Whittington Health NHS

Transforming Healthcare for Tomorrow

Our five year strategy in response to the listening exercise

Led by our clinicians in partnership with our community

July 2013

Transforming Healthcare for Tomorrow

Introduction

1. This paper was written following a three month listening exercise on the Whittington Health clinical strategy. The listening exercise took place from March to May 2013. It sought the views of stakeholders including our local communities on Whittington Health's clinical strategy as an integrated care organisation, and the implications for estates.

We have listened and changed our plans ... our purpose remains to improve the health of our community

2. The Whittington Health Board and every member of our staff have one common purpose, which is to secure the ongoing provision of the best possible care for the communities we serve. This purpose is at the core of our vision:

> *To be an outstanding provider of high quality joined up healthcare to local people in partnership with GPs, councils and other local providers*

3. To achieve this ambition, we will need to work hand-in-hand with our commissioners, our partners in particular social care, our communities, service users, patients and carers. Together we will meet the challenges and successfully transform our healthcare services.

4. We have listened to local people and have amended our plans. Our overall objective, however, remains to continue to transform as an integrated care organisation. Much of the detail still remains to be worked through. We expect to complete our revised plans, including their financial implications, by December 2013.

5. However, the following principles will now be included:

    - We won't close any beds so long as they are needed by patients and continue to be commissioned. As an integrated care organisation, we are able to look after more people in their homes and to provide more support outside hospital. But as patients are treated closer to home and lengths of stay reduce, we will where possible use the additional bed capacity to meet the potential growth in demand and to develop new services where these are requested by our commissioners

    - We will bring forward plans to upgrade our maternity facilities so that more women will choose to have their baby at The Whittington Hospital. We have the support of our commissioners to expand the capacity of our maternity services beyond the current 4,000 births per year

    - We will continue to rebalance and to develop our workforce to meet the challenges of transforming our healthcare. We will add the necessary

skills and change the skills-mix, but we won't make any changes to our workforce that compromises the quality of care. In the first instant we will reduce our reliance on temporary staff and increase our engagement with our staff

- We will not undertake any future sale of existing properties without consultation with our community. We will retain and continue to use the Jenner and the Whittington Education Centre

6. If we are to meet the challenges we face and remain a high quality provider of care for our local communities, we will need to change the way we deliver our services in the future. This includes:

    - Treating and continuing to support our patients in a co-ordinated fashion in convenient locations. On many occasions this will mean that patients no longer have to go to hospital but can be treated in the community or in their homes and by teams who better understand them and their individual needs

    - Developing new skills to enable our staff to work more productively and in different ways. We are introducing seven day working in the hospital and will use new technologies and better information to support this

    - Making the best use of public money to invest in new facilities from which to deliver our services

7. To make our plans a reality, we need to win the confidence and support of our key stakeholders. We need to show how our proposals for transforming healthcare are both in the best interests of the people we serve, and also affordable. In particular, we need to regain the trust and support of:

    - Our communities, who are passionate supporters of our hospital. We must be able to explain our proposals and what they will mean for patients, service users, our facilities and our staff

    - Our commissioners, especially Islington and Haringey Clinical Commissioning Groups, who are responsible for buying healthcare services on behalf of their patients

    - Our partners, in particular social care but also other providers of care, with whom we will collaborate to deliver services in a more joined up way

    - Our 4,000 staff who are central to the delivery of our plans and in whom we will continue to invest

    - Our governors and 6,500 members, who as we move forward will provide input on behalf of patients, service users, local populations and staff, helping to shape services for the future

- Our regulators, including the Care Quality Commission, the Trust Development Authority and, in due course, Monitor, the regulator of NHS Foundation Trusts, ensuring we continue to meet their requirements and our regulatory obligations

8. Our plans are necessarily ambitious, clinically led, patient focused and underpinned by commissioner demands to improve value. There will be significant changes to the way in which we care for our patients, the settings in which we provide this care, the ongoing support we will give, the skills of our staff and the information systems which support them.

9. The Board is confident that the interests of our communities and patients are best served through the progression of this strategy which underpins our plans for Whittington Health to become an NHS Foundation Trust. Foundation trust status will enable us to secure the future of the organisation and complete the realisation of our vision.

To achieve our ambition, together, we need to change the way we do things ... we have already started on this journey

10. An ageing population, rising birth rates, higher costs of treatments, a growing number of people with long term, often multiple, conditions, are all putting pressure on health services at a time of tight public finances. Providers meanwhile are faced with rising A&E attendances, higher costs of new commissioning standards, increased competition, growing public expectation of their care experience, and funding that isn't increasing in real terms.

11. Compared to how healthcare is currently delivered, going forward the NHS and Whittington Health will have to provide more care to more people with less money. At the same time we also want to improve the experience of care we provide. Across the NHS, healthcare delivery will have to change significantly to meet these challenges. Integrated care, delivered as close to home as possible, provides a major solution at a national level.

12. Whittington Health offers the safety and expertise of a teaching hospital with the convenience and responsiveness of community services. The Whittington Hospital is one of the safest hospitals in the country. We benefit from a highly trained and motivated workforce, excellent rigour in research and academic input, financial stability and some good facilities. But some of our premises are substandard or serve no clinical purpose and remain vacant. We have an obligation to ensure we use our assets in the most productive manner to maximise healthcare value.

13. Our integrated (or co-ordinated) care model will ensure that where the evidence supports it and it is proven to be in the interests of patients, we will reduce the time patients needlessly spend in hospital. Wherever possible patients and service users are to be treated in the community. We will use new technologies to improve communication and deliver more efficient, affordable and effective care closer to home.

14. Already a pioneer in integrated care, we will build on our foundation as an education and training provider of choice in London. We will continue to collaborate with commissioners, social care, Local Education and Training Board, GPs and other healthcare providers to develop new and innovative ways to train tomorrow's doctors and nurses.

15. We have made progress in building a secure platform from which to progress our vision to transform the healthcare we provide for our patients.

    - We are collecting and using better information to help us design and then target our services. We have, for example, begun to build a greater understanding of those patients at the highest risk and who make the most use of our services. This will help us to direct our resources and our new models of care towards the right patients at the right time in the right way

    - We are building strong relationships with partner organisations. Each of the previous organisations that came together to form Whittington Health had their own pre-existing relationships with commissioners, GPs and local authorities. In consolidating as one organisation we are able to work with our commissioners to develop uniform services to reduce health inequalities

    - Information flows and communication are improving, in turn supporting better co-ordination of care. A new electronic health record system is being implemented in The Whittington Hospital in August 2013. It will be rolled out to community services in October 2014. The new IT system will incorporate a dedicated portal providing GPs with immediate access to patients' hospital records. The system will also interface with the social care system, improving information sharing across organisations

    - Our relationship with GPs continues to improve. Dr Greg Battle, Medical Director for Integrated Care and a local GP, provides the Trust Board with an understanding of primary care, which informs strategic decision-making and direction. This ensures that services are developed across the whole care pathway as experienced by our patients and service users

    - As a member of University College London (UCL) Partners, we are engaging in research which benefits our patients

    - We continue to work with UCL and the Middlesex University to train future healthcare professionals. We are developing new training and education programmes on the delivery of integrated care

16. The plans below describe in more detail what we will do. They set out how we will achieve the triple aims of improved health outcomes, lower total healthcare costs and enhanced patient experience.

We have a way to go ..... but we can already describe our goals and the likely benefits for our community of patients, service users and carers

17. We have five main goals. Each of these is described below.

Integrate models of care and pathways to meet patient needs

- Whittington Health will continue to use evidence and research to develop new models of care and pathways that will deliver higher quality, better outcomes and a more financially sustainable position

- Care will only be provided in hospital when it is shown to be clinically appropriate and in the best interests of patients. This means that some services that are currently provided in hospital will be provided by our staff in the community, including patients' homes

- Patients with long term conditions and other high risk patient groups, such as frail older people, make up the majority of emergency admissions. Better care coordination for these key groups will reduce avoidable emergency admissions and acute readmissions

- As an integrated health and care organisation, we will continue to work in partnership with social care to develop pooled budgets to facilitate the integration of intermediate care and reablement services

The achievement of this goal will have measurable beneficial outcomes for our local population:

- Patients and service users will find the care they receive over time becomes more seamless and better co-ordinated. Care will be organised around their needs and not around the premises in which it is provided or the convenience of those providing it

- Community specialist teams and improved technology will reduce the number of times patients and service users are transferred between services and carers, thereby improving the efficiency of care provision

- Our patients, service users and carers will become better informed and, supported by our staff, be able to take part in decisions about their own care and manage their own conditions and treatment

Deliver efficient, affordable and effective services and pathways that improve outcomes

- Whittington Health is implementing more efficient pathways and services. Our plans reflect an evolution in services, workforce and skills mix, hospital wards, technology and our most important partnerships to achieve this

- This means, for an example, a particular focus on redesigning our urgent and emergency care pathways to ensure patients receive care in hospital only when clinically necessary

- We are expanding our successful Enhanced Recovery Programme which helps patients get better sooner. Patients will be encouraged to eat and drink and stay mobile while in hospital and be discharged as soon as they are fit to do so

- Our new Ambulatory Care Centre, located next to our Emergency Department will provide urgent and emergency care in an outpatient setting and avoid unnecessary admissions. For those who require additional support, our district nurses and 'hospital at home' service can provide care in the home or community settings

The achievement of this goal will have measurable beneficial outcomes for our local population:

- The number of avoidable hospital admissions will reduce. Patients will experience shorter length of stay and more day surgery which are better for patients

- Patient Pathway Co-ordinators will co-ordinate the care activities for individual patients with multiple or complex conditions

- A sustainable financial position will enable Whittington Health to re-invest savings in new services, staff and facilities

Ensure "no decision about me without me" through excellent patient and community engagement

- Patients, service users and carers want better communication, access to information and to be involved in decisions about their care. Our ambition is to embed shared decision-making into all our patient facing systems and processes

- Our interactive website 'WH Direct' will provide real time information about our full range of services including waiting times in our Emergency Department and clinics

- 'My WH', our patient portal, due in 2014, will provide on-line access to personal electronic health records. This will enable people to play a more active role in managing their own health. The self-service portal will allow patients and carers to choose and book appointments, view and file letters and test results, and to communicate directly with their health care professionals in a secure and confidential way

- We will further provide patient education and self-management programmes. This will include mobile applications to support people to manage their conditions and self help groups

The achievement of this goal will have measurable beneficial outcomes for our local population:

- With the right information shared in the right way, people with long term conditions will be better placed to manage their treatments with improved support, information and easier access

- Outcomes and patient experience will improve as our staff develop the skills and behaviours to engage more effectively with patients, service users and carers

- Access to information will be improved significantly, for example through the launch of easier to use patient-focused websites and portals, providing relevant information 24/7

Improving the health and well-being of local people

- Whittington Health is committed to supporting a reduction in health inequalities which exist within our local populations. We have a key role to play in reducing premature deaths

- We already provide a wide range of services in the community to keep people healthy and, wherever possible, out of hospital. This ranges from preventive services such as smoking cessation, health visiting and school nursing, sexual health to care provision such as community nursing, therapy services, podiatry, dentistry, paediatrics, audiology, substance misuse, learning disability and wheelchair services

- Our award winning services which are leaders in their fields include, for instance, the Michael Palin Centre for stammering children and Simmons House, a Tier 4 Child and Adolescent Mental Health in-patient unit

- We are working closely with our Clinical Commissioning Groups, social care and third sector organisations to develop supported living schemes, making use of telehealth and rapid response teams. We will continue to play an active role in the Transformation Board and Health and Wellbeing Boards

- The establishment of Academic Health Service Networks enables Whittington Health to work with UCLPartners' members to ensure the rapid introduction and diffusion of innovations and best practice. Combining with our own research and academic strengths will help begin to reduce health inequality across our communities

- We want to encourage people to take greater individual responsibility for their own health and well-being. We can help our communities to do this by endeavouring to use every interaction with our patients and service users to promote health

The achievement of this goal will have measurable beneficial outcomes for our local population:

- Increased participation and involvement in preventive services will improve population health and well-being, thereby reducing health inequalities in our local communities

Change the way we work by building a culture of education, innovation, partnership and continuous improvement

- Whittington Health is a leader in the development of integrated care. To maintain our high profile reputation for quality of care and education, the trust will need to become more flexible, creative and able to deliver more rapid implementation of innovation and change

Examples of how we will continue to transform to support our plans include:

- The creation of an integrated paper free digital organisation by 2015 that provides secure access to relevant real time information

- Strengthening our relationships with strategic partners such as councils, GPs, neighbouring trusts, UCLPartners, our Local Education Training Board and Clinical Commissioning Groups. We also plan to step up our current collaborations with the voluntary and third sectors, including for instance with Marie Curie

The strength of our partnerships will be crucial if Whittington Health is to lead collaborative delivery of a successful integrated care model in an increasingly competitive environment. For example:

    - While the great majority of our community service users are from Islington and Haringey, we also provide services in Camden, Barnet and Enfield. Our strategy is to strengthen our services in our current core markets and then grow our community services into and for the benefit of other areas as opportunities arise

    - GPs, as healthcare providers and commissioners of services, are critical operational partners

    - We already collaborate with other NHS providers such as University College London Hospitals (UCLH), Royal Free, Great Ormond Street, Camden and Islington, and Barnet, Enfield and Haringey, to provide specialist medical, surgical and specialty care including maternity, paediatrics and mental health, and also

some back office functions. Further extending these partnerships will give us resilience and flexibility where scale is required

- We continue to work closely with UCL and Middlesex University to build on our excellent reputation as a provider of high quality education and training for a range of healthcare professions. The closure of Archway campus has resulted in the education facilities on the site being reprovided at the Whittington Hospital site. We are developing an education strategy that will see Whittington Health developing innovative education programmes including in partnership with GPs

The achievement of this goal will have the following beneficial outcomes for our local population:

- There will be a more rapid diffusion of innovation by an educated informed workforce, supported by high quality education and as part of a leading Academic Health Science Centre / Network

- Patients and service users will have the opportunity to participate in research and in the design and development of new models of care

- Whittington Health will maintain operational flexibility to meet changes in the future healthcare needs of our local communities and those who purchase services on their behalf

18. As we achieve each of our five goals we will deliver our overall vision with our communities. If we can demonstrate that we have the skills together with the support of our community, commissioners and partners, Whittington Health will be ready to become an NHS foundation trust. We will then have the opportunity to deliver these plans together.

As we progress how will service user experience change?

19. We have described above what we are going to do to deliver each of our five strategic goals and, at a high level, how this will benefit our communities, our patients, users of our services and carers. But what will this really mean for individual users of each of our services?

20. In more practical terms, our plans will mean:

- Services will be better integrated around the needs of patients and communities, with more care and support provided in the home, the community and intermediate care settings. This will reduce the number of patients who currently face unnecessarily visits or admissions to hospital

- Along with our partners and following a successful pilot in North East Haringey, specialist community teams are ensuring proactive care and better support for patients, in particular, those with long term conditions.

This is in line with plans published by Clinical Commissioning Groups in both Haringey and Islington

The progressive development of our Enhanced Recovery care model will transform the way in which patients are treated, so that:

- Patients who attend the Emergency Department will be assessed and treated quickly, and where clinically appropriate, helped to return home the same day, avoiding unnecessary hospital admission

- When patients need to be admitted, they will be helped to stay more mobile, and to keep eating and drinking. This will help them recover quicker from illness and spend less time in hospital

- On discharge, more joined up support, where appropriate in partnership with others, will be provided for patients who need ongoing care

- Our workforce will be transformed, breaking down barriers between traditional acute and community services. We will encourage and support staff to work around the needs of patients rather than buildings and historical structures, at the same time ensuring a culture of innovation, learning and continuous improvement

- A £7m investment in Electronic Health Records will enable the Trust to embrace Digital First, the national strategy for using technology to transform care. Patient and GP dedicated websites or portals, and an increased use of remote access, including telehealth and telecare will promote independence and improve convenience for patients

- An ongoing programme of capital investment will enable us to offer better facilities or patients, service users and staff. A new £3m Ambulatory Care Centre is due to open winter 2013. We have also set aside £10m to improve the quality of our maternity facilities

- Financial sustainability and security will be achieved as we attract new business from having a reputation as a leading edge and innovative integrated care organisation

21. But perhaps most importantly for people who uses specific services, what changes and improvements can they expect to find? Some specific case related examples are described at the end of this paper.

22. We have described below just some of the care pathways which will be transformed as a result of these plans and some of the likely implications for the users of those services. Our detailed plans for these and other services continue to be developed and these will be available in December 2013.

Enhanced Recovery Programme

Our Enhanced Recovery Programme is transforming how patients are treated across the organisation. This evidence based programme is at the core of our plans.

The historic route was for patients to arrive at the Emergency Department and to then go through a diagnostic process, the end of which was to be admitted or discharged. If admitted, the patient would be treated and then wait to be discharged. Once discharged, in most cases, routine follow up would occur irrespective of actual need. For those with long term or multiple conditions this process would occur regularly.

The Enhanced Recovery Programme treats each patient as active participants in their recovery. Where possible, patients will be treated in our Ambulatory Care Centre and will not need to spend the night in hospital. For those who do need to stay in, they will be helped to eat and drink as well as keep moving while in hospital, which will speed up recovery. The result of the programme is:

- Patients and service users feeling that they are at the centre of decisions about their treatment
- Increased opportunity for them and their carers to discuss their treatment with healthcare professionals
- Avoidance of unnecessary admissions to hospital
- Discharge from hospital with support if required
- Seamless transition across organisations and services

In summary, in the future, our services will look and feel very different:

- Our Urgent Care Centre will continue to provide rapid assessment and treatment for patients with urgent primary care needs and minor injuries

- The Ambulatory Care Centre will provide ‘Home on the same day’ to those people for whom it is suitable. Doctors will diagnose and initiate treatment that can be continued at home, with support if needed from the ‘hospital at home’ team of nurses and therapists. This team will also enable in-patients to return home as early as possible, reducing length of stay and improving the patient experience

- Sick patients requiring emergency care will continue to be treated in the Emergency Department

- The majority of patients undergoing planned investigations and surgery will be efficiently treated in our state of the art Diagnostic and Treatment Centre, where day surgery will be the norm

- Patients will be provided with comprehensive aftercare information and support, including how to make contact with their attending consultant or nurse on discharge

- All patients will receive Enhanced Recovery care packages that have already been implemented successfully in surgical patients and shown to help patients get better sooner. Patients are able to return home and resume full activity quicker after episodes of acute illness

- Deteriorating patients will be cared for in the intensive care unit or in appropriate wards by the critical care outreach team. Continued innovation will ensure we retain our position as one of the safest hospitals, building on Whittington Health's consistent performance with one of the lowest Summary Hospital-level Mortality Indicator (SHMI) in the UK over the last two years

- Following an out-patient consultation or an acute care episode, some patients may need a follow-up appointment. Unless a face-to-face review is requested, patients will be offered as an alternative a choice of telephone, Skype or e-consultation, implementing the NHS' 'digital first' strategy

- For children who attend A&E, 'home on the same day' care will be the model of care whenever possible. Our plans build on the success of the single point of access to our children's services by improving access to acute paediatricians in the community and developing our links with neighbouring providers

- Our health visitors, nurses, therapists and paediatricians work together with schools and children's social services to support and safeguard vulnerable children. Sick children will be looked after as close to home as possible

Long term conditions

Patients with long term conditions such as diabetes, respiratory diseases (COPD), heart failure or chronic pain encounter frequent visits to hospital and regular readmissions for treatment and then follow-up procedures. This may not be in the best interest of patients or what the patient wants. It is also not an effective use of resources.

Better integrated care planning will ensure that these patients will:

- Have access to community based specialist teams who can support them in their own home wherever possible

- Receive personalised care plans as part of our 'Co-creating Health' model that reflects their preferences in relation to the management of their conditions

- Have access to our online portal ‘My WH’ which will allow individuals to:
    - View their personal healthcare records including their care plan
    - Choose and book appointments, view and file letters and test results
    - Access other information relevant to their conditions
    - Communicate with their carers and healthcare professionals in a secure digital environment

- Where appropriate patients will be supported to manage and monitor their condition at home with telehealth and telecare, thereby reducing the need for frequent out-patient follow-ups. Some patients will be able to receive chemotherapy, blood transfusions and other treatments at home rather than having to come to hospital

- Higher risk groups including frail older people and patients with complicated or multiple conditions will be allocated a named care co-ordinator who will be responsible for organising all aspects of their care. The care co-ordinator will be a member of the local Integrated primary care teams

- Patients in these groups will benefit from closer working between our staff and social care, who will provide a rapid response and reablement service at or close to home

Out-patient services

Some of our patients have complained about the apparent absence of co-ordination in out-patient care. Others have expressed frustrations with administrative processes which get in the way of a good experience.

We are implementing changes that will improve access and reduce the time patients spend in out-patients. This will reduce anxiety, improve patient experience and ensure the right treatment is provided in the right place.

Our plans include:

- Centralising receptions in order to improve patient experience on arrival. This will reduce duplication between clinics, increase staffing efficiency and stream patient activity more appropriately

- Integrating health records and clinic preparation functions within the main records library with the aim of improving workflow

- Establishing a central booking function and thereby integrating admissions, appointments and clinical activities

- Implementing a transcription model for the production of routine clinical letters that will be administered centrally. This will free up the Patient Pathway Co-ordination team to provide navigation and specialty administrative support

Maternity and children's services

Caring for women and families during pregnancy and in the early years for their children continue to be core services at Whittington Health.

Whilst Whittington Health has a long tradition of providing high quality maternity services, most of the facilities suffer from sub-standard premises and a historic lack of investment.

We have already committed £10m over the next five years to upgrade the existing maternity facilities. We have an example of what is possible in the modern birthing centre. With the local population projected to grow, we are in discussion with Islington and Haringey Clinical Commissioning Groups to develop a business case for a further £10m investment to increase the capacity of our maternity and neonatal units beyond the current 4,000 births per year.

In addition to the proposed significant investment in premises, we are also planning for further investment in:

- health visiting services - to provide high quality support in early years, which is proven to improve the long term outcomes of both children and expectant mothers. Our plans are to develop a more integrated service focused on the needs of the women and children we look after, supported by training and information

- enabling every woman to have a named midwife who will ensure the provision of personalised, one-to-one care throughout pregnancy, childbirth and the post natal period

Other examples of service developments

In addition to the changes above, we are also planning other improvements and enhancements in our services. These plans align with the main objectives and goals of our commissioners and also the future healthcare needs of our communities.

Our other service plans include:

- Delivering community based public health interventions. The development of our public healthcare services builds on the work we are undertaking to improve our profiling (age, ethnicity, smoking, drinking, obesity and exercise rates) and analysis of health risks in our community

  Examples of this include:
  - Training offered to front-line staff to provide smoking cessation advice to at least level 1 standard

- Staff such as health visitors, district nurses, dieticians and those who care for people with long term conditions who have increased interactions with the public are offered training to at least level 2 standard
- Management and development of our other public health and community activities such as our Stop Smoking Service in Islington
- Screening all adult patients who attend our Emergency Department and Urgent Care Centre for signs of alcohol misuse

- Integration of our gynaecology and sexual health services to develop a co-ordinated and accessible model of care which provides services to women in the right place and at the right time

As our services transform .... so will the skills, training and numbers of the people we need to deliver them

23. We have reflected on the comments and concerns we received about the future numbers and skills-mix of our workforce. We will continue to build our plans to support the delivery of improved services for our patients, service users and carers.

24. As with all NHS organisations, we continue to look carefully at how we can enhance the productivity of our workforce to provide services more efficiently. At the same time we are very conscious of the findings and recommendations from Robert Francis' inquiry at Mid Staffordshire. As funding remains flat and demand for our services and our costs continue to grow, we need to be more productive to remain financially stable. Other NHS organisations are making similar improvements in efficiency and if Whittington Health fails to take these tough decisions we will be left behind.

25. Any changes to numbers of staff, skill mix or roles will always be based on clinically led redesign of the services we provide. Patient safety remains paramount. But what is clear is that the changes in the services described will only deliver the full benefit to our patients and service users if the training, behaviour and skills of our staff also evolve at the same pace.

26. We employ about 3,800 whole time equivalent permanent and bank staff, together with an additional 160 agency staff. The total cost this year is £190m, or 70% of our total revenues. As we become better at providing services in the right location, and support this with information, technology and training, we can be both more productive and deliver better outcomes. Our detailed workforce plans will be developed alongside our service plans and will be available in December.

27. The service transformations will have a significant impact on our staff and skills-mix requirements. We won't make any changes to our staff which compromise the quality of care. Fewer, more complex cases will be cared for in hospital by a smaller number of highly skilled staff. But as wards remain open so we will retain the number and ratio of staff necessary to continue to provide the same high quality care. We will, however, increase the care and

support we provide in the community, with the creation of new roles with a range of skills to treat and support patients out of hospital.

28. Along with the development of our integrated care model will be a continuing emphasis on and investment in training and education, information, technology and innovation to enable improvements in productivity.

29. Whittington Health provides high quality care but we aim to become a great organisation in all we do. These plans will present challenges to ensure we attract and retain the right people with the skills to transform our healthcare delivery within a changing environment. We will support the development of our staff to provide them with the skills necessary to meet these challenges and excel.

30. To move from good to great takes energy, passion, motivation and drive from staff, supported by investment, incentivisation, innovation and proportionate and informed risk taking. Inspirational leadership and staff engagement throughout the organisation are paramount and these will be the key drivers of our continued success. We are taking immediate action to engage more closely with our staff to understand the support and inspiration they need to deliver excellent outcomes.

As our services transform .... so will the premises from which they will be delivered

31. In February 2013 we shared an estates strategy which envisaged the sale of some premises currently either unoccupied or potentially unsuited to the future services we will offer at Whittington Health. It was intended that the funds from the sale of those premises would be reinvested to upgrade our existing facilities or to provide improved replacement facilities.

32. As a result of concerns expressed by a significant number of local residents and other stakeholders we have rethought those plans. The revised principle which underpins our estates plan is that we will only progress with any disposals in consultation with the community and only then when:

    - The property isn't likely to be needed for our current or foreseeable future services

    - Any proceeds are necessary to ensure that we can reinvest in new facilities and also remain financially stable

    - The potential future or proposed alternative usage aligns with the interests of Whittington Health and our clinical commissioners

33. To this end and consistent with this principle the summary of our revised estates plans is as follows:

    - The Waterlow Building: we expect to engage imminently with Islington Council and our local community in the development of a planning brief

for this empty building. This will need to consider the council's planning policies and guidance as well as our commissioners' strategies and plans. The process of developing a planning brief will mean we will not be taking any quick decision about the disposal of this building as we will need to go through a public consultation exercise

- The Nurses Home: we will also include this site in discussions with the local authority and our local community. The cost of bringing this building up to modern standards isn't something we can afford. Higher quality accommodation is available in Sussex Way (half a mile from the hospital) for staff who wish to use it

- The Jenner Building and the Education Centre: we will now retain these premises and continue to use them

34. On 1 April 2013, Whittington Health took over the freehold or head lease of 16 properties across Islington and Haringey. We are tenants in a further 16 properties.

    - Since then the trust has been carrying out due diligence audits of compliance status. This work will be completed by the autumn and any remedial works will need to be funded by the trust on a risk assessed basis

    - A six-facet survey carried out by the trust by March 2013 established the condition of the properties, and an investment programme is under development for 2014/15

    - The trust is currently considering the range of services provided from each site and assessing how those services fit strategically with Service Development plans under development. Recommendations about the future configuration of properties will be prepared for wider consultation in 2014

What will this journey mean for the people who remain at the centre of our plans ... the patients and the communities we exist for?

35. Our plans continue to evolve and will inevitably do so throughout our journey of transformation. Our new commissioners are at the same time evolving their own strategies - affordable integrated care provided closer to home, clinically-led and focused on the users of services remain core objectives. We will continue to work with them to develop plans that will ensure the best healthcare outcomes at an affordable price. If we do that successfully, Whittington Health will in due course become an NHS foundation trust and we will then have the opportunity to work in partnership with others to lead delivery of our plans.

36. Finally, we would like to share some examples of how a multi-disciplinary, cross-organisational approach works. These examples (not their real names) will be multiplied many times over in the future if Whittington Health, with the

support of our communities, has the opportunity to complete the journey we have started.

- Marta is a 52 year old lady with cerebral palsy, reduced pituitary function, asthma, rheumatoid arthritis and an ileostomy. She needs to take medication six times a day. Prior to being referred to Whittington Health's Community Matron Sue, Marta had just been assessed as being eligible for continuing care (as she was unable to measure out her medication) which would have resulted in what little control she had over her life being taken away.

  Sue is familiar with Marta's medical and social history. She discussed the issues of Marta's care with Whittington Health's pharmacist in the community. Together, they devised a flag system for use within the Emergency Department at the Whittington Hospital. The system alerts Sue every time Marta presents in the department. If an admission is not required, Sue will arrange for appropriate support to be provided to allow Marta to remain independent and at home. Integrated working across hospital and community co-ordinated by one person, in this case the community matron, has enabled much better care and at reduced costs, which would not have been possible otherwise.

- Community matrons like Sue have been working closely with hospital colleagues to set up a virtual ward within our ambulatory care service. The virtual ward allows some patients to go home a day or two earlier or avoid hospital admission altogether, secure in the knowledge that they are still being monitored by Whittington Health staff. Virtual ward 'stays' can last anything from 24 hours to 12 weeks.

  How the virtual ward works can be seen in the case of Joy, a patient with a pre-existing neurological condition who had had a fall. Although her diagnostic scans in the Emergency Department were clear, there was a risk of further deterioration and it is usual for such patients to be admitted for 24 to 48 hour observation on the ward.

  Instead, Joy was discharged back to her own home and Sue, a community matron who first saw Joy in the Emergency Department, visited her at home the following day and again at 48 hours post discharge. With follow-up care, Sue was able to allay any concerns Joy or her family might have had about early discharge, thereby allowing her to return home which was what Joy wanted. Being in her own home not only helped Joy to recover quicker but also freed up valuable resources within the hospital. Joy's experience shows how a joined up approach (in-reach into hospitals and out of hospital care) can enable earlier discharge.

- Alice is a 95 year old lady who was referred to the Pharmacy Reablement Team due to concerns about her poor compliance with medications.

  Whittington Health's lead pharmacist for Care of Older People, Jyoti, first raised the case of Alice at the weekly West Haringey Integrated Care Teleconference. A teleconference will involve a multidisciplinary team of healthcare professionals who included Alice's GP, a consultant geriatrician, Haringey Social Services and a community matron. During the teleconference it became clearer that Alice had been prescribed too many medicines, some of which may not be beneficial to her overall care and should be stopped. The teleconference also agreed that a community matron should visit Alice and discuss with her why it is important for her to take the remaining medications. The community matron's visit provided Alice with the opportunity to discuss each of her medicines in detail with a healthcare professional. Understanding how she can better look after herself has now ensured Alice's ongoing medication compliance, with ensuing improvements in her well-being. Alice's experience shows the impact of a joined up, collaborative patient-focused approach, with empowerment through information and the benefits of care provided in the home.

- Our community Muscular Skeletal Chronic Pain clinic adopt a multi-disciplinary approach to the management of chronic pain. The clinic has physiotherapists, a psychologist and a hospital pharmacist, all in one place. Having all three expertises on site facilitates better diagnosis and treatment plans.

  Jim was a patient who had been treated by the chronic pain service. Following a road traffic accident, Jim experienced ongoing chronic pain with neurological symptoms which was affecting his sleep. He was at the time also facing other personal and business-related challenges. When he first presented at the clinic, the team discovered that his original prescriptions were at a sub-therapeutic (too low) level while also giving him adverse side-effects. The physiotherapists, psychologist and pharmacist worked together to devise a treatment plan for Jim. The physiotherapist taught Jim exercises that he could carry out at home to improve his condition. The psychologist helped Jim to understand the nature of chronic pain and what he can do to control his pain. The hospital pharmacist reviewed Jim's medications and was able to recommend to his GP that they should be changed to alternatives that improved his pain management with no side effects. The holistic approach to chronic pain would have been difficult without the integrated approach between our hospital and our community clinics.

37. In conclusion this paper sets out to articulate our clinical strategy as an integrated care organisation. We hope it builds a compelling case on care

closer to home, an ambition we share with our clinical commissioners and social care, who will have to consider its implications. We need to work with them and our stakeholders and local communities to realise this strategy. Its success will enable Whittington Health to continue to play a pivotal role in the transformation of the local NHS for the future.

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