Whittington Health NHS

Our Clinical Strategy 2015-2020

"Helping local people live longer, healthier lives"

Contents

foreword

Welcome to Whittington Health's clinical strategy 2015 to 2020. We are proud of our successful track record in serving patients and carers.

This Strategy demonstrates our ambition for the future and provides a framework of how the Trust will retain its exceptionally strong reputation by continuing to be patient focused, clinically led and high achieving.

Whittington Health embarked on an exciting journey in 2011 to improve patient safety and experience, by joining up community and hospital care, when it became one of the first in the country to be established as an Integrated Care Organisation. The journey continues with many areas of excellent service integration successfully embedded across Islington, Haringey and parts of Enfield, Hackney and Camden. These services are designing innovative pathways that are providing modern, safe and high-quality care to patients and carers.

Our aim is to treat patients as closely to home as possible and where it is appropriate. Examples include our pioneering Ambulatory Care service and our Hospital at Home service that is providing care at home for children and young people.

We are also at the forefront of delivering high-quality specialised care. Whittington Health is the lead provider of the new co-ordinated TB

service for North Central London; established in partnership with UCLH.

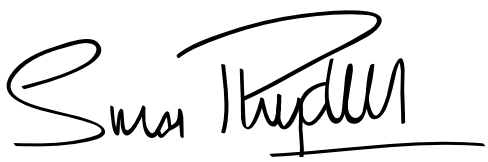
We have well-respected and innovative clinicians who are developing integrated pathways that are now providing improved joined-up care for patients.

Examples include our Heart Failure pathway, incorporating one-stop Rapid Access Heart Function clinics, and our Integrated Respiratory Pathway that has been nationally recognised by the King's Fund.

This Clinical Strategy is the result of engagement with internal and external stakeholders and we would like to sincerely thank everyone for their valuable support and help. The implementation of this Strategy will lead to a strong culture of clinical leadership to ensure we provide safe, personal, co-ordinated care for the community we serve.

Our vision for the next five years will build on the work we are already doing. We are proud to present our aspirations in this Strategy but we are not complacent and recognise there is much hard work ahead.

The genuine ambition and enthusiasm of all the staff, volunteers and stakeholders who have taken the Trust this far will make this Strategy come to life to help local people live longer, healthier lives.



Simon Pleydell
Chief Executive

Steve Hitchins
Chairman

1. our strategy

Our Clinical Strategy provides a framework and direction for the organisation to be a national leader in delivering safe, integrated care to our local community.

The strategy has been developed with staff and stakeholders to meet the challenges our community and the local health economy face over the next five years. It outlines our ambition as an integrated care provider, a 21st century provider of innovative community and hospital services.

Whittington Health has an excellent reputation for being innovative, responsive and flexible to the changing clinical needs of the local population. Our clinicians are encouraged to continuously evaluate their services and to adopt new ways of working across established boundaries in pursuit of improved outcomes.

Our relationship with our community and local partners is important to us. Whittington Health is a community asset. We are a key part of our community as they are to us; not only as a local health provider but also as an employer.

Over the next five years we will continue to strengthen our partnerships with mental health, social care and primary care services, alongside our other multi-agency partners to deliver our mission and vision and improve the health and outcomes for our local community.

This document provides the detailed thinking underpinning our mission and our vision, followed by six strategic goals. A number of principles are outlined which will support delivery of the goals. Our approach to delivering care focused on five population groups is described.

2. our mission

Our mission recognises that there are many determinants of health, not all of them within our remit to deliver. However, for us to support people to achieve this goal, we all agree that the most successful model will be local partnership working with a range of agencies.

Our locality has a long and strong history of joint working, which we will continue to develop. We recognise a need for a greater emphasis on prevention which will require a change of focus towards promoting health and wellbeing.

With the requirement to become a leader in prevention as well as treatment, we will need to look beyond traditional pathways of delivering care.

"Helping local people live longer, healthier lives"

3. our vision

"Provide safe, personal, co-ordinated care for the community we serve"

The mission statement describes the 'What', the Vision is the 'How'. Each word of our vision has been carefully chosen.

'Provide' distinguishes us as a provider first and foremost. However we may also commission services from others. We will ensure that relationships with local providers are strengthened to deliver improved patient experience and outcomes, for example, working with GP providers in our urgent care model.

'Safe' care requires constant attention and re-emphasis. The best health care organisations recognise the importance of an explicit safety agenda and we will ensure safety is a priority in every encounter we have.

'Personal' keeps the individual as a unique whole in our minds, and reminds clinicians that while guidelines and patient pathways are

aids to care they are NOT the rationale of care. In our personal encounters, we must allow compassion and judgement their proper place.

'Personal' also encompasses the opportunity to encourage supported self-management and to be sensitive to the new ways people increasingly want to engage, for example via technological advancements.

'Co-ordinated care' restates a key element of integrated care. We face multimorbidity in a population with increasingly complex needs. People require help in navigating the system. We will ensure their care is co-ordinated and not fragmented. The emphasis on health and wellbeing means that we will actively engage with all key providers involved in the care of our population.

'Communities we serve' - Whittington Health's acute patients come in large part (85%) from the boroughs of Islington and Haringey. Most of our community-based services are provided to these two boroughs, with some covering the boroughs of Camden, Hackney and Enfield.

These communities are vibrant, complex and multi-ethnic, and include considerable wealth and deprivation side by side. They provide the sorts of challenges that attract our staff.

As an organisation, we have opportunities to work in a wider geographical area where this makes sense for our communities and clinical pathways. We are deeply rooted in these communities as provider and employer. We have established and developing relationships with public, private and voluntary sector partners, and building long term relationships has been, and is, key to our strategy.

Our mission and vision will remain relevant, we believe, for the next five years and beyond.

4. strategic goals

Our Clinical Strategy will be delivered through achieving six key strategic goals.

4.1 To secure the best possible health and wellbeing for all our community.

We will ensure that everyone who has contact with our services will receive holistic care. Our focus will be on the treatment of illness, and also prevention and health promotion. We will develop a health promoting menu for all our staff to use in contact with service users, incorporating guidance and information that supports patient empowerment.

We will continue to work closely with our local authorities in both Haringey and Islington to respond to the joint strategic needs assessments. In particular this will involve closer working with public health.

Local voluntary organisations have a great role to play in contributing to health and wellbeing and preventing illness. We already engage with voluntary sector providers for certain care pathways and over the next five years our intention is to further develop these relationships. We will encourage clinical teams to build relationships with relevant voluntary sector organisations as part of integrating care.

To maximise the combined impact of integrated care on health and wellbeing we will become system leaders with our partners.

Each department and team will consider its role in preventing or reducing smoking, alcohol consumption, obesity and mental illness. Teams will focus on prevention in their specific area, for example, district nursing and prevention of pressure ulcers; orthopaedic team and prevention of accidents or falls; and midwives and health visitors and the prevention of perinatal mental illness.

Integrated care case study

Mr A was a new resident at a local nursing home and was reviewed after admission by a consultant from the integrated community ageing team (ICAT) for a comprehensive geriatric assessment.

Concerns were identified about this frail, elderly gentleman with long term conditions. ICAT liaised with the local mental health team and his GP to review his specialist care and medication.

A few weeks later he was admitted to Whittington hospital with an acute illness.

ICAT reviewed him the same day and liaised with the surgical team to enable a timely discharge.

ICAT continue to visit the nursing home once a month and provide ongoing support to Mr A and his GP.

NB: This photograph does not feature the case study contributors.

4.2 To integrate/co-ordinate care in person-centred teams

Within the organisation we will foster greater multidisciplinary team (MDT) working around the needs of the patients/clients we serve.

We will further refine patient pathways to minimise duplication and fragmentation. Our infrastructure and administration systems will need to be aligned to enable MDTs to deliver patient centred care.

Across Haringey and Islington there are eight localities within which we will work as part of MDTs - with GPs, social care, mental health services, the voluntary sector, and other secondary care providers.

We will share our approach to risk assessment, case management and care coordination. We will use technologies to support the development of new models of care.

We recognise that primary care has a unique role to play in integrated care. General practitioners are rooted in their communities, have a defined population to whom they offer continuity, and are usually patients' first contact with health services.

We will support our local GP practices to provide the best integrated care by directly providing primary care through our Hanley Road practice, working as partners in localities, and offering support and advice to individual and local groups of practices on a tailored basis.

Where there is a direct interface with GPs we will provide a named lead clinician who will act as a contact for support, advice and navigation for each of the localities in which we provide services. This will enable us to strengthen the relationship within each locality.

Multi-disciplinary care case study

These are the words of an 87 year old man admitted to Whittington Hospital with acute confusion, sepsis, and severe heart failure in 2007. His well-being during his treatment reflects his engagement, family support and effective integrated care at its best. The multi-disciplinary team (MDT) included his GP, the heart failure nurse specialist, the cardiac rehabilitation team and the cardiologist.

"By the time I was discharged from hospital, I knew I had received top rate medical and nursing treatment, but I also knew that some of my self-confidence had been shaken. I was unsure how far I could tax my post-failure heart. I had heard of the cardio-rehab programme, but I had no idea of what it entailed. It turned out to be the clincher. I was over-awed with the twice weekly two and a half hour sessions. In practice this meant a solid one hour's exercise, under Sharon's expert supervision. It provided a level of exercise against which I could measure how far I should push myself physically. This was enormously valuable, otherwise one would have felt in limbo with no guidelines or pointers to risk areas.

I am quite sure that without rehab I might easily have slipped into inactive depression, unsure what my next move should be."

Last year this patient celebrated his 94th birthday with his family during a trip to South America; evidence of the high quality of life he has and continues to enjoy since the excellent multi-disciplinary team's care and treatment.

NB: This photograph does not feature the case study contributors.

4.3 To deliver consistent high quality, safe services

We will build on our record of providing high quality and safe care. All clinicians strive to deliver the safest care of the highest quality – 'right first time, every time' – and a patient experience that exceeds expectations.

These key themes will continue to run throughout all our work. Moreover, the quality agenda must become embedded in the culture of every intervention both individually and within all clinical pathways.

We recognise that quality incorporates three key elements: clinical effectiveness, patient safety and patient experience.

Clinical effectiveness can be defined as the extent to which specific clinical interventions achieve what they are intended to achieve. Decisions to develop and provide services should be driven by evidence of both clinical and cost effectiveness. In practice, clinical effectiveness is about developing and delivering high quality care. Ideally, this should involve using the best available research evidence, together with clinical expertise and patient involvement. Where there is a limited evidence base, clinical effectiveness can be achieved through benchmarking, audit, and continuous improvement based on identifying and sharing good practice.

Regarding patient safety, our ambition is to deliver Zero Avoidable Harm. We will be at the forefront of the national Patient Safety Initiative 'Sign up to Safety'. We will reaffirm

our commitment to patient safety and aspire to be among the safest organisations in the NHS.

We will continuously improve patient experience. We will continue to refine our methods of obtaining feedback from patients and carers, shadow governors and others. We will seek to learn from that feedback. This will directly influence our plans for quality improvement and service development.

In driving improvements in quality we will continue to improve service delivery in the five core domains identified by the Care Quality Commission. We will ensure that our services are safe, effective, caring, responsive and well led.

Patient centred care case study

"Having a life threatening illness was something I never considered would happen to me.

I thought I was fit and healthy until I found a lump in my breast. I made an appointment with my GP and was referred to Whittington. The hospital propelled me through the system, not as a number or as a patient, but as a person. I was 27 years old and was diagnosed with breast cancer.

The day I was diagnosed, I had a specialist nurse comforting me and a consultant assuring me that everything would be ok. Tests happened really quickly and the medical team were amazing.

I had all my main treatment; chemotherapy, herceptin and surgery at Whittington with other appointments such as fertility treatment at specialist hospitals I booked a holiday around the time radiotherapy was due to start and my treatment plan was changed. The appointments were arranged for when it was convenient for me and this flexibility enabled me to have a normal life."

NB: This photograph does not feature the case study contributors.

4.4 To support our patients /Users in being active partners in their care

"Patients want to be listened to, to get good explanations from professionals, to get their questions answered, to share in decisions and to be treated with empathy and compassion."

National Voices' (2011) 'What patients want from integration'

Whittington Health has been a leader in developing patient centred approaches to care through our initial engagement in 'Co-creating health' in adult services, self-management programmes and approaches to patient and clinician activation. We have been part of the 'Better Conversations' initiative in our children's services. We will continue to embed these approaches in all our care pathways and take this to the next level by supporting all our users to be active partners in their care and in optimising their health and wellbeing. This will involve patients and clinicians in a culture change that will mean that every contact will equip people to play a greater role in managing their health and illness.

The evidence is increasing that 'supported self-management' is important in preventing deterioration in long term conditions and improving patient empowerment.

Whittington Health has been a national leader in this area and we will include the full range of patient centred approaches such as shared decision making and health literacy.

Managing care at home case study

"I went to my GP and he was worried that my baby had developed a bad cough and so sent us to A&E. When the hospital doctor looked at my son he was concerned that he was not feeding very well and was coughing a lot. He advised that we could stay overnight on the ward or stay in our own home and have support from the hospital at home nurses.

When I had the option to go home I was delighted. I felt that we would be more comfortable and relaxed at home and I could look after my other child as well. It is always scary when your child is not well but the nurses were fantastic. They came to see us every day and I could phone them if I was worried. I was not aware at first how comprehensive the service would be. The nurses kept in touch with the hospital consultant so he knew what was happening and they could decide on the treatment that my son needed; this was very reassuring. I was very confident in the care that my son received. The nurses were very knowledgeable and were able to tell me what to expect. They answered all my questions without making me feel stupid and I felt like I was fully involved in making decisions about what was happening.

I am sure that if the nurses had not kept coming to my home I would have gone back to hospital. The nurses were a link between the hospital and home and the whole experience was fantastic."

NB: This photograph does not feature the case study contributors. Photography by Jon Challicom, posed by models.

4.5 To be recognised as a leader in the fields of medical and multi-professional education, and population-based clinical research

Our ambition is to build on decades of leadership and excellence in this area at undergraduate and postgraduate level. As a key campus for UCL and Middlesex Universities we are well placed to train health care professionals of the future. We are a partner within University College London Partners (UCLP). This will enable us to deliver our vision and mission and engage and attract staff.

We have an established education strategy that has been clinically led, supported by UCLP which describes how we will deliver educational opportunities across multi professional groups.

We are the host of the local Community Provider Education Network and are currently developing education and training across disciplines to reflect the requirements of our Clinical Strategy. The success of this network has prompted a further expansion across a wider geography.

Our Clinical Strategy will be supported and enriched by a research strategy. Whittington Health is in a strong position to draw in research expertise and funds to lead in integrated care research. This will also improve staff engagement, contribute to ongoing debates about patient pathways and leverage academic interest and resources to deliver our mission.

Ambulatory care case study

A 50 year old male presented to the Emergency Department at the Whittington with multiple pulmonary embolisms (blockages of arteries) and gastric bleeding. Having previously suffered from a stroke he had significant cognitive difficulties and expressive dysphasia (disorder of speech) which made him particularly vulnerable with complex needs. He was assessed and referred for follow up by the ambulatory care centre.

A full multi-disciplinary team (MDT) review took place with a number of specialities including gastroenterology, haematology, the virtual ward community matrons, his GP and practice nurse. The aim was to centre care around the needs of this patient by co-ordinating care across both the hospital and community settings.
During his treatment, the patient was seen by Whittington virtual ward matrons in his own home and they liaised closely with the patient's GP and practice team to ensure regular treatment and monitoring. The co-ordination of care by the ambulatory care service enabled the patient to receive high quality integrated care at home, whilst attending hospital as an out-patient when appropriate. The virtual ward matrons carry out same role in a patient's home as they would if the patient was in a ward at the hospital.

Without the new ambulatory care service the patient would have had multiple lengthy admissions to hospital to receive treatment and care. The ambulatory care centre enabled the patient to remain at home whilst receiving co-ordinated between community services and the hospital.

NB: This photograph does not feature the case study contributors.

4.6 To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population

As an organisation, we have proved we innovate and constantly review and evaluate our services to meet our population's changing needs. Our organisation will need to adapt and change. Innovation will continue to be an essential part of how we develop and evolve services and our workforce.

In order to innovate successfully, quality improvement methodologies need to be a key skillset of all people delivering care.

There is an increased focus on demonstrating improved outcomes that are both patient reported and also more quantitative clinical outcomes.

We will continue to work with our commissioners as partners and respond innovatively to their outcome objectives. Initially we will work with partners to deliver improved outcomes to frail elderly people and people with long term conditions.

5. principles

To deliver the strategic goals of the organisation there are several principles that will help clinical teams develop their plans.

- Communication of who we are and what we do is important. We need to understand the needs of the local population. As clinical teams, especially where patients have ongoing care needs, we need to maintain registers that enable the coordination and management of care.
- We will further develop care planning across all clinical pathways, building on our work of enhanced recovery models and end of life care.
- Teams will need to ensure that they incorporate patient activation / empowerment/co-production in service development.
- Prevention and health promotion at every contact.
- We will deliver care in the most appropriate setting. This will allow us to be innovative in delivering patient centred working. Examples include locality working, virtual wards, multidisciplinary teams, conference calling, care at home, care in the hospital and ambulatory care.
- Clinical teams will reflect on the need to work with more specialist partners to ensure best outcomes for patients. This will continue to require close working with London-wide and national networks.
- Primary care as a partner. Clinical teams will ensure that the advice and support to general practice is readily accessible.
- Delivering high-value services. Value in health care is delivering the best outcomes efficiently and effectively within available resources.

6. population focus on delivering new models of care

We have held several workshops to consider how care will evolve over the next five years. Using a segmentation model developed by the King's Fund, the workshops focused on care of older people, people with long term conditions, and people with unplanned care needs, people with planned care needs, and women, children and families.

The following section reflects the discussions of the workshops and emergent themes and priorities. This is demonstrative of the engagement to date in considering the Clinical Strategy. It is by no means a complete and comprehensive detail of how our strategy will be delivered.

Many clinical teams and departments are not mentioned in the following five sections. Every clinical team will need to develop plans in response to the mission, vision and strategic goals.

6.1 older people

Older people are a key part of our local community whose numbers are set to increase. People over 65 currently make up about one in ten of the population of Islington and Haringey. There is a strong commitment to deliver a care model for older people that delivers improved outcomes and better patient experience.

An increasingly aging population often brings more complex clinical requirements, especially around managing discharges from hospital and community services. We will strengthen our discharge planning pathways across Whittington Health to ensure that discharges are well co-ordinated, with excellent, integrated planning around the needs of the individual.

We have a clear vision of supporting patients and their carers to be active participants in their care and self-management. We will ensure that every interaction will receive support and intervention around prevention and self-management. Anticipatory care (proactive care that anticipates the needs of patients) is a key component in helping to support people to remain independent, to avoid hospital admission, and to return to an active life after illness. IT systems will enable access all relevant data, enhancing all patient care, improving safety and reducing duplication.

To ensure that older people are managed in the best setting, we will deliver integrated care that is coordinated across the whole pathway. We will continue to develop clinical models around rapid response and intermediate care for older people. We have learnt that joint working between health and social care (e.g. our N19 project) offers considerable advantages to older people and staff. This improves the amount of time people spend supported in their homes and reduces their length of stay in hospital. We

intend to extend this way of working.

Our ambulatory care centre offers rapid intervention and has supported quicker access to care for the older population, thereby avoiding some unnecessary hosptial admissions. This model will need to be extended to ensure that urgent and emergency responses to the needs of the older people is fully integrated. The virtual ward model compliments ambulatory care by delivering fully supported specialist care in older people's homes. We intend to continuously improve and extend this model.

We are delivering an integrated community assessment team to nursing homes in Islington, advanced care planning with community geriatricians and local GPs. When hospital admission is necessary, we will strive to provide the best possible care on our 'care of the elderly' wards. Rehabilitation is a critical part of recovery and we will increase our rehabilitation capacity.

One of the key places to integrate care for older people will be within locality-based teams. We are working closely with mental health services and social care in both acute and community settings to ensure better integration of care.

Work will continue to be undertaken with advanced care planning, treatment escalation planning, working with all the relevant agencies and multidisciplinary teams, supporting the patient and their families to have the best end of life care possible.

Older people are often prescribed multiple medications. Effective Medicines Management is an essential part of providing high quality integrated care. We need to continue to work closely with GPs, community pharmacists and hospital pharmacists and other clinicians.

6.2 people with long term conditions

Many people across Haringey and Islington live with one or more long term conditions, such as diabetes, COPD, or heart failure. The number of people with one or more Long Term Condition (LTC) is predicted to rise in both boroughs.

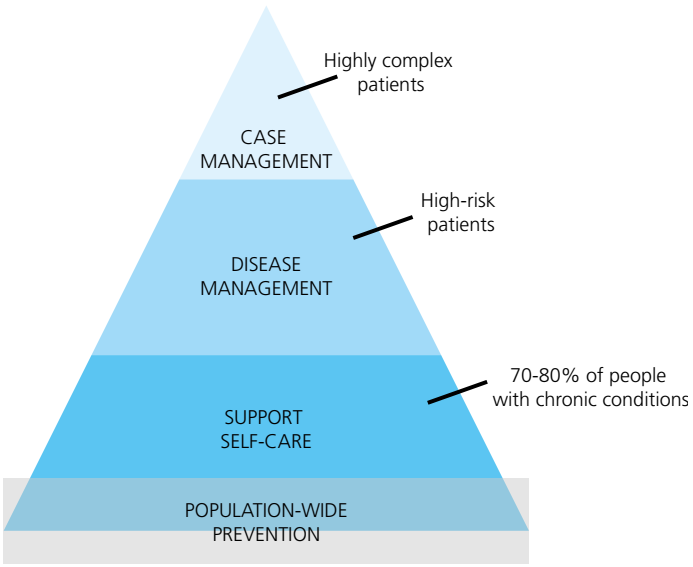
Our clinicians have been at the forefront of developing innovative and best practice models of care for this group, with work recognised nationally and across London.

We have developed a care coordination and case management approach with integrated pathways with local primary care. Some of our models use peer review and support to primary care in complex case review and clear care planning.

We will continue to embed these approaches across our medical specialities with the further development of multidisciplinary teams and new roles.

As the prevalence and complexity of patients with LTCs continues to grow, it will be become increasingly necessary to ensure that the right clinician is engaged in delivering the appropriate care to the patient.

Following the Kaiser model (see overleaf), our specialists will continue to deliver specialist services to highly complex patients with LTCs, while also working with the wider team of professionals to promote health and wellbeing.



To ensure a truly seamless and integrated model of care for people with LTCs, our locality-based teams will need to include GPs, psychology services, social care, and access to other services, such as nutrition and dietetics and speech and language therapy.

We recognise the importance of supported self-management and we will ensure that every interaction with patients with LTCs will receive support and intervention regarding relapse prevention and self-management strategies.

6.3 planned care

We will continue to strive to be the 'provider of choice' for local people for planned care.

We will ensure that it meets quality and safety standards. We will continue to streamline our pathways, coordinate care, and use the latest technology to improve access to care. We will continue to benchmark the care we provide.

Pathways will further build on our work to enhance recovery and prepare people for surgical procedures with a focus on optimising health and wellbeing before surgery.

Patients will be supported to have care as day case or ambulatory care where possible.

When a hospital stay is required, we will do our best to ensure it is for the appropriate duration.

We will ensure that when people leave hospital there will be appropriate care in place to support them at home. We will evolve our models of virtual working, with support and supervision for patients being cared for in the community.

Planned care will be delivered using 'one stop' arrangements where possible, where patients will receive diagnosis and treatment in one visit.

We will build on the models of care we have in community urology and community gynaecology, where people can be seen by specialists in community facilities closer to where they live.

We will expand our day case work in all specialties to deliver excellent care in an efficient and effective way. We will continue to develop 'straight to test' services, such as our endoscopy service, to improve the early detection of cancer.

We have a unique contribution to make in delivering a multidisciplinary approach across the whole obesity pathway from home to hospital and delivery of preventative services as well as intermediate care and specialist surgery.

To respond to the needs of our local population, we will focus our orthopaedic services on delivering exceptional joint replacement and repair. Orthopaedics also has a critical role to play in managing acute and chronic back pain.

Our orthopaedic team will deliver high quality and safe surgery where needed, with a focus on prevention and supporting people to manage their condition.

Following a diagnosis of cancer, integrated care planning is essential. We will work closely with our partners in London Cancer to support patients at every step of the pathway.

We have been nationally recognised for our work in acute oncology and will continue to strive for excellence.

By demonstrating the high value of our planned surgical pathways, we intend to grow our share of surgical work.

6.4 unplanned care

To meet the continuing demand for unplanned care will require ever closer working between providers locally and nationally.

To do this we will continue to provide the current range of emergency services and intensive care on the Whittington Hospital site.

We will guarantee high quality and safe services 24 hours a day, 7 days a week. We will respond in a timely way to individual needs and have an infrastructure that copes with peaks in demand.

We will ensure that people understand how to access our services and will work with partners to make care seamless and efficient. We will build health promotion and illness prevention into our unplanned care pathways. We will deliver innovative models of care to meet the continued rise in local demand.

Our community nursing models will need to respond to unplanned care developments in localities.

Where care requires more specialist input we will transfer patients in a timely and safe manner to a more specialist centre.

6.5 women, children and families

Whittington Health offers a wide range of services to women, children and families. We will continue to develop and integrate the excellent clinical services offered to our population.

Our maternity and neonatal services:
A core value of the maternity services within Whittington Health is to support people to have normal births where possible and to receive high quality care throughout pregnancy.

We aim to provide a range of options for local women to deliver their babies in their own home, in our midwifery-led birthing unit, or on a consultant-led labour ward.

We will build on our reputation of having caring, professional and friendly staff, and will see a significant redevelopment of our maternity and neonatal services. We have good team working and midwives who work both in the community and hospital setting. Increasingly we are building integrated working with community midwives and health visitors, alongside the family nurse partnership and PIPS (Parent Infant Psychology Service).

We plan to develop an integrated perinatal service. We will also continue our provision of complementary therapies to support pregnant women and women in labour.

Our neonatal unit is a level 2 unit which provides quality and safe care to premature babies that have been delivered at the Whittington, or elsewhere and require repatriation.

Our children's services: Our community and hospital services include some specialist community services; for example, Child and

Adolescent Mental Health Services (CAMHS), Speech and Language Therapy, and children looked after services. We also provide universal services to all children, such as health visiting and school nursing.

We are committed to continue to provide a full range of children's services. This includes everything from care at home to our inpatient ward. We aim to put the child at the centre of everything we do.

We are developing new models of care such as our Hospital at Home Service, to increase specialist support for children and families in their homes.

We recognise that children and families need timely and responsive services. There is a need for greater coordination between out of hours care, general practice, ambulatory care, and acute services. We aim to be a system leader in improving urgent care and unplanned care for children.

The inpatient and outpatient services delivered to children will continue to include cancer care, acute care and care of children with long term conditions.

The service also includes a fully integrated co-located paediatric mental health team, attending both to a rising trend in emergency admissions of suicidal teenage patients and also to complex/ medically unexplained presentations in children of all ages. This service will continue to develop to meet rising demand.

Children's services will work closely with general practice to offer advice and support and easy to access services. We will improve coordination of information technology.

There will be further embedding of preventative work that focuses on health and wellbeing especially breastfeeding support, parenting skills, allergy management and childhood obesity.

We will further develop our approach to engage children fully in their care, building on the 'Better Conversations' work.

Our mental health services including PIPS (Parent Infant Psychology Service), CAMHS, and Simmons House adolescent inpatient unit will all be involved in increasing our psychological support and also preventing mental illness or the ongoing long term impact of mental illness for children.

As medical advances continue, there will be a small but growing group of infants and children with complex long term conditions and learning difficulties who require ongoing multidisciplinary input from our teams.

We recognise the critical importance of transitional services for children and adolescents with long term conditions. We will improve the quality of the experience for children undergoing this transition. Getting this right is difficult and will require close working with adult services.

7. Conclusion

This clinical strategy demonstrates the wide range of clinical services already provided by Whittington Health, an integrated care organisation focused on the care of our local population.

Over the next five years we intend to continue to grow and improve the care we provide across our community and hospital settings.

The strategy lays out a clear mission and vision. The strategic goals will enable the vision and mission to be achieved. The principles will guide clinical teams to formulate detailed plans which will be annually reviewed over the time period of the strategy.

Our mission is clear ***"Helping local people live longer, healthier lives."***

The increasing complexity of the delivery of this mission requires an integrated approach that will require innovative thinking and behaviour change at all levels.

A partnership between patient, carer, community, commissioners and providers that is stronger than what has been to date.

To quote the NHS Five Year Forward view (NHS England 2014) 'there is now quite a broad consensus on what a better future should be'.

Our clinical strategy is a reflection of that broad consensus and we are now in a position at Whittington Health to be a leader in making that 'better future' real for our local population.

Whittington Health NHS

This document is available in different formats such as large print and audio or if you require a translated copy please contact us on 020 7288 3081 or communications@whitthealth.nhs.net. We will try our best to meet your needs.