 repair of neck of femur fracture surgery SSI risk is above the national 90th percentile in both above operations although the number of operations occurring are small and could distort percentages. It is recommended by UKHSA that surveillance should be undertaken in more than one consecutive period or continuously so that 'more precise rates can be estimated from a larger set of cumulative data' (UKHSA 2013 – Protocol for the Surveillance of Surgical Site Infection). Large bowel surgery is complex and often with urgency therefore considered an increased risk of infection and therefore will cease surveillance in 23/24. Surveillance on reduction of long bone fracture surgery will be considered as a replacement of NoFs in 23/24 given the low operations performed.

Patient Safety Incidents

Patient safety incidents

The Trust actively encourages incident reporting to strengthen a culture of openness and transparency which is closely linked with high quality and safe healthcare.

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Incident reporting has continued to increase to levels around those pre-pandemic. The patient safety team are continuing to raise awareness of the importance and usefulness of incident reporting through training based on the national patient safety syllabus.

Figure 1: Total number of incidents reported by financial quarters from 19/20 – 22/23 by level of harm.

	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4	20/21 Q1	20/21 Q2	20/21 Q3	20/21 Q4	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4
None	1279	1585	1582	1422	865	1128	1276	1196	1230	1121	1184	1018	1045	1128	1246	1302
Low / Minor (minimal harm)	479	420	457	461	463	439	535	558	649	643	636	555	633	619	552	646
Moderate (short term harm)	97	83	110	114	147	118	140	198	149	188	187	205	220	186	203	245
Severe (Permanent or long term harm)	9	2	7	3	6	3	5	5	4	3	3	2	5	3	5	6
Death - caused by the incident	0	1	1	1	1	1	1	2	2	0	0	0	2	2	1	1
Death - (NOT caused by the incident)	12	9	9	4	10	12	14	11	5	4	11	9	12	6	5	13
Total	1876	2100	2166	2005	1492	1701	1971	1970	2039	1959	2021	1789	1917	1944	2012	2213

Serious incidents

The Serious Incident (SI) Executive Approval Group (SIEAG), comprising the Medical Director, Chief Nurse and Director of Allied Health Professionals, Chief Operating Officer, the Associate Director of Quality Governance and Serious Incident Coordinator, meets weekly to monitor and review SI investigation reports as defined within NHS England's Serious Incident Framework (March 2015). In addition, internal root cause analysis investigations with recommendations and actions are monitored and reviewed by the panel.

All serious incidents are reported to North East London Commissioning Support Unit via the Strategic Executive Information System (StEIS) and a lead investigator is assigned by the Clinical Director of the relevant Integrated Clinical Service Unit (ICSU). All serious incidents are uploaded to the National Reporting and Learning System.

During 2022/23 there were 19 serious incidents reported on StEIS. As illustrated in the graph below, the number of Serious Incidents declared as a proportion of all patient safety incidents has been reducing since 2016. This is a positive trend, indicative of an open, transparent safety culture where reporting of incidents is encouraged, with a higher volume of incidents which are near misses or low harm incidents.

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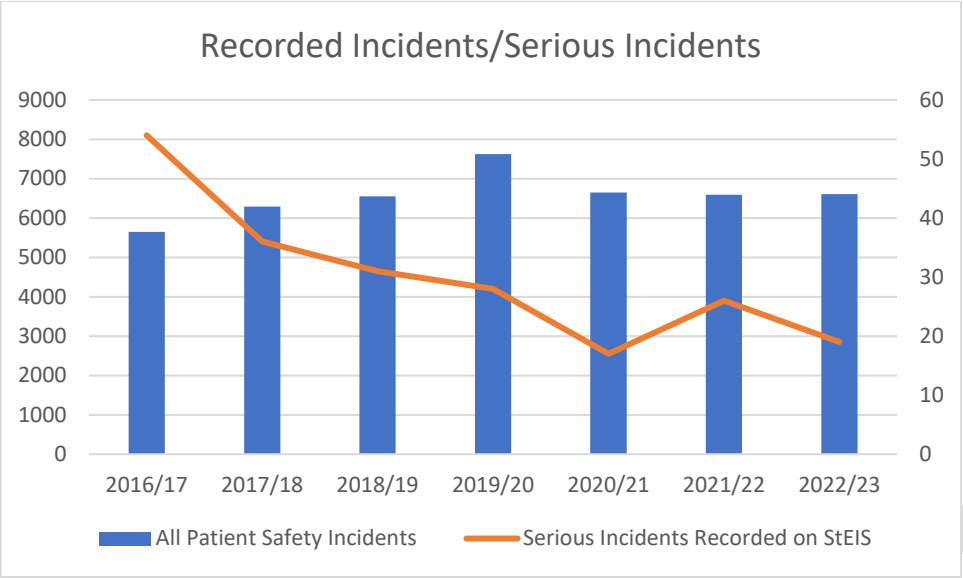
Figure 2: Serious Incidents declared, as a proportion of all patient safety incidents 2016-2023



In preparing for the new Patient Safety Incident Response Framework (PSIRF), Whittington Health have reviewed processes to ensure that the identification of systems issues and human factors remain at the forefront of our work with a focus on learning and improving practice. The Serious Incident Executive Advisory Group (SIEAG) have supported the use of alternative tools, such as After-Action Reviews, a Multidisciplinary team (MDT) approach, Quality Improvement projects and audit projects, to drive change.

Completed investigation reports with a summary letter, highlighting key findings and changes made as a result, are shared with the patient and/or family member with an offer of meeting with the Trust to discuss the findings.

Lessons learned following each investigation were shared with all staff and ICSUs involved in the care provided, through various methods including the 'Big 4' in theatres, and 'message of the week' in Maternity, Obstetrics, and other departments. Learning from incidents is shared through trust wide multimedia such as a regular patient safety newsletter, as well as at local ICSU Quality & Risk meetings and other internal media sources.

Never Events

A Never Event is defined as a serious, largely preventable, patient safety incident that should not occur if the available preventative measures have been implemented; this is a list of specific events defined nationally.

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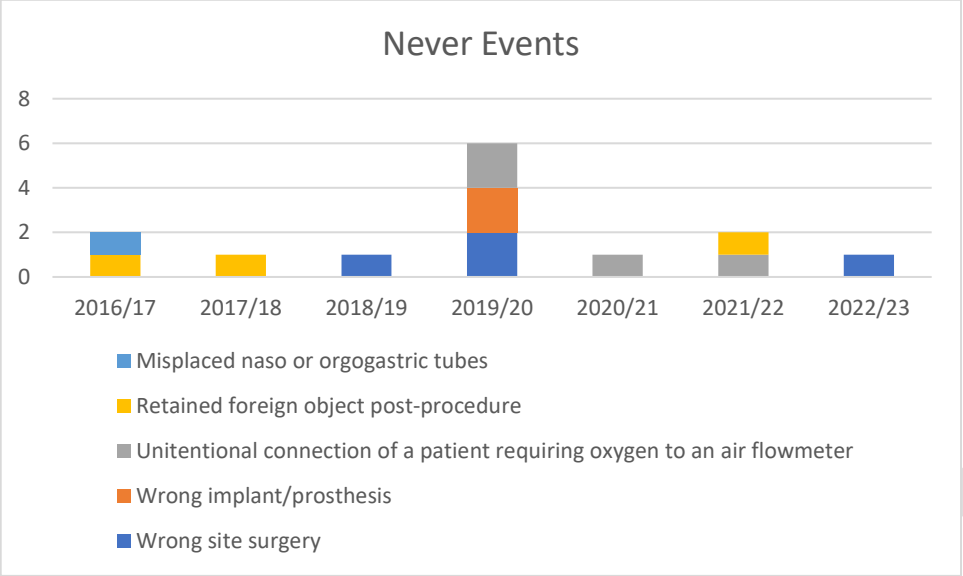
Figure 3: The number of Never Events reported by Whittington Health from 2016 to 2023



During 2022/23, the Trust reported one Never Event which was wrong site surgery.

A patient who was admitted to Whittington Health NHS Trust for an elective shoulder procedure in the Day Treatment Centre (DTC). As part of the anaesthetic plan, the patient was to be given a general anaesthetic and an interscalene brachial plexus block.

Unfortunately, the interscalene brachial plexus (nerve) block was performed on the incorrect side. This was immediately noted. Surgery was cancelled and rebooked for the following day. Subsequent surgery (and correct side block) occurred uneventfully on the following day 25/10/2022.

Learning from the incident:

- Remember to complete the WHO surgical list with the anaesthetist undertaking the procedure present.
- Remember to 'Stop Before You Block' for all anaesthetic team members involved in the procedure.
- To ensure patients are not asked leading questions about their procedures.

Duty of Candour

Since 2014 there has been a statutory duty of candour to be open and transparent with patients and families about patient safety incidents which have caused moderate harm or above. The Trust complies with its statutory obligations but also strives to apply being open principles for low harm patient safety incidents which do not meet the statutory criteria.

During 2022/23, 132 Duty of Candour requirements were completed.

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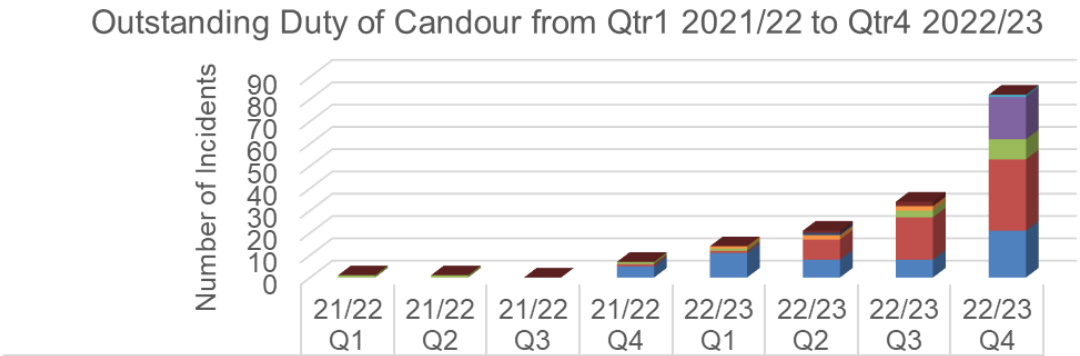
Figure 4: Outstanding Duty of Candour for incidents reported from Q1 2020/21 to Q4 2022/23



	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4
Nursing and Patient Experience	0	0	0	0	0	1	2	0
Strategy	0	0	0	0	0	1	0	0
Facilities and Estates	0	0	0	0	1	2	2	0
IM&T	0	0	0	0	0	0	0	1
ACS	0	0	0	0	0	0	0	19
ACW	1	1	0	1	1	0	3	9
EIM	0	0	0	1	1	9	19	32
S&C	0	0	0	5	11	8	8	21

There are currently 166 incidents between Qtr1 2021/22 to Qtr4 2022/23 across the Trust that have outstanding Duty of Candour requirements. This is a risk on the corporate risk register with mitigating actions in place to significantly reduce the backlog. ICSU risk managers are prioritising any incidents for which duty of candour is either not recorded on Datix or is outstanding to rectify any administrative errors.

Central Alerting System (CAS) Alerts

Patient safety alerts are issued via the CAS, which is a web-based cascading system for issuing alerts, important public health messages and other safety information and guidance to the NHS and other organisations. The Trust uses a cascade system to ensure that all relevant staff are informed of any alerts that affect their areas.
In 2022/23 the Trust received 34 safety alerts (of which eleven were National Patient Safety Alerts issued by NHS Improvement/NHS England). These have each been actioned and closed as appropriate.

Safety alerts are reviewed by the relevant group — for example Patient Safety Alerts are reviewed at Patient Safety Group, and Estates and Facilities alerts are reviewed at Health and Safety Committee — in addition there is a six-monthly Safety Alert Group in place to review performance regarding the closure of all CAS alerts.

The Quality Governance Committee monitors compliance with CAS alerts, and the Quality Assurance Committee receive updates on any concerns as part of the quarterly Quality report.

Freedom to Speak Up

The Freedom to Speak Up Guardian (FTSUG) for Whittington Health is continuously working to engage with teams and services across Community and Hospital departments and strengthen its relationships across the trust. The Guardian has adapted to meet the needs of staff over the course of the COVID-19 pandemic where there are less opportunities to meet staff face to face. As the year has ended, more people have been preferring face-to-face appointments as before the pandemic started.

The Guardian has worked closely with the communications team to review the Trust's media activity and promotion to refresh a focus on speaking up. the Trust launched the new **Speak Up badges** to improve the visibility of the Speak up Advocates network and allies across the Trust. The new badges state '**Freedom to Speak Up, Speak to me**" encouraging people to approach the network. The Intranet page was improved, enabling everyone to access it through the main page on the site. An all-staff email was sent to everyone in the organisation about Freedom to Speak Up (what we do, who we are and how to contact us). Another email is scheduled to be sent Spring 2022 as a reminder that everyone can reach out in a safe confidential way. Posters across the community health sites are being updated displaying information about the Speak Up Advocates working on that site. The Guardian continues to be part of the Nurse, Midwives and Allied Health Professionals Preceptorship Study Day and Newly Qualified Nurses Orientation Training, Health Care Support Worker (HCSW) Development Programme and Medical Education Induction to explain how to raise concerns safely and confidentially, raising the profile of FTSU. The Guardian continues to attend the Trust Induction Day for all new starters.

The collaboration between the FTSUG and the Organisational Development team and Human Resources continues to be fundamental to reinforce learning and acting on the concerns received. This collaboration has allowed the trust to challenge cultural behaviours, bullying and harassment and detriment in a serious, committed, and constructive way.

The Guardian has offered regular supervision and support to consolidate the network of Speak Up Advocates. Currently the network, representing diversity, equality, and inclusion across the Trust, has 45 Advocates, across job roles and services. They are trained to actively listen to colleagues raising concerns and provide unobstructive emotional support for staff in difficult meetings.

Whittington Health has been working closely with the joint Directors of Race, Equality, Diversity & Inclusion and all the Staff Networks to listen to staff concerns, promote a healthy and positive Speak Up culture and help remove additional barriers that staff may face in speaking up. Collaboration and mutual support are growing between the FTSUG and the Networks leadership, who have been escalating concerns and signposting accordingly to the Guardian some of the concerns raised within the network's members.

During this year, the FTSUG received 84 initial concerns that required action. These 84 concerns created 84 new opportunities for change and improvement. We always thank staff raising concerns for this valuable contribution. Considering the impact of COVID-19 and winter pressure, it is encouraging to see the number of concerns is returning to the levels seen prior to the Pandemic. Only two concerns were anonymous and have been reported internally and investigated. This hopefully represents a gradual change to an open and positive culture for raising concerns and suggests that staff are starting to feel more confident and safer to disclose their identities while speaking up. 54 concerns presented an element of bullying or harassment. 14 involved patient safety/ experience. Aligned with the National figures reported by the Guardians to the National Guardian office, the percentage of cases at

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Whittington Health involving an element of patient safety or quality of care has decreased, while cases involving elements of bullying and harassment have also dropped.

The plan for the next twelve months is to focus on the response of managers and leaders to staff who speak up and will be focused on a new National Guardian's Office Freedom to Speak Up e-learning package, in association with Health Education England. The first module – Speak Up – is for all workers. The second module, Listen Up, for managers, focuses on listening and understanding the barriers to speaking up. Also, following the national workforce race equality standard (WRES) in depth review of race equality and the WRES data at Whittington Health, there was feedback that some staff report still feeling cautious about speaking to the FTSUG or Advocates. Communication and work to support black and minority ethnic staff gaining further confidence in the role will be a priority over the next 6-12 months. Proactive engagement with our temporary, agency and bank workers is also a priority for the next 12 months.

Guardian for safe working hours – (GoSWH)

There continues to be a significant emphasis on the safety of junior doctors' working hours. This has been reflected in the ongoing engagement with the exception reporting process by both junior doctors and their supervisors. These clearly document the extra hours worked over and above their rostered hours, as well as the breaks that are missed. The time accrued through exception reports continue to be reimbursed with either time off in lieu or payment. The reasons for extra hours worked are analysed to try and effect change to prevent this from recurring where possible.

This year has seen ongoing issues with significant staff shortages across all training grades due to high levels of sickness coupled with high levels of acuity of patients, as we have seen across the wider NHS. There also continues to be high levels of fatigue and burnout amongst all staff and the hard work and resilience of junior doctors is to be commended.

There continues to be good engagement with the process of exception reporting as laid out in the 2016 terms and conditions. There has been an ongoing effort to encourage all specialities to promote and encourage the use of exception reporting and a particular emphasis on those at higher levels of training where low levels of exception reporting is typically seen. The reasons for this are being explored.

The Guardian of Safe Working Hours has worked closely with the junior doctors' forum to ensure there is a proactive approach to compliance with the 2016 terms and conditions. This is also where the spending of monies generated from exception reporting is discussed and decided. This process will continue.

Seven Day Service Standards

Whittington Health is committed to the 7 Day Hospital Services (7DS) Programme. The programme supports providers of acute services in tackling the variation in outcomes for patients admitted to hospitals in an emergency, at the weekend across the NHS in England. The Trust has made progress with all 4 priority standards, particularly Standard 6 where the Trust is now fully compliant for the first time this year. The Trust continues to do focussed improvement work on the remaining priority standards to move towards 100% compliance:

- **Standard 2**: Time to initial consultant review: this has been reaudited annually as part of the national Society of Acute Medicine Benchmarking Audit (SAMBA) and the Trust have

consistently showed that we meet time to initial consultant review with the exception of patients arriving between 1500 and 2000 as this would require significant investment as would require an extension of the standard working day of General Medical consultants to midnight. Currently the acute medical admissions are covered by a consultant on the floor from 0800 to 2000 in line with most acute medical units which allows for the teams to ensure the sickest and most complex patients are prioritised for review which may well explain why no complaints, clinical incidents or feedback from mortality reviews have included lack of timely consultant review as a quality concern over the last year when the Acute Medicine team have monitored for this outcome.

- **Standard 5**: Access to diagnostics: The magnetic resonance imaging (MRI) service is now available during daytime hours 7 days a week on site for spinal cord compression with out of hours cover still provided at The National Hospital for Neurology and Neurosurgery (NHNN). Echo cover increasing with training programme underway of Intensive Care Unit, Emergency Department, and acute medical staff to provide 7-day cover by 2025.This is taking longer than anticipated last year due to key staff being required to cover acute work.
- **Standard 6**: Access to consultant led interventions: All areas are compliant with either onsite or as network pathway with partner Trusts. Access to 24/7 Interventional Radiology is via an onsite 6-day daily service with emergency out of hours cover provided by University College London Hospital which is working well.
- **Standard 8**: Ongoing daily consultant-directed review: In most specialities this is place-Obstetrics and Gynaecology, Surgical specialities, ITU, Paediatrics but remains challenging in Medicine. The electronic record and handover system and effective daily meetings (Board Rounds) has allowed effective prioritisation for daily review but it must noted that at weekends the weekend consultant staffing in medicine not adequate to allow consultant level ward reviews rather this task is delegated to the ward registrar who asks for consultant input from the on-site consultant if required. This is under active review with QI plans for 2023-4 to trial adding in another weekend consultant to support the ward patients.

  The Trust is fully compliant with the remaining standards 1, 3, 4, 7, 9 and 10 which are assessed through self-assessment annually.

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Part 3: Review of Quality Performance

This section provides details on the progress the Trust is making with the Quality Account priorities 2020-23. the Key milestones and targets were identified for Year 3 (2022/23), and notwithstanding the impact of the COVID-19 pandemic the Trust has made significant progress.

Priority not achieved
Priority partially achieved
Priority achieved

Priority 1: Reducing harm from hospital acquired deconditioning

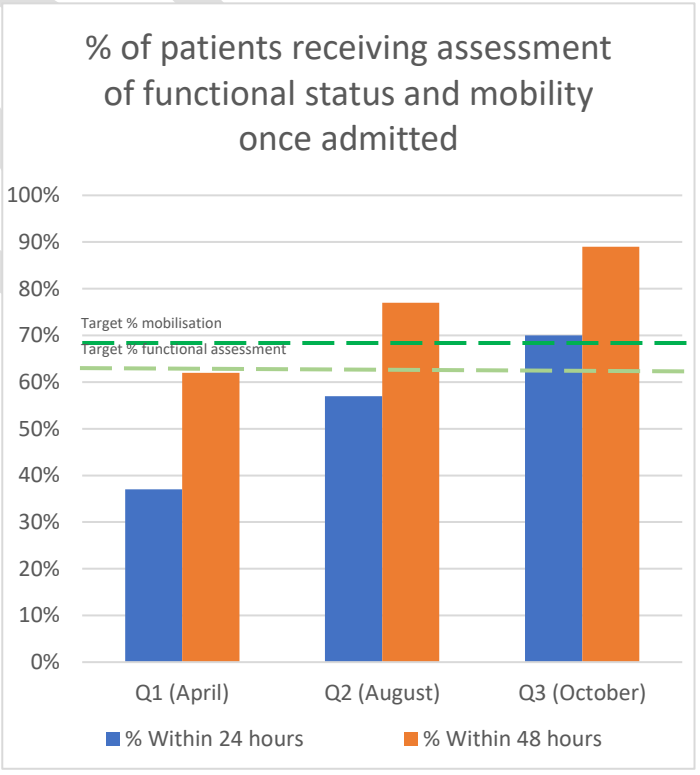
Aims for 2022/2023:

What did we achieve in 2022/23? – Project 1: Patients in Hospital

Project 1: Patients in Hospital:

- Goal 1: For 65% of patients to have assessment of functional status within 24 hours.
- Goal 2: For 70% of patients to be mobilised within 24 hours.
- Goal 3: To ensure that 15 patients are mobilised daily.

<u>Functional status & Mobilisation within 24 hours:</u>
During 2022-23, project work was undertaken by multidisciplinary (MDT) colleagues within the acute settings to promote the importance of early mobilisation to reduce hospital acquired deconditioning. It was identified that assessment of functional status included mobilisation, therefore intervention and audits for these goals were combined. Intervention across the year included: daily therapy attendance at ward board rounds and safety huddles; using clinical frailty score to identify and prioritise those requiring early assessment of mobilisation; development and promotion of clear therapy inclusion and exclusion criteria; MDT Falls presentation at local Grand Round to promote links between deconditioning and mobility.



Initial audits conducted in Q1 demonstrated a range of 37-51% of patients having an assessment of their functional status within 24 hours of admission, rising to a range of 62-74% being assessed within the first 48 hours of admission. Following engagement with therapy

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staff in the project, a clear inclusion and exclusion criteria was produced to identify those that would be appropriate for assessment within the first 24 hours of admission.

Audits conducted in Q2 demonstrated that functional assessment within 24 hours had increased to 57% (and up to 77% within 48 hours of admission). Further analysis of the data demonstrated the robustness of therapy screening, as 8 patients (out of 120) that did not receive an assessment during their admission all met the therapy exclusion criteria. Of those patients admitted for less than 24 hours, 100% received appropriate intervention, either receiving an assessment or excluded from assessment in line with the criteria produced.

A further audit conducted in Q3 demonstrated a further increase to 70% assessment within 24 hours, up to 89% within 48 hours of admission.

<u>Daily mobilisation:</u>

Coyle (a 32 bedded ward) was identified as a speciality ward that cares for those with neck of femur fractures, and therefore appropriate as a focal point for the daily mobilisation project.

In Q2, an audit of daily mobilisation was carried out, with results indicating that an average of 12 patients were mobilised per day, with an average of 69% of those appropriate to be mobilised.

The audits identified several reasons for patients declining to mobilise, including pain, fatigue, agitation, and nausea. Based on these results, the therapy team looked at ways to eradicate barriers. This included raising awareness of importance of mobility to patients, staff, and visitors with posters as well as staff education. Barriers to mobilisation were raised and discussed in daily board rounds, considering optimisation of analgesia, identification of patients that those independently mobile or able to be assisted by nursing staff (rather than solely reliant on therapy for mobilisation). Further ideas included focusing on toileting, washing, and dressing as ways to promote retaining independence and mobility.

Following these interventions, a repeat audit was carried out which demonstrated an improvement in daily mobilisation, with an average of 19 patients mobilised per day, and an average of 84% of those appropriate to be mobilised.

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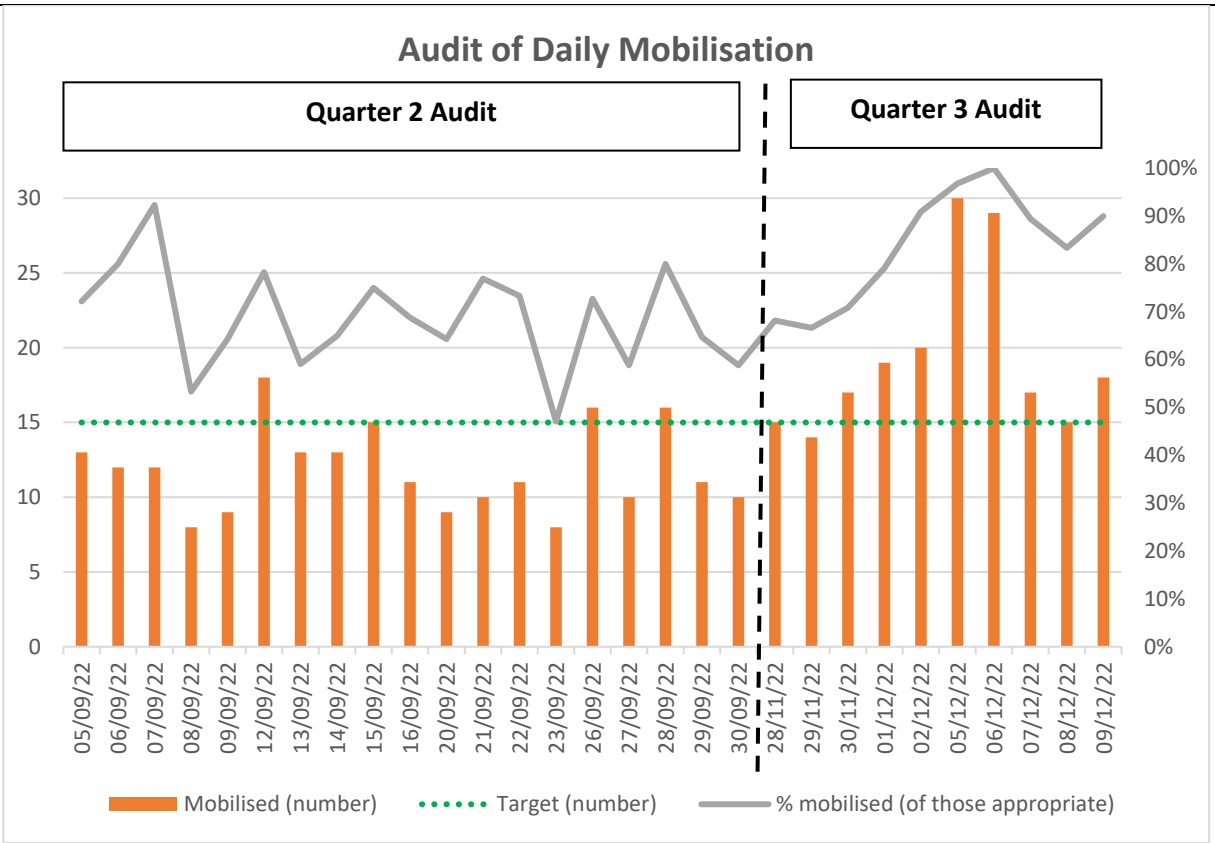

What did we achieve in 2022/23? – Project 2: Discharge

Project 2: Discharge:

- Goal 1: To reduce length of stay through implementation of a delirium discharge pathway pilot.
- Goal 2: Reduce medically optimised patients by 50% on a daily basis.
- Goal 3: Virtual Ward to utilise 20 beds daily (4 of these for patients with delirium)
- Goal 4: Reducing length of stay for patients who require a 'Trial without Catheter' (TWOC) by at least one day.

Delirium Discharge Pathway

This has been very successful in Islington, the number of people we have taken out on this pathway has been higher than anticipated. Further funding has been agreed by the Integrated Care Board (ICB) to continue to support this successful pathway. It was implemented in Haringey in January 2023 the delay was due to recruitment and funding challenges, that have now been resolved. The plan is to continue this priority until it is fully embedded in Haringey as well as Islington.

Reducing Medically Optimised Patients

This priority has not been achieved and will be rolled over to 2023/2024. There has been an increase in medically optimised patient delays which has been attributed to lack of placements and care resources in the community.

Virtual Ward Utilisation

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This priority has been consistently achieved throughout 2022/2023. Virtual ward has exceeded past the initial 20 bed usage at times due to the successful utilisation and we plan to increase the use of Virtual Ward bed usage for 2023/2024.

Reducing length of stay for patients who require a 'Trial without catheter'

This priority was not achieved as the pathway was only implemented in January 2023. This was due to funding being discontinued. Further funding streams have been agreed and the priority is being rolled over for 2023/2024 to maximise the impact on length of stay.

What did we achieve in 2022/23? – Project 3: Reducing admissions

Project 3: Reducing admissions:

- Goal 1: Utilisation of new falls pick up service to support people to be supported at home rather than requiring admission.
- Goal 2: Newly restructured Urgent Response and Recovery Care Group to streamline discharge and ensure patients are seen by the right clinician first time and within the new national guidance of 2 to 24 hours.

Information to follow.

Priority 2: Improving communication between clinicians, patients, and carers:

Aims for 2022/23:

We aim to improve communication with patients and their relatives by:

What did we achieve in 2022/23? - Project 1: Implementing Zesty

Project 1: Implementing Zesty (an online, secure, interactive platform that is easily accessible) to improve outpatient's experience and quality of communication.

- Goal 1: Introduction of Zesty in all outpatient clinics by the end of March 2023
- Goal 2: 30% of outpatients to be onboarded to the app by end of March 2023
- Goal 3: Improved patient satisfaction in outpatient communication.
- Goal 4: Improved timeliness of patient appointment correspondence showing a positive impact of reducing 'Did not attend' (DNA) rate.

The Zesty programme has made excellent progress in 2022/2023 having undertaken a successful pilot in Haematology and Respiratory service in Q1 of 2022, the technical processes work correctly and importantly we surpassed our patient registration target by 3% achieving 43%. The programme has received the green light for full acute roll out (Phase 1) with go live commencing from the 10th of January 2023.

Portal benefits include:

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- Reduction of physical outpatient appointment letters being printed and posted, therefore a reduction in costs
- Option to add appointments to personal calendars from the portal
- Patients don't need to worry about misplaced appointment letters, service contact details available on the portal
- NHS App integration - Early 2023 we will see the Zesty portal accessible via the NHS app through a single point of access for our patients using their existing NHS log ins.
- Reduced DNA rates - portal users can autonomously cancel and reschedule their appointments without calling a member of the booking team (Phase 2).
- Relieving pressure on booking staff and/or call centre and clinic staff by reducing the number of calls from patients* (Phase 2).

*Benefit dependant on adequate number of future available appointment slots.

Parallel to the Zesty Project, the Wayfinder Project has been gaining traction over the last few months and plans are for this to be ready for a go live decision by the end of January 2023. The Wayfinder Project is collaborative work with NHS England to integrate the Zesty Patient Portal into the NHS App for a single point of seamless access to outpatient appointment information.

The Project Management Office (PMO) are also exploring additional features within the portal which were not part of the initial project scope. These include:

- Forms/questionnaires for portal feedback,
- patient-initiated bookings,
- Community integration
- Clinical letters.

What did we achieve in 2022/23? - Project 2: Improving contact with NOK

Project 2: Improving timeliness of contact with a patient's Next of Kin (NOK) for those admitted to hospital.

- Goal 1: For 70% of NOK details to be checked within 24hrs of admission by end of March 2023.
- Goal 2: For 70% of NOKs to be contacted within 24 hours of admission by end of March 2023.

<u>NOK detail checking</u>

A baseline audit was conducted to establish the number of NOK details recorded on the inpatient electronic note system. It identified that of 889 adult, non-elective admissions in May 2022, 86% had NOK details recorded. For the remaining 14%, errors ranged from no information recorded, partial information recorded (e.g., name with no number, number with no name), or incomplete telephone numbers recorded. The audit identified that the system did not record when details were last updated. On exploration of this with Information Technology, it was identified that the system was not able to account for this, and that alternative ideas needed to be explored to ensure the information recorded was current and accurate. This led to multiple changes ideas, including:

✓ Emergency Department (ED) staff handing out NOK information cards for patients to fill out whilst they were in the waiting area and returning to front desk once completed, to avoid "bottle necking" occurring at the front desk when NOK details required updating, or in cases where patients were reluctant to provide details out loud in a busy ED environment.

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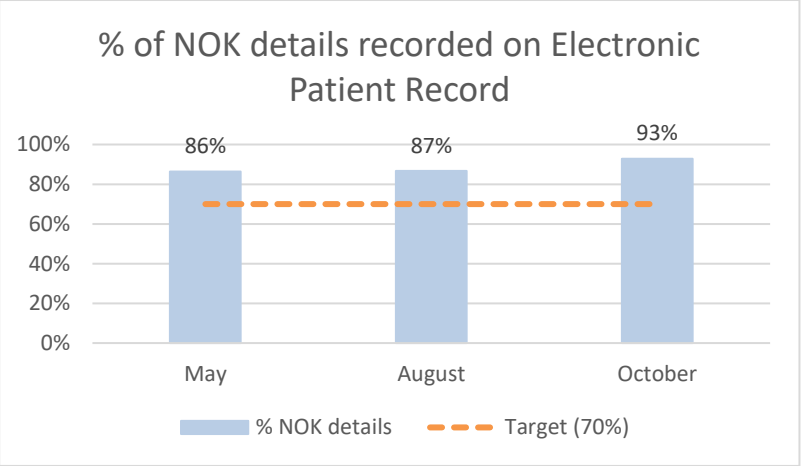
- ✓ ED administrative team sharing ideas about how they record updates on the system, using free text areas to include date/time of NOK updates, as well as recording if patients declined to give details or reported no known NOK.
- ✓ A prompt to check NOK details via admission board rounds was introduced.
- ✓ IT reviewed accessibility of EPR, to ensure that staff who may receive updates to NOK details have the correct access to update the system.

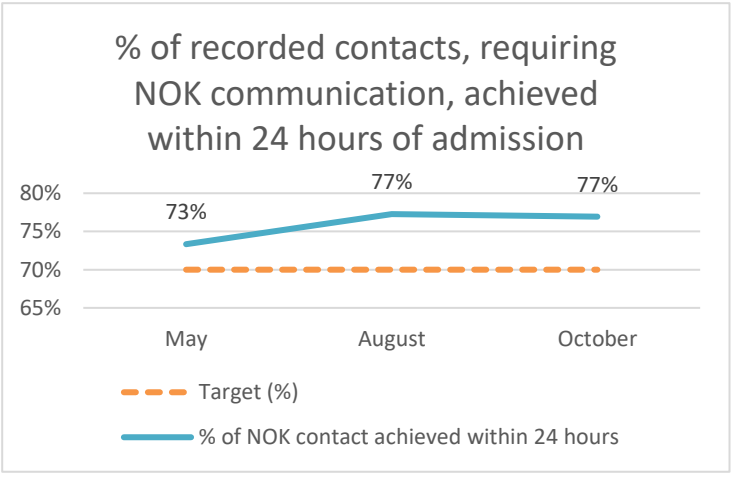
Following introduction of these, NOK details were re-audited in August and October. August data (883 non-elective adult admissions) showed a 1% increase in details recorded, with a further increase of 6% (13% above target) from baseline by October (970 non-elective adult admissions). Records with no information recorded fell from 8% at baseline to 3% by October. Although this shows improvement and an achievement of the target set, the gold standard for NOK contact details should be 100%, as in the event of emergencies or a change in a patient's ability to communicate and provide informed consent, NOK contact details would be required. It is therefore recommended that further improvement work continues with capturing and maintaining accurate NOK details.



<u>NOK Contact</u>

A baseline snap-shot audit of 30 patient records was conducted in May. 13 next of kins were contacted during their admission, 11 occurring within 24 hours of admission. Those not contacted included 15 patient (50%) where notes indicated there was no concern regarding the patient's communication, ability, or capacity, and the patient was provided with updates directly, with the expectation that they would provide the information they deemed necessary to their own NOK.

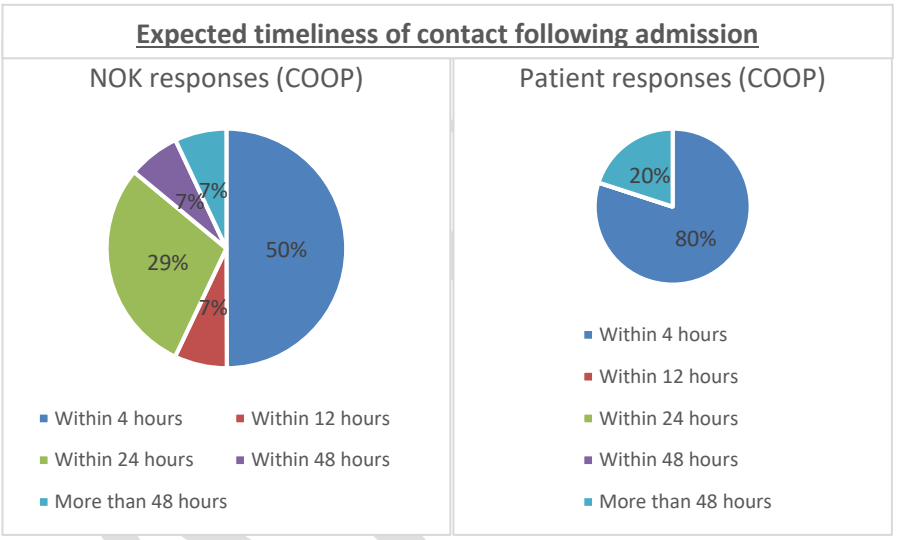
Following this audit, stakeholders within the admission wards were identified and consulted as to how to improve timeliness of NOK contact, as well as developing clear criteria for those requiring an update within 24 hours. This resulted in change ideas being introduced in Admissions including updating post take documentation that had a section regarding discussion with NOK/patient, and addition of a NOK discussion column in the electronic white board, placed in a prominent position to ensure it was highlighted during daily multidisciplinary (MDT) discussion.



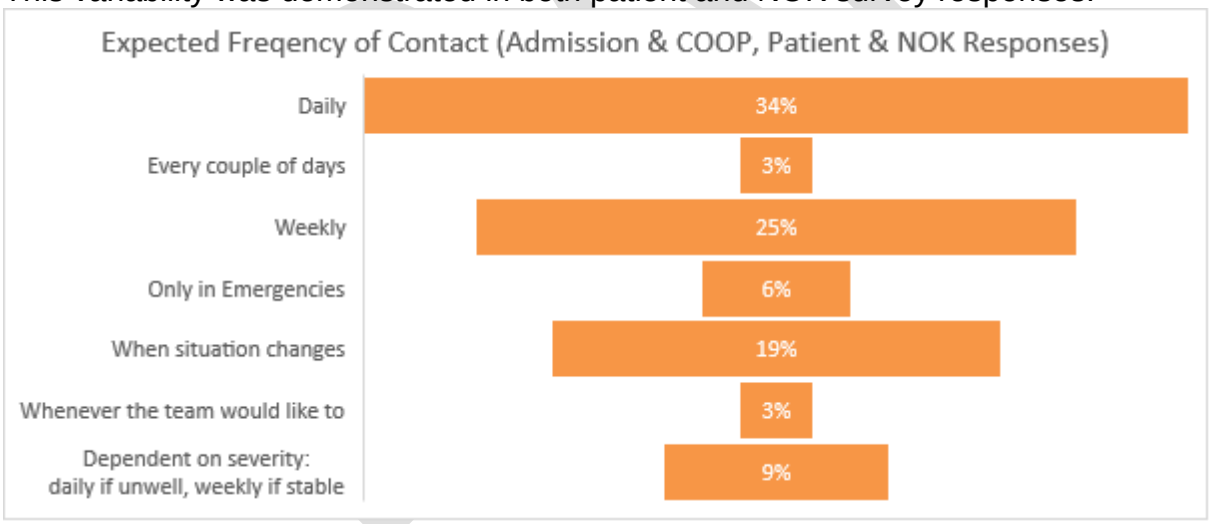
Further audits conducted in August and October demonstrated an increase from 73% to 77% of those requiring NOK contact achieved within 24 hours of admission (7% above target). Surveys conducted with patients on admission wards suggest that there may be a higher

percentage of contact occurring than is documented, as 36% of patients surveyed reported there had been contact made despite there being no record within clinical note.
Further scoping was carried out across the hospital, shifting focus from initial NOK contact within 24 hours of admission, to NOK contact across the whole hospital admission. Anecdotal feedback from Care of Older People (COOP) wards reported an increase in demand and expectation for NOK updates coinciding with the re-introduction of open visiting after the Covid pandemic, with queues forming outside the doctor's office during visiting hours. Based on these reports, surveys for patients and NOKs were designed and conducted on both COOP and Admission wards.

Survey results demonstrated a wide variety in expectation of timeliness and frequency of contact. Expectations for timeliness of contact ranged between 4 (50-80%) to more than 48 hours (7-20%) after admission, with frequency of contact expectation ranging from daily (34%), weekly (25%) or only in the event of change or emergency (6 and 19%).



This variability was demonstrated in both patient and NOK survey responses.



Qualitative results demonstrated updates expected would include updates of changes, test results, any concerns, discharge planning & change in location. Contact was most frequently expected from doctors (87.5%), although some responses acknowledged that the update could be received from other member of the MDT, if there was a structure to the update that included a brief medical summary as well as a general status update.
Following analysis of these surveys, project work has commenced on both Admission and COOP wards to develop standard expectations for the provision of NOK contact. These ideas include developing a standard for MDT staff to follow, and a welcome pack for individual wards, outlining key information for patient and NOKs, including expectation and frequency of contact, visiting hours, how to arrange meetings when required. Creation of these standards

will not only help clearly set out expectations but also ensures that NOKs who may not initiate contact with the hospital, continue to receive regular contact from the hospital. The aim of these projects is primarily to improve communication, whilst also ensuring efficiency of staff time. Further ideas for development include exploring whether there can be a collaborative approach to gaining collateral history that covers multiple elements of MDT care, therefore reducing incidences of duplicate conversations.

What did we achieve in 2022/23? - Project 3: Embedding the 'Dear Patient Letters'

Project 3: Embedding the "Dear Patient Letters" project to further improve communication between clinicians and service users.

- Goal 1: "Increase in quality metrics, in particular letters written to patient and in clear language."

Dear Patient Letters project has been running in the Trust since 2020, aiming to increase the usefulness of letters provided to patients about appointments they have attended. In previous years the project has seen success in delivering teaching and training on how to write letters in a patient friendly format including:

- Having the letters addressed directly to patients rather than GPs or other referrers.
- Using clear language and explaining medical terminology
- Providing next steps
- Providing clarity as to whether the patient is discharged or will be followed up
- Provide safety netting advice of what to do or look out for (for both patient and GP)
- Provide practical advice to promote self-management.

Awareness raising and promotion of these standards has continued throughout the year, including targeting of new medical staff at induction via training and induction packs, as well as using staff communications to highlight the importance of writing in patient friendly format. The library service runs regular sessions for staff across different forums regarding Health Literacy training, highlighting the importance of patients understanding their letters.
Following analysis of areas where this practice was not being consistently adopted, specific services were targeted to help explore the barriers to adopting this practice. Responses received demonstrated a reluctance to engage in the practice, with concerns that using ley terms rather than medical terms may result in less clear communication with GP and other medical colleagues, with the potential to dilute the significance of diagnoses or actions. This was particularly of concern in departments that use letters as their primary source for medical records and information. Suggestions to move forward with this were for departments to develop crib sheets or patient friendly information that could supplement letters where medical jargon needed to remain for the purpose of medical records and communicating with other specialities.

Services other than medical specialities have reporting adopting the practice including Intermediate Care Rehabilitation services. The Learning Disability service has also carried out a project to develop easy read formats of appointment letters and information about various inpatient processes, such as having an operation, going to the Emergency Department, and attending appointments.

Results across the year demonstrate uptake of the Dear Patient Letters project remains variable. Results were collected using spot-check audits across the year, using departments that identified in previous years of being high, low and randomly selected performing areas.

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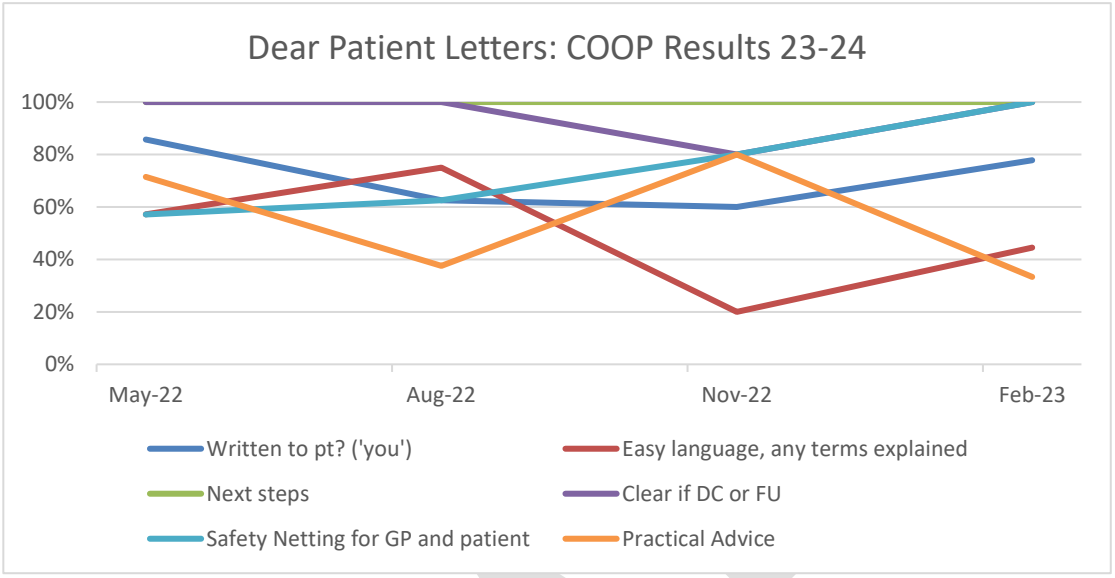
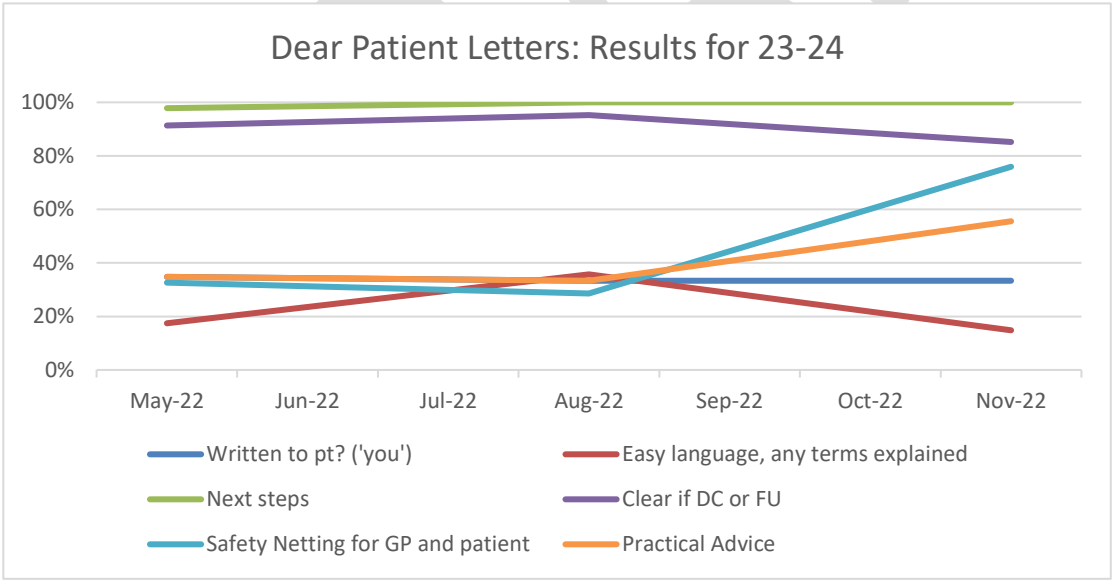
An audit of early adopters, Care of the Elderly Speciality, was conducted to determine whether practices are embedded. Results (as demonstrated in the below chart) demonstrate maintenance of next steps, improvements in safety netting, and ongoing variability in the other areas. On detailed analysis of these results, variability or downtrends appear secondary to new staff rather than discontinuation of practice in existing staff.



Results of spot-check audits conducted across a wider range of services across the year are shown in the chart below.



The results suggest that the areas of “next steps” and “clear if discharge or follow up” are consistently being documented. Improvements were seen within “safety netting” and “practical advice”, “written to patient” remained static at around a third of letters, and a downtrend in “easy language”.
Given the results, further ideas for improving communication with patients’ needs to be considered. A working group around Patient Information is currently being established to review the current processes of developing and reviewing Patient Information, such as

	leaflets, with a key focus on ensuring information available is provided in an appropriate format for those with lower-than-average health literacy, as well as those with additional needs.

Priority 3: Human Factors Education

Aims for 2022/23:
We aim to improve understanding and impact of human factors by:

What did we achieve in 2022/23? Project 1	
	Project 1: Delivering Trust wide Human Factors education through development of a sustainable, educational model. • Goal 1: Develop robust pathway to incorporate patient safety learning into the Simulation programme in a timely way. Due to the introduction of Patient Safety Incident Response Framework (PSIRF) this priority has been superseded. The Patient Safety Incident Response Framework was published in Q2 2022/23 which replaces the previous Serious Incident Framework (2015). The PSIRF is not a different way of describing what came before – it fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement with a focus on systems-based investigations and human factors. The transition to PSIRF is inextricably linked with human factors awareness and understanding. PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement. PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm. Whittington has laid some of the groundwork for this transition through the increased use of After-Action Reviews (AAR's) and work will continue as we transition over the next 12 months to the new framework.
What did we achieve in 2022/23? Project 2	
	Project 2: Raising awareness of the practical implications of human factors on patient safety. • Goal 1: Develop multiple channels to deliver patient safety syllabus level 1 'Basics of patient safety' to maximise exposure. Due to the introduction of Patient Safety Incident Response Framework (PSIRF) this priority has been superseded. Training on the new response framework will include human factors training as part of the wider patient safety learning package.

Priority 4: Improving blood transfusion care and treatment

Aims for 2022/23:
We aim to improve blood transfusion safety by:

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What did we achieve in 2022/23? - Project 1: Implementing a vein-to-vein tracking system

Project 1: Implementation of a vein-to-vein system to minimise risk of error during blood transfusion process.

- Goal 1: Vein to vein system to be in place by end of March 2023 including fully electronic transfusion documentation.

Information to follow.

What did we achieve in 2022/23? – Project 2: Blood Transfusion training

Project 2: Improving understanding of blood transfusion safety practices through training and awareness.

- Goal 1: To continue to increase compliance with blood transfusion training from the 2020 baseline and achieve over 60% compliance by end of 2022/23.

Information to follow.

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Priority 5: Addressing Health Inequalities in our local population.

Aims for 2022/23:
We aim to improve health inequalities by:

What did we achieve in 2022/23? - Project 1: Improving care and treatment of patients with sickle cell anaemia.

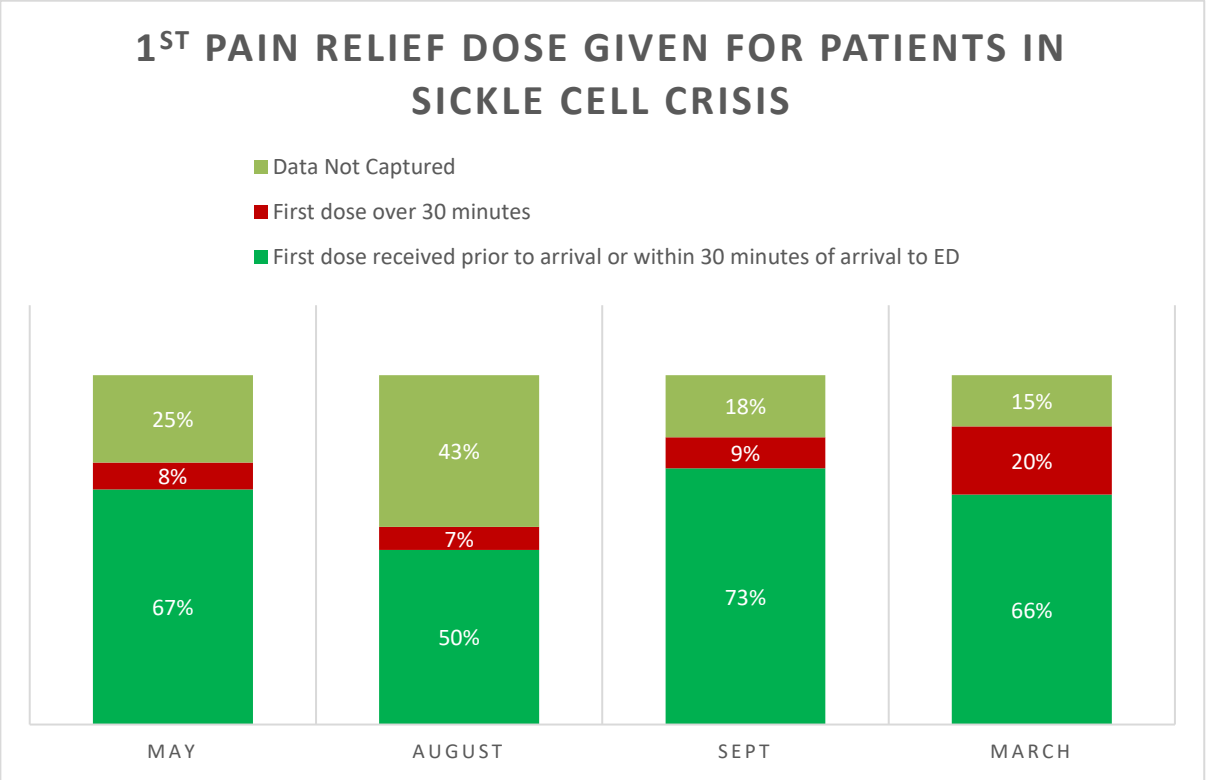
Project 1: Improving care and treatment of patients with sickle cell anaemia.

- Goal 1: Ensure 100% of sickle cell patients receive 1st dose of pain relief within 30mins of attendance to ED.
-

<u>Ensuring first dose received within 30 minutes of attendance</u>
Audits have been carried out throughout the year to measure the efficiency of delivery of pain relief against the target. Results for those requiring pain relief during their ED attendance are shown in the charts and table below:

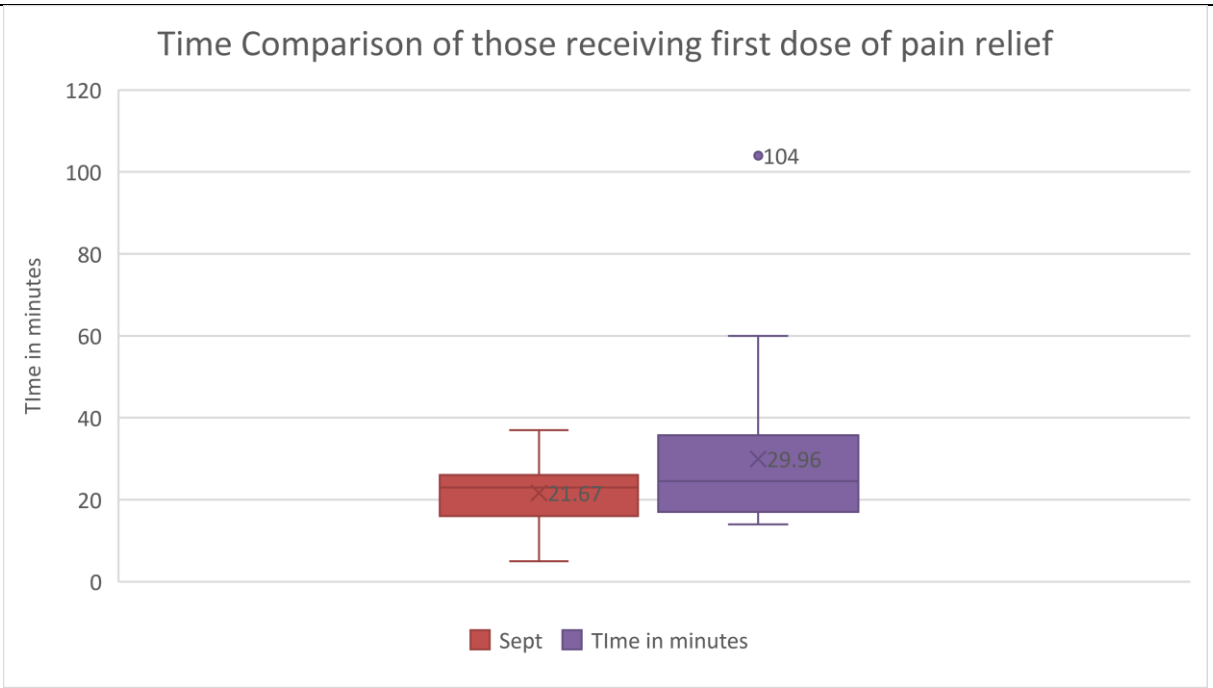
	May 2022	August 2022	Sept 2022	March 2023
1st dose received with London Ambulance Service (LAS)	22	5	10	11

1st dose received with 30 minutes	13	18	23	16
1st dose received over 30 minutes	4	3	4	8



On review of the data, data had not been captured for some cases due to discrepancies in the data being held in paper format. Audits across the year show an average of 64% receiving their first dose within 30 minutes, 36% below the target.

On further analysis, September data demonstrates an average time of 21.67 minutes to receive dose, compared to an increase in March of 29.96 minutes. In March data, there is an outlier of 104 minutes (and shown in the graph below). On review of this case, the patient presented to ED outside of their usual borough and were under the care of a Haematology service external to the Trust, which may have contributed to the delay seen in this individual case.



Across the year, QI projects have been commenced aiming to improve experience and efficiency of care for Sickle Cell Disease. This includes ED staff training aiming to reduce bias and increase awareness of need for urgency with medicine prescription. Teaching sessions have been held face to face and virtually, with patient representatives included as speakers during these sessions. This work will continue into 2023-2024 to reach a wider workforce audience.

Within Research there has also been a focus on Sickle Cell Disease. The STAR (Sickle and Thalassemia Alliance for Research) held its first meeting on 27th February 2023 and has since appointed two paediatric research nurses to further the aims of the alliance in increasing the availability of research for this patient cohort.

Whittington Health are actively participating in the work of the alliance and continue to deliver research studies that are of relevance and benefit to our patients. Studies that have been open to recruit SCD patients in the last year include Rare Diseases BioResource (NIHR) and CROSS WALK-a (A Study Evaluating the Safety, Pharmacokinetics, Pharmacodynamics and Efficacy of Crovalimab for the Management of Acute Uncomplicated Vaso-Occlusive Episodes in Participants with Sickle Cell Disease), with further studies in the pipeline for 2023/24.

What did we achieve in 2022/23? – Project 2: Raising awareness of prostate cancer

Project 2: Raising awareness of prostate cancer.

- Goal 1: Hold 20 Prostate cancer events by end of March 2023.

The target of 20 prostate cancer events has not been met this year, this was due to staff leading on the priority leaving the Trust. A Prostate Cancer Conference was held during Q2 2022/23, funded by Macmillan, organised by Casey Galloway and Tracey Palmer.

Speakers included: people with lived experience of prostate cancer, radiographer, psychosexual nurse specialist, dietician, representative from Maggie's. The all-day event focussed on health and wellbeing, living with diagnosis, recovering from treatment and side effects.

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Theatre groups performed using real life scenarios, and there were opportunities for attending patients to have a haircut / beard trim or massage.

Roughly 70 people attended, with 85% of those that completed questionnaires about the event being patients. 100% reported the conference was very useful or useful, and respondents had the opportunity to suggest further areas of information that they would like to receive.

Plans going forward include filming and sharing clips to be accessible through WHT and Macmillan; developing group sessions to be rolled out for people diagnosed with cancer; development of a support group; CBT training for prostate CNA; exercise and therapy sessions to be evaluated against patient outcomes measures; roll out of personalised cancer care objectives within services, with increased permanent staffing structure.

During the last financial year, we started a colorectal support group for patients who have ceased active treatment and are currently on the remote monitoring pathway. The groups meet 4 times a year and it has been very beneficial for the patients that have attended.

We are currently working on the planning of events specifically aimed at breast patients. We are planning a self-care day, having online workshops, and will also run the same 'side effects' course as with prostate patients. We therefore anticipate having 4 breast specific events separate to the running of the course and again if successful the course will be repeated throughout the year.

Work is currently being undertaken to survey lung cancer patients about their care and support needs as a means of identifying any gaps in the support that is being offered to them. This has historically been a 'harder to reach' group and socio-economic factors tend to be a barrier to them receiving adequate levels of support.

We have submitted a grant application to hopefully enable us to run Sex and Intimacy workshops for patients affected by cancer diagnoses. If successful plan on running a series of workshops for patients and staff (separately). The aim will be for some of the sessions to be gender specific and some to cater for the needs of more marginalised groups (e.g., LGBTQI+ communities).

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Part 4: Other Information

Local Performance Indicators

Goal	*Standard/benchmark*		*Whittington performance*		*Comments*
		21/22	*20/21*	*19/20*	
ED 4 hour waits	*95% to be seen in 4 hours*	***78.30%***	*87.4%*	*83.8%*	

RTT 18 Week Waits: Incomplete Pathways	*92% of patients to be waiting within 18 weeks*	***74.4%***	*65.6%*	*92.1%*	April 21 to Feb 22 (March 22 not yet available)
RTT patients waiting 52 weeks	*No patients to wait more than 52 weeks for treatment*	***7093***	*11094*	*2*	*Total Breaches reported as part of monthly submission, not individual patients. April 21 to Feb 22 as March 22 not yet available
Waits for diagnostic tests	*99% waiting less than 6 weeks*	***94.1%***	*72.1%*	*99.3%*	
Cancer: Urgent referral to first visit	*93% seen within 14 days*	**74.8%**	94.6%	94.8%	April 21 to Feb 22 (March 22 not yet available)
Cancer: Diagnosis to first treatment	*96% treated within 31 days*	**95.3%**	98.1%	98.8%	April 21 to Feb 22 (March 22 not yet available)
Cancer: Urgent referral to first treatment	*85% treated within 62 days*	**61.1%**	73.8%	84.0%	April 21 to Feb 22 (March 22 not yet available)
Improved Access to Psychological Therapies (IAPT)	*75% of referrals treated within 6 weeks*	**91.4%**	93.8%	95.1%	April 21 to Feb 22 (March 22 not yet available)

Summary Hospital-Level Mortality Indicator (SHMI)

Information to follow.

Annex 1: Statements from external stakeholders

Health Watch Islington feedback

Health Watch Haringey feedback

Commissioner feedback

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How to provide feedback

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

By writing to:
The Communications Department,
Whittington Health,
Magdala Avenue,
London. N19 5NF

By telephone:
020 7288 5983

By email:
communications.whitthealth@nhs.net

Publication:

The Whittington Health NHS Trust 2019/20 Quality Account will be published on the NHS Choices website by the 15th December 2020.

https://www.nhs.uk/pages/home.aspx

Accessible in other formats:

This document can be made available in other languages or formats, such as Braille or Large Print.

Please call **020 7288 3131** to request a copy.

Annex 2: Statement of directors' responsibilities for the quality report

Appendix 1: National Mandatory and Non-Mandatory Audits 2020/21

Title of Audit	Management Body	Participated in 2022/2023	If completed, number of records submitted (as total or % if requirement set)
Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder (MITRE) Audit	British Association of Urological Surgeons	✓	Data submitted: 4 cases
National Bariatric Surgery Registry	British Obesity & Metabolic Surgery Society	✓	Data submitted: 66 Cases
National Early Inflammatory Arthritis Audit	British Society for Rheumatology	✓	Data submitted: 100 Cases
Adult Respiratory Support Audit	British Thoracic Society	✓	carried forward to 2023/24 for completion.
Improving Quality in Crohn's and Colitis formerly Inflammatory Bowel Disease Audit	Inflammatory Bowel Disease Registry	✓	Data submitted: 95 Cases
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre	✓	Data submitted: 44 Cases
Case Mix Programme (CMP)	Intensive Care Society	✓	Data submitted: 464 Cases
Sentinel Stroke National Audit Programme (SSNAP) - to include Organisational Audit	Kings College London	✓	Data submitted: 53 Cases.
Myocardial Infarction Audit Project	National Institute for Cardiovascular Outcomes Research	✓	Data submitted: 77 Cases
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research	✓	Data submitted: 110 Cases
National End of Life Care Audit	NHS Benchmarking Network	X	Trust decision not to participate (rationale provided above)
Oesophago-gastric cancer (NAOGC)	NHS Digital	✓	Data submitted: 19 cases
National Diabetes Footcare Audit	NHS Digital	✓	Data submitted: 168 cases
Breast and Cosmetic Implant Registry (for cancer pts only)	NHS Digital	✓	Data submitted: 25 Cases
National Obesity Audit	NHS Digital	✓	Participated - see link to latest published data https://digital.nhs.uk/data-and-information/publications/statistical/national-obesity-audit/bariatric-surgical-procedures-21-22-final-and-q1-22-23-provisional

National Diabetes Inpatient Safety Audit	NHS Digital	✓	Data submitted: 2 cases
Diabetes (Adult - national core)	NHS Digital	✓	Data submitted: 1417 cases
National Pregnancy in Diabetes audit	NHS Digital	✓	Data submitted: 36 cases
National Bowel cancer Audit	NHS Digital	✓	Data submitted: 95 cases
LeDeR - Learning from lives and deaths of people with a learning disability and autistic people	NHS England	✓	Data submitted: 9 Cases
UK Parkinson's Audit	Parkinson's UK	✓	Data submitted: 80 cases
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	✓	Data submitted: 91 Cases
PQIP (applicable to spinal patients only)	Royal College of Anaesthetists	✓	Recommenced November 2022. Those patients who were approached did not wish to participate in the study.
Mental Health Self Harm	Royal College of Emergency Medicine	✓	carried forward to 2023/24 for completion.
Pain in Children (care in Emergency Departments)	Royal College of Emergency Medicine	✓	Data submitted: 269 cases (c/f 2021/22)
National Maternity and Perinatal Audit	Royal College of Obstetricians and Gynaecologists	✓	Data submitted: 2984 Cases
National Clinical Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Royal College of Paediatrics & Child Health	✓	Data submitted: 65 cases
National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health	✓	Data submitted: 108 cases
National Audit of Dementia - care in general hospitals	Royal College of Psychiatrists	✓	Data submitted: 173 Cases
Lung cancer (NLCA)	Royal College of Surgeons	✓	Data submitted: 74 Cases
National Audit of Metastatic Breast Cancer	Royal College of Surgeons	✓	Data submitted: 5 Cases
National Audit of Primary Breast Cancer	Royal College of Surgeons	✓	Data submitted: 140 Cases
National Audit of Breast Cancer in Older Patients	Royal College of Surgeons	✓	Data submitted: 41 Cases
National Prostate Cancer Audit	Royal College of Surgeons	✓	Data submitted: 155 Cases
Falls and Fragility Fractures Audit Programme (FFFAP) - Inpatient Falls	Royal College physicians	✓	Data submitted: 7 Cases

Falls and Fragility Fractures Audit Programme (FFFAP) - National Hip Fracture Database	Royal College Physicians	✓	Data submitted: 187 Cases
SAMBA 22	Society for Acute Medicine	✓	Data submitted: 47 cases
Neonatal Intensive and Special Care (NNAP)	The Royal College of Paediatrics and Child Health	✓	Data submitted: 409 Cases.
Major Trauma: The Trauma Audit & Research Network (TARN)	Trauma Audit & Research Network	✓	Data submitted: 296 Cases
UK Renal Registry National Acute Kidney Injury Audit	UK Kidney Association	✓	Data submitted: 5291 Cases
National Child Mortality Database	University of Bristol	✓	Review of published reports
National Audit of Cardiac Rehabilitation	University of York	✓	Data submitted: 347 Cases

Mental Health Clinical Outcome Review Programme			
Suicide and Homicide	National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) - University of Manchester	✓	If cases identified to WH then participate - none to date

Maternal, Newborn and Infant Clinical Outcome Review Programme **data on 19 cases were submitted to MBRRACE-UK who allocate to the appropriate work stream**			
Maternal mortality surveillance	MBRRACE-UK, led from the University of Oxford	✓	Ongoing
Perinatal mortality surveillance	MBRRACE-UK, led from the University of Oxford	✓	Ongoing
Perinatal mortality and serious morbidity confidential enquiry	MBRRACE-UK, led from the University of Oxford	✓	Ongoing
National perinatal mortality review tool	MBRRACE-UK, led from the University of Oxford	✓	Ongoing
Maternal mortality confidential enquiries	MBRRACE-UK, led from the University of Oxford	✓	Ongoing

Medical, Surgical and Child Health Clinical Outcome Review Programme			
Chron's Disease	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	6/6 cases submitted
Transition Study from Child to Adult Health Services	National Confidential Enquiry into Patient	✓	1/1 cases submitted

	Outcome and Death (NCEPOD)		
Epilepsy: Hospital attendance	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	5/6 cases = 84%
Testicular Torsion	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	3/3 cases submitted
Community Acquired Pneumonia Hospital Attendance	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	6/6 cases submitted

National Asthma and Chronic Obstructive Pulmonary Disease Audit programme			
Paediatric Asthma in Secondary Care	Royal College of Physicians	✓	Data submitted: 102 cases
Pulmonary rehabilitation	Royal College of Physicians	✓	Data submitted: 118 cases
COPD in Secondary Care	Royal College of Physicians	✓	Data submitted: 146 cases
Adult Asthma in Secondary Care	Royal College of Physicians	✓	Data submitted: 101 cases

Non-Mandatory National Audits 2022/2023

Project Title	Management Body	Status
COVID-19 Process Audit: a quality improvement initiative	NHS England	Completed
Audit of use of PET imaging during neoadjuvant chemotherapy for breast cancer	University College London Hospital	Completed
Cardiovascular outcomes after major abdominal surgery - CASCADE	STARSurg and EuroSurg	Data submitted
Learning Disability Improvement Standards for NHS Trusts Year 5	NHS Benchmarking Network	Data submitted
UK Comparative Audit of Acute Upper Gastrointestinal Bleeding: clinical management and the use of blood	NHS Blood and Transplant	Data submitted
National Comparative Audit of Blood Sample Collection and Labelling	NHS Blood and Transplant	Data submitted
NDA Integrated Specialist Survey	NHS Digital	Data submitted
Consultants sign off	Royal College of Emergency Medicine	Data submitted

Infection & Prevention Control	Royal College of Emergency Medicine	Data submitted
TRANSFER study: ThReatened preterm birth, Assessment of the Need for in utero tranSFER between 22+0-23+6 weeks' gestation	University of Birmingham, University Hospitals Bristol & Weston NHS Foundation Trust	Data submitted
National study of HIV in Pregnancy and Childhood (NSHPC)	NSHPC	Data submitted
Audit of Reversal of anticoagulation (warfarin/DOACs) in trauma patients	London & SE Trauma & Haematology Group	Data submitted
"End of life care in adVanced chrOnic LiVEr disease (EVOLVE)"	British Society of Gastroenterologists	on target
London-wide audit of TB management in patients with ocular TB – led by Moorfields	Pan-London LOOP TB pathway guidance	on target
Mandatory Surveillance of Healthcare Associated Infections	Public Health England	on target
Surgical Site Infection Surveillance Service	Public Health England	on target
Infection Prevention and Control	Royal College of Emergency Medicine	on target

Appendix 2 - Subcontracted Services

Organisation	Service Details
Camden and Islington NHS foundation trust	Psychological service
UCLH foundation trust	South Hub Tuberculosis resources
UCLH foundation trust	Ears Nose and Throat services
UCLH foundation trust	Provision of PET/CT scans
The Royal Free London NHS foundation trust	Ophthalmology services
Whittington Pharmacy CIC	Provision of pharmacy services
WISH Health Ltd A network of 8 local practices – four in north Islington and four in west Haringey	Primary care services to the urgent care centre at the Whittington hospital
The Thrombosis Research Institute	The Provision of 2 clinical sessions
Camden and Islington NHSFT	Provision of associate hospital managers panels and training under MHA

Tavistock and Portsman	CCN209- Agreement for the provision of services from Tavistock and Portsman NHS Foundation Trust – CAMHS OOH consultants
UCLH	SLT 4 days per week provision at Whittington
NHS Blood and Transplant	Contract for the supply of blood, blood components and services
NHS Blood and Transplant	Contract for the supply of Tissue and Ocular products
UCL Foundation Trust	Renewal addendum of combined screening services detailed in COMB1
Newcastle Upon Tyne Hospital NHS Foundation Trust	Department tests a wide range of patient and environmental specimens to detect the presence of pathogenic micro-organisms.
Epsom & St Helier University Hospital NHS Trust	Pathology Testing Service
Calderdale and Huddersfield NHS FT	Agreement relating to National Pathology Exchange Service (NPEx)

Appendix 3 - Patients 0-15 and 16+ readmitted within 28 days of discharge

Year and Month		0-15 years			16 Years +		
		Readmissions	Discharges	Readmission rate	Readmissions	Discharges	Readmission rate
2019/20	Apr	7	639	1.1%	205	2913	7.0%
	May	2	688	0.3%	163	2791	5.8%
	Jun	9	629	1.4%	143	2899	4.9%
	Jul	6	664	0.9%	167	2860	5.8%
	Aug	6	601	1.0%	179	2582	6.9%
	Sep	3	615	0.5%	177	2556	6.9%
	Oct	9	669	1.3%	187	2842	6.6%
	Nov	5	675	0.7%	166	2780	6.0%
	Dec	7	645	1.1%	157	2532	6.2%
	Jan	7	621	1.1%	169	2703	6.3%
	Feb	4	607	0.7%	151	2616	5.8%
	Mar	3	525	0.6%	117	1977	5.9%
2020/21	Apr	1	308	0.3%	96	967	9.9%
	May	2	387	0.5%	109	1220	8.9%
	Jun	6	447	1.3%	137	1748	7.8%
	Jul	3	547	0.5%	171	2296	7.4%
	Aug	3	570	0.5%	160	2042	7.8%
	Sep	6	630	1.0%	140	2302	6.1%
	Oct	7	715	1.0%	165	2353	7.0%
	Nov	7	683	1.0%	193	2383	8.1%
	Dec	10	674	1.5%	183	2322	7.9%

	Jan	13	599	2.2%	156	1853	8.4%
	Feb	8	632	1.3%	153	1922	8.0%
	Mar	14	875	1.6%	110	2442	4.5%
2021/22	Apr	4	573	0.7%	111	2132	5.2%
	May	5	595	0.8%	111	2134	5.2%
	Jun	14	1549	0.9%	167	4476	3.7%
	Jul	10	805	1.2%	213	2476	8.6%
	Aug	8	704	1.1%	164	2464	6.7%
	Sep	3	762	0.4%	209	2657	7.9%
	Oct	2	722	0.3%	162	2583	6.3%
	Nov	4	670	0.6%	140	2431	5.8%
	Dec	11	684	1.6%	132	2521	5.2%
	Jan	10	790	1.3%	111	2329	4.8%
	Feb	6	765	0.8%	128	2392	5.4%
	Mar	5	639	0.8%	113	2049	5.5%
2022/23	Apr	1	645	0.2%	151	2104	7.2%
	May	13	728	1.8%	150	2337	6.4%
	Jun	3	725	0.4%	123	2321	5.3%
	Jul	12	687	1.7%	138	2339	5.9%
	Aug	5	649	0.8%	130	2267	5.7%
	Sep	9	683	1.3%	99	2405	4.1%
	Oct	2	748	0.3%	118	2386	4.9%
	Nov	14	761	1.8%	103	2473	4.2%
	Dec	5	699	0.7%	106	2099	5.1%
	Jan	20	767	2.6%	99	2392	4.1%
	Feb	12	673	1.8%	70	2117	3.3%
	Mar	9	720	1.3%	95	2254	4.2%

Appendix 4 – Staff Survey score matrix 2022

Whittington Health Directorate/ICSU Report

The directorate/ICSU results for Whittington Health contain the results by directorate or ICSU for People Promise elements and theme results from the 2022 NHS Staff Survey. The below directorate results are compared to the unweighted average for the organisation.

**Each 2022 theme score for ICSUs and Directorates is graded in green with a '↑' symbol if the score is above organisational average, and red where the score is below organisational with a '↓' symbol. Where an ICSU or Directorate has scored the same as the organisations averaged it is graded black with a '-' symbol.*

Theme	WH Overall	ACW	ACS	COO	CYP	EIM	Facilities	Finance	IT	Medical Dir.	Nursing & Patient Exp.	Procurement	S&C	Trust Secretariat	Workforce
We are compassionate and inclusive	7.2	6.7 ↓	7.4 ↑	7.4 ↑	7.7 ↑	7.0 ↓	6.4 ↓	7.4 ↑	7.4 ↑	7.8 ↑	7.3 ↑	7.2 -	6.9 ↓	7.6 ↑	8.1 ↑
We are recognised and rewarded	5.8	5.1 ↓	5.9 ↑	6.0 ↑	6.3 ↑	5.6 ↓	5.1 ↓	6.3 ↑	5.9 ↑	6.8 ↑	6.2 ↑	5.9 ↑	5.3 ↓	6.6 ↑	7.3 ↑
We each have a voice that counts	6.7	6.0 ↓	6.8 ↑	7.2 ↑	7.1 ↑	6.5 ↓	6.3 ↓	6.8 ↑	6.6 ↓	7.0 ↑	7.1 ↑	6.8 ↑	6.3 ↓	7.2 ↑	7.1 ↑
We are safe and healthy	5.8	5.4 ↓	5.8 -	6.2 ↑	6 ↑	5.4 ↓	6.2 ↑	6.7 ↑	6.4 ↑	6.6 ↑	6.1 ↑	6.3 ↑	5.7 ↓	6.1 ↑	6.9 ↑
We are always learning	5.4	4.5 ↓	5.9 ↑	5.8 ↑	5.8 ↑	5.5 ↑	4.4 ↓	5.4 -	5.0 ↓	6.2 ↑	5.3 ↓	5.3 ↓	5.0 ↓	5.3 ↓	6.2 ↑
We work flexibly	6.0	5.8 ↓	6.1 ↑	6.8 ↑	6.7 ↑	5.6 ↓	5.8 ↓	6.8 ↑	6.3 ↑	6.8 ↑	7.0 ↑	6.4 ↑	5.7 ↓	7.0 ↑	8.0 ↑
We are a team	6.8	6.1 ↓	7.0 ↑	7.0 ↑	7.2 ↑	6.7 ↓	5.7 ↓	7.2 ↑	7.0 ↑	7.5 ↑	7.0 ↑	6.7 ↓	6.4 ↓	7.2 ↑	8.0 ↑
Staff Engagement	6.9	6.3 ↓	6.9 -	7.6 ↑	7.2 ↑	6.8 ↓	6.6 ↓	7.0 ↑	6.7 ↓	7.4 ↑	7.2 ↑	6.7 ↓	6.7 ↓	7.0 ↑	7.6 ↑
Morale	5.6	5.0 ↓	5.6 -	5.7 ↑	5.8 ↑	5.4 ↓	5.5 ↓	6.2 ↑	5.5 ↓	6.6 ↑	6.0 ↑	6.1 ↑	5.5 ↓	5.4 ↓	6.6 ↑

Appendix 5 – Equalities Indicators from the Staff Survey 2022

Equalities Indicators from the Staff Survey

In its fifth year, Workforce Disability Equality Standards (WDES) breakdowns are based on the responses to questions *Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?* In 2020, this question was shortened and the word '*disabilities*' removed to align with the standard question used by ONS. The question and related WDES results remain historically comparable since 2019, but the WDES labels have been updated to better reflect the new wording of the question. The word disability has now been replaced by 'long-term condition (LTC) or illness'

WDES (Workforce Disability Equality Standards) indicators reported in the Staff Survey for Whittington Health

The table overleaf, shows improvement in 6 out of 9 WDES indicators with areas such as experiencing abuse form managers and colleagues improving and where staff are experiencing bullying or abuse, reporting has improved. There is also an increase in staff with disabilities or long-term conditions believing the organisation provides equal opportunities and a positive shift towards the organisation making reasonable adjustments. There is an increase in staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months – an increase not mirrored in staff without a long-term condition. There is also a 1% increase in staff feeling pressure from their managers to come in to work despite feeling unwell – this may be because of the end of the government's guidance on

protecting vulnerable people during the Covid-19 pandemic in 2020/21. There is also a decrease in engagement for staff with LTC of 0.2 since 2021.

Table to show WDES Indicators	2019		2020		2021		2022	
Question	LTC or illness	WITHOUT LTC or illness	LTC or illness	WITHOUT LTC or illness	LTC or illness	WITHOUT LTC or illness	LTC or illness	WITHOUT LTC or illness
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months	33.4%	31.3%	32.8%	28.8%	33.4%	27.4%	**37.5%**	28.0%
Percentage of staff experiencing harassment bullying or abuse from a manager in the last 12 months	24.1%	16.3%	29.5%	13.4%	22.7%	13.8%	**22.3%**	11.2%
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	32.9%	23.5%	30.1%	19.0%	27.7%	19.9%	**26.5%**	17.3%
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or colleague reported it	48.7%	45.3%	43.8%	47.1%	44.7%	48.6%	**47.1%**	48.9%
Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	46.6%	50.2%	41.8%	49.7%	38.5%	49.2%	**40.1%**	51.8%
Percentage of staff who have felt pressure from their managers to come to work, despite not feeling well enough to perform their duties	33.5%	22%	37.4%	21.6%	28.5%	22.0%	**29.5%**	20.8%
Percentage of staff satisfied with the extent to which their organisation values their work	39.3%	51.6%	37.1%	53.7%	33.8%	46.5%	**34.7%**	45.6%
Percentage of staff with a long-lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work	68.1%	73.4%	67%	75.5%	62.3%	N/A	**64.7%**	N/A
Staff engagement score (0-10)	6.7	7.2	6.7	7.3	6.5	7.0	**6.3**	7.0

**Each 2022 response is graded in green if there has been a positive improvement for staff with a LTC or illness and red if a decline from the previous year.*

WRES indicators reported in the Staff Survey for Whittington Health

In its fifth year of reporting there are four indicators comparing the experience of B.A.M.E and white staff. NHS England report the findings under 'BME' staff whilst Whittington Health uses the acronym B.A.M.E.

**Each 2022 response is graded in green if there has been a positive improvement for B.A.M.E staff or red if a decline from the previous year*

The table overleaf shows a positive decline in three areas around discrimination at work from staff, managers and a positive improvement around career progression. There is a negative increase in staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last twelve months of 0.7%. This mirrors the national increase in bullying, harassment of abuse from patients or the public across the board.

Table to show WRES Indicators	2018		2019		2020		2021		2022	
Question	BME staff	White staff	BME staff	White staff	BME staff	White staff	BME staff	White staff	BME staff	White staff
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months	35.9%	30.5%	32.5%	30.6%	30.3%	28.9%	28.6%	27.9%	29.3%	30.4%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	36.2%	31.4%	31.9%	29.9%	29.7%	24.2%	27.7%	25.7%	25.4%	24.3%
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	35.8%	56.2%	39.7%	58.2%	39.7%	56.4%	39.9%	54.4%	41.2%	57.5%
Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	20.3%	9.5%	16.1%	7.8%	16.9%	8.2%	15.2%	8.3%	15.0%	9.4%

Appendix 6 – Clinical Coding External Audit Results 2022/23

Primary Diagnosis		Number of cases	% coding correct
	Number of primary diagnoses	200	
	Number of primary diagnoses Correct	175	**87.50 %**

Secondary Diagnosis		Number of cases	% coding correct
	Number of secondary diagnoses	600	
	Number of secondary diagnoses correct	543	**90.50 %**

Primary Procedures		Number of cases	% coding correct
	Number of primary procedures	159	
	Number of primary procedures correct	147	**92.45 %**

Secondary Procedures		Number of cases	% coding correct
	Number of secondary procedures	348	
	Number of secondary procedures correct	306	**87.93 %**

Appendix 7 – CQUIN progress for 2022/2023

2022-2023 CQUIN progress

Achieved
Not achieved
Partial achievement
No requirement to report for the quarter

CQUIN Scheme	Rationale/Objectives	Compliance		
CCG 1 - Flu vaccinations for frontline healthcare workers	Achieving 90% uptake of flu vaccinations by frontline staff with patient contact.	Q1	Q2	Q3
CCG 2 - Appropriate antibiotic prescribing for UTI in adults aged 16+	Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.	Q1	Q2	Q3
CCG 3 - Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	Achieving 60% of all unplanned CCU admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation and time of clinical response recorded.	Q1	Q2	Q3
CCG 4 - Compliance with timed diagnostic pathways for cancer services	Achieving 65% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways	Q1	Q2	Q3
CCG 5 - Treatment of community acquired pneumonia in line with BTS care bundle	Achieving 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle.	Q1	Q2	Q3
CCG 6 - Anaemia screening and treatment for all patients undergoing major elective surgery	Ensuring that 60% of major elective blood loss surgery patients are treated in line with NICE guideline NG24.	Q1	Q2	Q3

CCG 7 - Timely communication of changes to medicines to community pharmacists via the discharge medicines service	Timely communication of changes to medicines to community pharmacists via the discharge medicines service	Q1	Q2	Q3
CCG 8 - Supporting patients to drink, eat and mobilise after surgery	Ensuring that 70% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.	Q1	Q2	Q3
CCG 9 - Cirrhosis and fibrosis tests for alcohol dependent patients	Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.	Q1	Q2	Q3
CCG 13 - Malnutrition screening in the community	Achieving 70% of community hospital inpatients and community nursing contacts having a nutritional screening that meets NICE Quality Standard with evidence of actions against identified risks	Q1	Q2	Q3
CCG 14 - Assessment, diagnosis, and treatment of lower leg wounds	Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines.	Q1	Q2	Q3
Local Maternity CQUIN - 75% of continuity of carer for women from Black, Asian, Mixed and Minority ethnic communities and from the most deprived groups.	Ensuring continuity of carer for 75% of women from Black, Asian, Mixed and Minority ethnic communities and from the most deprived groups.	Q1	Q2	Q3