Quality Account 2023/24

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Part 1: Statement on Quality from the Chief Executive

Comms to provide

Part 1: Trust information and What is a Quality Account?

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 2023/24. 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.

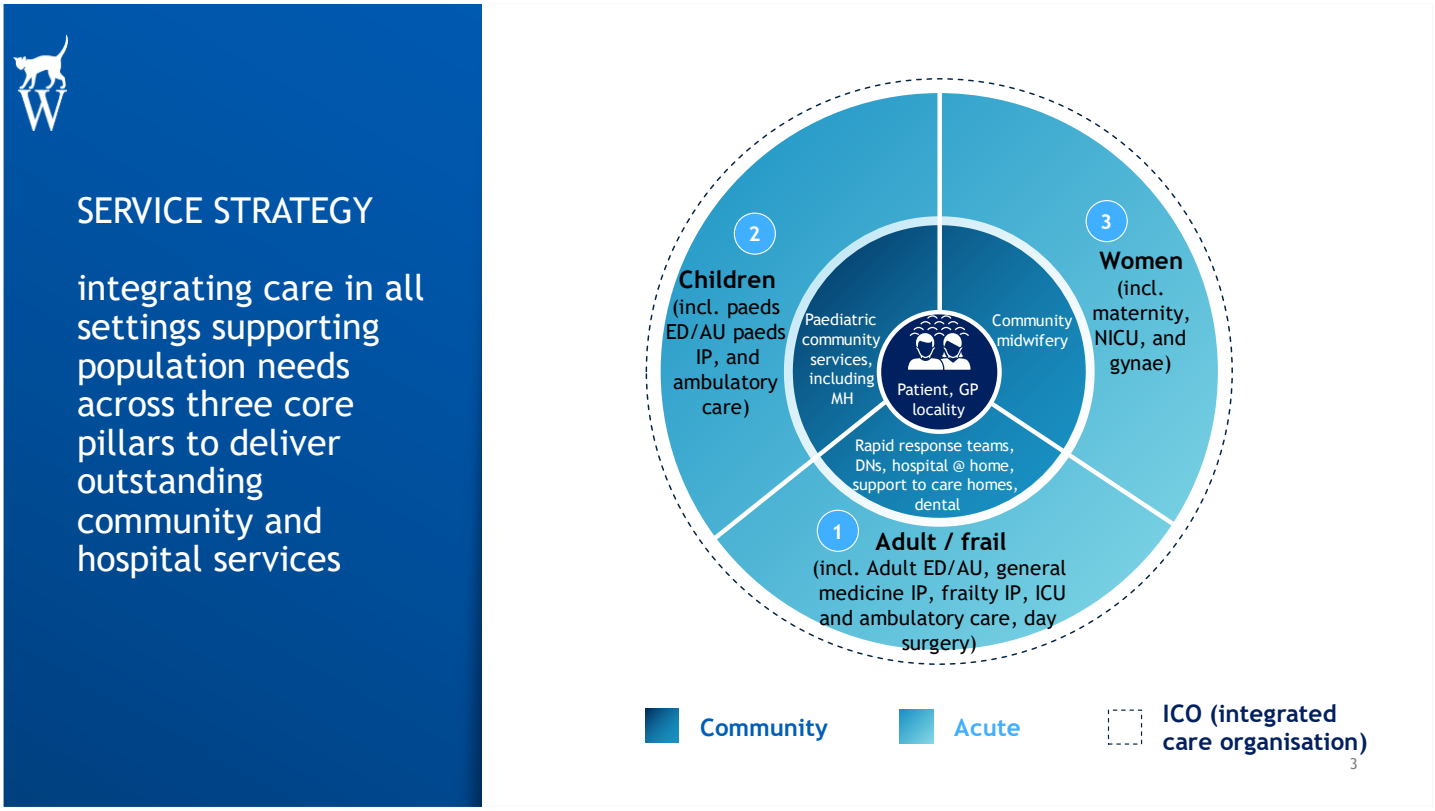
Our services and our approach are driven by our vision.
We have an excellent reputation for being innovative, responsive, and flexible to the changing clinical needs of the local population. We are treating more patients than ever before and are dedicated to improving services to deliver the best care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

The Trust's strategic objectives for 2024 onwards are:

What we do: Deliver outstanding safe and compassionate care in partnership with patients

Our clinical service strategy is:



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.

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 2024/25. 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 2023/24 Quality Account can be found in 'Part 3: Review of Quality Performance' which starts on page 46.

2.1 Priorities for improvement 2024 onwards

Whittington Health recognises that to achieve sustainable improvement, projects need to be long-term and effectively monitored. Quality priorities for 2024 onwards have been developed following a range of engagement events with the public and our stakeholders. We have aligned our priorities for 2024 onwards to the Patient Safety Incident Response Framework (PSIRF) priorities which are:

- Patient falls.
- Medication safety.
- Deteriorating patients.
- Pressure damage.
- Delayed treatment.
- Unsafe discharge.

They priorities were also aligned to the Trust's Corporate Objectives to "Deliver outstanding safe and compassionate care in partnership with patients".

- Ensuring patients are seen by the right person in the right place at the right time.
- Access and attendance
- Reducing health inequalities in our local population
- Improving the Trust Environment to Improve Patient Experience.

The other area of focus for the organisation is linking value to quality through our value improvement priorities around access, elective and flow. We will be setting up an "improvement faculty" to bring these different pieces of work together to ensure they are aligned.

Our consultation process.

Whittington Health recognises that to achieve sustainable improvement, projects need to be long-term and effectively monitored.

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 to help establish ongoing priorities and any new priorities to be added in 2024/25..

The specific objectives, to achieve the priorities set for 2024/25 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 2024/25 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 reviews 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.

- Ensuring patients are seen by the right person in the right place at the right time.
- Access and attendance.
- Reducing health inequalities in our local population.
- Improving the Trust Environment to Improve Patient Experience.

(One Asterix * indicates alignment to the value improvement priorities, and two ** indicates a PSIRF priority)

Quality Account Priority	Why are we focusing on this as an area for improvement?	What are we doing to improve?	Goals for 24/25
Ensuring patients are seen by the right person in the right place at the right time.	The NHS Long Term Plan pledges radical change for people needing planned care. Too often people are travelling for hours to a hospital appointment that lasts a few minutes when they could be saved time, cost and stress by the NHS doing things in a different way. Sometimes people are waiting months to be treated at their local hospital when they could be seen faster elsewhere if they knew where to look.	The ensuring patients are seen by the right person in the right place at the right time will improve patient flow* and patient experience by:	
		Reduce long waiting times for ASD/ADHD assessments, CAMHS and SLT services (** delayed treatment)	Reduce waiting times for 1st appointments across CAMHS, OT and SLT services by at least 20% by the end of March 2025.
		Reducing harm from community and hospital acquired pressure ulcers (** pressure damage).	50% reduction in category 4 pressure ulcers in the community based on 2023/2024 data. 25% reduction from 2023/24 reported incidents, of ALL full thickness pressure damage incidents in line with the new national reporting

	The Elective Care Improvement Programme* is leading transformative change on these and other areas to make sure patients needing planned care see the right person, in the right place, first and every time, and get the best possible outcomes, delivered in the most efficient way. This also aligns with our Trust objective to deliver outstanding safe and compassionate care in partnership with patients.		requirements on pressure damage. (All previous unstageable and deep tissue injury incidents will now be categorised at stage 3 pressure ulcers)
		Preventing unnecessary hospital admissions through supporting patients to stay well in their home environments.	To utilise up to 48 Virtual Ward beds 28 acute and 20 community (With remote monitoring support where needed). Meet Virtual ward and rapid response urgent response 2hr/4hr/24hour targets to ensure timely patient care and admission avoidance for 60% of the year (At least six months) Ensure 75% of patients are streamed to an appropriate care pathway to improve flow and overcrowding in the ED, subsequently reducing patient admissions and LOS by end March 2025.
		Reducing harm from Hospital Falls (** falls)	20% reduction of moderate and over harm in trust wide falls, which will reduce hospital bed days. Increase falls training compliance among all staff groups by 20% by March 2024
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. This also aligns with our Trust objective to deliver outstanding safe and compassionate care in	Improving the care, we provide to those with Sickle Cell disease.	Lead, develop and deliver a new co- designed NCL Community Red Cell (sickle cell) Service with partners and patients in NMUH and UCLH to deliver NHSE targets, reduce LOS and admissions. Implement the NHSE 'Sickle Cell Card' for at least 75% of Sickle Cell patients attending ED by March 2025
		Improving the care, we provide to those with Cancer or suspected Cancer, that have been	To expand on the previous success of Prostate cancer events, holding up to 40 cancer events by the end of

	partnership with patients.	identified as having health inequalities.	March 2025, with a focus on those that disproportionally affecting patients with health inequalities.
		Understand our population so we can target services such Continuity of carer to tackle health inequalities and improve outcomes for women and their families.	Implement 'Attend Anywhere' in Maternity by the end of March 2025. Fully implement Birmingham Symptom Specific Obstetric Triage System (BSOTS) in Maternity Triage by end of March 2025.
		Improving the care, we provide to those with Learning Disabilities	Further develop the intranet page for people with autism and learning difficulties to access and ensure a range of accessible information is provided to this cohort of patients ensuring we are treating and supporting those with Autism and LD effectively. 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 new information and training delivered shows a positive impact on patient experience and care. Deliver Oliver McGowan training to 80% of staff by March 2025.
		The appointment work stream focuses on improving communication, access, and attendance by:	
Improving access and attendance for appointments	We have received feedback from patient representatives that information around appointments can be confusing and access challenging.	Improving clarity within patient letters* and signposting around our sites	All outpatient letters to be reviewed and updated to ensure clinic and ward locations correctly matches hospital signage to improve wayfinding for patients. Implement a wayfinding strategy for patients and

Improving communication with patients	This includes comments around wayfinding on hospital sites; as well as poor communication being highlighted as a contributory factor in PALS contact, complaints, and incidents. Communication with patients / relatives in relation to care and treatment, responsiveness and attitude through patient feedback, surveys, PALs FFT. This also aligns with our Trust objective to deliver outstanding safe and compassionate care in partnership with patients.		carers to improve patient experience. 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 By the end of March 2025, this accessible information will be fully implemented, and accessible information will be further rolled out to other areas & topics as 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. Ensure a 10% reduction in complaints from patients relating to 'communication' across all ICSUs by the end of March 2025.
		Offering increased options to be able to attend more local sites for outpatient appointments*.	To offer Paediatric Blood Tests at Wood Green CDC by the end of March 2025.

Improving the Trust Environment to Improve Patient Experience.	We have received feedback from patients and their representatives, as well as national reports such as the Patient-led assessment of the care environment (PLACE) report and intelligence from the CQC and stakeholders that the hospital environment is not conducive to a high-quality patient experience. This also aligns with our Trust objective to deliver outstanding safe and compassionate care in partnership with patients.	We aim to make improvements to the hospital environment to ensure that we improve patient experience and feedback in this regard.	Work with estates team to identify opportunities to Transform ED Front of House to make the best possible use out of the space available to deliver: • An appropriately sized and comfortable waiting area for patients. • Effective triage and streaming cubicles. • A suitably sized rapid assessment area. • Review space available for patients with mental health needs to ensure it is of a high and appropriate standard. Improve the Cleanliness and condition / appearance and maintenance scores in the 2024 PLACE report to over 90% (PLACE assessment takes place in October 2024 and final report is released in February / March 2025)

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 2023/24

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) p report directly to the Chief Nurse.

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

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, 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 2023/24.
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 2023-24 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 2023/2024

During 2023/2024, 60 national clinical audits including 8 national confidential enquiries covered relevant health services that Whittington Health provides.

During that period, Whittington Health participated in 98% 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 in was the Society for Acute Medicine Benchmarking Audit (SAMBA). This decision was taken at senior clinician level with the following rationale:

''We are awaiting any result from anticipated changes in the GIM rota which should impact in time to consultant review, but this will not occur before this year's audit window. As no change in performance is currently expected, the time and effort (approximately 2 full days' time of reg/consultant time) required to complete the audit is not justified.''

The Trust is further awaiting an updated benchmarking tool from SAMBA which is less time consuming.''

The national clinical audits and national confidential enquiries that Whittington Health was eligible to participate in, and participated in, during 2023/2024 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 20 non-mandatory national audits, in which the Trust also participated during 2023/2024 **(Appendix 1).**

Whittington Health intends to continue to improve the processes for monitoring the recommendations of National Audits and Confidential Enquires in 2024/2025 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 audit will continue to be developed and effectiveness monitored.
- Multidisciplinary quality governance sessions will continue to include reflective learning on national clinical audit findings and associated quality improvement.
- The Clinical Effectiveness group will continue to ensure actions from national audit reports are scrutinised and monitored at the highest level in order to provide additional organisational assurance.
- Continued collaboration with our Quality Improvement lead(s) will identify appropriate project follow up subsequent to national audit report publication.

The reports of 25 national clinical audits/national confidential enquiries were reviewed by the provider in 2023/2024.

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

National Prostate Cancer Audit (NPCA)

The aim of the NPCA is to assess the process of care and its outcomes in men diagnosed with prostate cancer in England and Wales. The audit determines whether prostate cancer care is consistent with current recommended practice.

The review of the report provided excellent levels of assurance when compared to national performance.

The overall assurance from this report is **Green**

The action plan identified two areas with excellence levels of assurance:

	Action to be Taken
Review the NPCA completeness of data provided by the Trust	Ensure the documentation in Somerset Cancer register during the MDT is completed at the recommended level of detail, with clear documentation of the TNM staging, PSA, and performance score. Awareness of this will be raised to all MDT participants and MDT coordinators in the local governance meetings.
Review use of enzalutamide with ADT instead of Docetaxel	Liaison with the oncology MDT team to review usage.

Additional actions for improvement identified, as below:

	Action to be Taken
Family history of prostate, breast, and ovarian cancer. Genetic counselling	Ensure all members of the team and CNS explore family history on diagnosis and know who is responsible for genetic counselling in order to facilitate referral. Awareness will be raised to all MDT participants in the local governance meetings.
Specialist Gastroenterology service for bowel related SE of radiotherapy	Review the pathway for the referral of patients with gastroenterology SE after radiotherapy and see if there are any areas for improvement, with the increased alertness of the urology team members on appropriate pathways. Appropriate liaison with the oncology team to provide clinical input on the service available for these patients.
Initiation of hospital level PROMS to identify SE and	We need to integrate PROM questionnaires to patients followed up by our service after treatment. To quantify SE and support benchmarking for providers.

success of radical treatment	To raise this at our Audit meeting with the view to recruit team members to generate a Quality improvement project.
Investigate if any men with high-risk disease in the trust are not offered radical treatment	We need to review the number of these men and the reason not offered radical treatment in order to document this and prevent any lapses in our service. Will raise this matter in the governance meetings and promote an associated local audit.
Ensure patients are given standardised SMDT approved PIS regarding support for psychological and mental SE of PCa treatment	Ensure all members of the team and CNS explore family history on diagnosis to facilitate referral. Awareness of this will be further raised to all MDT participants in the local governance meetings.

National Neonatal Audit Programme: Your Baby's Care - Summary Report on 2022 data

The National Neonatal Audit Programme helps neonatal units give better care to babies who need specialist treatment. The programme assesses the following:

- Whether babies receive consistent, high-quality care.
- Whether babies have had the health checks recommended to reduce the risk of complications.
- How well babies are doing following this care.

The overall assurance from this report is **Green/Amber.**

Green Assurance

For 10 of the 12 NNAP (National Neonatal Audit Programme) measures included in the 2022 results, the Whittington performed at a higher standard than the national average, and for some of the measures the performance was considerably better.

Amber Assurance

For 2 of the 12 measures, the Whittington's Neonatal Unit performed at a lower standard than the national average. These included deferred cord clamping (although no longer a negative outlier) and temperature on admission.

Actions to be taken:

Temperature on admission: This is still slightly below national average although improving in 2023 NNAP data year to September. This is also the subject of a Trust QI project.

Deferred cord clamping: The Concord resuscitation trolley, to enable resuscitation with cord intact has been purchased. Results demonstrate a significant improvement from previous years. There is an ongoing QI project, and a request was submitted for inclusion on the CYP risk register.

National Lung Cancer Audit

The purpose of the National Lung Cancer Audit is to evaluate the patterns of care and outcomes for patients with lung cancer in England and Wales, and to support services to improve the quality of care for these patients.

The overall assurance from this report was **Amber.**

To improve patient care as a result of this report, the following has been actioned:

- To improve data completeness a permanent Lung cancer Coordinator is now in place.

To improve patient care as a result of this report, the following actions are to be taken forward:

- The pathway is to be reviewed to give better access to PET and CT reporting.
- In order for 90% of patients seen by CNS on diagnosis, the nurses cover each other's duties, and it has been suggested to retain the Macmillan support worker to further support the CNS.
- Resource the MDT according to commissioning guidance. The recommended staffing levels are 10 consultant PAs per 100 new patients.

Local Clinical Audits:

Whittington Health intends to continue to improve the processes for monitoring the recommendations of local clinical audits in 2024/2025 by ensuring:

- Reactive local audits, vital to patient safety, will remain of intrinsic value to clinical audit and effectiveness 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 pre-existing workshops. These sessions will be open to staff of all designations and grades.
- 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 78 local audits were reviewed by the provider in 2023/2024.

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

Audit on Optimal Cord Management

In August 2022, we were notified of negative outlier status for the National Neonatal Audit Programme NNAP 2021 measures.

The outlier status referred to the audit standard for ***Deferred cord clamping*****,** and for which we were a number of standard deviations from the expected measure.

From January to July 2022, the deferred cord clamping standard improved from 3.8% to 33% and the Trust instituted additional measures to further improve compliance, to include intensive training of obstetric and neonatal staff including a presentation at a perinatal meeting, and simulation exercises.

A local audit was undertaken to ascertain progress.

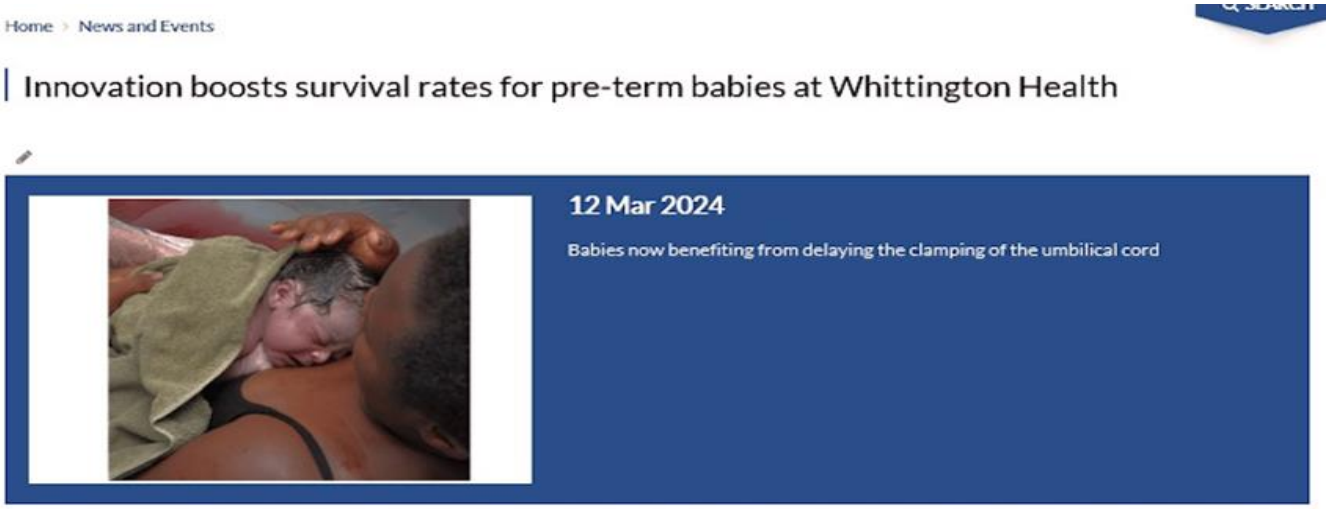
Whilst the results did not meet the standard of 80%, there was a continuous improvement noted, as demonstrated below:

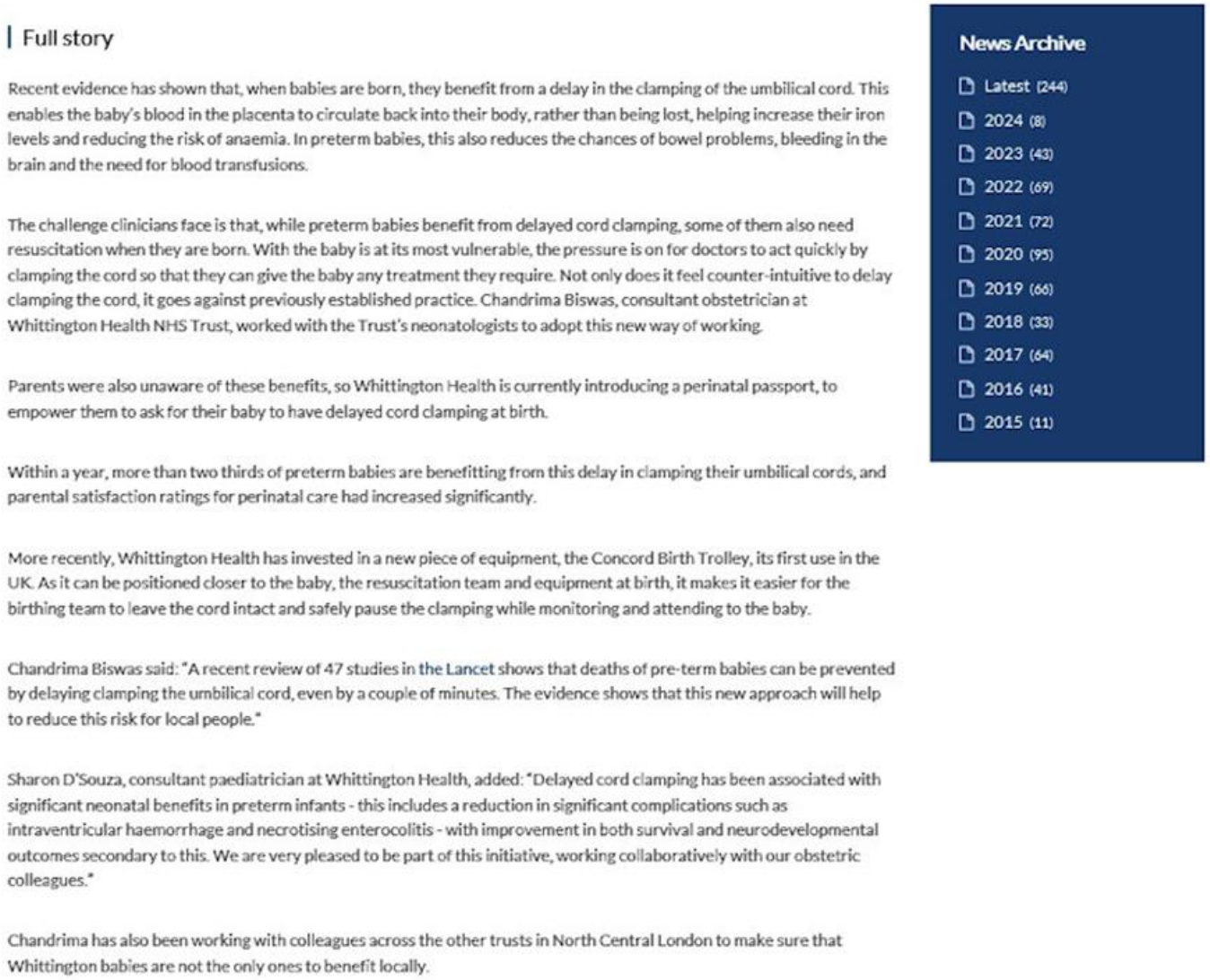
- 46% of babies <34 weeks gestation had DCC in period Jan – March 2023
- 59% of babies <34 weeks gestation had DCC in period Apr – Jun 2023

Actions to be taken:

- Continuous education programme to raise awareness especially with the new trainees arriving in September.
- Concord resuscitation trolley acquisition*
- A pre-term checklist for Neonatologists.
- Establishment of pre-term champions.

*On 12 March 2024, Whittington Health confirmed the acquisition of the Concord Birth Trolley, its first use in the UK (see below article from Trust Intranet).





Full story

Recent evidence has shown that, when babies are born, they benefit from a delay in the clamping of the umbilical cord. This enables the baby's blood in the placenta to circulate back into their body, rather than being lost, helping increase their iron levels and reducing the risk of anaemia. In preterm babies, this also reduces the chances of bowel problems, bleeding in the brain and the need for blood transfusions.

The challenge clinicians face is that, while preterm babies benefit from delayed cord clamping, some of them also need resuscitation when they are born. With the baby is at its most vulnerable, the pressure is on for doctors to act quickly by clamping the cord so that they can give the baby any treatment they require. Not only does it feel counter-intuitive to delay clamping the cord, it goes against previously established practice. Chandrima Biswas, consultant obstetrician at Whittington Health NHS Trust, worked with the Trust's neonatologists to adopt this new way of working.

Parents were also unaware of these benefits, so Whittington Health is currently introducing a perinatal passport, to empower them to ask for their baby to have delayed cord clamping at birth.

Within a year, more than two thirds of preterm babies are benefitting from this delay in clamping their umbilical cords, and parental satisfaction ratings for perinatal care had increased significantly.

More recently, Whittington Health has invested in a new piece of equipment, the Concord Birth Trolley, its first use in the UK. As it can be positioned closer to the baby, the resuscitation team and equipment at birth, it makes it easier for the birthing team to leave the cord intact and safely pause the clamping while monitoring and attending to the baby.

Chandrima Biswas said: "A recent review of 47 studies in the Lancet shows that deaths of pre-term babies can be prevented by delaying clamping the umbilical cord, even by a couple of minutes. The evidence shows that this new approach will help to reduce this risk for local people."

Sharon D'Souza, consultant paediatrician at Whittington Health, added: "Delayed cord clamping has been associated with significant neonatal benefits in preterm infants - this includes a reduction in significant complications such as intraventricular haemorrhage and necrotising enterocolitis - with improvement in both survival and neurodevelopmental outcomes secondary to this. We are very pleased to be part of this initiative, working collaboratively with our obstetric colleagues."

Chandrima has also been working with colleagues across the other trusts in North Central London to make sure that Whittington babies are not the only ones to benefit locally.

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Major haemorrhage (MH) protocol audit: The collection of emergency blood

The provision of blood during major haemorrhage (MH) calls in some areas within the hospital was unreliable and did not ensure the delivery of emergency blood in a consistent manner. The porter collection and delivery procedures were standardised to ensure all MH calls receive the same amount of stat blood in a timely manner,in all areas of the hospital. The major haemorrhage guideline and protocol documents the new procedure for collecting and returning emergency blood.

This clinical audit was required to ensure adherence with the new guideline and protocol following their implementation.

Criteria and Standards:

- 100% adherence with the protocol to collect and deliver 2 units upon the activation of a MH.

- 100% of RBC units are returned to the laboratory within 30min if not needed.

The results showed that the automatic collection of 2 units happened on 3/7 MH calls representing 43% compliance with the protocol.

The returning of RBC units within 30 minutes if not needed demonstrated 67% compliance with the protocol.

Action Taken:

The Transfusion Practitioner and Porter Facilities Manager met with the Portering staff to implement the following actions:

- Porter Management must ensure only porters trained in blood collection are allocated to MH calls.
- Transfusion practitioner to discuss any barriers with the Porter Management Team to training and devise an action plan to capture untrained staff.
- Porter Management must monitor training compliance to ensure staff have access to training, and track compliance to ensure staff are up to date with training.

A re-audit was subsequently undertaken demonstrating 87.5% of total adherence to the protocol.

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 *E. Coli* bloodstream infections. Targeting and improving the diagnosing and treatment of UTIs would help reduce avoidable infection rates, improve patient safety, reduce length of hospital stay, and in turn, release bed capacity.

Aim: 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.

Standards: A minimum of 40% compliance was expected for the following:

(1) diagnosis of UTI based on clinical signs/symptoms.

(2) diagnosis excluding urine dipstick in people aged 65+ years and in CAUTI.

(3) empirical antibiotic regimen prescribed following national/local guidance.

(4) urine sample sent to microbiology.

(5) documented review of urinary catheter made in CAUTI diagnosis, in order to meet the CQUIN CCG2 target [3].

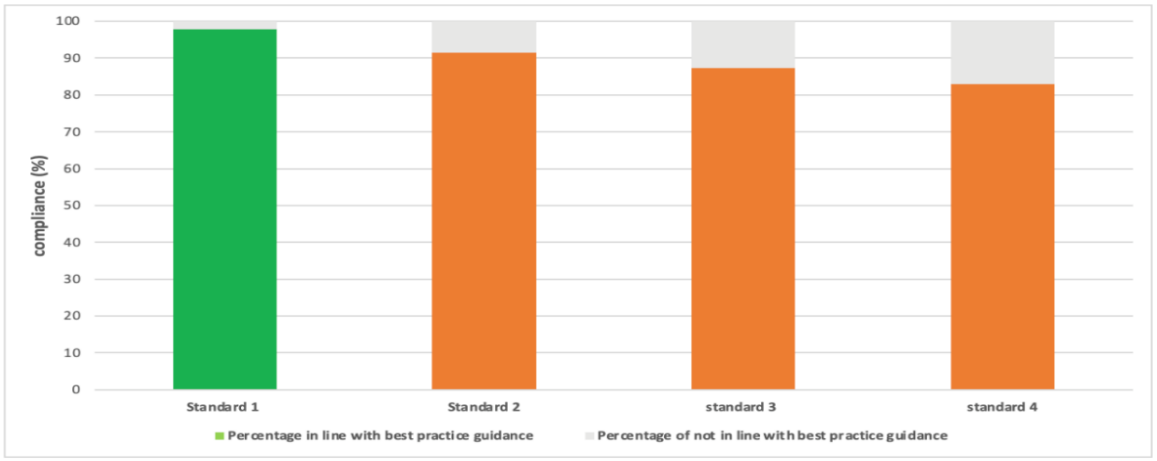
Methodology

A retrospective audit of 100 patient records of ages 16+ issued antibiotic prescriptions after a primary/secondary diagnosis of UTI in A&E, and in-patients from August to September 2022, were identified. Compliance to CQUIN standards were measured by accessing patient clinical records and cross-referencing documented clinical signs/symptoms/urinalysis and antibiotic regimen against national and local UTI diagnosing and treatment guidance.

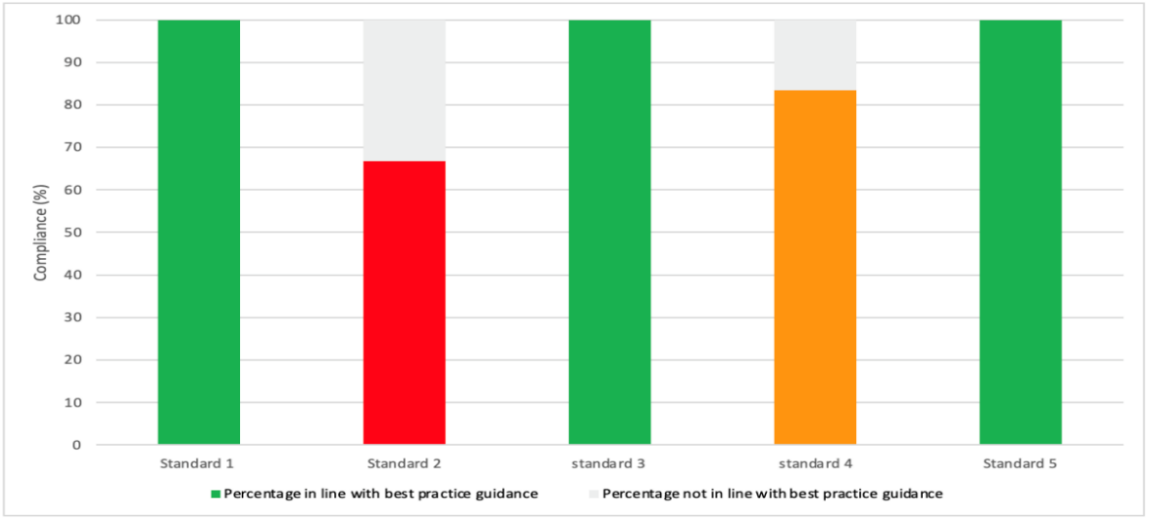
Results and discussion

70% of the antibiotic prescriptions complied with all 5 standards, meeting the 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 1.a). This indicated satisfactory use of antimicrobials; however, further work could be done to increase compliance to national guidance.

a)



b)



CAUTI antibiotic prescriptions showed good compliance to standards 1, 3 and 5, acceptable compliance to standard 4, but poor compliance to standard 2, which can increase the rate of UTI diagnosis in cases of benign bacteriuria. National guidelines do not recommend dipstick testing to diagnose UTIs in adults with indwelling urinary catheters, therefore, interventions must be implemented to increase compliance to standard 2 (see Figure 1.b)

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 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

The last year has seen progress in return to a 'business as usual' research landscape as delivery of COVID-19 research become an additional area for research activity rather than a primary focus. However, 2023-2024 still saw pressures and changes in service delivery that have prevented a 'new stable baseline' to be reached:

(i) The Covid era generated residual systemic impacts on 'research process' for all providers (e.g. commercial trial focus; 'research resets' across portfolios; and patient appetite for engagement.

(ii) Significant changes to the national infrastructure of the National Institute for Health and Care Research (NIHR) began and continue into 2024/25. These have required dynamic development of strategic partnerships and fiscal planning.

(iii) Whittington Health (WH) in-sourced the R&D office function during the year, having outsourced this for circa 8 years. The newly formed 'Research Support Service' provides a robust yet responsive service to ensure study set-up is proportionate and works with the Trust's developing priorities in an efficient and cost-effective way. A further benefit of insourcing the service has been the ability of the Trust to act as sponsor for research developed by our own staff with far greater success than previously seen.

Staffing and Staff Engagement

WH currently have 16.9 WTE research staff- an increase from 12.7 WTE the previous year of which we are proud. Of these WTEs, two support the in-sourced R&D office function, while two specialty specific research delivery roles (paediatrics and oncology) were also created. The remaining 0.2 increased the hours for an existing post.

The Trust already has established medical research fellow posts and consultant posts that incorporate research in job planning. However, these have been expanded: have facilitating protected time for research has been created in 3 clinical services (ED, CAMHS and The Michael Palin Centre), demonstrating an organisational commitment to furthering research capacity and capability.

We have made great efforts to increase links with UCL and are proud that the Joint-Director for Research and Innovation Mr Chetan Parmar has been appointed as Honorary Associate Professor at University College London.

Whether or not engaged directly through the Trust's Research Department, many other Trust clinicians remain research active. This is demonstrated by research publication records. A PubMed search for 'Whittington Health' OR 'Whittington NHS' reveals a steady rise in publications year on year, with more than 113 such papers published in the 12 months to March 2023.

The Trust currently holds 1 research grant; Professor Ibrahim Abubakar's £2.5 million NIHR Programme Grant for Applied Research: Research to Improve the Detection and Treatment of Latent Tuberculosis Infection (RID-TB) which has had a 'no-cost extension' in response to delays in meeting milestones, predominantly due to the COVID Pandemic and import changes in response to Brexit.

There has been a significant advancement in finding academic partnerships via London Metropolitan University which has supported clinical teams to begin developing their own research ideas. Currently physiotherapy, CAMHS, dietetics and haemoglobinopathy partnerships are underway.

At the time of writing (February 2024), 832 patients had been recruited into 53 NIHR portfolio studies during 2023/24 with further recruitment to follow. This figure is a positive return to previous levels of recruitment following a (Covid-recovery period) lower than usual figure in 22/23 (see table) and substantial increase in open studies. This return to previous levels of recruitment is facilitated by in sourcing the R&D office function therefore seeing a significant rise in the number of studies open to recruitment as well as the increase in staffing levels supporting study delivery. The insourced R&D office have demonstrated a dynamic process with study set-up timelines taking on average 60 days to confirm Capacity & Capability (C&C) with the outlying studies that cause that to be the average having significant sponsor generated delays. In addition, the first sponsored study under the new service was approved by the HRA within 48 hours and positive feedback has been received from colleagues that the process is simpler to navigate and more responsive. This is a significant step and a success of which we are proud.

	NIHR Portfolio		**Non-Portfolio**
	Patients recruited	**Number of recruiting studies**	**Number of recruiting studies**
Year			
2018-19	**1077**	**49**	**7**
2019-20	**848**	**29**	**5**
2020-21	**1241**	**20**	**4**
2021-22	**921**	**27**	**5**
2022-23	**689**	**30**	**4**
2023-24	**832**	**53**	**5**

Completed Trials and Outcomes

Publication of a selection of trials (performed at or recruiting at Whittington Health) in the last year are described below:

The 'heROIC' trial: Does the use of a robotic rehabilitation trainer change quality of life, range of movement and function in children with cerebral palsy? - Grodon - Child: Care, Health and Development Wiley Online Library.

‘Demonstrating the learning and impact of embedding participant involvement in a pandemic research study: the experience of the SARS-CoV-2 immunity and reinfection evaluation (SIREN) study UK, 2020-2023’ BMC Part of Springer Nature

GWAS and meta-analysis identifies 49 genetic variants underlying critical COVID-19. Nature.

Empagliflozin in patients admitted to hospital with COVID-19 (RECOVERY): a randomised, controlled, open-label, platform trial. The Lancet – Diabetes and Endocrinology.

Children presenting with diabetes and diabetic ketoacidosis to Emergency Departments during the COVID-19 pandemic in the UK and Ireland: an international retrospective observational study. Archives of Disease in Childhood.

686 The Mental Health Interventions for children with epilepsy (MICE) trial: 6 month outcomes. Archives of Disease in Childhood.

The benefits of continuing patient and public involvement as part of a randomised controlled trial during the Covid-19 global pandemic. Research for All.

Evaluation of a quality improvement intervention to reduce anastomotic leak following right colectomy (EAGLE): pragmatic, batched stepped-wedge, cluster-randomized trial in 64 countries. Br J Surg.

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.

Trust CQUINs for 2023/24 are:
• CQUIN01 - Flu vaccinations for frontline healthcare workers (Target) • CQUIN02 - Supporting patients to drink, eat and mobilise (DrEaM) after surgery (Target) • CQUIN03 - Prompt switching of intravenous to oral antibiotic (Target) • CQUIN05 - Identification and response to frailty in emergency departments (Reporting only) • CQUIN06 - Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service (Reporting only) • CQUIN07 - Recording of and response to NEWS2 score for unplanned critical care admissions (Target) • Local CQUIN: Core20plus5 (Target)

For 2023/24 the Trust is required to undertake 7 CQUIN Indicators (6 National and 1 Local). However, only 5 Indicators are included in the CQUIN payment scheme for 2023/24.

These CQUINs were set because they represent areas where improvements result in significant benefits to patient safety and experience.

Further details of the agreed goals for 2023/24 are available electronically at:
https://www.england.nhs.uk/publication/cquin-scheme-for-2023-24-annex-indicator-specifications/

CQUIN progress information for 2023/2024 can be found in **Appendix 7**.

2024/25 CQUIN Update

NHS England has paused the CQUIN scheme for 2024/25.

Registration with the Care Quality Commission (CQC)

Whittington Heath is registered with the Care Quality Commission (CQC) without any conditions. The CQC did not inspect the trust from April 2023 – March 2024.

There was a CQC Executive visit conducted in July 2023, this was an opportunity for CQC Executives to meet with the Trust Executive team, and the CQC Executives visited the following areas: Same day emergency care (SDEC), virtual ward, maternity, and the nursing recruitment teams. The visit was well received and the CQC Executives were very positive about the areas that they visited on the day.

There were three CQC relationship meetings held in 2023/2024, these focussed on Simmons House and medicines management. Simmons House was a focus due to a patient safety incident that occurred in October 2023The unit has been temporary closed to admissions since December 2023. The medicines management engagement meeting happens yearly with the CQC pharmacy team and the Trust pharmacy team, this was a positive meeting. The meeting focussed on the Trusts electronic prescribing and medicines administration system (EPMA) and insulin management. The CQC raised no issues following the meeting and were assured regarding the processes for electronic prescribing and medicines management at the Trust.

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, our critical care, community health services for children and 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 closed actions were reviewed with the responsible Integrated Clinical Service Units (ICSU) in 2024 to ensure that they are still relevant, and reflective of the current Trust position and they are monitored at the ICSU Quality meetings and via the Learn, Innovate, and Improve programme.

The CQC have been implementing their new single assessment framework from November 2023 – March 2024, although there are still some delays to the rollout Trusts have been notified. The new assessment framework has been developed to have a greater focus on care across local areas and systems, to make the CQC regulations less complex and more efficient, which will enable the CQC to regulate services in a smarter way and work better with health and social care sectors as they change and recover post COVID-19. Its aim is to use their new regulatory powers effectively to improve people's care. The domains from the old framework will remain and how the ratings are achieved. But the evidence gathered will be in the form of 'Quality statements.

The CQC are moving away from multiple assessment frameworks to a single assessment framework, using a constant ongoing assessment of quality and risk, gathering evidence at multiple points in time rather than the previous single point in time.

Quality statements will underpin the assessments rather than the previous key lines of enquiry (KLOEs); however, the quality statements are still named after the previous KLOEs.

The new quality statements represent the commitments that providers, commissioners, and system leaders should live up to. Expressed as 'we statements', they show what is needed to deliver high-quality, person-centred care. They directly relate to the CQC regulations already in place. When the CQC refer to 'people' they mean people who use services, their families, friends, and unpaid carers. This includes:

- people with protected equality characteristics
- those most likely to have a poorer experience of care or experience health inequalities.

To develop the quality statements, the CQC have used aspects of the Making It Real framework Making it Real - Think Local Act Personal.

This was co-produced by Think Local Act Personal (TLAP). They worked with a range of partners and people with lived experience of using health and care services. The Making it Real framework:

- support personalised care for people who use services.
- support people working in health, care and housing.
- contains a jargon-free set of personalised principles that focus on what matters to people.

The CQC have linked 'I statements' from Making it Real to each of the new 'quality statements. These will be used to:

- help people understand what a good experience of care looks and feels like.
- support the CQC in gathering and assessing evidence under the 'people's experience' evidence category.

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.

The Data Security and Protection (DSP) Toolkit is a policy delivery vehicle produced by the Department of Health; hosted and maintained by NHS England. It combines the legal framework including the UK General Data Protection Regulations (UK GDPR) and the Data Protection Act 2018, and central government guidance including the NHS Code of Practice on Confidentiality and the NHS Records Management Code of Practice. 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 the areas of IG training and supplier assurance. 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.

Regarding IG training, all staff are required to this annually. The Trust ended 2023/24 with 88% of staff being IG training compliant. 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.

Regarding supplier assurance, a project is currently underway to obtain evidence of appropriate certification and contact clauses from the Trust's IT suppliers.

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 2023/24.

Data Quality

The Trust continued monitor all national data submissions data quality at the point of submission and respond 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 was 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.

In order to improve data quality in 2023-24 the trust has established a Data Quality and Business Intelligence Group (DQBIG) where regular reviews of the data quality within clinical systems and reporting processes is regularly reviewed. This group includes key stakeholders covering Clinical Informatics, Operations, and Information Technology. The trust will continue to embed the following actions:

- Use of data quality dashboards for services to individually monitor their own data quality as required. Work is underway to develop a new Power BI dashboard that will include additional data quality metrics as well as bring internal as well as external data quality monitoring in one place.
- Issuing of regular data quality reports to specific services identified as requiring improvements.
- 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. The trust has purchased an audit tool to help with this.
- Systematic use of benchmarking of data where available.
- Running a programme of audits and actions plans
- Actively engage in any national or NCL-wide data quality improvement initiatives such as meeting the Emergency Care Data Set (ECDS) Conformance Indicators, matching of local and NCL community reports improving the Community dataset (CSDS)

Clinical Coding audit data is available in **Appendix 6**

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 453 adult patients who died during an acute admission in 2023. The SPCT saw well over half of these patients. Our referrals for March 2023 to March 2024 were 736 which is an increase on last year.

As well as increasing numbers of referrals, the complexity of our caseload has increased, particularly the amount of complex family support required. 66% of patients referred to SPCT in 2023/24 were in an unstable or deteriorating phase of their illness, only 10% were in a stable phase of 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 Universal Care Plan (UCP), so it is visible to all urgent and emergency care staff. In 2023/24, 332 palliative care patients had a UCP of which 109 were created or updated by the SPCT.

Quality and Performance Indicators

The Whittington did not take part in the National Audit of Care at the End of Life (NACEL) in 2022/23

due to such a quick turn round time to realistically implement the findings from the preceding years audit. In 2023 there was no national audit. We focused on education which had been highlighted in the 2021-2022 audit. This included running study days for RGNs and NAs on palliative care and communication skills training, participating in nursing and medical induction training sessions, teaching of student midwives and health care support workers and presenting at the hospital's grand round on our work in the emergency department.

The hospital is currently undergoing the NACEL 2024 audit which is now a larger audit completed across the year rather than just one snapshot period. The audit this year consists of case note reviews of at least 20 deceased patients each quarter, quality surveys to bereaved carers, staff reported measures and an overview of the hospital looking at workforce, training, numbers of inpatient beds and other data.

Learning from Deaths

During 2023/2024 there were 460 inpatient deaths at the Trust (this figure excludes patients who have died in the Emergency Department) with the following distribution across the year:

- 108 In the first quarter
- 123 In the second quarter
- 118 In the third quarter
- 111 In the fourth quarter.

Oversight
The Trust has an embedded process to screen, review and investigate inpatient deaths. Each Clinical Directorate has a mortality review process to undertake reviews on any appropriate deaths and to identify learning. The Mortality Review Group (MRG) provides scrutiny of mortality surveillance to ensure the Trust is driving quality improvement by using a systematic approach to mortality review and learning from death. The MRG reports to the Quality Governance Committee, cascading upwards to the Quality Assurance Committee and the Trust Board, via a Quarterly Learning from Deaths report, authored by the Associate Medical Director for Learning from Deaths and the Project Lead for Mortality.

Reviews
51/460 deaths for the year were identified as meeting the criteria for a structured judgement review. Of the 51 identified deaths, 38 case record reviews had been completed by the end of the financial year with others from more recent deaths in progress.

The table below shows the number of case record reviews by quarter and the number of deaths judged more than likely than not to have been due to problems in care:

	Quarter 1 2023/24	Quarter 2 2023/24	Quarter 3 2023/24	Quarter 4 2023/24
Number of structured judgement reviews	11	10	21	9
Number of deaths judged probably avoidable (more than 50:50)	0	0	0	0

	Quarter 1 2023/24	Quarter 2 2023/24	Quarter 3 2023/24	Quarter 4 2023/24

In Q2 there was one SJR where the death avoidability score was judged to be 3 (Probably avoidable (more than 50:50)). This is not included in the above table, as the death occurred in another hospital after transfer.

Summary of themes, learning and actions from Case Record Reviews

From the deaths reviewed in 2023/24 the main themes, learning and actions were:
Ongoing importance of recognition of impending death and good communication to patients and families by clinicians. There were many comments in reports regarding thorough multispecialty reviews of patients with complex problems and high risk of death, and regular senior reviews of patients.

Multidisciplinary and multispecialty discussions were frequently commented on.

Learning from end-of-life care and treatment escalation planning and DNACPR decisions was that early opportunities to have sensitive conversations during admissions, prior to actual end of life phase, could be helpful and that near end-of-life anticipatory medicines should be actively considered to avoid any delays in relief of patients' symptoms and prioritisation of their comfort. The importance of ensuring that staff review treatment escalation plans prior to starting new treatments was also noted. Additionally ensuring good communication with actively dying patients including the use of a translator where necessary.
There was evidence of excellent communication with mental health teams for patients with serious mental health problems.

Reviews of patients with learning disabilities highlighted the importance of multi-team advanced planning for complex patients with hospital passports being reviewed. Learning Disability specialist nurse referrals were made promptly, unrestricted access to carers/ support workers and family visiting and referral to palliative care were commented on.

Second opinions are helpful to some families coming to terms with a relative at end of life alongside pastoral and palliative care support.

Scoring system use is important and now regularly used, but also important to reflect that scoring systems may not encompass all risks such as frailty.

Evidence of appropriate referrals to the Specialist Nurse for Organ Donation (SNOD) and timely identification of Brain Stem Death.

Other themes were:

- Ensuring long stay surgical patients with multiple medical comorbidities are referred to the liaison care of the elderly team.
- Ensuring samples are collected and sent as promptly as possible for analysis.

- Ensuring patients are aware of the risks of discharge/ leaving ward areas.

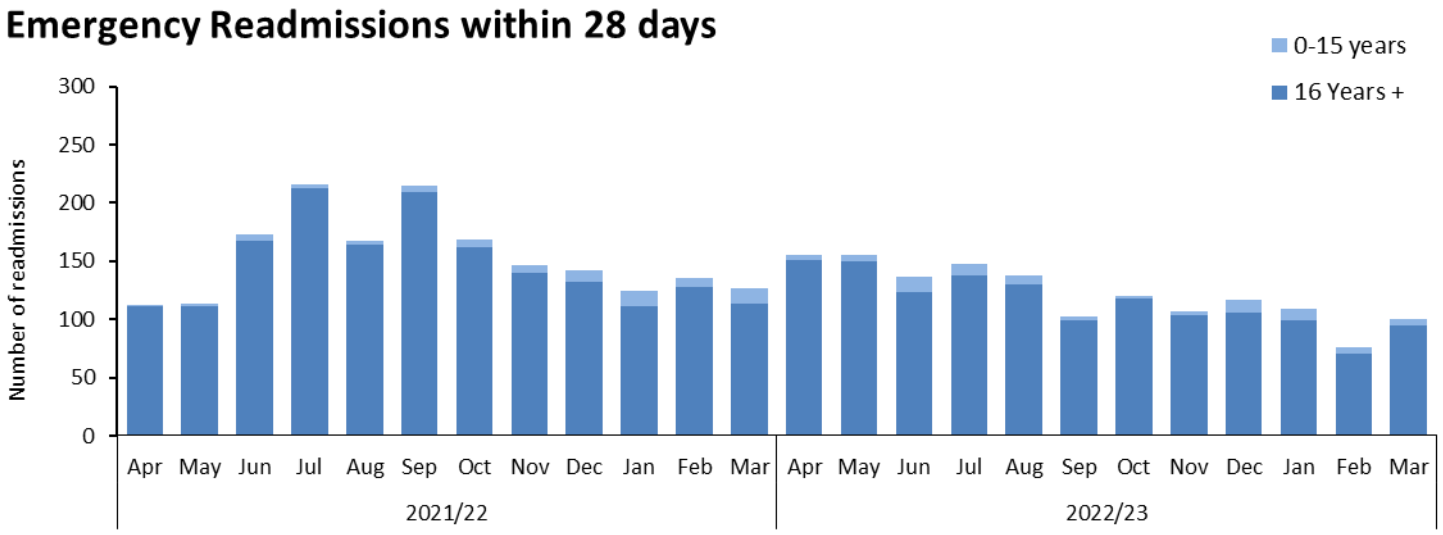
- Recognising that all patients readmitted to hospital need reassessment including observations.
- Teams must have in place recommendations when to call a consultant.
- Clarity about assigned responsible consultant for all patients is required.
- The importance of using the MicroGuide app to access antibiotic guidance and seeking advice from the Microbiology team.
- Documenting safety netting for patients being discharged from hospital.
- Ensuring that there is clear documentation regarding all patient reviews.
- Ensuring that referrals are received.

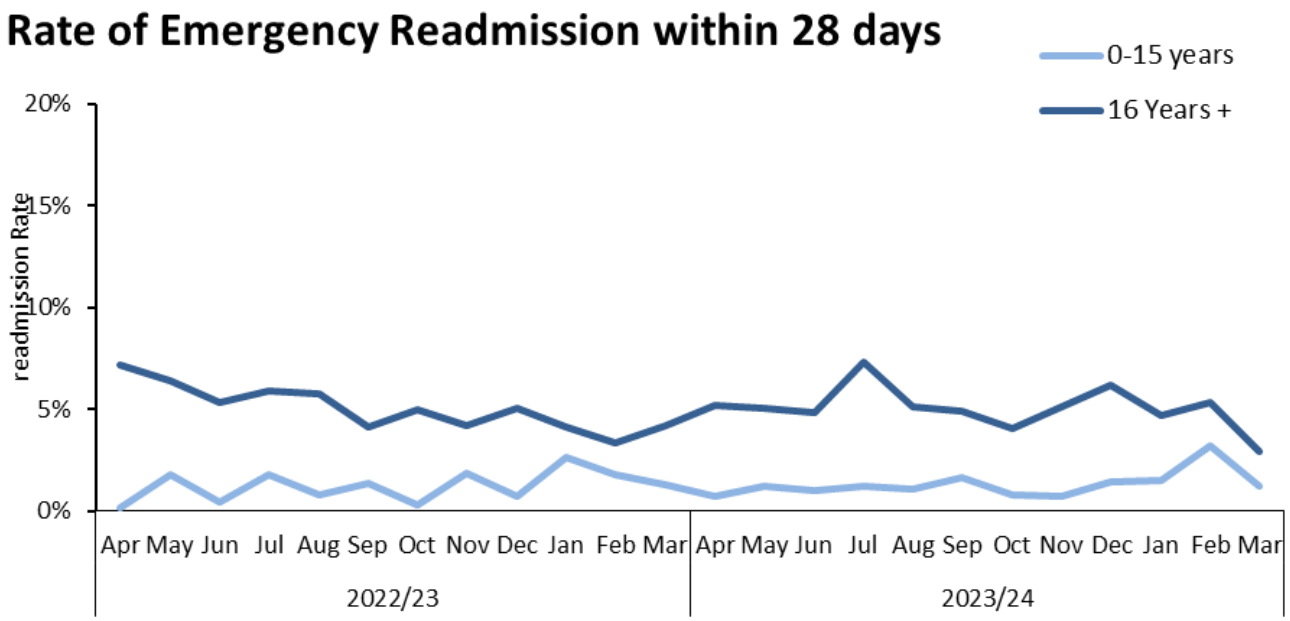
There were also many comments in reviews on excellent medical care delivered including management of acute medical problems, good perioperative care, and good adherence to resuscitation guidelines.

Medical Examiners Service

The Medical Examiners department is now well established and fully staffed and ready for the statutory changes coming in 2024 around the death certification process. This department provides reviews of case notes, discussions with members of clinical teams, supportive discussions with bereaved families and ensures accurate completed of the medical certificate of cause of death.

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.

During 2023 / 2024 New streaming pathways have been implemented in the Emergency Department 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 3**.

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

Learning from National Patient Surveys

The Trust received the results for four national patient experience surveys during 2023/24. These were:

- 2022 Adult Inpatient Survey (published September 2022)

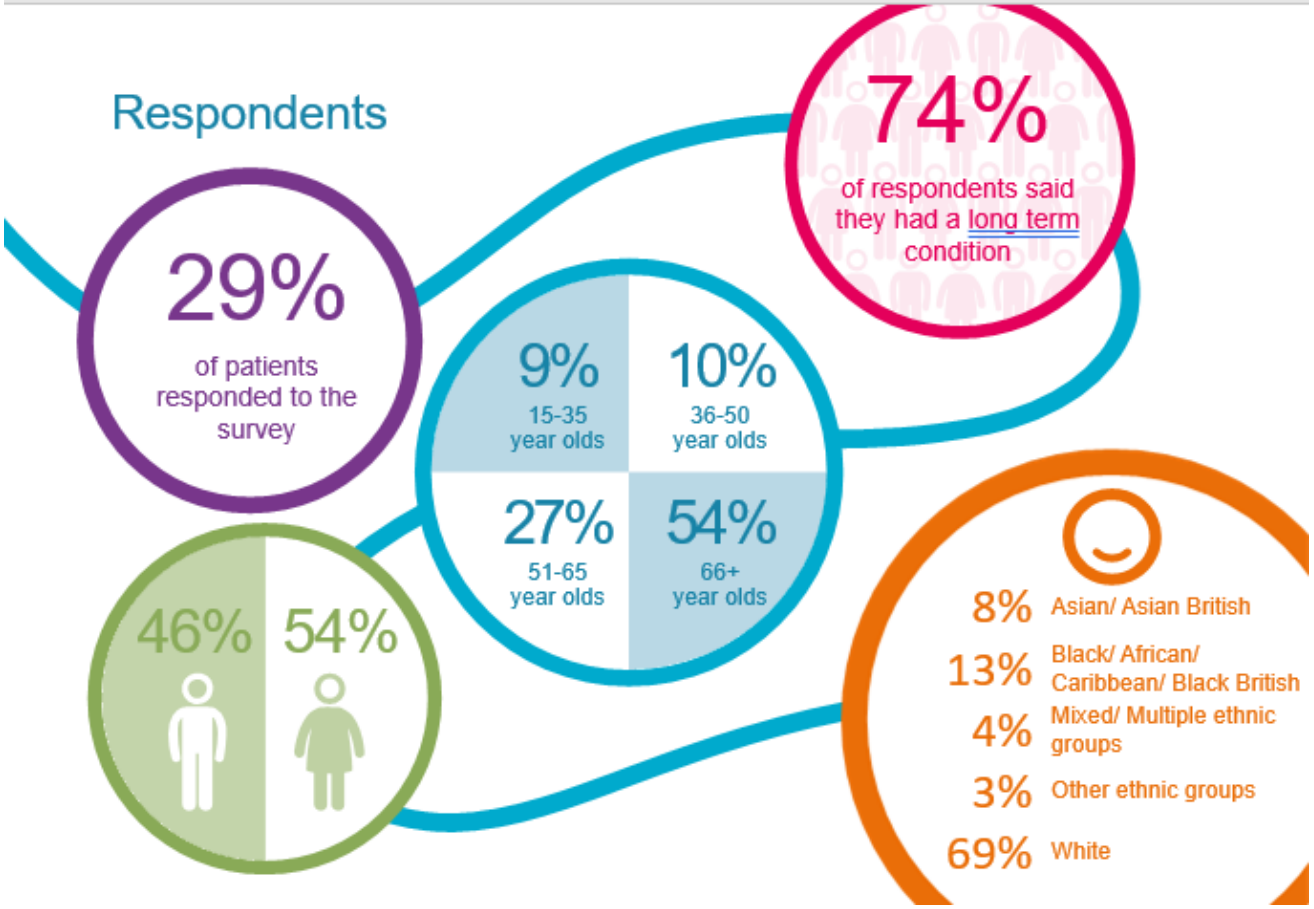
- 2022 Urgent & Emergency Care (UEC) (published July 2023)
- 2022 Cancer Patient Experience Survey (published July 2023)
- 2023 Maternity Survey (published February 2024)

Adult Inpatient Survey 2022

The adult national inpatient survey is held every year, patient cohort for the 2022 survey is those who spent one or more nights in hospital during November 2022, and fieldwork took place from January to April 2023. The findings were published nationally on 12 September 2023.

1250 people were invited to take part in the survey. 29% of people responded, a reduction of 1% response rate in comparison to our previous survey conducted in 2021. This percentage sits below the average response rate for similar organisations of 40%.

The survey, carried out by the Picker Institute 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:



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

- A decreased percentage response from those who were white from 70% to 69%
- An increase of 5% of women in comparison to 2024 survey (49%)
- 74% said they had a long-term condition, an increase of 1% from the 2021 survey.
- An increase of 1% (74%) of those reported having a long-term condition.

Focus on Inpatient views	
73 %	Rated overall experience as 7/10
96%	Treated with respect and dignity overall
99%	Had confidence and trust in the doctors

The key improvements and issues to address are summarised below:

Most Improved Scores			
	Question	2022	2021
	Q12. Food was very good or fairly good	**62%**	52%
	Q13. Got enough help from staff to eat meals	**85%**	76%
	Q11. Offered food that met dietary requirements	**94%**	85%
	Q41. Told who to contact if worried after discharge	**72%**	64%
	Q7. Staff explained reasons for changing wards at night	**84%**	76%

Top 5 Scores Against Picker Average			
	Question	2022	Picker Avg
	Q11. Offered food that met dietary requirements	**94%**	90%
	Q47. Asked to give views on quality of care during stay	**16%**	13%

	Q7. Staff explained reasons for changing wards at night	**84%**	81%
	Q13. Got enough help from staff to eat meals	**85%**	82%
	Q10. Able to take own medication when needed to	**89%**	87%

99%
Had confidence & trust in the doctors

Bottom 5 scores vs the Picker Average		
	60%	Able to get meals outside of mealtime
	55%	Did not mind waiting as long as did for admission
	46%	Not prevented from sleeping at night
	38%	Staff did not contradict each other about care and treatment
	55%	Rated overall experience as 7/10 or more

Key successes include people being offered food that met their dietary requirements (Q11), increasing from 85% in 2021 to 94% (above the picker average of 90%). Other successes were doctors included patients in conversation (Q18) at 97%, 1% above the Picker average and an increase of 3% on our

2021 results of 94% and (Q41) told who to contact if worried after discharge, at 72%, 8% increase on our 2021 results.

99% of respondents have confidence and trust in the doctors (Q17), and 96% of our patients were treated with dignity and respect (Q45). These positive results are testament to the hard work and care of our clinical staff, and we aim to improve on these scores and on the experience of our patients.

You said, we did.....

- Patient Experience and Volunteering team are currently supporting a number of areas to increase the feedback we receive, and this area will be a focus for the teams.
- Implemented Inpatient Ward Leaflets – at the side of each inpatient which provides information on how to obtain food outside of mealtimes, help with sleeping at night, carers charter and who to speak to if you are worried.
- Welcome to the Ward Boards rolled out - which comprises of a suite of three boards detailing information on compliments, complaints and FFT data, alongside you said we did, as result of our patients' feedback.
- You said, we did – intranet and internet page to provide transparency and learning – updated quarterly.
  Proactively recruiting volunteers to support obtaining feedback and ward befrienders.
- Re-introduced sleep well packs and sleep well postcards, with tips and tricks on how to have a restful night's sleep.

The patient experience team have developed a survey page for staff, to raise awareness of national survey programmes and survey results.

2024 National Survey Programme

- Children and young people: fieldwork July - October 2024, publications March 2025
- Urgent and emergency care: fieldwork April - July 2024, publication October 2024
- Maternity: fieldwork April - June 2024, publication December 2024
- Adult inpatient: fieldwork January - April 2025, publication August 2025

Staff Friends and Family Tests

Listening to Our Staff

This is the thirteenth year in which Whittington Health as an Integrated Care Organisation (ICO) has conducted the national staff survey and the sixth year in which the Trust opted to invite all eligible staff to complete it. It is the third year Whittington Health has opted to run the survey online only, which meant everyone received an online questionnaire via a personal link sent by email. 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 2023 NHS England-commissioned survey was sent to all staff in 122 NHS organisations. In 2023, 477, 643 staff nationally responded with a median response rate of 45%.
The findings from this NHS survey will be considered alongside the progress made on the five Trust-wide improvement areas from the 2022 Staff Survey. The analysis of these results will be discussed with the Trust Management Group (TMG) to agree priorities and the overall approach to the development of a staff survey action plan.
The Trust commissions the Picker Institute to run its survey, as do a further 62 other Acute and Acute & Community Trusts. In addition to the national comparisons, we have access to reports at ICSU,

directorate and individual service levels for a more detailed and local analysis. Nationally, Whittington Health was benchmarked against a total 122 similar Trusts.
This is the third year the survey results are aligned to the People Promise. There are seven People Promise elements. A total of 118 questions were asked in the 2023 survey, of these, 113 can be compared to 2022 and 100 can be positively scored. The results include every question where Whittington Health received at least ten responses, which is the minimum required.
This year, the data under the People Promise of 'We are safe and healthy', needs to be treated with caution as there was a national issue with the data quality. Results for questions 13a-d are absent. These questions ask about the experience of physical violence at work. This is currently under investigation by the Survey Coordination Centre and NHS England, and they will produce results at an organisational and aggregated level at the earliest opportunity. For Whittington Health, Picker estimates that approximately 129 respondents (6% of our total) may not have provided an answer to Q13a-d, because of this issue.
The 2023 survey asked three new questions which included the following themes: experience of unwanted sexual behaviour, availability of nutritious and affordable food, and frequency of home working. The COVID19 questions were removed from the 2023 staff survey.
A total of 2123 staff out of Whittington Health's (WH) 4865 eligible staff completed the survey. This equals a response rate of 44%, this is 2% below the Picker average of 46% for Acute and Acute & Community trusts. Despite an additional 104 staff completing the survey in 2023 compared to 2022, the actual response rate was down by 1% due to the increased number of eligible staff.

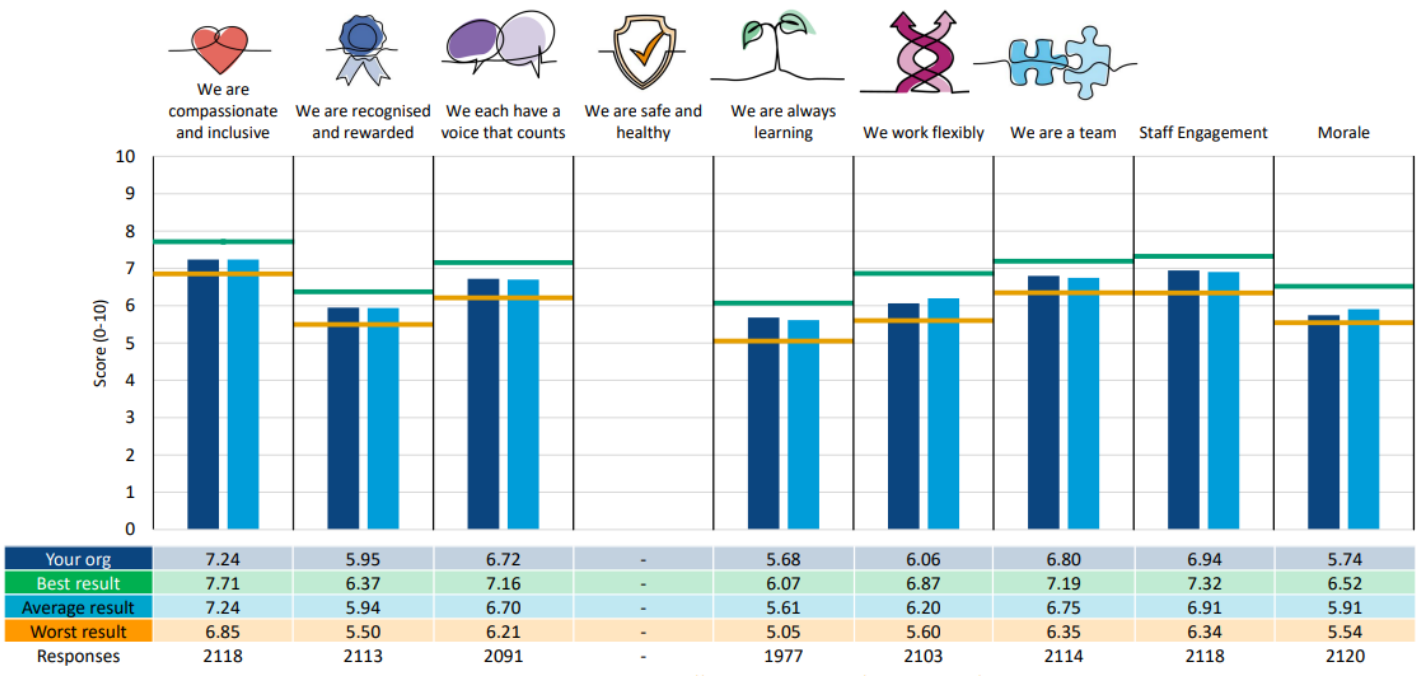
Staff Engagement Indicator
Whittington Health's staff engagement score is 6.94, which is slightly higher than the Picker average of 6.91. This has also been an improvement since the previous two years, which was 6.89 in 2021 and 6.81 in 2022.

The three key findings that make up the Engagement score are:
Advocacy: Staff recommendation of the trust as a place to work or receive treatment
Motivation: Staff motivation at work
Involvement: Staff ability to contribute towards improvements at work

Staff Morale Indicator
Whittington Health's score for staff morale is 5.74, slightly below the Picker average of 5.91. However, this result is an improvement from the morale score of the last two years, which was 5.56 in 2021 and 5.52 in 2022.

The key findings that make up the morale score are:
Staff retention/turnover – thinking about leaving the organisation
Work pressures
Stressors

Whittington Health – 2023 overall results – Themes
In 2023 Whittington Health is not ranked as 'worst' or 'best' in any of the themes. The Trust is slightly above average for the themes of: We are recognised and rewarded, We each have a voice that counts, We are always learning, We are a team and Staff Engagement. The Trust is average for one theme: We are compassionate and inclusive. The Trust has scored slightly below average for the themes of: We are safe and healthy, We work flexibly, and Morale. Due to a technical issue affecting questions under the We are safe and healthy theme nationally, accurate rankings are not available at the time of writing.



	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	Staff Engagement	Morale
Your org	7.24	5.95	6.72	-	5.68	6.06	6.80	6.94	5.74
Best result	7.71	6.37	7.16	-	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	-	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	-	5.05	5.60	6.35	6.34	5.54
Responses	2118	2113	2091	-	1977	2103	2114	2118	2120

Most improved scores

The table below shows the top five most improved scores for 2023 in comparison to 2022. We have seen improvements since 2022 in q4c satisfied with level of pay and q3h have adequate materials, supplies and equipment to do my work, which both featured in the most declined scores for 2022. In addition, we have seen improvements in q10c don't work any additional unpaid hours per week for the organisation, over and above contracted hours, which featured in the bottom 5 scores for 2022. Q10c and Q3h were part of the Trust-wide five improvement areas for 2022.

People Promise element or theme	Question	Org 2023	Org 2022
We are safe and healthy	q3i. Enough staff at organisation to do my job properly	31%	23%
We are recognised and rewarded	q4c. Satisfied with level of pay	27%	21%
Not themed	q10c. Don't work any additional unpaid hours per week for the organisation, over and above contracted hours	41%	35%
We are safe and healthy	q3h. Have adequate materials, supplies and equipment to do my work	51%	46%
We are safe and healthy	Q11c. In last 12 months, have not felt unwell due to work related stress	58%	53%

Most declined scores

The below table indicates the most declined areas in comparison to the 2022 staff survey results. Q11a also featured in the most declined scores for the 2022 results. We are better than the NHS average in q9c and q9d, as well as average for q20a, although they are our most declined scores.

People Promise Element or theme	Question	Org 2023	Org 2022
We are safe and healthy	Q11a. Organisation takes positive action on health and well-being	50%	51%
We are a team	Q9c. Immediate manager asks for my opinion before making decisions that affect my work	63%	64%
We each have a voice that counts	Q20a. Would feel secure raising concerns about unsafe clinical practice	70%	71%
We are a team	Q9d. Immediate manager takes a positive interest in my health & well-being	70%	71%
Staff Engagement	Q2c. Time often/always passes quickly when I am working	73%	74%

Highest and lowest ranking scores

The below table shows the top 5 scores for Whittington Health in comparison to the NHS average scores for NHS organisations, similar to Whittington Health. Q10b and q5c also featured in the top 5 scores for 2022 and both have improved by another 2%.

People Promise element or theme	Question	Org	Picker average
Not themed	Q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	74%	63%
Morale	Q5c. Relationships at work are unstrained	53%	47%
We are compassionate and inclusive	Q25b. Organisation acts on concerns raised by patients/service users	74%	69%
We are a team	Q7b. Team members often meet to discuss team's effectiveness	66%	61%
Not themed	Q19d. Feedback given on changes made following errors/near misses/incidents	64%	60%

The table below shows the bottom five scores for Whittington Health in comparison to the NHS average. We can see that there has been slight improvement in q31b on Disability: organisation made reasonable adjustment(s) to enable me to carry out work by 2% since 2022, which was one of the focus areas for Trust last year.

People Promise element or theme	Question	2023	Picker Average
Not themed	Q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	66%	74%
Not themed	Q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	41%	48%
Morale	Q26b. I am unlikely to look for a job at a new organisation in the next 12 months	45%	52%
We are safe and healthy	Q11a. Organisation takes positive action on health and well-being	50%	57%
Morale	Q26c. I am planning on leaving this organisation	51%	58%

Current Developments and Future Plans

Last year, the Organisational Development team hosted five listening events alongside the Executive team focusing on the five Trust-wide improvement areas which included two of the People Promise themes: 'we are safe and healthy'; and 'we are compassionate and inclusive'. After each listening event, an action plan was created by key stakeholders, executive leads, and subject matter experts, to help implement changes across the Trust.

As a result of these listening events, we have seen improvements in the 2023 results in the following four areas: having adequate materials; don't work any additional unpaid hours; career progression: reasonable adjustments. However, this year we have seen a slight decline in staff feeling that the organisation takes positive action on health and wellbeing.

Five Trust-Wide Improvement Area	People Promise theme	Staff Survey 2022 Results	Staff Survey Results 2023
1. Fairness in career progression	We are compassionate and inclusive	49% of staff believe our organisation acts fairly on career progression.	50% of staff believe our organisation acts fairy on career progression ↑
2. Working additional unpaid hours	Not themed	65% of staff are working additional unpaid hours.	57% of staff are working additional unpaid hours. ↑

3. Improving wellness at work	We are safe and healthy	51% of staff felt that the organisation takes a positive action on health and wellbeing.	49% of staff felt that the organisation takes positive action on health and wellbeing. ↓
4. Making reasonable adjustments for staff	Not themed	65% of staff felt that the organisation made reasonable adjustment(s) to enable them to carry out work with their disability.	66% of staff felt that the organisation made reasonable adjustment(s) to enable them to carry out work with their disability. ↑
5. Having adequate materials and supplies to do the job properly	We are safe and healthy	46% of staff felt that they had adequate materials, supplies and equipment to do their work properly.	52% of staff felt that they had adequate materials, supplies and equipment to do their work properly. ↑

The directorate/ICSU results for Whittington Health and score matrix can be found in **Appendix 4.**

Equalities Indicators from the Staff Survey

In its sixth 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?* The questions related to WDES results remain historically comparable since 2019, but the WDES labels have been updated to better reflect the new wording of the question, for example 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 WDES table can be seen in Appendix 5 shows **improvement** in **five out of the nine WDES indicators**, this includes: a decrease in staff with a long-term condition (LTC) or illness, who experience bullying or abuse from patients, managers or colleagues; staff with LTC or illness saying that they have felt pressure from their managers to come to work, despite feeling unwell; staff with LTC or illness feeling satisfied with the extent to which their organisation values their work; staff with LTC or illness saying that their employer has made adequate reasonable adjustments for them; and an increase in the staff engagement score of 0.1.

Significant effort from the Inclusion team has gone into improving reasonable adjustments for staff since the staff survey results of 2022, such as the holding of a Trust-wide listening event dedicated to this improvement area, the improvement of reasonable adjustment training, and further guidance to managers on how to carry out reasonable adjustments for staff.

However, two out of the nine WDES indicators have shown a decline since last year, these include the reporting of harassment, bullying or abuse at work of a staff with LTC or illness (by self or colleague), and staff with LTC or illness believing that their organisation provides equal opportunities for career progression or promotion.

Patient Feedback: Friends and Family Tests

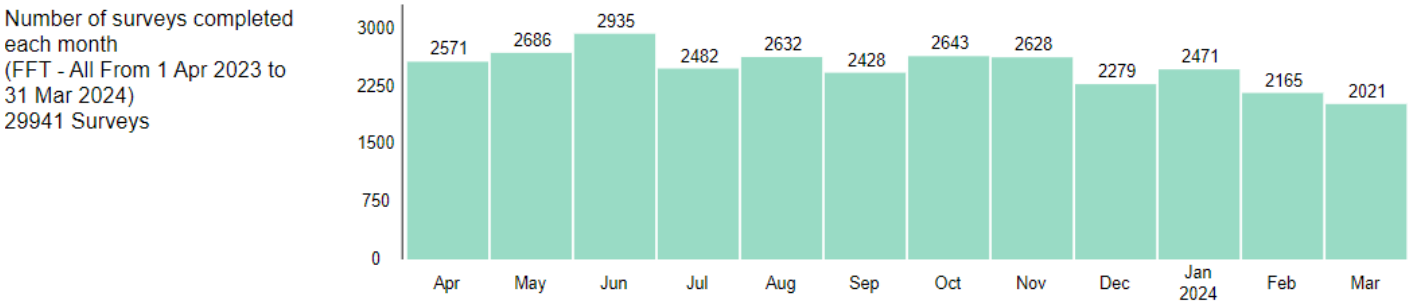
Family & Friends Test (FFT)

Response Rates

A total of 29,941 Friends & Family Tests (FFT) were completed for the year, this is an increase on the previous year of 1,269 (28,672)

June 2023 received the highest volume of submissions of 2,935, coinciding with focused intervention from the Patient Experience team in supporting the completion of FFT's through the use of volunteers.

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



Work continues within the Patient Experience Team and Voluntary Services to promote and collect FFT responses, with a focus for 2024-25 on recruiting ward befriender and FFT volunteers to support the completion of FFT's and improve on our patients' experience. This includes the ongoing work of collecting handwritten postcards to upload to the electronic reporting system. Volunteers provide additional support with FFT's in outpatients, maternity, and imaging with face-to-face collections.

The Patient Experience team have secured an additional 7 iPads to support volunteers obtaining feedback. The team introduced QR cards, these cards are attached to staff lanyards and acts as a reminder to staff to encourage feedback from patients. The QR cards are scanned, and the patient is then taken to an online survey. Our Day treatment centre has added their QR code to the appointment letters, and posters informing patients of our FFT's have been reintroduced in outpatient clinics and being placed in prominent positions.

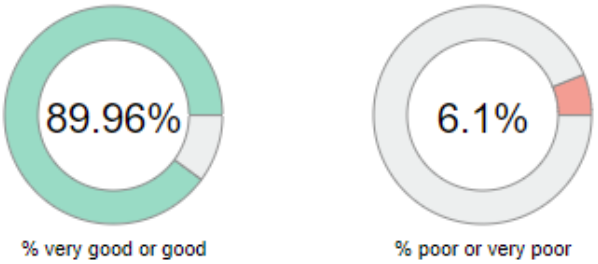
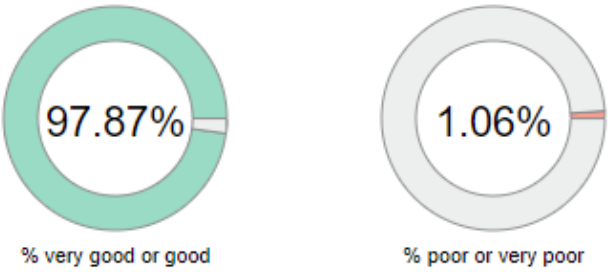
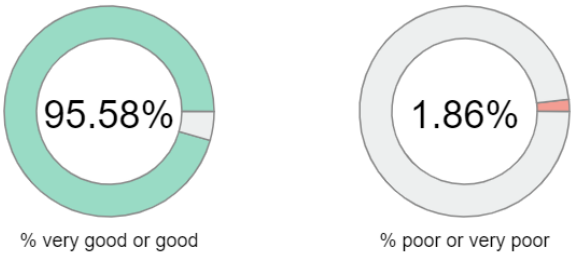
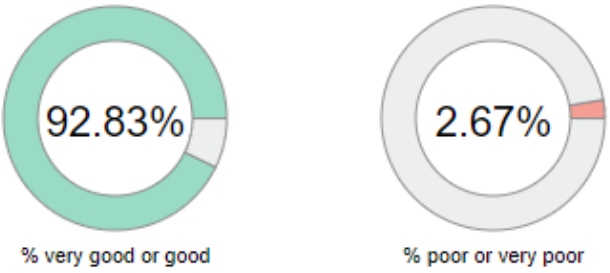
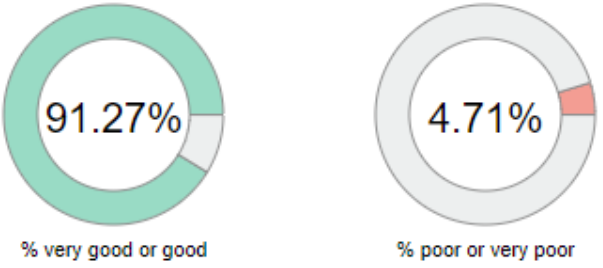
FFT responses are received from a range of sources, including:

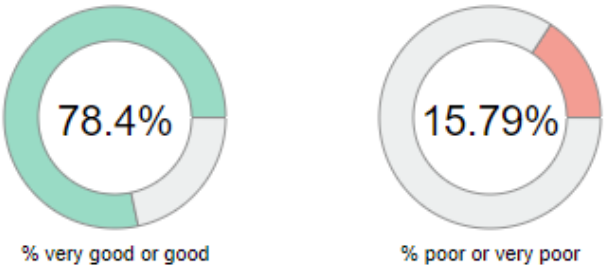
- SMS/text (11,138 responses)
- Smartphone app/tablet/kiosk before or at point of discharge or at appointment (7,285) responses
- Paper/postcards at the point of discharge (6,471 responses)
- Online survey after discharge/appointment (5,044 responses)
- Telephone survey after discharge of appointment (3 responses)

QR codes have been introduced across the Trust for each service, 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 7,767.

Scoring

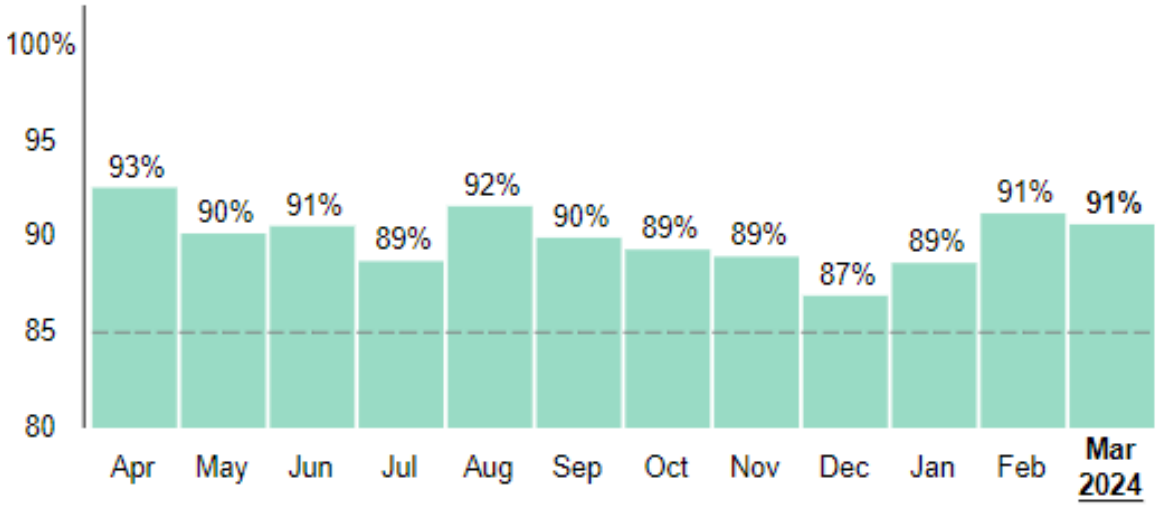
The below charts demonstrate the percentages of “very good/good” versus “poor/very poor” responses.

FFT - All	
FFT – Maternity Combined	
FFT - Community	
FFT - Inpatient	
FFT - Outpatient	

FFT – Emergency Department	

Overall positive scoring has increased by 6% from 84% to 89.96%, and we have seen a decrease in negative response from 7% to 6%. It is noted that the lowest scoring is within the Emergency Department and Outpatient FFTs, which has been significantly impacted by operational pressures, OPEL 4 and industrial action throughout the year. On further analysis, a success is that the Trust has maintained a level above the 85% NHS benchmark month on month.

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 and includes:

Ambition 1: Ensure that FFT questions are accessible to as many patients and carers as possible to ensure the responses reflect the diverse patient population.

Year 1 target: Return to baseline response rate from pre-COVID, ensuring that each area has the questions available in a range of languages and formats to maximise accessibility.

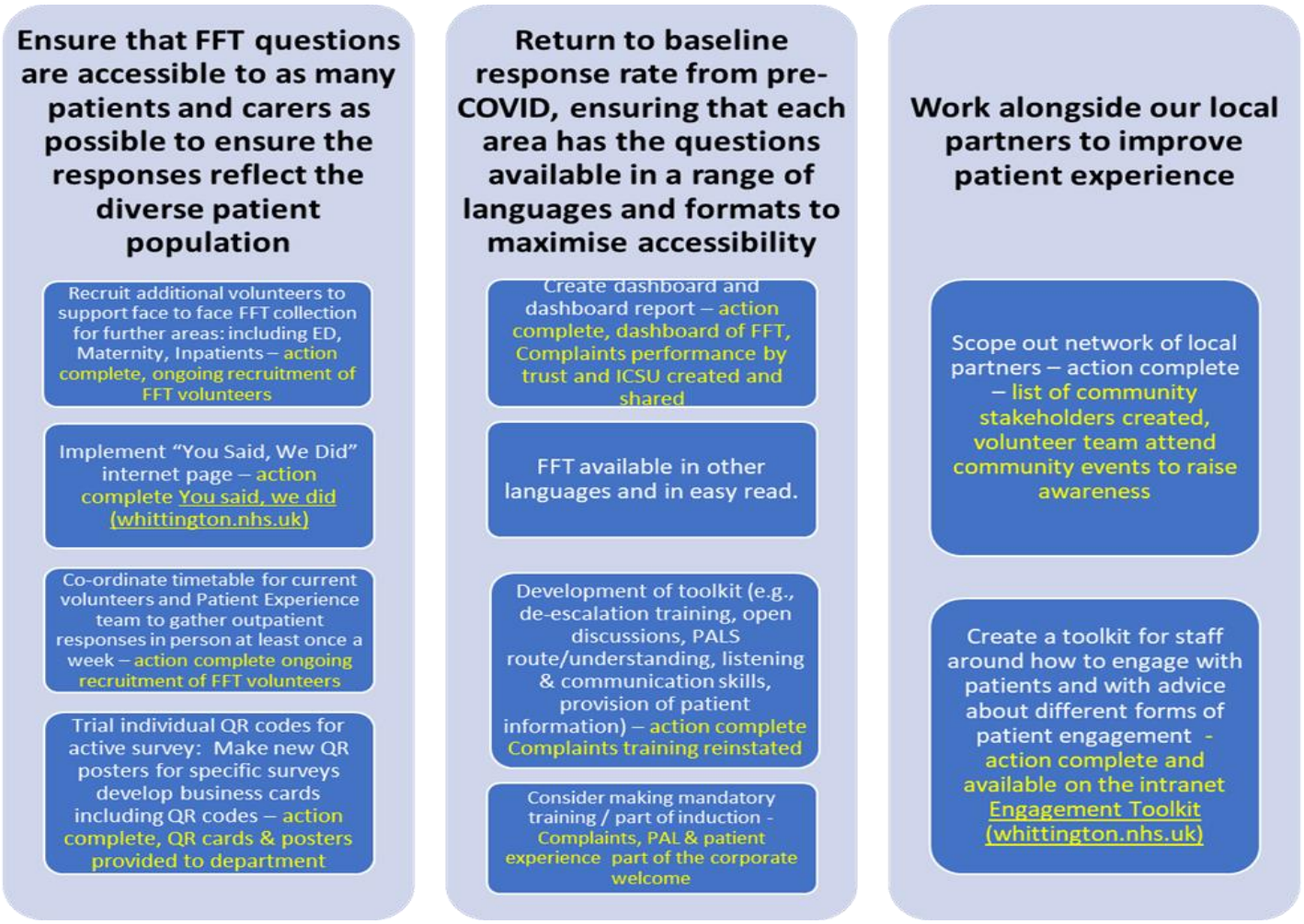
Ambition 2: To increase active patient involvement and participation throughout the Trust at all levels.

Year 1 target: Recruit patient experience and safety partners and evidence of co-design in QI projects; create a page on the patient facing internet for 'You Said We Did' which will be updated at least quarterly.

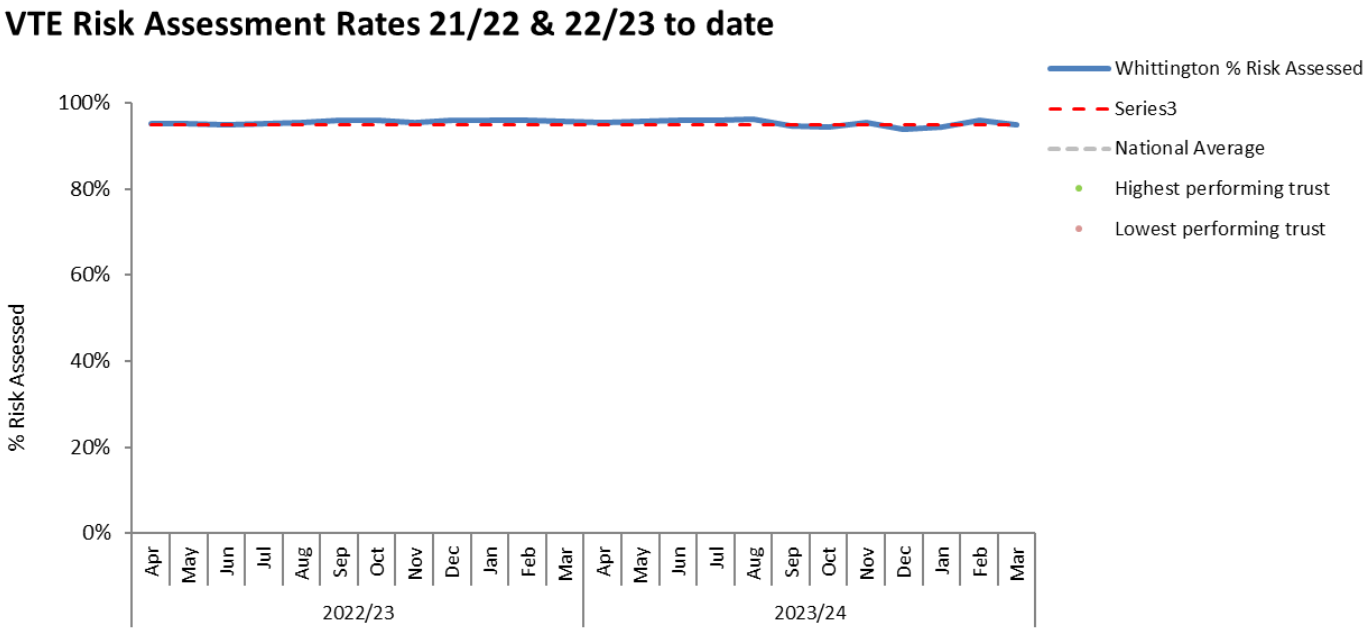
Ambition 1: Creating a standardised dashboard or report each quarter for each ICSU.

Ambition 2: Create a toolkit for staff around how to engage with patients and with advice about different forms of patient engagement.

Ambitions actioned during 2023-2024 include:



Venous Thromboembolism (VTE)



**From Q4 2019/20 the VTE data collection and publication had been suspended to release capacity for providers and commissioners to manage the COVID-19 pandemic. This was communicated on 28th March 2020.*

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

In the last financial year (April 2023 – March 2024), the Trust VTE Risk assessment (RA) compliance has overall averaged above 95%, as per the National Standards. The Trust monthly VTE risk assessment compliance has been consistently above 90%. We are providing continuous education and training and working with teams to ensure we are meeting the national standard monthly.

The following actions have been taken:

- Continuous close co-operation between the VTE pharmacist and Information Technology (IT) to ensure continuation and monitoring of mandatory VTE risk assessment completion on the Careflow clinical noting system.
- Education and training sessions to nurses, health care assistants, doctors, and pharmacists to ensure teams are completing VTE risk assessments for all admitted patients.
- Introducing the implementation of the electronic VTE RA in the paediatric patient cohort, this is currently a work in progress.

- A quality improvement project with pre-assessment clinic to convert paper bridging plans for anticoagulated patients to electronic to avoid issues with peri-operative bridging ensuring patient safety. This involves multidisciplinary working with the pre-assessment clinic consultant, IT, VTE pharmacist and the anticoagulation team.
- Weekly VTE team meetings to review actions to be taken to increase VTE RA compliance and update policies/guidelines.
- Weekly MDT meeting with the haematology consultant, anticoagulation team and VTE pharmacist to follow up complex VTE patients who need bridging plans or haematology reviews.
- A quarterly Thrombosis Committee meeting with a multidisciplinary representation.

Root Cause Analysis:

Root cause analysis represents an educational tool for healthcare professionals on VTE thromboprophylaxis. The VTE pharmacist and the haematology team are working together to ensure we continue to collect and analyse data to ensure we meet trust standards.

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

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

The team continues to work towards an application as VTE Exemplar Centre.

Infection prevention and control

The Head nurse for Infection Prevention and Control (IPC) services, 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, provide an IPC service to the hospital, dental and community services across Whittington Health NHS Trust, Monday to Friday with an out of hours support from Microbiology and the site team.

Operationally, IPC are a team of senior IPC nurses, and an IPC support team of admin, auditor and an information analyst who, whilst supporting national, regional and local reporting on health care acquired infections (HCAI), ensure the focus is firmly on infection prevention through surveillance, audit, education, training. Wherever incidence of acquired or known transmission of a high-profile (e.g., MRSA bacteraemia) and / or communicative pathogen (e.g., Covid-19) occurs, transmission-based precautions are applied, cases are reviewed and when necessary, closure of beds recommended.

The IPC team perform post infection reviews which surveys all aspects of the patient journey from pre-admission through to discharge when the patient acquires a Healthcare acquired infection (HCAI). This often includes a multi-disciplinary team review with rapid feedback of shared learning with the aim to identify how a case occurred and to identify actions that will prevent similar cases reoccurring in the future. The Infection Prevention and Control Committee (IPCC) meets quarterly to review, gather and evaluate the HCAI data, and related information (tables below) to ensure Trust-wide shared learning and to provide an appropriate platform for escalating outstanding actions.

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Health Care Acquired Infections (HCAI)

Whittington Health's IPC policy documents the importance of preventing and reducing rates of HCAI and the surveillance of potential incidents namely: Trust attributable bacteraemia's such as Methicillin Resistant Staphylococcus Aureus (MRSA and MSSA) and Escherichia Coli (E. Coli), Clostridium Difficile infection (CDI), HCAI outbreaks, Acute Respiratory Infections (ARI) (e.g., Influenza and COVID-19) across the Trust. 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.

Nosocomial, or 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.

Whittington Health, alongside other NHS commissioned services, refer to the NHS England National infection prevention and control manual (NIPCM) for England for best practice of IPC in both the acute and community settings. The Trust follow, among other important national mandatory and recommended guidance:

- Mandatory UKHSA Data Capture System, this is an integrated data reporting and analysis system for the mandatory surveillance of Staphylococcus aureus, Escherichia coli, Klebsiella spp., Pseudomonas aeruginosa bacteraemia and Clostridioides difficile infections, with the intention of reducing such infections through building better evidence base and allowing us to target problem areas.

- Acute Respiratory Infection (ARI), this guidance is consistent with the approach of managing COVID-19 increasingly in line with other ARIs, made possible by high vaccination coverage, high immunity amongst the population, and increased access to COVID-19 treatments.

- NHS Standard Contract 2023/24: Minimising Clostridioides difficile and Gram-negative bloodstream infections, set out the requirements to minimise rates of both Clostridioides difficile (C. difficile) and of Gram-negative bloodstream infections to threshold levels set by NHS England.

- Surgical Site Infection Surveillance Service, jointly run by UKHSA healthcare associated infection and antimicrobial resistance department (HCAI & AMR) this service helps hospitals in England record and follow up incidents of infection after surgery and use results to review or change practice as necessary. This service supports both the mandatory surveillance of SSI in 4 categories of orthopaedics and voluntary surveillance in 13 categories of surgical procedures.

Health Care Acquired Infections

Mandatory UKHSA Data Capture System

Methicillin Resistant Staphylococcus Aureus (MRSA)
Notwithstanding, NHS England's Patient Safety document, to deliver zero tolerance on MRSA bloodstream infections (BSI), the Trust have two bacteraemia's this year end 2023/24. Case one (December 23) was an unavoidable BSI in a very unwell ICU patient who was previously not known to WH as colonised with MRSA. The blood culture, screening and treatment was carried out well. The source of the second MRSA BSI (March 24) was from an infected peripheral vascular device site with delayed suppression treatment given. This case was deemed avoidable.

There is an extensive peripheral vascular device (PVD) quality improvement (QI) project underway within the Trust, incorporating education, training, audit and feedback around PVD care, communications through posters and reminders are given in handovers, and huddles reinforcing PVD care standards. This work will have implications for all blood stream infections acquired through a PVD. More work is in planning for suppression therapy and compliance with in 2024/25.

Methicillin Sensitive Staphylococcus Aureus (MSSA)
WH saw 6 healthcare-acquired cases of MSSA for 2023/24. There is no NHS standard contract for MSSA. However, there has been a 50% decrease in cases over the last 5 financial years (12 vs 6).

Gram-negative bacteraemia's
Due to the national rise in Gram-negative bloodstream infections (GNBSIs); namely E. coli, Pseudomonas aeruginosa and Klebsiella spp., and their increasing resistance to key antibiotics, the NHS long-term plan aims to reduce GNBSIs by 50% by 2024/25.

The national increase is reflected in our Trust levels of healthcare acquired GNBSIs. Year-end 2023/24 figures for Whittington Health Trust against the NHS standard contract thresholds are as follows:

- WH saw 3 healthcare-acquired cases of Pseudomonas aeruginosa for 2023/24 against an annual threshold of 2. There has been a 40% decrease in cases over the last 5 financial years (3 vs 5).

- WH saw 21 healthcare-acquired cases of E. coli for 2023/24 against an annual threshold of 19. There has been an 16% decrease in cases in the last five financial years (21 vs 25).

- WH saw 13 healthcare-acquired cases of Klebsiella spp. for 2023/24 against an annual threshold of 13. There has been a 16% increase in cases in the last five financial years (13 vs 11).

Although over annual thresholds (P. aeruginosa and E. coli) and equal to threshold (Klebsiella spp.) set by the NHS Standard Contract, numbers are considerably low.

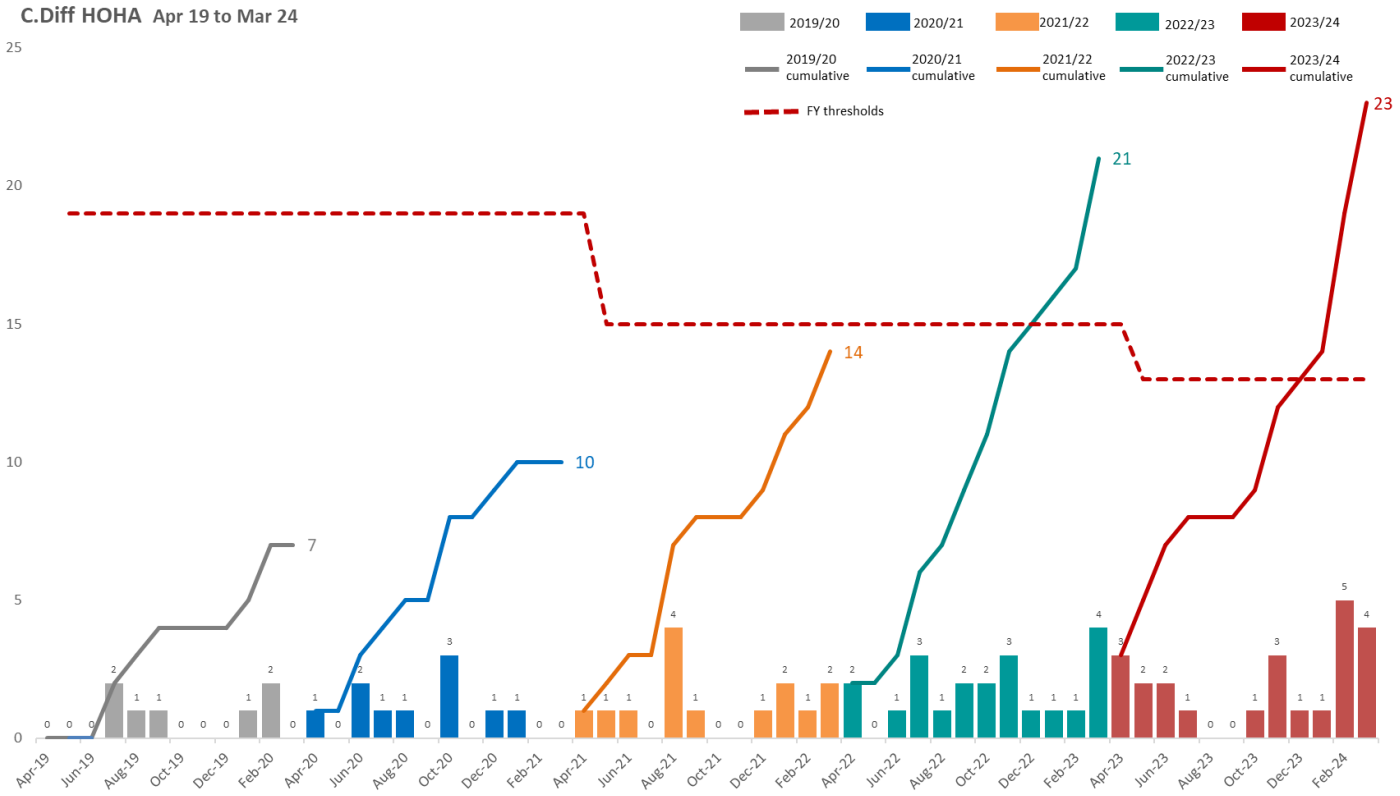
Clostridioides difficile Infection (CDI)
Whittington Health have passed the hospital acquired toxin+ Clostridioides *difficile* infection (CDI) trajectory [13], with 23 cases. Year end 23/24, with one case pending, there are 10 different ribotypes from 16 cases, whereby six could not be tested (unviable). Ten cases, who although shared the same ribotype(s) (002, 015, 014, 106, 023) were not linked in time or location, illustrating very low patient to patient transmission in hospital. However, a care of the elderly ward was the same location for the latter (023) which may indicate environmental transmission. There has been one probable

transmissible infection (076) linked to a lapse in policy (delay to isolate a relapse case of CDI). Unprecedented unviable samples may indicate local processing issues. Whittington Health microbiology laboratory is currently undertaking a review of standard operating procedures for CD testing.

GDH (Glutamate dehydrogenase)) positive, toxin negative cases (meaning Clostridioides difficile carriage), coupled with GDH positive, toxin positive (meaning infection and reportable) represented seven (n=19 cases) individually reported outbreaks to UKHSA.

UKHSA state 'Since January 2021 there has been an increase in Clostridioides *difficile* infections (CDI) for which there is no clear explanation. In addition to this national increase, a local change to testing in November 2022, resulting in more testing, is reflected in our Trust levels of hospital onset, healthcare associated (HOHA) CDI toxin+ cases as demonstrated in table one.

Table one. Trust levels of hospital onset, healthcare associated (HOHA) CDI toxin+ cases over five years. Whittington Health. 2019 – 2023.



A CDI exception review was carried out in July 2023 and again in February 2024. Key findings indicate speed of diagnosis is important for the efficient use of isolation facilities, and that clinicians should ensure that stool specimens are sent for toxin testing as soon as infective diarrhoea is suspected. The latter potentially preventing HOHAs if within the first 48 hours of admission.

Acute Respiratory Infection, including Covid-19

Acute respiratory infection (ARI) is defined as the acute onset of one or more of the respiratory symptoms listed at People with symptoms of a respiratory infection including COVID-19 and a clinician's judgement that the illness is due to a viral acute respiratory infection (for example COVID-19, influenza A and B, respiratory syncytial virus (RSV)).

Covid-19. Year end 23/24, there have been 89 definite COVID-19 HCAI cases and a reduced number of COVID-19 outbreaks (n=30) requiring management. Also seen nationally are reduced COVID-19 hospitalisations and mortality, and a reduced clinical severity of COVID-19 infection.

Influenza A and B. Year end 23/24, 25 patients acquired influenza A from a of total 308 (276 type A and 34 type B) influenza cases in the hospital. With 'flu season' starting in December (n=73), January peaked with 107 cases falling in February (n=55) and March (n=21) and reporting a total four outbreaks of influenza A (Dec23 – Mar24).

Respiratory Syntical Virus (RSV). Year end 23/24, 25 patients acquired RSV from a of total 279 RSV cases in the hospital. Incidence of RSV began in November (n=105), December (n=94), dropping in January (n=30). There were no outbreaks.

Surgical Site Infection Surveillance Service (SSISS)
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).

Whittington opted to report four quarters in 2023/24 on repair of neck of femur fracture surgery, with zero reported infection in quarters one (operations n=20), two (operations n=20) and four (operations n=21). There was one infection reported in quarter three from 31 operations performed.

A sample review of Caesarean section operations (n=123) was undertaken in the month in October 2023 for consideration to opt into the voluntary surveillance category of surgical procedures in 2024/25. This data is under review with key stakeholders.

Patient Safety Incidents

Serious incidents

During 2023/24 the Trust has been intensively preparing for its transition from the Serious Incident Framework (SIF) to the new Patient Safety Incident Response Framework (PSIRF). This is a statutory requirement for all NHS provider organisations. This will ensure the Trust can focus more time and resource on learning and improving and less on repetitive investigations; this is the very essence of the PSIRF.

An Executive-led implementation group has been established to drive this forward and additional project management support has been procured to ensure the Trust's transition is both effective and timely. Currently, the Trust is in the latter stages of its implementation plan and has recently provided the first tranche of required training to specific staff groups in human factors and systems methodologies, which are central to the PSIRF approach. The Serious Incident Executive Action Group (SIEAG) has been reconfigured to align with the requirement of PSIRF and is now the Whittington Improvement & Safety Huddle (WISH) so there is a greater focus on learning, improvement, compassionate engagement, and supportive oversight. The Trust is in the process of completing the transition, in agreement with the ICB, and will no longer be investigating incidents under the SIF.

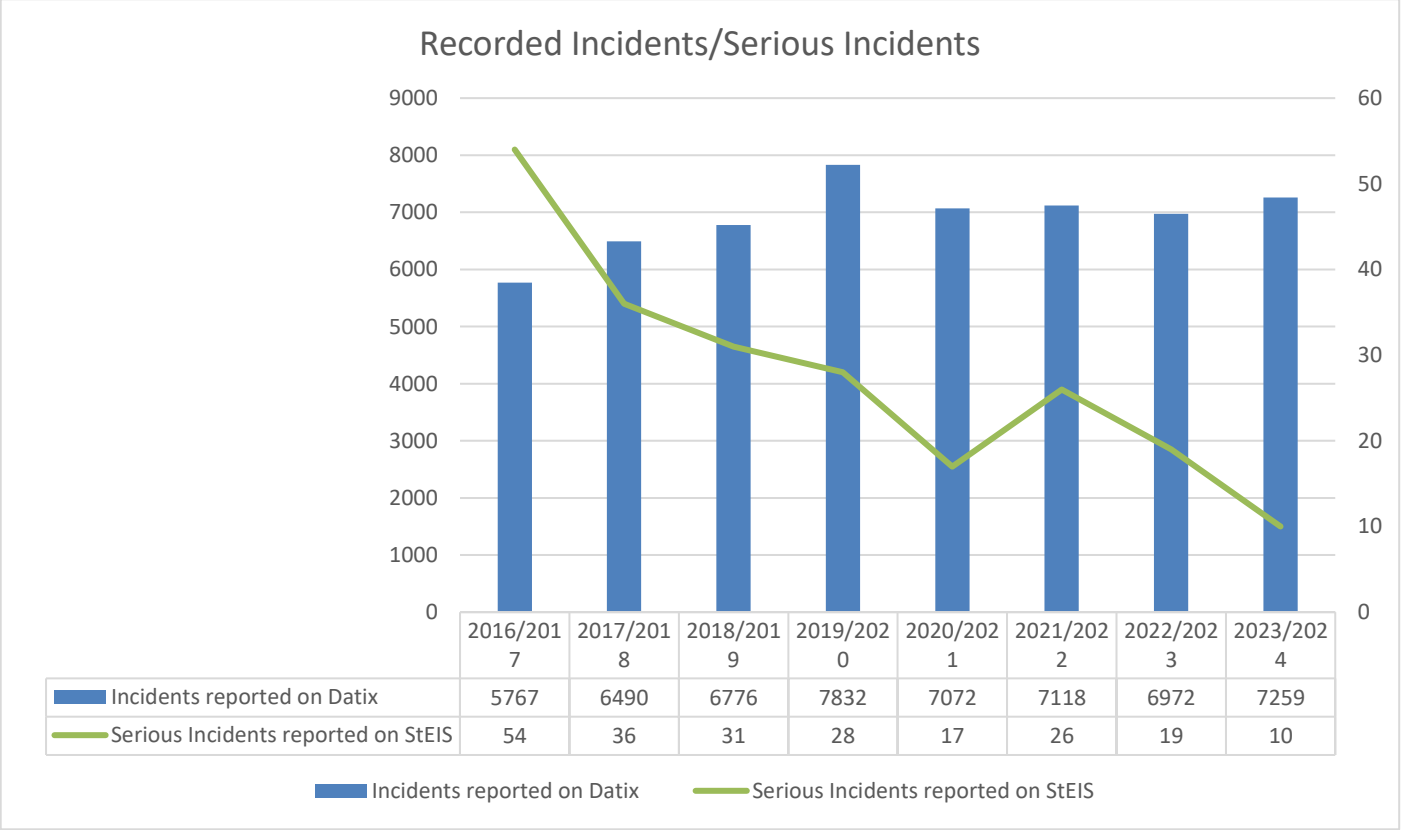
Under the PSIRF the Trust will no longer be required to declare serious incidents based on predefined thresholds. Instead, the Trust must select incidents that provide the greatest opportunities for new learning utilising the most appropriate learning response tool. The Trust will have improvement plans

and workstreams in place in relation to types of incidents where causal and contributory factors are well understood from analysis of multiple historic data sources (such as pressure related skin damage, falls and medication safety). This will ensure the Trust can focus more time and resource on learning and improving and less on repetitive investigations; this is the very essence of the PSIRF.

The PSIRF represents a significant culture shift for NHS organisations, and it is recognised that the Trust's approach and arrangements will take time to evolve and mature.

During 2023/24 there were 10 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.

Figure 1: Serious Incidents declared, as a proportion of all patient safety incidents 2016-2024



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 the Trust's work with a focus on learning and improving practice. WISH have supported the use of alternative tools, such as After-Action Reviews, SWARMS, and a Multidisciplinary team (MDT) approach, Quality Improvement (QI) projects and audit projects, to drive change.

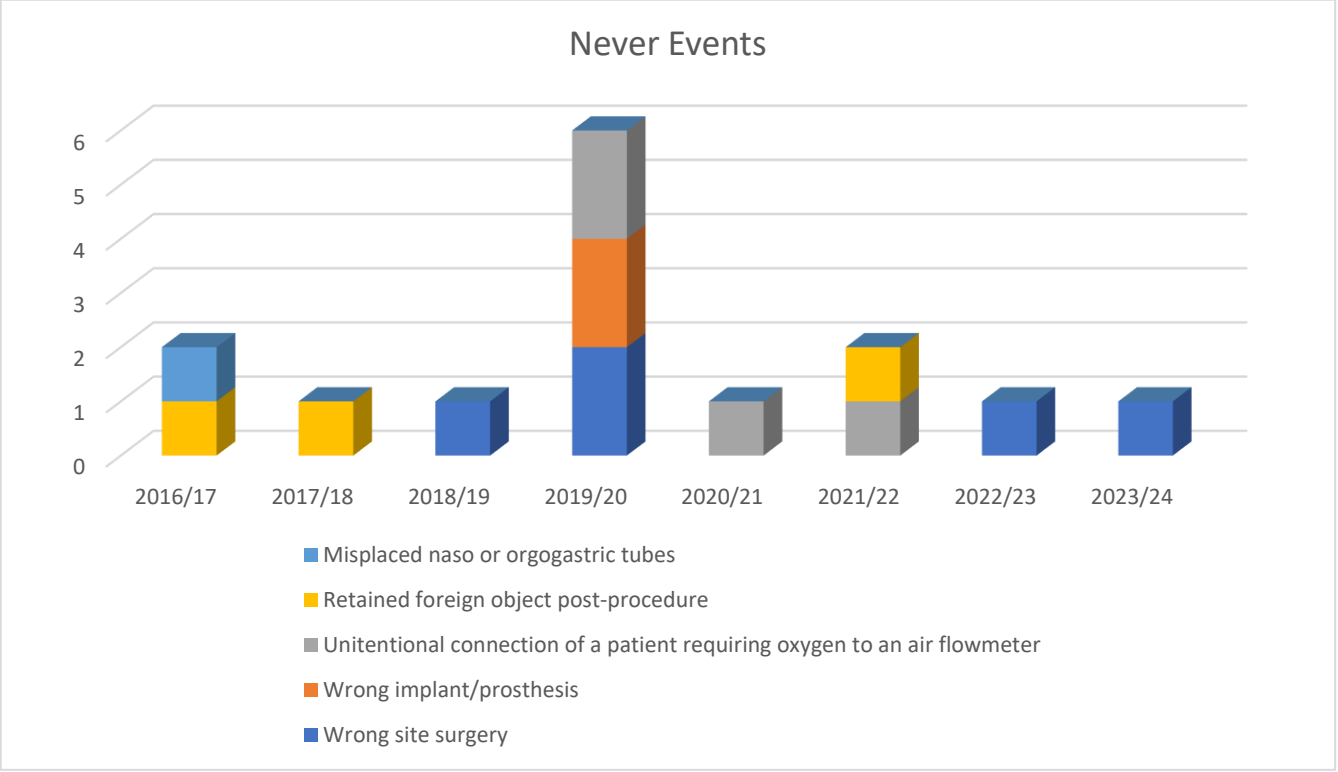
Completed investigation reports with a summary letter, highlighting key findings and changes made as a result, are shared with the patient and/or family member with an offer of a meeting with the Trust to discuss the findings.

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.

Figure 2: The number of Never Events reported by Whittington Health from 2016 to 2024



During 2023/24, the Trust reported one Never Event which was a wrong site surgery.

A patient underwent ureteric stenting and was discharged. An x-ray was used as a guide for the stent insertion procedure, but the imaging appeared to have been inverted at some point as it shows that the stent was in the correct position.

The patient returned via the emergency department with pain and abnormal renal function. Imaging showed that the stent was in the left ureter while the consent and intention of the original procedure was to stent the right ureter. The stent was removed, and the correct ureter stented.

Although this is a rare occurrence there is learning that can be embedded to mitigate the risk of recurrence:

- Urologists and theatres team to embed the process whereby it is ensured that both ureteric orifices are located prior to stent insertions.

- A second check should be done intraoperatively before the insertion of the guide in order to review the patient's imaging and correlate it with the surgical site.
- Imaging will implement a chart which will be placed on each theatre x-ray machine to aid decision making regarding orientation.

Maternity and Newborn Safety Investigations (MNSI) former Healthcare Safety Investigation Branch (HSIB) Maternity incidents

The Maternity and Newborn Safety Investigations (MNSI) programme is part of a national action plan to make maternity care safer. MNSI undertakes approximately 1,000 independent maternity safety investigations a year to identify common themes and influence systemic change. All NHS Trusts with maternity services in England refer incidents to MNSI.

MNSI investigates incidents that meet the criteria as previously defined within the Each Baby Counts programme or MNSI defined criteria for maternal deaths. During the investigations MNSI investigates all clinical aspects of the incident, as well as aspects of the workplace environment and culture surrounding the incident.

On 17 of July 2023 the Trust received updates on the HSIB maternity programme, the Maternity and Newborn Safety Investigation (MNSI) programme's transition to the Care Quality Commission (CQC):

- The MNSI is transitioning into new hosting arrangements with the Care Quality Commission (CQC) on 1 October 2023.

Between the 1 of April 2023 to the 31 of March 2024, Whittington Health one incident met MNSI criteria (Datix A101530/ MNSI MI-026257). The case was referred to MNSI (potential hypoxic ischaemic encephalopathy (HIE)). The family consented for MNSI to undertake the investigation. Following, initial internal multidisciplinary review care and service delivery problems were identified – Inconsistent, inaccurate or absence of documentation of fluid input/output/totals between practitioners.

To prevent recurrence the following immediate actions have been instigated:

- Professional Development Midwifery team undertaking daily ward rounds / spot checks – This allows individual feedback and 1:1 training.
- MEOWS, Fluid Balance, Fresh Eyes – included on the Maternity Mandatory update.
- Rolling monthly MEOWS, Fluid Balance, Fresh Eyes Audit - presented as a standing agenda item at the Maternity Clinical Governance and Safety Champions Meeting.
- Use of helicopter review stickers which require 2 hourly fluid balance documentation on the sticker.
- MEOWS/fluid balance charts to be checked / reviewed as part of a holistic review.

The MNSI final report for this patient safety incident made one safety recommendation:
"The Trust to ensure that staff are supported to follow the guidance for fluid balance in labour and the maternity pathway for sodium monitoring to reduce the risk of hyponatraemia in a mother and baby".

This aligned with the findings of the internal review and the actions to address this recommendation were already implemented as described above.

Perinatal Mortality Review Tool (PMRT)

Perinatal Mortality Review Tool (PMRT) supports systematic, multidisciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and babies who die in the post-neonatal period having received neonatal care. PMRT provides a structured process of review, learning, reporting and actions to improve future care.

Between 1 April 2023 and the 31March 2024, twelve cases met the eligibility criteria for PMRT review. The eligible cases were:

- Four stillbirths (24 weeks and 6 days; 35 weeks and 5 days; 34 weeks and 6 days and 27weeeks and 1day gestational age)
- Two pregnancy loss at 22 weeks and 5 days and at 23 weeks and 4 days gestational age. The first baby was diagnosed with Trisomy 15 following genetic testing after birth. baby was diagnosed antenatally as severe Intrauterine Growth Restriction(IUGR) and has been care for under the FMU team the second baby was diagnosed antenatally as severe Intrauterine Growth Restriction(IUGR).
- Three neonatal deaths – These babies were known to have fetal abnormalities antenatally, and a poor outcome was inevitable. The antenatal care was led by the Fetal Monitoring Unit (FMU) with input from the neonatal and palliative care teams. All cases have been subjected to PMRT review and the reports completed.
- Three terminations of pregnancy for fetal abnormalities detected antenatally.

Overall, for the year 2023 both the Trust's stillbirth and neonatal death rates were higher than for 2021. However, still within England stillbirth and neonatal death rates – As per table below:

Table 1: Still birth rates

Classification	Total Numbers	Possible exclusions	Total Rate 2023	Total Rate 2021	Rate with exclusions 2023	Rate with exclusions 2021	England Rates for 2021
24+0 weeks and over – Stillbirth	10	1 x TOP 2 x known anomalies. 1 x not booked, not delivered but counted in figures.	3.5 per 1000	2.47 per 1000	3.17 per 1000 2.81 per 1000 2.46 per 1000	2.47 per 1000	3.52 per 1000
Neonatal Death any gestation	5	2 x extreme prem 3 x known anomalies antenatally	1.76 per 1000	0.83 per 1000	0.7 per 1000	0.55 per 1000	1.60 per 1000

The use of the PMRT is a requirement for the Safety Action 1 of the Maternity Incentive Scheme Year 5. The Trust are currently on target for all PMRT reviews. Families have been involved in the PMRT reviews.

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 2023/24 the Trust received 26 safety alerts (Of which one was National Patient Safety Alerts issued by NHS Improvement/NHS England). One is currently overdue for closure, and one was closed 3 weeks after the deadline. The one overdue is being chased for an appropriate resolution and closure by the patient safety team. The rest were closed appropriately in time to meet the deadline.

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. FTSUG is working with trust leadership teams to create a culture where staff can speak up to protect patient safety and empower workers. As well as providing a safe and impartial alternative channel for workers to speak up to, the Guardian identify themes and provide challenges to their organisation to work proactively to tackle barriers to speaking up.

The successful collaboration model between the Freedom to Speak Up Guardian and our Non-Executive Director (NED) for FTSU will serve as an example to future FTSU NEDs. Our collaborative work, characterised by continuous support, has positively impacted the Guardian´s well-being, safety, and overall work development and confidence. In response to a request from the National Guardian Office, our example will be utilised as a reference for the training of future FTSU NEDs. Our NED for FTSU is crucial in supporting the Guardian, addressing concerns related to the Executive team, and providing ongoing support and advice. This collaborative model showcases the NED as a ‘Guardian to the Guardian’, emphasising the importance of their role in ensuring a supportive and effective FTSU environment.

The Guardian is taking proactive steps to enhance the effectiveness of the reporting system by engaging with the Datix team, Safeguarding, and PALS. This triangulation of information aims to provide senior leadership with a clearer picture for prompt action while also identifying areas of potential resistance to change. The Datix form has been updated to include the Guardian as a designated recipient for concerns.

Communication and visibility remain crucial, with the Guardian collaborating closely with the Communications Department to review media activity, ensuring broader outreach and clarification of roles.

Recognising the urgency of fostering a safe environment for employees to voice concerns, we have implemented a new and revised FTSU policy in alignment with national guidelines from NHS England and Education. This policy is designed to be accessible, user-friendly, and comprehensive, serving as a valuable tool for anyone seeking to raise concerns. It outlines various routes and key contacts available to assist individuals, ensuring a clear and supportive framework for addressing and resolving issues within our organisation.

The Guardian actively participates in key educational initiatives, including preceptorship study days, Newly Qualified Nurses Orientation Training, the Health Care Support Worker (HCSW) Development Programme, and medical education inductions. Through these engagements, the Guardian educates attendees on the safe and confidential means of raising concerns, elevating the visibility of FTSU. Additionally, the Guardian remains involved in the corporate induction day for new starters, and in instances of unavailability, Speak Up Advocates step in to provide coverage, further promoting their role and expanding their experience.

The FTSU Guardian and Human Resources (HR) Business Partners continue their close collaboration, listening and supporting colleagues in particular areas of concern.

The collaboration between the FTSUG, Head of Well-being and Staff Engagement and the Organisational Development (OD) team remains integral, fostering continuous learning and action on concerns received. This partnership enables the Trust to address cultural behaviours, bullying, harassment, and detriment in a serious, committed, and constructive manner, contributing to ongoing improvement in services and staff experience. The OD team actively participates in developing and training the Speak Up Advocates network. Additionally, the Freedom to Speak Up Guardian plays a key role in de-escalating conflicts, enhancing communication at both individual and team levels, and supporting the OD team in mediations, conflict resolutions and facilitated conversations.

In order to align of Network with the national guideline we will be renaming the Speak Up Advocates to Speak up Champions. The Guardian provides supervision and support to strengthen the Network of Speak Up Champions, which currently comprises 45 Champions, with over half being from a black and minority ethnic background (BAME). New Champions are actively sought to ensure continuity when some leave the Trust. The Guardian regularly holds Network and one-to-one meetings with FTSU Champions, offering support and collecting valuable feedback from various areas. Contrary to previous trends of staff disengagement in raising concerns, there is now a noticeable increase in engagement and a rise in concerns. To further encourage this positive trend, the Guardian collaborates with Champions to visit teams and services throughout the Trust, actively listening to individuals, identifying barriers, and promoting a safe culture for raising concerns, enhancing overall engagement, visibility, and awareness of FTSU.

In the current reporting period (April 2023 to March 2024 - quarters one to four), the Freedom to Speak Up Guardian received 73 initial concerns that required action. Quarter 1 and 2 had 38 concerns, Quarter 3 and 4 had 35 concerns. Notably, all of them were raised without anonymity. This absence of anonymous concerns underscores a noteworthy level of Trust in the FTSU as a secure and confidential channel for expressing concerns. While there is a slight increase in the number of concerns in Q4, it shows less concerns if compared to the preceding year (April 2022 to March 2023) when 84 initial cases were reported. The ongoing upward trend in concerns suggests a potential return to previous patterns, indicating a need for continued attention and analysis. For the first time since the

start of recording concerns in 2018, a quarter (Q3) shown an absence of concerns from register nurses and midwives. This professional group has been consistent in raising high numbers of concerns. This aspect require further reflection and engagement with Senior nursing leaders to promote visibility and learning. On the other hand, it is noticeable an Increase of concerns raised by Administrative and clerical staff.

The Guardian has identified several priorities for the next six months to re-enable staff engagement regarding raising concerns, and they include:

- In light of the identified challenges and opportunities for improvement in the speaking-up culture within the NHS, it is imperative to prioritise the implementation of comprehensive Freedom to Speak Up training for all staff. This training initiative aims to address barriers, enhance confidence, and empower individuals at all levels to voice concerns and contribute to a positive and responsive organisational culture. By promoting FTSU training, we seek to foster a workplace environment where every member feels supported and encouraged to speak up, ultimately contributing to improved patient safety, worker well-being, and organisational excellence.

- Prioritise regular visits to both community and hospital sites to maintain ongoing visibility of Freedom to Speak Up. Ensure that the FTSU Guardian is accessible and approachable during these visits to foster a culture of Trust and openness.

- Acknowledge and prioritise initiatives by the Speak Up Network. Consider further efforts to enhance promotion, visibility, education, and encouragement within the Network.

- Continue the recruitment and training of Advocates, focusing on areas not yet covered by the Network.

- Provide support and raise the FTSU profile in all the Staff Networks.

Guardian for safe working hours – (GoSWH)

The Guardian of Safe Working Hours (GoSWH) presents a quarterly report to the Board with the aim of providing context and assurance around safe working hours for Whittington Health junior doctors. 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 covered a period of intermittent industrial action by most junior doctors. This, coupled with high levels of acuity of patients has led to high levels of exception reporting over the year. Nationally there are lower than previous numbers of junior doctors available to fill bank and agency shifts which leaves on-call teams very stretched. There continue to be high levels of fatigue and burnout amongst all staff across the NHS and this has affected the Trust's doctors and dentists in training. Despite these challenges, 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 multifactorial.

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: From previous rounds of 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 via transfer to University College London Hospital which has worked well and will continued to be monitored via the clinical incident reporting system.
- **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. EIM will review if the change required to consultant job planning (with implications for weekday elective work particularly) is possible during 2024-25.

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

Part 3: Review of Quality Performance

This section provides details on the progress the Trust is making with the Quality Account priorities 2020-24. the Key milestones and targets were identified for Year 4 (2023/24).

Priority 1: Reducing harm from hospital acquired deconditioning.

Aims for 2023/2024:

What did we achieve in 2023/24? – Project 1: Pressure Care

Project 1: Pressure Care:

- Goal 1: To ensure 100% of patients have documentation of a full pressure ulcer risk assessment within 6 hours of admission, and an action plan (including all required pressure relieving equipment required) to manage risks identified in place within 24 hours of admission.

This priority has not been achieved in 2023/24, this has been due to challenges with the pressure care equipment provider NRS which have been reported nationally. As well as national changes to pressure ulcer reporting that were released in November 2023, and have come into effect as of the 1st April 2024.

Progress in 2023

In May 2023, an improvement meeting was held with representation from across the acute services, facilitated by Quality Improvement, focussing on process mapping the patient's journey from front door to discharge. This resulted in dynamic discussions about what already works well and what can be improved, with key themes including Quality of Care, Documentation, Education & Training and Equipment. In response to this, Pressure Care was the theme for the month of June at Back to the Floor sessions. Back to the Floor is a visible nursing leadership programme, launched in April 2023, where each Wednesday, senior nursing and AHP leads take the time to return to the floor with the aim of:

- Providing and cascading education
- Identifying potential solutions to problems
- Supporting junior staff with practical skills
- The topics for Pressure Care included:
- Assessment and Care Plans
- Documentations
- Categorisation & Escalation
- Equipment & Surfaces

Sessions were well attended by senior leads and key areas for improvement were identified, with opportunities for frontline staff to receive ad hoc training and support when gaps in knowledge and confidence were identified.

During Q2 and Q3, electronic nursing documentation was reviewed and updated to include Pressure Care Assessment, with prompts to signpost nursing staff on what assessments need to be done and any actions that need to be undertaken. An electronic documentation

template for Pressure Ulcer Plan was drafted. The publication of this documentation is under review, in order to ensure that the documents are up to date with NHSE Guidance, released in November, that changes the current Pressure Ulcer management and documentation, affecting categorisation, reporting and pressure ulcer assessment.

Aside from the Quality Account goal set, wider improvements within Pressure Care have continued throughout the year, resulting in an overall reduction in number of patients who have developed pressure damage attributable to Whittington Health. Achievements have included:

- Amendments to the acute equipment delivery service, increasing from 5 to 6-day service and inclusive of bank holidays.
- Nomination of skin care ambassadors in over 90% of clinical areas
- Guidance on skin assessment in range of skins tones
- Hospital wards achieving 129- and 140-days Pressure Ulcer free.

World "Stop the Pressure" Day was held in November, with events including hosting a stand in the Atrium to raise awareness, making pledges to make every contact, and free educational webinars were available. A Stop the Pressure Conference was held, with topics including Assessing skin (including in dark skin tones), Learning Disability and Mental Capacity, Nutrition, Podiatry, OT and Physio. The conference finished with a Patient Story about their experiences of Pressure Ulcers and the impact it has on their life. Talks were given by a range of MDT members and the conference was fully booked by a range of clinical frontline staff.

Work continues with transitioning from paper to electronic patient record care planning for pressure area care to allow more timely and accessible care records; but progression has been temporarily paused due to the prioritisation of undertaking similar activity for core general nursing care records on pilot wards.

As a result of this inaccurate data compliance with the KPI is not available without potential misrepresentation of the results. The workstream is planned to be recommenced in Q1 2024/25.

The NWCSP guidance document on the new Pressure Ulcer Care Pathway released in November 2023 has been a focus for the Trust pressure Ulcer Group in Quarter 4 necessitating a review and update of the Trust Pressure Ulcer Improvement Plan.

As well as work undertaken on Datix platform remodelling, communicating, and implementing the changes in the new categorisation and Datix reporting of pressure ulcer incidents. The changes to categorisation and Datix reporting was implemented on the 1st April 2024.

What did we achieve in 2023/24? – Project 2: Discharge & Reducing Admissions

Project 2: Discharge:

- Goal 1: To manage 4 patients per month (2 from Islington borough, 2 from Haringey borough) via the delirium discharge pathway.
- Goal 2: To reduce medically optimised patients that are unable to be discharged by 50% daily.
- Goal 3: To utilise up to 28 Virtual Ward beds daily, including 8 technology enabled virtual ward patients and those on the delirium pathway.
- Goal 4: 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

- Goal 5: To implement pathway for 'Trial without Catheter' (TWOC) at home, reducing the length of stay by at least one day.

What did we achieve

- Goal 1: To manage 4 patients per month (2 from Islington borough, 2 from Haringey borough) via the delirium discharge pathway.

  This target was not achieved. There were 8 patients that were admitted on the delirium pathway in 2023/24. Low utilisation has been attributed to awareness of the pathways available, especially among junior doctors who complete the most referrals. The low utilisation has been raised with the acute consultant geriatricians, and they have been asked to cascade this information to junior colleagues.

  Islington complex virtual ward has accepted more patients with reduced 4AT scores, (4AT is a screening tool designed for rapid and sensitive initial assessment of cognitive impairment and delirium.) whereas these patients could have been referred via the delirium pathway.

  The current capacity for delirium beds is 2 for Islington patients and 1 for Haringey. There will be an increase in beds in Haringey in 2024/25 bringing the total to 2 beds in line with Islington's capacity.

- Goal 2: Goal 2: To reduce medically optimised patients that are unable to be discharged by 50% daily.

  Medically optimised patients are managed by Islington and Haringey social services, so this target was not able to be tracked as this data is not shared with the Trust. However, non-medically optimised patients were regularly stepped down onto the virtual ward step down pathway, and there was noticeable improvement in these patients' length of stay during 2023/24.

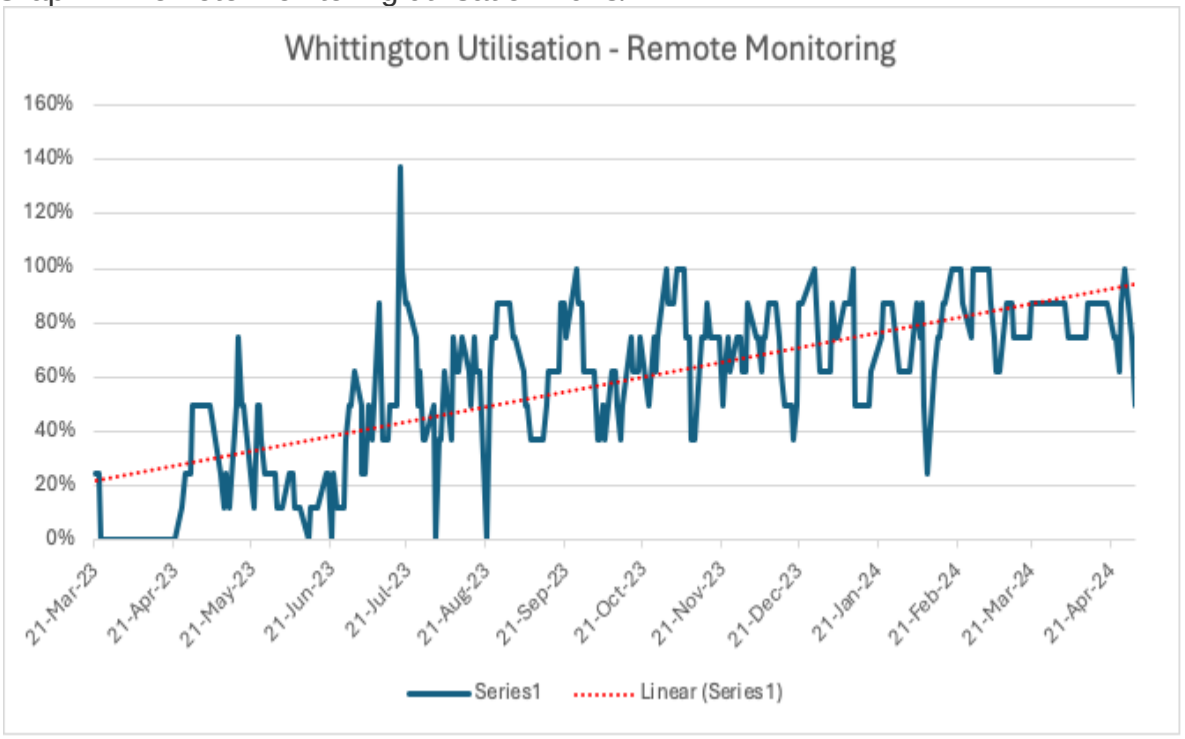
  Information for 01/04/2023 to 31/03/2024
  Total Patients accepted onto Virtual Wards: 1,508
  Step-Up from Community: 90
  Step-Down from Ward: 1,418

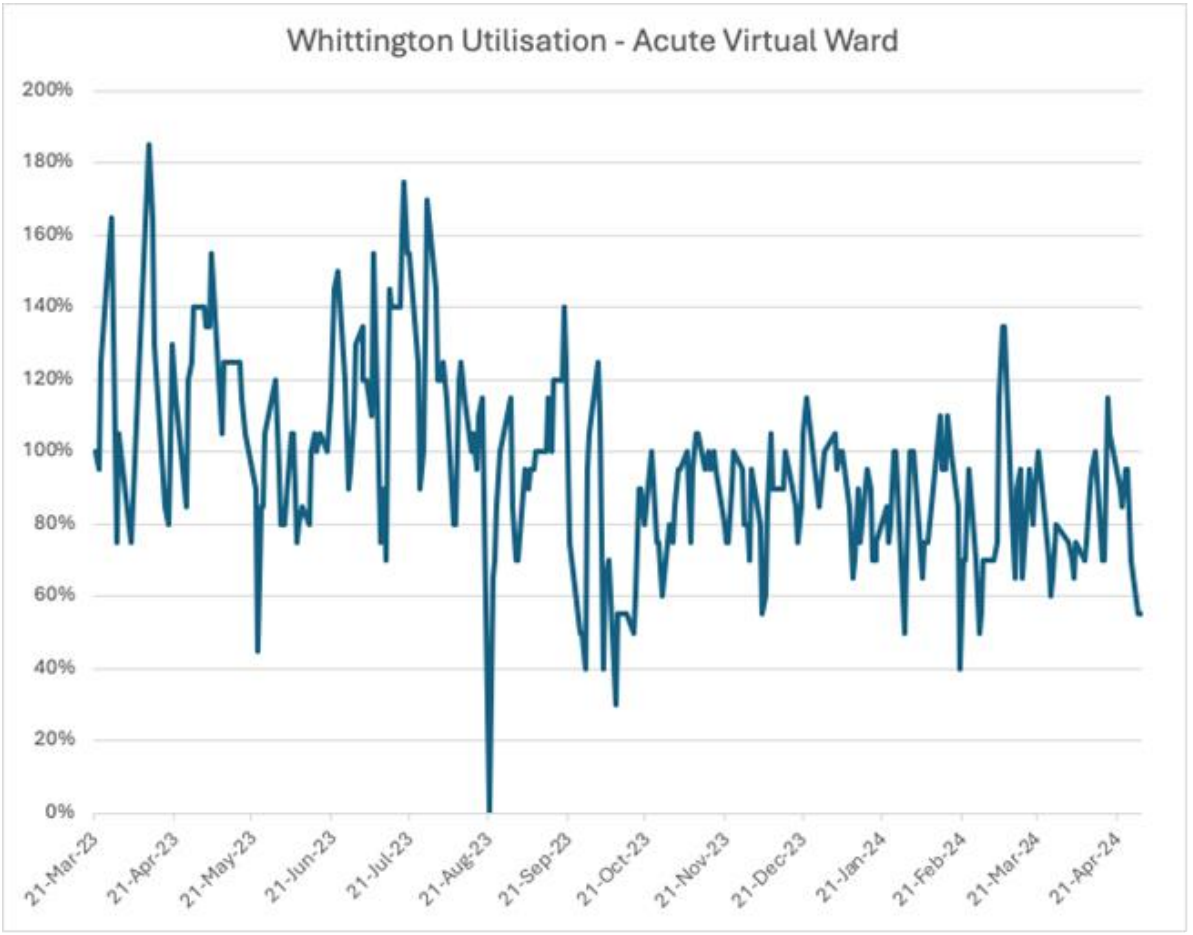
  Average LOS:
  • 1 to 4 Days - 56%
  • 5 to 9 Days - 29%
  • 10 to 14 Days - 0%
  •14 Days Plus - 15%

- Goal 3: To utilise up to 28 Virtual Ward beds daily, including 8 technology enabled virtual ward patients and those on the delirium pathway.

  This target was achieved. Virtual ward bed utilisation for 2023/24 was a total average of 95%. Remote monitoring beds ranged between 80% - 140/%. As shown in the graphs below:

Graph 1: Remote Monitoring utilisation 2023/24





Graph 2 – Virtual Ward Utilisation 2023/24

- Goal 4: 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.

  Haringey data

  The data for Haringey for patients being seen within the response timeframes of 2hrs, 4hrs and 24hrs has been achieved. Haringey has consistently met all targets during Q1, Q2, Q3 and Q4 for the 4-hour and 24-hour response times. In regard to the 2 hour target the only quarter that did not achieve the target was Q4 and this was due to winter pressures. The teams have done excellently in ensuring that patients are seen in a timely manner.

  Islington data

  The data for Islington patients being seen within the response timeframes of 2hrs, 4hrs and 24hrs was more variable. In regard to the 2-hour response times this was only achieved in Q1. The 4-hour target was achieved in Q3 and Q4 but not Q1 and Q2. However, the 24-hour target was consistently achieved across all quarters. There are larger numbers of patients being referred from Islington than Haringey and this has contributed to not achieving the 2-hour and 4 hour targets consistently.

- Goal 5: To implement pathway for 'Trial without Catheter' (TWOC) at home, reducing the length of stay by at least one day.

  This target was not achieved. Referrals from Trust into the community TWOC have been low - only 2 since the pathway went live. The lead District Nurse (DN) for QI, the bladder and bowel service lead and one of the acute geriatricians continue to work on making sure acute staff are aware of the pathway and send more referrals in for community TWOC. They look at all referrals coming from other sources including other healthcare professionals and from primary care. The communications team has also been involved in developing screensaver reminders to raise the profile of the service. The team have also included catheterisation training sessions for patients and are reviewing existing patients on the DN caseload with link nurses to see if suitable for the Community TWOC pathway.

What did we achieve in 2023/24? Project 3: Nutrition

- Goal 1: 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.

Throughout 2023-2024, work on improving nutrition and hydration for vulnerable patients, including those with Dementia and/or Learning Disabilities has been carried out.

A project in the community worked with a local care home on increasing hydration of their residents through adapting communication to personalise, encourage and give direction to enable residents to take drinks more regularly.

In the hospital, an increase in nutritional screening being completed was noted following awareness raising via the Back to the Floor programme. The month-long programme also highlighted further need for training in feeding, nutrition and hydration and an online learning package was designed to provide to all staff involved in support patients with eating and drinking. Alongside this, face to face training was provided to health care support workers.
A renewed focus on Nutrition has also been implemented via the introduction of Nutrition Champions being identified amongst the nursing staff.

Speech and Language Therapy and Dietetic documentation has been updated to include dietary preferences, cultural and allergy considerations and this change has also been reflected in nursing admission documentation to ensure this information is obtained as early as possible in admission.

Learning Disability:
An audit was conducted during Quarter 3 which demonstrated 121 alerts were received by the Learning Disability Clinical Nurse Specialist (LD CNS) for those with Learning Disability attending ED or admitted to the hospital. These alerts were reviewed daily from Monday-Friday and accepted as referrals. The LD CNS was able to provide support to these individuals, including ensuring that hospital passports are available and raising awareness to ensure that staff refer to this document as they contain specific eating, drinking and assistance levels required for each individual.

Dementia:
In Quarter 2, an audit demonstrated that 100% of patients with Dementia had a record of their next of kin (NOK) contact details. Contact with NOK was achieved within 24 hours of admission for 64% of patients, with an overall average of contact with NOK within 0.63 days of admission.

In Quarter 4, an audit of "What Matters to Me" was conducted of all patients with a diagnosis of dementia who were admitted to hospital. Of 41 patients, 32% had evidence of "What Matters to Me" uploaded to their electronic documentation. This percentage was noted to increase (45%) when there was active involvement from the Dementia CNS. Of those that had a "What Matters to Me" document, 100% had clear food preferences recorded that were personalised to the individuals.

Priority 2: Improving access and attendance for appointments.

Aims for 2023/24:

What did we achieve in 2023/24? Project 1: Zesty

- Goal 1: For 60% of outpatients to be using Zesty by end of March 2024.

What did we achieve in 2023/24?

- Goal 2: For DNA rates reduced in line with booking amendments functionality being introduced by end of March 2024.

What did we achieve in 2023/24? Project 2: Patient letters

- Goal 3: For outpatient letters to be reviewed and updated to ensure location correctly matches hospital signage.

During 2023, work was undertaken by IT and Quality Improvement to assess letters sent out for outpatient appointment. 1008 letter templates were identified as having a hospital site location associated with it. These were cross referenced with locations and 48 letter locations were identified.
These locations have all been reviewed and cross-matched with signage and it was confirmed that letters correctly reflect signage in place. One letter location was identified as no longer in use and IT worked with the relevant service to remove this clinic location from the system.

A new map and way-finder guide was produced with all letter locations and circulated to the way-finder volunteers. During 2023-2024, a further 25 volunteers were recruited, with a key role of way-finding in order to support people to find their appointments easily.

Feedback has been received from service users about confusion caused by historical Covid signage, directing people via one-way routes in order to maintain distance. This signage has been reviewed by Communications and Estates and Facilities in order to facilitate removal of any signage that is no longer required and has the potential to cause confusion when directing people around sites.

A challenge identified during the project is that when letter amendments are required, it requires significant manual burden, requiring each letter to be accessed individually. IT are reviewing options to create a central letter library for ease of access and allow changes to be made centrally.

What did we achieve in 2023/24? Project 3: Wood Green CDC

What did we achieve in 2023/24? Project 4: Accessible information for Learning Difficulties Patients

Priority 3: Reducing Health Inequalities in our local population

Aims for 2023/24

What did we achieve in 2023/24? Project 1 Sickle Cell

- Goal 1: Deliver training to 60% 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.

Training:

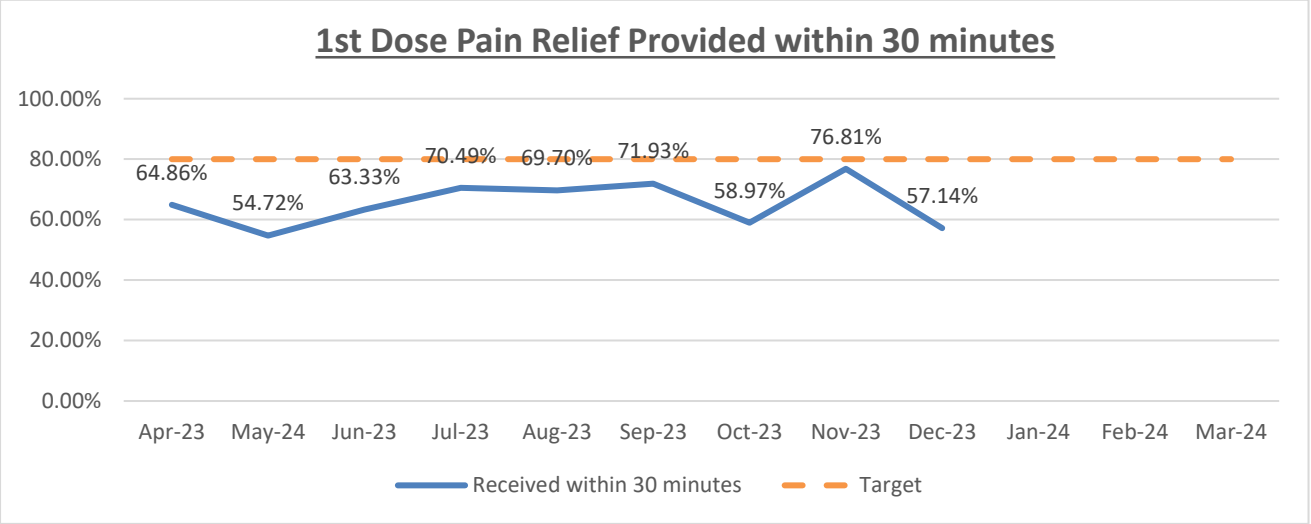
A project focussing on training staff continued during 2023-2024, with service users involved in the design and implementation of staff training to include education on the condition. Up to a third of ED staff had previously been trained, but this number reduced due to staff turnover. In quarter 2, 23 current nursing staff had received training, including education on the condition and potential bias, and further training sessions were delivered in February 2024, with 25 staff receiving training.

An e-learning package is additionally planned to be eliminated to be offered out to staff across the Trust.

In Quarter 3, Sickle Cell was one of the topics for a Back to the Floor session. Back to the Floor is a visible nursing leadership programme, run weekly with senior nursing and AHP leads in order to educate, problem solve and determine solutions within clinical settings across the Trust. The session was led by the Sickle Cell Lead Nurse and an Expert by Lived Experience who shared their experiences and provided further education around time to analgesia, recognising and acknowledging pain, and how to improve the patient journey during hospital admissions. The session was well received and the group discussed opportunities to improve the sickle cell pathway for patients when attending our hospital, as well as using the opportunity to raise awareness of the NHS England's Sickle Cell card.

In addition to training provision, ED and Ambulatory care have implemented Sickle Cell Nursing Advocates within their services to aid sharing of learning and training materials.

Pain Relief:



A new data collection tool was developed to accurately capture time between attendance and first dose of analgesia. The accuracy of the data collection continues to be monitored to ensure that it accurately captures timings and does not result in duplicated data.
Challenges in achieving the target have been impacted by Trust wide inpatient bed capacity pressures which impact on ED overcrowding and subsequent delays in treatment, particularly noted in December 2023. Although numbers remain below target, however the Sickle Cell Lead Nurse reported that service users are reporting a subjective improvement in their waits.

What did we achieve in 2023/24? Project 3: Prostate Cancer

- 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.

Part 4: Other Information

Local Performance Indicators

Goal	*Standard/benchmark*				*Whittington performance*	
		23/24	*22/23*	*21/22*	*20/21*	*19/20*
ED 4 hour waits	*95% to be seen in 4 hours*	***65.30%***	***68.40%***	***78.30%***	***87.4%***	***83.8%***
RTT 18 Week Waits: Incomplete Pathways	*92% of patients to be waiting within 18 weeks*	***66.2%***	***67.8%***	***74.4%***	***65.6%***	***92.1%***
RTT patients waiting 52 weeks	*No patients to wait more than 52 weeks for treatment*	***8007***	***6182***	***7093***	***11094***	***2***
Waits for diagnostic tests	*99% waiting less than 6 weeks*	***86.9%***	***85.9%***	***94.1%***	***72.1%***	***99.3%***
Cancer: Urgent referral to first visit	*93% seen within 14 days*	**51.8%**	**45.8%**	**74.8%**	**94.6%**	**94.8%**
Cancer: Diagnosis to first treatment	*96% treated within 31 days*	**93.4%**	**90.2%**	**95.3%**	**98.1%**	**98.8%**

Cancer: Urgent referral to first treatment	*85% treated within 62 days*	**63.3%**	**48.2%**	**61.1%**	**73.8%**	**84.0%**
Improved Access to Psychological Therapies (IAPT)	*75% of referrals treated within 6 weeks*	**93.2%**	**92.8%**	**91.4%**	**93.8%**	**95.1%**

Summary Hospital-Level Mortality Indicator (SHMI)

Summary Hospital-Level Mortality Indicator (SHMI)
The most recent data available (published 8 February 2024) covers the period October 2022 to September 2023

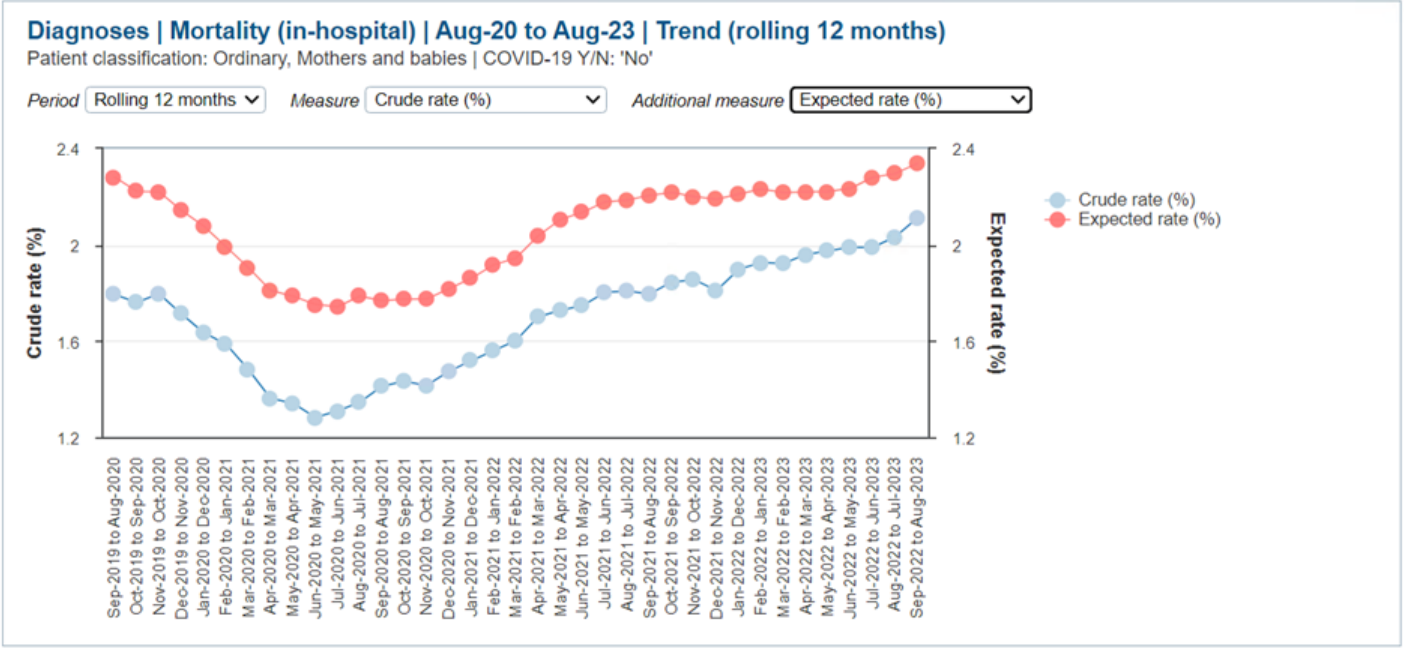
Whittington Trust SHMI score:	0.99	Compared to 0.94 reported for July 2022 to June 2023 period
Lowest National Score:	0.62	Royal Surrey County Hospital NHS Foundation Trust
Highest National Score:	1.18	Norfolk and Norwich University NHS Foundation Trust

13 Trusts were graded as having a lower-than-expected number of deaths.

10 Trusts were graded as having a higher-than-expected number of deaths.

96 Trusts, including Whittington Health, were graded as showing the number of deaths in line with expectations.

The SHMI represents a comparison against a standardised National Average. The 'national average' therefore is a standardised 1.0 and values significantly below 1.0 indicate a lower-than-expected number of mortalities (and vice versa for values significantly above). Historically the Whittington had a lower SHMI, shown in the graph below. Factors which may have influenced the increase in SHMI are an increase in crude death rates, potential under- coding which is currently being audited, increase in elective admissions, an overall decrease in hospital admissions and delays in discharging patients.



Annex 1: Statements from external stakeholders

Joint Health Overview and Scrutiny Committee for North Central London feedback

Feedback awaited once draft reviewed

HealthWatch Haringey feedback

Feedback awaited once draft reviewed

Commissioner feedback

Feedback awaited once draft reviewed

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 2023/24 Quality Account will be published on the Trust website by the 30th June 2024. A copy is also sent electronically to NHS England as per national requirements.

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

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

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

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

- Board minutes.
- Papers relating to the Quality Account reported to the Board.
- Feedback from Health Watch.
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009.

- the latest national patient survey.
- the latest national staff survey.
- feedback from Commissioners.
- the annual governance statement; and
- CQC Intelligent Monitoring reports.

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

The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and The Quality Account has been prepared in accordance with the Department of Health guidance.

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

Signatures to be added post Trust Board Meeting

Clare Dollery
Interim Chief Executive

Baroness Julia Neuberger DBE
Chair

Appendix 1: National Mandatory and Non-Mandatory Audits 2023/24

Title of Audit	Management Body	Participated in 2023/2024	If completed, number of records submitted (as total or % if requirement set)
National Bariatric Surgery Registry	British Obesity & Metabolic Surgery Society	✓	Data submitted: 84 cases
National Early Inflammatory Arthritis Audit	British Society for Rheumatology	✓	Data submitted: 13 cases
Adult Respiratory Support Audit	British Thoracic Society	✓	Data submitted: 19 cases
Improving Quality in Crohn's and Colitis [Note: previously named Inflammatory Bowel Disease Audit]	IBD Registry	✓	Data submitted: 49 cases
Case Mix Programme	Intensive Care National Audit & Research Centre	✓	Data submitted: 556 cases
National Cardiac Arrest Audit	Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK (RCUK)	✓	Data submitted: 49 cases
Sentinel Stroke National Audit Programme	King's College London	✓	Data submitted: 85 cases
Myocardial Ischaemia National Audit Project	National Institute for Cardiovascular Outcomes Research (NICOR) hosted at NHS Arden and Greater East Midlands CSU	✓	Data submitted: 81 cases
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research (NICOR) hosted at NHS Arden and Greater East Midlands CSU	✓	Data submitted: 198 cases
National Audit of Care at the End of Life	NHS Benchmarking Network	✓	Data collection period from January - December 2024
Audit of NICE Quality Standard QS138	NHS Blood and Transplant	✓	Data submitted: 37 cases
Bedside Transfusion Audit	NHS Blood and Transplant	✓	Data collection period from March 2024 - May 2024

Breast and Cosmetic Implant Registry	NHS England	✓	Data submitted: 18 cases
Learning from lives and deaths – People with a learning disability and autistic people	NHS England	✓	Data submitted: 5 cases
National Core Diabetes Audit	NHS England	✓	Data submitted: 1274 cases
National Diabetes Footcare Audit	NHS England	✓	Data submitted: 171 cases
National Diabetes Inpatient Safety Audit	NHS England	✓	Data submitted: 1 case
National Obesity Audit	NHS England	✓	Data submitted: 65 cases
National Pregnancy in Diabetes Audit	NHS England	✓	Data submitted: 34 cases
National Emergency Laparotomy Audit	Royal College of Anaesthetists	✓	Data submitted: 90 cases
Perioperative Quality Improvement Programme	Royal College of Anaesthetists	✓	Data submitted: 6 cases
Care of Older People	Royal College of Emergency Medicine	✓	Data submitted: 117 cases
Mental Health (Self-Harm)	Royal College of Emergency Medicine	✓	Data submitted: 250 cases
National Maternity and Perinatal Audit	Royal College of Obstetricians and Gynaecologists	✓	Data submitted: 2822 cases
National Neonatal Audit Programme	Royal College of Paediatrics and Child Health	✓	Data submitted: 348 cases
National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health	✓	Data submitted: 124 cases
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12)	Royal College of Paediatrics and Child Health	✓	Data submitted: 44 cases
National Audit of Inpatient Falls	Royal College of Physicians	✓	Data submitted: 3 cases
National Hip Fracture Database	Royal College of Physicians	✓	Data submitted: 167 cases
National Audit of Dementia: Care in general hospitals	Royal College of Psychiatrists	✓	Data submitted: 45 cases
National Audit of Metastatic Breast Cancer	Royal College of Surgeons of England	✓	If cases identified to WH then participate - none to date
National Audit of Primary Breast Cancer	Royal College of Surgeons of England	✓	Data submitted: 144 cases
National Lung Cancer Audit	Royal College of Surgeons of England	✓	Data submitted: 82 cases
National Prostate Cancer Audit	Royal College of Surgeons of England	✓	Data submitted: 103 cases

National Bowel Cancer Audit	Royal College of Surgeons of England	✓	Data submitted: 32 cases
National Oesophago-Gastric Cancer Audit	Royal College of Surgeons of England	✓	Data submitted: 9 cases
Society for Acute Medicine Benchmarking Audit	Society for Acute Medicine	Trust decision not to participate (rationale provided above)	N/A
BAUS Nephrostomy Audit	The British Association of Urological Surgeons	✓	Data submitted: 3 cases
The Trauma Audit & Research Network	The Trauma Audit & Research Network /University of Manchester	✓	Due to TARN's cyber attack data not able to be submitted. 450 suitable cases have been identified for submission.
UK Renal Registry National Acute Kidney Injury Audit	UK Kidney Association	✓	Data submitted: 5102 cases
National Child Mortality Database Programme	University of Bristol	✓	Review of published reports
National Audit of Cardiac Rehabilitation	University of York	✓	Data submitted: 419 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 11 cases were submitted to MBRRACE-UK who allocate to the appropriate work stream			
Maternal mortality confidential enquiries	MBRRACE-UK, led from the University of Oxford	✓	Ongoing
Maternal 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
Perinatal mortality surveillance	MBRRACE-UK, led from the University of Oxford	✓	Ongoing
National perinatal mortality review tool	MBRRACE-UK, led from the University of Oxford	✓	Ongoing

Medical, Surgical and Child Health Clinical Outcome Review Programme

Testicular Torsion	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	3/3 cases submitted
Juvenile idiopathic arthritis	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	4/4 cases submitted
Community Acquired Pneumonia Hospital Attendance	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	6/6 cases submitted
Crohn's Disease	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	6/6 cases submitted
End of Life Care	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	5/5 cases submitted
Endometriosis	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	5/5 cases submitted
Epilepsy: Hospital attendance	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	5/6 cases = 84%
Rehabilitation following Critical Illness	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	Study recently commenced

National Asthma and Chronic Obstructive Pulmonary Disease Audit programme			
Paediatric Asthma in Secondary Care	Royal College of Physicians	✓	Data submitted: 210 cases
Pulmonary rehabilitation	Royal College of Physicians	✓	Data submitted: 101 cases
COPD in Secondary Care	Royal College of Physicians	✓	Data submitted: 148 cases
Adult Asthma in Secondary Care	Royal College of Physicians	✓	Data submitted: 110 cases

Non-Mandatory National Audits 2023/2024

Project Title	Management Body	Status
Infection Prevention and Control	Royal College of Emergency Medicine	Completed
British Society of Dermatological Surgery 2022 Sustainability Audit	British Society of Dermatological Surgery	Completed
United Kingdom Obstetric Surveillance System – national audits of rare conditions of pregnancy	UKOSS National Perinatal Epidemiology Unit	Data submitted
Management of self-harm in children and young people presenting to A&E	Student Psychiatry Audit and Research Collaborative Steering Group	Data submitted
StarSurg: Operative and non-operative management of emergency presentations of colon and rectal cancer	STARSurg	Data submitted
NDA Integrated Specialist Survey	NHS Digital, NCAPOP	Data submitted
National study of HIV in Pregnancy and Childhood (NSHPC)	NSHPC	Data submitted
National Ovarian Cancer Audit	National Cancer Audit Collaborating Centre	Data submitted
National Pancreatic Cancer Audit	National Cancer Audit Collaborating Centre	Data submitted
National Non-Hodgkin Lymphoma Audit	National Cancer Audit Collaborating Centre	Data submitted
National Kidney Cancer Audit	National Cancer Audit Collaborating Centre	Data submitted
Mandatory Surveillance of Healthcare Associated Infections	Public Health England	Data submitted
Surgical Site Infection Surveillance Service	Public Health England	Data submitted
Vascular Access in Complicated Paediatric Appendicitis	University Hospital Southampton NHS Foundation Trust	Data submitted
London-wide audit of TB management in patients with ocular TB – led by Moorfields	Pan-London LOOP TB pathway guidance	Ongoing
NHS Digital Tobacco Dependence national data collection	NHS Digital	Ongoing
A 'Flash-Mob' UK national audit of the use of Reversal Agents in Patients antIcoagulated with Direct Oral anticoagulants (HaemSTAR RAPIDO)	national audit - HaemSTAR RAPIDO	Ongoing
Time critical medications	RCEM	Ongoing
Implementation of Hybrid Closed Loop technologies	NHS Digital	Ongoing
Audit of admissions to acute medical units of patients with eating disorders: assessing use and adherence to "Medical Emergencies in Eating Disorders (MEED)" guidelines.	The Student Psychiatry Audit and Research Collaborative, affiliated with the Royal College of Psychiatrists	Ongoing

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	Ear 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 Portman NHSFT	CCN209- Agreement for the provision of services from Tavistock and Portman 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)
Islington GP Group Limited (trading as Islington GP Federation)	Provision of ENT service
Healios Limited	Provision of • Neurodevelopmental screening ● Autism Assessments ● ADHD Assessments ● Dual Autism/ADHD Assessments ● Post diagnostic support
Health Services Laboratory	From 1st April 2024 pathology services provided
Everlight Radiology Limited	Out of hours imaging reporting.

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%
2023/24	Apr	4	583	0.7%	106	2040	5.2%
	May	9	734	1.2%	113	2247	5.0%
	Jun	7	689	1.0%	122	2522	4.8%
	Jul	8	668	1.2%	152	2073	7.3%
	Aug	7	637	1.1%	119	2337	5.1%
	Sep	12	728	1.6%	114	2320	4.9%
	Oct	6	748	0.8%	97	2408	4.0%
	Nov	6	836	0.7%	126	2475	5.1%
	Dec	11	758	1.5%	132	2136	6.2%
	Jan	11	735	1.5%	106	2259	4.7%
	Feb	22	683	3.2%	121	2280	5.3%
	Mar	9	740	1.2%	72	2490	2.9%

Appendix 4 – Staff Survey score matrix 2023

Whittington Health Directorate/ICSU Reporting

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 2023 theme score for ICSUs and Directorates is graded in green if the score is above organisational average, and red where the score is below organisational average. Where an ICSU or Directorate has scored the same as the organisation's average it is graded black.*

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	7.3	6.9	7.4	6.9	7.8	7.2	6.9	7.2	7.1	7.4	7.5	7.4	7.1	7.4	8.1
We are recognised and rewarded	6.0	5.5	6.1	6.2	6.5	5.8	5.8	6.3	5.5	6.4	6.5	6.3	5.7	6.6	7.2
We each have a voice that counts	6.8	6.3	6.9	7.4	7.2	6.7	6.5	6.7	6.5	6.6	7.3	6.9	6.6	7.0	7.2
We are safe and healthy	6.0	5.8	5.9	5.9	6.2	5.6	6.1	6.6	6.1	6.6	6.4	6.6	5.7	6.2	7.1
We are always learning	5.7	5.0	6.0	5.9	6.0	5.9	5.6	5.1	5.4	5.4	5.8	5.6	5.4	6.8	6.4
We work flexibly	6.2	5.4	6.2	6.2	6.7	5.9	6.4	6.9	6.2	6.1	6.5	6.6	5.7	7.2	8.0
We are a team	6.9	6.3	7.0	6.7	7.3	6.7	6.3	6.6	6.6	7.2	7.2	7.0	6.5	7.1	7.8
Staff Engagement	6.9	6.6	6.9	7.2	7.3	6.9	6.8	7.0	6.6	6.9	7.4	7.1	6.9	7.0	7.6
Morale	5.8	5.3	5.7	6.3	6.0	6.7	5.8	5.9	5.5	6.0	6.1	6.2	5.9	5.5	6.6

Appendix 5 – Equalities Indicators from the Staff Survey 2023

WDES (Workforce Disability Equality Standards) indicators reported in the Staff Survey Results 2023

The table below provides a comparison of the Workforce Disability Equality Standard (WDES) results in 2022 and 2023. WDES results are based on a series of indicators, of which 4, 5, 6, 7, 8 and 9 are drawn from the NHS Staff Survey. Each 2023 response has been colour graded, green indicates a positive improvement for staff with a Long-Term Condition (LTC) or illness and red indicates a decline from the previous year.

	Table to show WDES Indicators		2022		2023	
Indicator	**Question**	**Description**	**LTC or illness**	**WITHOUT LTC or illness**	**LTC or illness**	**WITHOUT LTC or illness**
4a	Q14a Q14b Q14c	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patients, Managers or Colleagues	53.1%	38.7%	50.9%	37.7%
4b	Q14d	Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or colleague reported it	46.5%	47.7%	44.6%	51.5%
5	Q15	Percentage of disabled staff compared to non-disabled staff believing that their trust provides equal opportunities for career progression or promotion	40.1%	51.8%	39.4%	54.2%
6	Q11e	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their managers to come to work, despite not feeling well enough to perform their duties	29.5%	20.7%	29.2%	19.2%
7	Q4b	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	34.7%	45.6%	38.4%	49.6%
8	Q30b	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	64.7%	N/A	66.1%	N/A
9a	E_4	Staff engagement score (0-10)	6.3	7.0	6.4	7.1

WRES Indicators Reported in the Staff Survey Results 2023

In its sixth year of reporting there are four indicators comparing the experience of Black, Minority, Ethnic staff (B.M.E) and white staff in Whittington Health. This table shows a comparison of the Workforce Race Equality Standard (WRES) indicators over a six-year period. Each 2023 response is graded in green if there has been an improvement for B.M.E staff; or red, if there has been a decline compared to the previous year.

The table below shows improvement in three out of the four WRES indicators i.e. the percentage of BME staff experiencing harassment, bullying or abuse from staff; BME staff believing that the organisation provides equal opportunities for career progression or promotion; and BME staff experiencing discrimination at work from manager/team leader or other colleagues. Fairness in career progression for BME staff has shown the greatest improvement and this reflects the increased career development opportunities available across the Trust for example the Band 2-7 BME Career Development Programme, as well as the Trust-wide listening event held last year. However, there has been a negative increase in staff experiencing harassment, bullying or abuse from patients, relatives, or the public of 0.7%.

Table to show WRES Indicators	2018		2019		2020		2021		2022		2023	
Question	**BME staff**	**White staff**	**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%	30.0%	27.2%
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%	25.1%	21.6%
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%	46.3%	56.4%
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%	11.8%	7.4%

Appendix 6 – Clinical Coding External Audit Results 2023/24

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	**90.2 %**

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	384	
	Number of secondary procedures correct	306	**87.93 %**

Appendix 7 – CQUIN progress for 2023/2024

The CQUINs are clinically lead by the medical directorates and overseen by the performance team.

Achieved
Not achieved
No requirement to report for the quarter

CQUIN Scheme	Rationale/Objectives	Compliance		
CQUIN01 - Flu vaccinations for frontline healthcare workers (Target)	Achieving 80% uptake of flu vaccinations by frontline staff with patient contact.	Q1	Q2	Q3
CQUIN02 - Supporting patients to drink, eat and mobilise (DrEaM) after surgery (Target)	Ensuring 80% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.	Q1	Q2	Q3
CQUIN03 - Prompt switching of intravenous to oral antibiotic (Target)	Achieving 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria.	Q1	Q2	Q3
CQUIN05 - Identification and response to frailty in emergency departments (Reporting only)	Achieving 30% of patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.	Q1	Q2	Q3
CQUIN06 - Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service (Reporting only)	Achieving 1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message. Despite there not being a requirement to report this CQUIN, it was achieved.	Q1	Q2	Q3
CQUIN07 - Recording of and response to NEWS2 score for unplanned critical care admissions (Target)	Achieving 30% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes.	Q1	Q2	Q3
Local CQUIN - Core20plus5 (Target)	Part A) Establish baselines for ethnicity recording, interpreting services, people accessing services who are experiencing homelessness and women experiencing moderate to severe or complex mental health difficulties directly arising from, or related to, their maternity experience. Part B) To identify those at greatest risk of a negative experience of healthcare.	Q1	Q2	Q3