**MEETING**

**HEALTH OVERVIEW AND SCRUTINY COMMITTEE**

**DATE AND TIME**

**MONDAY 12TH MAY, 2014**

**AT 7.00 PM**

**VENUE**

**HENDON TOWN HALL, THE BURROUGHS, NW4 4BG**

**TO: MEMBERS OF HEALTH OVERVIEW AND SCRUTINY COMMITTEE (Quorum 3)**

Chairman: Councillor Alison Cornelius,
Vice Chairman: Councillor Graham Old

**Councillors**

| | | |
|---|---|---|
| Maureen Braun | Arjun Mittra | Kate Salinger |
| Geof Cooke | Bridget Perry | Brian Schama |
| Julie Johnson | Barry Rawlings | |

**Substitute Members**

| | |
|---|---|
| John Hart | Kath McGuirk |
| Sury Khatri | Charlie O'Macauley |

**You are requested to attend the above meeting for which an agenda is attached.**

**Andrew Nathan – Head of Governance**

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**ASSURANCE GROUP**

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**Decisions of the Health Overview and Scrutiny Committee**

12 March 2014

AGENDA ITEM 1

Members Present:-

Councillor Alison Cornelius (Chairman)
Councillor Graham Old (Vice-Chairman)

Councillor Geof Cooke
Councillor Julie Johnson
Councillor Arjun Mittra
Councillor Bridget Perry
Councillor Barry Rawlings
Councillor Kate Salinger
Councillor Brian Schama

Also in attendance
Councillor Helena Hart – Cabinet Member for Public Health

Apologies for Absence
Councillor Maureen Braun

## 1. MINUTES

The Chairman updated the Committee in relation to minute items from the 12 December 2013 meeting as follows:

i) Item 1 (Transport Services – Finchley Memorial Hospital) – the Chairman reported that she had undertaken a site survey with Peter Cragg, a member of the Finchley Memorial Hospital Estates Group, to gauge demand for an on-site bus service. At the invitation of the Chairman, Mr Cragg addressed the Committee. He reported that during the first 30 minutes of the survey it had been ascertained that 21 hospital users had driven. During the whole survey it was ascertained that five had arrived by bus, three by hospital transport, one by bike and five had been driven by relatives or carers. Of those that had driven themselves, only two had indicated that they might have used public transport and an on-site bus service to access the hospital instead of driving. It was emphasised that it would be difficult to gauge potential demand at this time because two new GP practices that were relocating to Finchley Memorial Hospital (FMH) had not yet come on site. The practices were expected to be operating in April or May. The Chairman reported that the following walking distances had been measured: Accessing the site from Ballards Lane (Bow Lane) would require hospital users to walk an additional 213 meters (over and above the distance from the old hospital entrance); Accessing the site from Finchley High Road would require hospital users to walk an additional 38 meters (over and above the distance from the old hospital entrance). A Member informed the Committee that there was an Age UK petition which had been calling for a bus service at FMH.

ii) Item 5 (Members' Item – GP Services at Finchley Memorial Hospital) – at the invitation of the Chairman, Councillor Cooke addressed the Committee in relation to this minute item. He advised the Committee that it had been his understanding that it had been reported at the meeting on 12 December 2013 that Dr Thwe had been

given notice to leave her current premises by 31 January 2014. Councillor Cooke noted that Dr Thwe was still at the practice and questioned whether the committee's intervention had delayed the closure of the practice. He advised the Committee that it was Dr Thew's preference to move to 110 Ballards Lane, but this had been prevented by NHS England who were forcing her to relocate to FMH. Councillor Cooke advised the Committee that this information had not been reflected in the minutes of the 12 December 2013 meeting. The Chairman advised the Committee that when these points had been discussed at the meeting on 12 December 2013, the Barnet Clinical Commissioning Group Chief Officer had reported that NHS England could only require GP contracts to be renegotiated if all of the practice partners had retired. As Dr Thwe was still a partner at the practice, NHS England would not be able to force her to move or end her General Medical Services (GMS) contract.

iii) Item 7 (Barnet, Enfield and Haringey Clinical Strategy) – the Committee noted Barnet, Enfield and Haringey Programme Office had confirmed that the new car park at Barnet Hospital was now open.

iv) Item 8 (NHS Quality Accounts – Mid Year Update) – in relation to the section on BEH MHT, the Chairman highlighted that the ward which had seen improvements was The Oaks Ward at Chase Farm Hospital. The Committee agreed that the wording of the minutes should be amended to reflect this.

v) Item 8 (NHS Quality Accounts – Mid Year Update) – in relation to the section on Barnet, Enfield and Haringey Mental Health Trust (BEH MHT), the Chairman reported that a special meeting of the North Central London Joint Health Overview and Scrutiny Committee (NCL JHOSC) comprising Barnet, Enfield and Haringey Members only had taken place on 3 February 2014. The meeting had been attended by Clinical Commissioning Groups, Cabinet Members and local Healthwatch's. A follow-up meeting on issues relating to BEH MHT would be taking place on 24 March 2014

vi) Item 8 (NHS Quality Accounts – Mid Year Update) – the Committee noted a correction to the spelling of the word RESOLVED and requested the minutes should be amended to reflect this.

vii) Item 14 (Minutes of the NCL JHOSC – 4 October 2013) – the Committee noted that the requirements for the acquisition by the Royal Free London NHS Foundation Trust of Barnet & Chase Farm Hospitals NHS Trust had been considered at the NCL JHOSC on 7 February 2014.

viii) The Chairman reported that she had been advised that 40 – 45 women per day were visiting the Breast Screening Unit at Finchley Memorial Hospital and that the backlog had almost been cleared.

**RESOLVED that the minutes of the meeting held on the 12 December 2013 be agreed as a correct record, subject to the following amendments:**

**i) A reference to The Oaks Ward as detailed at item iv) above; and**

**ii) A reference to Dr Thwe being given notice to quit by NHS England by 31 January 2014 as outlined in ii) above.**

## 2. ABSENCE OF MEMBERS

Apologies for absence had been received from Councillor Braun.

## 3. DECLARATION OF MEMBERS' INTERESTS

| Member | Subject | Interest declared |
|---|---|---|
| Councillor Alison Cornelius | Agenda Item 7 (Barnet, Enfield and Haringey Clinical Strategy Update) and Item 8 (NHS Quality Accounts – Mid Year Update) | Non-pecuniary interest by nature of being on the chaplaincy team at Barnet Hospital |
| Councillor Arjun Mittra | Agenda Item 6 (GP Services at Finchley Memorial Hospital) | Non-pecuniary interest by nature of Dr Dodanwatwana being his family GP |

## 4. PUBLIC QUESTION TIME (IF ANY)

None.

## 5. MEMBERS' ITEMS (IF ANY)

None.

## 6. GP SERVICES AT FINCHLEY MEMORIAL HOSPITAL

The Committee welcomed Tessa Garvan, Assistant Head of Primary Care & Pharmacy North East and Central London at NHS England for the item.

In relation to Dr Thwe's practice, Ms Garvan confirmed that GP contracts only expired when there were no partners remaining. She advised the Committee that in the case of Dr Thwe's practice, there was still a partner in-situ so the GMS contract would continue. She clarified that NHS England were not requiring Dr Thwe to relocate her practice. The current practice accommodation was below the Care Quality Commission (CQC) minimum standard meaning that the current accommodation would need to be improved or the practice would need to relocate. If the practice were to relocate, it could move to any location and the move would be supported by NHS England. She added that there had been no pressure from NHS England for Dr Thwe to move to GP space at FMH.

Referring to the relocation of practices onto the FMH site, Ms Garvan advised the Committee that the moves had taken longer than anticipated due to legal barriers, but were expected to be completed in April or May. It was noted that project managers had now been appointed to progress the moves. Ms Garvan undertook to report back to the Committee with more substantive information as and when it became available.

In relation to the impact on West Finchley of dispersing the patient lists of The Finchley Practice (110 – 112 Ballards Lane) and Dr Thwe's practice (209 Ballards Lane), Ms Garvan reported that the patient list of The Finchley Practice had been dispersed at the end of January 2014. Following consideration of patient opinions, NHS England had been unable to find an ideal solution, but had given patients a choice of practices. It was confirmed that there was no intention to disperse the patient list at Dr Thwe's practice.

A Member commented that it was disappointing it had taken so long to get GP practices onto the FMH site. It was suggested that there should have been a coordinated plan to get them on site when the hospital opened.

Councillor Cooke advised the Committee that Dr Thwe had attended his Ward Surgery last year and had advised him that she was under notice from NHS England and her contract would be terminated. Ms Garvan reported that NHS England had not served Dr Thwe with any notices. It was agreed that if correspondence between Dr Thwe and Councillor Cooke could be located, that it be circulated to the Committee for information.

The Committee commented that it was difficult to get an overview of GP services in the borough, particularly premises issues, the general adequacy of services to serve the population and the impact of GP services on accident & emergency services. Ms Garvan advised the Committee that the Barnet Primary Care Trust had undertaken a premises condition review in 2012 which had included compliance with CQC standards. It was added that the CQC regularly reviewed premises standards and highlighted areas on non-compliance. It was expected that the situation with Dr Thwe's premises would be replicated elsewhere in Barnet. It was reported that a Barnet, Enfield and Haringey Partnership Board (which had representation from the Clinical Commissioning Groups, NHS Property Services and Community Health Partnerships) had been established to plan for premises availability in the three boroughs. It was noted that this was an important part of delivering the Barnet, Enfield and Haringey Clinical Strategy which required investment in GP services to reduce hospital admissions. A Member suggested that consideration should be given to included patient views in the development of plans (e.g. Healthwatch and Patient Participation Groups).

Members of the Committee reiterated concerns relating to the lack of a bus service within or on to the FMH site. It was highlighted that when new GP services came on site, demand was expected to increase.

**RESOLVED that:**

1. **The update on GP services at Finchley Memorial Hospital and in West Finchley as set out in the report and above be noted.**

2. **NHS England be requested to circulate the terms of reference of the Barnet, Enfield and Haringey Partnership Board which were considering estates matters in the three boroughs.**

3. **NHS England be requested to confirm the total number of patients and GPs transferring to Finchley Memorial Hospital from Cornwall House Surgery and Squires Lane Medical Practice.**

4. **The Committee add an item to the future work programme on GP service planning to review NHS England's strategic plans for GP provision and linkages to the Barnet, Enfield and Haringey Clinical Strategy.**

## 7. SITE ISSUES AT FINCHLEY MEMORIAL HOSPITAL

The Committee welcomed Dean Patterson, Head of Property and Facilities Management at Community Health Partnerships for the item.

At the request of the Chairman, Councillor Kate Salinger, who had brought a Members' Item to the Committee in December 2013 on these issues, advised the Committee that she was pleased that the benches had been reinstated on a trial basis.

In relation to the public transport issue, Mr Patterson advised the Committee that he had been in attendance at meetings where the FMH bus service issue had been discussed. He advised the Committee that as the head leaseholder, he would commission a survey into this issue to gauge demand and then report the findings back to his peers at the Lift Co. It was noted that Transport for London (TfL) had made it clear that they were not prepared to divert any existing routes on to the site on the basis of cost. A Member commented that this was a TfL issue and not an estates issue. It was highlighted that NHS premises should be served by public transport and a collective solution was required. In relation to the comment made by Community Health Partnerships in their written submission that FMH has never been served by a bus, a Member highlighted that the new hospital was much larger now than prior to the redevelopment.

The Committee questioned whether all of the requirements of the Travel Plan (a constituent part of the planning permission for the hospital redevelopment) had been implemented. Mr Patterson reported that the Hospital had sought advice at the planning application stage and there had been no requirement to include a bus route in the Travel Plan. He added that all planning conditions had been met and signed-off.

In response to a question from a Member, Mr Patterson reported that Community Health Partnerships managed 301 sites which had been transferred from the Lift Co. The other 3,600 sites which had previously been under the control of Primary Care Trusts had been transferred to NHS Property Services. Both NHS Property Services and Community Health Partnerships were wholly owned subsidiaries of the NHS. It was noted that NHS Property Services tended to be responsible for operational management, while the Lift Co. was responsible for design and build.

**RESOLVED that:**

1. **The update on site issues at Finchley Memorial Hospital as set out in the report and above be noted.**

2. **Community Health Partnerships be requested to report back to a future meeting of the Committee on any progress made in securing an on-site bus service at Finchley Memorial Hospital.**

## 8. BARNET HEALTHWATCH ENTER AND VIEW REPORT

The Committee welcomed Julie Pal, Chief Executive of CommUNITY Barnet, who was in attendance for the item. Ms Pal presented an Enter and View report on Woodfield House in West Hendon which had been visited by Healthwatch Barnet at the request of the CQC. It was reported that the CQC had previously issued two improvement notices to Woodfield House following an inspection. A further CQC inspection had been undertaken in May 2013 when Woodfield House had met all of the required standards.

Enter and View volunteers had visited Woodfield House on two occasions in July 2013. Detailed findings and the response of Woodfield House were set out in the Enter and View report set out in the agenda. The visit had resulted in a total of 17 recommendations being made. It was acknowledged that whilst most of these were

minor, they did have an impact on the quality of life for residents. Ms Pal reported that due to the number of recommendations made, Healthwatch Barnet would be making a further unannounced visit, the findings of which would be reported to the Committee in due course.

A Member raised a query regarding staffing levels during the night shift. Ms Pal undertook to request this information and circulate it to the Committee.

The Committee noted that the objective of the home was to reintegrate patients back into society. It was highlighted that all of the residents had been living there for over three years. Ms Pal undertook to refer this back to the Enter and View team. It was suggested that Barnet, Enfield and Haringey Mental Health Trust should be questioned on their reintegration plans for the patients.

**RESOLVED that:**

1. **The Committee note the Healthwatch Barnet Enter and View report into Woodfield House as set out above.**

2. **Healthwatch Barnet be requested to provide written responses to the queries relating to staffing levels and the tenure of residents as outlined in the preamble above.**

## 9. ANNUAL REPORT OF THE DIRECTOR FOR PUBLIC HEALTH

The Committee welcomed the Councillor Helena Hart, the Cabinet Member for Public Health, and the Director of Public Health, Dr Andrew Howe, for the item.

Dr Howe advised the Committee that the Report was a top level overview rather than a detailed performance report. It was noted that statistics and trends were set out in the Joint Strategic Needs Assessment and detailed performance targets were set out in the Health & Well-Being Strategy and Public Health Outcomes Framework. As such, the Director of Public Health's Annual Report was a call to action on physical activity rather than a detailed strategy and action plan.

Responding to a question, the Cabinet Member for Public Health reported that the Council's outdoor gyms would have a variety of equipment to cater for all abilities and that the existing one at Oak Hill Park was well used. She advised the Committee that there was an average of eight to 10 pieces of equipment in each outdoor gym.

A Member questioned how physical activity in schools was being monitored. The Director for Public Health reported that Barnet had a Healthy Schools Programme. The Public Health team undertook outreach work to provide materials and review the school's curriculum. It was noted that this was primarily targeted at primary schools.

Members questioned how successfully public health had been integrated into the Council, particularly in relation to the design of residential developments and urban spaces. Dr Howe reported that integration into the Council had progressed well, adding that he had been in discussions with the Regeneration team regarding integration of the public health agenda into strategic planning. A Member highlighted that Health Impact Assessments should be integrated into planning at the correct stage.


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**RESOLVED that:**

1. **The Committee note the Director of Public Health's Annual Report 2013 as set out above.**

2. **The Committee request that the Director of Public Health present a report to a future meeting to provide an update on the call to action on physical activity and delivery against targets in the Health and Well-Being Strategy.**

## 10. PUBLIC HEALTH COMMISSIONING INTENTIONS

The Committee welcomed the Councillor Helena Hart, the Cabinet Member for Public Health, and the Director of Public Health, Dr Andrew Howe, for the item.

Councillor Hart outlined achievements to date in relation to public health services. The Committee were informed that it was planned for overweight and obese residents to be supported to lose weight via obesity and weight management clinics. Further work was underway on cancer prevention with a plan to introduce cancer 'pop up shops'.

Dr Howe advised the Committee that 2013/14 had been a year of transition for the Public Health service and there had been some issues with the transfer of contracts from the Primary Care Trust, particularly in relation to sexual health services. It was reported that the re-commissioning of drugs and alcohol services was due to take place in the next eight to 12 months. The Committee were advised that there had been a focus on children's centres, early years and the healthy schools programme. It was highlighted that since public health services had come under local authority control, there had been a focus on initiatives to support people back to work and it was reported that these now included the allocation of a health coach. Public Health had also been working with the Barnet Clinical Commissioning Group on the self-care and integrated care agenda.

A Member questioned whether Public Health had been undertaking any dental hygiene promotional work in schools. Dr Howe reported that responsibilities in this area were split between public health and NHS England who were responsible for commissioning dental services. Public Health were promoting the "Brushing for Life" campaign and NHS England commissioned their own preventative work.

**RESOLVED that the update on Public Health Commissioning Intentions as set out in the report and above be noted.**

## 11. NHS HEALTH CHECKS SCRUTINY REVIEW

The Chairman welcomed Andrew Charlwood, the Overview and Scrutiny Manager, for the item. The Committee noted that it had been agreed at the 12 December 2013 meeting that the Committee would sign-off the NHS Health Checks Scrutiny Review via e-mail to enable the final report to be submitted to the Centre for Public Scrutiny in January 2014 to link to the body of work produced by the five NHS Health Checks Scrutiny Development Areas nationally.

At the request of the Chairman, Dr Howe provided an initial response to the Committee on the recommendations. He advised the Committee that the findings from the review would be used to guide the Health Checks programme in Barnet and Harrow. It was

noted that some of the recommendations were for Public Health England. Mr Charlwood confirmed that these recommendations would be submitted to Public Health England for response.

Councillor Hart advised the Committee that Cabinet were likely to accept the recommendations. The Committee were informed that she was supportive of Health Checks being undertaken in alternative settings. Members were advised that Dr Azim had been piloting a Health Checks outreach programme in West Hendon.

A Member highlighted that one of the recommendations proposed that Health Checks be offered to adults with learning difficulties from age 40 as this population cohort tended to suffered from a number of health conditions.

**RESOLVED that the findings and recommendations of the NHS Health Checks Scrutiny Review be noted.**

## 12. HEALTH OVERVIEW AND SCRUTINY FORWARD WORK PROGRAMME

**RESOLVED that:**

1. **The Health Overview and Scrutiny Committee Forward Work Programme be noted.**

2. **The Committee approve the addition of items to the Work Programme as detailed in the minute items above.**

## 13. ANY OTHER ITEMS THAT THE CHAIRMAN DECIDES ARE URGENT

**Acquisition of Barnet and Chase Farm Hospitals NHS Trust by the Royal Free London NHS Foundation Trust**

At the invitation of the Chairman, the Cabinet Member for Public Health updated the Committee on the acquisition of Barnet and Chase Farm Hospitals NHS Trust by the Royal Free London NHS Foundation Trust. She advised the Committee that final proposals would be considered by the Council of Governors of the Royal Free in June. All parties were supportive, including the Department of Health in relation to the financial aspects. Councillor Hart considered that the acquisition was vital to the health economy in Barnet. It was highlighted that the Royal Free London NHS Foundation Trust Council of Governors had not yet indicated their support. Councillor Hart advised the Committee that Camden patients needed to be persuaded that the acquisition would not be to their detriment.

The meeting finished at 9.22 pm

**THE LONDON BOROUGH OF CAMDEN**



At a meeting of the **NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY 28TH MARCH 2014** at 10am in the Council Chamber, Town Hall, Judd Street, London, WC1H 9JE

**MEMBERS OF THE COMMITTEE PRESENT**

Councillors Gideon Bull (Chair) LB Haringey, John Bryant (Vice Chair) LB Camden, Peter Brayshaw, LB Camden, Alison Cornelius, LB Barnet, Graham Old, LB Barnet, Jean-Roger Kaseki, LB Islington, Martin Klute, LB Islington, Anne-Marie Pearce, LB Enfield, Alev Cazimoglu, LB Enfield

**HEALTH PARTNERS PRESENT**

**The minutes should be read in conjunction with the agenda for the meeting. They are subject to approval and signature at the next meeting of the NCL Joint Health Overview and Scrutiny Committee.**

**MINUTES**

## 1. WELCOME AND APOLOGIES FOR ABSENCE

Apologies for lateness were received from Councillors Cornelius and Brayshaw.

## 2. DECLARATION OF INTEREST

For transparency, Councillor Brayshaw declared that he was a Governor at University College London Hospital.

For transparency, Councillor Cornelius declared that she was an assistant chaplain at Barnet Hospital.

In relation to Item 9, Moorfield Eye Hospital, Councillor Bull declared that he was an employee of the Hospital and would be stepping down from the Committee during the discussion of the item.

## 3. URGENT BUSINESS

There was no urgent business

## 4. MINUTES

Consideration was given to the minutes of the meeting held on 7th February 2014. The Committee commented on several action points as follows:

- Page 3, no response had been received from the Royal Free Hospital in relation to the last valuation of Chase Farm Hospital. **ACTION: Secretary to follow up with David Sloman and circulate to the Committee**.
- Page 5, clarification was requested on the review group and lessons learnt. **ACTION: Secretary to seek clarification and circulate the lessons learnt results to the Committee.**
- Page 9, the information requested from on the total spend across the five boroughs on mental health had not been received. Until it was received effective lobbying for increase funding could not take place by the Committee. **ACTION: Secretary to chase Liz Wise for the information.**
- Page 10, the letter to Norman Lamb was currently in the process of being written **ACTION: Secretary to check to ensure that the letter is sent and inform the Committee when this has been done.**

In relation to matters arising from the minutes, the following points were raised:-

- A report tabled at the last Enfield Clinical Commissioning Group by the Programme Director included a recommendation that the review of the implementation of the BEH Clinical Strategy would take place after 100 days. However in the North Middlesex board meeting, it had been stated that the review would take place after six months. It was requested that the timescale be clarified, **ACTION: Secretary.**
- One member of the Committee raised concerns that a planning application had been submitted to the London Borough of Enfield to build 100 homes on the Chase Farm site. The Committee requested a confirmation be sought to get a guarantee that any capital receipt the Royal Free Hospital get for the site be reinvested. **ACTION: Secretary.** The Committee noted that David Sloman of the Royal Free had stated at a meeting of Healthwatch Enfield that money would be reinvested, he was waiting for permission to publish the information.

Following discussion it was,

**RESOLVED –**

THAT the minutes of the meeting held on 7th February 2014 be signed as a correct record.

## 5. THE WHITTINGTON HOSPITAL – TRANSFORMATION PLANS

The Committee received an oral report from Steve Hitchens, the Chair of Whittington Health.

Mr Hitchens stated that new services were about to open and patients would start to be taken in from week beginning 31st March 2014. It was further noted that the two year plan would be taken to the Whittington Health Board on 1st April 2014. The business case had been submitted to the NHS Trust Development Authority (TDA). Whittington Health had improved from band four to band six in the Care Quality Commission's recent grading's. Whittington Health also had the lowest mortality rate in England. The Interim Chief Executive would take up the post on 1st April 2014. The Whittington Health's five year plan had been agreed with the TDA. It was stated that currently there was no clear vision for the future of Whittington Health; however the vision would develop over the next few months. The Committee noted that integrated care needed to be designed to meet the needs of the

patients and community. Cabinet Members from Islington and Haringey had attended Whittington Health Board meetings, which had improved communication.

Discussion took place and members of the Committee raised questions and concerns in relation to the departure of the Chief Executive; the requirements for a five year plan; Foundation Trust status; Whittington Health's vision, and employee buy in to the transformation process.

In response to questions and concerns, Mr Hitchens remarked that Dr Koh, the Chief Executive, was leaving her role on 28th March. She had been with the Whittington Hospital for three years. The chief executive vacancy would be advertised before the end of April. There was a requirement for every Trust who were no yet a Foundation Trust to have a five year plan. The five year plan was a visionary statement which would take more time to put together. The timescale for the plan was June 2014. The focus of the hospital was on the upcoming Care Quality Commission (CQC) inspection, the Foundation Trust application was still important, however the main issue was to become an integrated care organisation. In relation to the vision for the Whittington, it was noted that there was no overall big picture about what the integrated care organisation would look like, the hospital needed to be better engaged with its mental health partners and the vision needed to be enunciated by the community.

The Committee requested that the Committee receive a note clarifying where Whittington Health was in the integrated care process. It was further requested that the five year plan be brought to a future meeting before it was sent to the TDA.

**ACTION BY: Steven Hitchens (Chair Whittington Health)**
**Secretary**

In response to the request, it was noted that everything the Committee had previously seen was still relevant. However, what was needed was a document which gave the big picture and brought everything together. No date would be given in relation to when Foundation Trust status was planned for, there was no government timetable, therefore the CQC inspection was the main focus.

Further discussion took place in relation to the rebranding of Whittington Health, the staff survey and the hospital's website.

Following a lengthy discussion it was

**RESOLVED –**

THAT the report be noted.

**TO NOTE: All**

## 6. PRIMARY CARE - FUNDING

The Committee received a presentation from Alex Manu of NHS England. It was stated that Primary care generally meant GP services, which received 60-70% of the funding. The other services were community services, dental and ophthalmology. The primary medical services need modelled using the Carr-Hill formula, which took account of age-gender mix of registered patient lists, as well as factors in relation to health status of the population.

Discussion took place and Members of the Committee raised questions in relation to rents for GP premises; monitoring of performance for practices and GPs; and, the formulas used and whether they were or would be reappraised. In response to questions it was stated that the premises would be assessed on its current market rate and that's what the premises payment would be based on. The NHS would not pay more than what a district valuer valued rent and rates. Some small improvement grants were available, GPs submitted bids to receive the funding, however, the funding was not guaranteed, there were NHS guidelines. Not everything was 100% funded. Funding was only give to those areas being used to deliver primary care services. In relation to publication of GP earnings it was noted that GP average earnings were published, due to GPs being self-employed it was not strictly salaries. CQC inspections and the Quality Outcome Framework (QOF) was in place to ensure performance management of practices and individual GPs. Funding was based on list size and population health statistics. NHS England did have concerns about the reliability of GP lists as a basis of funding. It was not known if QOF points were publically available. It was stated that this point would be checked and the Committee informed.

**ACTION BY:** **Alex Manu (NHS England)**
**Secretary (Rob Mack)**

Further discussion took place in relation to performance and it was noted that the Clinical Commission Groups were responsible for strategy and the improvement of general services whereas NHS England were responsible for performance. In response to questions about mental health grants, it was noted that there was a gap in understanding about mental health conditions by GPs. In response to concerns about the reduction in primary care funding in London, it was noted that primary care funding was not just about the funding formula it was also about what primary care could do differently in the future to ensure it was sustainable and high quality.

Following a detailed discussion the Committee thanked Mr Manu for the presentation and it was

**RESOLVED –**

THAT the report be noted.

**TO NOTE:** **All**

## 7. PRIMARY CARE - CASE FOR CHANGE

Consideration was given to a report of NHS England. Jemma Gilbert introduced the report and stated that GP practices were feeling financially challenged as well as in terms of

capacity. It was felt that not all practices were fit for patients either. A great foundation of primary care had been built which was highly regarded domestically and internationally, however it need to built on. Scale would be a very important factor in developing primary care such as practices coming together collaboratively to solve sustainability issues. It was noted that the Call to Action had been published in January 2014, since the publication engagement work had been undertaken.

Discussion took place in relation to the timeframe for the case for change, it was noted that the delivery timeframe was five years, the first year was about describing the changes and getting the modelling right. An incentive was trying to be created for London practices which would encourage them to deliver change as a collective for their populations. Further discussion took place in relation to proactive care, it was noted that the proactive care worked with Public Health and Health and Wellbeing Boards, it recognised the need to co-develop services with the local community.

The consensus from the Committee was that it was a positive document however, five years was too long to deliver, there needed to be quick wins. The Committee also felt that the document needed to be lobbying for more money in primary care. In response to concerns in relation to the variation between practices it was noted that it was a statutory requirement of the Clinical Commissioning Groups around peer support, for them to create forums where practices could come together to share systems and outcomes and to learn from each other.

The Committee thanked Ms Gilbert for attending the meeting and requested that the development of the case for change be put as a standing item on the Committee's work programme.

**ACTION BY: Secretary (Rob Mack)**

**RESOLVED –**

THAT the report be noted.

**TO NOTE: All**

## 8. CANCER AND CARDIOVASCULAR SERVICES UPDATE

The Committee gave its consideration to a report of NHS England. Neil Kennett-Smith from North East London Commissioning Support Unit highlighted the key aspects. It was noted that further engagement was to take place from the 28th April 2014 following the approval of the initial business case. A short plain English leaflet on the proposals would also be developed and distributed to all stakeholders.

Members of the Committee raised questions in relation to transitional funding and the engagement process. In response, Mr Kennett-Smith remarked that PricewaterhouseCoopers had been appointed. They were working with three partners to understand the financial impacts. There would be a £94 million benefit over the next three to four year period. Although it would deliver financial benefits the main move to this model was for clinical outcomes. It was further noted that the plain English leaflet was currently being developed, it would go out with the engagement packs on 28th April, which would be after the final commissioner decisions on 25th April. Stakeholders would have six weeks in

which to respond to the engagement information. Deborah Fowler of Healthwatch Enfield commented that six weeks was adequate to respond, but it did depend on how much consultation was being done elsewhere.

Further discussion took place in relation to the timescale for the transition of services, it was noted that everything should be in place by early 2015, however there would be further capital development during 2015 and 2016, therefore everything would be completed by the end of 2016. In relation to the compensation payment to the University College London Hospital from Barts Hospital it was noted that it was normal practice to seek compensation when a Trust would lose a service that generated a financial surplus. It was requested that a financial clarification on the position of compensation be sent to Members of the Committee.

**ACTION BY: Neil Kennett-Smith, NELCSU**
**Secretary (Rob Mack)**

One Member of the Committee remarked that it did appear to be a short engagement period, however he acknowledged that the Committee had been kept well informed. Mr Kennett-Smith lastly stated that the engagement report for phase one had been published on 11th March and the recommendations in the report were subject to final decision on 25th April 2014.

Following discussion, it was

**RESOLVED –**

THAT the report be noted.

**TO NOTE: All**

## 9. MOORFIELD EYE HOSPITAL; PROPOSALS FOR RE-LOCATION

(The Chair left the meeting for consideration of this item and Councillor Bryant took the Chair)

The Committee gave its consideration to a report from Moorfields Eye Hospital NHS Foundation Trust. Tim Fry, Project Director, highlighted the key aspects of the report and gave a brief history of the project. He highlighted that with a new research, education and clinical care centre a better standard of care could be delivered. It was stressed that there was no intention for Moorfields to relocate further than the King's Cross St Pancras area.

Discussion took place and councillors from the London Borough of Islington stated that from and Islington Health Scrutiny perspective as the relocation was only a couple of miles away there was not a great deal of concern, if however it was to move further than King's Cross that would be considered a major change.

In response to questions from the Committee Tim Fry remarked that there were a number of sites being looked into, one building was currently being used for health services the other building was not. Due to the commercially sensitive nature of the process no further information could be given to the Committee at this time. It was not known what proportion

of patients currently arrived at the hospital via public transport, Tim Fry would find out that information and circulate it to the Committee.

**ACTION BY: Project Director, Moorfields Eye Hospital (Tim Fry)**
**Secretary (Rob Mack)**

The Committee remarked that it broadly supported the process to date, but it did highlight the importance of maintaining information. The Committee further stated that it was not a substantial change in service provision, subject to the relocation being local as set out in the report and past papers.

Following discussion, it was

**RESOLVED –**

THAT the report be noted.

**TO NOTE: All**

## 10. MEETING OF BARNET, ENFIELD AND HARINGEY MEMBERS

The Committee noted a statement from Barnet, Enfield and Haringey CCGs that stated that the Mental Health Strategies report would be going through Clinical Commissioning Group Boards in relevant boroughs during May and would not be publically available until after the local government elections. Members were concerned that this might mean that they were unable to influence budget decisions on mental health services for the forthcoming year and requested that Enfield CCG, as lead commissioner, be approached to request earlier sight of the report. In addition, they also proposed that a meeting of JHOSC Members from Barnet, Enfield and Haringey be arranged to take place on 2 May to discuss the issue further. It was noted that this would be subject to confirmation by participating boroughs that meeting at this time would be consistent with local guidance regarding activity during the Purdah period before the local government elections.

**ACTION BY: Secretary (Rob Mack**

## 11. WORK PLAN AND DATES FOR FUTURE MEETINGS

The Chair thanked the Members and Officers for their support over the year.

It was noted that the next meeting of the Committee would take place on 27th June at Islington Town Hall.

**Minutes End**

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AGENDA ITEM 7

| | |
|---|---|
| Meeting | Health Overview and Scrutiny Committee |
| Date | 12 May 2014 |
| **Subject** | **NHS Quality Accounts 2013/14** |
| Report of | Scrutiny Office |
| Summary | This report presents the Quality Accounts from NHS health service providers. The attached documents set out the quality of service provided by each provider. The committee is asked to scrutinise the Quality Accounts and to provide a statement to be included in the Account of each health service provider. |

| | |
|---|---|
| Officer Contributors | Anita Vukomanovic, Overview and Scrutiny Officer |
| Status (public or exempt) | Public |
| Wards Affected | All |
| Reason for urgency / exemption from call-in | N/A |
| Function of | Health Overview and Scrutiny Committee |
| Enclosures | Appendix 1 – North London Hospice Quality Account 2013/14<br>Appendix 2 – Royal Free Hospital NHS Foundation Trust Quality Accounts 2013/14<br>Appendix 3 – Community London Healthcare NHS Trust Quality Account 2013/14<br>Appendix 4 – Barnet and Chase Farm Hospitals NHS Trust Quality Account 2013/14<br>Appendix 5 – Barnet, Enfield and Haringey Mental Health NHS Trust Quality Account 2013/14<br>Appendix 6 – Barnet Health OSC 2013 Quality Accounts Submissions<br>Appendix 7 – Minute Extract – Quality Account Update Report: Health Overview and Scrutiny Committee 12 December 2013 (Minute Extract) |
| Contact for Further Information: | Anita Vukomanovic, Overview and Scrutiny Officer, 020 8359 7034, anita.vukomanovic@barnet.gov.uk |

## 1 RECOMMENDATIONS

**1.1 That, noting the requirement of NHS health service providers to produce quality accounts for 2013/14, the Committee provide a statement for inclusion in each of the Quality Accounts of the Health providers as set out in Appendices 1 to 5.**

## 2. RELEVANT PREVIOUS DECISIONS

2.1 Health Overview and Scrutiny Committee, 19 May 2011, Agenda Item 7 – Quality Accounts – the Committee received and made formal comments on the Quality Accounts of health partners.

2.2 Health Overview and Scrutiny Committee, 16 May 2012, Agenda Item 8 – Quality Accounts – the Committee received and made formal comments on the Quality Accounts of health partners.

2.3 Health Overview and Scrutiny Committee, 9 May 2013, Agenda Item 10 - the Committee received and made formal comments on the Quality Accounts of health partners.

## 3. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

3.1 The Overview and Scrutiny Committees must ensure that the work of Scrutiny is reflective of the Council's priorities.

3.2 The three priority outcomes set out in the 2013 – 2016 Corporate Plan are: –

- Promote responsible growth, development and success across the borough;
- Support families and individuals that need it – promoting independence, learning and well-being; and
- Improve the satisfaction of residents and businesses with the London Borough of Barnet as a place to live, work and study.

3.3 The work of the Barnet Health Overview and Scrutiny Committee supports the delivery of the following outcomes identified in the Corporate Plan:

- To sustain a strong partnership with the local NHS, so that families and individuals can maintain and improve their physical and mental health; and
- To promote a healthy, active, independent and informed over 55 population in the borough to encourage and support our residents to age well.

## 4. RISK MANAGEMENT ISSUES

4.1 None in the context of this report.

## 5. EQUALITIES AND DIVERSITY ISSUES

5.1 In addition to the Terms of Reference of the Committee, and in so far as relating to matters within its remit, the role of the Committee is to perform the Overview and Scrutiny role in relation to:

- The Council's leadership role in relation to diversity and inclusiveness; and
- The fulfilment of the Council's duties as employer including recruitment and retention, personnel, pensions and payroll services, staff development, equalities and health and safety.

5.2 Equality and diversity issues are a mandatory consideration in decision-making in the council pursuant to the Equality Act 2010. This means the council and all other organisations acting on its behalf must have due regard to the equality duties when exercising a public function. The broad purpose of this duty is to integrate considerations of equality and good relations into day to day business requiring equality considerations to be reflected into the design of policies and the delivery of services and for these to be kept under review. Health partners as relevant public bodies must similarly discharge their duties under the Equality Act 2010 and consideration of equalities issues should therefore form part of their reports.

## 6. USE OF RESOURCES IMPLICATIONS (Finance, Procurement, Performance & Value for Money, Staffing, IT, Property, Sustainability)

6.1 None in the context of this report.

## 7. LEGAL ISSUES

7.1 Section 244 of the National Health Service Act 2006 and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218; Part 4 Health Scrutiny by Local Authorities provides for the establishment of Health Overview and Scrutiny Committees by local authorities

7.2 Health and Social Care Act 2012, Section 12 – introduces section 2B to the NHS Act 2006 which imposes a new target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area.

7.3 NHS bodies and certain other bodies who provide health services to the NHS are required by legislation to publish Quality Accounts drafts of which must be submitted to the Health OSC for comment in accordance with section 9 of the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended.

## 8. CONSTITUTIONAL POWERS (Relevant section from the Constitution, Key/Non-Key Decision)

8.1 The scope of the Overview and Scrutiny Committees is contained within Part 2, Article 6 of the Council's Constitution.

8.2 The Terms of Reference of the Scrutiny Committees are included in the Overview and Scrutiny Procedure Rules (Part 4 of the Council's Constitution). The Health Overview and Scrutiny Committee has within its terms of reference responsibility:

i) To perform the overview and scrutiny role in relation to health issues which impact upon the residents of the London Borough of Barnet and the functions services and activities of the National Health Service (NHS) and NHS bodies located within the London Borough of Barnet and in other areas.

ii) To make reports and recommendations to the Executive and/or other relevant authorities on health issues which affect or may affect the borough and its residents.

iii) To invite executive officers and other relevant personnel of the Barnet Primary Care Trust, Barnet Clinical Commissioning Group, Barnet Health and Wellbeing Board and/or other health bodies to attend meetings of the Overview and Scrutiny Committee as appropriate.

## 9. BACKGROUND INFORMATION

9.1 Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality of services they provide, mirroring providers' publication of their financial accounts. All providers of NHS healthcare services in England, whether they are NHS bodies, private or third sector organisations must publish an annual Quality Account. Providers are exempt from reporting on any primary care or NHS Continuing Health care services.

9.2 The primary purpose of Quality Accounts is to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer, and encourage them to engage in the wider processes of continuous quality improvement. Providers are asked to consider three aspects of quality – patient experience, safety and clinical effectiveness. The visible product of this process – the Quality Account – is a document aimed at a local, public readership. This both reinforces transparency and helps persuade stakeholders that the organisation is committed to quality and improvement. Quality Accounts therefore go above and beyond regulatory requirements which focus on essential standards.

9.3 If designed well, the Accounts should assure commissioners, patients and the public that healthcare providers are regularly scrutinising each and every one of their services, concentrating on those that need the most attention.

9.4 Quality Accounts will be published on the NHS Choices website and providers will also have a duty to:

- Display a notice at their premises with information on how to obtain the latest Quality Account; and
- Provide hard copies of the latest Quality Account to those who request one.

9.5 The public, patients and others with an interest in their local provider will use a Quality Account to understand:

- Where an organisation is doing well and where improvements in service quality are required;
- What an organisation's priorities for improvement are for the coming year; and
- How an organisation has involved service users, staff and others with an interest in the organisation to help them evaluate the quality of their services and determine their priorities for improvement.

9.6 Commissioners and healthcare regulators, such as the Care Quality Commission, will use Quality Accounts to provide useful local information about how a provider is engaged in quality and tackles the need for improvement.

9.7 Scrutiny committees have been given the opportunity to comment on a provider's Quality Account before it is published as it is recognised that they have an existing role in the scrutiny of local health services, including the ongoing operation of and planning of services.

9.8 The powers of overview and scrutiny in relation to the NHS enable committees to review any matter relating to the planning, provision and operation of health services in the area of its local authority. Each local NHS body has a duty to consult the local overview and scrutiny committee(s) on any proposals it may have under consideration for any substantial development of the health service in the area of the committees' local authorities, or on any proposal to make any substantial variation in the provision of such service(s).

## 10. LIST OF BACKGROUND PAPERS

10.1 None.

| | |
|---|---|
| **Cleared by Finance (Officer's initials)** | **J.H** |
| **Cleared by Legal (Officer's initials)** | **L.C** |

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NORTH·LONDON
HOSPICE

Day Services
BARNET **Bereavement Support**
**Community** ENFIELD
Haringey **EDUCATION**
PATIENT **CARE**
North London Hospice
PALLIATIVE CARE SUPPORT SERVICES
**24-hour advice line for NLH patients and professionals**

OVER **90%**
**SUPPORTED AT HOME**


**1607** **individual patients**
cared for by all NLH services this year

# QUALITY ACCOUNT 2013-14

# CONTENTS

"You don't meet people like that so much any more but the Hospice is truly kind and caring - exceptionally."

## COMMUNITY PATIENT STORY

XXXX lives at home and cares for her father and also looks after her disabled mother. Her father is visited by a North London Hospice Community Clinical Nurse Specialist in Specialist Palliative Care (CNS).

"Dad has been receiving visits from the CNS since June. Our GP at that time referred dad to the Hospice and I admit that I was worried as I just associated the word Hospice with dying. But after I met the CNS and saw how lovely she was, I became much more confident and not worried at all.

I'm just so happy that our GP put us in touch.

There is always someone there to help and I can phone up at any time and never get told to call back. If the CNS isn't there at that moment, she will always call back in about 5 or 10 minutes – I've never waited longer than 10 minutes. All the people there are very helpful. I've never met them but everyone I speak to is lovely.

Dad is treated with complete respect and dignity. He really looks forward to the CNS's visits. I feel that she genuinely cares for him and I have 100% confidence in her, and I know dad has as well.

If anything happens and dad's not feeling well or something like that, he'll ask me to phone her, not the GP.

As well as the care being great for my dad, it's excellent for us, the family. My mum and I are both included and I feel that I understand everything that they are telling me. My dad's English isn't all that good and the CNS explains everything to me after she's spoken to dad.

We are kind, decent and caring people. You don't meet people like that so much any more but the Hospice is truly kind and caring - exceptionally.

I feel that I can ask our CNS anything. We recently had a problem with our landlord wanting us to move out, which dad is far too ill to do. The Hospice wrote a letter and that is all on hold now, thanks to them.

I arranged for some carers to come in for dad that we were going to have to pay for but again the CNS stepped in and sorted it all out for us.

Dad was quite poorly and not able to get out of his chair so the CNS arranged for an Occupational Therapist to come round and now the chair has been raised which is a real help. She helps us in every way.

If it was suggested that dad might want to come into the Hospice for any reason, I would have no concerns as I have 100% confidence in everyone there. Dad wouldn't want to come though as he's very proud and wants to die at home.

I would recommend the Hospice to anybody and everybody. The service that it provides is excellent – nothing like a hospital or the NHS. I'm so impressed – it is just fantastic."

# EXECUTIVE SUMMARY

The Quality Account is produced to inform current and prospective users, their families, our staff and supporters, commissioners and the public of our commitment to ensure quality across our services.

North London Hospice (NLH) is a registered charity (No.285300) and has been caring for people in the London Boroughs of Barnet, Enfield and Haringey since 1984.

It provides Community Specialist Palliative Care Teams, an Out-of-Hours Telephone Advice Service, Day Services, Inpatient Unit (IPU), Palliative Care Support Service (PCSS,NLH's Hospice at Home service) and a Loss and Transition Service (including Bereavement Service).

The following three priorities for improvement for 2014-15 are proposed:

Patient experience project - to develop our newly refurbished reception area driven by user feedback to provide a social environment for users.

Patient safety project - to ensure care needs are met and documented using structured care rounds on the In Patient Unit.

Clinical effectiveness project to respond to the Dementia Challenge (2012) by raising awareness of the needs of people with dementia especially at end of their lives.

Clinical effectiveness project to pilot the use of the holistic needs assessment tool which is completed by users to support clinicians delivery of person centred care.

The 2013-14 priorities for improvement projects are reported and have contributed already to increased user feedback around volunteering roles, the establishment of an ultrasound service for diagnosis of ascites and its safe management, the introduction of intentional care rounds to the In Patient Unit.

Key service developments are described. The remodelling of reception at the Finchley site and development of a meet and greet model of visitors being welcomed on arrival and supported in the reception area. Developments within our day services which include the provision of art services and a new psychological therapy service as well as plans to provide day therapy at Finchley site this coming year also. A new collaborative project with Macmillan Cancer Support to further test a model of care that maximizes patient choice by providing as much treatment and support in the home or the community.

Service data is highlighted and discussed. IPU had 314 admissions this year and their average length of stay was 13.3 days. 24% patients were discharged from IPU. The Day Service cared for a total of 184 patients and 160 therapy sessions were delivered to carers. The community teams cared for a total of 1251 patients in their own homes and supported 58% of these patients to die at home where this was their preferred place of care. PCSS cared for 278 patients and provided a total of 16,244 hours of one-to-one nursing care to people in their own homes.

NLH's user surveys revealed that 99% patients were satisfied with our service and 98% would recommend service to families and friends. User case studies reported on pages 5 and 52 provide two current users feedback (of NLH services this year's).

The Board of Trustees give assurance to the public of the quality of North London Hospice's clinical services.

# PART 1: CHIEF EXECUTIVE'S STATEMENT: STATEMENT OF QUALITY

On behalf of North London Hospice it gives me great pleasure to introduce the Annual Quality Account 2013/14. It demonstrates the level of quality of clinical care NLH provides.

The Quality Account provides North London Hospice with an opportunity to demonstrate its commitment to quality improvements. It also describes the quality priorities that we will be focusing on in 2014/2015.

NLH as a charity makes no charge to its patients or their families. It has cost £5.8 million to provide NLH care during 2013-14. NHS grants contributed 41%.

NLH's vision is that everyone in our diverse community affected by a potentially life limiting illness has equal access to the services and support they need to optimise their quality of life. NLH carries this out through:

- delivering specialist palliative care
- providing additional support and services to meet individual needs
- sharing our skills and experience to influence others providing care
- maximising and supporting community involvement

Our feedback from users remains excellent with 98% (n=119) of service users saying they would recommend NLH service to friends and family. There is no place for complacency and any critical feedback received from survey, comments cards, patient stories or complaints are investigated to identify the improvement or developments. In the coming year we will introduce real time user feedback reporting to better influence individual care.

I am pleased to report that routine unannounced inspections by the Care Quality Commission to both sites this year showed NLH to be compliant in all standards inspected.

NLH has cared for a total of 1607 individual patients this year who may have used several of our services at different times.90% of these patients were supported at home by NLH. In supporting patient's choice to die in their own homes, the community service enabled this in 58% of cases where the national average for cancer deaths is 24.5%.*6747 more hours of care were delivered by our expanding Palliative Care Support Service.

In 2014-15 four quality projects are proposed. A patient experience project will develop our newly refurbished reception area driven by user feedback to provide a social environment for users (see page 9). A patient safety project will ensure care needs are met and documented using structured care rounds on the In Patient Unit (see page 9). Our first of two clinical effectiveness projects will respond to the Dementia Challenge (2012) to raise awareness of the needs of people with dementia especially at end of their lives (see page 10). The second project will pilot the use of the holistic needs assessment tool which is completed by users to support clinicians deliver person centred care (see page 11).

This year sees NLH embarking on a collaborative project with Macmillan Cancer Support to further test a model of care that maximizes patient choice by providing as much treatment and support in the home or the community (see page 19).

As a Gold Standards Framework regional centre we have delivered training to some 50 care homes in our boroughs as well as extending it to Tower Hamlets, Hackney, Newham, Camden and Islington. This now covers 50 care homes.

NLH's Board of Trustees reviewed and approved this Quality Account at a meeting planned for

I Pam McClinton confirm that, to the best of my knowledge, the information set out in this Quality Account is accurate.

I welcome any comments or suggestions you may have on this Quality Account and on our care.

Quality care for end of life patients is what drives us, we hope this account demonstrates how we achieve this.

**Pam McClinton,**
**Chief Executive of North London Hospice**
**April 2014**

*Gao W, Ho YK, Verne J, Glickman and Higginson I (2013) Changing Patterns in Place of Cancer Death in England: A Population Based Study Journal of Palliative Medicine 26 March .

# INTRODUCTION

Quality Accounts provide information about the quality of the Hospice's clinical care and initiatives to the public, local authority scrutiny boards andNHS commissioners. Some sections and statements are mandatory for inclusion. These are italicised to help identify these.

NLH started to produce and share its Quality Accounts from June 2012. This year's Quality Account (QA) and previous year's QAs can be found on the internet (NHS Choices and NLH website) and copies are readily available to read in the reception areas at the Finchley and Enfield sites. Paper copies are available on request.

# OUR CLINICAL SERVICES

The Hospice's services are provided by specially trained multi-professional teams, which include doctors, nurses, physiotherapists, social workers, counsellors, spiritual care and chaplaincy as well as a range of volunteer roles. NLH offers the following clinical services:

1. Community Specialist Palliative Care Team (CSPCT)
2. An Out-of-Hours Telephone Advice Service
3. Day Services (DS)
4. Inpatient Unit (IPU)
5. Palliative Care Support Service (PCSS, NLH's Hospice at Home service)
6. Loss and Transition Service (including Bereavement Service)

For a full description of our services please see Appendix One



# PART 2

## Priorities for Improvement 2014-15

The following Priority For Improvement Projects for 2014-15 were identified by the clinical teams and endorsed by the Clinical Governance Sub Committee (now Quality, Safety and Risk Group), Board of Trustees and local commissioners and Health and Overview Scrutiny Committees.

The priorities for improvement projects are under the three required domains of patient experience, patient safety and clinical effectiveness:

## Patient Experience: Priority for Improvement

**The Living Room Project**

We have received feedback from a significant number of Inpatient Unit patients over the last year, indicating that patients who are active and mobile are feeling isolated, lonely and bored by being confined to their room. People staying in the Inpatient Unit could previously attend the Day Centre during their stay but this service was moved to the Hospice site in Enfield during 2012. Inpatients would like more interaction with other patients/visitors which is reiterated by patients who attend Day Services at our Enfield site and say that they find great benefit from meeting and being able to chat with other people in a similar position.

We would like the newly refurbished reception area at our Finchley site to be used by patients and visitors however they wish. We also want to bring in local community groups to see the work of the Hospice and offer them fundraising and volunteering opportunities as well as encourage them to contribute to social events or activities for the benefit of our users.

User feedback will be a key factor in determining how the space is used in the future and what is provided there.

## Patient Safety

**To ensure fundamental care needs are met and evidenced through structured intentional care rounding and improved documentation on IPU.**

The priority for improvement project commenced in the Autumn of 2013 on introducing Intentional Care Rounding (IC) on IPU (see page 43) is to be extended for 2014-15. NLH have seen benefits in patients identified at high risk from falls and pressure sores.

NLH want to introduce this initiative to:

- Reduce incidence of falls. NLH Quarter1 2013-14 figure =17.5 falls per 1000 OBDs (n=19/13) is taken as a baseline. The objective is to reduce falls to range between 6.5(NPSA benchmark*) and 12.5 falls per 1000 Occupied Bed Days (OBDs)
- Improve documentation of
    - Food and drink being within reach and received where appropriate or mouth care offered when oral nutrition is not appropriate. The objective is that there will be 100% documentation of this.
    - Pressure area positional changes. The objective is that there will be 100% documentation of appropriate position change.
- Consider the benefits of IC for all patients including patients in their last few days of life

* NPSA benchmark: National Patient Safety Agency national benchmarking figure for NHS falls

## How we hope to achieve this

The IPU team will continue with the momentum of introducing IC gained in the Autumn of 2013 to a staff selected high-risk group of patients. In the Spring of 2014 a revised checklist will be created which will be relevant to the care needs of patients in their last few days of life also so IC can be introduced for all IPU patients.

In 2014-15 IC will be rolled out to IPU patients regardless of staff perceived risk using a NLH adapted IC checklist in one of two teams on the IPU. The use of the checklist in achieving the above stated objectives will be monitored and the value of IC for all patients on IPU will be evaluated in the Spring of 2015.

| TIME | ACTION |
|---|---|
| April 2014 | Adapted tool introduced to IPU staff and planned Red team (9 beds) three month pilot |
| May 2014 | Pilot commences with Monthly review |
| August 2014 | Review of pilot |
| October 2014 | Consideration of roll out of adapted IC to all patients on IPU. |
| March 2015 | Final review |

# Clinical effectiveness:

**Project One: Dementia care**

At the North London Hospice we want to make a real difference to the lives of people with dementia and their carers by building on the National Dementia Strategy (2009) and the Prime Ministers challenge on dementia (2012).

There is a real opportunity to build on this nationally led momentum to improve our services and extend our reach to a wider community. This will impact on our inpatient unit, supporting people in the community and providing specialist training and education to care homes.

## We hope to achieve this by doing the following:

- Provide dementia awareness sessions for all staff and volunteers.
- Provide different levels of dementia training for staff according to identified needs.
- To train key staff from NLH to become Dementia trainers who can then deliver further training.
- We plan to deliver dementia training externally to care homes and district nurses.
- We will work in partnership with the Enfield Dementia Action Alliance initiative.
- We will use the Kings Fund Dementia friendly assessment tool to enable us to assess our current environment and help identify areas that need modification. We will then use this information to inform the Inpatient refurbishment plan. The assessment tool can then be repeated to ensure we have addressed the issues relevant to our care setting.
- We plan to trial a clinical assessment tool for monitoring dementia patient's symptoms who are unable to communicate verbally on the in patient unit.

**Project Two: Introduction of Holistic Needs Assessment to work with patients and carers**

The initial impetus for the development of the use of the Holistic Needs Assessment (HNA) came from the aim to improve communication and co-ordination of support provided by the multi disciplinary team (MDT), particularly psychosocial needs and internal referral to Supportive Care Team (consists of Specialist Social Workers, Spiritual Care Coordinator, Loss and Transition team and Supportive Care Volunteers). Some of our newer staff had experienced working with the Distress Thermometer as a useful to understand patients' stress in a number of areas; valuing the way that what is important to patients becomes highlighted rather than relying on professional judgement alone. London Cancer have now licensed the tool so this makes the development more viable. They will be providing familiarisation sessions and structures to implement the HNA.

We recognise that this development will require a change to current practice, which has established over many years within a busy workforce. Its success will depend on staff believing/feeling that it enhances their role and

is not 'just another procedure' to follow. Our aim is that twelve members of staff are providing access to the HNA to 120 Patient/carer cases during the first year-three staff members from the two community teams, day services and the In Patient Unit respectively.

## What we would like to achieve

- Improved understanding of patient stress/need
- More accurate record of patient stress identified by patients & carers in care plans
- Systematic way of ensuring patient defined need is included in MDT meetings - ensuring that the results of a patient's HNA are taken into account in the decision making process.
- A clearer mechanism for internal referral from staff qualified to assess psychosocial need (nursing and medical staff) to Supportive Care staff specifically trained to work with greater complexity in this area.
- A mechanism that will assist Clinical Supervision Development, i.e. help practitioners identify psychosocial complexity and their need for support to address this



"This has been the best organisation we have contacted since my husband was diagnosed with a brain tumour. Everybody we have seen has been caring, effecient, practical and supportive. Couldn't ask for more."

# Statements of Assurance from the Board

The following are a series of statements (italicised) that all providers must include in their Quality Account. Many of these statements are not directly applicable to specialist palliative care providers.

# Review of services

*During 2013-2014, North London Hospice provided and/or sub-contracted 1 service where the direct care was NHS funded and 3 services that were part NHS funded through a grant.*

*The North London Hospice has reviewed all the data available to them on the quality of care in these NHS services.*

*The NHS grant income received for these services reviewed in 2013-2014 represents 27 per cent of the total operational income generated by the North London Hospice for the reporting period 2013-2014.*

# Participation in clinical audits

*During 2013-2014, there were 0 national clinical audits and 0 national confidential enquiries covering NHS services that North London Hospice provides. During that period North London Hospice did not participate in any national clinical audits or national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries that North London Hospice (NLH) was eligible to participate in during 2013-2014 are as follows (nil). The national clinical audits and national confidential enquiries that North London Hospice participated in, and for which data collection was completed for 2013-2014, are listed below alongside 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 (nil). The reports of 0 national clinical audits are reviewed by the provider in 2013-2014 and North London Hospice intends to take the following actions to improve the quality of healthcare provided (nil).*

To ensure that NLH is providing a consistently high quality service, it conducts its own clinical audits.

*The provider reviewed the reports of 7 local clinical audits in 2013-14 and North London Hospice undertook the following actions to improve the quality of healthcare provided.* A further, 6 were proposed and have been transferred over to next year's audit plan. More were planned but not completed in year. The reasons for this were the need to implement improvements first, staffing issues and national driver changes. In NLH Audit Strategy this year, the Audit Steering Group Chair has highlighted the need to increase competence and quality of audits. A business case is to be prepared for an Audit Lead post to support staff training. Additionally awareness had been raised of increased organizational support for audit and audit is to be included in staff appraisals and the 14-15 strategic plan.

NLH has taken or intends to take the following actions to improve the quality of healthcare provided:

# Summary of Audits 2013-14:

| AUDIT TOPICS | KEY FINDINGS | ACTIONS | ACTIONS OUTSTANDING |
|---|---|---|---|
| Internal CQC standards across services audit | All standards were met. 40% standards some actions for improvement were identified. | Consent policy to be reviewed. | IPU Consultant to action (May 14) |
| | | Safeguarding and DOLS process require further embedding. Action plan in place. | Ongoing. Completion of action plan June 14. |
| | | Care plans require development so incorporated into iCare. Work in process. | IPU nursing management leading (June 14)<br>Draft being consulted upon. Completion due June 14 |
| | | First assessment and risk assessment tools need to be made into SMART forms. Work in process. | Complete |
| | | In Patient volunteer communication log needs nutritional requirements updating-now in place. | Drug room being developed to support practice and training review planned after. |
| | | Single nurse admin training and competency require review. | By end July 14 |
| | | PAT testing periodicity required review. Asset register to be updated and policy updated | |
| | | Clinical waste SLA required | Completion due Dec 14. |
| | | H&S Audit and Enviro Audits due. In process | |
| | | Review of staff files so more ordered and usable. Programme underway. | By June 2014 |

| AUDIT TOPICS | KEY FINDINGS | ACTIONS | ACTIONS OUTSTANDING |
|---|---|---|---|
| | | Nurses' competency working group to be set up. Set up.<br><br>Standard induction document required.<br><br>Agreed list of abbreviations required. Draft list being consulted on. | By September 2014 |
| External Infection Control | Extensive audit Some recurrent IPU themes from last year relate to refurbishment need.<br><br>Enfield site included for first time and minor areas identified. | IPU plan with costings currently being considered.<br><br>Enfield action plan underway. | IPU refurbishment due to commence April 14. |
| Advanced care Planning | Overall evidence of an ACP discussion, or decision not to discuss ACP was documented in 23/40 (57.5%) notes<br><br>This overall documentation included patients who were offered ACP discussions but declined conversation or were unable to participate in ACP. Patients without capacity, but for whom care planning discussions were held in best interests, are included.<br><br>3 patients overall had completed an ADRT. | Present results to community team business meeting<br><br>Lead discussion with CNSs re use of ACP code and SMART forms to understand reasons not used<br><br>Agree standard for documentation in 1st visit and MDT forms and use of ACP code<br><br>Revise SMART form attached to ACP code and introduce new form<br><br>Teaching session for community team<br><br>Use of MDT monitor to en sure code in place | Planned for next meeting<br><br>Draft SMART form being consulted upon by team |

| AUDIT TOPICS | KEY FINDINGS | ACTIONS | ACTIONS OUTSTANDING |
|---|---|---|---|
| LCP Communication Audit | 95% records show relative aware patient dying<br><br>42% records of conversation with relative prior to commencing pathway<br><br>80% record of ongoing conversations re pathway use<br><br>40% use of ICare code for conversations | Leaflet introduced for families re use of LCP.<br><br>In view of national LCP review recommendations issues relating to communication and documentation will be incorporated into new end of life care plans | Leaflets were introduced but now withdrawn due to LCP withdrawal<br><br>Awaiting national recommendations<br><br>End of life care plan documentation has been adapted. Work ongoing to amalgamate this with care rounding work. |
| Anti emetic prescribing in the Community | In 79% cases drugs were documented and review plans were in place. 62% adherence to 1st line prescribing and 67% to 2nd line. Unable to comment on teams adherence to guidelines as audit identified it was not always clear if initial prescriber was advised by NLH. | Guidelines to be reviewed including access.<br><br>Standards to be set on documentation of prescribing advice | Guidelines reviewed, awaiting ratification at Q&R<br><br>Standards agreed and to be incorporated into operational policy (May 14) |
| Re audit of documentation of opioids on ICare for community patients | Total agreement between medication chart and notes 43% (45% in 2012-13)<br><br>No prescribing outside guidelines noted | Ops policy to include standards expected re documentation and communicated at induction<br><br>Medication monitor introduced in MDT meeting to ensure drug chart completed<br><br>All staff training on ICare documentation of medication | Operational policy due to be updated by May 14<br><br>Commenced and ongoing<br><br>Ongoing |

| AUDIT TOPICS | KEY FINDINGS | ACTIONS | ACTIONS OUTSTANDING |
|---|---|---|---|
| Baseline ascites practice and documentation audit | In general documentation was good. Each patient had a full admission clerking with a drug history and with a plan for paracentesis.<br><br>There was a lack of documentation of plans for future paracentesis procedures and discussions with patients about the proposed benefits of these future drains. | Develop discharge summaries template<br><br>Develop ICare SMART form re paracentesis to ensure key information documented.<br><br>Develop policy and pathway re ascites referral for paracentesis<br><br>Repeat audit after introduction of NLH ultrasound service. | Jo Brady to action by May 14<br><br>Jo Brady to action by May 14<br><br>Policy written and peer review. Awaiting agreement by policy group<br><br>All patients requiring paracentesis accessed an ultrasound since development of ultrasound service.<br><br>Will aim to review policy adherence once ratified and embedded. |

## Research

*The number of patients receiving NHS services, provided or sub-contracted by North London Hospice in 2032/2014, that were recruited during that period to participate in research approved by a research ethics committee was 0.*

*There were no appropriate, national, ethically approved research studies in palliative care in which NLH was contracted to participate in.*

## Quality improvement and innovation goals agreed with our commissioners

*North London Hospice income in 2013/2014 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.*

## What others say about us

*NLH is required to register with the Care Quality Commission and its current registration status is unconditional. North London Hospice has the following conditions on its registration (none).*

This registration system ensures that people can expect services to meet essential standards of quality and safety that respect their dignity and protect their rights

*The Care Quality Commission has not taken any enforcement action against North London Hospice during 2013- 2014.*

NLH is fully compliant with "Essential Standards of Quality and Safety" (Care Quality Commission, 2010).

In February 2014 (Finchley site) and November2013 (Enfield site) the CQC carried out unannounced inspections as part of a routine schedule of planned reviews. Full details can be viewed at www.cqc.org.uk/node 293531 and www.cqc.org.uk/node/504055 respectively.They observed how people were being cared for, talked to staff and talked to people who used our services. NLH was found to be compliant in all of the areas assessed.

*North London Hospice has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.*

## Data quality

*North London Hospice did not submit records during 2013-2014 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data as it is not applicable to independent hospices.*

## Information Governance Toolkit Version 11 submission March 2014

The IG Toolkit is an online system which requires NHS organisations and business partners to assess themselves against Department of Health Information Governance Standards. For a more detailed explanation see Appendix Two page 50.

In March we completed the year end report and the Hospice has declared compliance at Level 2 for all the Standards. In addition we have compliance on 24 standards at Level 3. North London Hospice Information Governance assessment reports overall score for 2013-14 was 96% and was graded as satisfactory. The Hospice has been unable to declare competence at Level 3 against three Standards. In each case, the reason is that we have not completed a formal satisfaction survey to check that service users feel confident that their confidentiality is respected. For the Hospice to be compliant in 2014/15 we have included a suitable question in the User Survey for that year.

To access the report see https://www.igt.hscic.gov.uk/AssessmentReportCriteria.aspx?tk=417355612015766&lnv=3&cb=fd03fc cd-efaa-42b3-93bc-4b80534f46ee&sViewOrgId=10252&sDesc=8A601

## Action Plan for 2014/15

During 2014/15 the Hospice will aim to achieve compliance at Level 3, subject to the publication of the revised V12 of the IGT, due July 2014.

## Connecting to the NHS System (N3)

The Hospice has applied to the Health and Social Care Information Centre for access to the NHS N3 network. This has been approved and in September the necessary lines and equipment were installed.

Following the connection to the N3 service, identified Hospice staff have access to the nhs.net e-mail system. NHSmail is a secure service, approved for the transmission of patient data. Using NHSmail instead of traditional paper and phone based processes speeds up communication, benefitting patients

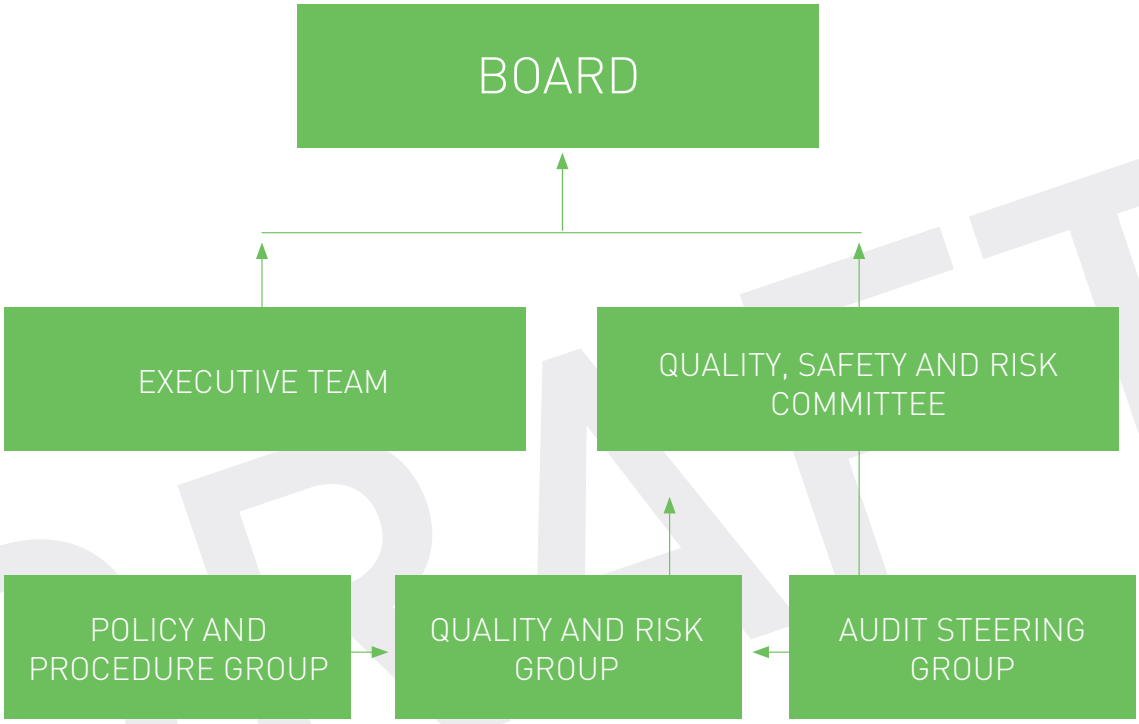
In due course, it will allow the Hospice to fully engage with the Coordinate my Care service which shares information between healthcare providers in coordinating care which is focused around patient preferences.

*North London Hospice was not subject to the payments by results clinical coding audit during 2013-14 by the Audit Commission.* This is not applicable to independent hospices.

# PART 3: QUALITY OVERVIEW

## Quality Systems

NLH has quality at the centre of its agenda. The Executive Team identified "A unified organisation which is financially viable and delivering high quality services" as its overall strategic planning aim for the subsequent three years in December 2011. It has six main groups that oversee quality review and development within the organisation.




See Appendix Three (see page 50) for role description of above groups

## Key Service Developments of 2013-14:

**Remodelling of Reception area at Finchley site**

A DoH grant awarded in April 2013 enabled us to undertake an 8-week project to re-model our Reception Area and communal space and we now have an area, which is bright, light and airy where patients and visitors can sit and chat over a cup of tea, and where patients and their families can enjoy a meal together. We also have four multi – purpose rooms to be used for a range of patient focused activities.

**Meet and Greet development at Finchley site**

Following the success of the "meet and greet" model of working at our Enfield site we now have a similar way of working at Finchley. In office hours, every visitor is met at the door by a volunteer or staff member and directed or supported accordingly. The role of our Front of House team has been enhanced to ensure we display behaviours, which allow visitors, and patients to feel acknowledged and looked after from the moment they arrive to the moment they leave. Our goal is to ensure there is always someone available when anyone wants to talk or would like to have some company. Spending time at the Hospice can be difficult so we aim to do all we can to make it as comfortable as possible.

### Day Services Developments

Work has been taking place to develop our range of programmed therapies in anticipation of growth in numbers of patients and carers using the service and the move to cross-site working so that day services will be more accessible. A new chef has helped create a vibrant atmosphere, providing restaurant standard meals. The menu is seasonal, using products we have sourced from local supplies. Funding has been secured from an individual donor for an Art Therapist for six months, who provides an Art Therapy Group as well as seeing individual patients. The Psychological Therapies service started in the autumn of 2013 providing programmes of support to individual patients and carers.

### Therapy Dog Visits

Registered Therapy Dog, Blossom, and her owner, have joined the team in the Open Space every Thursday. The In Patient Unit also have a therapy dog called Simba who visits weekly.

### Wound management on IPU

In 2012-13 wound care planning was a Priority for Improvement project. IPU nurses were surveyed about their learning needs in this area and an audit of pressure sore documentation was completed. Subsequently wound care competencies were written and training sessions were held. This year further training has occurred and governance agreement is being sought from SMT before implementing competencies. A reaudit is planned for 2015-16 audit cycle.

### Community Intervention Project

NLH were successful in a bid it put together to Macmillan Cancer Support to become one of six pilot sites for a 2-year joint Community project which would further test a model of care that maximizes patient choice by providing as much treatment and support in the home or the community. The overall aims of the project are to provide data on how realistic and cost effective to the NHS this model of care is.

Our vision for the project is to develop and integrate our day care services with our community services to provide greater patient choice and flexibility in out of hospital/hospice care. In addition, we wish to extend our range of community clinical and voluntary services and introduce further capability for rapid response when a patient is in crisis and the ability to support patients earlier on in their illness trajectory. Delivery of our vision for this project will enhance our existing services

Both Barnet and Enfield Community Services have adopted PCSS with great success and hence the number of patients using the service has steadily increased over the year. Due to this increase of activity, an electronic booking system will be introduced in 2014. This will expatiate the process providing a greater scope for management of an increased number of staff, and therefore enable more patients to receive the service.

### PCSS developments

PCSS has been providing volunteers as a friendly neighbour scheme for over a year. Limited recourses have meant growth has been slow. This was identified as a need and therefore within the Community Intervention project funded by Macmillan Cancer Support, there is provision for a Volunteer Coordinator to work with existing NLH Volunteer Leads to increase the number of volunteers and promotes the service within patients homes.

Following an audit on the last audit cycle, there was an identified need for a greater awareness of personal safety for our lone workers. An 'Am I Safe?' culture has been introduced throughout the service.

# Partnership working

In addition to the clinical service provision, NLH works with voluntary and statutory agencies within the locality in the following ways:

1. NLH is actively involved in local End-of-Life Boards which work in partnership to achieve local end-of-life strategies and share best practice.
2. Clinicians attend General Practice Gold Standard Framework meetings which review the care of end of life patients being cared for by individual practice teams.
3. NLH is part of PallE8 a specialist palliative and end of life care expert group for North Central and North East London.
4. NLH is a member of Enfield Dementia Action Alliance (see page 10)
5. NLH is providing specialist palliative care input into Barnet CCG's 'frail elderly MDT' pilot. Initial assessment suggests the MDT is reducing unnecessary admissions. This will be reviewed formally in June of this year.
6. NLH participates in London Cancer's Psychosocial Forum which has developed a multiagency approach to introducing the Holistic Needs Assessment (see page 11).
7. In 2013 NLH embarked on some early work for hospice services to benchmark incident data for falls, pressure ulcers and medicine errors. This has proved to be difficult due to the inconsistency between hospices of how such data is collected and the lack of data analysis resources within small independent hospice organisations. This inter hospice group has however proved invaluable in sharing good practice. Help the Hospice the national organisation for Hospices is now going to build on this early work and as a result have set up a national benchmarking exercise which NLH have registered to be a pilot site. Data will start to be shared this year.

# Education and training

**NLH delivers for external professionals**

- Bi-annually 'Introduction to Palliative Care' course aimed at trained nurses and allied health professionals and runs over four days.
- 'Introduction to Palliative Care' course aimed at Health Care Assistants and Support Workers and runs over four half days.
- Syringe driver training, assisting nursing homes and district nurses to become familiar with the new CME T34 syringe driver.
- Twice a year we run a session for King's College Medical students, providing them with an insight into palliative care and the role of the hospice.

**New this year:**

- We have also run a new course this year, 'Communication skills and advance care planning'.
- As a Gold Standards Framework regional centre for end-of-life training for care homes the hospice has commenced three training programmes for over 50 care homes in the boroughs of Barnet, Enfield, Haringey, Tower Hamlets, Hackney, Newham, Camden and Islington.

**NLH provides a variety of training placements for:**

- Placements for Specialty Registrars from LETB- Health Education North Central and East London and SHOs from Barnet General Practitioner Vocational Training Scheme
- Student nurses with the University of Hertfordshire
- Social work students' placements with London South Bank University

- Half & one day hospice placements for final year medical students
- Chaplaincy placements
- Work experience for 16 and 17 year-olds wishing to apply for nurse, medical, allied health professional training.

NLH provides a rolling induction programme for  NLH new staff and volunteers as well as annual mandatory training. Additional internal training is also provided for staff. This year, 10 clinicians have attended an in-depth advanced communication skills course.

## Care Environment

On a daily basis the Facilities team at NLH seek to create a welcoming, pleasant and comfortable care environment, which makes patients, and their visitors feel at ease. Safety and cleanliness are at the centre of our routines. During our most recent CQC inspection of the Finchley site one of our patients stated, "they clean everything every day and even that is done with care." Another said, "the cleanliness is excellent, the floors are always being mopped and the sinks are cleaned too."  The CQC inspector noted the patient rooms and clinical areas were clean and free from clutter. As a team we are delighted that patients are satisfied with the levels of cleanliness in the Hospice.  Alongside the need to have a clean environment is our desire to maintain a homely and relaxed atmosphere, little touches such as the volunteer flower ladies who look after our plants and arrange flowers make this achievable. Whenever possible patients are encouraged to use the outside space to have some fresh air and see a different perspective.



"The only complaint he had was boredom. When he felt well he would have liked maybe to see other patients. It makes the time go quicker. He never saw any of them."

# SERVICE ACTIVITY DATA

## IPU Service

The figures for the In Patient Unit have been provided in line with the Minimum Data Set information collected by the National Council for Palliative Care. This data relates to completed admissions by end of March 2014.

| ALL ADMISSIONS | 2011 TO 2012 | 2012 TO 2013 | APRIL 2013 TO MARCH 2014 | | | |
|---|---|---|---|---|---|---|
| | | | BARNET | ENFIELD | HARINGEY | TOTAL |
| **Admissions to the IPU:** | | | | | | |
| Patient Admissions | 304 | 313 | 161 | 131 | 22 | 314 |
| % Patients with cancer | 90% | 89% | 83% | 88% | 86% | 86% |
| % Patients with non cancer | 10% | 11% | 17% | 12% | 14% | 14% |
| **Completed in patient stays:** | | | | | | |
| Total number discharged | 82 | 89 | 37 | 39 | 6 | 82 |
| Discharged to acute | 12 | 4 | 3 | 3 | 1 | 7 |
| % patients returning home | 25% | 25% | 24% | 25% | 24% | 24% |
| Total number of patients | 233 | 264 | 125 | 113 | 18 | 256 |
| % patients who died | 72% | 74% | 75% | 72% | 72% | 73% |
| Average length of stay | 14 | 12.6 | 14.2 | 12.2 | 8.5 | 13.3 |
| Day Cases | 4 | 9 | 0 | 3 | 5 | 8 |

**Analysis:**

- Activity has not changed significantly compared to previous two years data.
- Except the percentage of patients with a non cancer diagnosis has increased to 14% compared to 115 in 22012-13 and 10% in 2011-12.

# Bed Usage

| ALL ADMISSIONS | 2011 TO 2012 | 2012 TO 2013 | APRIL 2013 TO MARCH 2014 | | | |
|---|---|---|---|---|---|---|
| | | | BARNET | ENFIELD | HARINGEY | TOTAL |
| Bed Occupancy | 73% | 73% | 39% | 30% | 3% | 73% |
| Closed bed days | 156 | 85 | | | | |

**Analysis:**

- Bed occupancy has remained at 73% on NLH's 17 bedded IPU.
- Closed bed days at 116 was higher than 2012-13 of 85 days but lower than 2011-12 figures of 156.

**Comment:**

- The majority of closed bed days was due to plumbing problems that were experienced during the year in several different patient rooms which have now been rectified. There were also closed bed days due to deep cleaning requirements of rooms in which patients with MRSA had been cared for.
- There have been times when there has been capacity to admit but no patients ready or on the list for admission.
- Staffing issues have affected bed occupancy this year. IPU staff sickness and junior doctors maternity cover have impacted. Staff sickness is being addressed from the 1st April 2014 with the implementation of the Bradford Score (looks at frequent short sickness episodes within a framework of actions).
- This year the rotas of doctors on IPU have been adjusted to enable seven day a week planned admissions.

# Day Care Services

This is the first full year data is available on the new model of Day Service at the Enfield site which started caring for patients in August 2012.

| | APRIL 2013 TO FEBRUARY 2014 | | | TOTAL |
|---|---|---|---|---|
| | BARNET | ENFIELD | HARINGEY | TOTAL |
| Total number of Patients | 64 | 110 | 10 | 184 |
| Patient Attendances | 294 | 603 | 30 | 927 |
| % patients with cancer | 80% | 94% | 90% | 88% |
| % patients with non cancer | 20% | 6% | 10% | 12% |
| Therapy session -patient | 461 | 1116 | 61 | 1638 |
| Therapy session- carer | 58 | 95 | 7 | 160 |

**Analysis:**

- It is noted that more Enfield patients use Enfield Day Service than Barnet patients.

**Comment:**

These differences have been noted. It has always been NLH's vision to deliver day services sessions at the Finchley site once the new Day Services model was established at Enfield and resources allowed expansion to two sites. Day service expansion to the Finchley site is planned for the summer of 2014.

# COMMUNITY TEAMS

## Highlight information

| | 2011 TO 2012 | 2012 TO 2013 | APRIL 2013 TO MARCH 2014 | | | |
|---|---|---|---|---|---|---|
| | | | BARNET | ENFIELD | HARINGEY | TOTAL |
| Total number of Patients | 1237 | 1265 | 634 | 567 | 50 | 1251 |
| % Patients with cancer | 79% | 76% | 77% | 82% | 88% | 80% |
| % Patients with non cancer | 21% | 24% | 23% | 18% | 12% | 20% |
| Number of Patients who died within the Service | 717 | 772 | 346 | 299 | 27 | 672 |
| Died (%) at home (care home) | 56% | 55% | 57% | 59% | 37% | 58% |
| Died (%) hospice | 24% | 22% | 20% | 20% | 40% | 21% |
| Died (%) hospital | 19% | 20% | 21% | 21% | 20% | 20% |
| Died (%) other | 1% | 3% | 2% | 0 | 3% | 1% |
| Average number of Visits and Telephone Calls made by the Community Team to each patient during office hours | | | | | | |
| Visits | 5 | 5 | 4.7 | 5.5 | 6 | 5.1 |
| Phone calls to Patient/Family | 16 | 12 | 11 | 13 | 11 | 12 |
| Phone calls to other professionals | 9 | 12 | 8 | 8 | 8 | 8 |
| Average number of Telephone Calls made out of hours and at weekends to each patient | | | | | | |
| Phone calls to Patient/Family | 0.5 | 3 | 2 | 3 | 3 | 2 |
| Phone calls to other professionals | 0.6 | 1 | 1 | 1 | 1 | 1 |

**Analysis:**

- Total number of patients cared for by the service has remained fairly consistent with previous two years.
- The percentage of non cancer patients has decreased to 20% compared to 24% in 2012-13 but similar to 2011-12 figure of 21%.
- Less patients are dying with the service 54% versus 61% in 2012-13 and 58% in 2011-12.
- More patients are being supported to die at home 58% versus 55% in 2012-13 and 56% in 2011-12.
- The average number of visits made to community patients during office hours remains consistent at a total of 5.1 as have the average number of phone calls to patients and families at 12 per patient.
- It is noted that the average number of telephone calls to professionals has decreased to 8 from 12 in 2012-13 and 9 in 2011-12.

**Comments:**

- The drop in 4% of non-cancer patients between 2013-14 compared to 2012-13 may be attributable to the presence of the new Day Service model which may be where these patients are being seen.
- It is to be noted that staff are logging more multiple calls into one entry affecting re number of professional calls.

# Palliative Care Support Service (PCSS)

| | 2011 TO 2012 | 2012 TO 2013 | APRIL 2013 TO MARCH 2014 | | |
|---|---|---|---|---|---|
| | | | BARNET | ENFIELD | TOTAL |
| Total number of Patients | 188 | 241 | 143(142) | 135 | 278 (277) |
| % Patients with cancer | 82% | 83% | 78% (78%) | 84% (84%) | 81% (81%) |
| % Patients with non cancer | 18% | 17% | 22% (22%) | 16% (16%) | 19% (19%) |
| Total hours direct care | 8339 | 9497 | 8751 (6785) | 7493 | 16244 (14278) |
| Average hours direct care per patient | 44 | 39.25 | 61.2 (47.8) | 55.5 | 58.4 (51.55) |

Total year figures are provided out of brackets.

The totals in bracket do not include care given to a Barnet resident who required high levels of multidisciplinary specialist care that could only be provided in an inpatient hospice setting. This patient was cared for on the IPU from December 2013 and required PCSS nursing care as well as IPU team care. An additional 1,966 hours of care have been given since admission. If these hours are included the average hours of direct care for Barnet patients is 61.2 and for the Service as a whole, 58.4, as detailed above.

| PCSS CARE PROVIDED FOR EACH BOROUGH APRIL 2013 TO MARCH 2014 | | | |
|---|---|---|---|
| | BARNET | ENFIELD | TOTAL |
| Total hours of care | 8751 | 7493 | 16244 |
| Health Care Assistants | 8073 (92%) | 6893 (92%) | 14966 (92%) |
| Registered Nurses | 678 (8%) | 600 (8%) | 1278 (8%) |

**Analysis:**

- Total number of patients has increased by 15 % since 2012-13.
- There has been a very slight increase in care provided to non cancer patients (19% in 2013-14 vs 17% in 2012-1 and 18% 2011-12)
- Total hours of direct care has increased by71% since 2012-13
- Average hours of direct care per patient has increased to 51.55 (not including complex IPU patient) a rise of 31% versus 39.2 in 2012-13
- The division of care between HCAs and RNs in consistent across boroughs at 92% HCA and 8% RN.

# Supportive Care Team

| | OCTOBER 2013 TO MARCH 2014 | | | |
|---|---|---|---|---|
| | BARNET | ENFIELD | HARINGEY | TOTAL |
| **1. Spiritual Care Team (IPU)** | | | | |
| Number of clients in the In Patient Unit | 134 | 110 | 18 | 313 |
| Number of clients seen by the Spiritual care Coordinator | 47 | 42 | 9 | 98 |
| Number of contacts by Spiritual Care Coordinator | 95 | 86 | 13 | 194 |
| Average number of contacts by Spiritual Care Co-ordinator | 2.0 | 2.0 | 1.4 | 2.0 |
| Number of clients seen by the Spiritual Care Chaplains | 60 | 53 | 7 | 120 |
| Number of contacts by volunteer IPU Chaplin's | 318 | 330 | 30 | 678 |
| Average number of contacts by volunteer IPU Chaplains | 5.3 | 6.2 | 4.3 | 5.7 |
| **2. Social Workers Team (IPU and Community)** | | | | |
| Number of clients seen by Social Workers | 133 | 166 | 14 | 263 |
| Number of face to face visits by Social Workers | 264 | 215 | 35 | 514 |
| Number of Telephone Contacts by Social Workers | 711 | 503 | 76 | 1290 |
| Average number of contacts by Social Workers | 7.3 | 4.3 | 7.9 | 6.9 |
| **3. Loss and Transition Service (including Crimson Volunteers)** | | | | |
| Number of clients seen by Staff | 45 | 41 | 4 | 90 |
| Number of visits made by Staff | 102 | 119 | 12 | 233 |
| Average number of visits by staff per client | 2.25 | 2.9 | 3 | 2.6 |
| Number of clients seen by Volunteers | 27 | 25 | 3 | 55 |
| Number of Volunteer Sessions | 323 | 308 | 33 | 664 |
| Average number of sessions by Volunteers per client | 12 | 12.3 | 11 | 12.1 |

Client=patient or significant others

**Comment:**

This is the first year we have reported on Supportive care team activity. Supportive Care makes a significant contribution to the multi-disciplinary team working who support patients and families. This ranges from specialist professional support provided by the Spiritual Care Co-ordinator, Specialist Social Work staff as well as Loss and Transition staff who offer bereavement support for more complex situations. Integral to our social work and spiritual care offer is the vital work undertaken by dedicated volunteer chaplains who are volunteers as well as trained volunteers attached to the Loss & Transition service which is part of the community team and who provide pre and post bereavement emotional support. In a six month period these volunteers have provided 664 support session whilst their chaplaincy colleagues provided 678 contacts to patients on the Inpatient Unit. This amounts to an involvement by Supportive Care volunteers for 223 times during an average month. This is a significant contribution to our service delivery and it takes a great deal of dedication by paid staff to train and support volunteers to provide this so that in the community volunteers are able to provide quality and quantity of time thatt patients and carers need.Equally in the IPU the combination of only one staff member and a team of volunteer chaplainswho make up thee spiritual care team has resulted in a high degree of response and support.

# SERVICE USER EXPERIENCE:

NLH remains committed to listening to the views of patients, relatives, carers and friends across all of its services. Since 2011 NLH has been sending out user surveys annually. Comments cards remain in use. Since 2012 NLH has been gathering patient stories to add richer narrative data to our user feedback. These have enabled us to gain more up to date feedback and as also not anonymised enables us to take immediate action. This is known as real time reporting and is an area we plan to develop further in 2014-15 with new external funding for real time reporting software and devices.

**The following are key performance measures we rate NLH against.**

| QUALITY AND PERFORMANCE INDICATORS | QUALITY AND PERFORMANCE INDICATOR(S) | THRESHOLD | OUTCOME 2012-13 | OUTCOME 2013-14 |
|---|---|---|---|---|
| Service User Experience | % of patient/carers satisfied with the service | 80% | 100% (n=87) rated care as satisfactory and above | 99% (n=102) rated care as satisfactory and above |
| Service User Experience | % who would recommend service to friends & family | 80% | 98% (n=85) would recommend service to friends & family | 98% (n=103) would recommend service to friends & family |
| Relatives Experience | % of patient/carers satisfied with the service | 80% | 100% (n=138) rated care as satisfactory and above | 99% (n=116) rated care as satisfactory and above |
| Relatives Experience | % who would recommend service to friends & family | 80% | 99% (n=216) would recommend service to friends & family | 98% (n=119) would recommend service to friends & family |

# Surveys:

232 survey responses were received from the total of 729 sent to:

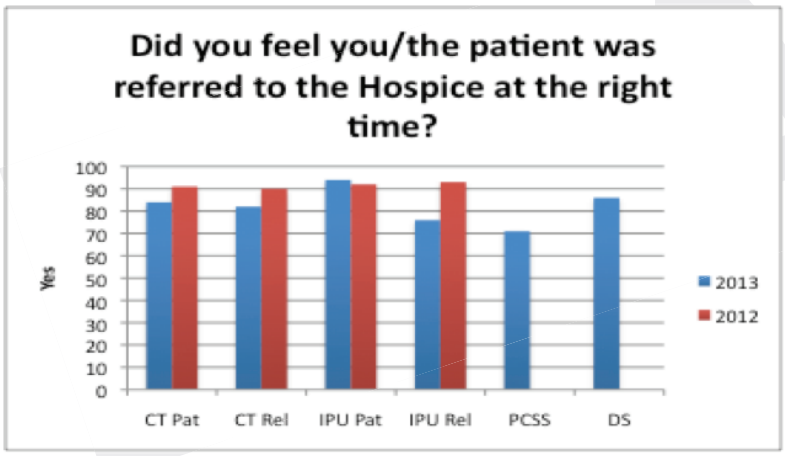
- Community Team patients (CT)
- Relatives/carers of Community Team patients (CT Rel)
- Inpatient Unit patients (IPU)
- Relatives/carers of Inpatient Unit patients (IPU Rel)
- Relatives/carers of patients who used the Palliative Care Support Service (PCSS)
- Day Services (DS) patients*

*Day Service patients were not surveyed in 2012 as the service was not fully operational during the survey period, so no comparisons with 2013 are available.

As in previous years, the results have been calculated using the answer Yes/Agreed in any degree (including Sometimes/Somewhat).

3 Key Performance Indicators were measured in the 2012-13 & 2013-14 surveys:

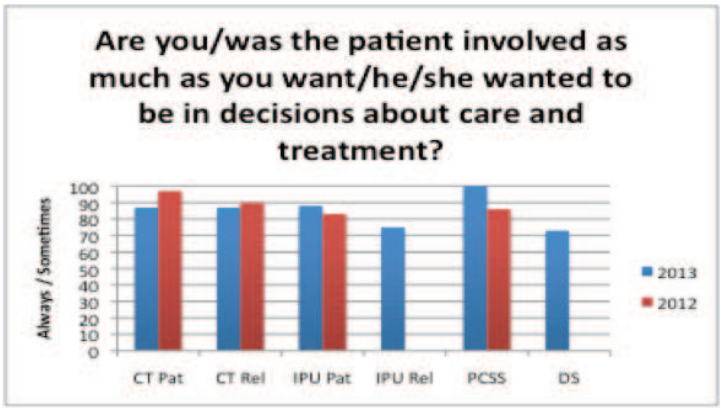
**Key Performance Indicator 1: 2013**




| | | |
|---|---|---|
| CT Pat | 84% | N=61 |
| CT Rel | 82% | N=51 |
| IPU Pat | 94% | N=18 |
| IPU Rel | 76% | N=46 |
| PCSS | 71% | N=24 |
| DS | 86% | N=28 |

The results show that patients felt that they had been referred at the right time. However there was an increase in CT and IPU relatives feeling referrals should have been made sooner.

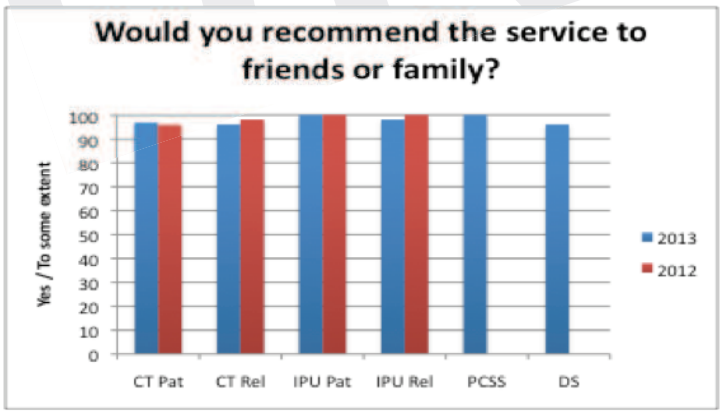
Key Performance Indicator 2: 2013




| | | |
|---|---|---|
| CT Pat | 87% | N=60 |
| CT Rel | 87% | N=51 |
| IPU Pat | 88% | N=17 |
| IPU Rel | 75% | N=35 |
| PCSS | 100% | N=22 |
| DS | 73% | N=26 |

2013 has seen an increase in positive responses from PCSS & IPU patients. Two CT patients responded 'No', however we cannot determine if they felt they wanted to be more or less involved.

Key Performance Indicator 3 - NHS Family and Friends test




This question is for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from A&E. It is not currently a mandatory question for other healthcare providers but is likely to become one in the future. The Hospice has included this question to all services since the first surveys in 2011.

| | CT Pats | CT Rels | IPU Pats | IPU Rels | PCSS | DS |
|---|---|---|---|---|---|---|
| 2013 n= | 59 | 53 | 18 | 43 | 23 | 26 |

The average of all services is the same as in 2012 at 98%. The IPU Rels reduction is due to one person responding 'Not Sure'. The Ct Rels reduction is due to 3 people responding 'To some extent'.

**Other Key results:**

Overall care rated 'satisfactory' and above

| | CT | CT Rel | IPU | IPU Rel | PCSS | DS | Average |
|---|---|---|---|---|---|---|---|
| 2013 | 100% | 96% | 100% | 98% | 100% | 96% | 98% |
| n= | 58 | 51 | 18 | 42 | 23 | 26 | |
| 2012 | 100% | 100% | 100% | 100% | 100% | - | 100% |
| n= | 74 | 88 | 13 | 43 | 7 | - | |

**Were you/the patient treated with respect and dignity?**

| | CT | CT Rel | IPU | IPU Rel | PCSS | DS | Average |
|---|---|---|---|---|---|---|---|
| 2013 | 100% | 98% | 100% | 100% | 100% | 96% | 99% |
| n= | 59 | 52 | 18 | 41 | 23 | 28 | |
| 2012 | 97% | n/a | 100% | 100% | 100% | - | 99% |
| n= | 75 | n/a | 11 | 42 | 7 | - | - |

The surveys also gave an opportunity to make individual comments throughout.

## Comments:

| TOTAL NO. OF COMMENTS INCLUDED: | 612 | |
|---|---|---|
| Positive comments: | 338 | 55% |
| Negative comments: | 122 | 20% |

| SERVICE | POSITIVE | NEGATIVE | OTHER |
|---|---|---|---|
| Community Team patients (n=56) | 70% | 4% | 26% |
| Community Team relatives (n=87) | 60% | 21% | 19% |
| Inpatient Unit patients (n=92) | 47% | 27% | 26% |
| Inpatient Unit relatives (n=183) | 55% | 16% | 29% |
| Palliative Care Support Service (n=86) | 59% | 28% | 13% |
| Day Service Patients (n=108) | 48% | 21% | 31% |

**Some comments from surveys:**

" Overall the staff at the Hospice do an excellent job. They are caring and listen to what you have to say. They also give excellent service with regards to controlling side effects as a result of treatment and are able to prescribe necessary drugs to help."

"I don't like the unwillingness of staff to let patients get up before 8am. I have asked to be moved to my chair before 8am & staff are reluctant to oblige"

"Thank you for your lovely and kind support to me and my family. It was my great pleasure being here and they did make my life a bit easier and also manage my pain."

## Case Studies

By giving people the opportunity to tell their own story, we can hear about their experience as a whole and it is often the smaller details that give us greater insight into what makes a difference to patients and families in our care.

Case studies have been obtained from across all services - some involve more than one service. Two examples of these are on pages...and ...

| SERVICE | TOTAL | POSITIVE | NEGATIVE | MIXED | OTHER ISSUES |
|---|---|---|---|---|---|
| Inpatient Unit | 10 | 8 | | 1 | 1 |
| Community Teams | 4 | 4 | | | |
| Day Services | 10 | 7 | 1 | 2 | |
| PCSS | 0 | | | | |
| Mixed | 1 | | | 1 | |

NLH is committed to listening to the views of patients, relatives, carers and friends across all services. We will continue to ensure that staff across the organisation consider these views when evaluating and developing services.

User feedback is sent to service management teams at least every quarter and action plans are created. These action plans are monitored by User Involvement Lead and Governance groups as agenda items.

# COMPLAINTS

| Quality Performance Indicator | Threshold | Outcome 2011-12 | Outcome 2012-13 | Outcome 2013-14 |
|---|---|---|---|---|
| Number of Complaints | 25 | 31 | 19 | 34 |

| Quality Performance Indicator | Outcome 2011-12 | Outcome 2012-13 | Outcome 2013-14 |
|---|---|---|---|
| Investigations completed at 31st Mar 14 | 25 | 14 | 25 |
| Investigations incomplete at 31st Mar 14 | 6 | 5 | 9 |
| Investigations completed, complaint upheld/partially upheld | 21 | 13 | 18 |
| Investigations completed, complaint not upheld | 4 | 1 | 7 |

| | | | | | |
|---|---|---|---|---|---|
| The number of complaints action plans completed | 90% | 100% | 19(90.4%) completed 2 (9.6%) Action Plans being completed | 14 (100%) completed | 17 (65%) completed. 9 (35%) action plans being completed) |

**Analysis:**

It is noted that complaints have increased to 34 from 19 in 2012-13 but were 31 in 2011-12. It is highlighted that NLH also reports here complaints received from its retail operations (number =8).

Trends examined during the year were:

- Managing patient expectation (August 2013)
- Staff communication (November 2013)
- Care quality (December 2013).

Some actions taken by NLH in response to complaints are:

- Community service standard re repeated patient calls in short period trigger a home visit.
- Communications training attendance for identified staff
- Plan for assessment of literacy and numeracy at recruitment.
- Staff communication training needs analysis
- Specific staff training on care of a patient with multiple sclerosis/hydration in the dying cared for by PCSS
- Shops memo re not selling real fur

No complaints were referred to The Parliamentary and Health Service Ombudsman.

# PATIENT SAFETY

## Incidents

| | 2011-12 | 2012-13 | April 2013 to March 2014 | | | |
|---|---|---|---|---|---|---|
| Total number of Incidents | 207 | | 279 | | 246 | |
| Number of Clinical Incidents | 147 | 71% | 168 | 60% | 167 | 68% |

- Slips, Trips and Falls remain the most frequent clinical incident reported (see further discussion below).
- 5 root cause analyses (RCA) were undertaken to examine deeper the causes of incidents and action plans developed and learning shared.
- One incident had a "catastrophic" harm level and related to a patient suicide.RCA identified nothing that NLH could have done to prevent this occurring.
- Six of the 168 incidents (3.6% of all incidents) were scored as major. This is a drop in the previous year where the incidence was 5% (n=279) Quarter One Incident Review noted peak time of all incidences of 1200-1800. This was communicated to all staff to increase vigilance and awareness and no new peak time was noted in subsequent quarters.
- An increase in Drug Error incidents reported prompted a retrospective drug error review along with on-going monthly scrutiny. Omissions were the commonest of errors. It was reinforced the importance of not interrupting staff during drug administration. Errors were detected sometime after drug was due despite the practice of repeated drug chart scrutiny. Results showed no specific identified trends relating to times of day or how busy the unit was. There were trends noted however around staff involvement. A retrospective Specific Staff Drug Error Review (1st October 2012-30th September 2013) was undertaken to review individuals involved and to address any competency and training needs. The key learning identified was to review policy/procedure around Single Nurse Administartion Training competencies/when staff undertake a re-test.

  The number of reported drug errors has decreased since these issues were highlighted to the team.
- 49 reported incidents related to pressure sore presence on admission or development (see page 37). This is an increase since 2012-13 and 2011-12 when there were 11 each year reported through the incidence process. This however can be attributed to new procedure of the reporting of grade two pressure sores which account for 39 incidents reported this year.

**Comment:**

- The scrutiny of all patient safety incidents continue through our incident reporting process and review where any learning or ongoing risk is identified and acted on. Monthly scrutiny through governance structures looking for trends and service risks occur.
- Risk assessments and risk registers are monitored and risk reduction measures undertaken where possible.

# Falls:

| | 2011-12 | | 2012-13 | | 2013-14 | |
|---|---|---|---|---|---|---|
| Number of Patient related Slips/Trips/Falls (% of all incidents) | 57 | 28% | 60 | 22% | 59 | 24% |
| Falls per occupied bed days | 12.9 | | 13.45 | | 13.2 | |

National benchmark of 6.5 falls per 1000 bed days

**Analysis:**

- One patient suffered a major injury as a result of their fall. Risk reduction measures were in place but due to the patient having underlying bone condition, the patient suffered a pathological fracture to her arm.
- Number of falls per occupied bed days has fallen slightly to 13.2 compared to 2012-13 when it was 13.45 but is higher than 2011-12 figure of 12.9%.

**Comment:**

Higher incidence of falls are recognised in hospices due to the deteriorating condition of hospice patients. Confusion, unsteady walking, deteriorating continence and patient's personal struggle to accept the limitations of their illness are common contributory factors in hospice patients.

Individual patient risk assessments for falls are completed on admission and reviewed regularly, guidance and therapy is given by the physiotherapist. In May 2013 Intentional Rounding with the implementation of the Red Flag Checklist for patients identified by the nursing team as high risk patients of falls or unable to use the call bell was implemented (see pages 43-44) to reduce the level of falls. A Falls Group has been set up on IPU to review IPU Falls Management. and Falls risk assessment and screening tool is being amended to more effectively demonstrate NICE guidance (June13) so that staff's awareness is heightened. A Falls Audit is planned for 2014-15 and training sessions for clinical staff on falls risk will be given.

Interhospice benchmarking work has seen the sharing of practices to reduce incidence and harm (eg Red Flag list, patient movement sensors), to more objectively categorise harm levels and will help NLH scrutinise it falls incidence further in the light of similar units.

# Pressure sore monitoring and reporting

Over the last two years, NLH has reported here the number of patients who developed pressure sores of the more severe level grades 3 and 4 and reported on number of patients admitted with these, those that developed them within 72 hours of admission and those that developed them after 72 hours of admission. This supported NLH in embedding pressure sore monitoring and mandatory external reporting to CQC, commissioners and local authority safeguarding services which is now routine practice.

From 2013-14 NLH focus has been on the last group (those that have developedpressure sores grade 2 and above after 72 hours of admission) which need careful monitoring to ensure the incidence of these does not reflect sub optimal care. The Department of Health as part of its Patient Safety First Campaign has defined pressure sores as "avoidable" and "unavoidable" (see appendix five page 51 for definition).Grade 3 and above pressure sore development after 72 hours of admission are detailed here.

# Summary of pressure sores reported April 2013 to March 2014

| | UNAVOIDABLE | AVOIDABLE |
|---|---|---|
| Developed Grade 3 more than 72 hours of admission | 9 | 0 |
| Pressure Sores developed Grade 3 more than 72 hours of admission per 1000 Occupied Bed Days* | 2.02 | 0 |

*Occupied bed Days = 4462

**Analysis:**

- Of the 9 pressure sores of grade 3 and above that developed after 72 hours of admission, none were deemed avoidable.

**Comment:**

There have been no patients with grade 4 pressure sores cared for on the IPU in2013-14.

In September 2013 A Pressure Sore Case Review of quarter one of all pressure sores grade 3 was completed. Good practice was noted and it was noted that all cases had contributory factors for developing pressure sores and were unavoidable. As part of the review NICE Guidance (Sept 2005) was re-examined and an action plan to improve practice further was implemented. The following actions have been taken:

- Skin Changes at Life's End (SCALE) Final Consensus Statement of the European Pressure Ulcer Advisory Panel (2009) noted as evidence to support increased vulnerability and incidence of pressure sores in hospice client group
- Standard of pressure ulcers assessed within 6 hours of admission embedded in practice through addition to admission checklist
- More pressure relieving booties obtained
- Patients with grade 1 and above pressure sores are now commenced on Intentional Care Rounding.
- All patients with grade 2 pressure sores are now reported through incident reporting process as trigger to review care and prevent development of grade 3 and above pressure sores.

# Infection Control

| QUALITY AND PERFORMANCE INDICATOR(S) | NUMBER 2011-12 | NUMBER 2012-13 | NUMBER 2013 –14 |
|---|---|---|---|
| The number of patients known to be infected with MRSA on admission to the IPU | 2 | 4 | 3 |
| The number of patients known to be infected with Clostridium Difficile, Pseudomonas, Salmonella, ESBL or Klebsiella pneumonia on admission to the IPU | 0 | 0 | 2 with known Clostridium Difficile |
| Patients who contracted these infections whilst on the IPU | 0 | 0 | 0 |

NLH notes patient's infective status on admission and tests where clinically indicated. The clinical team agree, on an individual basis, what is the most appropriate treatment plan, if any, depending on the patient's condition. During 2013-14 there were no cases noted where patients contracted reportable infections whilst on the IPU.



# PRIORITIES FOR IMPROVEMENT 2013-14

Following consultation with hospice staff and local palliative care commissioners and scrutineers, the following three priorities for improvement were agreed for 2013-14:

## Priorities for Improvement 2013-2014

The following priorities for improvement for 2013-2014 were identified by the clinical teams and were endorsed by our internal governance structures.

The priorities for improvement are under the three required domains of patient experience, patient safety and clinical effectiveness:

## 1. Priority One: Patient Experience

The Hospice is developing its volunteer workforce into new roles to more closely and more flexibly match the need of patients and their carers. Alongside this user need is the Hospice's goal to develop a more skilled and patient-centred volunteer workforce. New roles currently exist supporting patients living at home and their families (through the first year following their bereavement). They work alongside the Hospice's community, day service and Palliative Care Support Service teams providing emotional and practical support. New volunteer roles are planned for Finchley Site Hospitality and the in-patient unit.

This project proposed to survey service users, as well as volunteers and affected staff, concerning the impact of the newly developed and future volunteer roles on the patient experience.



| ACTION | LEAD | COMPLETED BY | UPDATE AS AT OCTOBER 2013 | REVISED COMPLETION DATE |
|---|---|---|---|---|
| Inaugural meeting of Project Group to identify key elements of the survey | DD | April 2013 | Completed | N/A |
| Appoint Volunteer Transition Lead, who will join the Project Group | DD | May 2013 | Completed | N/A |
| Recruit survey volunteers ( User Involvement volunteers) | DD/ DM | May 2013 | Completed (carried out by User Involvement Vols as part of main survey – see below) | N/A |
| Agree survey template - the Annual User Survey was noted tocover overall effectiveness without specific reference to volunteer contribution. It was agreed to incorporate specific volunteer questions as part of annual user surveys and greed through service leads (Day Services, PCSS, Community). A specific survey for reception/ hospitality (usually 'welcoming' is covered by the IPU survey) | DD/ DU/ DM | May/June 2013 | Decision was taken to ask a generic question about volunteering rather than service-specific and include this in the general survey. Unfortunately the capacity to locate the specific service relating to the feedback was not incorporated into the form. This has now been addressed (Rider to survey form). | N/A |
| SURVEY PERIOD – BETWEEN JUNE TO DECEMBER 2013 | | | | |
| Complete current Reception volunteers survey early on to help obtain a baseline for the transition role – to develop this volunteer group into Hospitality Volunteers | DD/ DU/ DM | June/July 2013 | It was not possible to carry out an early survey due to the closure of Reception while refurbishment took place | N/A |
| Analyse Reception survey to assist joint work plan between transition role and Facilities Manager to help further develop Hospitality role | DD/ DU/ DM | July 2013 | 13 responses were received from Front of House service users. Despite overwhelmingly positive assessments, there was slight indication that some improvement might be required in willingness to listen and inspiring confidence. These are areas now included in training to further develop the role. | April 2014 |

## Overall Summary/Analysis

- Apart from the Front of House results, eight responses were received from IPU service users and 16 from users of the Community/at Home service. Across the board, assessments were overwhelmingly positive, with the few imperfect assessments appearing under 'Knowledge of their role', 'Willingness to listen' and 'Your confidence in them'. As for Front of House volunteers, these aspects now form key elements of training for IPU and Community volunteers.

  Many respondents rated staff activity rather than that of volunteers (sometimes also confusing NLH nurses with 'Macmillan nurses'), and often patients/carers did not know whether particular elements of their experience involved staff activity or volunteers activity. Given the generally high assessments (few would wish to criticise volunteers), the value of the survey was reduced in that it will be difficult to identify more positive perceptions generated by changes currently underway (even any reduced satisfaction level might be difficult to detect, given likely continuing high levels of user gratitude).

  The intention to run a follow-up survey for comparison purposes has been put back due to a longer transition exercise than had been anticipated, and disruption arising from Open Area development (including closure of the Coffee Shop – a significant element of the Hospitality service). Time is required for changes to bed in.

- Whilst the same questions regarding volunteering will be asked in the User Survey 2014-15, there might be an alternative survey aimed at Front of House volunteering.

  Staff involvement: initiatives are developing to address staff involvement e.g. Living Room Project and Staff & Volunteer Steering Group relevant to Front of House role as well as investment of a staff member on IPU to oversee ward volunteer development and a further investment in a volunteer coordinating role attached to the Palliative Care Support Service. In Day Services we have re-structured the Centre Manager role to be Therapies Lead with specific responsibility to oversee and support generic volunteers.

# PRIORITY TWO: PATIENT SAFETY INTRODUCTION OF ULTRASOUND SERVICE

We are currently developing an ultrasound service for IPU patients, which can also be accessed by community patients who are able to attend the hospice for assessment. This will improve the diagnostic certainty regarding the presence of significant ascites and exclude differential diagnoses. It will also enable us to identify if proceeding to paracentesis is safe and appropriate.

The use of ultrasound commenced on IPU in January 2013 following the medical restructuring of the unit.

This year has seen access to ultrasound for inpatients prior to paracentesis available 5 days a week. Therefore it is now standard practice for all inpatients to be assessed by ultrasound prior to paracentesis. The long-term plan is to have all 4 consultants and the day services Clinical Nurse Specialist trained to facilitate the access of ultrasound assessment for community patients also. The consultant conducting the ultrasound examinations now completes a logbook monitoring all patients. This includes the results of the ultrasound assessment, whether we proceeded to paracentesis and the outcome of the paracentesis procedure. It also includes a reflection on any learning derived from the use of the ultrasound and how it may have influenced the clinical decision-making, patient safety and overall care.

We have completed the baseline audit of paracentesis activity on the unit prior to introduction of the ultrasound assessment to assess practice. The results of this audit have informed the development of a paracentesis policy and pathway. This policy has been drafted and will be reviewed at the policy group then via the governance structure. We hope to implement this by March 2014. Once embedded we will audit adherence to the policy in the audit year 15/16.

| ACTION | LEAD | COMPLETED BY |
|---|---|---|
| IPU ultrasound assessment pre paracentesis for ascites management for Inpatients | JB | Commenced Jan 13 |
| Log Book maintained on cases treated and reflection on cases where complications occur | JB | Commenced Jan 13 |
| Baseline audit of paracentesis activity on IPU | JB | Completed August 2013 |
| Protocol on Paracentesis approved by Q&R and QSR | | 1st Draft completed October 2013. For review by Policy group then Q&R and QSR. Aim to implement by March 2014 |
| Review of access to IPU ultrasound service on IPU | | Review level of access to ultrasound from January 2013 (Complete by Feb 2014) |
| Audit of adherence to the new NLH protocol and policy for paracentesis | | Audit adherence to policy once implemented (This audit will be conducted in the audit cycle 15/16 to ensure we have had time to embed the new policy and protocol) |

# PRIORITY THREE: CLINICAL EFFECTIVENESS

## Implementation of the most up to date version (version 12) of the Liverpool Care Pathway tool into the community (Barnet and Enfield)

This project was commenced and closed in Autumn 2013 following national guidance that this tool would no longer be best practice. Below records actions that were taken in bold, actions planned within project but not actioned are in normal font.

| ACTION | LEAD | COMPLETED BY |
|---|---|---|
| **WORK UNDERWAY PRIOR TO APRIL PROJECT START:** | | |
| **• Meeting with Judith Tobin (GP)re proposed changes** | **LP** | **28/1/13** |
| **• Meeting with DN (Barnet) – re proposed changes** | **LP** | **Feb 2013** |
| **• Meeting with NLH Community Team re proposed changes** | | |
| **• Pathway adapted for local community use.** | | |
| **• Adapted pathway presented to CQG** | | |
| **• Pathway presented to Enfield commissioner and End of Life Steering Group** | | |
| PROJECT CLOSED | | |
| Teaching to Community CNSs<br>Explore implementation | LP | May 2013 |
| Agreement from Enfield CCG to take responsibility for LCP document | JB | June 2013 |
| If above agreement gained & offer of our support accepted: | | |
| Clinical Governance Committee | Comm. SMT | July 2013 |
| Submit to Liverpool (Marie Curie Palliative Care institute) for matching | Comm. SMT | July 2013 |
| Confirm implementation programme with CNS/DNs teams | Comm. SMT | Aug 2013 |
| Implement V12 LCP to community – to include adapting current LCP training delivered by NLH CNSs to DNS | Comm. SMT | Sept 2013 |
| Audit after 6/12 of use (of complete document using audit tool provided by Liverpool) ?? appropriate | Comm. SMT | March 2014 |

A new project was proposed for the second two quarters of 2013-14 and will roll into 2014-15.

# Introduction of intentional care rounding on IPU to reduce patient falls

Intentional Care Rounding (IR) has been developed as evidence based structured process and used in the UK as part of larger quality improvement initiatives such as the NHS "Harm Free" care campaign. It involves health care professionals carrying out regular individualised patient checks at set intervals. Integrated with patient centred care planning it provides a focus on regular attention to the fundamental needs of the patient.

NLH saw 60 patient falls in 2012/13 which equated to 13.45 falls per 1000 occupied bed days. None of these falls resulted in a major injury. NLH are aware that due to the deteriorating nature of its IPU client group, who are often in the last days of life and adjusting to reducing independence and function, it is highly likely that despite optimum care to minimise falls, patients will fall. The benefits of introducing IR was highlighted at the inter hospice quality benchmarking group that NLH attends. A member hospice had experienced a reduction in falls following the introduction of IR; NLH considered it an initiative to explore to maximise best practice.

Following the cessation of its 2013-14 priority for improvement project relating to the Liverpool Care Pathway detailed on page 42, NLH decided to introduce IR on its IPU in Autumn 2013-14 to evaluate its potential to reduce falls on the inpatient unit.

**How it was done:**

September 2013

- IR introduced to the team. Its potential in documenting pressure area repositioning and nutritional support noted as an additional value. Implementation plan was agreed
- IR commenced on IPU patients identified at increase risk re falls/ pressure areas

October/November 2013

- One month review identified :
  - staff had embraced tool and were carrying out 2 hourly assessment.
  - Further reinforcement and monitoring was required.
  - IPU Falls Group to look if tool needs adapting from falls risk viewpoint.
  - Its lack of application to patients in the last few days of life was noted and the need to review the tool to extend its use to this group was realised.

December/January:

- Considered the need to evaluate the extension of IC to all IPU patients.
- SMT discussed how to link with LCP review work and need for adaptation of tool.
- Implementation plan agreed for 2014-15 extension.
- Outcome measures agreed.

April 2014:

- Tool is being adapted for use with end of life patients.
- formal review by shift coordinator is to be Introduced to review daily use of IR in IPU patients
- Plan for extension of IR for all patients from October 2014 is being developed.

**Results:**

Falls in 2012-13

Total falls =60

Falls per 1000 occupied bed days =13.45

Falls in 2013-14

Total falls = 59

Falls per occupied bed days =13.2

## Falls per 1000 Occupied Bed Days (OBD's)

| | QUARTER 1 | QUARTER 2 | QUARTER 3 | QUARTER 4 | TOTAL |
|---|---|---|---|---|---|
| Falls | 18 | 13 | 10 | 18 | 59 |
| OBD's | 1083 | 1041 | 1180 | 1158 | 4459 |
| Falls per 1000 OBDs | 16.6 | 12.5 | 8.5 | 15.5 | 13.2 |

**Analysis:**

IC may be attributable to the drop in falls noted in quarter three from 16.6 and 12.5 in previous two quarters to 8.5 in quarter three but an increase to 15.5 was noted in the last quarter. Plan for 2014-15:

To give this project time to embed and see if a difference can be made this project is to be continued in 2014-15 as a priority for improvement.

# WHAT NLH STAFF SAY ABOUT THE ORGANISATION

NLH employs a total of 160 regular staff and 23 bank staff, and benefits from the efforts of some 950 volunteers who are used as required in clinical and non-clinical roles. The Hospice has many staff working part time or flexible hours.

| | 2011-12 | 2012-13 | 2013-14 |
|---|---|---|---|
| Staff joined | 17 | 38 | 52 |
| Staff left | 21 | 16 | 30 |

The following significant staff improvement initiatives have been put in place this year:

- A revised Performance Development Review (PDR) process and documentation that was implemented within the nursing workforce in 2013-14 is being rolled-out across the whole Hospice. It includes review against the hospice core value's and this year key management dimensions have been added for review where indicated.
- In 2014 we have embarked on the fourth year of NLH's Management Development Programme which will concentrate on specific skills alongside continuing to improve reflecting on management experience across departments and disciplines.
- A monthly staff newsletter is also compiled and distributed to keep all staff aware of what is happening across the Hospice.
- Review of all Human Resources policies and procedures is almost complete.
    - The composition of a new staff Information and Communication Forum is being finalised.
- Staff.Care is a staff rostering and workforce management system which was introduced in 2013. Its provides a new HR management system for the Hospice. In addition it provides the following functions:
    - 1. Staff rostering
    - 2. Work planning
    - 3. Annual leave management system
    - 4. Sickness management
- During 2013/14 each of these functions have been introduced in the Inpatient Unit. During Quarter 1 2014/15 It is planned that the Work Planning system will be introduced to the Palliative Care Support Service. This will enable the team to manage the service more efficiently and providing a saving of both time and costs. During the year the Annual Leave and Sickness management system will be introduced across the Hospice.
- A review of clinical supervision has continued this year. The Clinical Directors have been working with the Institute of Family Therapy to consider reflexivity in order to lead in a co-ordinated way around the issue. Clinical managers are leading in their respective departments on enhancing or introducing reflective and reflexive processes in to their regular team schedule and we are jointly considering the best way to take forward a revised group approach to clinical supervision.
- Following our last staff survey in 2012, NLH are currently exploring a combined staff and volunteer survey for 2015-2016

# NLH BOARD OF TRUSTEES QUALITY ACCOUNT COMMENT

The Board welcomes this year's Quality Account as another positive milestone on the journey that is about continuous improvement, maintaining high standards and being responsive to the views and experience of patients, carers and staff.

In a challenging financial and political climate, the evidence in this report of sustained improvements and high standards of care is a tribute to a committed workforce that includes dedicated staff from a range of disciplines and an impressive cohort of volunteers, without whom, the work of the Hospice could not be sustained at this high standard.

Once again, the Board is assured by the progress made against the priorities identified for this year. Building on the Volunteer Strategy that includes the comprehensive development of the critical volunteer resource has progressed well, with carefully tailored training that enables volunteers to be used to their optimum capacity. This is an evolving matrix of skills development, training and matching of capability to best meet the needs of individuals and families. The rich diversity of skills and experience in the volunteer workforce underpins the Hospice's capacity to extend its care and support more widely.

Progress on the introduction of innovative ultra sound diagnostic procedures have contributed to more responsive clinical care to alleviate distressing symptoms. This is a significant contribution to the quality of care that the Hospice is able to provide.

Work underway in relation to achieving shared standards across our partner organisations relating to the then 'Liverpool Care Pathway' was curtailed due to a review of national guidance. However, the Hospice moved swiftly to identify further areas for improvement addressing personal care needs more systematically through intentional care rounds which also addressed risks associated with falls, fundamental elements in the experience of any patient at the Hospice.

The Board fully endorses the priorities for 2014/15, welcoming the ambitions for a more social environment for IPU, the continued attention to structured care rounds and the focus on raising awareness around Dementia and its life limiting implications as well as supporting the focus on holistic assessment to inform genuine person centred care.

We remain committed to the belief that it is the experience of our service users that matters most, and that our principal priority is realising the dignified, respectful and safe care that people want for themselves and for their loved ones.

**John Bryce**

**Chair**

**North London Hospice Board of Trustees**

# STATEMENTS FROM COMMISSIONERS, HEALTHWATCH, HEALTH OVERVIEW AND SCRUTINY COMMITTEES

# APPENDIX ONE: OUR CLINICAL SERVICES

## 1.Community Specialist Palliative Care Teams (CSPCT)

They are a team of Clinical Nurse Specialist, Doctors, Physiotherapists, Social Workers who work in the Community to provide expert specialist advice to patients and health care professionals. They cover the Borough of Barnet, Enfield and parts of Haringey. They work closely with, and compliment the local statutory Health and Social Care services such as General Practitioners, District Nurses, Social Services, Hospital teams and other Health and Social care Professionals.

The service emphasis is based on:-

* Care closer to home

*The Facilitation of timely and high quality palliative care

This is achieved by providing:-

* Specialist advice to patients and health care professional on symptom control issues

* Specialist advice and support on the physical, psychological, emotional and financial needs of the patients and their carers. An out-of-hours telephone advice service

Community patients are given the out-of-hours advice telephone number for advice out of office hours. Local professionals can also access this service out of hours for palliative care advice as needed. Calls are dealt with between 1700-0900 by a senior nurse on the inpatient unit. At weekends and bank holidays, a community Clinical Nurse Specialist deals with calls between 0900-1700 hours.

## 2. Day Services

Day Services based in our new building in Enfield provides additional specialist palliative care support to patients and carers using a new bespoke day service model. The service offers a range of programmes providing a safe and inviting environment and the opportunity to discuss physical and emotional symptoms, concerns and anxieties.

The clinical team is supported by a large number of volunteers providing flexible support as well as professional volunteers who provide a range of complementary therapies including acupuncture, reiki, reflexology, massage and hypnotherapy. Art therapy and individual psychological therapy are also provided, as well as a relaxation group, CAB Macmillan Welfare Benefits Project, beauty therapy and hair dressing, alongside the hands-on care. Carers/families can attend carer's groups and can join "Open Space" activities and relaxation groups. Nutritious, low cost lunches are on offer in the cafe.

Day Therapies are currently running four days a week, including a physiotherapy clinic on Mondays. In early 2013, in response to commissioner feedback, the service's referral criteria expanded to also offer specific timed intervention for adults with potentially life-limiting illnesses, whom fit the following criteria:

- Those who are recovering post treatment/surgery and are in need of psychological and/or physical support to optimize strength, confidence and self- management
- Those who may benefit from physiotherapy assessment to improve, maintain, accept or self-manage their level of function
- Those who have a poor prognosis and are likely to deteriorate but have no specific symptoms or need for Community Team involvement

NLH aims to eventually offer a five-day a week service to include out-patients clinics, clinical interventions such as an infusion and transfusion service, as well as additional therapies, such as music therapy, creative writing and psychological therapy groups. Bereavement support will also be developed alongside the Loss & Transition Service, to include an art therapy bereavement group.

By the summer of 2014, Day Services will be operating across sites, with most services currently offered in Enfield also available in the newly refurbished space on the Finchley site.

## 3. Inpatient unit (IPU)

NLH has 17 single en-suite rooms offering specialist 24-hour care. Patients can be admitted for various reasons including symptom control or end-of-life care. As the unit is a specialist palliative care facility, it is unable to provide long-term care.

## 4. Palliative Care Support Service (PCSS)

Most people would like to be cared for and finally to die in their own homes, in familiar surroundings with the people they love.

The Hospice's Palliative Care Support Service enables more people to do this.

The service works in partnership with the district nurses and clinical nurse specialists providing additional hands-on care at home for patients.

## 5. Loss and Transition Service (including Bereavement Service)

The Loss and Transition Support Service supports:

- Individual North London Hospice patients in coping with the emotional effects of loss of health.
- Their families/close friends in coping emotionally with their roles as carers and adjustment to change over time.
- Patients' bereaved families/close friends in expressing their grief and eventually to make the transition to a new way of living.

The support is provided by volunteers who we have trained in support skills on our Oyster Training Programme or who are qualified counsellors. This service is in addition to that provided by our specialist palliative care staff (nurses, social workers and doctors) and is offered pre-bereavement and for up to 14 months after bereavement. This service is developing social drop-in bereavement groups on both sites and supports our ranging response to bereavement including our regular Ceremonies of Remembrance as well as events that commemorate those who have died, such as Light up a Life.

# APPENDIX TWO: INFORMATION GOVERNANCE

## Information Governance

Information Governance (IG) refers to the way in which organisations process and handle information, ensuring this is in a secure and confidential manner. It includes information relating to our service users as well as personal information held about our staff and volunteers and corporate information e.g. finance and accounting records.

IG provides a framework in which North London Hospice is able to deal consistently with, and adhere to, the regulations, codes of practice and law on how information is handled e.g. Data Protection Act 1998, Confidentiality NHS Code of Practice.

For the Hospice the purpose of the annual assessment is to provide IG assurance to:

1. The Department of Health and NHS commissioners of services
2. The Health and Social Care Information Centre (HSCIC) as part of the terms and conditions of using national systems, including N3

The Hospice is measured against four initiative sets and 27 standards. The four sets are:

1. Information Governance Management
2. Confidentiality and Data Protection Assurance
3. Information Security Assurance
4. Clinical Information Assurance



# APPENDIX THREE: HOSPICE GROUPS THAT OVERSEE AND REVIEW QUALITY WITHIN NLH

## Hospice Board

The Board is accountable and responsible for ensuring NLH has an effective programme for managing risks of all types and ensuring quality. In order to verify that risks are being managed appropriately and that the organisation can deliver its objectives, the Board will receive assurance from the Quality, Safety and Risk Group for clinical and non-clinical risks. It reviews NLHs Balance Scorecard1 bi annually.

## Executive Team

ET will review NLH's Balance Scorecard quarterly.

Quality, Safety and Risk Group The QSR is a sub committee of the Board and provides assurance that an effective system of control for all risks and monitoring of quality is maintained. It reviews NLH's Balance Scorecard quarterly and ensures action plans are delivered as indicated. The committee also reviews the results of audit work completed on the Hospice's Audit Steering Group and the policy review and development work completed in the Policy and Procedure Group.

## Quality and Risk (Q&R)

The Q&R reports to the QSR with overarching responsibility for ensuring that risk is identified and properly managed. It will advise on controls for high level c risks and to develop the concept of residual risk and ensure that all Directorates take an active role in risk management and that this includes the active development of Risk Registers2.

The Q&R is also responsible together with the QSR to ensure that the treatment and care provided by hospice clinical services is subject to systematic, comprehensive and regular quality monitoring.

## Audit Steering Group (ASG)

The ASG is responsible for providing assurance of all audit activity through reports to the Q&R and QSR. The ASG presents its Audit Plan and Audit Reports and recommendations to the Q&R and QSR for approval and will also ensure that any risks identified during an audit process will be added to the appropriate Service Risk Register

## Policy and Procedure Group (PPG)

The PPG group ensures the review of all NLH policies and procedures. It reports to the Q&R and QSR.

# APPENDIX FOUR: DEFINITION OF AVOIDABLE AND UNAVOIDABLE PRESSURE SORES

## Avoidable Pressure Ulcer:

"Avoidable" means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: evaluate the person's clinical condition and pressure ulcer risk factors; plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate."

## Unavoidable Pressure Ulcer:

"Unavoidable" means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person's clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals; and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence"

## Department of Health, Patient Safety First (2014)

# APPENDIX 5 PATIENT CASE STUDY

**XXXX has been visiting Day Services for the last 5 months. On this occasion she was accompanied by her daughter.**

"I was diagnosed with cancer about 3 years ago and was visiting Nightingale Cancer Trust in Enfield – they suggested that perhaps I should come to North London Hospice.

When I arrived for the first time I was a bit worried about what to expect although I'd stayed at St. Joseph's Hospice on two precious occasions. That was a lovely place – even the people who served the food were nice.

As soon as I came into North London Hospice I felt very welcomed.

I have reflexology every week which is lovely – I enjoy it. The lady uses oils when she does the massage.

I like to chat to my friends here – everyone is my friend. I do my knitting too and a volunteer is showing me how to crochet. A volunteer comes to collect me and I really enjoy my day.

I see the physiotherapist – my wish is to be able to stand up. She has made me feel that I might walk again one day. I would like more physiotherapy.

The volunteers are so nice – I've no complaints about them. They all treat me well and are nice and friendly. There is no chef here now and I miss him – he used to tease me! Today we have jacket potatoes, cheese and salad on the menu – the food is alright.

My CNS comes to visit me and she sorted out my pain very quickly.

I am treated with respect here and I would ask for something if I wanted it. You can ask for anything tea, biscuits, chocolate.

It's very nice and very good here and I'm well looked after. When I feel well I really look forward to coming."

**XXXX's daughter**

"I'm really happy for mum to come here – she interacts and engages with all the other people. It's also good for my dad to have some time off as he has to look after her all the time. Mum gets pampered here and she likes that.

Sometimes she likes to stay in bed all day but now she has something to get up for. As soon as she arrives she bursts into smiles – she's so happy.

Mum was in a lot of pain a few weeks ago but now her CNS has sorted her out, she's a different person. It makes me happy to see her so content.

I think that it might be good for her to talk to someone about how she feels about her illness – she's not really done that at all.

I can see that she is emotionally supported here and that helps her and makes her happier – if mum is feeling ok then I feel ok. "

"So many staff. Everyone is so polite. This is like a 5 star hotel."

" Overall the staff at the Hospice do an excellent job. They are caring and listen to what you have to say. They also give excellent service with regards to controlling side effects as a result of treatment and are able to prescribe necessary drugs to help."

"The Hospice always tried to meet our needs."

# ACCESSING FURTHER COPIES

Copies of this Quality Account may be downloaded from either **www.northlondonhospice.org**

or **www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Pages/quality-accounts-2013-2013.aspx**

# HOW TO PROVIDE FEEDBACK ON THE ACCOUNT

North London Hospice welcomes feedback, good or bad, on this Quality Account.

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Registered Charity No. 285300

# Our Quality Report and Accounts 2014

## The Royal Free London NHS Foundation Trust (Draft)

## A statement on the QUALITY of our services

## from our chief executive

It gives me great pleasure to introduce the Royal Free's 2013/14 quality report, which assures our local population, patients and commissioners that we continuously strive to provide the highest level of clinical care.

We have now completed our second year as a foundation trust and I am pleased to report that we are meeting all the quality objectives set for us by Monitor, the regulator of foundation trusts.

It is 18 months since we last had a patient with an acquired *methicillin resistant staphylococcus aureus* (MRSA) bacteraemia. We have also made progress in our control *of Clostridium difficile* infection, focusing on the way we use antibiotics that sometimes cause this infection. Cases have fallen from 50 in 2013/14 to 35 this year.

At a time where there has been increased pressure on accident and emergency departments, we have been able to maintain performance against the waiting time targets.

In the past two years we have concentrated on our World Class Care programme, designed to improve patient and staff experience and in recent months we have further strengthened our focus on safety with a new patient safety programme. This will build on work we have already undertaken in a number of areas including the management of sepsis, reducing hospital acquired pressure ulcers and minimising the risk of patient falls. Much of this work is undertaken jointly with other organisations within our academic health science network, UCLPartners

We continue to invest in our clinical, research and teaching facilities. Our patron HRH The Duke of York opened the first phase of the new Institute of Immunity and Transplantation, which we are developing with UCL and the Royal Free Charity. We also opened the latest phase of our new intensive care unit which provides modern facilities for our sickest patients. Our new simulation centre, which allows staff to practise surgical techniques using the latest simulation technology, was opened by Sir Bruce Keogh, medical director of the NHS.

During the past year we have begun the detailed planning for our proposed acquisition of Barnet and Chase Farm Hospitals NHS Trust planned for July 2014. We firmly believe that the enlarged organisation will be able to deliver even better local care and the specialist services we are renowned for. The expanded organisation is being designed by the clinicians of both existing trusts, closely working with commissioners, local GPs and representatives from our local population. The overriding aim is to build upon the best of both organisations.

I believe the evidence provided in this quality report demonstrates our continuing commitment to providing the highest quality clinical care.

I confirm that to the best of my knowledge the information provided in this document is accurate.

**David Sloman**

Chief Executive

The Royal Free London NHS Foundation Trust

Date

Our commitment is to offer world class care, every one of us, with every patient and every colleague, every day.  So everyone at the Royal Free can feel...

***Welcome*** all the time

***Respected*** and cared for

Confident because we are ***communicating*** clearly

***Reassured***  that they are in safe hands.

## Priorities for improvement and statement of assurance from the board

In this part of the quality report we review our performance against our key quality priorities for 2013/14 and provide examples that illustrate how individual services and specialities are focused on quality improvement. We also provide key data relating to our performance and outline our priorities for improvement in 2014/15.

### Performance against our key quality objectives

We place great importance on constantly improving our services and the quality of our patient care. Last year we committed to three key quality improvement objectives. These were:

**Priority one: World class care including staff satisfaction and patient experience**

**Priority two: To further develop our clinical outcome measures**

**Priority three: To launch a patient safety programme across the trust.**

Over the following pages, we set out how we have performed against these objectives.

## Performance against our three key quality objectives

## Priority one: World class care for patients and staff

Continuous quality improvements enable the Royal Free to deliver the highest standards of patient care and ensure that our dedicated workforce is well supported and the personal and professional needs of staff are met.

Last year, a key quality objective committed to providing world class care and work to embed our world class care values has been a priority for the benefit of patients and staff across the trust.

Our world class values (WCC) were launched at the Royal Free in April 2012 and are a promise to deliver world class care every day.

The values govern our behaviours towards our patients and our colleagues and were developed by patients and staff in a series of events called ‘In your shoes’ during which individual patients described their experiences to individual members of staff.

Discussions with staff then focused on how improvements could be made to the way we interact with our patients. We also looked at how the working lives of our staff could be improved. Research shows that how staff feel has a significant effect on how patients feel while in our care.

Training sessions introduced the values to teams and 3,181 members of staff – 63% of the workforce - attended. Staff then took the actions back to their areas of work for discussion and implementation.

During 2013, our corporate induction and the recruitment, probation and appraisal policies and procedures were reviewed to ensure they aligned with the world class care ethos.

In recruitment, new staff are assessed against our world class care values as well as their knowledge, skills and experience. Work continues to ensure that potential candidates are aware of and endorse the values, helping to make the Royal Free a fair, diverse and desirable place to work.

The appraisal process was also reviewed to ensure that all staff are appraised against the WCC values in addition to work objectives. Documentation has been redesigned to make it more user friendly and staff have been given training in the new process.

We reviewed the probation process to include our values as part of the performance measures against which new starters are measured. The values are now included in the first formal review and final review.

Workshops have been held to ensure that managers adopt appropriate management styles to support the values. These workshops were rolled out in targeted areas across the trust where bullying and harassment was highlighted as an issue.

Both our patient improvement plans and staff improvement plans are closely linked and monitored by our patient and staff experience committee.

We believe that staff who are well treated and feel appreciated at work are likely to provide a better experience for the patients they care for and each quarter we make awards to individuals and teams who have demonstrated particular dedication to our ethos.

The findings from the national NHS staff survey results for 2013 placed the trust in the top 20% of trusts for staff engagement and shows continuous improvement.

The engagement score is calculated using three key findings around staff ability to contribute towards improvement, staff recommendation of the trust as a place to work and staff motivation at work. The trust scored in the highest 20% for the first two questions and above average for the third.

In comparison with other acute trusts nationally, the trust scored average or above on 18 scores and below average, or in the worst 20% of trusts, on 10 scores. This represents a small improvement compared to the previous year.

The trust results continue to improve slightly with this year seeing positive movement in the following areas:

- Percentage of staff appraised from 78% in 2012 to 91% in 2013 (national average 84%)
- Percentage of staff receiving health and safety training in the last 12 months from 66% in 2012 to 76% in 2013 (national average 76%)
- Percentage of staff reporting good communication between senior management and staff from 29% in 2012 to 36% in 2013 (national average 29%).

There were a number of areas that improved from the 2012 trust results, however the improvement was not significant enough to position the trust to be better than the national average, as follows:

- The percentage of staff suffering work related stress in the last 12 months reduced by 2% from 40% in 2012 to 38% in 2013 (national average 37%)
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months reduced by 6% from 38% in 2012 to 32% in 2013 (national average 29%)
- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months decreased by 4% from 38% in 2012 to 34% in 2013 (national average 24%). This area is identified in the trusts bottom ranking scores and needs to remain within our staff experience improvement plan for 2014/15

- Percentage of staff feeling pressure in last 3 months to attend work when unwell reduced by 3% from 33% in 2012 to 30% in 2013 (national average 28%)
- Percentage of staff believing the trust provides equal opportunities for career progression or promotion increased by 2% from 78% in 2012 to 80% in 2013 (national average 88%)
- Percentage of staff experiencing discrimination at work in last 12 months decreased by 2% from 23% in 2012 to 21% in 2013 (national average 11%)

## Priority 2: Continue to develop our clinical performance metrics

We have appointed an associate medical director for clinical performance who leads on the further development of measures, or metrics, we use to assess our clinical performance.

We have published online additional detail about most of our metrics and have added current data where available.

Last year, we analysed the national clinical audit programmes to which we contribute to see where we had not performed as well as we would have liked and have focused our improvement plans on these areas. We have seen improvements in:

- Timely referral from GP for patients requiring carotid intervention
- Survival after bowel cancer surgery
- Microbiological stool examination in children with inflammatory bowel disease
- Gene testing for cystic fibrosis in bronchiectasis
- Adherence to antibiotic prescribing guidelines in pneumonia
- Referral to pulmonary rehabilitation for patients receiving non-invasive ventilation.

We have identified three aspects of diabetes care for which it has proved challenging to make the improvements we wanted. This is now an improvement priority for clinical effectiveness in the coming year (see Priorities for Improvement for 2014/15).

We have identified shared metrics with UCLH which will provide the greatest opportunity to learn from one another.

In developing our patient-defined metrics, we have looked first to the national clinical audits which have already developed metrics in partnership with patients. The national audits which have introduced these include diabetes, epilepsy and inflammatory bowel disease. By participating in these national schemes we will be able to compare our performance with other organisations and learn useful lessons about what works well.

We held an open event at which patients were invited to have their say on what we measure. We described our performance across many clinical metrics and are using patients' comments as well as other patient feedback to select new metrics.

## Priority 3: Patient safety programme

The development of a patient safety programme was one of our key quality objectives for 2013/2014. We aim to be a national leader in patient safety and have designed a patient safety programme to improve our patient safety culture and capability generally.

**Patient safety culture and capability**

- **Governance arrangements**

  In the past year we have strengthened our emphasis on excellence in patient safety with the appointment of an associate medical director for patient safety and a lead nurse for patient safety. The patient safety programme reports to the newly established patient safety programme board, chaired our deputy chief executive. The trust has also established a board-level patient safety committee to provide oversight of patient safety across the organisation. We have also been successful in a joint bid with Bart's Health for a patient safety 'Darzi Fellow', a junior doctor who will be now able to spend one year of their training in service improvement.

- **Incident reporting**

  We have implemented an online web based system for reporting and learning from patient safety incidents. This large cross-organisational implementation has increased our ability to report and respond to safety incidents at pace. It will also allow us to track trends in safety incidents in the organisation more readily such that we can target our improvement work. The organisation has also substantially improved the speed and effectiveness in which it investigates serious incidents against the national reporting framework.

- **Patient safety education**

  The patient safety programme successfully bid for a £235,000 patient safety education grant from Health Education England. This has been used to strengthen our simulation training through investment in equipment and staff for onsite re-enactments of serious incidents and simulation training of high

risk procedures. We have also invested in a course to deliver safety training to our most junior doctors and 150 incident managers.

**Priority clinical workstreams**

- **Patient handover**

  A project is underway to improve communication and team working in our 'hospital at night' team, who work with acutely ill patients. A multidisciplinary approach has been introduced which once further refined will be introduced to other clinical areas. Nurse handover and in particular safety briefings have been improved.

- **Medicines safety**

  A medicines safety committee has been set up to review medication incidents and oversee improvements in prescribing safety. A priority has been to reduce incidents relating to the administration of penicillin to penicillin-allergic patients. One tool has been a video which has seen a reduction of penicillin prescribing errors of 85%. We are also focusing on reducing 'missed doses' of medicines as well as improving the safety of anticoagulation and insulin prescribing.

- **Surgical safety**

  A key priority for 2013/2014 has been the implementation of the NPSA (National Patient Safety Agency) 'five steps to safer surgery', informed by the World Health Organisation Surgical Checklist. This has been shown to improve team-working and communication in theatre, reducing surgical errors such as retained swabs or wrong site surgery (both defined as safety 'never events'). The improvement team has initially targeted the middle three aspects of the 'five steps'. In 2013/2014 there have been no surgical 'never events'.

- **'Sepsis 6' success'**

  We launched our sepsis reduction programme in 2010. This is designed to spot sepsis earlier and implement a bundle of six specific treatments quickly. Mortality of patients on the sepsis pathway has been reduced by 10% and the length of time that patients suffering from sepsis have to stay in hospital has been halved. During the year, 80% compliance has been achieved and there have been no serious untoward incidents relating to sepsis within the trust for 18 months.

  The sepsis improvement team has achieved national recognition. In November 2013 they won the Nursing Times award in the emergency and

critical care category and in December 2013 the Royal Free Hospital Sepsis 6 app was highly commended by the Health Education Award Committee. In April 2014 the team is presented its work at the International Forum on Quality and Safety in Healthcare in Paris.

- **Acute kidney injury**

  Acute kidney injury (AKI), or acute kidney failure, is also a priority area for improvement and the trust has led the development of the North Central London Acute Kidney Injury Network to improve collaborative team working among different organisations caring for patients with AKI. This has included implementation of an AKI care bundle for basic ward care, collaborative audit, the development of an extensive online and mobile app educational package and implementation of pathology electronic alerting.

  The project was acknowledged as a national exemplar case study in the recent Future Hospital Commission (FHC) report and was selected as one of two case studies presented at the February 2014 Future Hospital Commission launch event.

  The work has been extended across London, our AKI team securing a £200,000 NHS England innovation award to further develop systems to identify patients with AKI early and assess risk of deterioration. The team has also won an NHS England Small Business Research and Innovation Grant to develop a tool to aid referral and decision making when patients develop AKI.

  **Venous thromboembolism prevention**

  This collaboration between anticoagulation services, pharmacy and ward teams, has enjoyed continued success. Trust-wide compliance with thrombosis risk assessment was persistently above 95%, with a mean compliance rate of 96.4%. Risk assessing for thrombosis, and then using preventative medication when appropriate, reduces the likelihood of patients developing a blood clot in the legs or lungs during hospitalisation.

- **Nasogastric tube placement**

  The nutrition team has developed clear policies for the insertion of nasogastric tubes and checks on them, working closely with ward staff. Compliance remains high and there have been no ‘never events’ attributed to nasogastric tubes during the year.

## Our priorities for improvement in 2014/15

To help us provide the best possible care to our patients, each year we set three quality improvements priorities for the year ahead, which are monitored by the trust board.

One focuses on patient experience, one on clinical effectiveness and one on patient safety.  Before setting these, we seek the views of our patients, staff and the local community.

We invited representatives from our stakeholders to give their opinion on what our priorities should be. These included staff, commissioners and our governors.

The trust board considered the responses and agreed the following three priorities for 2014/15.

## Priority one: World class patient information to reflect our world class care

A key priority for 2014/15 will be to ensure that our World Class Care values are embedded in all aspects of our work with patients and staff.

Our world class care programme emphasises consistency in patient care and the standards include communicating clearly and providing reassurance.

Building on our world class care values, we have set a key quality improvement priority for the year ahead to improve patient information across the trust.

The project is being supported by the Royal Free Charity.

Providing quality assured patient information reflects our world class care standards and puts these values into practice.

Between July and November 2013, we carried out a short-term patient information project to look at the quality and access of patient information across the trust.

We carried out a range of interviews with key stakeholders, documentary analysis and a review of patient information on our website.

We also undertook a trust-wide stock-take and looked in particular at how patient information is provided to outpatients.

The project revealed that despite our reputation for high quality care, the way we provide patient information is not consistent and is fragmented with no centralised overview or dedicated resource to maintain or develop provision.

Whilst there is evidence of good practice, this knowledge and learning is not shared across the trust.

Currently new or revised patient information is produced in a number of ways and in different areas. This fragmented approach is costly to the trust and health professionals, but most importantly to patients in terms of negative impact on their experience and, potentially, health outcome.

Patient information on our website also varies greatly, with majority of the literature at least four years old.

With website 'hits' reaching almost 400 a day, demand for patient information is high and there is an expectation that the Royal Free will provide accurate and up-to-date information for patients. This expectation is reflected in national policy with quality assured, accessible patient information a mandatory requirement.

It is anticipated that we can transform the way we provide patient information over the next 18 months.

Starting in April 2014, we plan to improve the provision of patient information in the following ways:

- Centralise the provision of patient information and appoint a patient information manager with a dedicated budget

- Define our role as a patient information provider to ensure consistent, easy access to maintained, quality assured patient information for both patients and health professionals

- Consider marketing the improvement of patient information as part of our world class care programme and establish an ongoing marketing and communications programme

- Look at how we produce patient information – internally, contracted externally or a combination of the two

- Introduce a phased approach to improving patient information and engage with key stakeholders throughout

- Involve patients in the development of all patient information

- As an interim measure, review racks in outpatients to ensure that literature on display is not out of date, is appropriate to the clinic, and the trust

- Collate all current patient information onto a patient information database in a standardised format

- Review literature published before 2010 with the relevant department

- Establish and introduce three pilot sites for patient information - ophthalmology, renal, and pre-assessment - and over a nine month period develop and test the process for producing patient information and the setting up of a new patient information system with a centralised ratification and production process

- As part of the pilot scheme, improve the way information is distributed and displayed, for example racking, use of screens and provision in consulting rooms

- Explore how our navigators and volunteers could help with the way we provide patient information, for example signposting and replenishing racks

- Explore the potential of a partnership with the NHS nationally and with key charities to establish an exemplar model for patient information provision

- Set up a new patient information system and patient information policy which is available on the intranet, along with associated templates and resources (for example online training) to support staff in producing patient information

- Works towards Information Standard certification.

## Priority 2: In-patient diabetes care

Many patients with kidney and vascular disease also suffer from diabetes.

Indeed, because of the particular range of specialist services we offer on any one day at the Royal Free Hospital, nearly a quarter of our in-patients will have diabetes. In addition, many patients on our specialist liver unit will require help with blood sugar control.

Over the past few years, a national audit on in-patients with diabetes has helped us identify where we need to improve aspects of our diabetes care. Our own monitoring has also highlighted concerns, for example, medication errors related to insulin.

Diabetes is therefore one of our key priorities in 2014/15. Our specific aims are to:

- Improve meals and mealtimes for our inpatients with diabetes
- Improve the management of insulin and other diabetic medications on our wards
- Improve foot assessments for patients with diabetes.

We will explore innovative solutions to these themes and consult with our academic health science partnership to learn from experience at other organisations. Progress will be monitored by our clinical performance committee.

## Priority three – To continue our patient safety programme

Our key priorities for the patient safety programme for 2014/15 are set out below:

**Patient safety culture and capability**

A key objective for the coming year is to improve trust-wide communication on safety issues to ensure that we improve dissemination of learning from incidents.

We will further strengthen our incident investigation and processes for addressing safety issues throughout the organisation. We also seek to further improve education and mandatory training in patient safety.

**Priority clinical workstreams**

Priority clinical areas for improvement are as follows:

- **Surgical safety**

We aim to be more than 95% compliance with all aspects of the 'five steps to safer surgery' guidance.

- **Medicines safety**

We will focus our efforts on insulin prescribing safety and reduction of medication 'missed dosages'.

- **Procedural safety**

We have started a programme of work to reduce complication rates from central venous line insertions.

- **Action on abnormal diagnostic images**

We have started a programme of work to ensure all abnormal x-ray images are actioned promptly.

- **Falls and pressure ulcers**

These priority areas for patient safety will be the subject of further structured improvement work across the trust.

Existing improvement work in sepsis, acute kidney injury, venous thromboembolism prevention, handover and nasogastric feeding will continue.

## Statements of assurance from the board

This section contains eight statutory statements concerning the quality of services provided by the Royal Free NHS Foundation Trust. These are common to all trust quality accounts and therefore provide a basis for comparison between organisations.

Where appropriate, we have provided additional information that provides a local context to the information provided in the statutory statement.

### Information on review of services

During 2013/14 the Royal Free London NHS Foundation Trust provided and/or sub-contracted 27 relevant health services.

The Royal Free has reviewed all the data available to the trust on the quality of care in 27 of these relevant health services.

The income generated by the relevant health services reviewed in 2013/14 represents 95% of the total income generated from the provision of relevant health services by the Royal Free London NHS Foundation Trust for 2013/14.

*(please note the above represents **Month Eleven** the Month 12 figure will be provided in May 14 for the final QA)*

### Additional information

In this context we define each service as a distinct clinical directorate that is used to plan, monitor and report clinical activity and financial information – this is commonly known as service line reporting. Each individual service line can incorporate one or more clinical services.

### Information on participation in clinical audits and national confidential enquiries

The reports of 32 national clinical audits published in 2013 were reviewed by the provider in 2013/14 and the Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

| National clinical audit | Actions to improve quality |
|---|---|
| In-patient diabetes (adult) | Develop strategy for in-patient diabetes care<br>Improve meals and mealtimes for patients with diabetes<br>Improve foot assessment<br>Improve management of diabetic medication, including insulin |
| Diabetes (adults) | Develop pathway for insulin pump patients with poor glucose control |
| Dementia | Improve discharge planning and assessment of carers' current needs by assessing patients within 24 hours of admission<br>Develop dementia volunteer roles<br>Introduce carers' clinic and carer education |
| Inflammatory bowel disease (adult) | Improve access to an in-patient specialist dietitian<br>Improve access to specialist ward and additional toilet facilities<br>Develop guidelines for acute severe gastritis<br>Introduce further training in care of inflammatory disease |
| Renal colic | Improve pain assessment |
| Fractured hip | Introduce new regional analgesia technique<br>Improve pain assessment |
| Childhood epilepsy | Improve access to EEG |
| Feverish children | Incorporate fever discharge checklist into electronic patient management system |

| | |
|---|---|
| Elective Infra-renal aneurysm repair | Continue development of multidisciplinary team and specialist pre-operative assessment |

The reports of 195 local clinical audits were reviewed by the provider in 2013/14 and the Royal Free London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

We intend to improve the **clinical effectiveness** of our services by:

- Developing or revising a number of care pathways, including:
  - Out-of-hospital cardiac arrest
  - Primary angioplasty for non-STEMI heart attack
  - Alcohol disorders in A&E
  - Delirium in A&E
  - Fractured hip in A&E
  - Upper gastro-intestinal bleeding in A&E
  - Elective cardioversion of patients with atrial fibrillation
  - Wound drain management after complex breast reconstruction
  - Fluid management after complex breast reconstruction
  - Anticoagulation after liver transplantation
  - Pain management for hip fracture patients
  - Opioid prescribing in palliative care
  - Incidental findings on imaging
  - Organ donation.

- Continuing implementation of revised or existing care pathways, including:
  - Enhanced recovery after hepatobiliary surgery
  - Rehabilitation after intensive care
  - Platelet transfusion
  - Transport of critically-ill patients
  - Nutritional support for elderly patients
  - Organ transplantation
  - Chest pain in A&E
  - Head injuries in A&E
  - Respiratory infections in A&E
  - Back pain in A&E
  - Epilepsy in A&E
  - CMV treatment for transplant patients
  - Hepatitis B screening for patients receiving chemotherapy
  - Avoiding perioperative hypothermia
  - VTE prophylaxis in orthopaedics.

- Addressing further training needs, identified through our local clinical audit programme, in the following areas:
    - Enhanced recovery pathway
    - Continence care
    - Pain management for hip fracture patients
    - Anti-psychotic prescribing
    - Pain assessment in cognitive impairment
    - Safe management of epidural analgesia on wards
    - Monitoring immunosuppressant therapy.

- Improving the documentation (where possible making use of electronic prescribing) of the following:
    - Falls screening
    - Pain assessment in cognitive impairment
    - Consent prior to surgery
    - Indications for anti-psychotic therapy
    - Disease-severity scoring for patients on anti-TNF therapy
    - Tumour staging in nephrectomy patients
    - Protection of central nervous system for lymphoma patients at high-risk
    - Minimum datasets for histopathology specimens
    - Community patient medication.

We intend to improve **safety** by:

- Monitoring safety and efficacy of new investigations: for example
    - hepatitis virus infection
    - thyroid disease
    - intra-operative assessment of tumour spread (one-step nucleic acid molecular assay of sentinel lymph nodes).

- Monitoring safety and efficacy new drugs and procedures: for example
    - Antivirals for hepatitis C
    - Sildenafil for digital ulcers in systemic sclerosis
    - Associating liver partition and portal vein ligation for staged hepatectomy
    - Radiofrequency ablation of renal cell cancers
    - Selective internal radiation therapy
    - Electrochemotherapy
    - Epidural adhesiolysis
    - Sugammadex.

- Reducing radiation exposure for the following:
    - Radio-iodine for thyroid disease
    - Investigation of amyloidosis
    - Routine use of post-operative x-ray.

We intend to improve the **patient experience** through introduction or review of the following aspects of care:

- Online pre-assessment for surgery
- Pre-operative starvation advice for children
- Early mobilisation after Caesarean section
- Advice to patients prior to DEXA scans
- Communication of biopsy results to patients in dermatology
- Patient recall following chlamydia and gonorrhoea test-positive results.

**Participation in clinical audits**

| National clinical audits for inclusion in quality report 2013/14 | Data collection completed in 2013/14 | RFL eligible to participate | RFL participated in 2013/14 | Rate of case ascertainment (%) |
|---|---|---|---|---|
| National Diabetes Audit | √ | √ | √ | 99.8% |
| National in-patient diabetes Audit | √ | √ | √ | N=96 |
| National Elective Surgery PROMs: Four Operations | √ | √ | √ | N=533 |
| Adult Cardiac Interventions: NICOR Coronary Angioplasty | √ | √ | √ | 100% |
| MINAP: Acute myocardial infarction and other ACS | √ | √ | √ | 100% |
| National Heart Failure Audit 2012/13 | √ | √ | √ | 209/325=64% |
| TARN: Severe Trauma | √ | √ | √ | N=123 |
| Renal Registry: Renal Replacement Therapy | √ | √ | √ | N=1995 |
| College of Emergency Medicine: Sepsis | √ | √ | √ | N=50 (100%) |
| College of Emergency Medicine: moderate or severe asthma in A&E | √ | √ | √ | N=50 (100%) |

| | | | | |
|---|---|---|---|---|
| RCPCH National Paediatric Diabetes Audit | √ | √ | √ | N=66 |
| British Thoracic Society: Paediatric Asthma | √ | √ | √ | N=9 |
| National Joint Registry | √ | √ | √ | 97% |
| Cardiac Rhythm Management | √ | √ | √ | 100% |
| Falls & Fragility Fractures: Hip fracture | √ | √ | √ | N=167 (100%) |
| Falls & Fragility Fractures: Anaesthetic sprint audit | √ | √ | √ | 100% |
| National Neonatal Audit | √ | √ | √ | 100% |
| National Vascular Registry | √ | √ | √ | N=79 |
| ICNARC CMPD: Adult Critical Care | √ | √ | √ | 0% |
| Sentinel Stroke National Audit Programme (SSNAP) | √ | √ | √ | >90% |
| National Lung Cancer Audit | √ | √ | √ | 88/86 (102%) |
| National Bowel Cancer Audit | √ | √ | √ | 81/106=76% |
| National Oesophago-gastric Cancer Audit | √ | √ | √ | 97% |
| National Comparative Audit of Blood Transfusion: Use of Anti-D | √ | √ | √ | N=14 |
| Inflammatory Bowel Disease (Adult) | √ | √ | √ | N=30 (100%) |
| Inflammatory Bowel Disease (Paediatric) | √ | √ | √ | N=7 |
| ICNARC: Cardiac Arrest | √ | √ | √ | N=219 |
| British Thoracic Society:: Emergency Use of Oxygen | √ | √ | √ | N=49 |
| National Pulmonary Hypertension Audit | √ | √ | √ | 100% |
| National audit of seizures in hospitals | √ | √ | √ | N=30 (100%) |
| College of Emergency Medicine: paracetamol overdose | X | √ | √ | Still open |
| National Childhood Epilepsy Audit (Epilepsy 12) | X | √ | √ | Still open |

| | | | | |
|---|---|---|---|---|
| National emergency laparotomy audit | X | √ | √ | Still open |
| National Chronic Obstructive Pulmonary Disease audit programme | X | √ | √ | Still open |
| Rheumatoid & early inflammatory arthritis | X | √ | √ | Still open |
| British Thoracic Society:: Paediatric bronchiectasis | √ | x | n/a | n/a |
| National Comparative Audit of Blood Transfusion: Patients in Neuro-critical Care Units | √ | x | n/a | n/a |
| Paediatric Intensive Care (PICANet) | √ | x | n/a | n/a |
| Congenital Heart Disease | √ | x | n/a | n/a |
| Adult cardiac surgery | √ | x | n/a | n/a |
| Head & Neck Cancer Audit | √ | x | n/a | n/a |
| Prescribing Observatory for Mental Health | √ | x | n/a | n/a |
| National Audit of Schizophrenia | √ | x | n/a | n/a |
| | | | | |
| Total: | | | | |
| Clinical Outcome Review Programme (previously the National Confidential Enquiries, and Centre for Maternal and Child Death Enquiries): | | | | |
| NCEPOD: Lower limb amputation | √ | √ | √ | 100% |
| NCEPOD: Tracheostomy | √ | √ | √ | 100% |
| National Confidential Inquiry into Suicides & Homicides | X | x | x | - |
| Maternal, newborn and infant (MBBRACE-UK) | √ | √ | √ | Open |
| In addition, the Royal Free London NHS Foundation Trust participated in the following national audits by submitting data in 2013/14 | | | | |
| National Endoscopy Audit: Colonoscopy completion rates | | | | |
| National Comparative Audit of Blood Transfusion: Patient information & consent | | | | |
| Health Protection Agency: Surgical Site Infection rates | | | | |
| British Association of Urological Surgeons: Nephrectomy Audit | | | | |

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|---|
| British Association of Urological Surgeons: Surveillance & Treatment of Renal Masses |
| Baseline Survey of HIV Perinatal, Paediatric and Young Person's Pathways |
| UK Neonatal Collaboration Necrotising Enterocolitis Audit |
| National Audit of Cardiac Rehabilitation |
| British Association of Endocrine and Thyroid Surgeons: Thyroid and Parathyroid surgery |
| British Society of Rheumatology: National Audit of Gout |
| Royal Free London NHS Foundation Trust reviewed the results of the following national audits and confidential enquiries which published reports but did not collect data in 2013/14 |
| NCEPOD: Managing the flow |
| NCEPOD: Measuring the units |
| College of Emergency Medicine: Ureteric colic |
| College of Emergency Medicine: Fractured neck of femur |
| College of Emergency Medicine: Feverish children |
| National Audit of Dementia |
| British Thoracic Society: Adult asthma |
| British Thoracic Society: Adult pneumonia |
| British Thoracic Society: Adult bronchiectasis |
| British Thoracic Society: Non-invasive ventilation |

### Additional information

ICNARC CMPD adult critical care: despite making significant improvements to our data quality for this audit, ICNARC were unable to accept our data for 2013/14. We are working to ensure our 2014/15 data will be accepted.

### Information on participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Royal Free London NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 4,562.

**Additional information**

The above figure includes 2,550 patients recruited into studies on the NIHR portfolio and 2,012 patients recruited into studies that are not on the NIHR portfolio. This figure is somewhat lower than that reported last year.

The breadth of research taking place within the trust is far reaching and includes clinical and medical device trials, research involving human tissue and quantitative and qualitative research, as well as observational research.

**Information on use of CQUIN payment framework**

A proportion of the Royal Free London NHS Foundation Trust income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between the Royal Free London NHS Foundation Trust and NHS North East London Commissioning Support Unit and NHS England with whom we entered into a contract, agreement or arrangement with through the commissioning for quality and innovation (CQUIN) payment framework.

Further details of the agreed goals for 2013/14 and for the following 12-month period are available electronically by emailing rfquality@nhs.net.

**Additional information**

Our CQUIN payment framework for 2013/14 was agreed with NHS North East London Commissioning Support Unit and NHS England as follows:

| CQUIN scheme priorities 2013/2014 | Objective rationale |
|---|---|
| Venous thromboembolism | Venous thromboembolism (VTE), or clotting of the blood, is a significant cause of mortality, long-term disability and chronic ill health. We closely analyse every case to discover root cause. |
| Friends and family test | This national initiative will provide timely, detailed feedback from patients about their experience in order to improve services for the user. There is significant room for improving the level of feedback received from patients across England. |
| Dementia | A quarter of beds in the NHS are occupied by people with dementia. Their length of stay is longer than people without dementia and they often receive suboptimal care. Half of those admitted have never been diagnosed before admission and referral to appropriate specialist community services is often |

| | |
|---|---|
| | poor. Improvement in assessment and referral will give significant improvements in the quality of care and substantial savings. |
| NHS safety thermometer | Participation in data collection is an important step in reducing harm in four areas of concern highlighted nationally. A particular focus is on reducing incidents of pressure ulcers in hospital and the local community. |
| COPD (chronic obstructive pulmonary disease) discharge bundle | Use of the bundle has been proven to improve the care of patients admitted to hospital with an exacerbation of COPD, improve their understanding of the disease, reduce future reliance on hospital care and reduce chances of further admissions. |
| Prevention – stop smoking and alcohol screening | Helping patients to stop smoking is among the most effective and cost-effective of all interventions the NHS can offer patients. Simple advice from a clinician, during routine patient contact, can have a small but significant effect on smoking cessation. Alcohol-related problems represent a significant share of potentially preventable attendances to accident and emergency departments and urgent care centres, as well as emergency admissions. Screening for alcohol risk has been shown to reduce subsequent attendances and alcohol consumption. |
| Integrated care | There is a significant number of frail older people admitted to hospital. Identification and assessment of these patients, sharing information with GPs and participating in multidisciplinary meetings help to improve care and reduce the cost of treating these patients. |
| National quality dashboard | The aim is to ensure that providers implement and routinely use the required clinical dashboards for specialised services |
| Highly specialised services | This covers very rare diseases whose treatment is carried out at a very limited number of centres in the UK. These centres must participate in an annual workshop to encourage learning and the spread of best practice. |
| Bone marrow transplantation | To improve the gathering of various aspects of donor data for these procedures to inform better safety and effectiveness. |
| Renal transplant and dialysis | To increase the use of a national online renal database for dialysis and transplantation patients, empowering them to better manage their condition and medications by allowing easier access to test results and therefore monitoring of their progress. |
| Haemophilia | Joint health and preventing joint damage/progression is the key driver to many aspects of haemophilia care. The aim is to establish a baseline for patients against which future care can be assessed. There is |

| | |
|---|---|
| | also a drive for centres to record patients' treatment data in an electronic format that is accessible to the patients to encourage shared responsibility for the use of very expensive treatment products. |

**Information on Care Quality Commission statement of assurance**

The Royal Free London NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered with the CQC with no conditions attached to registration.

The Care Quality Commission has not taken enforcement action against the Royal Free London NHS Foundation Trust during 2013/14.

The Royal Free London NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

**Additional information**

This year we had two inspections. In October 2013, the CQC undertook a re-inspection of the Royal Free Hospital site following the implementation of actions to ensure the safe storage of medicines. The inspection confirmed that we were compliant with all 16 essential standards.

The second inspection in February 2014 saw nine inspectors visit a number of wards and departments as part of a routine unannounced inspection. Inspectors found that our patients rated our care and services very highly and enjoyed attending for their care with us. The trust met all seven standards being assessed, including consent to care and treatment, care and welfare of the people who use our services, cleanliness and infection control and supporting staff.

**Information on data quality**

The trust submitted information during 2013/14 to the secondary uses service (SUS) for inclusion in the hospital episode statistics, which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.1% for in-patient care
- 99.2% for out-patient care
- 93.5% for accident and emergency care.

The percentage which included the patient's valid GP registration code was:

- 99.7% for in-patient care
- 99.9% for out-patient care
- 100% for accident and emergency care.

**Additional information**

The figures above are taken directly from the SUS data quality dashboard provider view, which is based on the provisional April 2013 to January 2014 SUS data at the month 10 inclusion date.

**Information governance toolkit attainment levels**

The trust's information governance assessment report score for 2013/14 was 69%.

**Additional information**

Information governance is the process that ensures we have necessary safeguards in place for the use of patient and personal information, as directed by the Department of Health and set out within national standards.

Our score on the information governance toolkit was one per cent lower than last year because of lower training rates.

During 2013/14 the trust was audited by the Information Commissioner's Office and the trust was given 'reasonable assurance', meaning that there are arrangements for data protection compliance in place at the trust.

**Payment by results clinical coding audit**

The trust was not subject to the Payment by Results clinical coding audit during 2013/14 by the Audit Commission.

**Additional information**

Clinical coding is the process by which medical terminology written by clinicians to describe a patient's diagnosis, treatment and management is translated into

standard, recognised codes in a computer system. It is important to note that the clinical coding error rate refers to the accuracy of this process of translation and does not mean that the patient's diagnosis or treatment was incorrect in the medical record. Furthermore, where the clinical coding has been termed 'incorrect' this most commonly means that a condition or treatment was not coded as specifically as it could have been, and not that there was an error.

## Our quality performance indicators

*(The data in this section will be updated for the final accounts with year end data where appropriate***)**

As a foundation trust we are required to report against the following core set of indicators in 2013.

| Indicator | Royal Free Performance Jul 11 - Jun 12 | Royal Free Performance Jul 12 - Jun 13 | National Average Performance Jul 12 - Jun 13 | Highest Performing NHS Trust Performance Jul 12 - Jun 13 | Lowest Performing NHS Trust Performance Jul 12 - Jun 13 | Actions to be taken to improve performance |
|---|---|---|---|---|---|---|
| The value and banding of the summary hospital-level mortality indicator for the trust | 74.3 (3) | 80.7 (3) | 101.9 (2) | 62.6 (3) | 115.6 (1) | The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre. SHMI (Summary Hospital Mortality Indicator) is a clinical performance measure which calculates the actual number of deaths following admission to hospital against those expected. The latest data available covers the 12 months to June 2013. During this period the Royal Free had a mortality risk score of 80.7, which represents a risk of mortality 19.3% lower than expected for our case mix. This represents a mortality risk statistically significantly below (better than) expected with the Royal Free ranked eight lowest amongst English NHS Trusts. The banding (figure in brackets) is calculated 1 to 3 with 3 being the lowest (best) banding.<br>The Royal Free London NHS Foundation Trust has taken the following actions to improve the mortality risk score and so the quality of its services:<br>A monthly SHMI report is presented to the trust Board and a quarterly report to the clinical performance committee. Any statistically significantly variations in the mortality risk rate are investigated, appropriate action taken and a feedback report provided to the trust board and the clinical performance committee at their next meetings. |

| Indicator | Royal Free Performance Jul 11 - Jun 12 | Royal Free Performance Jul 12 - Jun 13 | National Average Performance Jul 12 - Jun 13 | Highest Performing NHS Trust Performance Jul 12 - Jun 13 | Lowest Performing NHS Trust Performance Jul 12 - Jun 13 | Actions to be taken to improve performance |
|---|---|---|---|---|---|---|
| The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period | 24.8% | 25.5% | 19.6% | 44.1% | 0.0% | The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre.<br>The percentage of patient deaths with palliative care coded at either diagnosis or specialty level is included as a contextual indicator to the SHMI indicator. This is on the basis that other methods of calculating the relative risk of mortality make allowances for palliative care whereas the SHMI does not take palliative care into account.<br>The Royal Free London NHS Foundation Trust intends to take the following actions to improve the mortality risk score and so the quality of its services:<br>Presenting a monthly report to the trust board and a quarterly report to the clinical performance committee detailing the percentage of patient deaths with palliative care coding. Any statistically significantly variations in percentage of palliative care coded deaths will be investigated with a feedback report provided to the trust board and the clinical performance committee at their next meetings. |

| Indicator | Royal Free Performance 2011/12 | Royal Free Performance2 012/2013 | National Average Performance 2012/2013 | Highest Performing NHS Trust Performance 2012/2013 | Lowest Performing NHS Trust Performanc e 2012/2013 | Actions to be taken to improve performance |
|---|---|---|---|---|---|---|
| Patient reported outcome measures scores for: | | | | | | The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to internal trust data.<br>The NHS asks patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. This helps hospitals measure and improve the quality of care provided.<br>A negative score indicates that health and quality of life has not improved whereas a positive score suggests there has been improvement.<br>While the trust is not receiving a negative score against any of the outcome measures knee replacement surgery has been identified as an outlier by the Care Quality Commission (CQC). The CQC produce a quarterly Intelligent Monitoring Report for all NHS Trusts. The CQC has developed the system to monitor a range of key indicators for NHS acute and specialist hospitals. The most recent report (March 2014) has identified the negative nature of patient feedback following knee replacement surgery as a Risk.<br><br>The Royal Free London NHS Foundation Trust intends to take the following actions to improve the patient reported outcome measure scores and so the quality of its services:<br>Reviewing the initial consultation process to ensure that expected outcomes are clear and patient expectations are realistic, improving patient information to ensure that risks and benefits are outlined clearly and reviewing information provided at discharge to help patients achieve good outcomes post operatively. |
| (i) groin hernia surgery | 0.05 | 0.07 | 0.08 | 0.13 | 0.03 | |
| (ii) varicose vein surgery | 0.08 | 0.09 | 0.10 | 0.17 | 0.02 | |
| (iii) hip replacement surgery | 0.39 | 0.38 | 0.43 | 0.54 | 0.32 | |
| (iv) knee replacement surgery | 0.26 | 0.27 | 0.32 | 0.37 | 0.20 | |

| Indicator | Royal Free Performance 2010/2011 | Royal Free Performance 2011/2012 | National Average Performance 2011/2012 | Highest Performing NHS Trust Performance 2011/2012 | Lowest Performing NHS Trust Performance 2011/2012 | Actions to be taken to improve performance |
|---|---|---|---|---|---|---|
| The percentage of patients readmitted to the trust within 28 days of discharge for patients aged:<br>(i) 0 to 15<br>(ii) 16 or over<br><br>**Note: Trusts with zero readmissions have been excluded from the data** | <br>7.18<br>12.34 | <br>5.86<br>13.36 | <br>9.55<br>11.33 | <br>5.1<br>7.74 | <br>14.94<br>13.8 | The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to internal trust data.<br><br>The Royal Free carefully monitors the rate of emergency readmissions as a measure for quality of care and the appropriateness of discharge. A low, or reducing, rate of readmission is seen as evidence of good quality care.<br><br>The rate of readmissions at the Royal Free is below (better) than the national average for children and over (worse) for adults. The trust has undertaken detailed enquiries into patients classified as readmissions with our public health doctors, working with GP's, identifying the underlying causes of readmissions. This is supporting the introduction of new clinical strategies designed to improve the quality of care provided and reduce the incidence of readmissions. In addition the trust has identified a number of data quality issues affecting the readmission rate, including the incorrect recording of planned admissions. The trust is working with its staff to improve data quality in this area. |

| Indicator | Royal Free Performance 2011/2012 | Royal Free Performance2 012/2013 | National Average Performance 2012/2013 | Highest Performing NHS Trust Performance 2012/2013 | Lowest Performing NHS Trust Performanc e 2012/2013 | Actions to be taken to improve performance |
|---|---|---|---|---|---|---|
| The trust's commissioning for quality and innovation indicator score with regard to its responsiveness to the personal needs of its patients | 66.9 | 65.6 | 68.1 | 84.4 | 57.4 | The NHS has prioritised, through its commissioning strategy, an improvement in hospitals responsiveness to the personal needs of its patients. Information is gathered through patient surveys. A higher score suggests better performance. Trust performance is below (worse than) the national average.<br><br>The Royal Free London NHS Foundation Trust intends to take the following actions to improve its responsiveness to the personal needs of its patients:<br>The trust has a comprehensive patient experience improvement plan overseen by the user experience committee, a sub-committee of the trust board. During February 2014 the trust received an unannounced inspection by the Care Quality Commission. The inspection is designed to answer the following questions about services:<br>Are they safe?<br>Are they effective?<br>Are they caring?<br>Are they well led?<br>Are they responsive to people's needs?<br>The initial draft written report suggests that all standards have been met, however the final report will not be issued until late March 14. |

| Indicator | Royal Free Performance 2012 | Royal Free Performance 2013 | National Average Performance 2013 | Highest Performing NHS Trust Performance 2013 | Lowest Performing NHS Trust Performance 2013 | Actions to be taken to improve performance |
|---|---|---|---|---|---|---|
| The percentage of staff employed by, or under contract to, the trust who would recommend the trust as a provider of care to their family or friends | 72.6% | 76.2% | 64.5% | 93.7% | 39.6% | The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to published survey results.<br><br>Each year the NHS surveys its staff and one of the questions looks at whether or not staff would recommend their hospital as a care provider to family or friends. The trust performs significantly better than the national average on this measure.<br><br>The Royal Free London NHS Foundation Trust activities to enhance engagement of staff have resulted in an increase of the percentage of staff who would recommend their hospital as a care provider to family or friends:<br>The trust has implemented world class care programme embodying the core values of welcoming, respectful, communicating and reassuring. These are the four words which describe how we interact with each other and our patients. For the year ahead the continuation of our world class care programme anticipates even greater clinical and staff engagement. |

| Indicator | Royal Free PerformanceJul 13 - Sep 13 | Royal Free PerformanceOct 13 - Dec 13 | National Average Performance Oct 13 - Dec 13 | Highest Performing NHS Trust Performance Oct 13 - Dec 13 | Lowest Performing NHS Trust Performance Oct 13 - Dec 13 | Actions to be taken to improve performance |
|---|---|---|---|---|---|---|
| The percentage of patients who were admitted to hospital and were risk assessed for venous thromboembolism during the reporting period. | 96.1% | 98.0% | 96.0% | 100.0% | 78.0% | The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre and compared to internal trust data.<br><br>Many deaths in hospital result each year from Venous Thromboembolism (VTE), these deaths are potentially preventable. The government has therefore set hospitals a target requiring 90% of patients to be assessed in relation to risk of VTE.<br><br>The Royal Free performed better than the 95% national target and performed better than the national average.<br><br>The Royal Free London NHS Foundation Trust intends to take the following actions to improve its VTE risk assessment rate:<br>The trust reports its rate of hospital acquired thromboembolism (HAT) to the monthly meeting of the trust board and the quarterly meeting of the clinical performance committee. Any significant variations in the incidence of HAT are subject to investigation with a feedback report provided to the trust board and clinical performance committee at their next meetings. In addition the Thrombosis Unit conduct a detailed clinical audit into each reported case of HAT with finding shared with the wider clinical community. |

| Indicator | Royal Free Performance 2011/2012 | Royal Free Performance2 012/2013 | National Average Performance 2012/2013 | Highest Performing NHS Trust Performance 2012/2013 | Lowest Performing NHS Trust Performanc e 2012/2013 | Actions to be taken to improve performance |
|---|---|---|---|---|---|---|
| The rate per 100,000 bed days of cases of *C.difficile* infection that have occurred among patients aged two and over | 19.3 | 30.5 | 16.3 | 0 | 30.8 | The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the Health & Social Care Information Centre, compared to internal trust data, and data hosted by the Health Protection Agency.<br><br>*Clostridium Difficile* can cause severe diarrhoea and vomiting, the infection has been known to spread within hospitals particularly during the winter months. Reducing the rate of *Clostridium Difficile* infections is a key government target.<br>Royal Free performance was significantly higher (worse) than the national average during 2012/13.<br><br>The Royal Free London NHS Foundation Trust intends to take the following actions to reduce the rate of C. difficile infections:<br>In order to demonstrate robust governance and ensure performance improvement the trust asked for independent scrutiny, by a national expert of our infection control processes. The trust also invited two other national experts to review adherence to infection control policy. The action plan arising from the reviews has been considered at the Trust Executive Committee, the Clinical Performance Committee and Trust Board. The recommendations are being fully implemented. In addition the trust is ensuring that all staff adhere to the trust's infection control policies, including hand hygiene and dress code.<br><br>It is also important to note the significant improvement in performance since October 2013. The trust has now recorded 5 consecutive months where compliance with the in-month |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | trajectory has been achieved. |
| Indicator | Royal Free Performance Oct 11 - Mar 12 | Royal Free PerformanceOct 12 - Mar 13 | National Average Performance Oct 12 - Mar 13 | Highest Performing NHS Trust Performance Oct 12 - Mar 13 | Lowest Performing NHS Trust Performance Oct 12 - Mar 13 | Actions to be taken to improve performance |

| | | | | | | |
|---|---|---|---|---|---|---|
| The number and rate of patient safety incidents that occurred during the reporting period | 451 (0.94) | 2,528 (6.3) | 5,048 (7.5) | 2,290 (3.2) | 11,495 (13.7) | The Royal Free London NHS Foundation Trust considers that this data is as described for the following reasons; the data has been sourced from the National Reporting and Learning System (NRLS). However the trust has advised NRLS that data submitted between October 2011 and March 2012 was incomplete due to technical issues with exporting data. The trust worked with the NRLS staff and the technical issue was resolved, hence the increase in reported incidents for the period October 2012 to March 2013.<br>The Royal Free London NHS Foundation Trust has since taken the following actions to improve its reporting rate:<br>1) The trust purchased a web-based reporting tool with the aim of simplifying the process for staff to report incidents and to export data to NRLS. Experience from other trusts has indicated that the introduction of a web-based tool significantly increases the volume of forms submitted by staff. The web based system went live during February 2013.<br>2) In addition the trust has developed a patient safety campaign with the aim of focusing on improving the patient safety culture, including encouraging staff to report incidents and providing timely feedback to staff on the outcomes and learning resulting from incident investigations.<br>We have robust processes in place to capture incidents. However there are risks at every trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. Whilst we have provided training to staff and there are various policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe this is in line with all other trusts.<br>There is also clinical judgement in the classification of an incident as 'severe harm' as it requires moderation and judgement against subjective criteria and processes. This can be evidenced as classifications can change once they are reviewed. Therefore, it could be expected that the number of severe incidents could change from that shown here due to this review process |
| The number and percentage of such patient safety incidents that resulted in severe harm or death | 13 (2.8%) | 25 (1%) | 23.2 (0.4%) | 2 (0.1%) | 74 (1.4%) | |

## Auditor's statement

Our external auditors PwC are required under Monitor's '2013/14 Detailed Guidance for External Assurance on Quality Reports' to perform testing on two national indicators. A detailed definition and explanation of the criteria applied for the measurement of the indicators tested by PwC is included below:

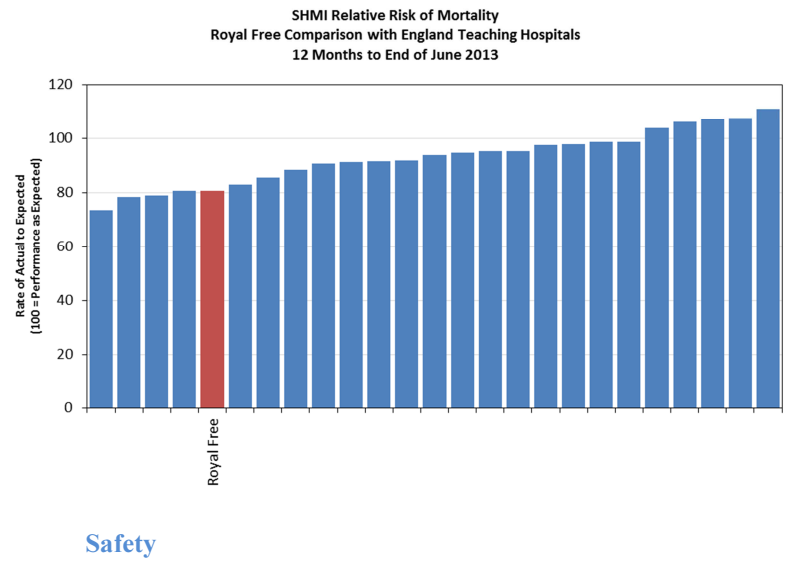
*INFORMATION TO BE SUPPLIED BY PwC*

## Quality performance indicators

An overview of the quality of care based on performance against key national indicator priorities is detailed within our annual report.

This section of the Royal Free's quality report contains an overview of quality of care offered by the trust based on performance against indicators selected by the board in consultation with our stakeholders. They cover three dimensions of quality:

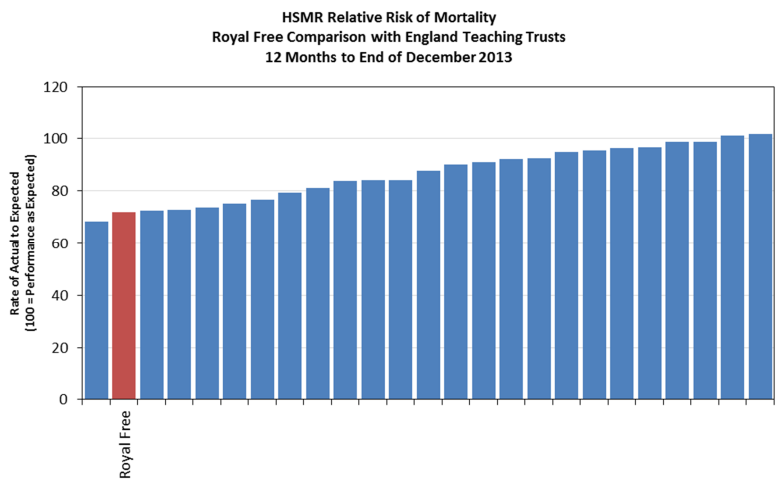
- Patient safety
- Clinical effectiveness
- Patient experience.



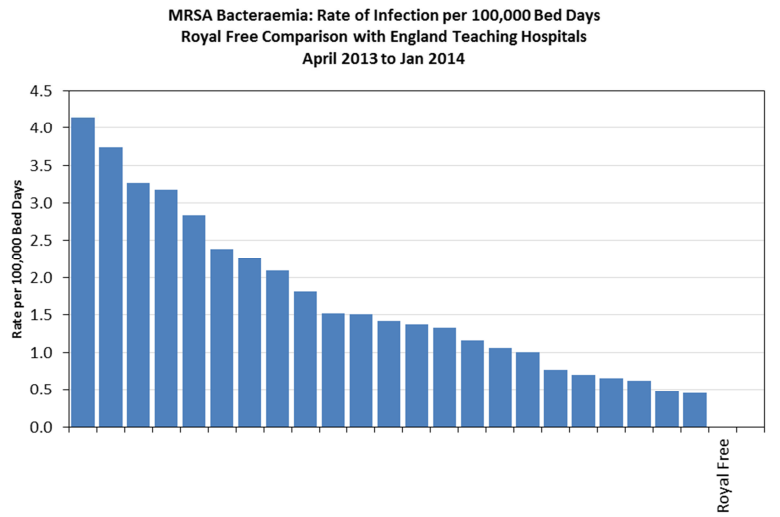

SHMI (summary hospital mortality indicator) is a clinical performance measure which calculates the actual number of deaths following admission to hospital against those expected.

The observed volume of deaths is shown alongside the expected number (casemix adjusted) and this calculates the ratio of actual to expected deaths to create an index of 100. A relative risk of 100 would indicate performance exactly as expected. A relative risk of 95 would indicate a rate 5% below (better than) expected with a figure of 105 indicating a performance five per cent higher (worse than) expected.

For the 12-month period ending June 2013, the most recent period for which data is available, the Royal Free's SHMI ratio was 80.7 or 19.3% better than expected. For this period the Royal Free had the fifth lowest rate of any English teaching trust.




The most recent HSMR (hospital standardised mortality ratio) data shows that for the 12 months to the end of December 2013 we recorded the second lowest relative risk of mortality of any English teaching trust with a relative risk of mortality of 72.5, which is 27.5% below (statistically significantly better than) expected.

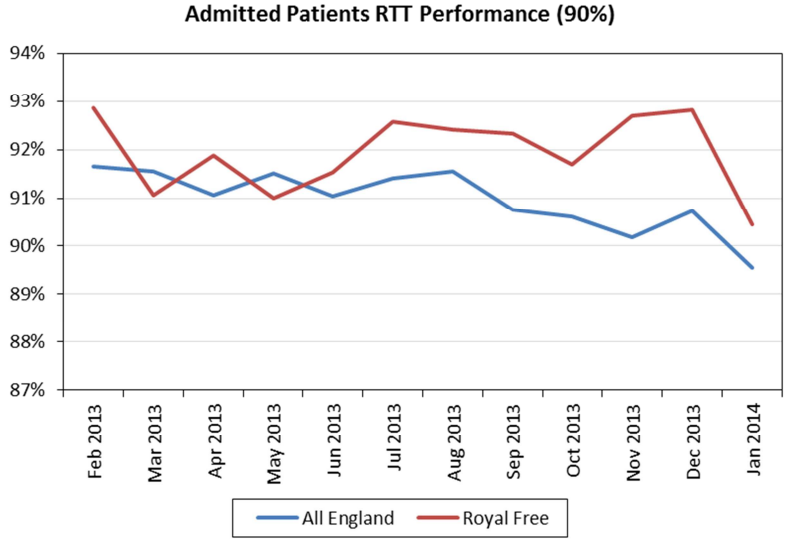



MRSA is an antibiotic resistant infection associated with admissions to hospital. The infection can cause an acute illness particularly when a patient's immune system may be compromised due to an underlying illness.

Reducing the rate of MRSA infections is a key government target. The infection rate is seen as an indicator of the degree to which hospitals prevent the risk of infection by ensuring their facilities are clean and their staff comply with infection control procedures.

During 2013/14 the Royal Free had zero attributable cases of MRSA, compared to the previous year's total of one. This means the Royal Free is the joint best performing trust out 25 English teaching hospitals during this period.

Safety




A maximum waiting of 18 weeks from referral to treatment is a key government access target.

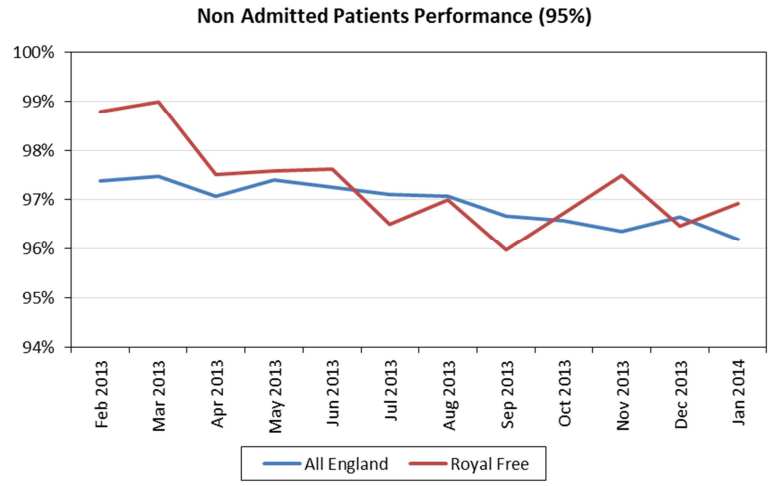
We have consistently remained above the 90% standard for patients requiring admission, with the Royal Free performing better than the average performance of English acute trusts in all but two months.

However, as the chart demonstrates, the proportion of patients treated within 18 weeks has reduced during January 2014 as it has across the NHS. This is mainly due to seasonal pressures with extra capacity being made available for emergency rather

## Effectiveness

than elective patients.

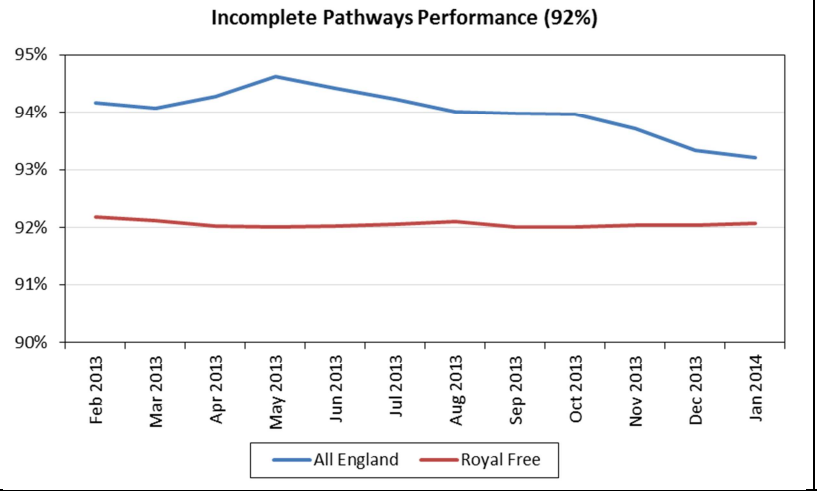
The standard requires that 95% of out-patients are treated within 18 weeks. The Royal Free has consistently outperformed this measure and outperformed the English NHS in all but four months during the year.

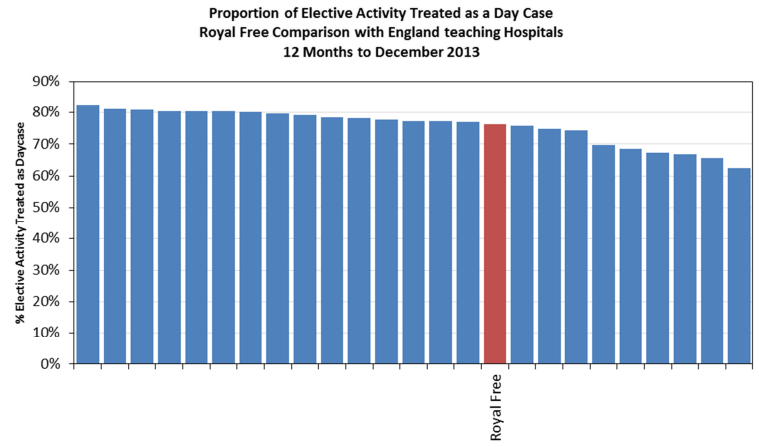



Longer waits for treatment for patients with incomplete pathways suggest that some patients may be actively waiting for treatment for longer than the 18 week standard. The Government has therefore set an additional target requiring 92% of patients actively waiting for treatment to have waited less than 18 weeks.

The trust has achieved this standard each month throughout the period February 2013 to January 2014.

The Royal Free will prioritise waiting list reductions in key specialties in the first half of 2014/15. This will ensure that performance improves and patients have shorter waits for admission and treatment.

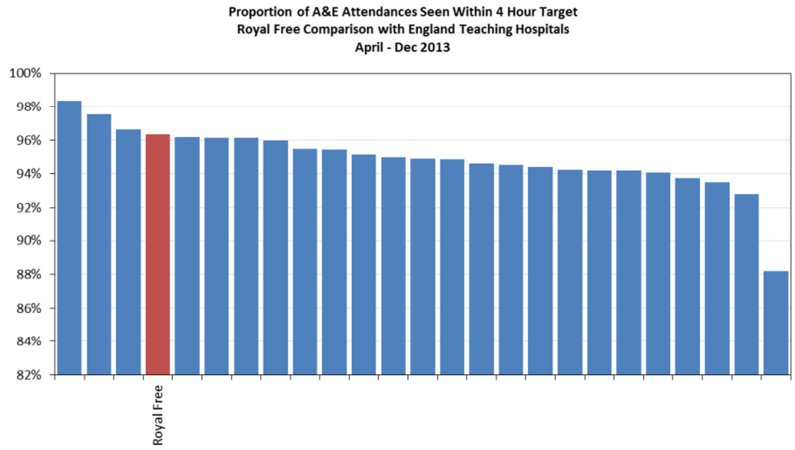





Day cases are procedures that allow you to come to hospital, have your treatment and go home, all on the same day. A high day case rate is seen as good practice both from a patient's perspective and in terms of efficient use of resources.

The graph compares the Royal Free's performance to the performance of English teaching trusts.

## Effectiveness



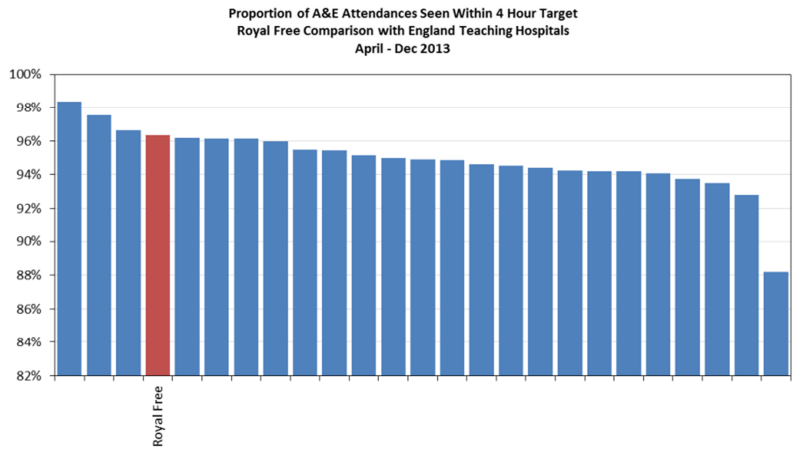

The accident and emergency department is often the patient's point of arrival, especially in an emergency when patients are in need of urgent treatment.

Historically, patients often had to wait a long time from arrival in A&E to be assessed and treated.

The graph summarises the Royal Free's performance in relation to meeting the four hour maximum wait time standard compared to the performance of English teaching hospitals.

A higher percentage is good as it reflects short waiting times. During the year the Royal Free was the fourth best performing teaching trust

## Effectiveness

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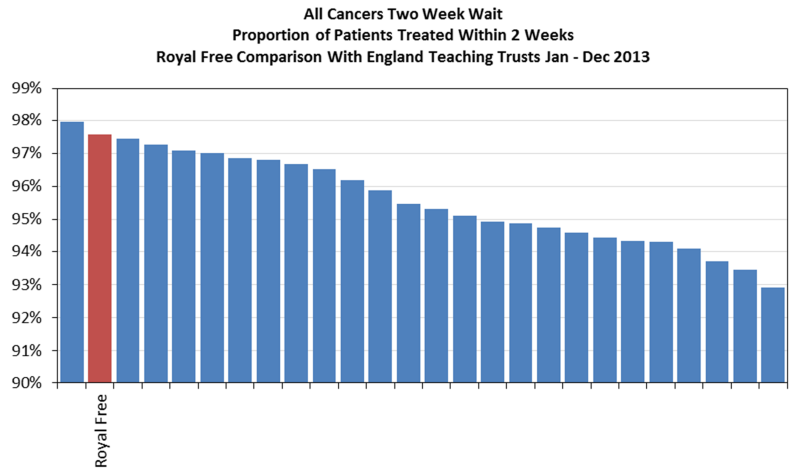
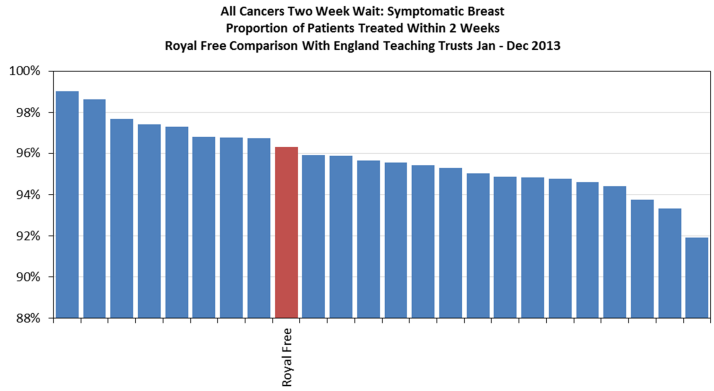
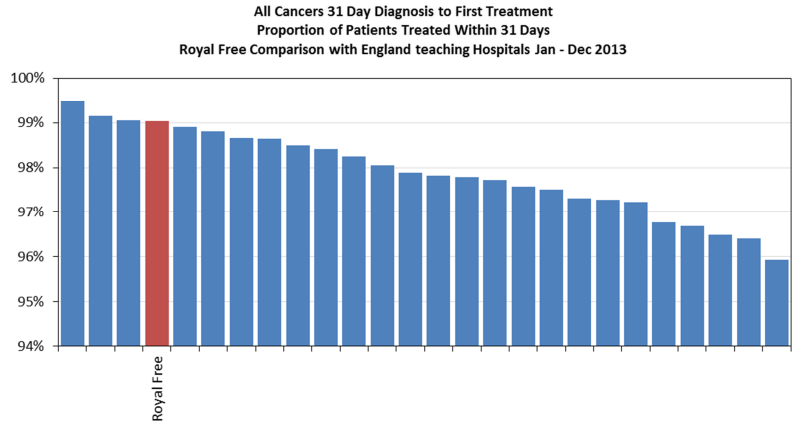
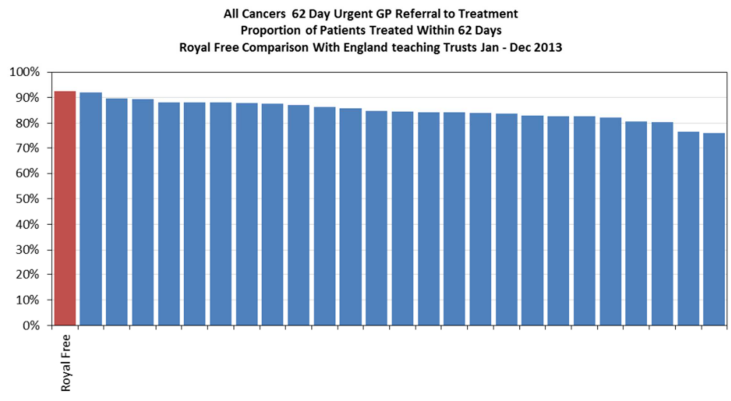



Effectiveness



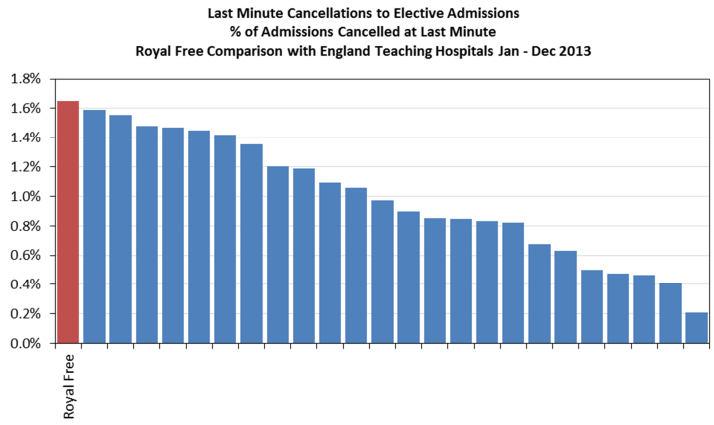

Effectiveness

Clinical evidence demonstrates that the sooner patients urgently referred with cancer symptoms are assessed, diagnosed and treated, the better the clinical outcomes and survival rates.

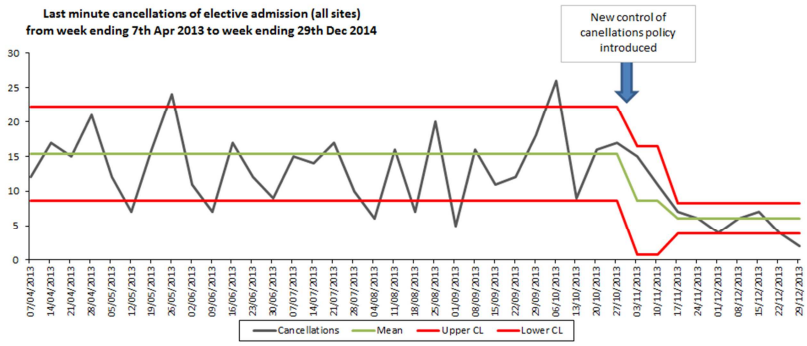
National targets require 93% of patients urgently referred by their GP to be seen within two weeks, 96% of patients to be receiving first treatment within 31 days of the decision to treat and 85% of patients to be receiving first definitive treatment within 62 days of referral.

For the most recent period for which national data is available, January to December 2013, the Royal Free performed better than the national targets on all these measures and was the second best performing English teaching hospital for two week waits, the fourth best for 31 day waits and the best performing in relation to the 62-day target.

The graphs present the Royal Free's performance relative to English teaching trust performance.




Patient experience



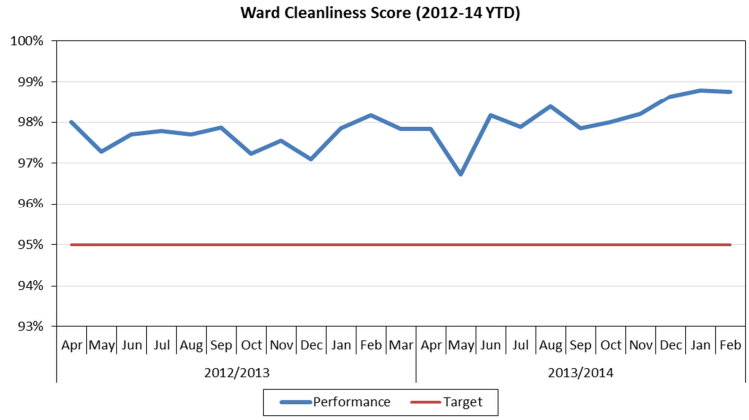

Patient experience

Cancelling operations on the day of, or following admission, is extremely upsetting for patients and results in longer waiting times for treatment.

This year there has been an increase in the number of cancelled operations. In part this has been due to an increase in emergency activity with the trust having to prioritise admissions especially for those patients attending A&E.

However during November 2013, the Royal Free introduced a control of cancellations policy which prioritised the reduction of cancellations in order to improve patient experience. The impact was immediate and significant; the second graph opposite demonstrates the effect.

For 2014/15 the trust will look closely at the expected planned and emergency activity particularly over the winter months to ensure there is sufficient emergency capacity without the need to inconvenience patients by cancelling planned operations.




Patient experience

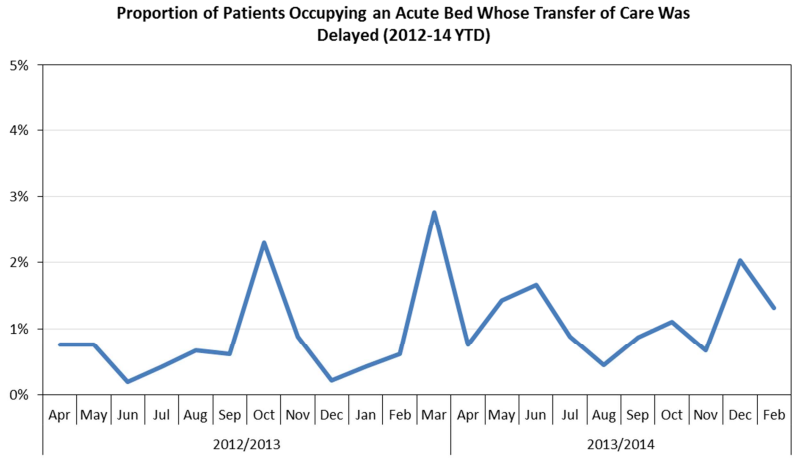
Ward cleanliness scores are derived from assessments undertaken by the patient environment action team, which includes patients, patient representatives and members of the public.

The scores were well above the required standard throughout the year.

Patient experience

A delayed transfer is when a patient is occupying a hospital bed due to the lack of appropriate facilities in the community or because the hospital has not properly organised the patient's transfer once the patient is well enough to leave.

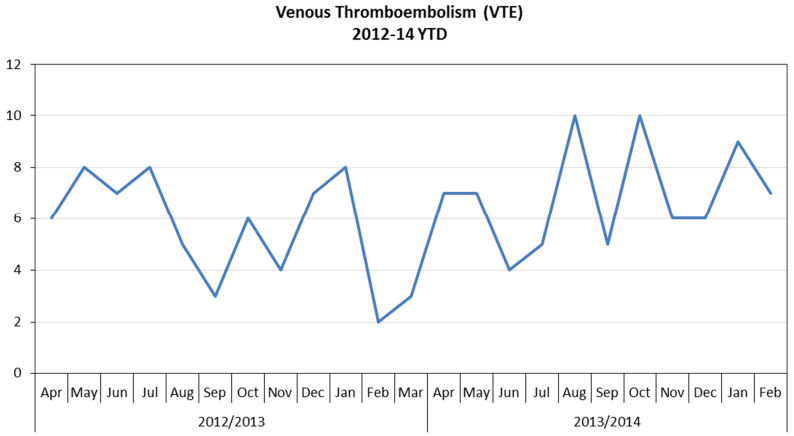
It means patients are not cared for in an appropriate environment for their needs and is an inefficient use of taxpayers' money. The aim therefore




is to reduce the number of delayed transfers.

Through more effective working with our community partners and better internal organisation, the rate of delayed transfers of care has reduced significantly since 2009. However we have seen a recent increase, particularly in the winter months when the pressure on services is at its greatest. Most of these delays were associated with patients waiting for further NHS care provision. These included patients waiting for general, stroke and neurological rehabilitation and continuing healthcare-funded placements.

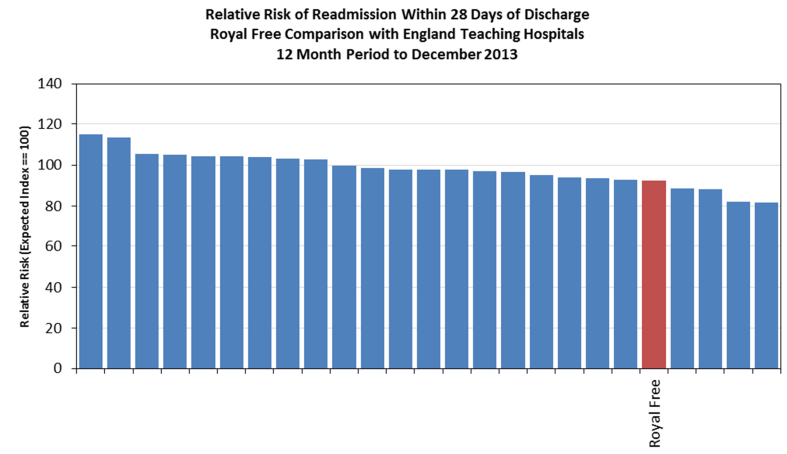
The trust is working with its partners and commissioning agencies to improve the position for 2014/15.




Many deaths in hospital result each year from hospital acquired thromboembolism (HAT). Some of these deaths could be prevented. The government has therefore set hospitals a target requiring 95% of patients to be assessed in relation to this risk. The Royal Free met or performed better than the target for 2013/14.

We recorded 67 cases of HAT in 2012/13 and 76 cases in 2013/14. We report our rate of hospital acquired thromboembolism to the monthly meeting of the trust board and the quarterly meeting of the clinical performance committee. Any significant variations in the incidence are subject to investigation with a feedback report provided to the trust board and clinical performance committee. In addition the thrombosis unit conducts a detailed clinical audit into each reported case and findings are shared with the wider clinical community.

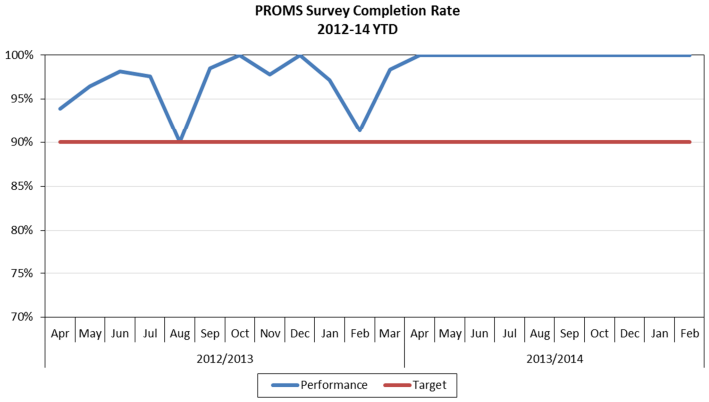
**Safety**




Effectiveness

We carefully monitor the rate of emergency re-admissions as a measure of the quality of care and the appropriateness of discharge. We work with commissioners, GPs and local authorities to reduce the rate of re-admissions.

A low, or reducing, rate of re-admission is seen as evidence of good quality care. The chart presents our performance relative to English teaching hospital performance with the Royal Free being the fifth best performing.

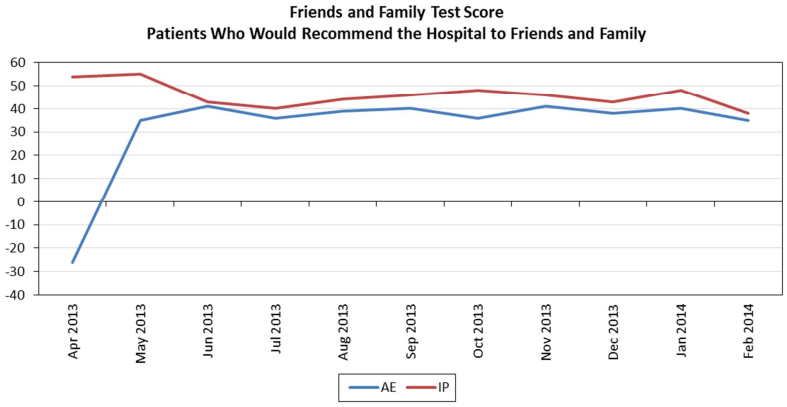



Effectiveness

We are required to record national patient reported outcomes measures in four clinical procedures:

- Inguinal hernia
- Varicose veins
- Knee replacement
- Hip replacement

The trust has achieved or exceeded the 90% target for every month of the past two years.




Patient experience

The friends and family test (FFT) was introduced in April 2012. Its purpose is to improve patient experience of care and identify the best performing hospitals in England.

FFT aims to provide a simple, headline metric which, when combined with follow-up questions, can be used to drive cultural change and continuous improvements in the quality of care received by NHS patients. Across England the survey covers 4,500 NHS wards and 144 A&E services.

## Appendices

### Appendix A

The views of our patients, local community, governors and staff are essential in helping us maintain and develop high quality clinical services. We carried out a series of exercises to ensure we engaged our various stakeholders and partners as much as possible in developing this quality report.

We sent this year's draft quality report to the following organisations for comment on xxxxxx 2014:

- Healthwatch Barnet
- Healthwatch Camden
- Barnet Health Oversight and Scrutiny Committee
- Camden Health Oversight and Scrutiny Committee
- North and East London Commissioning Support Unit
- Barnet Clinical Commissioning Group
- Camden Clinical Commissioning Group

Our external auditor, PwC, also reviewed our Quality Report and we have incorporated its preliminary comments into the final version.

The following statements have been received from our stakeholders.

### Statements from clinical commissioning boards and overview and scrutiny committees

*(insert replies from the following organisations)*

- Healthwatch Barnet
- Healthwatch Camden

- Barnet Health Oversight and Scrutiny Committee
- Camden Health Oversight and Scrutiny Committee
- North and East London Commissioning Support Unit
- Barnet Clinical Commissioning Group
- Camden Clinical Commissioning Group.

**Appendix B**

**Response to comments**

In response to comments received from xxxxxxxxxxxxxxxxxxxxx we have outlined our responses in the following table.

**Appendix C**

**Statement of directors' responsibilities in respect of the quality report**

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare quality accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

The content of the quality report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2013/14*;

The content of the quality report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2013 to June 2014
- Papers relating to quality reported to the board over the period April 2013 to June 2014
- Feedback from commissioners dated [*XX/XX/2014*]
- Feedback from governors dated [*XX/XX/2014*]
- Feedback from local Healthwatch organisations dated [*XX/XX/2014*]

- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated [*XX/XX/20XX*]
- The latest national patient survey [*XX/XX/20XX*]
- The latest national staff survey [*XX/XX/20XX*]
- The head of internal audit's annual opinion over the trust's control environment dated [*XX/XX/20XX*]
- CQC quality and risk profiles dated [*XX/XX/20XX*].

The quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;

The performance information in the quality report is reliable and accurate;

There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;

The data underpinning the measures of performance in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

The quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board

*(NB: sign and date in any colour ink except black)*

*Insert sig*

**Dominic Dodd**
Chairman
Date.....

*Insert sig*

**David Sloman**
Chief Executive
Date.....

**Appendix D**

**Independent auditor's limited assurance report to the council of governors of the Royal Free London NHS Foundation Trust on the annual quality report**

*(To insert – please advise where this comes from)*

**Appendix E**

**A guide to quality within the trust**

**March 2014**

This guide describes how we ensure we provide patients with high quality services.

It describes what quality means for the trust and how we set a culture of quality and high standards throughout the organisation.

The guide was originally adapted from the quality governance memorandum prepared for our 2011 foundation trust application and has most recently been revised and updated for inclusion in the trust's 2013/14 quality account. It is based on the quality governance framework used by Monitor, the regulator of foundation trusts. Quality governance is divided into four main domains: strategy, cultures and capabilities, processes and structures and metrics.

**What is quality?**

The term 'quality' can be used in different ways. In some circumstances it describes how a product measures up to a predetermined specification: did it do what it said on the tin? In other contexts quality is measured against expectation: was it what I thought it would be? Frequently it is simply used to mean excellence - a quality product.

At the Royal Free our focus is on excellence and we therefore aim to provide services of the highest possible quality. This is reflected in our world class care values, which are also embedded in our corporate objectives and reflect our governing objectives:

- **To deliver excellent patient outcomes, teaching and research.** Our aim is to be in the top 10% of our relevant peers. This means maintaining our

excellent infection control and patient safety record, continuing to develop and invest in our research and research capacity and developing outcomes measures at clinical service line level.

- **To offer excellent patient and staff experience.** Our aim is again to be in the top 10% of our relevant peers. The main challenge here is addressing the variability of the patient experience and ensuring we engage all staff in the running and development of the trust and give our staff the skills, resources and support they need to perform to the optimum of their ability.
- **To deliver excellent financial performance and value for taxpayers' money**. To be in the top 10% of our relevant peers, we must have a major focus on productivity and service transformation as we meet the financial challenges ahead.
- **To be safe and compliant with the law and the standards and targets set by our regulators and other relevant bodies.** This includes health and safety legislation, the CQC regulatory standards and the standards and targets within the NHS operating framework
- **To build a strong organisation fit for the future.** We must ensure that we have the infrastructure, processes and people in place to enable us to deliver the four objectives described above.

In autumn 2011 we launched our world class care programme, designed to improve patient and staff experience within the trust. As part of this we listened to hundreds of our patients and staff members and have worked with them to develop a set of commitments and standards which we expect all staff to adopt. The standards are:

- to be positively **welcoming**
- to be actively **respectful**
- to **communicate** clearly
- to be visibly **reassuring**

The Royal Free already demonstrates high quality performance in many areas. For example:

- The trust consistently has one of the lowest hospital standardised mortality rates (HSMR) and summary hospital-level mortality indicators (SHMI) in England
- No MRSA bacteraemia has occurred within the trust for 18 months
- The trust has the second highest number of highly-cited research publications of English NHS trusts.

There are also areas in which we know quality must improve. These include:

- The administrative processes which support patients and staff
- Levels of reported bullying by staff
- Overall patient experience
- Rates and timeliness of serious incident reporting

**Strategy**

**How quality drives the trust's strategy**

Each year the board approves three high-level quality improvement objectives that are published in our annual quality account. These are agreed following extensive consultation with external stakeholders including the trust's governors, Barnet and Camden Healthwatch, Barnet and Camden health scrutiny committees and local CCGs. In addition our trust members complete an online survey. Internally, discussions are held at executive and board level and with staff groups.

Our 2013/14 quality improvement objectives were:

- In the area of patient experience, to continue our World Class Care programme. Our specific aims were to identify and share learnings from the world class ward programme; continue our work around supporting teams to consistently give world class care through the delivery of core and bespoke development programmes, integrating these with our response to the Francis report and the Secretary of State for Health's requirement to conduct listening events with staff; and maintain and develop our programme of engagement activities with patients and the public, ensuring that the voice of our service users is central to our business.
- In the area of clinical effectiveness, to continue the development of our specialty-based clinical outcome metrics. Our specific aims were to appoint an associate medical director for clinical performance; complete the publication of current data for all our speciality level metrics; develop achievable improvement plans for these metrics, taking into account what other trusts have been able to achieve, both nationally and among UCLPartners; continue work within our academic health science partnership, UCLPartners, to develop common clinical outcome metrics that we can use to compare performance between organisations; begin the development of patient-defined clinical performance metrics.
- In the area of patient safety, to launch a patient safety programme with a focus on key areas of patient safety that have arisen from our analysis of clinical incidents occurring within the trust, patient complaints, national guidance and from discussion with our stakeholders, including patients and governors.

The clinical performance committee and trust board receive regular updates on progress against these objectives.

The trust also drives quality improvement through its Quality, Innovation, Productivity and Prevention (QIPP) programme, led by the director of integrated care; and the Commissioning for Quality and Innovation (CQUIN) scheme led by the director of planning. The QIPP programme incorporates transformational and transactional aspects of clinical management to support the delivery of quality services while at the same time reducing costs over the next five years. The programme responds both to financial pressures, resulting from flat income and expected increase in demand, and our commitment to delivering high quality services. There are currently more than 70 active QIPP projects. The CQUIN programme is agreed each year with our commissioners following extensive discussion and, where appropriate, co-development.

In addition to our annual high-level quality objectives, QIPP, and CQUIN programmes, the trust demonstrates its commitment to innovation through its approach to quality improvement. This has included development of adult and paediatric early warning systems, the first introduction in the UK of Schwartz Rounds, introduction of the productive ward, participation in the Institute of Health Improvement's Safer Patient Initiative and improvement work aimed at early recognition of sepsis. Most recently the trust has launched a new patient safety programme under the sponsorship of the deputy chief executive. Our improvement work is increasingly developed in partnership with other NHS organisations, usually through UCLPartners, our academic health science network. Our system-wide work on the management of deteriorating patients is a prime example of this approach. A selection of other quality improvement initiatives is described each year within our annual quality account. In the latest quality account, published in June 2013, we reported on projects to:

- Improve diagnosis and treatment of heart failure
- Improve waiting times for cancer patients
- Help patients with diabetes receive safer care
- Cure haemophilia through gene therapy
- Prevent elderly patients having unnecessary admissions to hospital
- Improve in-patient care of the elderly.

In recent years the board has been particularly concerned that improvements occur with respect to patient and staff experience, particularly through our World Class Care programme.

The trust communicates and discusses quality initiatives with staff, patients and other external stakeholders in a variety of ways. These include the annual quality account, which we publish with our annual report and financial accounts in this single document, regular electronic briefings by the chief executive, meetings of governors, and staff engagement sessions.

**How the board is aware of potential risks to quality**

Our risk management strategy outlines the trust's approach to risk and details the processes in place to manage risk. The trust maintains a risk register and a board assurance framework (BAF), both of which are reviewed and revised on a regular basis. The trust executive committee reviews the risk register, with additional oversight and assurance being provided by the patient safety and compliance committee. Additional review is also undertaken at the clinical performance committee and the audit committee. The risk register is populated from a variety of sources including risk registers maintained within each clinical division, incident forms, audits, benchmarking and external reviews. The BAF is regularly reviewed at the strategy and investment committee and is also reviewed at other board committees. The risk register and board assurance framework both contain actions to mitigate risk; these are regularly reviewed.

The trust board also uses a variety of other mechanisms to assess potential risks to quality. These include our programme of 'Go see' visits, in which directors are paired with clinical areas that they visit on a regular basis; regular reports to the board from the director of infection prevention and control; a range of inspections by external regulators that are monitored by the patient safety committee (formerly the risk, governance and regulation committee); our quality road map self-assessment process for CQC outcomes; and a wide range of metrics used to monitor performance. The trust participates in national in-patient and out-patient surveys, and collects data for the friends and family test (FFT) through a telephone-based methodology. The trust encourages external stakeholders to identify risks to quality through a variety of formal and informal means. These include the patient advice and liaison service (PALS), patient representative groups, Healthwatch, public board meetings, local commissioners, council of governors and the local health scrutiny committees. The board's patient and staff experience committee has the key responsibility for monitoring and improving the quality of patient and staff experience.

The QIPP programme is a key component of the trust's quality improvement process. However, we recognise that there is also a potential for some QIPP projects that primarily focus on cost reduction to have an adverse effect on quality. To avoid this, all QIPP projects are assessed for their potential impact on quality before and after implementation, including a detailed quality impact assessment. QIPP projects are separately reviewed by the medical director and the director of nursing for any potential negative impact on quality. A separate clinical advisory group, consisting of clinicians not directly involved in developing QIPP programmes, also provides additional scrutiny. In addition the board monitors a set of specific trust wide metrics that may be adversely affected by cost improvement projects.

## Capabilities and culture

### How the board ensures it has the necessary leadership, skills and knowledge to deliver the quality agenda

In 2013/14, the trust board consisted of five executive directors (including the chief executive) and six non-executive directors (including the chairman). Three of the executive directors and one of the non-executive directors have clinical backgrounds. In addition, board meetings are attended by a number of other executives, including the three divisional directors who are practicing clinicians. Board members have a wide range of experience and backgrounds, including other NHS organisations, other public sector bodies and the private sector.

The current board committee structure is shown in figure 1 on page x and has been designed to ensure that integrated quality governance is aligned with our governing principles and corporate objectives. A non-executive director chairs all board committees, with the exception of the trust executive committee. Three clinical divisions, established around strong clinical leadership, support the board.

Quality is central to the agendas of the board and all its committees, with a regular focus on quality metrics. Recent examples where the board has clearly taken a central role in quality improvement include the focus on infection control with a sustained reduction in acquired MRSA bacteraemias and renewed focus on reduction in Clostridium difficile infections, the development of a set of around 90 clinical outcome metrics, mostly at specialty level, and a focus on scrutiny of the results of national clinical audits.

The board participates in a comprehensive continuing development programme, which has included an external assessment of its skills and capabilities. Regular board seminars provide the opportunity for directors to expand their knowledge and skills of specific issues including quality governance.

### How the board promotes a quality-focused culture throughout the trust

The board has promoted a number of quality strategies and initiatives that have been developed and implemented with extensive staff engagement. As already described, these include the development of the annual quality account, the drive to improve infection control, the QIPP programme, the patient safety programme, the development of clinical outcome metrics for each clinical business unit and, most importantly, our World Class Care programme. These and other quality-focused programmes have helped promote a quality-focused culture throughout the organisation. Senior executives are directly involved in specific quality improvement initiatives; for example the director of nursing is responsible for the falls reduction programme, our infection control programme and the World Class Care programme; the medical director is responsible for the development of clinical outcome metrics;

the director of integrated care is responsible for the QIPP programme; the deputy chief executive sponsors our patient safety programme.

The board actively encourages staff to participate in quality initiatives. Our EUREKA scheme encouraged staff to suggest quality schemes as part of the QIPP programme. Annual staff achievement awards recognise those individuals and teams who have made a significant contribution to high quality within the trust. Using our clinical incident reporting system, we encourage staff to report errors and adverse events that have, or could have, an adverse impact on quality. This has been strengthened by our recent implementation of the Datix web system for electronic reporting of incidents.

Staff members receive training and experience in service improvement methodology through direct participation in quality improvement projects, such as our theatre improvement project and our work on sepsis management. Quality improvement projects are reported and communicated by a number of means, including the annual quality account, a weekly electronic newsletter to staff, a quarterly newsletter to staff, information to members and monthly briefings of staff by the chief executive.

The trust carries out robust recruitment and human resources practices that ensure we have a high quality workforce that is safe and responsible in delivering care. We review our policies and procedures regularly with service user involvement and our staff are equipped with the right skills and professional training to keep us compliant with our external and regulatory obligations. We have recently focused on embedding our World Class Care values in our recruitment processes.

**Processes and structures**

**Roles and accountabilities in relation to quality governance**

The trust board is ultimately responsible for the quality of service provided by the Royal Free. It agrees the overall strategic direction for continuous quality improvement, encapsulated by the top 10% aspiration within the governing objectives; sets a culture which promotes the delivery and development of high quality services; and monitors how the trust performs against objectives. Trust board meetings do not treat quality as a separate agenda item as we believe quality should form an integrated part of discussions and decisions in all areas, clinical and non-clinical. Each year the board agrees three high level quality improvement goals that are published in the annual quality account.

The chief executive's scheme of delegation describes the responsibilities of individual executive directors. The medical director has overall accountability for the quality of clinical services and is responsible for clinical performance and patient safety; the director of nursing is responsible for CQC compliance and patient experience.

Board committees are aligned with the governing objectives and have a key role in quality governance:

- The **clinical performance committee** meets quarterly and is responsible for seeking and securing assurance that the trust's clinical services, research efforts and education activities achieve the high levels of performance expected of them by the board, namely 'outcomes consistently in the top 10% in the UK versus relevant peers'. It monitors performance against the trust's three high-level quality objectives, reviews data concerning mortality by specialty and diagnostic group, reviews national clinical audits and undertakes reviews of specialties where concerns may have arisen regarding clinical quality. It is working with service lines to develop a series of outcome measures which, whenever possible, will be benchmarked against other organisations.

- The **patient and staff experience committee** meets bi-monthly and is responsible for seeking and securing assurance that the trust's services are delivered to its customers (GPs and patients) so as to achieve the high levels of performance expected of them by the board, namely 'recommendation rates consistently in the top 10% in the UK versus relevant peers'.

- The **patient safety committee** is a new committee which has replaced the risk, governance and regulation committee. It meets monthly and monitors patient safety through review of patient safety metrics such as falls and pressure ulcers, review of serious incidents and oversight of the patient safety programme. It is also responsible for ensuring that the trust is fully compliant with all its regulatory duties.

- The **trust executive committee** meets weekly. The role of the committee is to support and advise the chief executive in running the trust, in meeting the requirements of the operating framework and on strategic priorities and objectives.

- The **finance and performance committee** meets monthly and is responsible for seeking and securing assurance that the trust achieves the high levels of financial and operational performance expected by the board, namely 'consistently in the top 10% in the UK versus relevant peers'.

- The **integration committee** meets monthly and is responsible for overseeing the integration plan, providing assurance to the trust board on progress on integration of the Royal Free London NHS Foundation Trust and Barnet and Chase Farm Hospitals NHS Trust and ensuring sufficient oversight is given to realising the benefits articulated in the integrated business plan for the acquisition.

- The **strategy and investment committee** now meets bi-monthly and is responsible for ensuring that the trust's strategy and major investment decisions support the achievement of its governing objectives.

- The **audit committee** meets five times a year. It provides the board with an independent and objective review of the effectiveness of the organisation's governance, risk management and internal control systems. It receives evidence and gathers assurance from a variety of sources about the overall quality of care provided by the trust.

- The **remuneration committee** meets as required and consists of the trust chairman and non-executive directors. It is responsible for all decisions concerning the remuneration and terms of service for corporate managers.

Beneath the level of board committees, other committees and working groups also play an important role in quality governance. These include groups that have a focus on a specific issue, such as the committee that ensures the trust is compliant with the Human Tissue Act, to those with a broader remit such as the education committee. Our 2011 review of quality governance recommended that the majority of these groups should report into the trust executive committee, as this is the board committee that meets most regularly and is able to address operational issues most rapidly. It also provides a key link to the trusts clinical divisions. Reports from these groups are also made available to other board committees, on a regular or ad hoc basis as appropriate.

The trust's clinical services operate within three divisions: transplantation and specialised services, urgent care and surgery and associated services. Each division contains a number of service lines (clinical business units). Divisions focus on quality within a variety of forums, including divisional quality and safety boards to provide a specific divisional focus to quality governance.

**Processes for escalating and resolving issues and managing performance**

The trust committee and reporting structure has already been described. In addition, the trust uses other mechanisms to gather and escalate quality issues. These include the risk register and the board assurance framework, risk management reports, clinical audit programmes and our internal audit plan. The trust has a whistle-blowing policy that is available to all staff on our intranet.

**How the board actively engages patients, staff and stakeholders**

To emphasise our patient focused approach, each board meeting begins with 'patient voices' in which an executive director reads one recent letter of complaint and one of praise.

The board actively encourages patients, staff and other stakeholders to engage in our drive for high quality through a variety of means. Examples include:

- The extensive engagement that is undertaken for our annual quality account
- Patient focus groups that have been established in a number of specific areas
- The trust's council of governors and membership which have been in place since 2008, initially in shadow form, and since April 2012 with full powers. The board consults the council and members concerning quality and responds to quality issues raised by the governors. Governors sit on the clinical performance committee, the patient and staff experience committee and the patient safety committee
- Board members and governors regularly undertake 'Go see' visits to clinical areas, which involve speaking with patients
- The patient and staff experience committee regularly reviews the results of patient and staff feedback.
- The board regularly engages with local Healthwatch and health scrutiny committees
- The trust meets commissioners, including GP representatives, in a monthly clinical quality group attended by the trust medical director and director of nursing
- The trust has a director of integrated care who is responsible for working with commissioners and GPs to develop high quality community based services
- We are one of the few acute trusts to have a public health team that works within the trust and with our local community to promote health and wellbeing improvement.

The trust is committed to making its quality performance outcomes as accessible as possible. For example, our comprehensive board performance dashboard is included within the published papers of our quarterly public board meetings. Our quality account includes a comprehensive set of quality data together with easily understandable descriptions of each metric. Performance metrics are also discussed with commissioners at regular monthly quality review meetings. We have recently begun placing performance metrics on our external internet site.

**Measurement**

**How appropriate quality information is analysed and challenged**

The trust already generates a large volume of metrics relating to the quality of operational performance, patient safety, patient experience and clinical outcomes. The trust metrics library currently consists of more than 200 measurements. This is supplemented by metrics provided by external agencies such as Dr Foster. Additional metrics are also under development, for example the clinical performance committee has developed clinical outcome metrics at clinical business unit level and six education and research metrics at organisational level.

Since the appointment of a director of information management and technology in 2010, the board performance dashboard has undergone extensive development. This now provides a comprehensive set of clinical and non-clinical metrics and includes:

- Metrics related to national priorities and regulatory requirements, for example A&E metrics
- Metrics specifically related to safety, clinical effectiveness and patient experience
- Metrics specifically related to early warning of quality deterioration, for example patient falls, average length of stay
- Metrics related to adverse events and harm, for example never events, MRSA rates
- Monitors risk ratings
- RAG rating and an overall commentary on performance.

The board dashboard is focused on those metrics that are most relevant to the governing principals and corporate objectives. Further metrics are reviewed in other trust committees: for example the operations board reviews a comprehensive set of operational performance metrics and the user experience committee reviews patient and staff survey metrics. Divisional dashboards include division-specific metrics. The trust executive committee reviews a ward-based 'heat map' of patient experience, workforce and safety metrics on a monthly basis. The patient safety and compliance committee reviews the trusts quarterly self-assessment of compliance with CQC standards.

The trust is currently implementing service line reporting within its clinical business units. This will facilitate better analysis of metrics at specialty and consultant level. Consultant-level outcomes are monitored at the clinical performance committee.

Each metric is overseen by a board committee and/or executive director.

**How the board assures the robustness of quality information**

The data quality committee is responsible for monitoring and reviewing the quality of data captured by the trust's systems. This is supplemented by internal audit reviews and external reviews such as the Audit Commission's audit of our 'payment by results' systems and processes. External auditors also review the quality of data in our most recent quality account. Action plans are agreed following data audits and monitored by the relevant committee.

The accuracy of coding is reviewed as part of the payment by results audit and is reported in the quality account. The trust has established a clinical data quality group to drive improvement in clinical documentation and coding quality.

The trust is increasingly using electronic systems to capture and report key metrics and the information team is currently developing the automation of such reporting.

The trust actively encourages participation in national clinical audits and confidential enquiries. The clinical performance committee reviews the outcome from these audits and when concerns arise will undertake specific reviews.

**How quality information is used effectively**

The trust dashboard includes red, amber, green rating of individual metrics against targets and shows trends of performance overtime. Wherever possible, the trust also benchmarks performance against comparable organisations. All reports include the most recently available data. The trust is increasingly working towards on-demand electronic availability of metrics from its extensive metrics library.

The regular review of metrics has helped drive a number of improvements in quality. Examples include:

- Improvement in MRSA rates and *C. Difficile*
- Improvement in the number of cancelled operations
- Improvement in early intervention in sepsis.

All metrics are now presented in a consistent format within the board dashboard using statistical process control methodology.

# Quality Account 2013/14

## CONTENTS PAGE

## ABOUT OUR QUALITY ACCOUNT 2013/14

Welcome to the Central London Community Health Trust (CLCH) Quality Account for 2013/14. The Quality Account is a summary of our performance in the last year in relation to our quality priorities and national requirements. We have incorporated feedback from our clinical teams this year showing how they have changed the way they deliver care in order to improve the quality of our services.

### What is a Quality Account?

A Quality Account is an annual report that providers of NHS healthcare services must publish to inform the public of the quality of the services they provide. This is so you know more about our commitment to provide you with the best quality healthcare services. It also encourages us to focus on service quality and helps us find ways to continually improve.

### Why has CLCH produced a Quality Account?

CLCH is a community healthcare provider providing healthcare to people in their homes and the local community and therefore we are statutorily required to publish a Quality Account. This is the third year that we have done so.

### What does the CLCH Quality Account include?

Over the last year we have collected a lot of information on the quality of all of our services within the three areas of quality defined by the Department of Health: safety, clinical effectiveness and patient experience. We have used the information to look at how well we have performed over the past year (2013/14) and to identify where we could improve over the next year, and we have defined six main priorities for improvement which we set out later in our Quality Account. Throughout the account we have described how *Quality Matters* providing real stories of how our services have implemented quality. For the first time this year, to provide you with further information, we have also attached, as an appendix, the Trust's annual complaints report.

This Quality Account covers the four boroughs in which we were working during 2013/14: Hammersmith and Fulham (H&F), Kensington and Chelsea (K&C), Westminster, and Barnet. Further information can be found about this on the publications section of our website www.clch.nhs.uk

### Developing the Quality Priorities 2012/13

The development of the Trust's Quality Account and Quality Priorities has been done in consultation with a variety of internal and external stakeholders. To make sure that our priorities matched those of our patients, carers, partners and the wider public, we invited a range of individuals and groups to contribute to our quality account. We also have a Quality Stakeholder Reference Group (QSRG, with representatives from Healthwatch and local authority overview and scrutiny committees (OSCs) which provided comments and feedback. More detailed information regarding the response to the consultation can be found at the end of the section on our quality priorities for 2014/15

## How can I get involved now and in future?

At the end of this document you will find details of how to let us know what you think of our Quality Account, what we can improve on and how you can be involved in developing the report for next year.

If you would like to receive a printed copy of the CLCH Quality Account, please contact us via e-mail to **communications@clch.nhs.uk** or telephone us on **020 7798 1420**.

## ABOUT CLCH

We provide healthcare from more than 160 locally based sites and in many cases in people's own homes in order to make access to our services as easy as possible.

### The full range of CLCH services includes:

- Adult community nursing services – including 24 hour district nursing, community matrons and case management
- Child and family services - including health visiting, school nursing, children's community nursing teams, speech and language therapy, blood disorders, and children's occupational therapy
- Rehabilitation and therapies - including physiotherapy, occupational therapy, foot care, speech and language therapy, osteopathy
- End of life care – for people with complex, substantial, ongoing needs caused by disability or chronic illness.
- Specialist services to include Offender health services – at HMP Wormwood Scrubs
- Continuing care – services for older people who can no longer live independently due to a disability or chronic illness, or following hospital treatment
- Specialist services – including elements of long term condition management (diabetes, heart failure, lung disease), community dental services, sexual health and contraceptive services, psychological therapies
- Walk-in and urgent care centres – providing care for people with minor illnesses, minor injuries and providing a range of health promotion activities and advice.

Further and more detailed information will be made about our services in our annual report but if you would like more information now about our services in each area, please visit our website www.clch.nhs.uk

*Map to be inserted here*

## CHIEF EXECUTIVE'S STATEMENT

TBC

## STATEMENT OF THE CHAIR OF THE QUALITY COMMITTEE

TBC

## LOOKING BACK - QUALITY IN 2013/14

### Progress against our Quality Strategy and Risk Management Strategy

Quality Strategy: The Quality Strategy was created to provide a framework through which improvements in the services the Trust offers to patients can be focused and measured. Three campaigns were identified to focus the quality improvements the Trust wished to make, with clear objectives described, to be achieved over a three year period. The three campaigns are:

- Campaign 1: A Positive Patient Experience;
- Campaign 2: Preventing harm;
- Campaign 3: Smart, Effective Care.

Each Campaign was divided into two key components, Gathering Feedback and Improving Services and has clear high level vision statements of where we aim to be as a Trust in year one, two and three.

**Campaign One** This campaign had seven key performance indicators (KPIs) for 2013-14. Of these six were fully achieved, with one not being achieved.

The KPI not yet achieved is: *There will be a 5% reduction in complaints related to poor communication and attitude.*

| Year | Total Complaints | About attitude of staff | Percentage |
|---|---|---|---|
| 2012-13 | 113 | 19 | 16.8 |
| 2013-14 | 93 | 18 | 19.3 |

An action plan has been developed with the relevant services to improve the position next year including:

- Continued rollout of the Trust's Excellence in Customer Service Training for staff.
- A review and restructure has taken place for some reception teams which aims to create consistency in roles across administration and reception services and improve patient experience and care.

**Campaign Two** This campaign had four KPIs for 2013-14, three of which were fully achieved and one not achieved.

The KPI not achieved was 95*% of incidents will be reviewed by the handler within 7 days and 100% within 14 days* as the year end position was 88%. In response to this, it has now been agreed that Patient Safety Managers will continue to work with the divisions to encourage timely review of each incident.

**Campaign Three This** campaign had four KPIs, one of which was fully achieved with two being partially achieved. During the course of the year one KPI became no longer applicable.

The details of those KPIs partially achieved were:

*Each service has a defined set of clinical standards (based on Trust /CQC/NICE/professional clinical guidelines.* To ensure full achievement with this KPI, the Clinical Effectiveness Group is working with services to produce two clinical standards to be monitored throughout the year. Work is also ongoing to set KPIs related to clinical standards for 2014/15.

*Ten teams across the Trust will develop and pilot exemplar team/service quality assurance measures*: To ensure full compliance with this KPI, CLCH is working with Buckingham University to develop an exemplar ward/team assessment tool.

The KPI that became no longer applicable was: *CLCH will achieve NHS Litigation Authority (NHSLA) level 2.* This was because the NHSLA changed its assessment process and no longer undertakes assessments.

**KPIs from Quality Strategy**

| | QUALITY STRATEGY | Level of achievement | Comment |
|---|---|---|---|
| **1** | **Campaign One: A Positive Patient Experience** | **Due Date:31st March 2014** | |
| 1.1 | Regular reports are received at service level across 100% of services which include feedback from patients | Fully Achieved | |
| 1.2 | Compassion in Care will be launched across the organisation, with a clear work plan | Fully Achieved | |
| 1.3 | Recommendations from the Francis report will be taken forward | Fully Achieved | |
| 1.4 | Divisional objectives will be written to improve the patient experience | Fully Achieved | |
| 1.5 | Divisional objectives are cascaded to individual team members | Fully Achieved | |
| 1.6 | Implement the 15 steps challenge across the organisation | Fully Achieved | |
| 1.7 | There will be a 5% reduction in complaints related to poor communication and attitude | Not achieved | The figures show an increase of 2.5% since last year. |
| **2** | **Campaign Two: Preventing Harm** | **Due Date:31st March 2014** | |
| 2.1 | Themes arising from incidents will be collated and analysed by division and discussed at integrated governance meetings | Fully Achieved | |
| 2.2 | Base line “level of harm" (Total number of incidents 2012/13) will be established by each Division | Fully Achieved | |
| 2.3 | Serious incidents reduced by 10% | Fully Achieved | The reduction was 30% |
| 2.4 | 95% of incidents will be reviewed by the handler within 7 days, 100% within 14 days. | Not Achieved | Year-end position was 88%. PSMs working with divisions to encourage timely review of each incident. |

| 3 | Campaign Three: Smart Effective Care | Due Date:31st March 2014 | |
|---|---|---|---|
| 3.1 | Each division will have three clinical outcomes, based on NICE guidance, with clear method of assessment | Fully achieved | |
| 3.2 | Each service has a defined set of clinical standards (Based on Trust /CQC/NICE/professional clinical guidelines) | Partially achieved | The Clinical Effectiveness Group is working with services to produce two clinical standards to be monitored throughout the year. Work is also ongoing to set KPIs related to clinical standards for 2014/15. |
| 3.3 | Each division will provide relevant evidence for clinical effectiveness NHSLA level 2 standards | NHSLA has suspended the assessment process. | As there is no further NHSLA assessment this KPI will not be reported going forward. The clinical effectiveness group will set and monitor criteria for linked policies on NICE and professional guidance. |
| 3.4 | Ten teams across the Trust will develop and pilot exemplar team/service quality assurance measures | Partially achieved | CLCH is working with Buckinghamshire University to develop an exemplar ward/team assessment tool. The assessment tool comprises of a set of quality indicators to assess the level of quality at which wards/teams are currently performing at, as well as evidence their performance against those quality indicators. The indicators are based on the Trusts Quality Strategy campaigns, Care Quality Commission assessment standards and the six C's, (care, compassion, courage, commitment, competence and communication). Teams will be encouraged to apply for exemplar status and assessed against the indicator criteria to identify their strengths and areas for development. It is proposed that the pilot teams will nominate themselves for exemplar status in the New Year. |

## Risk Management Strategy (RMS)

The purpose of the Risk Management Strategy was to detail the Trust's framework within which the Trust leads, directs and controls the risks to its key functions in order to comply with Health & Safety legislation, Terms of Authorisation and its strategic objectives. The document outlined the work plan for 2013/14 including key success criteria (KPIs). The work plan is managed by the Chief Nurse and Director of Quality Governance and is divided into four progressive steps, moving from Basic, through Bronze to Silver, then Gold, with deadlines set throughout the year.

There are 31 KPIs associated with the RMS and these were broken down as follows:
Basic (8); Bronze (6); Silver (9), and Gold (8).

Out of the total 31 KPIS, 29 (including all of the basic, bronze and silver KPIs) were fully achieved, and 2 were partially achieved.

The details of those partially achieved are:

*90% of services are using their risk registers and service improvements can be clearly demonstrated.* This was because not all services were able to identify risks although proactive risk assessments have been carried out.

*90% of service lines have a CLIPS (Complaints, Litigation, Incidents and Patient Advice and Litigation Service (PALS)/ quality group where they identify key themes and actions and report into the divisional group.* This was partially achieved as Specialist Community Nursing Therapies (SCNT) achieved a total of 88% and because some services are very small consisting of one or two staff so arranging a CLIPS meeting was not been possible. However going forward the new Clinical Business Units (CBUs) will each have a CLIPS meeting.

Whilst good progress has been made this year, some KPIs (as described above) in both strategies were not fully achieved. These will be taken forward for 2014-15, along with the year two targets taken from both the strategies.

| | RISK MANAGEMENT STRATEGY | | |
|---|---|---|---|
| **1** | **Basic Category** | **Due Date: 30th June 2013** | **Update** |
| 1.1 | All Divisional risk registers in place | Fully achieved | |
| 1.2 | Corporate risk register is in place. | Fully achieved | |
| 1.3 | Each Division has a quality group in place. | Fully achieved | |
| 1.4 | The Patient Safety & Risk Group is established. | Fully achieved | |
| 1.5 | Risk is being integrated throughout the organisation. | Fully achieved | |
| 1.6 | All staff are well supported and trained in risk management. | Fully achieved | |
| 1.7 | Recommendations of external risk reviews have been implemented. | Fully achieved | |
| 1.8 | The Board is receiving service specific and outlier information in relation to key risks | Fully achieved | |
| **2** | **Bronze Category** | **Due Date: 30th Sept 2013** | |
| 2.1 | Corporate risk register in place and 75% of risks are now being managed in a timely manner. | Fully Achieved | |
| 2.2 | 50% Service level risk registers are in place across the organisation. | Fully achieved | |
| 2.3 | 50% of service lines have a CLIPs/ quality group in place which report to the Divisional group. | Fully achieved | |

| | | | |
|---|---|---|---|
| 2.4 | The Patient Safety & Risk Group is well attended and reporting effectively to the Quality Committee. | Fully Achieved | |
| 2.5 | Service level score cards are being used to manage risk KPIs. | Fully achieved | |
| 2.6 | The Committees and Board are receiving risk data which is benchmarked and identifies key outliers. | Fully achieved | |
| 3 | **Silver Category** | **Due Date: 30th December 2013** | **Update** |
| 3.1 | 75% Service level risk registers are being consistently completed and managed and discussed at Divisional level. | Fully achieved | |
| 3.2 | The corporate risk register is well challenged and 85% of risks are being reduced on the register within timescales. | Fully Achieved | |
| 3.3 | 75% of service lines have a CLIPs/quality group in place and themes and service improvements are being identified. | Fully Achieved | |
| 3.4 | All Patient Safety sub groups have clear objectives and are reporting to the PSRG. | Fully Achieved | |
| 3.5 | The Quality Committee is satisfied with the information received from PSRG. | Fully Achieved | |
| 3.6 | Incident reporting is increasing in line with Quality Strategy objectives with a reduction in harm. | Fully Achieved | |
| 3.7 | The KPIs used for risk have been reviewed at service level to meet individual service needs. | Fully Achieved | |
| 3.8 | Risk targets are being met across the trust. | Fully Achieved | |
| 3.9 | Benchmark and outlier information is being well presented to Committees and Board. | Fully Achieved | |

| 4 | Gold Category | Due Date: 31st March 2014 | Update |
|---|---|---|---|
| 4.1 | 90% of services are using their risk registers and service improvements can be clearly demonstrated. | Partially Achieved | As described above |
| 4.1a | Allied Primary Care Services (APCS) | Partially achieved | Currently stands at 78%. All areas have reviewed possible risks. Going forward the new CBUs will review risks and bring new ones forward through the agreed process. |
| 4.1b | Children's Health and Development (CHD) | Partially achieved | Currently stands at 87%. All areas have reviewed possible risks. Going forward the new CBUs will review risks and bring new ones forward through the agreed process. |
| 4.1c | Networked Community Nursing and Rehabilitation (NCNR) | Fully Achieved | |
| 4.1d | Specialist Community Nursing (SPCN) | Partially achieved | Currently stands at 80%. All services have been reviewing possibly risks and taken them forward if necessary. Going forward the new CBUs will review risks and bring new ones forward through the agreed process. |
| 4.2 | Service improvement can be demonstrated from risks on the corporate risk register and 95% of risks are reduced within set timescales. | Fully Achieved | |
| 4.2a | APCS | " | |
| 4.2b | CHD | " | |
| 4.2c | NCNR | " | |
| 4.2d | SPCN | " | |

| | | | |
|---|---|---|---|
| 4.3 | 90% of service lines have a CLIP/quality group where they identify key themes and actions and report into the divisional group. | Partially Achieved | |
| 4.3a | APCS | Fully Achieved | |
| 4.3b | CHD | Fully Achieved | |
| 4.3c | NCNR | Fully Achieved | |
| 4.3d | SCNT | Partially achieved | Currently at 88% as some of the services are very small consisting of one or two staff and a CLIPS meeting has not been possible to achieve. Going forward the new CBUs will each have a CLIPS meeting. |
| 4.4 | The Patient Safety and Risk Group (PRSR) is able to demonstrate clear improvements in risk reporting and management. | Fully Achieved | |
| 4.5 | The Quality Committee is assured that risk is being well managed throughout the Trust. | Fully Achieved | |
| 4.6 | Incident reporting is increasing in line with Quality Strategy objectives with reduction in harm. | Fully Achieved | |
| 4.7 | There are clear KPIs from service level to Board which are being met and there is clear evidence of service improvement. | Fully Achieved | |
| 4.8 | Reports to the Board demonstrate clarity and accuracy and clearly identify outlier and benchmarked information and plans for improvement. | Fully Achieved | |

**QUALITY MATTERS - FAMILYSTART**

The following is feedback provided from families that participated in the Family Start programme. FamilyStart was a pilot programme for children aged 4-12 years and their families providing a personalised approach to make healthy lifestyle choices together. FamilyStart took place over 6 months (April to October 2013) and offered families 3 appointments with a school nurse either at school or a health centre in Kensington and Chelsea. Topics covered included healthy and regular eating, portion sizes, snack options, food label reading, physical activity information and support to be more active.

**Year 3 – Parent of a completer child**

"My daughter's measurements were showing that she was overweight and it was good that somebody looked after us rather than just informing us about it. I called the school nurse directly who was very flexible with the dates and times for the appointments. I saw the same person, and I think it's very good to see the same person rather than changing. The School nurse was very nice, warm, and very careful with her choice of words as obesity is a very sensitive matter for children. I enjoyed the programme as it makes you aware of different ways of doing things, and makes children aware of certain things as well, which will change the outcome. However the programme should be longer, maybe 5 appointments, with the first appointments being every 4 weeks and then every 6 weeks."

**Reception – Parent of completer children**

"The teacher advised us we should be seen. I didn't know my children were overweight, they were measured in school and I received the letter saying they were overweight. I contacted the school nurses after receiving the letter with their measurements, then I saw a lady and she was very nice. She measured them and told me exactly what they should drink, types of milk and juice, and what types of food they should eat. It was good. I saw different school nurses, I don't blame them but I'm a kind of person that like to deal with one person, then you can build a relationship, they know you and you don't need to explain every time the same. All the school nurses we saw were happy and friendly, they knew what they were doing, especially the second one. She was dealing with the children in a very professionally way, I was happy with her. I didn't know my children were overweight, now I know the weight they should be, I didn't know they should got out and be active every day, now I know. People need advice. The advices were very helpful and I'm really happy with them, I don't have any complaint."

**Reception – Parent of a non-completer child**

"I wasn't worried about anything because I know how I feed my family. All my children see a paediatrician in London and Paris and I knew there was no problem with my daughter. I went to the school and talked directly to the school nurse and asked to do the measurements again because I couldn't take that. The school nurse was very friendly and relaxed. She took all the measurements and she said "sorry they made a mistake. There is nothing wrong with her height and weight, they are in proportion". I was very happy with the fact my daughter was measured. I was not worried about her weight but if you were I would be happy to do the programme to know what to do about it. This is fantastic, because sometimes we don't really check things and you don't realise. But when you have people to go and check this and let you know I think it is the best thing.

I was really happy with the service you provided because this was followed up, it was not something that you just receive a letter and nothing else is done, you were concerned and ready to help me, and this is really good. This is very good especially because you see lots of overweight children.
I'm happy with what you guys are doing."

**Year 6 – Completer child**

"I was seen by the school nurse in the school and the clinic. At first I didn't know why I was there, in my first appointment I was told that I was booked for the family start programme and from then I liked it and I was interacting more. What I liked the most was probably coming down and have like a meeting/appointment, it was quite fun. Every single time I went I had to be measured for my height and weight. I don't remember what BMI is but the nurse explained every single event, she would always discuss things, the first thing she would do was discussing my weight and how I had improved it, and this was clear. She was nice and I was comfortable being there talking to her. My weight lowered by 1kg in the first appointment, in the second it lowered by more, the third it was the same amount as the second, it was decreasing, and the height was ascending. The school nurse said she was proud and the results were excellent, and on the last day, the last appointment she said I had improved that I was not overweight anymore, which meant I had lost weight and followed the rules, and I was healthy weight.
I don't eat as much as I did before, I eat more healthily, I do more physical activity, I easily participate in more events with sports. I feel happy and more confident. I liked the programme."

## OUR WORK ON RESPONDING TO NATIONAL ENQUIRIES AND REPORTS

We incorporated the findings from the Francis Report published in February 2013 together with the Government's initial response, the Keogh Review, the Berwick Report and the Cavendish Review. The Clwyd-Hart review of complaints was also considered and the recommendations included in our revised complaints policy.

The majority of milestones set in the original Francis Matrix and the updated national report matrix have been met and in January 2014 an assessment of the risk of not achieving all the milestones was presented to the quality committee. Six of the milestone areas have been achieved; six were partly achieved and three remain outstanding.

The outstanding milestones were:

- Reduction in paperwork for front line staff (by a third), creating time to care by introducing electronic/ digital solutions to reduce paperwork
- Audit of recruitment processes to demonstrate values questions asked and staff survey to shows high levels of understanding and commitment to Trust values
- Audit of dementia, mental health and learning disability care and of vulnerable adults policy

| | ***Milestones (extracted from Maturity Matrix)*** | ***RAG status (April 2014)*** | ***Comment*** |
|---|---|---|---|
| 1 | Wide programme of training in relation to Duty of Candour<br><br>Candour and transparency fully understood by all staff | Partial | Work commenced but "wide" roll out will need to be associated with annual mandatory training updates and therefore will be achieved throughout 2014/15<br><br>Two "being Open" sessions were commissioned by the L&D team and delivered in December with 40 participants attending. Further discussion since between Head of L&D and Head of Patient Safety regarding further training but firm plans for roll out are yet to be decided. |
| 2 | Reduction in incidents of avoidable harm | Partial | Improved / increased incident reporting may mean actual numbers not reduced; other measures e.g. patient safety thermometer may give better indication of harm<br><br>See also comment re point 10 below. |
| 3 | Reduction in paperwork for front line staff (by a third) Creating time to care by introducing electronic/ digital solutions to reduce paperwork | Not achieved | Work is still on-going but reductions in paperwork are not being realised. Electronic systems are being implemented slowly. |

| | | | |
|---|---|---|---|
| 4 | Staffing levels reviewed using evidence | Achieved / On-going | Evidence for staffing levels in community settings weak, professional opinions still required.<br><br>Reviews undertaken and presented to the Board |
| 5 | Leaders at all levels to have agreed objectives with regard to engaging with patients (back to the floor activities)<br><br>All staff (with the exception of some administrative staff) visit a clinical area and talk with at least one patient and members of staff once a week | Achieved | "Clinical Fridays" commenced. Some changes made to process after initial visits. |
| 6 | Active engagement with Health and Wellbeing boards and achieve all commissioning quality objectives | Achieved | Stakeholder engagement good; validation / agreement of CQUIN achievement still awaited |
| 7 | Staff survey results triangulated with patient feedback to plan development | Achieved | Integrated Performance KPUIs across Quality, operations, Finance and HR are in discussion for agreement at Board after which these will be disseminated via Divisional structure and incorporated in subsidiary performance frameworks |
| 8 | Performance data published on trust website; communications team publish outcomes; performance measures open and transparent | Partial | The Quality Information Balanced Scorecard form and content is agreed and in prototype testing, to be released on the Intranet via QlikView by the end of April |
| 9 | Exceed expectations and achieve exemplar team status | Partial | The Exemplar team project is underway and good practice/ measures from Salford are being reviewed; system will be in place to start to access teams for exemplar status with roll out in 2014/15 |

| | | | |
|---|---|---|---|
| 10. | Trust Never events substantially reduced within the year | Achieved | CLCH has had no incidents of national reportable 'Never Events' since the list was published by Department of Health, in 2011.<br>For Internal SIs : Total 2012-13 was 11. Total for 2013-14 was 21. The target to reduce the number of Bespoke Never Events has not been achieved.<br>With the improvements in the risk management arrangements across the Trust and great scrutiny of incidents reported, the number of cases has increased this year. It is anticipated that the improvements will be seen in 2014-15 as the lessons learned from this year's cases are cascaded across the trust via the CLIPS meetings and newsletters. |
| 11. | Accountability framework for managers devised with clear outcomes for actions when things go wrong<br><br>Trust regulatory regime in place for all patient/ client facing groups<br><br>Barring systems especially in relation to HCAs to be explicit<br><br>Prior to any national roll out of re-validation of nurses all RNs to have support to ensure up to date and fit for purpose | Partial | Disciplinary policies in place; Expectations discussed as part of PADRs.<br><br>Further work with Staff Side organisations will be needed before a barring scheme can be implemented.<br><br>Support is in place for RNs but further work will be needed in 2014/15 to access impact of revalidation |
| 12. | Audit of recruitment processes to demonstrate values questions asked<br><br>Staff survey shows high levels of understanding and commitment to Trust values | Not achieved | Audit will be completed by April. |
| 13. | Stronger voice for clinical staff expressed through a clinical leadership forum | Achieved | Clinical Leadership Group is being established. Membership identified. Inaugural meeting in April 2014.<br><br>CRG has been in place throughout 2013/14 |
| 14. | HCA workforce demonstrate high levels of skill and are receiving training and supervision | Partial | Support and training in place but further work is needed to ensure all staff in this group access. This will be linked to further development of the use of competencies/ and use of skills training/ simulation |

| | | | |
|---|---|---|---|
| 15. | Audit of dementia, mental health and learning disability care<br><br>Audit of vulnerable adults policy | Not achieved | No plans in place. Under discussion to be included in work plans for 2014/15 but audits will not be achieved by April 2014. |

The full maturity matrix can be found at appendix two.

**QUALITY MATTERS – MSK SERVICE**
The musculo-skeletal service in Barnet developed a physiotherapy group specifically for Farsi-speaking patients which included translation. The service won a CLCH innovation award and was reported in the Chartered Society of Physiotherapy Journal

## OUR QUALITY IMPROVEMENTS 2013-14

This section describes how we performed against the 10 quality priorities we set ourselves last year.

## POSITIVE PATIENT EXPERIENCE

Our priorities for improving the patient experience in 2013/14 were:

- Ensure that we are providing compassionate care to all our patients
- Act on patient feedback to help ensure long lasting improvements
- Implement the 15 Steps Challenge

### Ensure that we are providing compassionate care to all our patients

***Compassion in Care Project***

As well as being a quality priority, this was also part of campaign one of the Trust's Quality Strategy and with reference to the recent report 'Compassion in Practice, Nursing, Midwifery and Care Staff, Our Vision and Strategy' (Cummings and Bennett, 2012), work was taken forward across the Trust to promote compassionate care and the Compassion in Care project was launched across four pilot sites on October 4th 2013. The project is being taken forward with City University, building on work previously undertaken with them on dignity in care, best practice guidance in care for older people in acute settings and quality of life in care homes. The project aims to promote compassionate care with frontline staff initially across pilot areas in different clinical contexts namely; adult rehabilitation services, HMP Wormwood Scrubs and the Pembridge Palliative Care Unit. It provides expert facilitation of front line care staff in the development of projects and work streams to help deliver the 6Cs (care, compassion, competence, communication, courage and commitment) in line with the NHS England Compassion in Practice vision and strategy

A number of Compassionate care projects were identified in the pilot areas. These included the development of vision and values based philosophy of care statements by the multi- disciplinary teams working within the rehabilitation units, a social activity programme within one of the rehabilitation units and a documentation and communication project across our rehabilitation wards. At the Pembridge Palliative Care Unit a proposal was written for Schwartz rounds by the Chaplain, and a project has been developed across the day centre and the inpatient unit to promote patient well-being by the multi-disciplinary team. The project was launched very successfully in the prison and two Compassion in Care projects have been identified, and are being taken forward by prison nursing staff. Senior staff from the Department of the Health who visited the Trust were interested in the project and its impact on care delivery and its measurement in practice. The Chief Nurse for England has agreed to visit the Trust on May 12th to be a guest speaker at the Trusts Compassion in Care celebration event.

The Compassion in care project has been rolled out successfully across the Community settings and excellent projects have also been identified within the Children's and Adults Division. The Compassion in Care Co-coordinator has also met with staff from the Community Palliative Care Team to identify projects. Work is also being taken forward with the Picker Institute to identify Compassion in care indicators of success which are aligned to the model of Compassionate

relationship centered care which is currently being developed with City University and will be presented to the Compassion in Care Board for their approval prior to their implementation.

***Exemplar Ward/Community Assessment Tool.***

The draft Trust exemplar ward/ community assessment tool has been developed in collaboration with Buckingham University. This draft exemplar assessment tool incorporates the Essence of Care standards; the 6C's and key clinical indicators and also provides evidence for Care Quality Commission standards. The draft assessment framework is designed around thirteen standards, supporting clinicians in practice to understand how they deliver care, what works well and where further developments are needed. It is proposed that the exemplar teams will also demonstrate innovation and creativity in practice. The draft tool, once approved in the Trust, will be taken forward in different clinical settings and, it is envisaged that the process of its development and findings will be written up for publication with Buckinghamshire University.

## Acting on patient feedback to help ensure long-lasting improvement

*Specifically that each Division should have clear objectives in place to improve the patient experience based on analysis of feedback and incidents. These objectives to be cascaded to individual staff level and every member of staff to have at least one objective to improve the experience they offer to their patients. The Net Promoter score to be consistently above 75 in each Division.*

During 2013-14 we established a comprehensive patient experience feedback programme across our 66 services. This included telephone, paper and electronic surveys, the collection of patient stories, reporting of complaints and complements, and the introduction of clinical visits using the *15 step challenge*. Feedback on experience is gained from patients across our services, and each division has a formalised action plan for improvement based on this. The information and resultant action plans are presented and monitored at the Patient Experience Committee on a monthly basis.

As part of staff appraisal, individuals are required to link their development objectives to trust objectives, including the delivery of safe, effective and person centered care to patients and ensuring our patient and staff survey feedback improves year on year and is above the NHS for all services.

The Friends and Family Test has been added to our patient surveys to provide a simple measure of people's experience (net promoter score). During the year, we adopted the National method for calculating our net promoter score which required us to adjust our target from 75 to 62%. We achieved this measure within some of our services, and this remains a focus for our future improvement.

In response to the following question in the 2013 staff survey 65% of our staff agreed with the following statement. "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"

### Implement the 15 Step Challenge

*Specifically that the 15 step Challenge will be launched across the organisation. A Both Sides now approach to be taken with patients. Patient stories to be collected digitally coded and analysed. Findings from work will be used to initiate continuous improvement cycles*

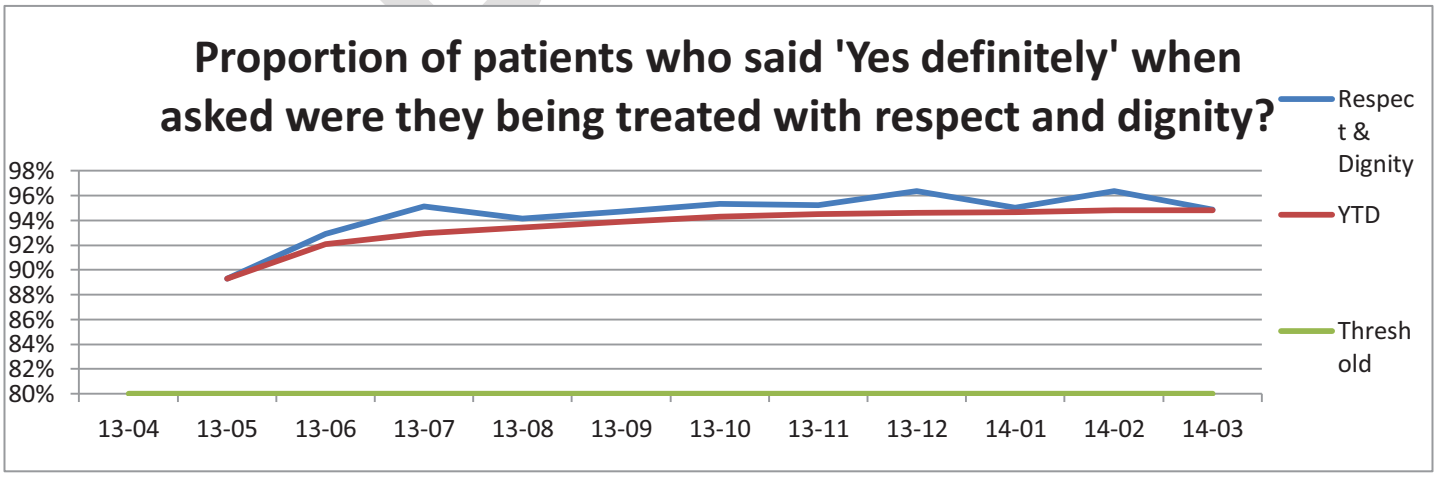
The *15 steps challenge* is a tool to help staff and patients work together to identify improvements that will enhance patient experience and it is coordinated by the Patient and Public Experience (PPE) team. The challenge is based on the concept that a patient can tell what kind of care they will receive within 15 steps of entering a site.

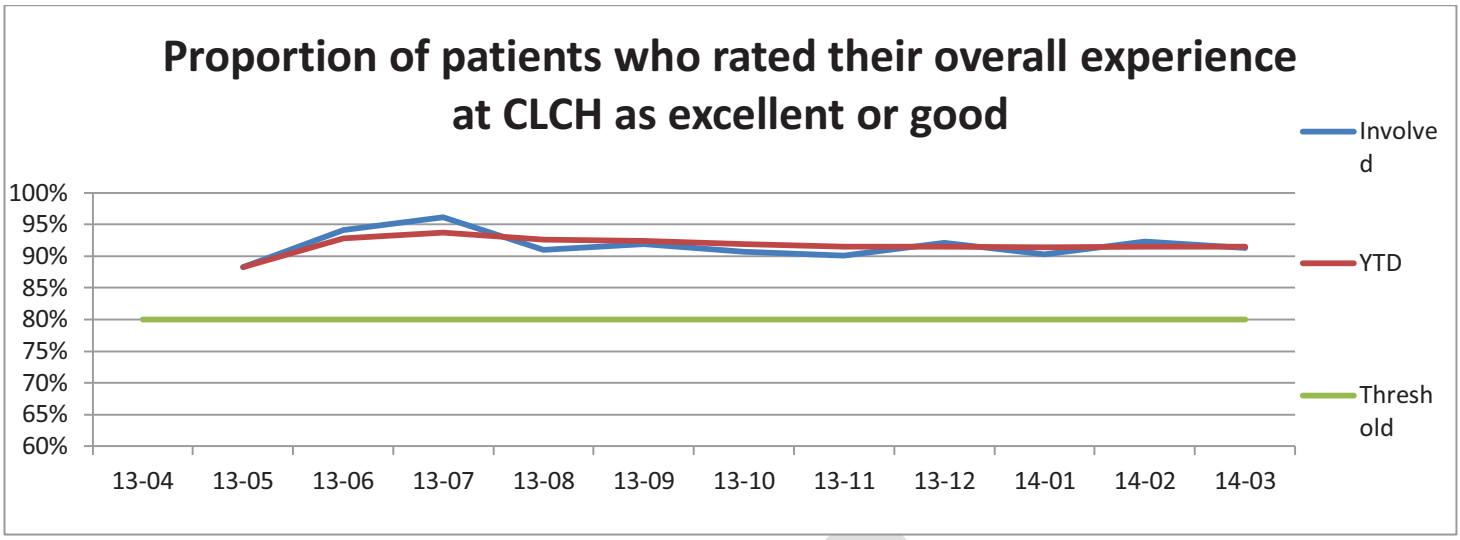
The tool is utilised by taking a visiting team, comprised of board members, trust members, patient representatives and staff members from the quality directorate, to various sites and focussing on sites which accommodate bedded patients. During the visit, the team are asked to record their observations of first entering the site. They then speak to patients and their families (if they are available). The themes they focus on in these conversations are whether the patients feel the site is: Welcoming, safe, caring, well organised and calm. Following the visit, the feedback is recorded and then shared with divisional director and senior manager of the service. An action plan is created based on the feedback and a review visit will take place 6 months after the initial visit.

The visits occur approximately every two months and some of the common themes which have been identified in the visits so far are;

- Storage space,
- Handover between different clinical teams,
- Communication and management of expectations around treatment and discharge.

Since October 2013, more than twenty members of staff have been trained to capture patient stories across our organisation. A programme of patient stories has been agreed with each of the divisions and learning from these is linked to patient experience action plans. Patient stories now form a routine element of learning from patient experience and a patient story is presented at each of our trust Board meetings. A process for gathering digital patient stories has been developed, and the first of these is available on the trust website.






**QUALITY MATTERS – PRINCESS LOUISE NURSING HOME**

The Trust was awarded a fund from the Department of Health to improve the environment for patients with dementia in Prince Louise Nursing Home

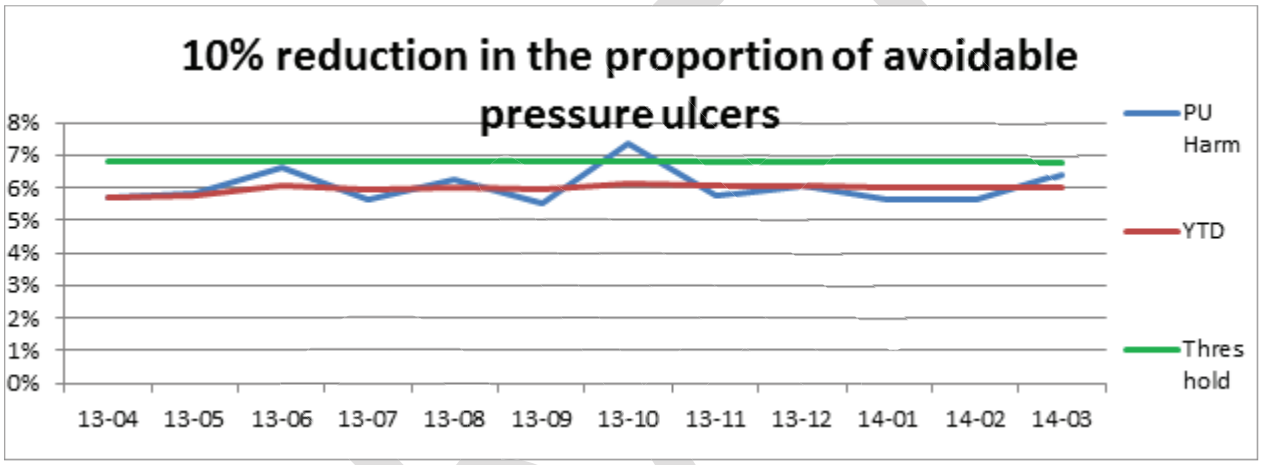
## PREVENTING HARM

Our quality priorities for 2013/14 relating to Preventing Harm were to:

- Reduce number of avoidable pressure ulcers in the community by at least 10%
- Reduce the number of catheter associated urinary tract infections in the community by at least 10%
- Reduce the number of falls that cause harm in bedded rehabilitation services by at least 10%
- Reduce the number of new VTE by at least 10%

### Reduce the number of avoidable pressure ulcers in the community by at least 10%

We made steady progress against this target in 2013/14. The incidence of pressure ulcers was reduced and we achieved our target to reduce pressure ulcer by 10%. The prevalence of pressure ulcers was reduced and we achieved our target to reduce pressure ulcers by 10%. In order to achieve our 10% reduction we needed to have a prevalence of pressure ulcers at under 6.9%.




We undertook a range of measures and initiatives to achieve the reduction in pressure ulcers in 2013/14 as follows:

**May 2013**

- NICE poster distributed to clinical teams
- Wound Assessment and Evaluation Forms amended and distributed to all clinical teams.
- Pressure ulcer prevention and management training and audit provided in 4 Barnet independent Nursing Homes.

**June 2013**

- SSKIN and Top Tips posters distributed to all clinical teams.
- Tissue Viability Team site set up on the CLCH Hub providing access to the whole suite of pressure ulcer prevention and management resources.
- Pressure ulcer training reviewed to incorporate DATIX reporting.
- District Nurse contact details provided to the Wheelchair Service to improve liaison between clinicians.

**July 2013**

- New CLCH Prevention and Management of Pressure Ulcer Policy produced and launched.
- Pressure ulcer training places offered to independent Residential and Nursing Homes.

**August 2013**

- Pressure ulcer safeguarding checklist distributed to all clinical teams and to Barnet Nursing Homes.

**September 2013**

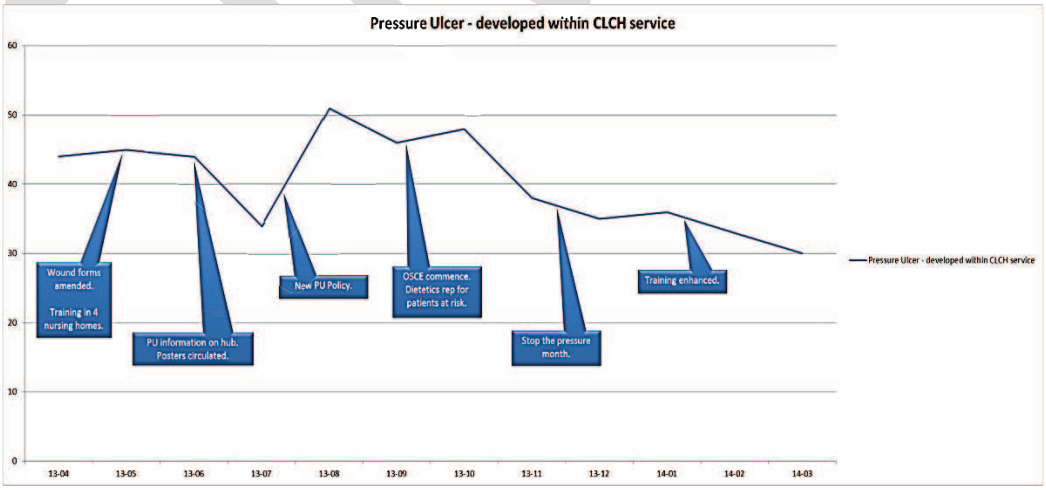
- Barnet dietetics service opened access for referrals to patients with and at risk of developing pressure ulcers.
- Observed Structured Clinical Examinations commenced to test clinical competency following training.

**November 2013**

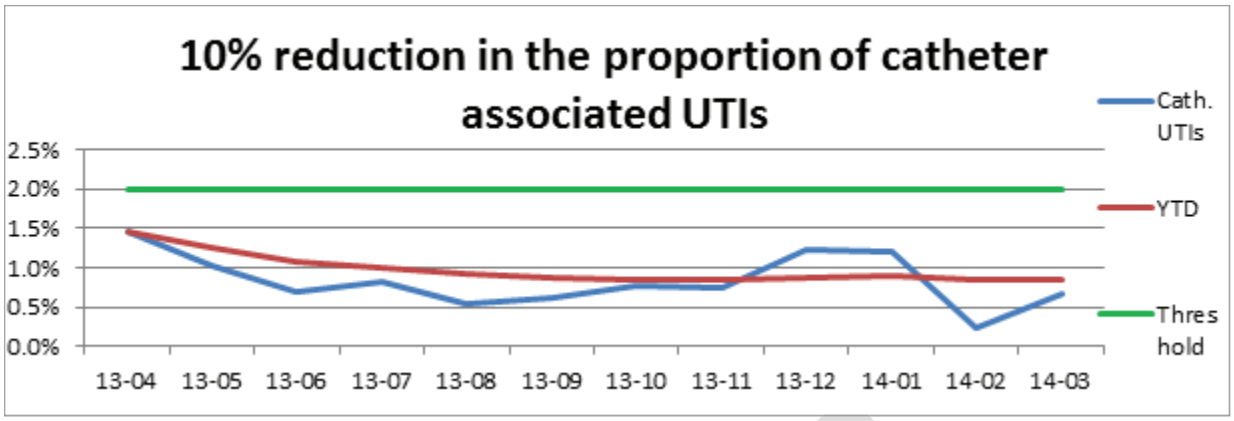
- Stop The Pressure month campaign roadshow taken around various sites across the 4 boroughs.

**January 2014**

- Pressure ulcer training reviewed to enhance wheelchair and seating section of training.
- Moving and handling advisor identified suitable equipment, i.e. sling and hoist, that can be used when dressing pressure ulcers particularly on heals and other hard to reach areas. Details distributed to clinical teams.
- Patient information leaflets regarding pressure ulcer prevention, distributed to podiatrists.
- NICE Pressure Clinical Audit for District Nursing: audit report produced by JL and sent to managers and Clinical Leads.
- NICE Pressure Clinical Audit for District Nursing: Poster produced, data being added by Quality Team.
- Documents and resources produced by the CLCH Pressure Ulcer Working Group sent to Community Education and Provider Network.
  We were one of only 3 trusts that submitted these resources and the only Trust that submitted the full set.



## Reduce the number of catheter associated urinary tract infections by at least 10%

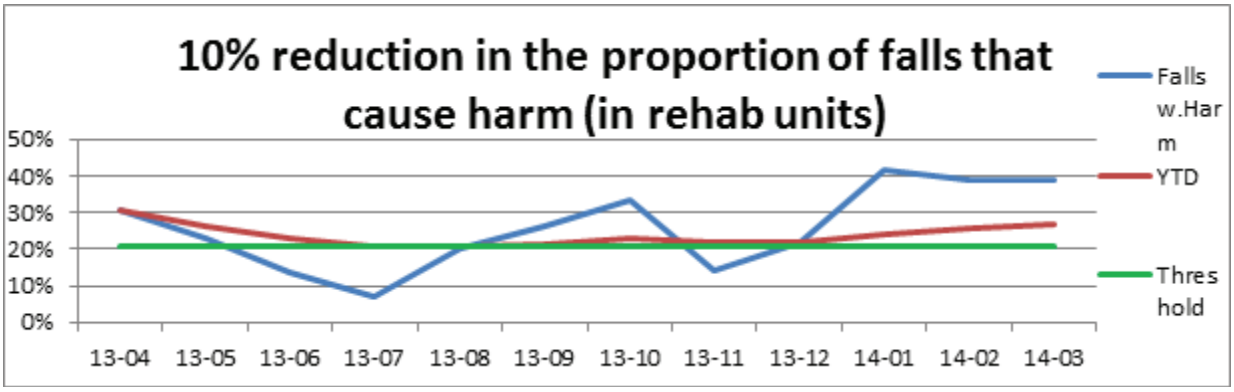



CLCH nurses and doctors with guidance from the CAUTI Steering Group successfully reduced the number of urinary catheters in situ and associated infections across CLCH by more than 10% during 2013-14.

Factors contributing to the reduction in infection included heightened awareness amongst staff and patients / carers, and more frequent assessments on whether urinary catheters in place were needed or whether alternative solutions were available. Greater awareness was achieved with training, the use of flow charts, the design and distribution of a patient leaflet, improving documentation of catheter care, and the purchase of more bladder scanners with associated training.

Going forward we will continue to work on ensuring there are valid reasons to insert or maintain a urinary catheter in situ. Alternative solutions will be considered to avoid long term catheterisation where possible. This will further reduce the risks and rates of catheter associated infection.

### Reduce the number of falls that cause harm in bedded rehabilitation units by at least 10%



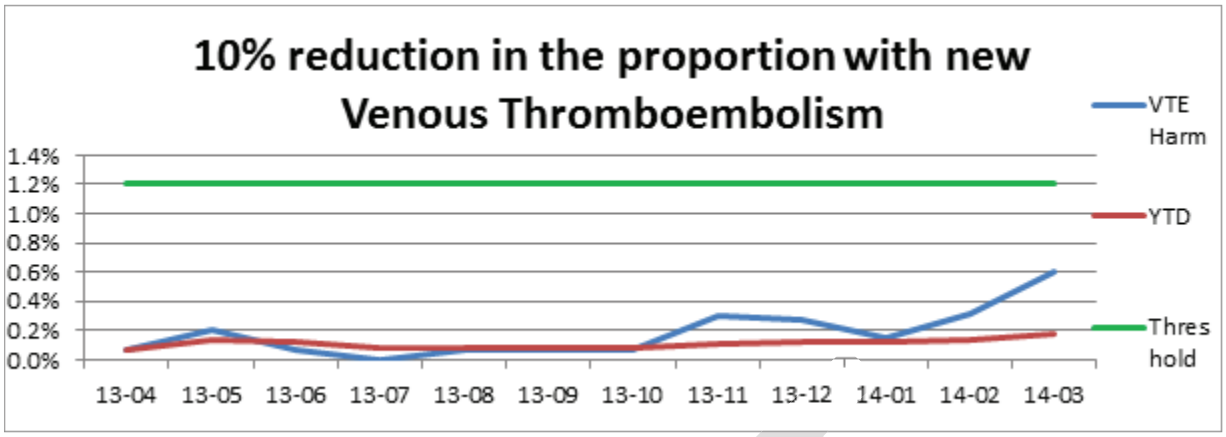

### Falls Steering Group

Following the creation of the Falls Steering Group a number of actions were put into place to reduce the number of falls. These included neurological observations training with falls training on all units now implemented. A slips, trips and falls link workers forum has been established with training for Falls link workers now in place. Training packages have also been created for district nursing teams. Slips, trips and falls e-learning has been launched with bespoke training for children's' and offender health services currently being developed. In depth work to understand falls at three of the four of the trust's hotspots, namely Jade ward, Marjorie Warren Ward, Princess Louise Kensington has been undertaken. The work at Pembridge is ongoing but is yet to be completed.

Other initiatives to reduce the number of falls include a trial of "colours reducing falls" an award winning scheme that will be piloted on Jade ward in 2014. An updated version of the bed rail policy is being produced to ensure compliance with best practice and there has been a review of equipment on all wards, for example cot sides and footwear as well as beds that lower to floor.

Despite these initiatives, we have not yet achieved the reductions we aimed for this year. We will be reviewing the action plans associated with falls prevention and work will continue on this project.

## Reduce the number of new venous thromboembolism by at least 10%




*(Further information to be provided on this)*

## SMART EFFECTIVE CARE

*(We are awaiting further information on elements of this section)*

Our objectives in 2012/13 related to smart, effective care were as follows:

- Each service within CLCH will aim to achieve at least 3 clinical outcomes based on best practice
- Strengthen and streamline clinical record keeping to support patient pathways
- Reduce the number of unplanned hospital admissions for patients with long term conditions that are on CLCH case loads.

### Each service within CLCH will aim to achieve at least 3 clinical outcomes based on best practice

'Campaign Three of the Quality Strategy, Smart, Effective Care', stated that CLCH would build on the substantial organisational work that had developed Patient Reported Outcome Measures (PROMs) and identify a catalogue of clinical outcomes that clearly demonstrated 'measures of success' with each service expected to have a method of assessing these outcomes.

### CLCH Clinical Outcome Framework.

Although the measurement of clinical outcomes is increasingly prevalent within the NHS, it is still and under developed area within community Trusts. To address this CLCH has developed a local clinical outcomes framework with the group defining a clinical outcome as follows:

*A Clinical Outcome is a measurable change in health status, attitude or behaviour of an individual, group of people or population which is attributable to an intervention or series of interventions.*

To date, more than 150 clinical outcomes have been developed with the majority being agreed by the Clinical Effectiveness Group. Further work is required to identify a suite of measures against the outcomes agreed, to capture baseline data, apply improvement goals and to develop this work to reflect value.

### Strengthen and streamline clinical record keeping to support patient pathways

Work this year included: *Awaiting final information*

**Reduce the number of unplanned hospital admissions for patients with long term conditions that are on CLCH case loads.**

*Further information awaited on this section*

Work this year included:

- Implementing systems of care, i.e. virtual wards/village models and evolving Whole System pathways that improve early prediction of changes in conditions and translation into appropriate interventions.
- Identifying skills sets within community teams to facilitate increased ambulatory care in a community setting and links to appropriate specialist teams to support maintenance in a community setting.
- Use of assistive technology to provid3e early warning of changes in conditions to intervene earlier
- Link the above points to a co-designed Community intervention service that integrates health and social care, particularly re0-ablement, services more effectively.
- Use IT platforms and intra-operability to improve patient information available in an acute, community and primary care setting thus increasing the ability to make decisions on admission or discharge from EDs
- Further develop CIS in-reach functions to identify patients within acute wards earlier and reduce both length of stay and definition of an appropriate final discharge destination.

**QUALITY MATTERS - DENTAL SERVICES**

The Community and Specialist Dental Service treats patients from vulnerable groups who are unable to access high street Dentists for various reasons such as physical, medical or behavioural issues. Sometimes, it can be challenging to collect meaningful experience feedback from these patients due to communication difficulties such as speech, language, literacy.

The service took part in the pilot for capturing patient stories with a group of patients who have learning disabilities and/or their parents/carers. The stories were taken by Speech and Language Therapists in either in the dental clinic or the patient's own home. Ten stories will collected over the 3 Inner Boroughs (5 from Westminster, 3 from Kensington and Chelsea and 2 from Hammersmith and Fulham)

Positive themes were friendly, patient staff with a good understanding of the complex needs of their patients; appointment times to suit them and appreciation of the extra time given to their appointment due to their additional needs; overall satisfaction with the quality of service provided.

Areas for improvement were also identified. These were that signage in some Health Centres were hard to find and difficult to read; unclear of where to go on arrival as no specific Dental reception in most areas and the Front of House staff did not have details of dental appointments; patients weren't aware of who their appointment was with or for what they were attending for; some patients found the dental treatment uncomfortable; literature/leaflets given to patients are difficult to read/understand.

In response to the feedback received the following changes were made within the service:

- Easy read signage placed in Health Centres
- The Dental service records system (Kodak R4) has been installed on the Front of House Reception PCs so the patient's arrival can be recorded and Dental Staff are aware the patient has arrived
- The appointment letters have been adapted to Easy read and show a photo of the front of the building, a photo of the Dentist/Therapist they have an appointment with and a clock face to indicate the time of the appointment.
- Training for Dentist/Therapists in Inhalation Sedation which means that all patients can now be offered an appointment for treatment under sedation
- All patient leaflets are now available in Easy-read

The service is the process of contacting the patients who took part in patient stories to thank them and explain the changes made to the service as a direct result of their feedback.

## LOOKING FORWARD

### OUR PRIORITIES FOR IMPROVEMENT 2014/15

In this section we have detailed our quality improvement priorities for the coming year. The identification of priorities including consultation process is described in more detail in the next section.

### Positive Patient Experience

1. We will improve user involvement and participation in developing and improving services at the trust
2. All services will actively use patient feedback for improvement including using new feedback through the Family and Friends Test (FFT)

### Preventing Harm

3. We will continue to demonstrate an increase in the reporting of incidents across the trust whilst reducing the level of harm caused to patients
4. We will reduce the incidence of medication errors across the Trust by a minimum of 10%

### Smart Effective Care

5. We will seek further improvement in consistent communication between the community nursing teams and the patient's GP after initial assessment of a patient and following discharge.
6. We will ensure that, where national clinical guidelines have been produced by the National Institute for Health and Clinical Excellence (NICE) which are relevant to the care we provide, we will demonstrate we are using them in everyday practice

### How Will We Monitor Progress on these Aspects of Quality Improvement?

All of these elements will be measured; some monthly, some quarterly so that the Trust can show that it is improving the experience of the patients, their safety and the effectiveness of the services.

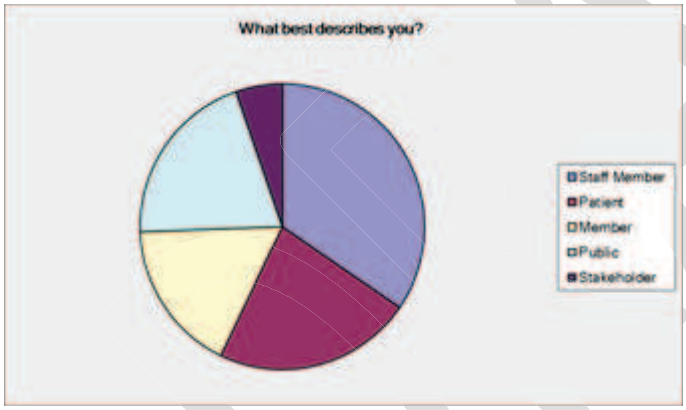
The progress on all planned quality improvements will be monitored monthly by the Trust Quality Committee. This committee will report at least quarterly directly to the Trust Board of Directors.

## WHO DID WE INVOLVE AND ENGAGE WITH TO DETERMINE OUR QUALITY PRIORITIES?

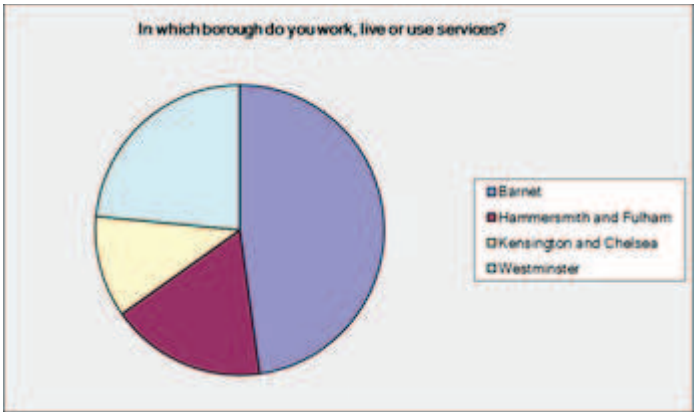
An initial long list of quality priorities was drawn up based on discussion with Trust groups as well as by looking at our performance against a range of quality indicators. We then consulted on the long list with members of the public and staff via the survey as detailed below. In addition we wrote to the chairs of Health watch, Overview and scrutiny Committees and CCG Chairs asking for suggestions to be included in the account. Based on this we chose our list of quality priorities for 2014/15.

The responses by group and borough were as follows:

| **What best describes you?** | | |
|---|---|---|
| **Answer Options** | **Response Percent** | **Response Count** |
| Staff Member | 34.6% | 46 |
| Patient | 22.6% | 30 |
| Member | 17.3% | 23 |
| Public | 20.3% | 27 |
| Stakeholder | 5.3% | 7 |
| | ***answered question*** | **133** |




| **In which borough do you work, live or use services?** | | |
|---|---|---|
| **Answer Options** | **Response Percent** | **Response Count** |
| Barnet | 47.8% | 55 |
| Hammersmith and Fulham | 17.4% | 20 |
| Kensington and Chelsea | 11.3% | 13 |
| Westminster | 23.5% | 27 |
| Other (please specify) | | 22 |
| | ***answered question*** | **115** |




The following information shows how staff and members of the public ranked our suggested priorities:

| **Positive patient experience** | | |
|---|---|---|
| **Answer Options** | **Response Percent** | **Response Count** |
| We will develop and implement an end of life strategy for the Trust which improves the experience for patients, their relatives friends and carers | 35.6% | 47 |
| We will reduce complaints and PALS comments related to poor attitude or communication by 10% | 40.9% | 54 |
| All services will actively use patient feedback for improvement. (This will be evidenced by demonstrating to the Patient Experience Group that they have delivered measurable in-year improvements in response to patients' feedback) | 48.5% | 64 |
| We will publish more information about the performance of our services, | 12.1% | 16 |
| We will improve user involvement and participation in developing and improving services at the trust | 49.2% | 65 |
| Other (please specify) | | 12 |
| | ***answered question*** | **132** |

| Preventing harm | | |
|---|---|---|
| **Answer Options** | **Response Percent** | **Response Count** |
| We be in the top 10% of community trusts in England in relation to incidence of NEW pressure ulcers acquired in our care | 22.7% | 29 |
| We will reduce the incidence of falls resulting in harm in our bedded units by 10% | 25.8% | 33 |
| We will continue to demonstrate an increase in the reporting of incidents across the trust whilst reducing the level of harm caused to patients | 41.4% | 53 |
| We will reduce the incidence of medication errors across the Trust | 46.1% | 59 |
| We will continue to reduce the prevalence of harm to patients as demonstrated by the patient safety thermometer | 22.7% | 29 |
| All medication errors involving high risk medication, anticoagulants and insulin to be defined as never events. The Trust target for 2013/14 is zero events | 38.3% | 49 |
| Other (please specify) | | 9 |
| | ***answered question*** | **128** |

| Smart effective care | | |
|---|---|---|
| **Answer Options** | **Response Percent** | **Response Count** |
| We will ensure that, where national clinical guidelines have been produced by the National Institute for Health and Clinical Excellence (NICE) which are relevant to the care we provide, we will demonstrate we are using them in everyday practice | 37.7% | 49 |
| We will ensure that each service will identify and publish a minimum of 6 clinical outcomes based on NICE guidance and international best practice. | 16.2% | 21 |
| All services will actively measure 3 clinical outcomes and will be able to demonstrate that they have delivered against an expected threshold of acceptable performance. | 16.2% | 21 |
| We will make further improvements in the standard of our record keeping. We will audit our performance every quarter. | 20.0% | 26 |
| We will work with our partners to demonstrate improvements in integrated care with both healthcare and local authority partners how measured | 35.4% | 46 |
| We will seek further improvement in consistent communication between the community nursing teams and the patient's GP after initial assessment of a patient and following discharge. | 45.4% | 59 |
| We will further reduce the amount of hospital admissions for patients receiving our services | 16.9% | 22 |
| Other (please specify) | | 6 |
| | ***answered question*** | **130** |

## REVIEW OF QUALITY PERFORMANCE – REQUIRED INFORMATION

### CARE QUALITY COMMISSION

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. From April 2010, all NHS Trusts have been legally obligated to register with the CQC. CLCH is registered with the CQC and its current registration status is *registered without conditions.* Furthermore the CQC has not taken enforcement action against CLCH during 2013/14 and CLCH has not participated in any special reviews or investigations by the CQC during the reporting period.

### Summary of inspections

During 2013/14 the CQC undertook, as part of their scheduled programme of inspections, 8 unannounced inspections at 8 of the trusts registered locations. As part of this process, the CQC found that CLCH was meeting all the essential standards of quality and safety as follows.

### Finchley Memorial Hospital Walk-in Centre – Inspection Date: 29th April 2013

The Trust was found to be meeting the following standards
Outcome 1 – Respecting and involving people who use services
Outcome 4 – Care and Welfare of people who use services
Outcome 6 – Co-operating with other providers
Outcome 7 – Safeguarding people who use services from abuse
Outcome 14 – Supporting workers

### Finchley Memorial Hospital Intermediate Care Ward – Inspection Date: 18th June 2013

The Trust was found to be meeting the following standards
Outcome 4 – Care and Welfare of people who use services
Outcome 6 – Co-operating with other providers
Outcome 11 – Safety, availability and suitability of equipment
Outcome 16 – Assessing and monitoring the quality of service provision
Outcome 17 – Complaints
Outcome 21 – Records

### St Charles Urgent Care Centre – Inspection Date: 31st October 2013

The Trust was found to be meeting the following standards
Outcome 4 – Care and Welfare of people who use services
Outcome 6 – Co-operating with other providers
Outcome 8 – Cleanliness and infection control
Outcome 13 – Staffing
Outcome 17 – Complaints

However in respect of complaints CLCH was asked to consider the following:
*The provider may wish to note that some of the recent complaints had not been responded to within the timescales set out in the policy.* In response to this, the Customer Services Manager will ensure that in future, where possible, that complaints are managed and responded to within the guidelines outlined in the complaints policy. Furthermore the policy is being revised to ensure that the timescales are made absolutely clear.

### Parsons Green Walk-in Centre – Inspection Date: 31st October 2013

The Trust was found to be meeting the following standards
Outcome 4 – Care and Welfare of people who use services
Outcome 6 – Co-operating with other providers
Outcome 8 – Cleanliness and infection control
Outcome 13 – Staffing
Outcome 17 – Complaints

In respect of cleanliness and infection control CLCH was asked to consider the following *The provider may wish to note that there were some individual areas where more cleaning was needed, such as windowsills and some of the examination couches. The provider may wish to note that there were some sharps bins that had not been dated when they had been put together and there were some full sharps bins in clinical rooms .*In response to this, an action plan template was issued and actions were completed by the service in December 2013. The Estates and Facilities Manager met with the cleaning company and more checks have since been put in place. The examination couches have now been re-upholstered. All sharps bins were immediately reviewed / dated and disposed of in the correct manner and all staff were reminded of the correct procedure.

### Pembridge Palliative Care Unit – Inspection Date: 14th November 2013

The Trust was found to be meeting the following standards
Outcome 1 – Respecting and involving people who use services
Outcome 4 – Care and Welfare of people who use services
Outcome 8 – Cleanliness and infection control
Outcome 12 – Requirements relating to workers
Outcome 17 – Complaints

In respect of cleanliness and infection control, CLCH was asked to consider the following: *The provider may wish to note that there were areas in some of the communal bathrooms where there were potential infection control hazards such as staining to the floors or tears in the fabric. During the inspection the provider resolved to address these issues.* In response an action plan was agreed and the required works were completed in the first week of February 2014.

### Princess Louise Nursing Home – Inspection Date: 28th November 2013

The Trust was found to be meeting the following standards
Outcome 1 – Respecting and involving people who use services
Outcome 4 – Care and Welfare of people who use services
Outcome 8 – Cleanliness and infection control
Outcome 13 – Staffing
Outcome 17 – Complaints

In respect of care and welfare of people who use services, CLCH was asked to consider the following; *the provider may wish to note that not all medical emergency drugs and equipment was kept in the same place on each floor, and where it was kept on each floor varied. Not all staff were aware of where this equipment was.* In response the following actions were completed, all emergency drugs i.e. anaphylactic kit are now kept in the drug trolley on each unit. This is being handed over daily and a laminated label is placed outside the drug trolley indicating an emergency drug is inside and its expiry date. Clear and visible signs are displayed in each unit to indicate the location of resuscitation bag and defibrillator.

### Jade Ward, Edgware Community Hospital – Inspection Date: 2nd December 2013

The Trust was found to be meeting the following standards
Outcome 1 – Respecting and involving people who use services
Outcome 4 – Care and Welfare of people who use services
Outcome 5 – Meeting nutritional needs
Outcome 13 – Staffing
Outcome 14 – Supporting workers
Outcome 16 – Assessing and monitoring the quality of service provision

### Edgware Community Hospital Walk-in Centre – Inspection Date: 24th/30th January 2014

The Trust was found to be meeting the following standards
Outcome 1 – Respecting and involving people who use services
Outcome 4 – Care and Welfare of people who use services
Outcome 8 – Cleanliness and infection control
Outcome 14 – Supporting workers
Outcome 16 – Assessing and monitoring the quality of service provision

If you would like further information about the trust's registration and the CQQ's inspection reports, please see the following websites.

http://www.cqc.org.uk/directory/ryx#providertabs-1 for more details regarding registration
http://www.cqc.org.uk/directory/ryx#providertabs-1 for more details regarding inspection.

## CQUIN PAYMENT FRAMEWORK:

A proportion of CLCH's income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between CLCH and Barnet CCG, and CLCH and the three CCGs which make up North West London (NWL) Clinical Commissioning Groups

Our achievements against the CQUIN goals for 2014/15 are detailed in the following table:

*(Please note information in the table is still draft in some cases)*

| CQUIN | Goal | Plan TOTAL £ | Forecast 13/14 £ |
|---|---|---|---|
| NHS Safety Thermometer | To reduce avoidable pressure ulcers in NHS provided care | 98,705 | 98,705 |
| Frequent A&E attenders | Improving attendance to admission rate of frequent attenders and related 4 hour breach profile in A/E departments, | 987,054 | 908,090 |
| Cloud and IT Systems | Scoping, preparation for large scale rollout and piloting of a single clinical information system across primary and community care services. Development and implementation of the diagnostics cloud to allow access to full diagnostics information shared across multiple settings of care. | 394,822 | 394,822 |
| Frail Elderly | The agreed aim of the service is to improve awareness of clinical support in the community by hospital staff in order to decrease average length of stays and bed occupancy rates. This should also lead to an improved outcome for patients so that their discharge is more effectively managed and synchronised better with transport and homecare arrangements. | 493,527 | 394,822 |
| **INWL TOTAL** | | **1,974,108** | **1,796,438** |

| | | | |
|---|---|---|---|
| NHS Safety Thermometer | To reduce avoidable pressure ulcers in NHS provided care | 101,984 | 101,984 |
| Outcomes | Commissioners wish to incentivise the development of robust outcome measures for Community Healthcare services.<br>This is a validated outcome measure that utilises a variety of domains to assess a patient's health status.<br>The intention of the CQUIN is to assist the development, use and reporting of this outcome measure for the Musculoskeletal Physiotherapy Service and the Parkinson's Service. | 173,373 | 173,373 |
| Falls | Building on the 2012/13 CLCH CQUIN from NHS NCL which focused on ensuring the capture of information regarding patients who are at risk of falling and ensuring that actions are taken to address issues that have arisen. The intention is to embed these assessments in the District Nursing Teams' standard operating procedures. | 40,794 | 15,297 |
| Pressure Ulcers | Improved outcomes for patients with pressure ulcers | 203,968 | 201,419 |
| Integrated Care | Integrated care is significantly affected by how providers work together to transform unscheduled care into planned care and to normalise this way of working, for specific cohorts of patients while enabling those patients to maximise their self-care skills. The goal of this CQUIN is to achieve as much system change as possible and focuses on embedding the multidisciplinary case conference as a routine tool | 292,899 | 292,899 |
| Prevention | To encourage more successful quits among patients who smoke by improving the stop smoking offer for patients seen in selected community services in North Central London. | 181,532 | 180,965 |
| School Nursing | To improve adolescent health outcome (11-18 yrs.) | 25,292 | 25,292 |
| **NCL TOTAL** | | **1,019,842** | **991,228** |
| | | | |
| **TOTAL** | | **2,993,950** | **2,787,667** |

**QUALITY MATTERS - DEVELOPING A MENTAL HEALTH PATHWAY IN OFFENDER HEALTHCARE**

Developing an integrated mental health pathway involves establishing a single point of referral for primary care mental health referrals

A health needs assessment in January 2013, identified that the prevalence of mental health disorders was higher in the prison population than in the local community. A high proportion of prisoners experience symptoms of mild to moderate depression and anxiety and many demonstrate incidents of non-suicidal self-harm.

Eighteen months prior, Offender Healthcare developed a primary care mental health (PCMH) model which replicated on a small scale, the model of care provided by the Kensington and Chelsea PCMH service. This service was based on the Improving Access to Psychological Therapies (IAPT) and provided an assessment with options for Step 2 guided self-help on the wings or attendance in groups run in the Seacole Centre.

The Seacole Centre within HMP Wormwood Scrubs prison is a unique therapeutic environment which provided group interventions for those patients with mild to moderate mental health conditions. Due to staffing establishment the centre was not fully utilised and scope of interventions was limited.
An away day in May 2013 with key stakeholders indicated a need to review the model in order to better meet the needs of the patient group, with particular reference to the high turnover of prisoners within the establishment.

There was a clear need for the PCMH service to ensure that there was an integrated pathway between secondary ( Mental Health In Reach team - MHIR) and tertiary services ( 17 bedded inpatient unit - H3) and that key partners / referrers throughout the establishment were aware of referral criteria and interventions available.

In addition to the established budget, additional recurrent funding was allocated by the commissioner and enabled the development of additional staffing and new group resources with external partners to provide an innovative and responsive service to effectively meet the needs of service users.

**Changes/Improvement made**

The improvement was to ensure there was a clear and integrated mental health pathway and to provide a single point of access to the PCMH service in order to reduce waiting lists and enable patients to have faster access to the appropriate intervention. Further improvements included the following:

- Integrated Mental Health pathway document written jointly by key stakeholders which clearly sets out pathway and resource available
- Monthly working group with key referrers / stakeholders established to ensure involved and aware of changes and developments
- The development of an integrated referral form which provides clear and distinctive criteria between the primary and secondary mental health services, key information to support referrer in decision making and providing referral information to facilitate efficient response from team ( attached)
- A member of the PCHM team attends the weekly MHIR team referrals meeting to review and discuss any cases which may be borderline or patients known to both services

- Focussed communication strategy with key stakeholders such as wing nurses, GP's, prison partners to ensure they understand new ways of working and use new referral process
- Ongoing individual follow up with referrers to ensure correct use of form and understanding of new resource and ways of working in order to embed

Furthermore patients are now able to access service more quickly as waiting times have been reduced from four to six weeks for assessment to two weeks. Implementation of a new model for managing initial assessments by team will reduce this further to one week

Patients receive a comprehensive assessment by the PCMH team who identify needs and establish a treatment plan for individual and/or group treatment

An integrated referral form provides information to those referring to assist in decision making and understand criteria for each service - this has helped substantive staff but the service also currently relies on locum GP staff

## DATA QUALITY AND INFORMATION GOVERNANCE

CLCH recognises that good quality data is essential for the effective delivery of patient care and to enable continuous improvements in the quality of this care. The Trust is therefore fully committed to improving the quality of the data in use across all of its services. The following is a summary of the actions that CLCH has taken to improve its data quality.

- The data quality strategy and action plan was revised, improved and implemented
- Key roles were appointed to, including the appointment of an interim Trust Data Quality Manager and local Data Quality Leads & Champions for all corporate and clinical directorates
- A Data Quality Forum was set up which now meets on regular basis
- A dedicated online data quality training course for all CLCH staff was created
- The Trust has invested in an upgrade to its business intelligence software.

CLCH also improved its performance reporting against data quality metrics and these are now included in the monthly board reports. A facility has been set up online to allow service managers to monitor the quality of their data against key data quality metrics, and to improve their performance against these metrics. Further improvements to the service include the implementation of a rolling programme of data quality audits across the Trust.

### NHS number and General Medical Practice Code Validity

CLCH submitted records during 2013/14 to the Secondary Uses Service (SUS), relating to activity in our walk-in centres. The NHS number coverage for this period was 94.3% and the practice code coverage was 99.7%. The Trust therefore exceeded its target of 90% coverage for both of these measures in 2013/14, and will continue its efforts to improve practice code coverage to achieve the national target of 95.8% during 2014/15.

### Clinical coding error rate

CLCH was not subject to the Payment by Results clinical coding audit during 2013/14 by the Audit Commission.

### Information Governance Toolkit Attainment Levels

The Trust achieving a score of 75% against the toolkit. This represents overall satisfactory compliance.

## PARTICIPATION IN RESEARCH 2013/14

CLCH remains committed to supporting staff and external researchers to undertake high quality research activity to improve and advance healthcare provision. The Trust also aims to become a centre of excellence in `out of hospital community healthcare provision and innovation'.

CLCH currently hosts or sponsors around 38 research studies including interventional (trials), observational and qualitative studies. The latter often considers both staff and patient perceptions and experiences across a range of services.

The Research and Development team consists of the Head of Research & Development, the KRIS Library Team and HealthInform service. HealthInform provides consumer health information to the public and clinical teams within CLCH where requested. The Head of Research & Development is responsible for ensuring that all studies are conducted in line with the Department of Health Research Governance Framework requirements (DH, 2005) and that they have all relevant approvals before commencing.

There were a number of key research related improvements last year. These included a second CLCH Research Conference hosted in September 2013. At the conference, research undertaken within the Trust was celebrated. In December 2013 there was a Research & Service Evaluation staff update event. A monthly research and development newsletter was created for CLCH staff and a research data base was created highlighting the current state of research activity. Furthermore the Trust was actively involved in the National Institute for Health Research (NIHR) Portfolio studies. These are studies that the NHS supports and encourages public involvement in research. CLCH also actively supports the NIHR Research *Saved my life* campaign

The following are examples of studies that CLCH was involved in

- Preventable unplanned admission rates
- Markers identifying risk of viral induced exacerbation in Chronic obstructive pulmonary disease (COPD)
- The last journey together
- How do elders with a fear of falling experience activity restriction?
- The delivery of compassionate care: the role of the middle manager
- Assessing children's language skills

In the future, CLCH is keen to increase its research capability through identifying and supporting staff to take on the roles of either Sponsor or Principle Investigator which are supported by access to relevant training. This would allow the Trust to take part in more NHS supported 'Portfolio' studies. These are studies deemed to be of excellent quality and come with additional resources and support.

The number of patients receiving NHS services provided or sub-contracted by CLCH in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 9.

**QUALITY MATTERS - COMMUNITY REHABILITATION**

Clinicians identified a training and development need in managing clients with seating and postural needs in the community this includes clients who reside in nursing and residential care.

In order to ensure clinicians were providing appropriate seating and postural care management an awareness session was initially set up to review current static seating available on the joint equipment list and evaluate it effectiveness to meet functional, and health benefits for the clients. The session provided peer learning and expert advice from the manufacturer of products.

CLCH therapies were influential to gain agreement from the equipment commissioning to provide specialist static seating on the standard catalogue. Thereby reducing the waiting time for clients to be provided suitable seating options and reduce secondary health problems, improve function and quality of life.

A CLCH training workshop coordinated by rehab clinicians working at Princess Louise Nursing Home and led by Martina Tierney (Occupational Therapist) a leading figure in the research and development of specialist seating. The workshop delivered training on posture and the principals of correct seating assessment and provision.

The speakers also provided the latest research and evidence on health and wellbeing benefits of seating. Martina and her research team have just published the effectiveness of specialist seating in nursing home with a reduction of pressure ulcers in 88% when seated appropriately in specialist seating packages.

Moving forward a working group has been set up to develop a standardised CLCH assessment form and protocol on the issuing, and review of bespoke specialist seating to ensure clinicians are providing the most effective seating package to meet the clients goals.

## PARTICIPATON IN CLINICAL AUDIT

At the start of 2013/14 a thorough review of clinical audit in CLCH was carried out under the auspices of the Medical Director. Following the implementation of new processes for clinical audit across CLCH, both processes and structures were reviewed by our internal auditors, Parkhill, and found to provide 'substantial assurance' to the Board and the organisation. A set of key performance Indicators (KPIs) were agreed with Parkhill and are regularly monitored through the Quality Assurance Team and reported to the Clinical Audit and Research Steering Group, Quality Committee and Audit Committee.

During 2013/14, three national clinical audits covered NHS services that CLCH provides; no national confidential enquiries applied to our services.

During 2013/14, CLCH participated in all of the national clinical audits that it was eligible to participate in and these are listed below.

### The national clinical audits that CLCH participated

| National Clinical Audits | Participation | Number of cases submitted or reason for non-participation |
|---|---|---|
| Chronic Obstructive Pulmonary Disease (COPD) | Yes | Registered for National Clinical Audit<br>Data collection for the Community Trust component of the audit has been moved to 2014/15 |
| National Stroke Audit | Yes | Registered for National Clinical Audit<br>The audit is continuous and will overlap into 2014/15. The initial start-up of this audit was slower for community services during this period. Data collection is continuing. |
| National Audit of Intermediate Care | Yes | Registered for National Clinical Audit<br>Individual boroughs are still awaiting hard copy results from the National Audit Office. As soon as these have been received, the teams will be preparing a summary of the results and developing an action plan. |

The Clinical Audit and Research Steering Group (CARSG) reviews National Clinical Audits which the trust has participated in during previous years to ensure learning from audit findings. CLCH participated in the national Parkinson's Audit in 2012 and we are awaiting a summary report from Parkinson's UK scheduled to be published April/May 2014. Together with recommendations and actions developed by each participating service, this will be reviewed by the CARSG at the next meeting in May 2014.

There were 31 completed clinical audits that were reviewed by the provider between April 2013 – March 2014 and these are listed in the table below. The reports of these clinical audits were formally reviewed by CLCH and the trust will be taking the following actions (as described in the table) to improve the quality of healthcare provided.

*(Please note information in the table is still to be finalised in some cases depending on when the audit took place)*

| No | Item | Service | Outcome and Actions 2013/14 |
|---|---|---|---|
| 1 | Clinical Record Keeping | All Services | We have seen significant improvement in the target compliance achieved for all criteria audited. In the previous 2012/13 audit, 56% compliance was achieved; in the Trust-wide re-audit in 2013/14 services achieved 87% compliance across all criteria audited. The performance target of 85% was therefore achieved and exceeded. Services with less than 85% compliance are targeted for additional audits and/or actions. Further audits in 2014/15 will be undertaken to ensure that the current standards are maintained and improved. |
| 2 | Anticoagulation audit into Mechanical Heart valve patients | Anticoagulation | Patients that have undergone mechanical cardiac valve replacement and that are managed within the Hammersmith and Fulham anticoagulation service are being appropriately risk assessed and treated according to their individual clinical history according to best practice and the current clinical guidelines and evidence base. |
| 3 | Dental recall audit NICE guideline CG19 | Community Dental Services | The repeated audit revealed that one service failed to reach the 80% target set to see patients. This is a big improvement on the previous audit (51%) carried out in 2012. 5 key recommendations have been made including the need to recruit more dentists to see new patients who are now in post. This will be kept under review. |
| 4 | Audit of Compliance with NICE Guidance on Antibiotic Prophylaxis for Infective Endocarditis | Community Dental Services | The standards of the audit have been met and is concluded that the dentists in Barnet Community Dental Services are complying with the NICE guidance regarding the prescription of antibiotics for prophylaxis for infective endocarditis. |
| 5 | Audit of 6 and 12 month stroke reviews carried out across CLCH (bedded areas) | Community Rehab Service | The National Stroke Strategy (2007) set out the need to conduct holistic stroke reviews at 6 month and 12 months post hospital discharge to ensure that any unmet needs related to stroke are addressed. Stroke Reviews will be re-audited for the period January – March 2014. |
| 6 | Compliance to MUST Screening in Continuing Care | Continuing Care | Audit in 3 care homes. Support and training to be continued regarding the use of different aspects of the MUST tool |
| 7 | Falls audit | Continuing Care Nursing Homes | Monthly audit of CLCH Multi-factorial Risk Assessment Tool to continue. Feedback to be presented in staff meetings. Incomplete/ untimely assessments to be monitored and the staff responsible questioned in order to offer 1:1 training/supervision as appropriate |
| 8 | Liraglutide Starting and stopping following NICE guidelines | Diabetes | Re audit 90% compliant. Each nurse is responsible for ensuring that patients are reviewed 6 monthly as a minimum and if DNA, GP advised to stop Liraglutide |

| No | Item | Service | Outcome 2013/14 |
|---|---|---|---|
| 9 | Home enteral tube feeding (HEFT) audit compliance with NICE Guidelines CG32 | Dietetics | Dieticians to renew feeding regimes and upload to IT system (RIO); ensure wider audit of documentation including H2H form. Ensure that all patients receive home visit within 2 weeks of discharge or to seek justification from staff |
| 10 | NICE Guideline Pressure Ulcer CG029 | District Nursing | Audit showed that nurses are completing pressure ulcer risk assessments for patients who already have a pressure ulcer but also for those who are potentially at risk of developing a pressure ulcer. Monthly review of all patients on the DN caseload who are at risk of developing a pressure ulcer. |
| 11 | 6 Week Maternal Contact Clinical Practice Standard Pilot | Health Visiting | This baseline audit arose from the need to ascertain SCPHN compliance with NICE Guidance CG45 (2007) and CG37 (2006). Audited against the Maternal Mood Assessment to identify women with depression at first visit to primary care. Training rolled out to SCPHNs. |
| 12 | Mealtime mantra audit | Infection Control | 8 wards re-audited all scored 95% and above.<br>All staff handling food to attend Food Hygiene training. Food mantra training to be provided locally by Property services. Individual action plans to be completed within 4 weeks of report received. |
| 13 | Hand hygiene validation audits - bedded services | Infection Control | Re-audit scores 93-100%. Meeting was set up with the nursing home manager and staff to discuss the 5 moments for hand hygiene. 1:1 hand hygiene training for all staff on specific wards, after which they were asked to sign a contract to agree that they had completed and understood the training and were aware that any breaches might lead to disciplinary action |
| 14 | Endoscopy /day surgery audit | Infection Control | Generally good compliance with CFPP 01-06, Essential Quality Requirements. In order to meet Best Practice, major building work is needed - CLCH senior management currently in discussions with the provider hospital to fund this project. Possible withdrawal of endoscopy services from ECH |
| 15 | Aseptic Non Touch Technique(ANTT) validation audit | Infection Control | Generally good ANTT compliance (95%). Poor uptake of eLearning by end of March 2014 - to be re-launched. ANTT eLearning launched mandatory for CLCH staff carrying out invasive procedures. Competency checks by managers as per ANTT policy. |
| 16 | Trust-wide hand hygiene audit | Infection Control | Generally good compliance but varied return rate. Non-compliance issues addressed by auditor at the time of audit. Non - compliance issues addressed by individual auditor at the time of audit. |
| 17 | Surveillance of MRSA, C diff and CAUTI - bedded services | Infection Control | Every patient with identified infection followed up and cross infection prevented. Individual patients followed up immediately and appropriate IC advice given. No cross infection |
| 18 | UNICEF Baby Friendly Stage 3 Mother's Audit No 3 (re-audit) | Public Health Nutrition with: Nursing / Therapies / Children's Health | CLCH likely to receive UNICEF Stage 3 BFI Accreditation as a result of high quality breast feeding services. |

| No | Item | Service | Outcome 2013/14 |
|---|---|---|---|
| 19 | Safe and Secure Handling of Medicines Audits (services using/stocking medicines) | Medicines Management | Negative assurance received on the quality of audit reports from work conducted under SLA. A review on how these audits are conducted took place after SLAs were withdrawn and services bought in house. Audits to recommence in 2014-15 after re-training of staff and new process in place for conducting them |
| 20 | Cold Chain Audit (bedded areas) | Medicines Management | Up to date Cold Chain Policy in place. Robust management of medicines and the cold chain - to be confirmed in next audit in 2014/15 |
| 21 | Cold Chain Audit (services) | Medicines Management | Up to date Cold Chain Policy now in place. Robust management of medicines and the cold chain - to be confirmed in next audit in 2014/15 |
| 22 | Antibiotics Audit | Medicines Management | Re-education of prescribers by ward/unit pharmacists and results of audit fed back. Also shared with home managers of units where prescribing was outside of guidelines. Adherence to local antimicrobial guidelines, re-audit in 2014-15. |
| 23 | Audit of NICE Guidance for Anxiety (CG22) | Psychological Health | To consider 'dropped out' cases in greater depth in case management to look for patterns or common presentations. Evaluation project on those who drop out of treatment being conducted within service. Currently completing actions. |
| 24 | Audit of NICE Guidelines for Depression (CG23) | Psychological Health | New investment offered to service has been targeted at guided self-help, our least intrusive intervention. This team does all initial triage and now triages to their own team wherever possible. More patients are now starting with least intrusive intervention, even if stepped up to more intensive treatment thereafter. |
| 25 | Safeguarding - mental capacity and best interest assessment | Safeguarding adults | The overall findings are that supervision is delivered by the CLCH safeguarding teams is compliant with CLCH policy and the experience of the supervisees is positive. A comparison with the CLCH safeguarding supervision 2012 demonstrates improvements in both compliance with supervision policy and practitioners perceptions and rating of supervision in 2013. |
| 26 | Enuresis Audit CG -School Nursing | School Nursing | The results demonstrate that there has been an improvement in delivering care for enuresis in line with NICE guidance. Training of all staff in enuresis, assessment, advice re fluids, use of alarms and medication to be provided at least annually at the school nurse training week |
| 27 | Compliance with NICE guidelines, particularly obesity NICE guidelines | Specialist Weight Management | The results show that the Specialist Weight Management Service are compliant with all 5 guidelines, and can provide supporting evidence. SWMS are meeting NICE guideline standards and delivering a service that is both evidence-based and provides a positive patient experience. |

| No | Item | Service | Outcome 2013/14 |
|---|---|---|---|
| 28 | Radiology: missed fractures | Walk in Centre (WiC / UCC | The overall percentage of abnormalities being missed by clinicians in the Walk in Centre is low (< 2% of the total number of images taken). This reflects overall good practice. Some GPs in the WiC are being encouraged to reflect on their competences. |
| 29 | Auditing elements of the clinical management of women with acute cystitis symptoms in a NHS Walk-In-Centre | Walk in Centre / UCC | Overall good compliance with the local guidelines was found. 3 key recommendations for improving practice were made. |
| 30 | Re-audit of the Management of Upper Respiratory Tract Infections in adults in Soho Walk in Centre – antibiotic prescribing (CG69) | Walk in Centre / UCC | (CG69). Upper respiratory tract infections (URTI) account for a large percentage of increasing attendance. Areas of good practice previously highlighted have been maintained. Guidance and targeted meetings and documentations reviews have been actioned. |
| 31 | Chest pain - WIC treatment | Walk in Centre / UCC | Results of audit communicated to all staff with a summary of the relevant parts of the NICE guidelines indicating where practice needs to improve. Discussed same at staff meetings. Planned re-audit in June for period March-May 2014 to assess for improvements in practice. |

## MANDATED DATA

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death. Central London Community Health NHS Trust considers that this data is as described for the following reasons [insert reasons]. The Central London Community Health NHS Trust has taken the following actions to improve this and so the quality of its services, by undertaking the following actions.

*Information on this to be inserted. This is due to the fact that the March 2014 data has been delayed by a technical issue within NRLS. It is anticipated to be available at the end of April 2014.*

The other mandated indicator relating to *the percentage of patients being readmitted to a hospital which forms part of the trust* does not apply to CLCH as CLCH has not previously been required to report on this

## Review of Services

During 2013/14 CLCH provided and or sub contracted 55 NHS services. CLCH has reviewed all the data available to them on the quality of care in 100% services. The income generated by the NHS services reviewed in 2013/14 represents 100 percent of the total income generated from the provision of NHS services by CLCH for 2013/14.

**STATEMENTS FROM OUR LOCAL OVERVIEW AND SCRUTINY COMMITTEES, CLINICAL COMMISSIONING GROUPS AND HEALTHWATCH**

*To be inserted post consultation*

**Barnet CCG**

**Hammersmith and Fulham, Central London and West London Clinical Commissioning Groups**

**Barnet overview and scrutiny committee**

**Hammersmith and Fulham Overview and Scrutiny Committee**

**RBKC and WCC Overview and Scrutiny Committee**

**Healthwatch Barnet**

**Healthwatch – Central West London**

## FEEDBACK

Now that you have read our Quality Account, we would really like to know what you think, how we can improve and how you would like to be involved in developing our Quality Accounts in future. We will be putting a short feedback survey on our website which should only take five minutes to complete.

Go to: **www.clch.nhs.uk** and fill out the survey online. Alternatively you will be able to download a copy of the survey, fill it in and post it to:
Patient and public engagement
Central London Community Healthcare NHS Trust
6th Floor 64 Victoria Street
London
SW1E 6QP

Please write to us if you would like us to send you a paper copy using the address above or via email to **communications@clch.nhs.uk**. Alternatively, if you or someone you know would like to provide feedback in a different format or request a copy of the survey by phone, call our communications team on **020 7798 1420.**

## FURTHER ADVICE AND INFORMATION

***If you would like to talk about CLCH's services or your experiences***

If you would like to talk to someone about your experiences of CLCH services or you need to know
If you would like to find a service, please contact our patient advice and liaison service (PALS) in confidence via email **clchpals@nhs.net** or on **0800 368 0412**.

## USEFUL CONTACTS AND LINKS

**CLCH Patient Advice and Liaison Service (PALS)**

**e:** pals@clch.nhs.uk

**t:** 0800 368 0412

**Switchboard for service contacts**

**t:** 020 7798 1300

### Local Healthwatch

**Central West London Healthwatch - For Hammersmith and Fulham, Kensington and Chelsea and Westminster**

Email: healthwatchcwl@hestia.org

Telephone: 020 8968 7049

**Barnet Healthwatch**

Telephone: 0208 364 8400 x 218 or 219

www.healthwatchbarnet.co.uk

### Local Clinical Commissioning Groups

**Barnet CCG**

Telephone: 020 8952 2381

www.barnetccg.nhs.uk

**Central London CCG**

Telephone: 020 3350 4321

www.centrallondonccg.nhs.uk

**Hammersmith and Fulham CCG**

Telephone: 020 7150 8000

www.hammersmithfulhamccg.nhs.uk

**West London CCG**

Telephone 0207 150 8000

www.westlondonccg.nhs.uk

### Local councils

**Barnet**

Telephone: 020 8359 2000

www.barnet.gov.uk

**Hammersmith and Fulham**

Telephone: 020 8748 3020

www.lbhf.gov.uk

**Kensington and Chelsea**
Telephone: 020 7361 3000
www.rbkc.gov.uk

**Westminster**
Telephone: 020 7641 6000
www.westminster.gov.uk

## Healthcare organizations

**Care Quality Commission**
Telephone 03000 61 61 61
www.cqc.org.uk

**NHS Choices**
www.nhs.uk

**APPENDIX 1 – COMPLAINTS ANNUAL REPORT**

## 1.0 Introduction

1.1. This is the Complaints Annual Report for Central London Community Healthcare NHS Trust ( CLCH) for the period 1 April 2013 to 31 March 2014.

1.2. The current complaint handling regulations were introduced in April 2009 (The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 Statutory Instrument), together with guidance from the Department of Health ('Listening, Responding, and Improving 2009"). A direct relationship between the Ombudsman and health bodies is embedded within the complaints system's structure. The Ombudsman has stated that when the NHS listens to patients and takes action on what they say, it can make a direct and immediate difference to the care and treatment that patient's experience.

1.3. Through its complaints policy, the Trust ensures that people, and those acting on their behalf have their comments and complaints listened to and acted on effectively, and know that they will not be discriminated against for making a complaint.

1.4. The issues raised from complaints are dealt with in a sensitive and timely manner to prevent reoccurrence or escalation of incidents. Staff are trained and supported to do this by acknowledging the problem or concern being raised and where possible resolving the issue at an early stage. The complaints and concerns we receive inform the action plans relating to the Patient Experience.

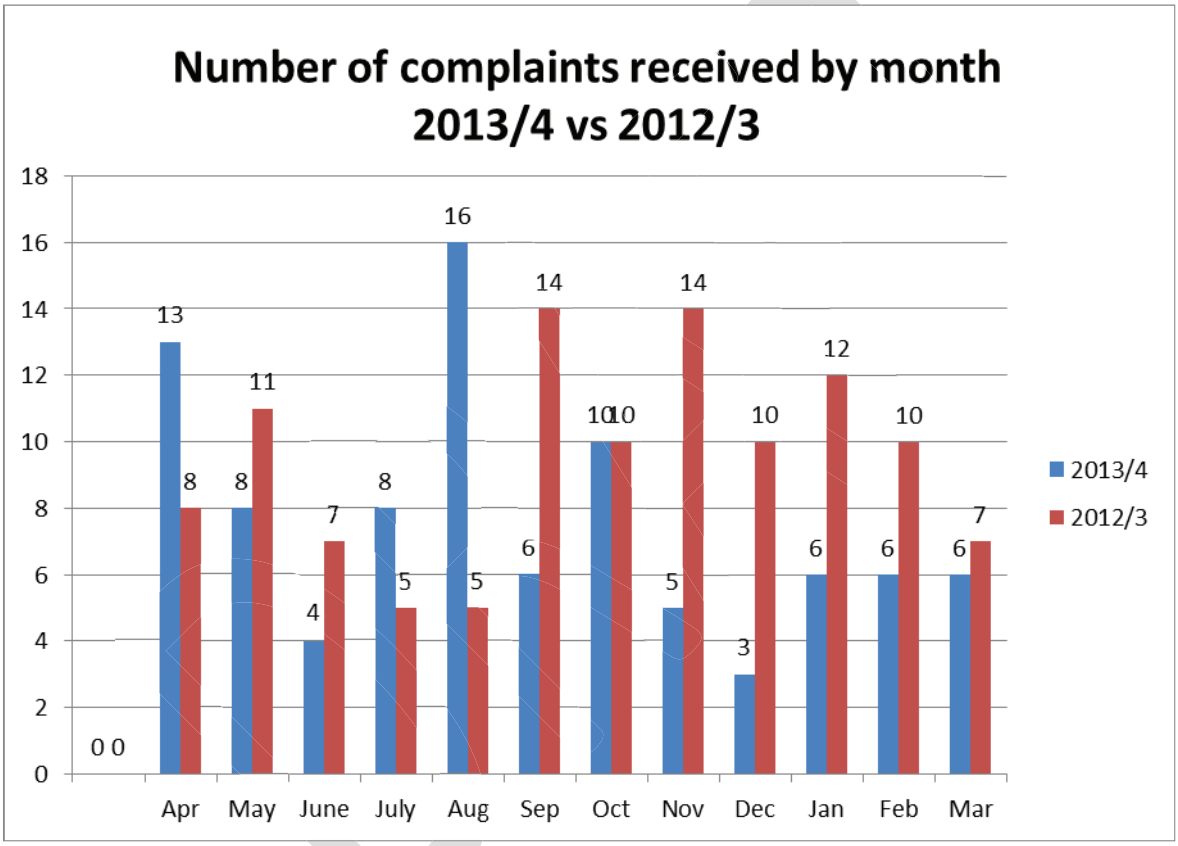
## 2.0 Complaints received

2.1. A total of 92 formal complaints were received by the Trust during 2013/2014. This is a decrease of 20 (19%) complaints on the previous year.

2.2. Complaints received by month.

The following chart illustrates the number of complaints received by month in 2013-4 vs. 2012-3.

**Chart 1**




2.3. Complaints received by Clinical Commissioning Groups (CCGs)

The following table illustrates the number of complaints received by CCG. A reduction of 62% in the number of complaints received regarding services provided in the Barnet CCG is the driver for the overall reduction in complaints received Trustwide this year versus last year.

**Table 1**

| Borough | Number of complaints received | |
|---|---|---|
| | 2013/14 | 2012/13 |
| Barnet CCG | **27** | **43** |
| Hammersmith and Fulham CCG | **17** | **20** |
| West London CCG | **19** | **22** |
| Central London Health CCG | **28** | **26** |
| Corporate | **1** | **2** |
| **Total** | **92** | **113** |

### 3.0 Analysis of complaints received.

3.1 Complaints received by Division.

The following table illustrates the number of complaints received by Division.

**Table 2**

| Division | Number of complaints received |
|---|---|
| Allied Primary Care Services | **37** |
| Child Health and Development | **8** |
| Corporate Services | **2** |
| Networked Community Nursing and Rehabilitation | **10** |
| Specialist Community Nursing | **35** |
| Total | **92** |

3.2. 21 of complaints received by Allied Primary Care Services were regarding the Urgent Care and Walk-in Centres.

3.3. 4 of the complaints received by the Child Development Service were regarding the Health Visiting Service.

3.4. 5 of the complaints received by the Networked Community Nursing and Rehabilitation Service were regarding the District / Community Nursing Service.

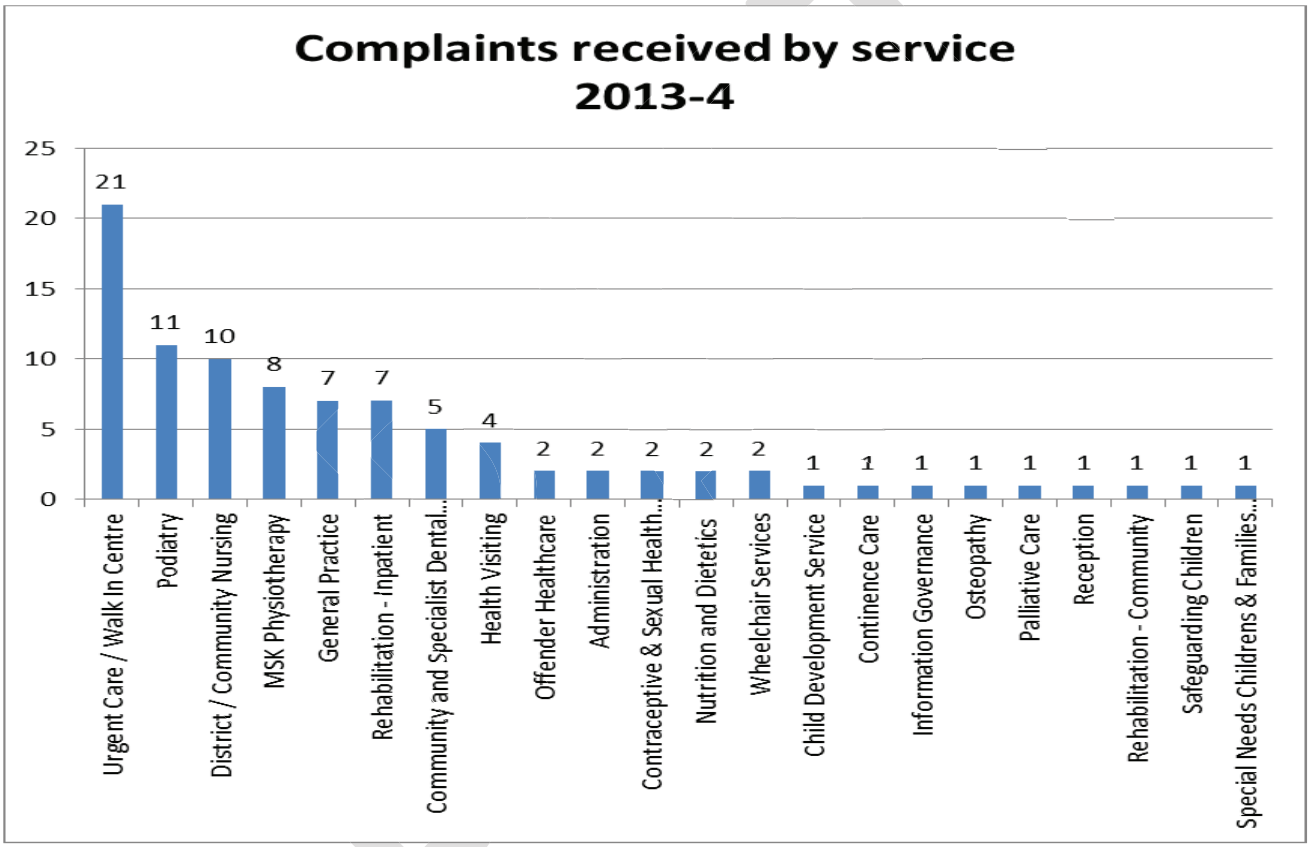
3.5. 11 of the complaints received by the Specialist Community Nursing Service were regarding the Podiatry Service 8 about the Musculoskeletal Service.

Further analysis is provided under section 3.2 of this report.

3.6. Complaints by service

The following chart illustrates the number of complaints received by service.

**Chart 2**




The following trends and themes emerged from complaints received were:

3.7. Urgent Care and Walk-in Centres (21)

Clinical care and treatment 13

3 of the complaints were regarding misdiagnosis.

Rudeness or conduct of staff 7

There were 3 complaints regarding different staff members at St Charles UCC.

3.8. District /Community Nursing (10)

Clinical care and treatment 8

No trends in clinical themes although communication between patients and staff was a factor in 6 of the complaints.

3.9. Podiatry (11)

Clinical care and treatment 6

The management of the patients' expectations regarding the possibility of bleeding during or after treatment was a factor in three of these complaints.

3.10. In-patient rehabilitation (7)

Clinical care and treatment 7

3.11. Three of the complaints were regarding falls or other harm caused to patients during their stay on at Finchley Memorial Hospital. Two complaints were regarding care and treatment provided at Athlone House.

3.12. Musculoskeletal Physiotherapy (8)

Three of these complaints were regarding the appointments or referral process.

3.13. GP Services (7)

Clinical care and treatment 5

3.14. Three of these complaints were regarding the treatment and behaviour of a particular GP.

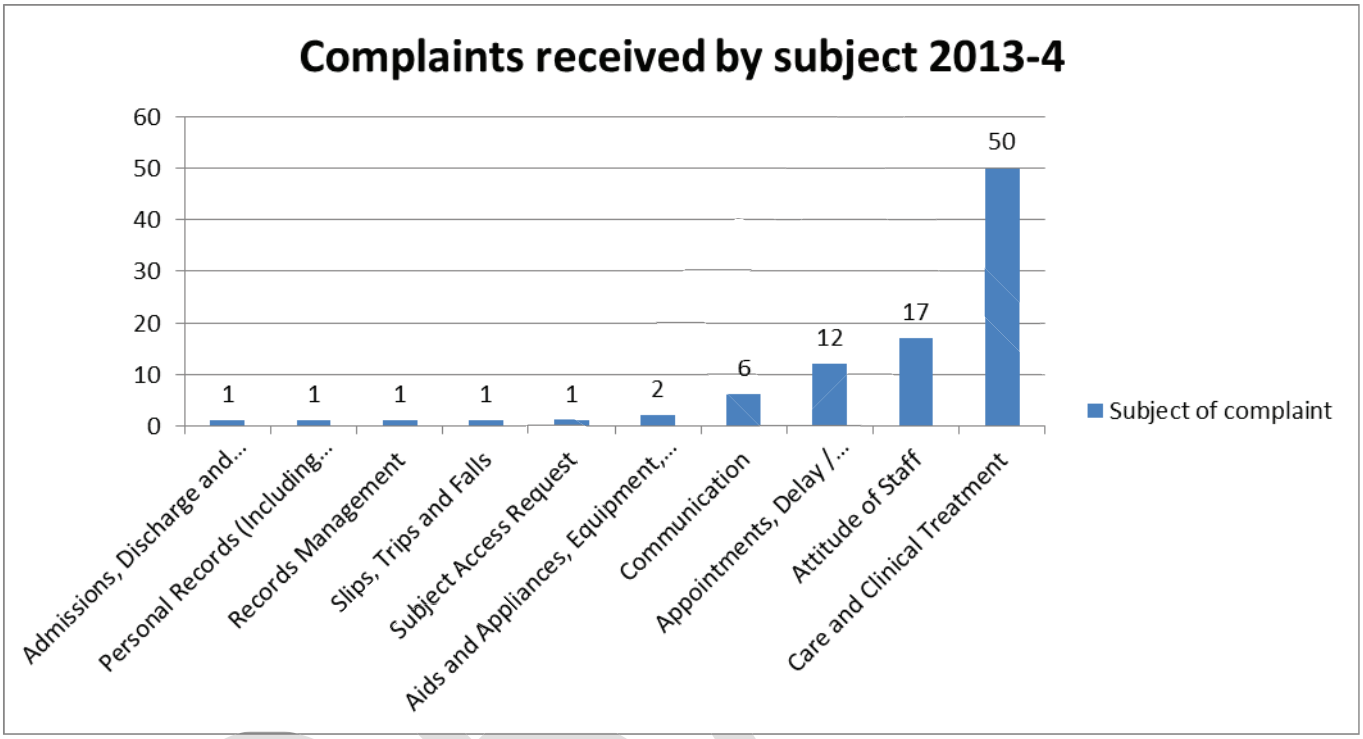
3.15. Health Visiting

Two of these complaints were regarding the vaccination process.

## 4.0 Complaints received by subject

4.1. The following chart illustrates the number of complaints received by subject.

**Chart 3**




**NB: The subjects of complaints are classified by the main theme of the complaint, as required by the annual submission of complaints data to the Health and Social Care Information Centre.**

4.2. The top three subjects remain the same as the previous year; unhappy about aspects of their clinical treatment, staff attitude (also taken to mean rude) delays and/ or process regarding appointments.

**Table 3**

| Top three complaint themes | Total Number of Complaints Received (2013 / 2014) | Total Number of Complaints Received (2012 / 2013) |
|---|---|---|
| Unhappy with Treatment | 50 | 50 |
| Staff Attitude | 17 | 19 |
| Appointments | 12 | 10 |

4.3. Unhappy with Treatment. The category 'unhappy with treatment' covers a wide spectrum. In 4 cases, complainants reported that their treatment and/or side effects were not fully explained. In addition to the themes reported in section 3 of this report the following trends were found:

**Table 4**

| Subject | Total Number of Complaints Received |
|---|---|
| Discharge | 3 |
| Misdiagnosis | 6 |
| Catheter | 2 |
| Infection control | 1 |
| Medication | 5 |

4.4. Staff attitude can often be the complainant's perception of the way they were addressed or treated by staff. When describing their perception of some staff, rudeness, insensitivity and a general lack of concern were the most common themes.

4.5. A target was set to achieve a 5% year on year reduction in complaints and incidents related to poor communication and attitude. This year saw 18% of complaints regarding this subject, an increase of 1%.

4.6. As a means of addressing this issue, the appropriate members of staff have received further Customer Service Training as well as enhanced supervision. The Trust has also set out values and standards of behaviour expected. Any members of staff who do not reach these standards will undertake a customer care training workshop and will be monitored closely under supervision.

4.7. There were no trends in the 12 complaints received regarding appointments in terms of the service affected.

**5.Response times to complaints**

5.1. All complaints were investigated within the timescales agreed with the complainant. It should be noted that in some cases the timescale initially agreed with the complainant was extended after it had been explained why and re-agreed with them.

5.2. 17 (18%) of complaints received were in investigated within 25 working days.

The majority of the complaints closed outside of the agreed timescales were either due to the complexities of the investigation. Other reasons, although to a lesser degree, included staff that were the subject of the complaint not being available due to sickness or leave. Additionally there were delays awaiting contact from complainant to clarify their complaint or awaiting proof of consent where required. One of the Trust's aims for 2013/14 is to build on the considerable work already undertaken to improve response timescales.

## 6.0 Local resolution meetings

6.1. Two meetings took place of which one resulted in a positive outcome. Another meeting with a patient was did not take place due to the patient being unwell.

## 7.0 Complaints referred to the Parliamentary & Health Service Ombudsman (PHSO).

7.1. Under the current complaints legislation, Trusts have six months in which to endeavour to resolve a complaint to the complainant's satisfaction. If the complainant remains dissatisfied with the response they receive, they can ask the Ombudsman to independently review their complaint.

7.2. From April 2013, the Ombudsman's office advised that they would begin investigating and sharing reports on more of the complaints. This is part of their new strategy 'More Impact for More People'. They stated that they will be investigating thousands rather than hundreds of complaints each year. The Ombudsman will continue to publish figures for the number of complaints they investigate about each organisation in their jurisdiction, but will be explicit that their change of process is a reason for the significant increase in the number of investigations they will undertake during 2013/14.

7.3. During 2013/14 the PHSO did not request case files or a formal review of any complaints made against CLCH.

## 8.0 Reopened complaints

8.1. Complainants who were unhappy with their responses felt that there were discrepancies between what was said in the response and their recollection of events. Some complainants felt that the investigation had been superficial and had not addressed the concerns raised. Others identified that they were unhappy with the tone of the response and that the Trust had failed to offer a sincere apology. A number of complainants wanted further information in order to help them understand the decisions made about their care. Of the complaints that were re-opened 17 were resolved through further responses.

## 9.0 Change of practice

9.1. A fundamental aspect of the complaints process is ensuring that the organisation learns and improves from the experience of receiving and managing complaints. Each complaint investigated

will have recorded, as a feature of the final outcome, the lessons learned and what action has been, or will be taken as a result of the investigation.

9.2. The resulting actions are currently monitored by the Patient Experience Group and the lessons learned disseminated throughout the organisation. The actions from those complaints risk graded as medium to high are monitored via the Trust's Risk Register.

9.3. The Customer Service Manager also presents emerging themes or trends to the Complaints, Litigation, Incidents, PALS, Serious Incidents (CLIPS) Group on a bi-monthly basis. The CLIPS Group provides the Trust's forum for discussing and sharing lessons in an open and supportive environment. Where required learning bulletins can be quickly disseminated via email or through the appropriate governance structure.

9.4. A quarterly cumulative thematic report is produced to enable the Trust to monitor any themes or trends arising from complaints throughout the year, so that any issues can be addressed accordingly.

9.5. The commissioners of CLCH's services also receive a monthly report on the lessons Actions and lessons learned from complaints originating from their specific geographical areas.

9.6. The table below highlights a selection of some of the changes and improvements made as a result of complaints received over the past year.

**Table 5**

| Specialism | What we did… |
|---|---|
| GP Practice<br>Milne House | In order to improve the patient experience the practice has recently installed a patient check-in machine which allows patients visiting the practice to check themselves in. Therefore patients contacting the practice by telephone will have their calls answered more promptly. |
| Podiatry Surgery | The podiatry nail surgery post-surgical advice sheet has been updated to more robust advice on accessing urgent care if the need arises. |
| Palliative Care<br>Pembridge Unit | The unit has now obtained a further 11 beds which lower to the floor thereby reducing the risk of falls. |
| Ultrasound Scan and Biomechanics | Additional temporary staff were employed to help reduce a short term increase in waiting times. |

| | |
|---|---|
| Single Point of Access | All “Choose and Book” appointments are followed up with a confirmation letter which includes the address of the clinic.<br><br>The SPA will inform “Choose and Book” callers of the clinic venue as well as the date and time of appointment. |
| Rehabilitation-In patient | The following recommendations have been identified and are being implemented by all wards:<br><br>On admission, the ward staff will liaise with both patient and family to identify the patient's individual needs in relation to preference of health care worker.<br><br>An induction program to be developed and implemented for use by agency staff on their first duty on the ward.<br><br>When a patient is found to have poor core balance then guidance for managing this will be included in the patients care plan.<br><br>Families of patients to be informed that they will be provided with clear outcomes from an incident and have an opportunity to respond.<br><br>All ward staff will also undertake refresher training in effective communication which will include how to deal with concerns raised by relatives and carers in order to allay relatives' fears and anxieties with regards service delivery and patient safety. |
| MSK Physiotherapy<br>Finchley Memorial Hospital | To help reduce caller waiting times that the service is now open at the earlier time of 8am. |



We continue to review the lessons learned process and have introduced systems of robust trend analysis in order to enable the Trust to monitor and act upon any recurring themes. One of our corporate objectives this year will be to ensure that lessons learned are embedded into service delivery and that the process is included in the review of the Complaints Policy & Procedure.

**10.0 Equality Data**

10.1. When written complaints are received this information is not usually provided and an attempt to capture this is made at a later stage by way of a phone call, or by letter, if a contact number is

available. We gather this information and pass it on to the Equality & Diversity team to help assess whether we are providing equal access and treatment for different groups of people. The data requested is as follows: Ethnicity, Age, Sexual Orientation, Religion or beliefs.

## 11.0 Key achievements in 2012/2013

11.1. The team has attended a number of Operations Directorate team meetings to provide training in the management of complaints, concerns, comments and compliments for staff who undertake investigations or are involved in the process.

11.2. Implemented a new e-learning Complaints and PALS module, which will has replaced this section on the Corporate Induction Programme, and provide a more interactive experience for users.

11.3 Participated in NHS England's pilot of a new transparent patient feedback service with the working title of 'Care Connect'.

11.4. The Trust's Complaints Policy and Procedures have been reviewed in line with Department of Health guidelines and the recommendations from the Mid Staffordshire NHS Foundation Trust Public Inquiry (The Francis Report-Effective Complaints Handling) and the Report of handling of complaints by NHS hospitals in England by Ann Clwyd MP and Professor Tricia Hart.

11.5 Participated in a number of public stakeholder events. For example, provided a stall at the 'Time of your Life Health Fair ' organised by Age UK Kensington & Chelsea and provided a key note speaker at the "How to Complain" community event organised by Healthwatch.

11.6 Provided support to Trust's 'Excellence in Customer Service' training programme.

## 12.0 Aims for 2013/4

12.1. The complaints regulations do not stipulate a specific time-scale for responding to complaints; the Trust has therefore determined three levels of response to complaints and a target for response to Low/Medium Risk complaints has been set at 25 working days.
12.2. Work with the Business Intelligence team to further develop its "QlikView" reporting function to enable the Directorates to access quality reports about complaints, comments, concerns and compliments received about their services.

12.3. Enhance the Customer Service section on the Trust Internet to provide, for example, transparency to the public in its management of complaints, the actions take and the lessons learned from them. A Compliments section will also be introduced.

12.4. Further develop the Customer Service Satisfaction Questionnaire to encourage service users to complete and return.

12.5. Build on the success of service team visits last year and providing further complaints training sessions across the Trust for staff who undertake investigations.

12.6. Provide further support to Trust's 'Excellence in Customer Service' training programme.

12.7. Work with local and national complaints networks to provide better benchmarking data with Trusts delivering comparable services.

12.8. Explore synergies and more integrated working with the Patient and Public Engagement Team with which the Customer Service Team has been integrated.

12.9. Evaluate the possible use of volunteers within the Customer Service Team.

**13.0 Conclusion**

13.1. The Trust continues to be proactive in its management of complaints and recognises that complaints provide invaluable feedback about the services we provide.

13.2. Work during 2014/15 will continue to build on that already undertaken this year, focusing on ensuring that lessons are learned from complaints and concerns. The Trust will continue to seek assurance that all actions have been undertaken and changes are made to service delivery where appropriate.

## APPENDIX 2 - FRANCIS MATURITY MATRIX

### *Appendix 2: National report recommendations – Integrated Matrix (v4.1)*

### (v.4.1 updated January 2014)

| | BASIC | | BRONZE | | SILVER | GOLD |
|---|---|---|---|---|---|---|
| | Starting off | Progress | Early Days | Progress | Good | Exemplar |
| | May 2013 | July 2013 | September 2013 | Jan 2014 | January 2014 | April 2014 |
| **1. PREVENTING PROBLEMS** | Quality strategy and Risk management Strategy approved by the Board<br><br>Listening events held across Trust<br><br>Quality Account developed in collaboration with patients, staff and key stakeholders | Completed<br><br>Completed<br><br>Completed | Quality Strategy and Risk Management Strategy launched across Trust<br><br>Quality conference held to disseminate best practice Quality Account disseminated and objectives on track. | Completed<br><br>Completed<br><br>Completed | Quality Strategy and Risk Management Strategy Objectives clearly embedded across the Trust and Strategy targets on track. | Zero tolerance to culture of poor care<br>Year One Quality Strategy and Risk Management Strategy Objectives being met.<br>Engagement of all staff demonstrated through staff survey (Everyone's Business)<br>Quality Account objectives met. |
| All actions this line cross ref to Berwick 3 / 8<br><br>Keogh 3 | Patient stories presented to the Board and PPE strategy successfully rolled out across Divisions | Completed<br><br>PPE strategy on track with expected outcomes. | PPE strategy refreshed and being implemented across divisions | Completed | 15 Steps programme implemented and cycles of improvement identified | Patient stories used across all services<br>Refreshed PPE objectives being met.<br>Patient feedback actively used by all services to improve care |
| All actions this line cross ref to Berwick 7 | Being Open Policy in place | In place. | Policy reviewed and awareness increased as part of Quality Strategy launch | Competed. | Wider programme of training in relation to Duty of Candour | Audit of SI investigations demonstrates Being Open policy is successful. |
| | Patient Safety Thermometer implemented | Completed | Review of policies and guidelines on intranet site<br><br>Understanding of incidents by service. | Ongoing<br><br>Completed | Reduction in incidents of avoidable harm | Embedded culture of patient safety demonstrated through achievement of Risk management Strategy Objectives |
| | Productive series used to help "release time to care" | Partial implementation in some teams/ units. | Complete capacity and capability review across community nursing<br><br>Staffing levels are reviewed using evidence based tools<br>Cross ref Keogh 6<br>Cavendish 17<br>Berwick 4 | Completed<br><br>Initial work / in progress | Reducing paperwork for front line staff (by 1/3)<br><br>Staffing levels and training are reviewed using evidence based tools<br><br>Trust Board will receive publish and endorse information on staffing | Creating time to Care by introducing electronic/ digital solutions to reduce paperwork Aligns Cavendish 12<br><br>Trust Board will receive, publish and endorse information on staffing at least twice per year |
| | CLCH working closely with TDA, CCGs and NHS England in relation to Quality measures and objectives | On-going | All CQUINs and quality performance information on track with afore mentioned. | Completed / On-going | Work with local commissioners to develop local quality incentives for 2014/15 | Active engagement with Health and Wellbeing boards and achieve all commissioning quality objectives. |

| | BASIC | | BRONZE | | SILVER | GOLD |
|---|---|---|---|---|---|---|
| | Starting off | Progress | Early Days | Progress | Good | Exemplar |
| | May 2013 | July 2013 | September 2013 | Jan 2014 | January 2014 | April 2014 |
| | | | | | | |
| **2. DETECTING PROBLEMS QUICKLY**<br>All actions this line cross ref to Berwick 3 / 8; and Keogh 3<br>Actions this line cross ref Keogh 2 | PREMS in place<br><br>Analysis of patient feedback being undertaken including friends and family test | Completed<br><br>On-going | PREMs, complaints and other patient feedback disseminated at Quality conference<br>Net Promoter Score in line with Quality Strategy Objectives. | Completed<br><br>On track | Themes and outcomes of all complaints published monthly on the trust website. | Staff survey results / medical revalidation feedback used to complement patient feedback and plan developments for coming year. |
| | Performance scorecard includes key quality metrics by division | Completed | KPIs developed as part of quality and risk management strategies and published across all services<br><br>Development of QlikView<br><br>At least three key clinical outcomes for each service published on the trust website | Completed<br><br>On-going<br><br>Identified – not on website yet | Performance data published on trust website<br><br>Communications team publish outcomes widely | Performance measures – open and transparent<br><br>Scorecards demonstrate prompt action when concerns arise.<br>Clinical Reference Group monitoring of CIPs has been successful in identifying any concerns quickly. |
| NEW ACTIONS<br><br>Keogh 1 | | | Trust Resuscitation Group reviewed Deteriorating Patient Policy | Completed | Implementation of National Early Warning Score (NEWS) | |
| | Incident reporting well established<br><br>Serious Incident review – every case treated individually. 48 hr executive review. RCA panels for all SIs | In place - on-going<br><br>Completed | Staff encouraged to speak up (whistleblowing) reinforced as part of Quality Strategy launch<br><br>Risk Managers review SI process | Completed<br><br>Completed | All incidents involving patients are discussed with the patient and their family | Internal Inspection programme to be established by the compliance team<br><br>Candour and transparency fully understood by all staff |
| | | | | | | |
| **3. TAKING ACTION PROMPTLY** | Board has established secondary set of standards for reporting related to patient care<br><br>Intentional rounding in place in in-patient areas | Completed<br><br>Completed | Standards for key areas of patient care established and disseminated through professional leads | On-going – in tandem with Compassion in care and skills project | Clear sets of fundamental standards in each service, backed by evidence.<br><br>Where fundamental standards of care are being breached firm action will be taken until resolved. | Develop standards which demonstrate we want to exceed expectations and go beyond providing basic care.<br>Achieve Exemplar Team status as outlined in the Quality Strategy |
| | Trust Learning from Experience (CLIPS) group established | CLIPS groups in place at Trust level and also at service level across divisions | CLIPS groups established in divisions to ensure learning from complaints/ incidents<br>Learning from Experience Newsletter developed | Completed<br><br>Completed | Clear examples demonstrated of improving practice following an incident or complaint. | Trust Quality Objectives for 2014/15 developed based on clear understanding of lessons learned form this year |
| | Never events reported and investigated as part of SI policy | On-going | Bespoke 'Never Events' developed within the Trust and targets set for reduction | Outstanding action | All Trust Never Events reported, investigated and lessons learned | Trust Never Events substantially reduced within the year. |
| | | | | | | |

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| **4. ENSURING ROBUST ACCOUNT-ABILITY**<br><br>All actions this line cross ref to Keogh 4 / 5 | Board Assurance Framework and Risks registers in place and reviewed by internal auditors | Completed | Board Assurance Framework and Corporate Risk Register regularly reviewed to ensure actions are being taken to reduce risks. | Completed | Accountability framework for managers to be devised with clear outcomes for actions when things go wrong.<br><br>Cross refs to Berwick 9 / 10 | Risk Registers and Board Assurance Framework together with Accountability Framework for Managers demonstrating clear lines of assurance and accountability. |
| | Medical Director and Chief Nurse complete weekly Quality Rounds. All NEDs and Executive Directors regularly undertake visits to clinical areas. | Log of NEDS visit being collated<br><br>Chief Nurse "Clinical Fridays" on-going. | Strategy for all executive directors and NEDs clinical engagement agreed including plan for feedback and action | Partial – needs dissemination within Trust<br><br>"Clinical Fridays" implement in January | Leaders at all levels to have agreed objectives with regard to engaging with patients (e.g. back to the floor activities).<br>Cross Refs to Keogh 8 | All staff ( with the exception of some administrative posts) visit a clinical area and talk with at least one patient and members of staff at least once a week. |
| Actions this line cross ref to Cavendish 1 / 2 / 3 | Some Healthcare Assistants have clear competency frameworks in place.<br><br>Staff are referred to regulatory, professional bodies where appropriate.<br><br>Re-validation process commenced for Doctors | On-going<br><br>On-going as necessary.<br><br>Process in place | Road shows to increase profile and understanding of fitness for practice requirements<br><br>HCA competencies re-defined and discussed with staff.<br><br>Doctors revalidation process continued | Outstanding action<br><br>On-going<br><br>On-going | Trust regulatory regime in place for all patient/client facing groups<br>HCA competencies introduced, together with training and monitoring system -<br>Cross ref to Cavendish 14 / 15<br>Berwick 9 / 10 | Barring systems especially in relation to HCAs to be explicit<br><br>Triggers for referral to professional regulators to be made explicit<br>Year One Doctors revalidations complete.<br>Prior to introduction of a national scheme of RN revalidation ensure that all RNs have support to be up-to-date and fit for purpose |
| | Questions asked to all staff regarding their specific values. | Completed. | All recruitment to patient/client facing positions to include a "values" assessment of the candidate<br><br>Cross ref to Cavendish 6 | Completed | Audit of recruitment processes demonstrate values questions asked and marry with Trust values.<br>One culture campaign fully implemented with trust values understood by all staff | Work with HEI providers to ensure standards for pre-registration education have an emphasis on care and compassion.<br>Cross refs to Cavendish 7<br><br>Staff demonstrate in the Staff survey high levels of understanding and commitment to Trust values. |
| | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **5. ENSURING STAFF ARE TRAINED AND MOTIVATED**<br><br>Actions this line cross ref to Berwick 1 / 2<br><br>Keogh 5 | Nursing supervisory ward managers (Band 7 Sisters appointed for in-patient areas in Barnet) in place<br><br>District Nursing team leaders currently have 50% clinical caseloads<br><br>Professional Leads attend monthly Clinical Reference Group<br><br>Francis Listening Events well attended by staff | Ongoing implementation<br><br>In place. part of Capacity and Demand project.<br><br>On-going (good attendance)<br><br>Completed | Review Trust Learning and Development Strategy to ensure training provided for staff meets patient need.<br><br>Continue with staff listening events every month.<br><br>Cross refs to Berwick 1 / 2 / 6 | Outstanding action for new Dep Chief Nurse (education)<br><br>Completed | Stronger voice for clinical staff expressed through a clinical leadership forum/ compassion council in each Division ( ? profession specific)<br><br>Cross ref Keogh 7 / 8 | Leadership development programme reviewed and developed.<br>Fit for purpose learning and development activities well attended.<br>Talent drawn from the clinical professions into management of the Trust where possible |
| Actions this line cross ref to Cavendish 1 /2/ 3 / 10 / 13 | Competency framework established for support staff including record keeping, customer care, communication, confidentiality alongside clinical competencies.<br><br>Generic JDs and PSs for bands 3 and 4. | Ongoing review of Competencies. | 50% of band 3 staff (where needed) will have completed or are enrolled on a QCF | Partial – actual % not known | Continue work Pan-London to develop consistent bands 1-4 development alongside NHS London. Trust representation in bands 1-4 development group, with Bucks New University and London South Bank University | HCA workforce demonstrate high levels of skill and are receiving appropriate levels of training and supervision. |
| Actions cross ref to all Cavendish recommendations | Participation in the Cavendish Review. | Review considered | | | | Respond to Cavendish Review |
| | Discussions underway with City University re commencement of Compassion in Care project. | Completed | Commence Compassion in Care project with City University (Barnet in-patient facilities) | Completed - | Full implementation of the national 6Cs (CNO campaign) | Implement and embed the principles in the 6Cs and demonstrate progress through Trust wide audit. |
| | Some staff have had specific dementia, mental health and learning disabilities training but this has not been undertaken consistently across the Trust. | Ongoing | Increase dementia, mental health and learning disability training and awareness to all staff working with vulnerable patients.<br>Further develop the Trust Strategy for the Care of Vulnerable Adults based on new national guidance. | Outstanding action<br><br>On-going | Complete a specific audit of dementia, mental health and learning disability care across the Trust based on recommendations from national strategies and guidance. | Work with HEIs to provide high quality clinical placements for students in relation to elderly, frail patients.<br>Audit implementation of the Vulnerable Adults policy and review any associated incidents or complaints.<br>Integrated roles developed between health and social care, in line with commissioning intentions and with a view of providing seamless transition of care |

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Barnet and Chase Farm Hospitals NHS
NHS Trust

# DRAFT
## Quality Account 2013-14

**Contents**

Reflections Rounds: ‘Caring for the caregivers’ and ‘Compassion in care’
Transanal Endoscopic Microsurgery (TEMS)
Home for Lunch and Green Friday
Improving the pace of treatment
Accreditation for the Sterile Services Department
Chase Farm Macmillan Information Centre
Stop and Help

**The views of our stakeholders**

**A statement on the quality of our services from our Chief Executive**

I am proud to present the Trust's fifth set of quality accounts at the end of a year that has seen huge changes in the way we deliver our services. Following years of planning and a thorough implementation process, the Barnet Enfield and Haringey (BEH) Clinical Strategy is now a reality; we transferred all Maternity and Emergency services from Chase Farm Hospital to Barnet Hospital in November/December 2013 with the intention of improving the quality of care in both of these specialties. Our partner in these changes was North Middlesex Hospital, which also expanded its Emergency and Maternity units to absorb the workload from Chase Farm Hospital. With specialists now focused at two locations rather than three, our patients can expect better clinical outcomes from these teams, whilst an Urgent Care Centre remains open at Chase Farm Hospital to take care of minor illnesses.

Understandably, given the scale of the changes and the process needed to implement them, the BEH Clinical Strategy grabbed most of our headlines over the last 12 months - but it is not the only way in which we have been improving our services. The Friends and Family Test was implemented in the summer and sought to ask all of our patients whether they would recommend the care they received to a loved one. This feedback enables us to target weak spots in our service and implement both short and long term solutions to a variety of issues. Our infection control aims got a big boost thanks to a new two year hand hygiene campaign 'I Can, You Can, We Can', whilst Chase Farm Hospital's kitchen was the recipient of the Food Standards Agency's top hygiene rating. Our dementia care moved forward courtesy of the money we received at the end of the previous Mayor of Barnet's Fundraising Appeal. This amounted to over £40,000 to invest in installing Tiptree Tables on Barnet Hospital's wards, which give dementia patients a sense of normality during their treatment.

A high quality service needs a well functioning workforce and we're extremely appreciative of the patience shown by our staff during all the recent and upcoming changes. In light of the need to support them and help them to support each other, we've established a series of staff sessions known as Reflections rounds, that allow employees of all professional groups to come together and share inspiring examples of how they've continued to make a difference. Feedback from the initial sessions has been excellent, with many examples of good patient care being discussed and we will continue these into 2014/15.

The Trust was pleased to be one of the organisations named in a National Institute for Health Research Clinical Research Network report as contributing to the rise in NHS research studies, having increased the number of our own studies from 22 to 27. You can read about some of these research studies later in this report.

We had a number of unannounced visits by the CQC during the year including a visit to a surgical ward (Canterbury ward) in the summer which found that four of the six essential standards of quality and safety were not being met. These

included respecting and involving service users, staffing issues and cooperating with other providers. This was an area already recognised by the Trust with active measures in place to resolve these problems. A subsequent visit by the CQC has praised the changes which have been made.

We expect to become part of a Foundation Trust in summer 2014 through being acquired by Royal Free London NHS Foundation Trust. As a result of this, we have aligned our quality priorities for 2014/15 to be in line with the Royal Free London as we look forward to a joint future serving the residents of Barnet, Enfield and Camden together.

This acquisition has been planned because it makes clinical as well as financial sense. Senior clinicians from both trusts have been meeting to decide how best to combine our services in a way that meets the needs of local people whilst remaining financially viable long into the future. It is not anticipated that the merger will see a significant change in the day to day work of our patient-facing staff, though it will mean big changes at management level with the implementation of a clinical board.

It is a requirement of the quality account regulations that the Chief Executive takes personal responsibility that information within this document is accurate and I am happy to give you my reassurance that this is indeed the case.

**Priorities for improvement and statement of assurance from the board**

In this part of the quality report we review our performance against our key quality priorities for 2013/14 and provide examples that illustrate how individual services and specialities are focused on quality improvement. We also provide key data relating to our performance and outline our priorities for improvement in 2014/15.

**Performance against our key quality objectives**

We place great importance on constantly improving our services and the quality of our patient care. Last year we committed to three key quality improvement objectives. These were:

**Priority one: Excellent care including staff satisfaction and patient experience**

**Priority two: To further develop our clinical outcome measures**

**Priority three: To launch a patient safety programme across the trust.**

Over the following pages, we set out how we have performed against these objectives.

**Performance against our three key quality objectives**

**Priority one** Dementia services

The Trust received half of the £80,000+ raised by the former Mayor of Barnet, Councillor Brian Schama for dementia services across his borough. We are investing this money in Tiptree Tables; tables of everyday items that give dementia patients a sense of normal life during their stay in our hospitals. This has meant rebuilding the reception areas in our wards so that the new tables form a permanent part of our service.

The national Audit of dementia report, produced in 2013, has demonstrated a significant improvement in the service we provide for people with dementia. These include improved access to out of hours psychiatry services and staff training with the deployment of a rapid access and intervention service (RAID).

The Trust has developed a new strategy action plan based on the National Audit of Dementia report for 2014/2015. The Trust has also been involved in the UCLP project for training staff in dementia awareness and has over achieved on the target it was set..

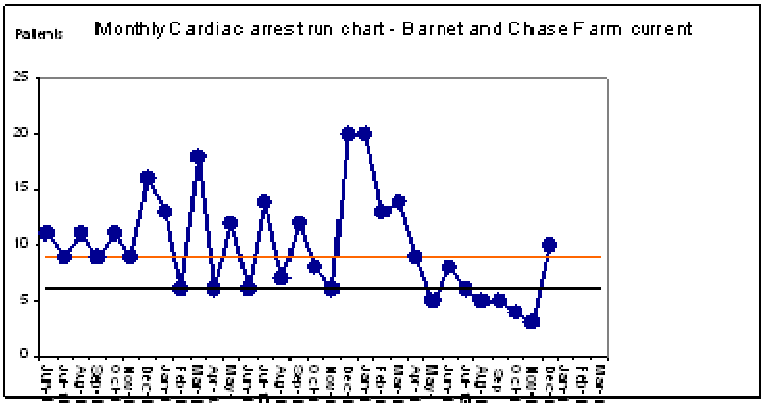
A recent visit from the Care Quality Commission has praised the Trust for the quality of dementia care and noted that it was very clear form the way in which staff cared for patients with dementia that they had been trained and that training had a very positive impact on the quality of patient care.

**Priority two** National Safety Thermometer

*Deteriorating Patient Project - Reduction of cardiac arrests*

**A sustained and significant reduction in cardiac arrests has been achieved by the Trust in the second and third quarters of the year (July-December 2013).**

The Trust has continued to collaborate with the UCLP Deteriorating Patient project over the past 12 months, with the aim of a 50% reduction in cardiac arrests. A sustained and significant reduction has been achieved, and the project, led by UCLP, was in the final 10 shortlisted in the category of Patient Safety, at the National HSJ Awards in London in October. Our data is represented below.




**Cardiac Arrest totals**
Jul-Dec 2011 = 65
Jul-Dec 2012 = 67
Jul-Dec 2013 = 33

The total of cardiac arrests over comparable 6 month periods for the past 3 years demonstrates a 50% reduction. Reducing cardiac arrests is a key indicator of quality care in two ways:

Early identification by ward teams of patients who are acutely unwell and at further risk of deterioration allows support and intervention by critical care outreach teams or transfer to HDU or ITU.

Some patients may not be appropriate for acute intervention and recognising these patients allows for timely discussions with the patient, and their family so that their care can be planned to allow a peaceful and dignified end to their life.

In line with key recommendations of the NCEPOD Report published in June 2012 - 'A time to Intervene', the Trust is implementing Treatment Escalation Plans for all acute admissions. This is an explicit plan of care for the treatment of every patient based on their individual needs and likely response to treatment in the event of deterioration. The TEP is made in consultation with the patient and or their family so that there is a partnership and confidence between clinicians, patients and families.

A Trust-wide event was held in August to bring the role of investigating and learning from Serious Incidents into focus. The role of the Trust serious incident panel was explored, and the importance of learning from the past to improve the future was discussed.

For example, a trust wide working group is looking at new suppliers for our blood gas machines to allow automatic population of results into the electronic patient record, ensuring these are immediately available to clinicians. Much of the background work has been completed by our IT Department to also allow automatic population of fields on the Electronic patient Record so that high serum lactate results can be flagged to clinicians. This project will enable much earlier recognition of patients at risk from severe shock, and allow earlier intervention.

*Sepsis - Trust campaign on the Sepsis 6*

In September 2013 the Trust began a major campaign to improve our recognition and management of patients with sepsis. Sepsis carries a high

mortality rate compared to many other conditions (higher for example than stroke or myocardial infarction) but if recognised and treated within 1 hour, the chances of survival increase significantly. The Trust campaign focuses on delivery of 'The Sepsis 6', a Bundle of six interventions which can be delivered by any healthcare professional.

A new sepsis bundle pathway has been implemented and promoted, Barnet ED now have dedicated Sepsis 6 trollies, which enable all 6 interventions to be delivered without delay, and a new e-learning package is now on line for all clinical staff to undertake. Sepsis 6 tea parties, pens, mugs and sepsis 6 champions in white polo shirts with the 'Keep Calm and Do the Sepsis 6' logo are all an important part of keeping sepsis awareness in the clinical arena.

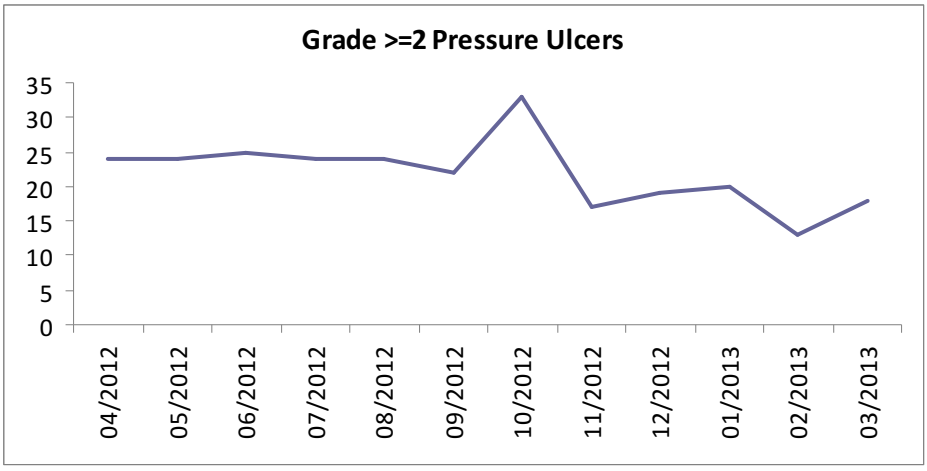
**Priority three** Pressure ulcers

Avoidable hospital acquired pressure ulcers (often called pressure sores) remain a key indicator of the quality of nursing care. This is an area of concern for the whole health economy and a source of pain and discomfort for our patients.

The Trust gives high priority to this and a zero tolerance approach to avoidable pressure ulcers has been implemented with ongoing focus being given to this area of care. The Trust is currently taking part in an initiative led by University College London Partnership that aims to eliminate avoidable hospital acquired pressure ulcers by 2014. This project facilitates enhanced learning, improved communication between Trusts and the sharing of initiatives that have been successful in a variety of clinical areas.

Moving forward, the tissue viability service remains committed to the delivery of education and continued improvement in prevention of avoidable hospital acquired pressure ulcers and has planned training, education and competency based assessments to improve staff knowledge and skills.

The graph below shows an overall decline in the number of grade 2 pressure ulcers over the last 12 months.



**Priority four** Administration standards

**Our plan for making administrative improvements involves:**

- Empowering our front-line staff to redesign our Clinical Offices and using Continuous Improvement to devise the most efficient processes and record them as Standard Operations - also known as the inverted triangle approach.
- Introducing new technology to provide faster turnaround of patient letters as well as integrating into our electronic patient record system to maintain the 'patient context'.
- Forming 'clinical offices' to provide single points of access for groups of specialties.

Similarly, we have also empowered our staff in Patient Records and Patient Services, who have benchmarked their processes against other external organisations.

In Patient Services, we are upgrading the telephone and call centre technology by installing additional phone lines to deliver a better service, so that 80% of calls are handled in 30 seconds.

We are introducing direct patient bookings to make appointments easier for patients and also implementing a new appointment reminder service, which uses agent calls, so that patients will be given a personalised service. This has been presaged by the highly successful introduction of online appointments for phlebotomy.

We have integrated our admissions office into Patient Services to further streamline our internal processes. The new self check-in kiosk technology introduced last year is being extended across all clinics to enable receptionists to provide a better service to patients as well as automating clinical outcomes.

Our staff are being trained by one of the UK's leading practitioner of Continuous Improvement. When all these changes have been introduced, they will measure the performance of their own teams to ensure that problems are identified and resolved, as well as continually improving the service to patients.

**Priority five** Liverpool Care Pathway with an emphasis on dignity, respect and compassion

An independent review, commissioned by Care and Support minister Norman Lamb and published in summer 2013, recommended that the use of the Liverpool Care Pathway be phased out nationally over the next 6-12 months. The review panel recognised that, when applied correctly, the Liverpool Care Pathway does help patients have a dignified and pain-free death, and they supported the ethical principles underpinning it as representing best practise in care of the dying. However, given the many cases of misapplication with failure to take account of individual needs, they felt that its use should come to a close.

The report made 44 recommendations in total. In particular they suggested that the LCP is replaced by a personalised end of life care plan backed by good practise guidance specific to disease groups. The Trust reviewed these recommendations in full, withdrew the use of the LCP and has introduced a new process designed by its palliative care team, embodying a personalised approach to terminal care management. This is being audited on a regular basis and no complaints have been received in relation to it.

**Priority six** Complaints to Trust Board

Recent national reports including the Francis Report and Keogh reviews have identified the need to embrace complaints as a powerful source of information for improvement. Barnet and Chase Farm Hospitals NHS Trust is committed to promoting an open culture of feedback and improvement. Complaints are viewed as a valuable source of feedback and are used to inform learning and improvements in the experience of our patients.

Lengthy discussion of complaints at Trust Board is part of the Board's development programme and we are focused on understanding and improving the quality of complaint responses. The Chief Executive reads and signs all responses. The Director of Nursing, and where appropriate the Medical Director, also reads the complaint responses in order to ensure they fully address concerns raised and that lessons are being learned from complaints. More serious complaints may lead to investigations through a Serious Incident process, involving an independent investigation and panel led by the Medical Director/Director of Nursing. The Trust's Non executive directors regularly read a randomly picked selection of complaints and responses.

The main area of improvement with regards to complaints management is the timeliness and efficiency of handling the complaint. Focused work throughout 2013/2014 was carried out and remains on-going to improve the complaints process.

*Initial acknowledgement*

The Department of Health's 2009 complaint regulations require that all complaints are acknowledged within a target time of three working days. In Quarter 1 (Q1) and Q2 (2013/2014), 97 out of the 173 formal complaints (which equates to 56.1%) were acknowledged within the first three days. This has significantly improved in Q3 with 89.8% of all complaints being acknowledged within the first three days - an improvement of 33.7%. This was achieved by holding tailored 'complaints' meetings and raising awareness of the importance of acknowledging all complaints with the complaints facilitators. Work remains ongoing and the target is 100%.

*Duration of complaints investigations*

In Q1 and Q2, the average number of days taken to process a complaint was 123.8 days whereas in Q3 it was 96.6 days. In order to reduce the duration of

the investigations a number of strategies are currently being implemented which include:

- undertaking a 'whole process complaint review' including data analysis and case review by a designated 'Complaints Review Group'
- strengthening existing processes for reviewing complaints performance data including response times by holding meetings with people responsible or associated with complaints
- weekly 'Open Complaints Lists' (OCL) used to engage senior management and requiring them to outline what actions will be carried out to close complaints
- additional staff resources have been made available
- training for Foundation doctors with regards to handling complaints and legal claims.

**Our priorities for improvement in 2014/15**

Due to the acquisition process by the Royal Free London NHS Foundation Trust, we are looking to combine the quality priorities of the two organisations so that, as a consequence, there can be a seamless process of governance integration.

We would like to assure our local communities that the needs of all patients have been taken into account by the Royal Free in the writing of their priorities which have looked at the catchment area of both existing trusts.

**Priority one: World class patient information to reflect our world class care**

Patient information should be clear to read, with easily understood terminology and available in whichever format (electronic or hardcopy) best suits the patient. It should include contact details or links to websites for further advice. It should be honest with the patient about risks and side effects and - where helpful - it should include pictures or diagrams to explain the procedure taking place.

These and other essential ingredients for good patient information are all required under NHSLA guidelines and so it is essential that leaflets for patients at all three sites of the future enlarged trust abide by these rules. In order to achieve these main aims the joint organisation will be undertaking the following:

- Set up a new patient information system and patient information policy which is available on the intranet, along with associated templates and resources (for example online training) to support staff in producing patient information.
- Centralise the provision of patient information and appoint a patient information manager with a dedicated budget
- Define our role as a patient information provider to ensure consistent, easy access to maintained, quality assured patient information for both patients and health professionals

- Look at how we produce patient information - internally, contracted externally or a combination of the two
- As an interim measure, review racks in outpatients to ensure that literature on display is not out of date, is appropriate to the clinic, and the trust

**Priority two: Reducing cancellations**

Reducing 'Did Not Attend' (DNA) rates is vital to patient experience because keeping an unused slot open in the hope that the patient might eventually arrive increases waiting times for everyone else. Thus bringing down DNA rates is an important part of achieving the next quality priority, reducing Outpatient waiting times.

It has other impacts on patient experience. Since the same staff time is paid for on a wasted slot as it would be for a used one, this is money from departmental budgets that could be saved and used on improving the convenience of patient environments.

**Priority three: Reducing Outpatient department waiting times**

Patients are often understandably anxious before an appointment, and delays in the waiting room can only increase the sense of anxiety. Thus it is important for patient experience that they are seen on time or, where delays are unavoidable, kept informed of when they will be seen.

**Priority four: Inpatient diabetes care**

Many patients with kidney and vascular disease also suffer from diabetes. Indeed, because of the particular range of specialist services we offer on any one day at the Royal Free Hospital, nearly a quarter of our in-patients will have diabetes. In addition, many patients on our specialist liver unit will require help with blood sugar control.

Over the past few years, a national audit on in-patients with diabetes has helped us identify where we need to improve aspects of our diabetes care. Our own monitoring has also highlighted concerns, for example, medication errors related to insulin.

Diabetes is therefore one of our key priorities in 2014/15. Our specific aims are to:

- Ensure nutritional balance at mealtimes for our inpatients with diabetes
- Improve the management of insulin and other diabetic medications on our wards
- Improve foot assessments for patients with diabetes.

We will explore innovative solutions to these themes and consult with our academic health science partnership to learn from experience at other organisations. Progress will be monitored by our clinical performance committee.

**Priority five - To continue our patient safety programme**

Our key priorities for the patient safety programme for 2014/15 are set out below:

**Patient safety culture and capability**

A key objective for the coming year is to improve trust-wide communication on safety issues to ensure that we improve dissemination of learning from incidents.

We will further strengthen our incident investigation and processes for addressing safety issues throughout the organisation. We also seek to further improve education and mandatory training in patient safety.

**Priority clinical work streams**

Priority clinical areas for improvement are as follows:

- **Surgical safety**

We aim to be more than 95% compliance with all aspects of the 'five steps to safer surgery' guidance - this is line with the World Health Organisation Checklist.

- **Medicines safety**

We will focus our efforts on insulin prescribing safety and reduction of medication 'missed dosages' through mandated insulin training.

- **Procedural safety**

We will continue to ensure compliance with the use of ANTT in the insertion of all venous and arterial cannulae across the Trust.

- **Action on abnormal images**

We have commenced a programme of work to ensure all radiological imaging is promptly reviewed and actioned with particular emphasis on emergency work. This will be carried through from last year's progression in this area.

*Pressure ulcers*

As seen earlier in this report, hospital acquired pressure ulcers were a priority over the previous year and remain a priority for the coming year as well. A zero tolerance approach to avoidable pressure ulcers has been implemented with ongoing focus being given to this area of care.

The Trust is currently taking part in an initiative led by University College London Partnership that aims to eliminate avoidable hospital acquired pressure

ulcers by 2014. This project facilitates enhanced learning, improved communication between Trusts and the sharing of initiatives that have been successful in a variety of clinical areas.

Moving forward, the tissue viability service remains committed to the delivery of education and continued improvement in prevention of avoidable hospital acquired pressure ulcers and has planned training, education and competency based assessments to improve staff knowledge and skills.

**Statements of assurance from the Board**

This section contains eight statutory statements concerning the quality of services provided by the Barnet and Chase Farm Hospitals NHS Trust. These are common to all trust quality accounts and therefore provide a basis for comparison between organisations.

Where appropriate, we have provided additional information that provides a local context to the information provided in the statutory statement.

**Statement one** Review of services

During 2013/14 Barnet and Chase Farm Hospitals NHS Trust provided 40 NHS services. Barnet and Chase Farm Hospitals NHS Trust has reviewed the data available to it on the quality of care in all of these services. The income generated by the NHS services reviewed in 2013/14 represents 100% of the total income generated from the provision of NHS services by Barnet and Chase Farm Hospitals NHS Trust for 2013/14.

Additional information

In this context we define each service as a distinct clinical directorate that is used to plan, monitor and report clinical activity and financial information - this is commonly known as service line reporting. Each individual service line can incorporate one or more clinical services. Clinical directorates routinely monitor demand and output data for all services and in aggregate this includes various quality measures. Few services are assessed in isolation. Some very specialised services are routinely reviewed as part of the national commissioning group's processes. Each directorate is lead by a senior clinician reporting via the Trust's management structure to the Trust Board.

The Integrated Performance Report is discussed at every Trust Board meeting. It includes information on clinical activity at directorate level ranging from activity data to contract metrics such as Consultant to Consultant referrals.

**Statement two** Participation in clinical audits and national confidential enquiries

**National clinical audits for inclusion in quality accounts 2012/13**

During 2013/2014, Barnet and Chase Farm Hospitals NHS Trust was eligible to participate in twenty eight national clinical audits and two national confidential enquiries.

Of those, the Trust participated in 25/30 (83%) national clinical audits and 2 (100%) national confidential enquiries. These are listed in the table below. The table also highlights the number of cases submitted to each audit or enquiry if available.

**National clinical audits for inclusion in quality accounts 2012/13**

| Name of audit/confidential enquiry | Data collection 2013/14 | Barnet and Chase Farm Hospitals NHS Trust participation |
|---|---|---|
| Adult critical care (Case Mix Programme - ICNARC CMP) | **Yes** | Up to 31.12.13 there were 2 separate submissions, one for CFH and one for BH. Data thereafter will be submitted as one site.<br><br>CFH<br>Data sent up to end of September and is currently being validated. December data not in yet because of delay caused by BEH Clinical Strategy move.<br><br>BH<br>Data sent up to end of June and is currently being validated. |
| Emergency Laparotomy | **Yes** | The Trust has registered. Organisational data was collected to 02.09.13.<br><br>Clinical data collection commenced 07.01.14. This is a prospective audit so data is submitted as soon as possible prior/during/after surgery. |
| Emergency use of oxygen (British Thoracic Society) | **No** | The Trust did not participate in audit. |
| Chronic Obstructive Pulmonary Disease (COPD) | **Yes** | BCF has registered to participate in the audit. Data collection commenced on 01.02.14 to 30.04.14 (30 and 90 day outcome data, along with mortality data). Update to be provided at the end of the audit period<br>January 2015: Publication of national report. |
| National Joint Registry (NJR) | **Yes** | The Annual report published does not breakdown data by Trusts, but collectively on prosthesis. |
| National Confidential Enquiry into Patient Outcome and Death (NCEPOD) | **Yes** | 1) Subarachnoid Haemorrhage: Managing the Flow (November 2013)<br>2) Alcohol Related Liver Disease: Measuring the Units (June 2013) |
| Severe trauma (Trauma Audit and Research Network - TARN) | **Yes** | The Trust has been submitting data since April 2012. During 2013 161 cases were submitted with another 34 cases to enter. |
| Falls and Fragility Fractures Audit programme, includes Hip fracture database (NHFD) | **Yes** | The Falls and Fragility Fractures:<br>202 patients were added to the NHFD database for CFH and 316 patients for BH. |

| | | |
|---|---|---|
| National Comparative Audit of Blood Transfusion - programme contains the following audits:<br>a) O neg blood use<br>b) Medical use of blood<br>c) Bedside transfusion<br>d) Platelet use | **Yes** | Blood transfusion audits are undertaken regularly as part of Trust Blood Transfusion Policy. |
| Bowel cancer (NBOCAP) | **Yes** | In the 2013 NBOCAP report the Trust submitted 210 cases which was 95% case ascertainment in comparison to those identified in HES/PEDW.<br>100% cases were discussed at MDT<br>97.3% patients were seen by clinical nurse specialists.<br>Of the 117 patients having major surgery from this cohort 71.8% had laparoscopic surgery attempted.<br>The adjusted 30-day mortality rate was 2.7%<br>The adjusted 90-day mortality rate was 2.8%. |
| Head and neck oncology (DAHNO) | **Yes** | The audit year runs from November to October each year. For the period November 2012 to October 2013, 92 patient cases were submitted. The Trust is awaiting verification of data by DAHNO. |
| Lung cancer (NLCA) | **Yes** | Data for 2013 can be uploaded to the national data base until 30.06.14. It is expected that approximately 300 patients will be uploaded by this time, the highest number in the network.<br><br>The National Lung Cancer Audit Report for patients seen in the Trust from 01.01.12 to 31.12.12 was published on 04.12.13. The total number of patients submitted was 247. |
| CEM - Severe sepsis and septic shock | **Yes** | Both Emergency Medicine sites registered. The data collection period was from 01.08.13 to 31.01.14 for BH and until 09.12.13 for CFH. Update awaited. |
| CEM - Paracetamol overdose | **Yes** | Both Emergency Medicine sites registered. The data collection period was from 01.08.13 to 31.01.14 for BH and until 09.12.13 for CFH. Update awaited. |
| Acute coronary syndrome or Acute myocardial infarction (MINAP) | **Yes** | This is an ongoing audit with continuous submission of data on all patients with suspected myocardial infarction.<br>During 2013, CFH submitted 28 cases (up to the closure of A&E at CFH). BH submitted 232 cases. |
| Cardiac Rhythm Management (HRM) | **Yes** | BH submitted 200 procedures of all types since 01.04.13 to date. |
| Heart failure (HF) | **Yes** | The number of records submitted to date from April 2013 is 264. |
| National Cardiac Arrest Audit (NCAA) | **No** | The Trust did not participate in this audit. Aall cardiac arrests outside A&E are routinely followed up by the Trust's core Recognition of the Deteriorating Patient group. There has been a reduction of over 50% of cardiac arrests in the last year as a result. |

| | | |
|---|---|---|
| CEM - Moderate or severe asthma in children | **Yes** | The audit ended on 31.03.14.<br>National Audit reports will be published thereafter.<br><br>CFH Emergency Department closed on 09.12.13. Data for CFH was collected up until 31.11.13. As agreed with the National Audit team, data collected will be analysed separately for both CFH and BH Emergency Departments.<br>It is expected that less than the target 50 cases will be collected for the CFH ED. |
| Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA) | **No** | The Trust did not participate in this audit. However, work is ongoing to fund the Diamond Database required for this audit. |
| Diabetes (Paediatric) (NPDA) | **Yes** | The audit for 2012-13 closed on 31.01.14. 180 cases were submitted to the audit. The final audit report will be published early 2015. Data submission for the 2013-14 audits will begin on 1404.14 and close on 14.07.14. |
| Inflammatory bowel disease (IBD)<br>Includes: Paediatric Inflammatory Bowel Disease Services. | **Yes** | Only BH registered for the audit as there is no Emergency Department at CFH. 15 cases were submitted during 2013.<br>BH completed the organisational audit which was submitted on 31.03.14. |
| Sentinel Stroke National Audit Programme (SSNAP) - programme combines the following audits: a) Sentinel stroke audit<br>b) Stroke improvement national audit project | **Yes** | The audit commenced December 2012. To date, 41 cases for BH and 4 cases for CFH have been submitted. |
| Elective surgery (National PROMs Programme) | **Yes** | PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.<br>Questionnaires returned for BCF for the period April 2013-December 2013:<br>Hip - 215<br>Knee - 212<br>Hernia - 46<br>Varicose Vein - None.<br>Reports are published on a monthly basis directly by HSCIC |
| Epilepsy 12 audit (Childhood Epilepsy - 12 measures of quality applied to the first 12 months of care after the initial paediatric assessment) | **Yes** | The identification of applicable patients by the Trust and primary data collection commenced 01.03.13-31.12.13.<br>Completion of data on each relevant patient will take place between 01.01.14-30.04.14. |
| Maternal infant and perinatal (MBRRACE-UK)*<br><br>(Also known as Maternal, Newborn and Infant Clinical Outcome Review Programme) | **Yes** | Cases to be audited are reported as they happen. No BCF cases were identified/selected by (MBRRACE-UK). |

| | | |
|---|---|---|
| Parkinson's disease (National Parkinson's Audit) | **No** | The Trust did not participate in this audit. |
| National Audit of Seizure management in Hospitals | **No** | The Trust did not participate in this audit. |
| Paediatric asthma (British Thoracic Society) | **Yes** | The data collection period is from 01.11.2013-28.02.14. Update to be provided at the end of the audit period. |

Barnet and Chase Farm Hospitals NHS Trust was not eligible to participate in the audits listed below in 2013/2014 as the Trust does not provide these services.

| | | |
|---|---|---|
| Congenital heart disease (Paediatric cardiac surgery) (CHD) | | N/A |
| Coronary angioplasty (subscription funded from April 2012) | | N/A |
| Adult cardiac surgery audit (ACS) | | N/A |
| Paediatric intensive care (PICANet) | | N/A |
| Renal replacement therapy (Renal Registry) | | N/A |
| Prescribing in mental health services (POMH) | | N/A |
| National audit of schizophrenia | | N/A |
| Pulmonary hypertension (Pulmonary Hypertension Audit) | | N/A |
| Paediatric Bronchiectasis (British Thoracic Society) | | N/A |

The Trust took part in 156 local clinical audits. These are reviewed by the directorate and any changes to practice/risks identified are managed locally, unless they impact on other areas or the Trust as a whole, in which case the appropriate action is taken in collaboration with the relevant groups

Additional information

In addition to the above, the Trust participated in the two audits listed below by providing data via the MDT. The procedures itself are performed at Specialist Centres/Units, not at Barnet and Chase Farm Hospitals NHS Trust.

1. Peripheral vascular surgery (VSGBI Vascular Surgery Database, NVD)

2. Oesophago-gastric cancer (NAOGC)

Although eligible to, the Trust did not participate in the following audits during 2013/2014:

1. Parkinson's disease (National Parkinson's Audit)
2. National Cardiac Arrest Audit (NCAA)
3. Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)
4. Emergency use of oxygen (British Thoracic Society)
5. National Audit of Seizure management in Hospitals

The Trust did not submit data for the National Parkinson's Audit because it was felt that the audit was more community rather than hospital based. However, the Trust will participate in this audit in 2014/15.

The Trust did not participate in the National Cardiac Arrest Audit because the Trust's resuscitation service continues to concentrate on changes to service provision leading to a greater than 50% reduction in cardiac arrests in the last year. However, a working group regularly reviews the notes of those who have suffered a cardiac arrest and the information obtained assists the Trust's efforts better to identify and care for the deteriorating patient.

The Trust is still awaiting installation of a Diamond Database necessary for participation in the Diabetes audits. The Diamond Database business case has been approved by the Trust and is being installed, whilst the staff appointments to run this are being made.

The Trust was not involved in the emergency use of oxygen audit due to lack of Consultant resources which was particularly stretched in relation to the implementation of the BEH Clinical Strategy. However, we do have an ongoing internal improvement programme and expect to participate in the 2014/15 audit.

The Trust did not participate in the National Audit of Seizure Management as this is conducted within the A&E department where staff time has been unavailable owing to the joint pressure of winter activity and the changes of the BEH Clinical Strategy.

We intend to submit data to the next audit round for all these audits.

In addition to the national audits, the Trust undertakes a local annual audit programme in response to its own requirements. Results of local clinical audits are reviewed in detail within the directorates and lessons learned and/or changes to practice are highlighted at the Trust's Clinical Governance Committee. The audits are documented on the Trust's bespoke database.

**Statement three** Participation in clinical research

**The number of patients receiving NHS services provided or subcontracted by Barnet and Chase Farm NHS Trust in 2013/2014 that**

**were recruited during that period to participate in research approved by a research ethics committee was 134.**

Research is a core part of the NHS and remains embedded within the NHS Constitution with the expectation that all patients will be invited to take part in research which is relevant to them. Research is vitally important to the NHS because the outcomes are used to improve the quality of services delivered to patients.

**Our research portfolio**

Over the last year we have significantly developed the Trust's R&D processes and have invested significantly in the team required to develop its research portfolio. We operate a growing portfolio of both academic and commercial research. All clinical trials, whether supported by a pharmaceutical company or another organisation such as the National Institute of Health Research (NIHR), are designed to meet high quality standards. A rigorous system of checks is in place to ensure that these standards are consistently met, including a review by an independent ethical committee and the requirement to obtain permission from the NHS organisation that is to act as the research site.

We continue to expand the number and range of studies that we offer within the Trust. In 2013/14:

- 26 National Institute for Health Research (NIHR) studies were actively recruiting patients
- Over 300 hundred patients recruited in research in previous years were in follow-up
- The areas of research included cancer, cardiovascular, child health, dermatology, gastroenterology, mental health, neurology, orthopaedics, rheumatology, and stroke.
- 14 more studies are currently being set-up.
- We have increased the number of Trust research investigators to over 30.
- Our investigators authored more than 20 publications since December 2011.

**Trust research team**

The Trust Research Team continues to be led by Dr Ameet Bakhai, Consultant Cardiologist, who was appointed to the post of the Trust R&D Director in December 2012. Further research appointments this year included:

- Dr Heather Angus-Leppan, Consultant Neurologist and Epilepsy Lead for Royal Free and Barnet Hospitals, Honorary Senior Lecturer, Neurosciences R&D Lead
- Liba Stones, first Trust R&D Manager
- Lai Lim, Lead Cardiology Nurse
- Vinodh Krishnamurthy, Physician Associate in stroke research

- Virginia Jennings, Cancer Clinical Trials Research Assistant

The Trust operates a monthly R&D Committee chaired by Dr Bakhai, reporting to the Clinical Governance and Risk Committee.

**Our collaborations**

The Trust is an active member of University College London Partners (UCLP) which is one of five accredited academic health science systems in the UK. We actively support the 'harmonisation project', a single system for study review across multiple trusts in the Central and East London Local Clinical Research Network. The harmonisation project provides the Trust with the opportunity to work in partnership with some of the most research intensive institutions in the country.

Dr Bakhai acts as the network Cardiovascular Research Lead which is charge of cardiovascular studies across 8 hospitals. The Trust R&D Manager, Liba Stones, acts as the Division Portfolio Officer with a role in coordinating the set-up and management of studies. Cardiovascular research funds 14 members of staff and operates studies which recruited 1963 patients in 2013/14. In the last three months, additional funding of £250,000 was secured for additional manpower and projects.

We are part of the Quintiles Extended Prime Site initiative of 6 hospitals aimed at delivering an efficient set-up and management of commercial research.

In 2013/14 we have been successful in securing a place in the National Institute of Health Research (NIHR) Leadership Support and Development Programme, joining a peer network and working group of around 40 leading research active Trusts.

Active collaboration is under way in the Royal Free to ensure the combined trust takes full advantage of the opportunities for collaboration and integration made available through the acquisition.

**Funding**

We have secured external funding to over £250,000 for the period 1 April 2013-31 March 2014 to support the NIHR Portfolio Research. This represented an increase on last year, in recognition of our improved performance in NIHR research and enabled us to appoint new research posts.

**Snapshot of open studies**

**British Society for Rheumatology Biologics Registers – Ankylosing Spondilitis (BSRBR-AS)**

The British Society for Rheumatology commissioned the University of Aberdeen to set up this study to monitor the safety of treatments for Ankylosing Spondilitis

(AS) and to find out more about how treatments affect the lives of patients in areas such as work, driving and general quality of life. The Principal Investigator at Barnet and Chase Farm the study is Dr Jeffrey Lee, Consultant Rheumatologist and General Physician. The study was approved in June 2013 and so far recruited 11 patients.

**British Association of Dermatologists' Biological Interventions Register (BADBIR)**

The purpose of this research study is to assess whether the new biological treatments used in the treatment of psoriasis have any side effects when used long-term. The study involves following up patients taking a number of different drugs for psoriasis and assessing the frequency that long-term side effects occur. The study is funded by the British Association of Dermatologists (BAD) and coordinated/sponsored by the University of Manchester. The study has been opened since 2006 at Barnet and Chase Farm and our Principal Investigator is Dr Wanda Robles, Consultant Dermatologist and Senior Lecturer in Dermatology. In 2013/14 the study recruited 15 patients. For more information, see www.badbir.org

**Optimal Personalised Treatment of early breast cancer using Multi-parameter Analysis - preliminary study (Optima *prelim*)**

OPTIMA *prelim* is a 'randomised controlled trial' which seeks to advance treatment of breast cancer by using tests to identify women who are likely to benefit from chemotherapy and those would do just as well with hormone treatment only. This trial is funded by the National Institute for Health Research (NIHR) and sponsored by University College London. The Principal Investigator at Barnet and Chase Farm is Dr Rob Stein, Consultant and Senior Lecturer in Medical Oncology. The study has been running at Barnet and Chase Farm Hospitals NHS Trust since 2012 and recruited 15 patients in 2013/14.

**Can Shoulder Arthroscopy Work? (CSAW)**

The aim of the CSAW study is to find out what the best way is to treat persistent shoulder pain and examine ways to improve communication about treatments with for people with shoulder complaints. The study is funded by Arthritis Research UK and sponsored by the University of Oxford. At Barnet and Chase Farm Hospitals NHS Trust the study was opened in September 2012. The Trust Principal Investigator is Mr Dan Rossouw, Consultant Orthopaedic Surgeon. 6 patients were recruited in 2013/14.

**Statement four** Use of CQUIN payment framework

The Trust has been working with a variety of Commissioning Groups for 2013/14 in order to deliver a quality service for local patients. Each Commissioning group had specific areas of focus for quality improvement initiatives with payment conditional upon achievement of associated milestones.

The CQUIN Indicators for 2013/14 account for Trust income of 2.5% of the Acute Contract value. The Trust's payments for the CQUIN Indicators were included as part of the agreed financial settlement for NEL Commissioners for 2013/14 therefore the performance for the CQUIN Indicators continued to be reported in line with the Acute Contract for 2012/13 with no financial impact. For NHS England and Herts CCGs payment has been made in agreement of milestones achieved.

THE TRUST'S IMPROVEMENT PROGRAMME CONSISTED OF:

Nationally mandated

- Improving patient experience - Friends and Family
- Reduce number of pressure ulcers and falls
- Improving dementia awareness, referral and support of the carers.
- Improving process of Venous thromboembolic assessment

Locally Agreed

- Improving patient pathways within the emergency department
- Improving the management and dispensing of drugs
- Reviewing patient experience - walking in their shoes
- Prevention - providing advice, signposting and referral for smokers and people with alcohol issues
- Improving discharge advice for patients with Chronic Obstructive Pulmonary Disease
- Providing an improved integrated approach to patient care

NHS England

Neo-natal Intensive Care (NICU)

- Improvement in volume of mothers opting for breastfeed on discharge
- Improvement of proportion of pre-term babies who start total parental nutrition by day 2 of life

| CQUIN scheme priorities 2013/2014 | Objective Rationale |
|---|---|
| Friends and Family | A way of gauging how likely patients are to recommend the Trust to their loved ones. This will provide valuable feedback on the overall experience patients have of their care. |
| NHS Safety Thermometer | Participation in data collection is an important preparatory step for providers reducing harm in areas of concern highlighted nationally by establishing national baselines of performance. This will allow the establishment of quality improvement aims for future years. |
| VTE | Venous thrombo embolism (VTE) is a significant cause |

| | |
|---|---|
| | of mortality, long term disability and chronic ill health. |
| Dementia Screening | 25% of beds in the NHS are occupied by people with dementia. Their length of stay is longer than people without dementia and they often receive suboptimal care. Half of those admitted have never been diagnosed prior to admission and referral out to appropriate specialist community services is often poor. Improvement in assessment and referral will give significant improvements in the quality of care and substantial savings. |
| Chronic obstructive pulmonary disease (COPD) discharge bundle | Use of the bundle has been proven to improve the care of patients admitted to hospital with an exacerbation of COPD, improve their understanding of the disease, reduce future reliance on secondary care and reduce chances of further admissions |
| Integrated Care | Frail older people are a significant population in terms of numbers and hospital activity. Identification and assessment of frail older people, sharing information with primary care and participation in MDT case conferences will help in reducing expensive hospital admissions amongst this cohort of patients. |
| Prevention – Smoking | Helping patients to stop smoking is among the most effective and cost-effective of all interventions the NHS can offer. Simple advice from a clinician during routine patient contact can have a small but significant effect on smoking cessation. |
| Prevention - Alcohol Screening | Alcohol-related problems represent a significant share of potentially preventable attendances to emergency departments and urgent care centres. Screening for alcohol risk has been shown to reduce subsequent attendances and alcohol consumption. |
| Ambulatory Care | AEC is an approach which results in a significant proportion of emergency adult patients being managed safely and efficiently on the same day avoiding admission to a hospital bed. |
| Medicine Management | Aimed at improving patients' knowledge about their medicines, how to take them and any side effects that they may experience. |
| Patient Experience | The 15 Steps Challenge is a series of toolkits. They have been co-produced with patients, service users, carers, relatives, volunteers, staff, governors and senior leaders, to help look at care in a variety of settings through the eyes of patients and service users, to help capture what good quality care looks, sounds and feels like. |
| Making Every Contact Count (MECC) | Working with staff and patients to reduce risks and improve health in relation to smoking. |

**Statement five** Care Quality Commission statement of assurance

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is fully compliant.

The Care Quality Commission has not taken enforcement action against the Trust during 2013/14.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Additional information

Between 1 April 2013 and 31 March 2014 the Trust had four inspections.

The first was in November 2013 and looked at the birth unit and maxillofacial outpatients in Edgware Community Hospital. The Trust met five essential standards and no action was needed.

The second inspection was at Barnet Hospital's new Maternity Unit in December 2013. Four standards were met and no action was required.

The third inspection was at Chase Farm Hospital, also in December 2013. 10 standards were inspected, of which three specifically related to a thematic review of the quality of care provided to support people living with dementia. The Trust met nine of the standards; the one that was missed was cleanliness and infection control and only required action by theatres to address the issue. Following this announcement in the report, the Trust declared it had an externally-shared action plan in place that was being monitored at a CQC compliance group and reported to at a Quality and Safety Committee. The Trust now believes it is fully compliant and has so advised the CQC requesting a further inspection.

The fourth inspection was at Barnet Hospital in January 2014. It looked at six essential standards of which five were met. Action was needed on the sixth standard which related to medical records; the Trust developed action plans to improve this and has shared them with the CQC, from whom we are awaiting further feedback.

**Statement six** Data quality

**Standards for Data Quality are monitored by a host of external bodies including Monitor, the CQC (Care Quality Commission), DoH (via the Information Governance Toolkit) and our Commissioners. Regular analysis of key quality indicators benchmarked against national comparisons and/or improvement over time also help to identify priorities for improvement.**

During the course of 2013/14 the Data Quality team were involved in the following:

- responding to over 98% of helpdesk calls on the same day
- assisting the clinical coding team to achieve 100% coding of diagnosis and treatment thereby improving both clinical care & financial reimbursement
- running data quality awareness sessions for staff to ensure high standards are met and maintained.
- monitoring standards, both internal and external, reporting progress against targets and providing project plans and guidelines for improvement.

Barnet and Chase Farm Hospitals NHS Trust submitted records during 2013/14 (April-December) to the Secondary Uses Service (SUS) for inclusion in the hospital episodes statistics, which are included in the latest published data.

**The percentage of records in the published data which included the patient's valid NHS Number was (London average in brackets):**

**2013/14**
98.4% for admitted patient care (97.3%)
98.9% for outpatient care (98.1%)
91.9% for Accident and Emergency care (89.8%)

**The percentage of records in the published data which included the patient's valid General Medical Practice Code was (London average in brackets):**

**2013/14**
99.9% for admitted patient care (99.7%)
99.8% for outpatient care (99.8%)
99.8% for Accident and Emergency care (99.4%)

**Statement seven** Information Governance Toolkit attainment levels

The Trust's 'information governance assessment report score' overall score for 2012/13 was 95% and was graded green.

Additional information

Information governance is the process that ensures we have necessary safeguards in place for the use of patient and personal information, as directed by the Department of Health and set out within national standards. The trust's overall score was satisfactory, meaning that a level two or above was achieved for all 45 requirements.

**Statement eight** Payment by Results clinical coding audit

The Payment by Results (PbR) Data Assurance Framework supports the improvement of data quality which underpins payments and financial flows within the NHS. The assurance framework is carried out on behalf of the Department of Health (DH) and is a key component of the PbR system.

This year Barnet and Chase Farm Hospitals NHS Trust has not been selected for the Payment by Results Data Assurance Framework

Following the 2012-13 Payment by Results Data Assurance Framework audit, the Coding Department has taken major steps to improve the Trust's coding.

To improve data quality, coders have received Coding Refresher and Specialty Workshop training, provided by the London Clinical Coding Academy. Monthly coded data review audits and individual coder audits are also undertaken, with regular feedback given to coding team and individual coder on any errors identified.

Additional information

Clinical coding is the process by which medical terminology written by clinicians to describe a patient's diagnosis, treatment and management is translated into standard, recognised codes in a computer system. It is important to note that the clinical coding error rate refers to the accuracy of this process of translation, and does not mean that the patient's diagnosis or treatment was incorrect in the medical record. Furthermore, in the definition to determine the clinical coding error rate, 'incorrect' most commonly means that a condition or treatment was not coded as specifically as it could have been, rather than there was an error.

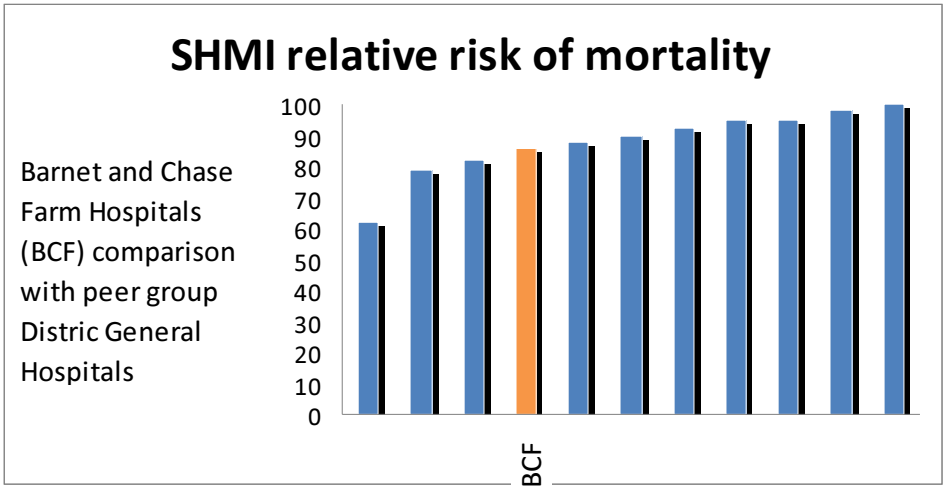
Data quality is monitored by the Hospital Management Board which receives a quarterly report containing progress against Key Performance Indictors.

**Our quality performance indicators**

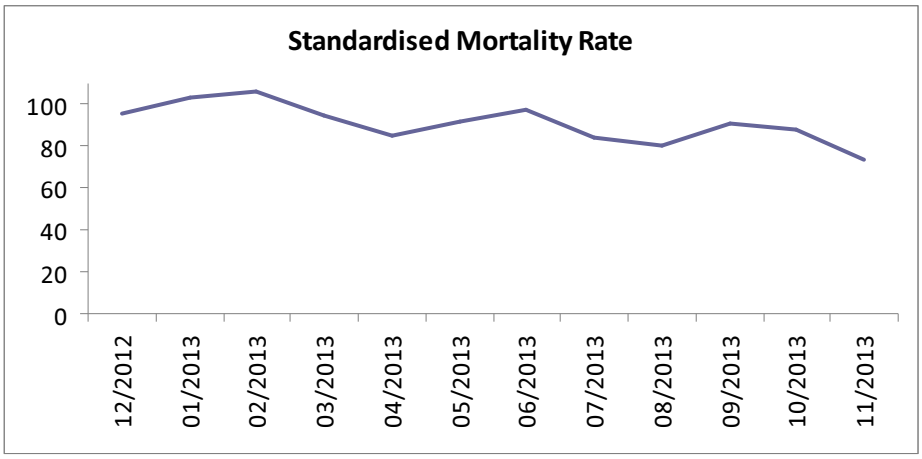
An overview of the quality of care based on performance in 2013/14 against key national indicator priorities is detailed within our annual report.

This section contains an overview of quality of care offered by the Trust based on performance in 2013/14 against indicators selected by the Board in consultation with stakeholders. They cover the three dimensions of quality:

- patient safety
- clinical effectiveness
- patient experience.

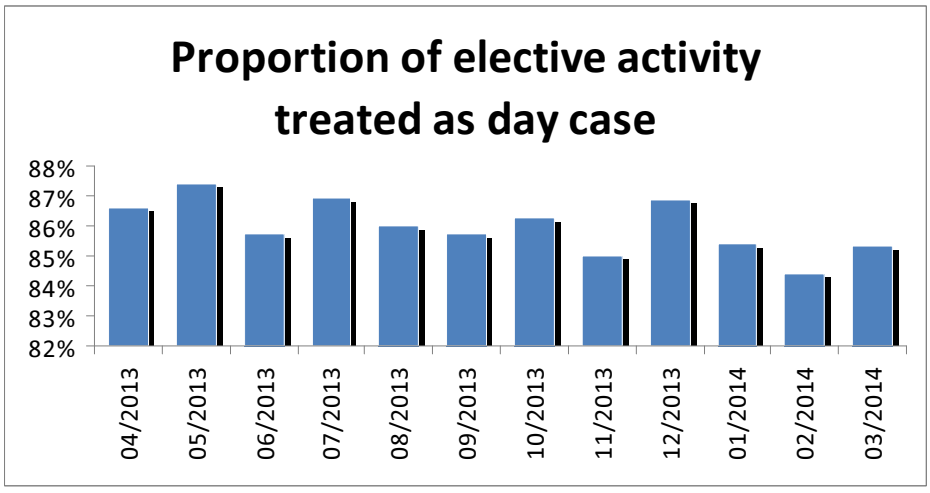



Safety



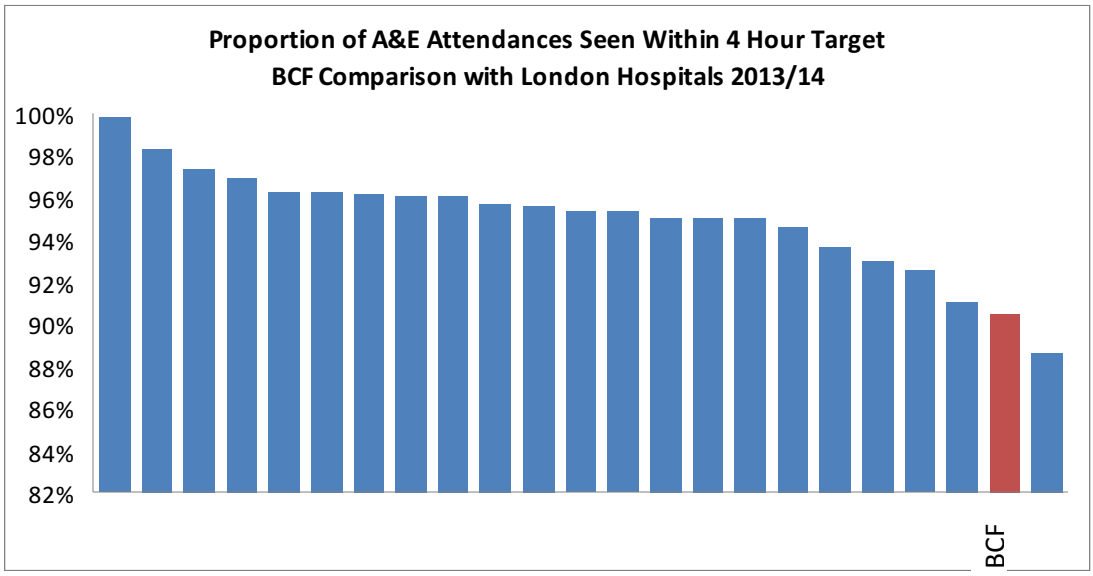

Safety

The Trust has a MSMR of 80 which compares very favourably with the rest of London and the UK (13th best in the country). This is a measure of the likelihood of dying in the organisation where 100 is the national average. A figure lower than 100 indicates a lower than average result.




Effectiveness

This represents the Trust's ongoing improvement with its day surgery processes.

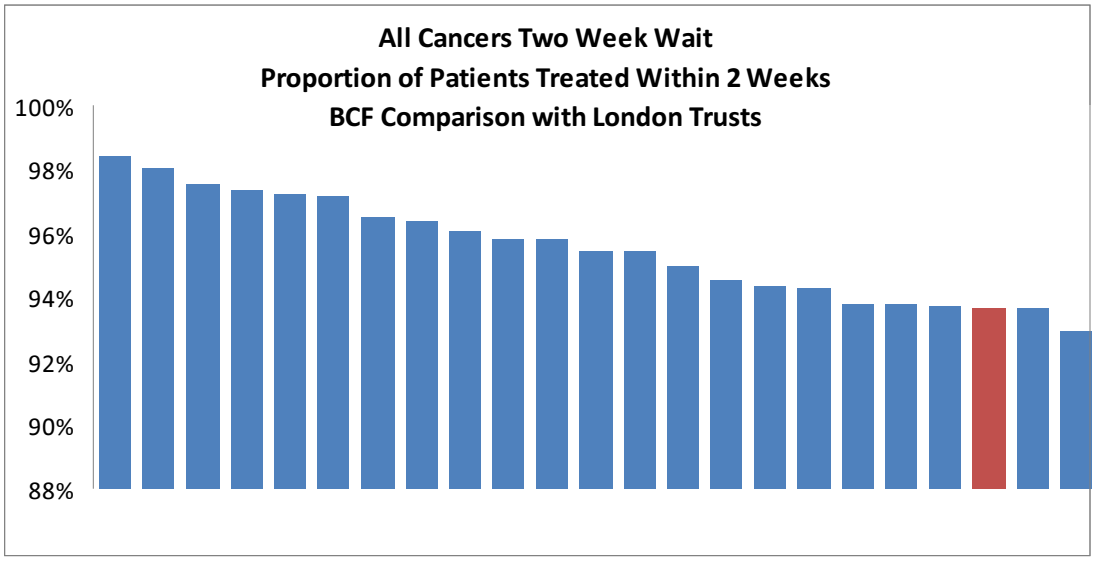


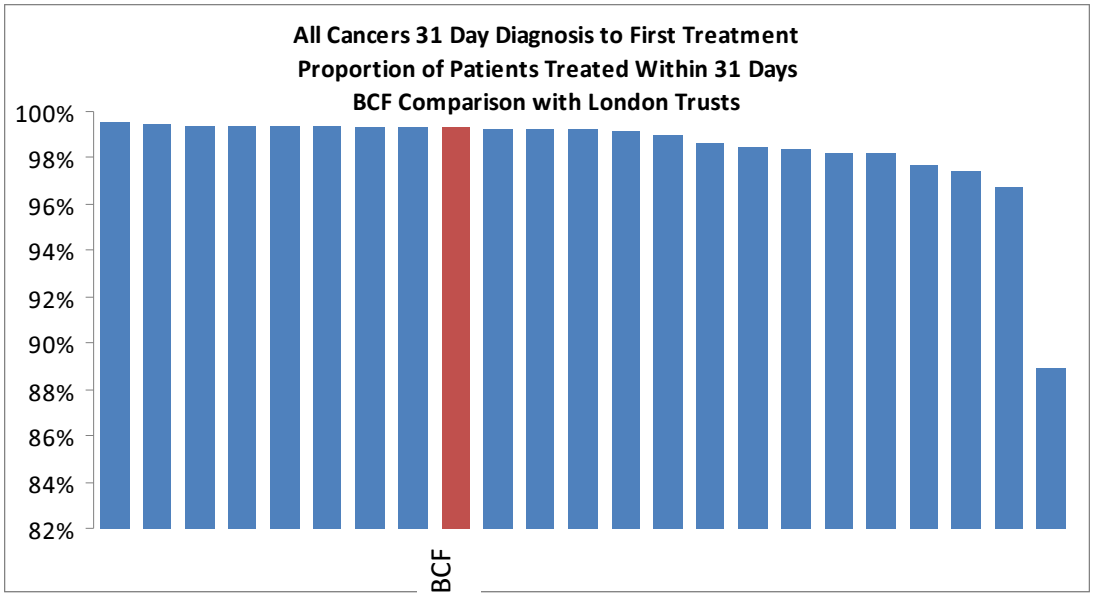

The Emergency department is often the patient's point of arrival, especially in an emergency when patients are in need of urgent treatment.

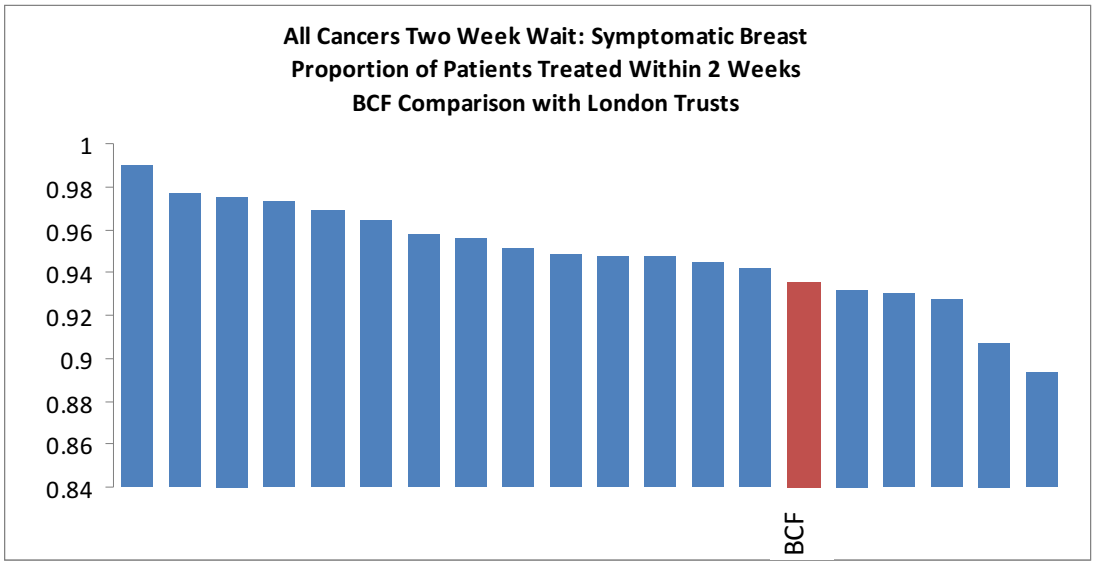
Historically, patients often had to wait a long time from arrival in A&E to be assessed and treated.

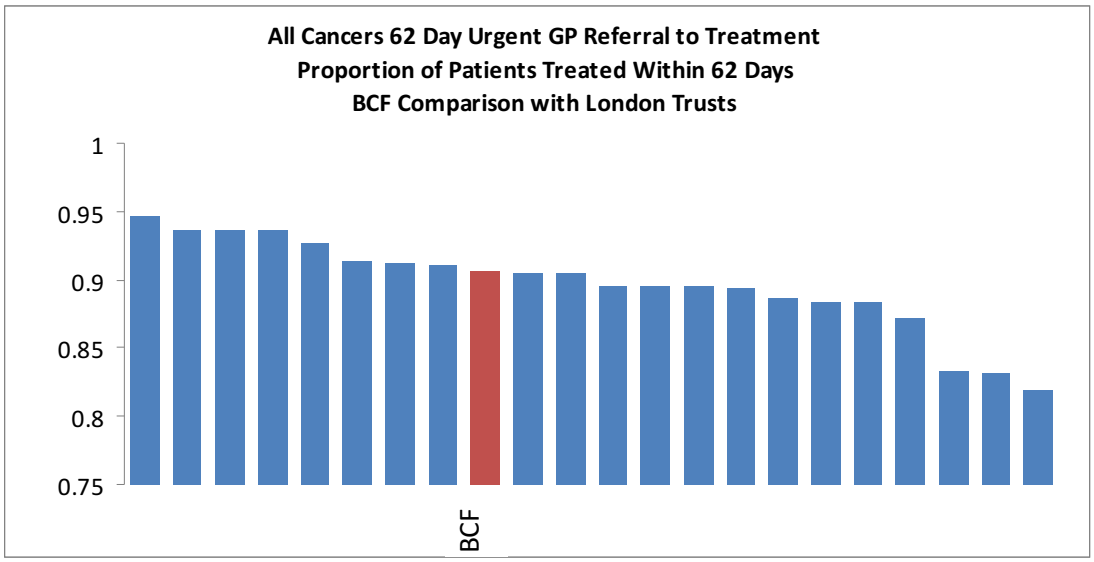
The graph summarises Barnet and Chase Farm Hospitals NHS Trust performance in relation to meeting the four hour maximum wait time standard compared to the performance of London Hospitals. The performance for 2013/14 was 90.4%..

The Trust has experienced significant difficulties in maintaining the 4 hour target during the process of BEH transition. However the Trust has seen this as important target and in the last month has been maintaining compliance with the national standard of 95% or more.




All Cancers 31 Day Diagnosis to First Treatment
Proportion of Patients Treated Within 31 Days
BCF Comparison with London Trusts
100%
98%
96%
94%
92%
90%
88%
86%
84%
82%
BCF


All Cancers Two Week Wait: Symptomatic Breast
Proportion of Patients Treated Within 2 Weeks
BCF Comparison with London Trusts
1
0.98
0.96
0.94
0.92
0.9
0.88
0.86
0.84
BCF


All Cancers 62 Day Urgent GP Referral to Treatment
Proportion of Patients Treated Within 62 Days
BCF Comparison with London Trusts
1
0.95
0.9
0.85
0.8
0.75
BCF

Clinical evidence demonstrates that the sooner patients urgently referred with cancer symptoms are assessed, diagnosed and treated, the better the clinical outcomes and survival rates.

National targets require 93% of patients urgently referred by their GP to be seen within two weeks, 96% of patients to be receiving first treatment within 31 days of the decision to treat and 85% of patients to be receiving first definitive treatment within 62 days of referral.

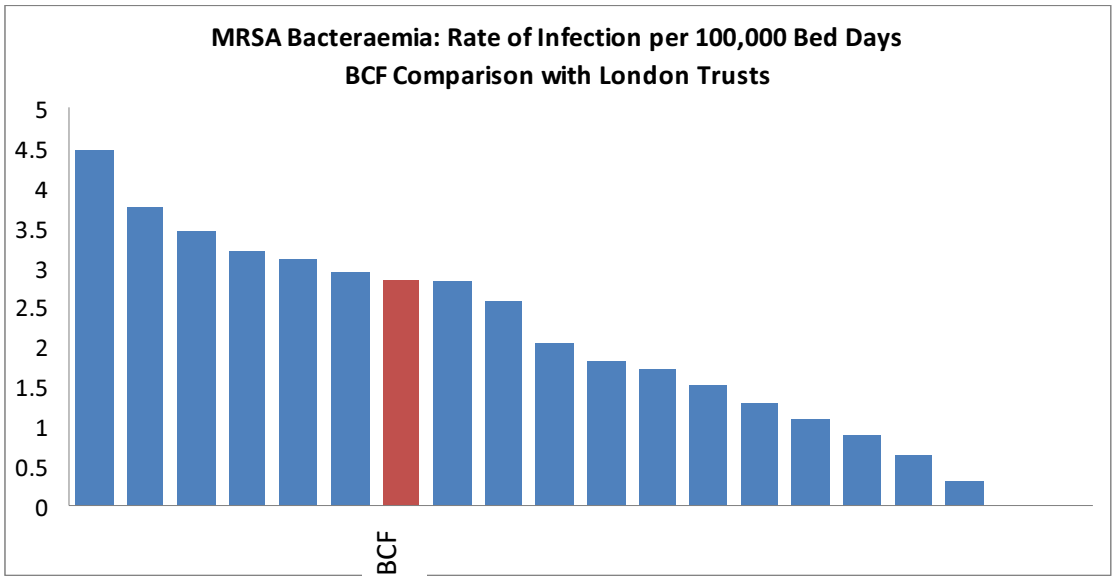
For the period for which national data is available April-December 2013, BCF performed better than the national targets.

From April-December 2013 for All Cancers Two Week Wait BCF achieved 93.7% passing the National Target and were third lowest performance Trust in London.

From April-December 2013 for All Cancers 31 Day Diagnosis to First Treatment BCF achieved 99.3% passing the National Target and were ranked 9th Trust in London.

From April-December 2013 for All Cancers 62 Day BCF achieved 91% passing the National Target and were ranked 9th Trust in London.

From April-December 2013 for All Cancers 2 Week Wait Symptomatic Breast BCF achieved 94% passing the National Target and were ranked 15th Trust in London.

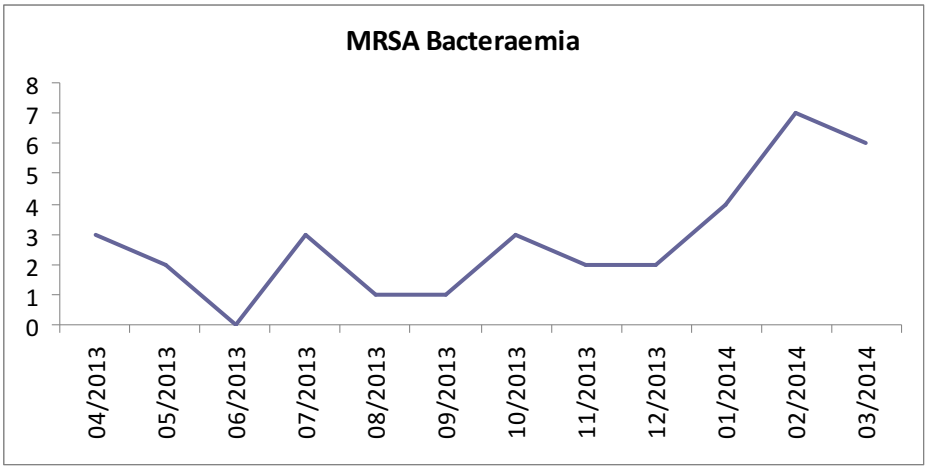



MRSA is an antibiotic resistant infection associated with admissions to hospital. The infection can cause an acute illness particularly when a patient's immune system may be compromised due to an underlying illness.

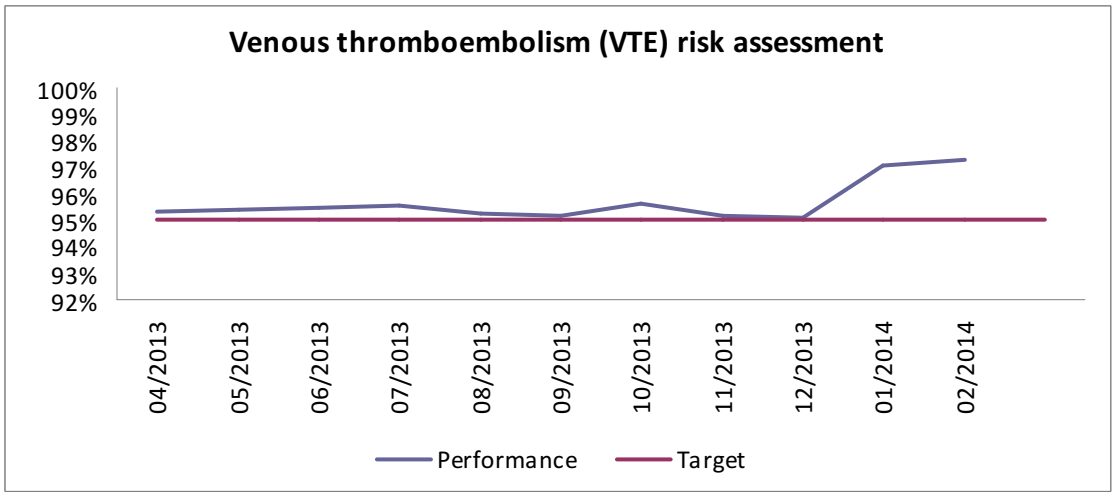
Reducing the rate of MRSA infections is a key government target. The infection rate is seen as an indicator of the degree to which hospitals prevent the risk of

infection by ensuring their facilities are clean and their staff comply with infection control procedures.

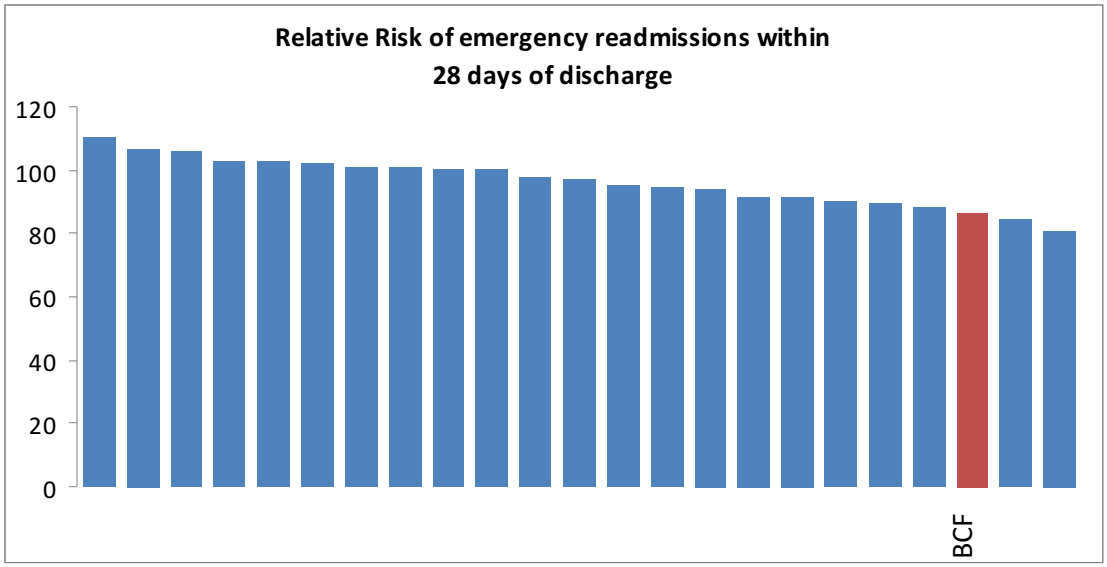
During 2013/14 BCF had 6 cases attributed to MRSA with a 2.8 Rate per 100,000 bed days.




This graph shows that we failed to meet our target of zero MRSA infections in 2013/14. There were actually six cases, of which four were directly affected by their treatment here.



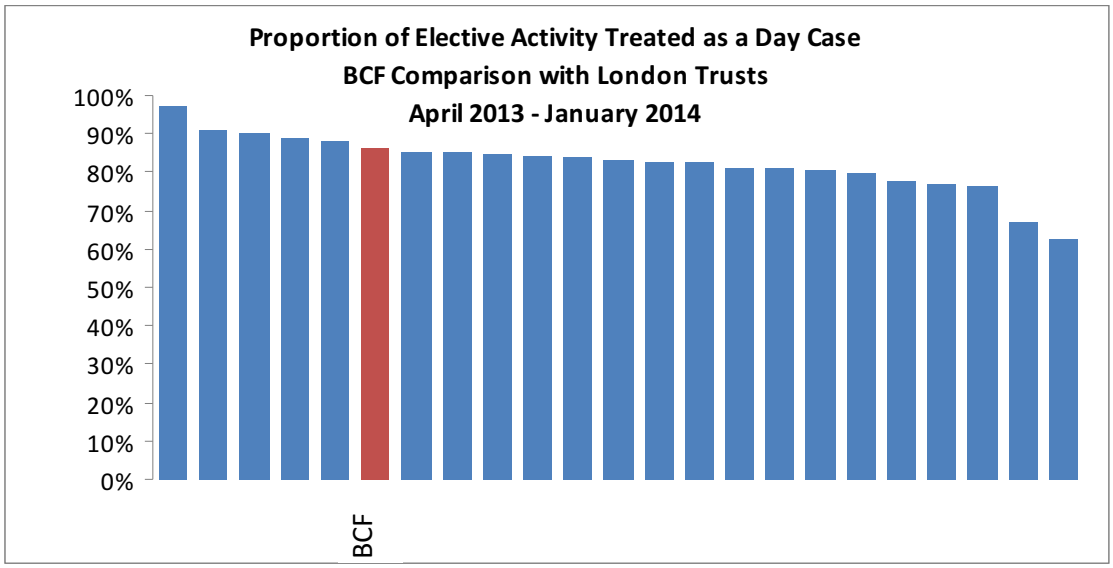

Many deaths in hospital result each year from hospital acquired thromboembolism (HAT). Some of these deaths could be prevented. The government has therefore set hospitals a target requiring 95% of patients to be assessed in relation to this risk. BCF met or performed better than the target for 2013/14.



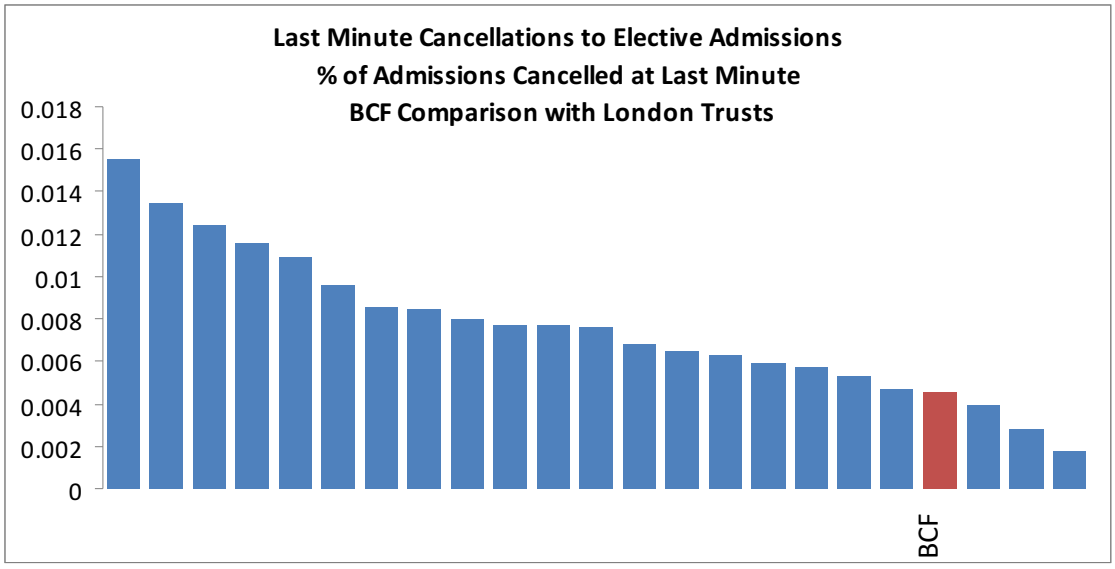

We carefully monitor the rate of emergency re-admissions as a measure of the quality of care and the appropriateness of discharge.

A low, or reducing, rate of re-admissions is seen as evidence of good quality care.

The chart presents the relative risk of readmission in which BCF has a rate of 86.7 which is within expected levels. Compared to other London Trusts we have a lower relative risk. This chart demonstrates that, during the BEH Clinical Strategy implementation period, the Trust had a relatively low risk of readmission as compared to its peer organisations.

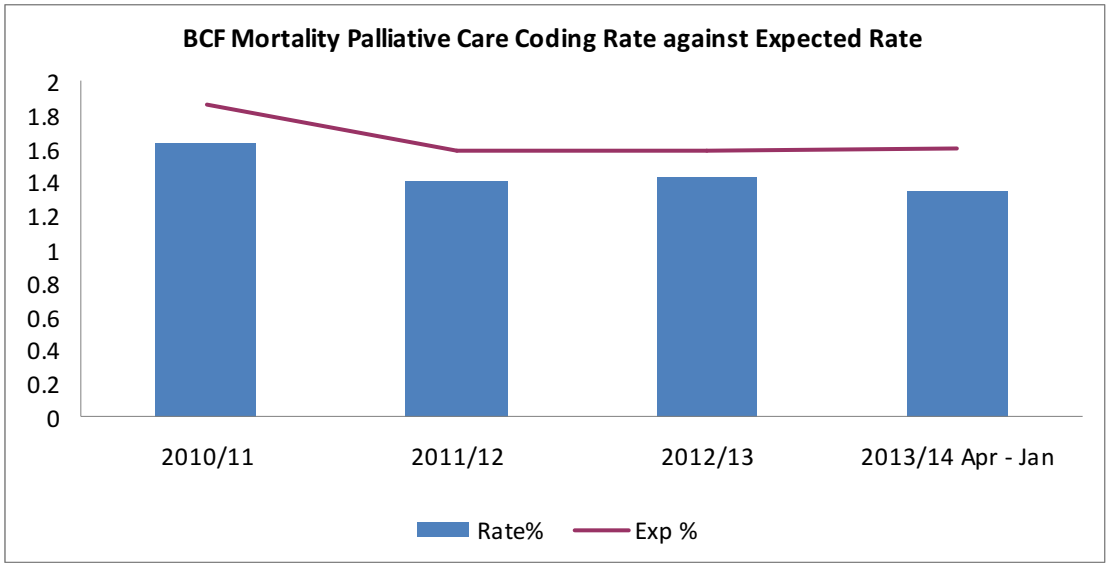



Day cases are procedures that allow you to come to hospital, have your treatment and go home, all on the same day. A high day case rate is seen as good practice both from a patients perspective and in terms of efficient use of resources.



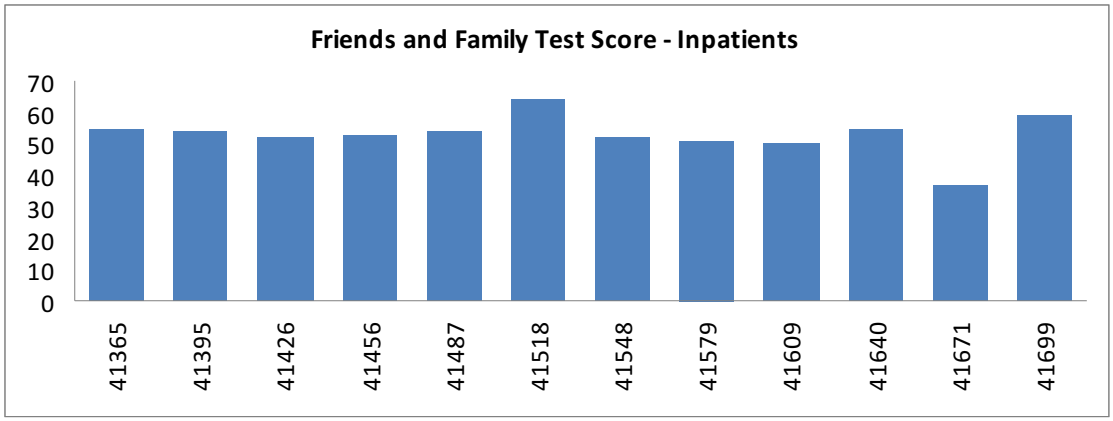

Cancelling operations on the day of, or following admission, is extremely upsetting for patients and results in longer waiting times for treatment.

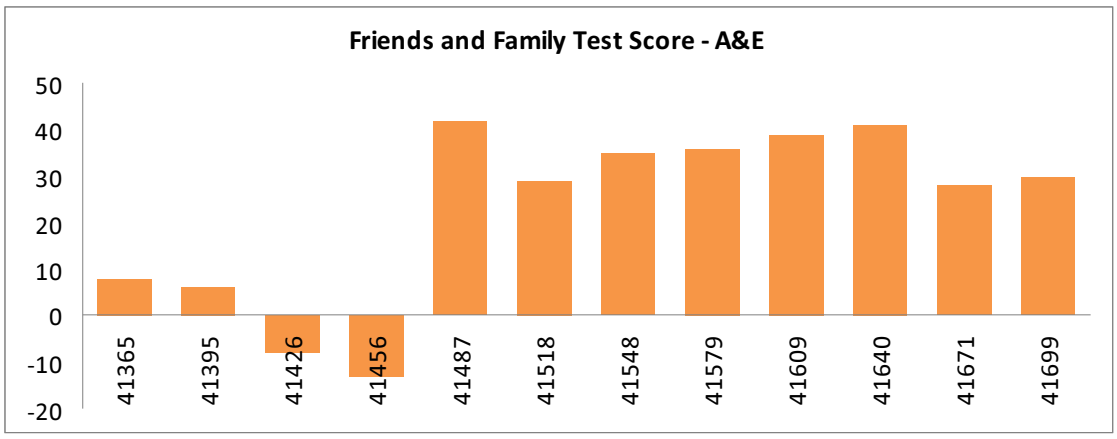
In the period April-December 2013 BCF had the 4th lowest rate when compared to London Hospitals.




This graph displays the yearly mortality rate for palliative care for the Trust over a 4 year period. This is a percentage of deaths in the Trust that are coded as having been seen by the Palliative care team.

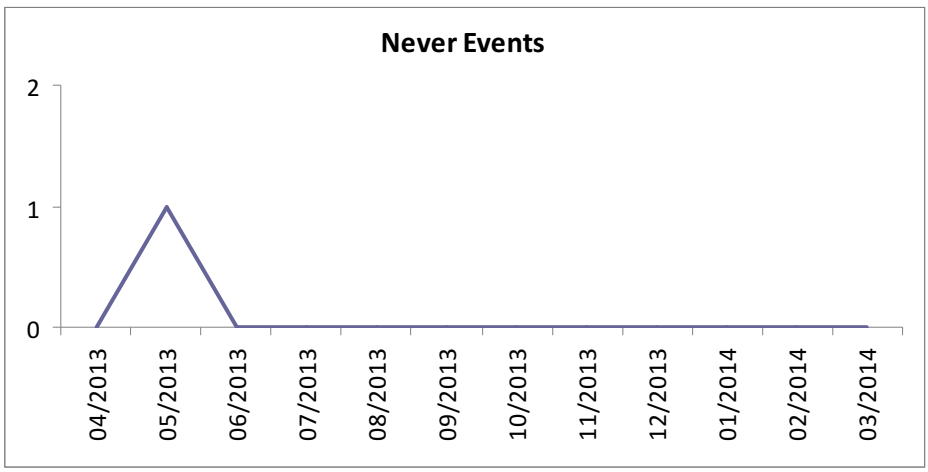
The graph shows the BCF performance rate against what the expected rate. BCF have consistently been below this.




The friends and family test (FFT) was introduced in April 2012. Its purpose is to improve patient experience of care and identify the best performing hospitals in England.

FFT aims to provide a simple, headline metric which, when combined with follow up questions, can be used to drive cultural change and continuous improvements in the quality of care received by NHS patients.




The Trust has fully investigated the never event and shared learning both within the organisation and externally to other parties.

## Focus on Quality and Improvement

### Barnet Enfield and Haringey (BEH) Clinical Strategy

The Barnet Enfield and Haringey Clinical Strategy became a reality in November and December 2013, as first Maternity and then Emergency services were moved from Chase Farm Hospital into expanded facilities at Barnet Hospital and at North Middlesex University Hospital. This long planned focusing of these services in North London at two sites rather than three was driven by a need to increase clinical effectiveness. Patients now benefit from improved Consultant cover across a full range of services and it is expected that improved outcomes will accrue.

The emergency medical and surgical services now benefit from significantly higher levels of Consultant input - allowing improvement in both clinical services to patients and training. However, emergency work flows have been significantly higher at Barnet than pre-BEH modelling predicted. The Trust is actively implementing new models of working, e.g. Post Acute Care Enablement (PACE), Triage and Rapid Elderly Assessment Treatment (TREAT) and Rapid Assessment Intervention and Decision (RAID) and is working with its community partners to ensure the best possible processes for patient care.

### I can, You can, We can make a difference with hand hygiene

A new hand hygiene campaign - 'I Can, You Can, We Can, make a difference for patients' - was launched in 2013/14 to inspire the fight against healthcare associated infections (HCAIs). It features a series of visually striking banners and posters that can be seen throughout all our hospital sites, together with a number of hand washing-themed pictures drawn by younger patients at the Trust.

The campaign also includes a music video based on Gangnam Style, 'Use This Handwash Style!'. The video features over 300 members of staff cleaning their hands to a specially-amended version of the song.

The video proved popular across the world attracting over 20,000 hits on You Tube.

### GUM patients benefit from new text messaging service

The Clare Simpson Clinic - the Trust's Genito Urinary Medicine (GUM) service - provides free, confidential advice and treatment of sexually transmitted infection (including HIV). Although they welcome referrals from GPs, this is an open access service; patients do not need to be referred.

In 2013/14 they introduced a text based booking system within the morning clinics and appointments are available at other times throughout the week at Barnet Hospital.

Reserving a time slot is a hassle free way for patients to see our sexual health team within their morning clinics, men's clinic and young persons clinic at Barnet. Time slots are limited and fill up quickly, if there are no spaces available patients are put onto a 'Wait list'. If a space then becomes available they receive a text and will have 10 minutes to respond to it. If they are texting outside of the reserving a time slot opening hours they may be asked to repeat their request for a slot the next day.

Texts are charged at the standard mobile network rate for sending them, but it's free to receive texts from the clinic. Reserving a time slot is open from 7pm the night before a clinic.

The Clare Simpson Clinic also runs a service in Edgware Community Hospital, where they phased out walk-in clinics and replaced them with the texting service in April.

**New infusion suite opens at Finchley Memorial Hospital**

Cancer patients are benefiting from a brand new infusion suite which is bringing care closer to their homes.

The nurse-led service at Finchley Memorial Hospital (FMH) is a joint project between the Trust and Royal Free London NHS Foundation Trust. Some cancer patients can receive chemotherapy infusions and supportive treatments in the purpose-designed unit instead of having to travel to the Royal Free, Barnet Hospital or Chase Farm Hospital.

All patients will continue to start their treatment at the Royal Free, Barnet or Chase Farm hospitals but, where clinically appropriate, and patients are offered the choice of continuing their treatment at FMH if this is more convenient for them. Patients also continue to have regular appointments with their oncologist or haematologist at Barnet, Chase Farm or Royal Free hospitals.

More than 1,300 infusions every year are expected to be conducted at the unit, which is open 9am-5pm, Monday-Friday.

**Reflections Rounds: 'Caring for the caregivers' and 'Compassion in care'**

The Trust embarked on a new series of staff sessions in 2013/14 that will bring employees together to share experiences on how they can deal with the personal pressures of providing better patient care.

Reflections Rounds are monthly 1 hour meetings that are open to staff members of every profession and grade within the Trust. The round can consist of one to four cases for reflection about patient and staff experience.

The first session was attended by over 150 members of staff with many spontaneous workshops afterwards. It was an introduction of things to come and an explanation of how it would benefit attendees, who were encouraged to share information via an online group and think of cases that they could bring

back to future sessions. Feedback after the event was overwhelmingly positive, with most attendees saying that they plan to come again.

*Developing our culture of compassionate care*

Over 100 members of staff came together for a workshop in July that looked at developing a culture of compassionate care within the Trust. With compassion defined at the start of the workshop as a “deep awareness of the suffering of another coupled with the wish to relieve it”, staff looked at the Mid Staffordshire report and asked whether similar incidents could have taken place at Barnet and Chase Farm Hospitals. Using anonymous real patient stories and working in multidisciplinary groups, staff explored what compassion meant to them, why this sometimes went wrong and the next steps that were needed to ensure compassion was evident at all times.

The workshop was led by a member of PRAG - the Patient, Relatives and Advisory Group. The workshop output will be reported through to the Trust Board via the Patient Experience Strategy Group. Anyone who would like to be involved in the group should contact Terina Riches, Director of Nursing.

The event was described as productive and useful by those who attended and further, similar workshops are now being planned.

**Transanal Endoscopic Microsurgery (TEMS)**

The Trust’s Minimally Invasive Surgical Unit was chosen to be a Tertiary Referral Unit for the provision of Transanal Endoscopic Microsurgery (TEMS) in 2013/14. This is a minimally invasive technique which involves using a special operating scope with magnified views to remove rectal tumours that cannot be dealt with using colonoscopic (endoscopy) or other local excision methods.

Previously, Trust patients who were deemed suitable for TEMS were sent to Oxford or Central London, which was very inconvenient for them. In 2008 two of the Trust’s Consultant Colorectal Surgeons decided to provide the service at the Trust. They underwent appropriate training and mentoring. The specialised equipment required was purchased using charitable funds from the League of Friends and now both surgeons undertake the procedure independently. They have now undertaken 26 cases with six patients with early rectal cancer. There have been very few complications and no deaths. All patients are discussed at a special MDT (multi disciplinary team) meeting and are seen in the outpatient clinic prior to any procedure to meet the surgeon and our Clinical Nurse Specialists.

This is a major achievement and means that other hospitals such as University College London Hospital, North Middlesex Hospital, Royal Free Hospital, Whittington Hospital and Princess Alexandra Hospital can send suitable patients to the Trust for consideration for TEMS.

This will considerably raise the profile of the Trust's Minimally Invasive Surgical Unit both regionally and nationally, but more importantly provide a specialist service to our patients locally and close to home.

**Home for Lunch and Green Friday**

Home for Lunch is a new initiative at Chase Farm Hospital that brings huge convenience to patients both when they come into hospital and also when they leave. It involves a drive to discharge patients, where possible, on the morning of their last day in hospital rather than in the afternoon.

Discharging current patients in the morning will also be more convenient to patients who've just arrived at hospital. With more beds available earlier in the day, those in A&E can be admitted sooner onto the wards, drastically reducing their waiting times and improves the patient experience. The new processes may also be expanded into Barnet Hospital.

The aim of Green Friday (at Barnet Hospital only) is to identify potential discharges for the weekend to support and increase the number of patients who are medically fit for discharge at weekends.

Ward teams complete a Green Friday discharge form if they think a patient is nearly ready for discharge, this will then enable the Multi Disciplinary Team (MDT) to discharge patients within set guidelines.

**Improving the pace of treatment**

Important projects that have started at our Trust include Triage and Rapid Elderly Assessment Treatment (TREAT) and Post Acute Care Enablement (PACE).

TREAT is a multi-disciplinary team based in the new Acute Assessment Unit at Barnet Hospital's Emergency Department. They provide rapid assessment with admission avoidance for patients aged over 80, allowing patients to return home without the need for a hospital admission.

The desired outcome for this work is both admission avoidance and prevention of re-attendance to the Emergency Department by ensuring that the best care for elderly patients is provided in the most suitable care setting.

The multi-disciplinary team will include Care of the Elderly Consultants, junior doctors, occupational therapists and specialist nurses who will review elderly patients and where necessary provide further assessment via follow up (in hospital outpatient clinics). A clinical management plan will be developed, redirecting the patient into pathways in the community.

PACE provides early supported discharge for patients who are not yet medically fit but are able to finish their current care in their own home. The desired outcome is to reduce length of stay and improve patient flow across the system by providing clinically safe care in a more pleasant surrounding.

A case-finder from Central London Community Healthcare, based at Barnet Hospital, works with medical teams to 'pull' patients from secondary care into community services to be cared for at home. PACE will also work closely with the TREAT service.

**Accreditation for the Sterile Services Department**

Since March 2007 all Trusts have been required to plan towards gaining accreditation for their SSD based on standards that relates specifically to medical products, process controls and quality. This requirement has been on the Trust's risk register and is seen as a key milestone objective to the development of the Sterile Services Department and the service it provides to theatres and users.

Following the conclusion of a recent independent audit, Barnet and Chase Farm SSD has been awarded accreditation.

The Sterile Services Department can now not only supply our own Trust, but also any other organisation with products within their scope. This is a significant achievement considering where the unit has come from. The staff have had to take on and implement new working practices, changing the way they have been doing things for a long time to ensure that they comply with the new regulations. The staff have been flexible and adapted very well. They have embraced the changes, understanding the significance and enhancements that this brings to the department.

**Chase Farm Macmillan Information Centre**

Following on from the success of the Barnet Macmillan Cancer Information and Support Centre, Chase Farm Hospital now also benefits from the new appointment of a second Macmillan Information Specialist (MIS). The service offers good quality and appropriate information on all aspects of living with and beyond cancer, including practical, emotional and financial advice.

The MIS attends clinics, meeting and supporting patients and carers who require additional support or who are in need of a listening ear. Patients or carers who don't get to meet the MIS in clinics can call to discuss issues over the phone or arrange to meet for a quiet and informal chat. The MIS also offers information on local and national support centres and organisations for both patients and carers.

Plans for a permanent Macmillan Information and Support Centre with a 'drop in' facility are in progress as part of the new hospital development plans. In the interim, there will be information displays providing booklets and resources at locations around the hospital.

**Stop and Help**

‘Stop and Help’ is a new Trust initiative encouraging staff to stop and help a visitor who looks lost on our premises. This work is bolstered by the Trust’s Behaviour Standards:

• Greet everyone in a friendly manner, including patients and visitors
• Introduce yourself by name and role
• Wear an identification badge that is visible to the public at all times and dress appropriately at all times
• Treat everyone courteously with respect and dignity
• Speak clearly at all times, without haste or impatience
• Listen actively, don’t interrupt or presume you know what people are going to say.

Appendices

APPENDIX A

The views of our patients, local community, governors and staff are essential in helping us maintain and develop high quality clinical services. We carried out a series of exercises to ensure we engaged our various stakeholders and partners as much as possible in developing this quality report.

We sent this year's draft quality report to the following organisations for comment on XX/XX/2014:

- Healthwatch Barnet
- Healthwatch Enfield
- Barnet Health Overview and Scrutiny Committee
- Enfield Health Overview and Scrutiny Committee
- North and East London Commissioning Support Unit
- Barnet Clinical Commissioning Group
- Enfield Clinical Commissioning Group
- Hertfordshire Clinical Commissioning Group

Our external auditor, Grant Thornton, also reviewed our quality report and we have incorporated its preliminary comments into the final version.

The following statements have been received from our stakeholders.

**Statements from clinical commissioning boards and overview and scrutiny committees**

*(insert replies from the following organisations)*

- Healthwatch Barnet
- Healthwatch Enfield
- Barnet Health Overview and Scrutiny Committee
- Enfield Health Overview and Scrutiny Committee
- North and East London Commissioning Support Unit
- Barnet Clinical Commissioning Group
- Enfield Clinical Commissioning Group
- Hertfordshire Clinical Commissioning Group

APPENDIX B

**Response to comments** (for future drafts)

In response to comments received from xxx we have outlined our responses in the following table.

APPENDIX C

**Statement of directors' responsibilities in respect of the quality report**

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare quality accounts for each financial year.

The content of the quality report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2013 to June 2014
- Papers relating to quality reported to the board over the period April 2013 to June 2014
- Feedback from commissioners dated [*XX/XX/2014*]
- Feedback from local Healthwatch organisations dated [*XX/XX/2014*]
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated [*XX/XX/20XX*]
- The latest national patient survey [*XX/XX/20XX*]
- The latest national staff survey [*XX/XX/20XX*]
- The head of internal audit's annual opinion over the trust's control environment dated [*XX/XX/20XX*]
- CQC quality and risk profiles dated [*XX/XX/20XX*].

The quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;

The performance information in the quality report is reliable and accurate;

There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;

The data underpinning the measures of performance in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

The quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board

*(NB: sign and date in any colour ink except black)*

*Insert signature*

**Baroness Wall of New Barnet**
Chairman
Date.....

*Insert signature*

**Dr Tim Peachey**
Chief Executive
Date.....

APPENDIX D

**Independent auditor's limited assurance report to the Trust Board of Barnet and Chase Farm Hospitals NHS Trust on the annual quality report**

The Board reviewed structures in light of the Keogh, Francis and Berwick reports to allow increased opportunity for appropriate debate and discussion of the many governing issues taking place in NHS organisations. The Trust Board created a number of committees (Quality and Safety and finance) chaired by Non-Executive Directors where detailed discussions take place on quality and safety.

These committees report directly to the main Trust Board. Furthermore the Trust has created a Quality Improvement Board - chaired by the Chief Operating Officer and attended by senior clinician representatives from each directorate reporting to the Trust Board at each Trust Board meeting. The directors in turn present their Key Performance Indicators (KPIs) in relation to infection control, read and discuss a complaint and compliment.

The Board reviews the KPIs of the Trust across all areas at each Board meeting as well as detailed discussion around issues such as the national patients' survey.

The Executive and Non Executives of the Trust Board undertake regular workarounds of the clinical areas. The Board also regularly undertakes a process of the nationally prescribed 15 step challenge which is aimed at ensuring the Board are well organised and demonstrate focus and patient centred.

The Trust seeks and encourages feedback from patients and families using its services, both via the standardised Friends and Family Test and also Patient Feedback Trackers.

The Trust has a requirement for all members of its staff to undergo a documented annual appraisal and in the case of medical staff an enhanced appraisal reflecting the requirements of the GMC. This has allowed the organisation to proceed through the new medical revalidation process of the GMC.

As a consequence of the BEH Clinical Strategy the Trust has been able to produce a 7/7 Consultant dedicated emergency, medical and surgical service and can now meet the staff requirements laid down by NHS London, with the exception of a few areas which can only be met by cooperation with external partners.

| | |
|---|---|
| Title: | **Quality Account 2013-2014 Draft** |
| Report to: | Stakeholders and Trust Board |
| Date: | April 2014 |
| Security Classification: | |
| Purpose: To summarise the Trust's current position with regards to Quality indicators for the 2013-14 Quality Account | |
| Sponsor: | Mary Sexton, Executive Director of Nursing, Quality and Governance |
| Author: | Clara Wessinger, Head of Clinical Audit and Effectiveness<br>Maria Green, Senior Quality Administrator |
| Report History | First Report |
| Budgetary, Financial/Resource Implications: | Resource and financial implications for implementation of quality improvement are assessed by service lines |
| Equality & Diversity Implications: | None |
| Trust Objectives & Risk Implications – link to Board Assurance Framework and/or Corporate Risk Register: | Links to all Trust core strategic objectives. Financial implications related to CQUIN payment for associated quality targets. |
| Action required: | To provide feedback and suggestions for development of the final quality account |

# TABLE OF CONTENTS

# Barnet Enfield and Haringey Quality Account
# 2013 – 2014
# Introduction from Maria Kane, Chief Executive

The Quality Account is a summary of the way in which Barnet Enfield and Haringey Mental Health NHS Trust monitors and promotes quality of care across the organisation. The document is developed in partnership with our service users, clinicians and stakeholders, who collectively develop the priorities for improving quality in the organisation in the coming year, and identify challenges and good practice throughout the year. This process of development includes public workshops, local working groups, and regular quality meetings at all levels of the organisation.

We have linked our Quality Account to the Trust's Clinical and Quality Strategy to drive forward change and to further develop a culture of care and compassion for all patients and provide better support for carers. A number of new initiatives have been implemented to improve access to our services for both patients and GPs; empowering GPs to be able to manage patients in primary care effectively through the development of the new Primary Care Academy which offers training and development support for local GPs; simplifying access to our services with simple and clear access routes into our services for urgent and routine referrals; establishing a 24 hour urgent referral service, providing immediate assistance and support to referrers and providing a response by the Trust's Urgent Care Team within four hours and providing a telephone Advice Line for GPs to raise any clinical issues with Trust Consultants and obtain advice and support.

Barnet Enfield and Haringey Mental Health NHS Trust (BEH) is a large provider of integrated mental health and community health services. We currently employ 2836 staff and our annual income in 2013-14 is £193 million. The Trust provides specialist mental health services to people living in the London Boroughs of Barnet, Enfield and Haringey, and a range of more specialist mental health services to our core catchment area and beyond, including eating disorders services, drug and alcohol services, child and adolescent mental health services, and forensic services, providing assessment and/or treatment in secure conditions for individuals who may have come into contract with the Criminal Justice System. In addition to mental health services, we provide community services in Enfield. These services include sexual health, health visiting and nursing for long term illnesses including diabetes and heart failure. These multi-disciplinary teams have specialist skills and care for children, young people, adults and older people.

Over the last three years, the numbers of patients being referred to us has increased by 11%. Over the same period, our funding has reduced by 13% in real terms, as our costs have risen faster than our income. This financial year we have received 31,067 referrals for mental health services, of which 28,770 were accepted by the service. An additional 2,251 patients were admitted to inpatient care in mental health services. In Enfield Community Serves, we received 40,817 referrals, of which 40,717 were accepted by the service. An additional 14,017 patients accessed self-referral services in Enfield Community Services. In 2013-14 we have addressed some challenging targets, both practically and financially, while managing an increasingly complex level of need in the population. Despite these challenges, we have made progress and have much to celebrate, while there is much yet to achieve. I am very aware that all staff are under a lot of pressure and are struggling at times to continue to provide the levels of high quality, safe and compassionate care to patients that we are all committed to. I want to say a big personal thank you to all staff for the fantastic work they have done this year. I continue to be very proud to work with staff who are so motivated and committed to caring for patients.

## Follow-up on our 2013-2014 priorities

The Trust, agreed the following three priorities to improve the quality of care across our Trust, with input from staff, service users, carers and partnership organisations. As we had met our 2012-13 targets with regards to improving therapeutic engagement between staff and service users and their carers and ensuring all service users have an identified care goal, agreement was reached to add two new priorities for 2013-2014. Under Experience: Carers Strategy/Triangle of Care and under Effectiveness: Improve focus on patient identified care goals. As the target was not reached for improving communication with GPs, it was agreed that the Trust should continue to focus on further developing our partnerships with primary care colleagues as new strategies were being implemented to improve results.

| Priorities for 2013 – 2014 | |
|---|---|
| **Safety -** Improve communication with GPs | **65%** |
| **Experience -** Carers Strategy / Triangle of care | **87%** |
| **Effectiveness -** Patent Reported Outcome Measures (PROMs) *(% of patients who have submitted self-reporting outcome data)* | **30% MH ECS** TBC |

- **Safety**
  We have continued to monitor our communication with our GP colleagues to ascertain if the new schemes which were implemented and imbedded improved the care delivered to our patients from both the Trust's perspective and those of our GPs. Communication protocols, new discharge and referral templates were introduced; a new telephony system is now in place in the Trust enabling provision of a tailored access point enabling GPs to receive accurate direction to services.

- **Experience**
  Triangle of Care is a process of developing the involvement and support offered to carers of mental health services users. It includes ensuring that carers are identified, provided with information, provided with support for their own needs, and are valued as an expert source in input into the assessment and planning of care for patients. Following feedback from our carers within the Mental Health Trust we have launched a carer's strategy which will enhance staff understanding the needs of carers, provide carers with crisis resolution strategies and monitor our carer involvement against nationally recognised benchmarks as provided through the triangle of care programme.

- **Effectiveness**
  PROMS are mandatory this year as a part of our CQUIN contract. The Trust agreed two nationally accredited patient reported outcome measure tools to be implemented across mental health and community services. SWEMWBS was launched in Triage services in November 2013. Triage teams are receiving weekly performance updates to monitor compliance. EQ5D was launched in Diabetes, Respiratory and Musculoskeletal (MSK) services in November 2013.

## Where are we going? Our priorities for 2014-2015

The following priorities are proposed for consideration by our stakeholders and Trust Board, based on feedback from our Stakeholder Workshop in April 2014. Further development of timescales and measurable outcomes will be considered prior to publication.

| Priorities for 2014 – 2015 |
|---|
| **Safety** – Service changes to be underpinned by quality monitoring and data. |
| **Experience** – Implement Carer Strategy and update Patient Experience Strategy to include mystery shopping, thematic analysis and lessons learnt, and strategy for communicating with and involving stakeholders. |
| **Effectiveness** – Consolidate and rationalise information, with the aim of keeping patients' needs at the heart of quality improvement. |

## Where are we now? Summary of 2013 - 2014 performance

The following information is a mix of Trust, National and Mandatory reporting on a core set of quality indicators selected to help monitor and compare the quality of our services year on year and against targets or benchmarks.

***Table 1 – Quality Indicators for April 2013 – December 2013**, including previous achievement and benchmarking or internal targets. The last column shows national benchmarks indicated in white text, and internal targets in black text where no national benchmarks are available.*

| Safety | | 2010 - 2011 | 2011 - 2012 | 2012 - 2013 | 2013 - 2014 | National Benchmark / Internal Trust Targets |
|---|---|---|---|---|---|---|
| GP Communications | *Discharge letters within 1 week of discharge from inpatient services (previous target)* | 55% | 75% | 79% | n/a | **95%** |
| | Assessment, review and discharge letters sent within 24 hours based on a sample of **320** records audited in 2013-2014. | n/a | n/a | n/a | **65%** | **98%** |
| | GP survey based on **79** surveys returned in 2013-2014. | n/a | n/a | n/a | **44%** | **80%** |
| Patient Safety Incidents - | Number of incidents reported monthly (pcm) - based on a total of **6992** in 2013-2014. | 369 pcm | 408 pcm | 472 pcm | **583pcm** | 10% Increase in reporting |
| | Percentage patient safety incidents of which were severe or death - based on a total of **3605** incidents in 2013-2014. | n/a | n/a | **0.2%** Severe or Death | **1.19%** Severe or Death | 2012-213 average 1.39% |

| | | | | | | |
|---|---|---|---|---|---|---|
| 7-day follow up after discharge from inpatient care - based on **1253** service users discharged from inpatient services in Q1-3 2013-2014. | | 99.98% | 99.81% | 99.40% | **99%** | **97.44%** |
| **Experience** | | 2010 - 2011 | 2011 - 2012 | 2012 - 2013 | **2013 - 2014 Q1-3** | **National Benchmark / Internal Trust Targets** |
| Triangle of Care – An evaluation of involvement and support offered to carers based on carer surveys, record keeping audits, team observations and interviews with staff, patients and carers in 2013-2014. | | n/a | n/a | n/a | **87%** | **80%** |
| Patient and Carer Experience | Based on **221** responses to national mental health survey in 2012 (data issued in 2013) | n/a | 66% | 67% | **65%** | **67%** |
| | Based on **18,556** responses to internal patient and carer survey in 2013-2014. | MH: 81%<br>ECS: 90.5% | MH: 77%<br>ECS: 90.5% | All Services 87% | **90%** | **80%** |
| Staff Survey - Staff would recommend this Trust - Based on **464** responses to national staff survey in 2012 (data issued in 2013) | | 66% | 65% | 70% | **70%** | **71%** |
| Complaints – number of complaints received by 1000 population in 2012-13 | | n/a | n/a | n/a | **0.24** | **0.34** (London MH Trusts average) |
| Staff training – compliance with mandatory training in Q1-3 2013-2014. | | n/a | n/a | n/a | **85%** | **85%** |
| Crisis Resolution Home Treatment Team Assessment – the percentage of admissions to acute wards for which home treatment teams provided initial assessment out of 1228 inpatient admissions in Q1-3 2013-2014. | | n/a | n/a | 98.7% | **98.5%** | **95%** |
| **Effectiveness** | | 2010 - 2011 | 2011 - 2012 | 2012 - 2013 | **2013 - 2014 Q1-3** | **National Benchmark / Internal Trust Targets** |
| Trust wide PROMS – EQ-5D and SWEMWBS launched end of November : *(% of patients who have submitted self-reporting outcome data)* | | n/a | n/a | n/a | **ECS ?%<br>MH 30%** | **10% ECS / 30% MH** |
| Patient identified care goals – indicating development of patient identified goals and involvement in care planning based on an audit of 4572 patient records in Q1-3 2013-2014. | | n/a | 93% | 94% | **95%** | **90%** |
| Emergency Readmissions– Based on 25 emergency readmissions to adult mental health wards out of 1167 admissions in Q1-3 2013-2014. | | n/a | 4% | 1.7% | **2.1%** | **<5%** |

## ORGANISATIONAL LEARNING

The Trust follows a clinical governance and assurance structure with the aim of identifying and celebrating good practice as well as identifying problematic areas quickly to ensure timely remedial action can occur. This governance process increases ownership of quality and safety improvements across all services in the organisation and ensures quality is at the heart of the Trust agenda. Our governance structure is made up of three components:

- **Deep Dive Committees**
  All of the service lines have their own monthly Deep Dive Committee meetings. These are chaired by the Director of Nursing / Deputy Director of Nursing to enable a deeper analysis and scrutiny of those service areas. It is a process that identifies both positive practice and areas in which further developments are required. Each area will produce an action plan to take to Service Line Clinical Governance Committees, which will monitor its implementation.

- **Service Line Clinical Governance Committees**
  Following the Deep Dive Committee, service leads will present their plans for improvement and actions they have completed to this committee.

- **Service Improvement Committee**
  This forum provides an opportunity for teams to present learning from improvement projects with colleagues in other services. It is both a celebration of successful improvements in organisational quality, and a chance for other trust leaders to learn from their peers. It is jointly chaired by the Medical and the Director of Nursing. The agenda focuses upon outlining how the service lines have overcome areas of concern and variation in order to drive improvement and improve patient experience.

  The following presentations have been delivered in the past year:

  - See, Think Act - Improving Staffs Understanding of Patient Risks
  - The Path To MSNAP Accreditation
  - Peer Support – Enfield Mental Health Users Group
  - Reflections On Pressure Area Care In A Forensic Setting -“Barriers, Road Blocks and Managing Diverse Clinical Opinion”
  - QFI/Jonah Process
  - The Club Drug Clinic
  - Art Therapy focused Mentalisation Based Therapy Introduction - Portrait of Self and Other
  - Update on Service Transformation
  - Family Interventions within the Psychosis service line
  - Mint Hosting the National Learning Disability Week
  - Team Process Maps: A Journey through the why, what how and lessons learnt

## You Said, We Did…

## Regent House project is complete

Six months after plans were made to change, modify and improve the services provided at Regent House (formerly known as Camlet 2) the project was completed at the end of October 2013.

The 23 medium secure beds were adapted and changed to 26 low secure beds which meant a rigorous change affecting both staff and patients. Regent House now contains two low secure wards named by the patients after British rivers - Severn and Derwent. The gardens to both these wards were developed and improved for patient use. The three extra bedrooms were made into en-suite rooms by combining previous interview/ therapy rooms. The reception space was improved and a new room built for therapies and patient visitors. The seclusion room on Derwent ward was decommissioned and changed into an interview room / home cinema at the patient's request.

Phil Jackson, low secure project lead, said: *"The Regent House project has been successful in merging with existing low secure services at Blue Nile House and both areas are working towards using the Good Lives Model of care within care planning and patient focus in the community."*

Within these changes a new low secure learning disability pathway was also created and has been implemented on Derwent ward. This has added a great deal of individualised specialist services to better meet the needs of our forensic patients.

Phil continues: *"We held a party in December to celebrate the opening of Regent House, which was a great success. Some of the patients showed a DVD that they had created with staff charting the changes of 'before & after' which included photos and video footage with a background of music."*

*"At the launch party one patient thanked all the staff who helped make the positive changes to the ward and he went on to say that he looks forward to using the new garden a great deal more".*

The Forensic Service now offers 41 low secure inpatient rehabilitation beds with a learning disabilities pathway and a four patient self-contained flat.

## Patient says thank you with a painting

Maria (right) presenting her painting to the Home Treatment Team

A young patient has thanked the team that helped her to get back on the road to recovery by painting a picture especially for them. Maria Halkou 23 from Enfield decided to paint the picture for the Enfield Crisis Resolution Home Treatment Team.

Maria said: *"The support and care that I received from the team was so good that I wanted to give them something back. I have always enjoyed painting so I painted them a picture that I hope they can display in their office to remind them of me."*

Faye Eatally, Crisis Resolution Home Treatment Team deputy manager said: *"We regularly receive positive feedback, but this is the first time that we have had a patient paint a picture for us and we are all very pleased. More importantly, we are delighted that Maria and her family consider that the treatment we have provided has really made a difference and that she is now well on the road to recovery."*

Elaine Bucknor, patient experience and complaints management advisor, was the person who spotted the painting in the home treatment team's office and suggested it would make a great story.

Elaine said: *"When I saw the painting I thought it was so nice that we needed to spread the word about it. This demonstrates that Maria had a very good patient experience with the trust which is something that we must commend the home treatment team for."*

## TRUST Achievements…

## Mental Health Trust and Met Police Partnership wins top award

An innovative and important partnership between Barnet, Enfield and Haringey Mental Health NHS Trust and the Metropolitan Police Service has been recognised with a prestigious policing award.

The team, which is made up of staff from the Trust and the police, was presented with the top prize for diversity at last week's Excellence in Total Policing Awards in recognition of their work to support people with mental health conditions. The multidisciplinary team of doctors, nurses and police officers has an important role to play in protecting high profile public figures, but their work also has a significant public health impact.

The Fixated Threat Assessment Centre (FTAC) consultant psychiatrist Dr Frank Farnham says that: *"by making an assessment of an individual the team is often able to put people in touch with their local mental health or primary care services. This early intervention allows people with mental health problems to be identified and provided with appropriate treatment much sooner than may have happened otherwise."*

Detective Chief Inspector Carol Kinley-Smith, who heads up FTAC, said: *"I am incredibly proud of the team. Mental health is a huge priority for the police at the moment, and this team is an excellent example of how effective partnership working can support both police and NHS objectives by protecting public figures and helping people get the care and support they need".*

## National Police and Court Liaison/Diversion Pilot

The Trust has been successful in its bid to be the London pilot site and one of 14 sites nationally to trial the new operating mode for liaison and diversion services at police stations. The pilot will form part of a national evaluation, which will go towards the final business case to put to the treasury to release the funds to roll out the model nationwide. This will see the service locally extend into the police stations of Enfield and Islington, provide a five day per week service at Highbury Magistrates Court and extend our delivery to all ages and those with assumed vulnerabilities.

## Trust awarded University Status

Middlesex University has awarded 'University Affiliated' status to the Trust. The agreement will enhance the current partnership between the two organisations, demonstrating a strong commitment to education, research and development.

The agreement builds on the existing strong relationship between the University and the Trust, which has previously included opportunities for clinical placements for nursing students, bespoke and innovative educational projects for staff development, and evaluation and research projects on critical clinical practice questions.
Skills and knowledge at both organisations will be enhanced by the partnership, which will see clinicians from the Mental Health Trust working with Middlesex students and sharing their front line expertise, and Middlesex University experts providing training for staff at the Trust. This includes opportunities for Trust staff to gain university level qualifications for projects they carry out in the workplace.

Middlesex University Pro Vice-Chancellor and Dean of the School of Health and Education Jan Williams said:
*"Middlesex University and the Trust have collaborated for a number of years on student placements, conferences and continuing professional development so we are delighted to have the opportunity to formally extend our partnership. We're looking forward to working together to respond to the challenges facing mental health and community health service users and staff, through research and development of innovative ways of working."*

Maria Kane, Trust Chief Executive said:
*"Our relationship with Middlesex University is a crucial part of how we advance our research, develop our workforce and support the training of the next generation of NHS staff, so I am thrilled that we are able to strengthen our partnership through this agreement. We will be looking for new and innovative ways to work together to continue to improve the health and wellbeing of the community our Trust serves."*

# Staff Achievements…

## Denise is a top trainer

Denise Hall in Workforce Development was awarded trainer of the month for January by University College London Partners (UCLP) in acknowledgement of her sterling efforts in delivering dementia training across the Trust.

Denise, a skills trainer, delivers a range of training courses including the Trust's induction course said: *"I feel very honoured to have won this award. More importantly it recognises the work we are doing at the Trust to raise awareness about dementia."*

As part of her award Denise was presented with a gold project badge, a certificate of achievement and £250 to spend on items or initiatives related to delivering better dementia care in the Trust.

## Trust clinician is also a top teacher …

A Trust clinician has been chosen as a 'top teacher' by students from the University College London (UCL) medical school.

Dr Robert Tobiansky, who works in psychiatry for the elderly, received the award after his students voted for him as one of the teachers who were particularly helpful or inspiring to them during their studies.

Throughout the year UCL students are given the opportunity to nominate their teachers and during 2012/13 over 1800 votes were cast and from there 70 award winners were chosen.

## Karl takes tea with the Queen

Karl Sunkersing has been rewarded for his dedication to the NHS by being selected to attend a royal garden party at Buckingham Palace.

Karl, who is a trained psychiatric and general nurse, has worked for the NHS for 43 years. He currently works as the ECT co-ordinator and bed capacity manager at Chase Farm Hospital.

Oliver Treacy, Service Director for Crisis & Emergency, said: "I am delighted that Karl was selected to attend a Royal garden party as it is recognition for the years of dedicated service that he has given to the NHS. He frequently goes beyond the call of duty and shows great empathy with all mentally ill patients, frequently giving up his own time to ensure that services are provided."

Karl was accompanied to the garden party by Lynne Parry

Karl Sunkersing (left) with Lynne Parry and Oliver Treacy

Joy Ihenyen has recently trained to become the Trust's first independent pharmacist prescriber. Following her training Joy worked as a general pharmacist at the Whittington before joining North Middlesex Hospital as a HIV pharmacist. She joined this Trust in 2006 as a mental health pharmacist.

Joy says: "most of my work is ward based. It involves attending ward rounds with the multidisciplinary team and talking to patients about their medication. This is with a view to helping them understand what the medication does and the importance of taking them. I also do day to day clinical screening of new patients and ensure that the right medication is prescribed for the patient.

Congratulations to staff nurse Amelia Bioku, who successfully achieved her MSc in Mental Health Studies with merit on 4 December 2013. Amelia, who works on Suffolk ward, said: *"I strongly believe it is essential for nurses to be knowledgeable, skilful and most importantly, to keep abreast of mental health nursing, in order to deliver safe and effective care based on evidence based practice. I would like to thank Sean Edwards, ward manager and those nurses who participated in the study for their support. I would also like thank my previous ward manager, Rey Bermudez who supported me with the funding."*

Ros Glancy, practice standards lead, said: *"Amelia's dedication and enthusiasm is really inspiring and we would like to wish her continued success for the future."*

## Celebrating the work of Activity Co-ordinators

Staff and service users got together recently at Chase Farm to celebrate the work of the volunteer activity coordinators and thank them for the valuable work that they have done during the year. The activity coordinators are all volunteers who organise physical and other activities on the inpatient wards at Chase Farm. Paul McKevitt, Service Manager, said: "On behalf of the trust I would like to thank the activity coordinators for all of the valuable work they have done for the trust and our patients. They really support the ward staff by organising activities for the patients and as ex-service users themselves they are able to understand the issues and changes that the service users face. I would also like to thank Melina Back and Kate Holmes from EMU (Enfield Mental Health Users Group) for all of their hard work in establishing the activity coordinators network."

**Paul McKevitt with Melinda Back and Kate Holmes**

# Celebrating our Commitment to Excellence Awards

Over 300 members of staff got together to celebrate the achievements of colleagues in the annual staff awards ceremony „Celebrating our Commitment to Excellence".
More than 80 people were nominated in the seven categories and the winners were announced on the night. Colleagues with 30 or more years of NHS service were also recognised.

Michael Fox, Trust Chairman, welcomed everyone to the awards ceremony saying: "This event is a demonstration of the Trust's on-going commitment to excellence. It is one way of saying thank you to all staff in what has been another challenging year for the Trust and the wider NHS."

During the evening members of the first 10 teams to take part in the Listening into Action programme were congratulated for their work. The teams, along with their sponsors, have been working hard to make improvements for the benefit of patients and staff.

Maria Kane gave a closing speech congratulating all of the award winners and acknowledging that the awards were just a snapshot of the good work that takes place throughout the Trust.

***Audrey Carter***

### Compassion In Care Award

*Audrey is a healthcare assistant on Avon Ward in Forensic. She is regarded as one of the back bones of the numerous successes on the ward.*

*Audrey cares for every service user equally with respect and humanity.*

### Clinician of the Year

*Bernie and Tanya from the ECS intermediate care team have been instrumental in the development of integrated services for admission avoidance and the older person's assessment unit. Their contribution as the lead community clinicians has been exemplary providing leadership across the interface of primary and secondary care to improve the care for older people.*

***Bernie Sandford & Tanya Pugh***

***Sue Steward***

### Supporting Star

*Sue supports staff in the dementia and cognitive impairment service in using RiO .She has developed systems and procedures for the teams to ensure the quality of data and compliance which has shown in the positive results in all performance reports and targets..*

## Innovation Award - *Multi Sensory Room*

*Helen Blatchford and Despina Tzanidaki scooped the innovation award to install a special sensory area for children to use when visiting Cedar House at St Michael's Hospital in Enfield.*

## Manager of the Year

*Helen Brindley, a manager in the Haringey complex care team, is fabulous at leading managerially and operationally, she is also clinically excellent. Helen is essential to the functioning of the service and well-being of the staff and clients*

## Diamond Team

*During the year the Barnet Complex Care Team have overcome many challenges through strong clinical leadership and excellent team working.*

## Chief Executive's Award for Excellence

*Catherin Marfelle, a healthcare assistant on Juniper ward, in forensic, is a resourceful and thoughtful person who everyone looks to for wisdom. She is often the first to identify problems and is not a person to ignore them if they interfere with the standard of work that she commits to*

## The LiA Pioneers

The success of the first 10 Listening into Action (LiA) pioneering teams was recognised at the awards ceremony. Team representatives were presented with an award for their hard work on improvement projects. The projects range from enhancing services for older patients by creating a therapeutic space outside the Hawthorn Unit at Chase Farm to reinstating the Trust's direct access to pathology results. The teams are seeing the results of their hard work as changes are implemented across the Trust.

# Performance Review

Barnet Enfield and Haringey Mental Health NHS Trust considers that the data is as described for the following reasons: the indicators selected for this report were chosen based on several factors which ensure that this information provides an accurate and well-balance depiction of the quality of our services. Indicators must be based on data collected continuously and across all relevant services provided by the Trust. Data must be from a source which is quality reviewed for accuracy. The data must be based on information presented and discussed in quality and improvement forums at all levels of management to ensure that lessons and actions taken to improve services form a part of Trust governance.

Barnet Enfield and Haringey Mental Health NHS Trust intends to take (or has taken) the actions described in the following performance review tables to improve performance against targets, and so the quality of its services, by regularly monitoring and planning improvements through clinical governance and performance improvement structures. Data is provided to teams and service lines through deep dive meetings and performance meetings wherein areas for improvement actions are agreed and monitored. Where teams show significant improvements, these lessons are shared with colleagues in service improvement committees.

## PATIENT SAFETY

### GP Communication

| | |
|---|---|
| Why did we choose to focus on this? | It was agreed that the Trust should continue to focus on improving shared care between mental health and primary care clinicians to support improved outcomes for both physical and mental health conditions for our service users. |
| What was our target? | Our target consisted of a series of communication standards (developed in collaboration with our commissioners), as well as a programme of work to redesign access to services and information to better meet the needs of our Primary Care colleagues. |
| What did we achieve? | This financial year, the Trust was set a more challenging target with regard to letters to GPs, moving the time frame from 1-2 weeks down to 24 hours. This target has proved challenging, and although we are not currently meeting our target we can see a quarter on quarter improvement demonstrating that the actions put in place to address the gaps in delivery are being effective.<br><br>The Trust has put in place a number of new services and monitoring processes to improve GP communication. GP views have been collected systematically through quarterly GP satisfaction surveys in each borough as well as through the Primary Care Academy. The strategy the Trust has taken to address some of the issues raised has been to utilise the Primary Care Academy to provide specialist training, provide communication through the GP newsletter and service transformation to respond to these issues.<br><br>**Primary Care Academy:** The Trust has been successful in securing £90k in funding from Health Education England. This will be used to develop our e-learning platform, and our Recovery Library. There is now a designated administrator and also service user input to these sessions. There is a regular Steering Board for the Primary Care Academies, attended by the Trust, Haringey Clinical Commissioning Mental Health lead, and service user representatives. We have planned sessions in all three boroughs for the next 6 months and will be delivered by Marc Lester, Deputy Medical Director assisted by Simon Harwin, Crisis and Emergency Service Line Manager.<br><br>There has been excellent feedback from attendees at the sessions run to date, with more than half of attendees stating that they felt more confident with aspects of care and practice following the workshops. The Primary Care Academies have also achieved RCGP |

accreditation.

**Crisis Referrals:** As previously reported, the Trust responded to GP concerns about access to crisis services by introducing two new services: Triage Service and Crisis Resolution and Home treatment (CRHT). The Triage operates from 9am to 9pm Monday to Friday and provides face to face patient assessments for non-urgent or routine referrals.

The new CRHT service operates 24 hours a day, 7 days a week, for urgent referrals for anyone in a crisis, assessing service users wherever they are at the point of referral e.g. GP surgery, A&E , their own home etc. Monitoring of the impact of this service transformation is on-going. A six-month review will be held in May 2014.

**GP Survey :** A survey of GPs regarding their satisfaction with the communication they have received produced the following:

| GP Satisfaction Survey - Quarter 3 | |
|---|---|
| October | 42% |
| November | 49% |
| December | 50% |

**GP Advice Line:** In May 2013, the Trust introduced an advice line to provide GPs with access to generic clinical advice telephone conferences with psychiatrists within working hours. The objective was to address GP concerns which demonstrated a lack of clinical capacity amongst GPs and also enhance communication and help develop professional relations.

From May to December, 144 appointments have been booked, with a breakdown by borough as follows:

Barnet –101 Enfield – 30 Haringey – 13

Analysis of calls has shown the following breakdown of content:

| **Advice sought regarding:** | Barnet | Enfield | Haringey | **Total** |
|---|---|---|---|---|
| Patient's deteriorating condition | 11 | 3 | 2 | 16 |
| Management of patient's condition | 17 | 5 | 1 | 23 |
| Medication Advice | 41 | 10 | 6 | 57 |
| Referral/service provision advice | 11 | 5 | 1 | 17 |
| Other | 21 | 7 | 3 | 31 |
| **Totals** | **101** | **30** | **13** | **144** |

**GP Letters:** An audit of letters sent to GPs following assessment, review or discharge of patients has been conducted. Results indicate that although we are not yet meeting our targets, there has been a quarter on quarter increase in achievement. A review of our administration systems and a mapping exercise identified areas for improvement in the communication process including a proposed email to fax communication protocol, and a need to review letter templates. The positive increase in results would indicate that the strategies which have so far been implemented are being effective in both increasing staff awareness of the Trust's objectives and also to re-assess how to better manage internal processes.

| Trust results for GP letters - by quarter | communication sent within 24 hours | content average |
|---|---|---|
| Quarter 1 | 34% | 76% |
| Quarter 2 | 40% | 82% |
| Quarter 3 | 58% | 87% |
| Quarter 4 | 52% | 86% |

| | |
|---|---|
| What needs to improve? | 1. Standardised communication templates to be reviewed to fit service specifications and CQUIN content standards.<br>2. Clinical staff to use NHS net email to send communication directly to safe haven faxes via email.<br>3. Regular newsletter to CCGs about progress, and regular briefings for meetings with three CCG Chairs and Accountable Officers. |
| How will we continue to monitor and report? | We will continue to monitor and report our progress to our commissioners through our Quality Clinical meetings. Reviewing our GP survey to assess the success of changes made following implementation of actions taken. |

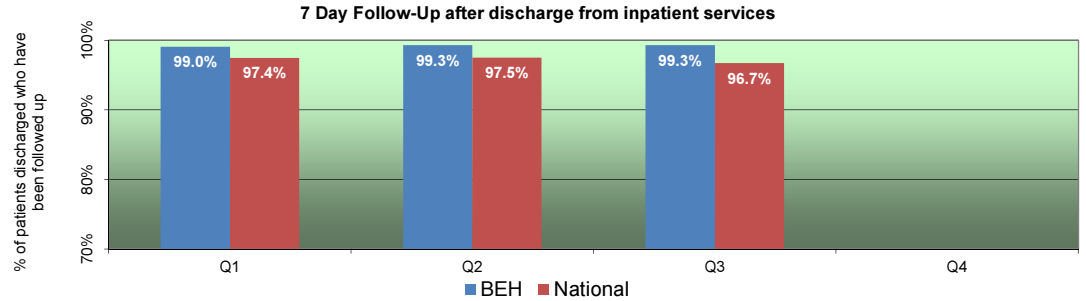
## Patient Safety Incidents

| | |
|---|---|
| Why did we choose to focus on this? | All NHS trust are required to report incidents of harm, violence, or errors which could have a potentially negative impact on service users, visitors or staff. We are now required to report the number of patient safety incidents and the percentage of those which resulted in severe harm or death. The Trust has historically been in the lowest reporting percentile compared to other trusts. We have implemented many strategies to raise staff awareness of the importance of reporting all incidents as a means of learning and openness.<br><br>Further improvements to patient safety have been developed through participation in the Harm Free Care project and use of NHS Safety Thermometer, which collects information about harm from incidents based on individual service user experience. More information about Harm Free Care can be found on the following website: www.harmfreecare.org |
| What was our target? | To achieve a 10% increase on 2012-13 rates of incident reporting.<br>To maintain high levels of harm free care, in line with national average. |
| What did we achieve? | Higher levels of reporting of incidents are an indication that a Trust is embracing a culture of transparency and learning. The Trust had set a target for increasing the rate of incident reporting from 2012-13 by 10%. Reporting in 2013-14 has increased by 24% from 2012-13.<br><br>The percentage of patient safety incidents resulting in severe harm or death for the Trust between April 2013 and March 2014 is 1.19%. This rate is below the 2012-13 national average of 1.39%.<br><br>The Trust participates in the National Patient Safety Thermometer Harm Free Care Programme, which provides monthly census data of all patients seen across the country on a given day, and measures the level of harm experienced by those patients based on four categories; pressure ulcers, falls, urinary tract infections and venus thromboembolism. Barnet Enfield and Haringey has demonstrated 93% harm free care in 2013-14, in line with the national average for all trusts. |
| What needs to improve? | A programme of on-going training is in place to raise awareness that the Trust can learn from and make improvements through reporting and learning from incidents. Action plans generated by discussion of these incidents at risk and governance meetings will be monitored. |

| | |
|---|---|
| How will we continue to monitor and report? | Incident reports are monitored through Trust and local governance committees. Teams hold discussion about timeliness of response to incidents as well as a thematic analysis of the learning from incidents. Action plans are developed based on these discussions and preventative measures taken where necessary. Serious Incidents Review meetings are regularly held where discussions on implementing change are agreed. Service Managers are able to monitor both the recording and reviewing of incidents which are then discussed during meetings and supervision. |

## Follow-up after discharge

| | |
|---|---|
| Why did we choose to focus on this? | The first seven days following discharge from hospital is the point at which service users are most vulnerable and at greatest risk of relapsing. The Trust aims to contact service users by means of face to face contact, if not, over the phone to establish their wellbeing and to monitor their progress. |
| What was our target? | To provide follow up care within 7 days of discharge to 100% of service users against the national target of 95%. |
| What did we achieve? | The Trust is maintaining its performance above nationally set benchmarks.<br><br>Both internal auditing and national reporting indicate that the Trust (in blue in the graph below) is achieving an average of 99.2% against a National average (in red in the graph below) compliance rate of 97.21%. National target for this indicator is set at 95% compliance. This figure is based on performance data of 1253 service users discharged from inpatient services in 2013-14. |




***The following table shows the data published by the Trust to the Health Sector Compensation Information System from April to December 2012.***

| proportion of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care | Q1 based on data submitted to HSCIC | Q2 based on data submitted to HSCIC | Q3 based on data submitted to HSCIC | Q4 based on data submitted to HSCIC |
|---|---|---|---|---|
| lowest | 94.10% | 90.70% | 77.20% | data not yet available |
| BEH | 99.04% | 99.29% | 99.28% | data not yet available |
| Highest | 100.00% | 100.00% | 100.00% | data not yet available |
| England | 97.44% | 97.47% | 96.71% | data not yet available |

| | |
|---|---|
| What needs to improve? | *Teams will improve recording of quality of contact in greater detail. If personal contact is not established to follow up and properly record client's wellbeing and needs, telephone contact with client or contact with a carer should be made to ascertain the client's current position.* |

| | |
|---|---|
| How will we continue to monitor and report? | Maintain high levels of compliance. Daily review of 7 day follow-up is managed and monitored by teams through daily review of discharge activity. Performance is also monitored through weekly exception reports, monthly service line meetings and at Board Committee level. |

# PATIENT EXPERIENCE

## Triangle of Care – *Key Priority*

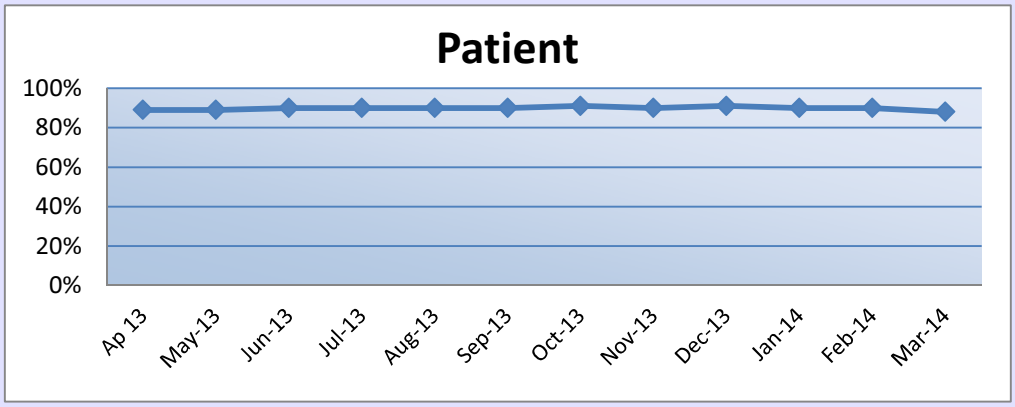
<table>
<tr><td>Why did we choose to focus on this?</td><td>It was agreed that the Trust, having met its target for improving our therapeutic engagement with service users, change its priority to Triangle of Care. This is a process of developing the involvement and support offered to carers of mental health services users. It includes ensuring that carers are identified, provided with information, provided with support for their own needs, and are valued as an expert source in input into the assessment and planning of care for patients.</td></tr>
<tr><td>What was our target?</td><td>To develop a new carers strategy in consultation with carers group, local authority and other local stakeholders to support this practice.</td></tr>
<tr><td>What did we achieve?</td><td>The ‘Triangle of Care’ is described as a therapeutic alliance between service user, staff member and carer that promotes safety, supports recovery and sustains wellbeing.It involves listening, sharing and learning from each other, in an environment of safety, respect and honesty.<br><br>The Triangle of Care covers 6 key standards:<br>1) Carers and the essential role they play are identified at first contact or as soon as possible thereafter.<br>2) Staff are ‘carer aware’ and trained in carer engagement strategies.<br>3) Policy and practice protocols re: confidentiality and sharing information, are in place.<br>4) Defined post(s) responsible for carers are in place.<br>5) A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.<br>6) A range of carer support services is available.<br><br>The Trust monitors these standards through a range of surveys,service inspections and record audit. The following table shows our combined performance against these standards in 2013-14.
<table>
<tr><td></td><td>2013-14 Q1</td><td>2013-14 Q2</td><td>2013-14 Q3</td><td>2013-14 Q4</td></tr>
<tr><td>Triangle of Care</td><td>77%</td><td>89%</td><td>91%</td><td>90%</td></tr>
</table>
The Trust has developed a Carers Strategy in collaboration with local carers groups and Barnet, Enfield and Haringey Local Authority. This strategy is due to be launched in 2014.</td></tr>
<tr><td>What needs to improve?</td><td>The Carers Strategy identifies a number of actions, which will be available on the Trust website following publication.</td></tr>
<tr><td>How we will continue to monitor and report?</td><td>The strategy identifies clear goals and standards which are measured through a number of sources of intelligence, including surveys, records audits, observation of teams and ward environments, and interviews with service users and carers.</td></tr>
</table>

## Patient and Carer Experience

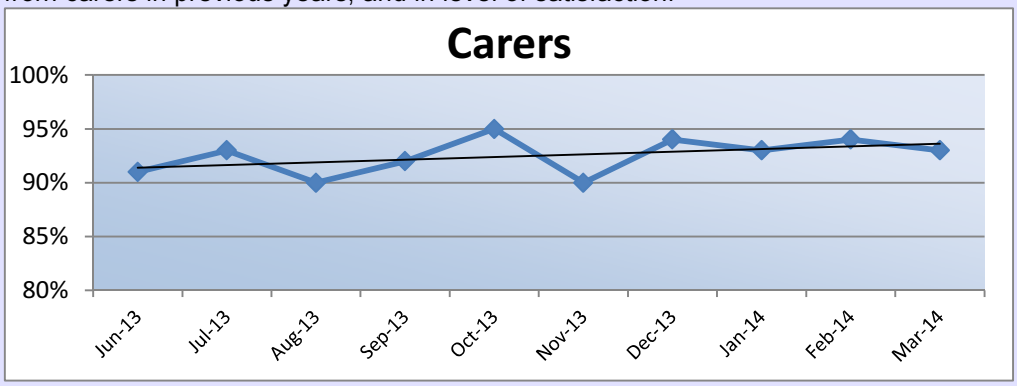
| | |
|---|---|
| Why did we choose to focus on this? | To improve the quality of services that the Trust delivers, it is important to understand what service users think about their care and treatment. The Trust participates in the national mental health community service user survey on an annual basis. Results received in 2013 show that the results for the Trust are in line with the national average for every question. The Trust conducts an additional "real time" internal survey for both patients and carers, based on the themes of the national survey but amended for relevance to inpatient and community services. This real time survey has collected 18,566 responses between April and March 2014. The results show that patients and carers are reporting increased satisfaction with services.<br><br>Local service user groups in Barnet, Enfield and Haringey are working with the Trust to develop a set of patient involvement standards, which will be monitored by volunteers from service user groups. This information will form a part of our quality dashboard and will be included in future Quality Account reports. |
| What was our target? | To maintain scores at the average national for mental health services in London.<br>Internal survey target has been set to 80% satisfaction. |
| What did we achieve? | At the start of 2013, a questionnaire was sent to 850 people who received community mental health services. Responses were received from 221 service users at Barnet, Enfield and Haringey Mental Health NHS Trust. The overall Trust score is in line with the national and London-wide average scores recorded as "About the same; the trust is performing about the same for that particular question as most other trusts that took part in the survey." |

| 2012 Mental Health Survey Results London and Urban MH trusts | BEH | CANDI | CNWL | East London | NELFT | Oxleas | SLAM | SWLSG | West London | National Rating |
|---|---|---|---|---|---|---|---|---|---|---|
| Overall | 6.5 | 6.7 | 6.6 | 6.5 | 6.5 | 6.6 | 6.7 | 6.6 | 6.7 |  |
| How would you rate the care you have received from NHS Mental Health Services in the last 12 months? | 6.7 | 6.8 | 6.9 | 6.9 | 6.7 | 7.2 | 7.1 | 6.9 | 7 |  |
| Have NHS mental health services involved a member of your family or someone else close to you, as much as you would like? | 6.3 | 6.7 | 6.4 | 6.2 | 6.2 | 6 | 6.3 | 6.2 | 6.3 |  |
| Patient's experience of contact with a health or social care worker during the reporting period. | 8.1 | 8.2 | 8.3 | 8.7 | 8.4 | 8.1 | 8.7 | 8.4 | 8.4 |  |

Internal survey of 12,897 patients across all service lines indicates a rise in patient satisfaction within our services.




1,821 returns were received by carers who indicate a rise in both the numbers of responses from carers in previous years, and in level of satisfaction.




| | |
|---|---|
| What needs to improve? | "You said – We did" boards to inform patients and carers of the initiatives which have been developed based on feedback from surveys was launched. Feedback to both patients and carers on service developments, survey results and action plans will be shared through the Trust website and newsletters. The national Friends and Family Test will be added to our local surveys, providing real time feedback which can be benchmarked nationally. |
| How we will continue to monitor and report? | Patient experience is an important area in which the Trust receives monthly feedback on its performance and this data is discussed in clinical governance groups. Teams use their feedback to identify local improvement plans and to share good practice. |

## Staff Survey: Would staff recommend this Trust?

| | |
|---|---|
| Why did we choose to focus on this? | Barnet Enfield and Haringey Mental Health NHS Trust employs 2836 individuals and one of its values is to support its staff to be the best they can be. Training and continual support by appraisals and supervision allow staff to feel heard and valued in their workplace.<br><br>The people we employ to provide care are our most precious resource. Their wellbeing and views of our service will have a direct impact on the quality of care we provide. To help us measure staff satisfaction in the workplace, we will use the national staff survey. This will have an impact on the experience of our service users; therefore it is important that staff feel positive about the service provided by the Trust. |
| What was our target? | To achieve scores within the national average. To improve Trust wide communication with staff on all matters, including performance, achievements, promotions etc. |

| | |
|---|---|
| What did we achieve? | 1436 members of staff completed the 2013 National NHS Staff Survey and 51% reported that they would recommend the Trust as a provider of care to their family or friends. This compares to a national average across other mental health providers of 59%. Individual clinicians believe that they are delivering good care to our patients so the focus of 2014 is to increase the number of staff who would recommend the Trust overall as a provider of care towards this higher figure.<br><br>The Staff Friends and Family test has to be undertaken with staff every quarter and will be published by NHS England.<br><br>The two minute update "Take 2" launched last year has continued to help keep staff informed of Trust news and events and is being used by more staff to bring events and news to the attention of all staff.<br><br>After a hugely successful first year, the Trust's Listening into Action programme is ready to move onwards and upwards into its second year. The first set of teams have completed their projects and embedded new ways of working into day-to-day activity to improve services for patients and the working life of our staff. The programme makes a fundamental shift in the way we lead and work, putting staff, the people who know the most, at the centre of change, empowering them as individuals and within a team to get on and make change happen. This has been a great success with identifying quick fix initiatives as well as long term projects.<br><br>Staff training was identified as one area for improvement from the last survey. The Trust is now meeting its own internally set targets for compliance with mandatory training. To maintain and improve compliance rates, training registers are reviewed in each service line and teams review this data monthly to identify staff that have yet to complete or need refresher training. The Trust aims to maintain and exceed the target of 85% compliance by year end. |

| | Staff Count | Compliant | Trust | Corporate | C&E | DCI | ECS | Estates | Forensic | Psychosis | SCNP |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Child Protection | 2583 | 2064 | 84% | 89% | 72% | 90% | 96% | 79% | 70% | 89% | 77% |
| Adult Protection | 2583 | 2064 | 84% | 89% | 72% | 90% | 96% | 79% | 70% | 89% | 77% |
| Equality and Diversity | 2583 | 2064 | 84% | 89% | 72% | 90% | 96% | 79% | 70% | 89% | 77% |
| Fire Awareness | 2583 | 2064 | 84% | 89% | 72% | 90% | 96% | 79% | 70% | 89% | 77% |
| Health and Safety | 2583 | 2064 | 84% | 89% | 72% | 90% | 96% | 79% | 70% | 89% | 77% |
| Infection Control | 2583 | 2064 | 84% | 89% | 72% | 90% | 96% | 79% | 70% | 89% | 77% |
| Information Governance | 2583 | 2149 | 85% | 89% | 74% | 88% | 92% | 87% | 82% | 94% | 79% |
| Published compliance as at 31 December 2013 | | | **85%** | 88% | 75% | 87% | 91% | 89% | 84% | 95% | 79% |

| | |
|---|---|
| What needs to improve? | To continue to develop further improvement plans through the Listening into Action programme. |

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|---|---|
| How will we continue to monitor and report? | We will continue to conduct regular staff surveys. Staff have been encouraged through the Listening into Action initiative to use the 'Pulse Check' questionnaire tool to allow the organisation to better understand how they are feeling working for the Trust. This will give the Trust more insight to drive actions and changes. |

## Complaints

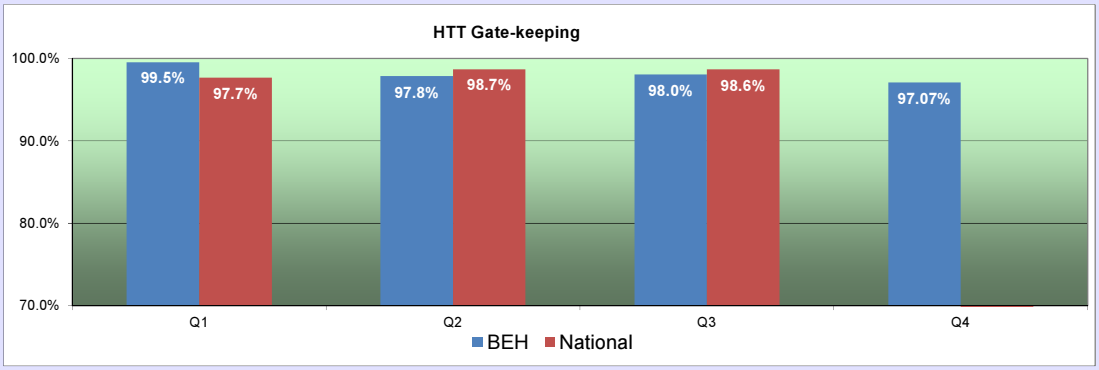
| | |
|---|---|
| Why did we choose to focus on this? | Service users, relatives and carers provide a valuable perspective into how we provide care. By understanding why people complain, and the nature of the issues raised, we can endeavour as service providers to work in partnership with all our stakeholders to improve the quality of care and treatment. The Trust endeavours to use complaints information to identify and mitigate against risks, improve and to embed changes within our services. |
| What was our target? | The Trust aims to resolve problems which arise through internal mechanisms before a formal complaint is issued, and thereby to minimise the number of formal complaints received. |
| What did we achieve? | The following table shows the number of formal complaints received by all London Mental Health Trusts, as provided by HSCIC, ranked according to the population size of localities covered by each trust. Barnet Enfield and Haringey receive lower numbers of formal complaints based on population size than the majority of London trusts. |

| London Trusts | total complaints 2010-11 | total complaints 2011-12 | total complaints 2012-13 | population by london borough *based on 2011 census* | 2012-13 complaints rate per 1000 population |
|---|---|---|---|---|---|
| North East London NHS Foundation Trust | nil reported | 174 | 169 | 959,200 | 0.18 |
| Oxleas NHS Foundation Trust | 110 | 179 | 161 | 796,000 | 0.20 |
| Barnet, Enfield and Haringey Mental Health NHS Trust | 251 | 215 | 220 | 923,800 | 0.24 |
| Central and North West London NHS Foundation Trust | 238 | 306 | 331 | 1,202,300 | 0.28 |
| Camden and Islington NHS Foundation Trust | nil reported | 121 | 151 | 426,400 | 0.35 |
| South West London and St George's Mental Health NHS Trust | 343 | 356 | 376 | 1,043,900 | 0.36 |
| West London Mental Health NHS Trust | 224 | 197 | 307 | 774,900 | 0.40 |
| South London and Maudsley NHS Foundation Trust | 551 | 555 | 551 | 1,230,700 | 0.45 |
| East London NHS Foundation Trust | 318 | 462 | 440 | 538,600 | 0.82 |
| **All london MH** | **2035** | **2565** | **2706** | **7,895,800** | **0.34** |

| | |
|---|---|
| | The most common category of complaint across the Trust continues to be dissatisfaction with clinical care and treatment followed by staff approach and attitude at both clinical and administrative levels. Poor communication in terms of providing accurate referral and aftercare information to both service users and carers appears as an issue across Service Lines. Furthermore, at a local level, service users have expressed concerns that they have found it difficult to get responses from teams after having left telephone messages. |
| What needs to improve? | The Trust would like to improve the timeliness with which we respond to formal complaints, and have set high targets for response times. While we have made improvements to the complaints process to meet these challenging targets, the Trust acknowledges that there is still more to be done in this area and as such will be reviewing the themes associated with delays in the process and shall address these issues with appropriate action. |
| How will we continue to monitor and report? | The Complaints Team holds weekly Complaints Status Update meetings to track the progress of complaints responses from Service Lines. Service Line managers allocate suitably trained and experienced staff to investigate complaints. The duties of the allocated investigators include contacting complainants and drafting Service Line complaints responses. Actions from the weekly Complaints Team Status Update meetings are forwarded to the relevant Service Line Assistant Director and direct line manager in order to ensure timely completion of complaints within the deadline. Complaint reports, outstanding action plans and lessons learned are presented to monthly Service Line Serious Incident meetings and quarterly Service Line Deep Dive meetings. |

## Home Treatment Team Assessment

| | |
|---|---|
| Why did we choose to focus on this? | The function of the Crisis Resolution Home Treatment Team (CRHT) is to provide intensive care and support in patients' homes as an alternative to acute inpatient admission. By providing an alternative to patients in crisis, gatekeeping allows the Trust to focus inpatient resources only where the greatest need is indicated, and allow patients to be treated within the least restrictive environment. |
| What was our target? | 95% of inpatient admissions to be reviewed by the HTT. |
| What did we achieve? | The Trust is currently gatekeeping 97.11% of admissions to inpatient wards. Q4 National data is not yet available, but at Q3 the Trust was achieving 98.5% exceeding the national benchmark of 98.34%.<br><br>The following data is extracted from the patient record system and crossed checked with team managers to ensure all cases have been reviewed by the home treatment team prior to admission. The data shows the following for the period of April 2013 – March 2014 |




The following table shows the data published by the Trust to the Health Sector Compensation Information System from April to December 2012.

| Proportion of admissions to acute wards that were gate kept by the CRHT teams | Q1 based on data submitted to HSCIC | Q2 based on data submitted to HSCIC | Q3 based on data submitted to HSCIC | Q3 based on data submitted to HSCIC |
|---|---|---|---|---|
| lowest | 74.50% | 89.80% | 85.50% | data not yet available |
| BEH | 99.52% | 97.84% | 98.02% | 97.07% |
| Highest | 100.00% | 100.00% | 100.00% | data not yet available |
| England | 97.68% | 98.67% | 98.64% | data not yet available |

| | |
|---|---|
| What needs to improve? | Performance leads are working with managers to develop a more consistent recording system to monitor this activity. |
| How will we continue to monitor and report? | Performance reports will review this data monthly in operational management review meetings. |

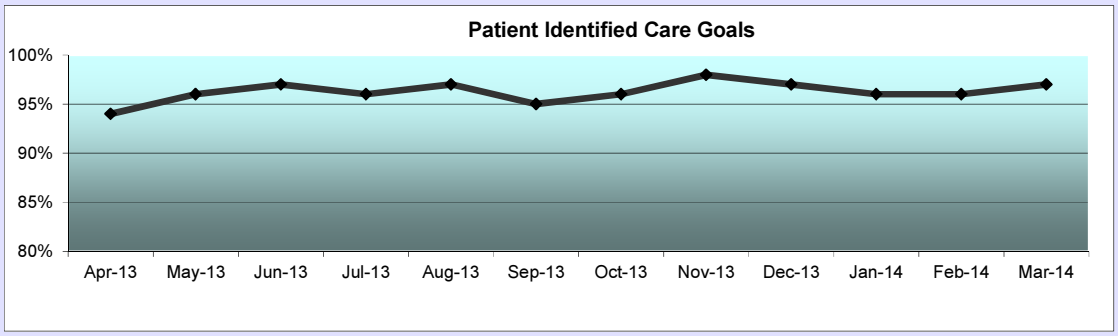
# CLINICAL EFFECTIVENESS

## Patent Reported Outcome Measures (PROMs) – *Key Priority*

| | |
|---|---|
| Why did we choose to focus on this? | Patient Reported Outcomes are a valuable way for Trusts to understand the effectiveness of the treatment and care provided as reported by the service users themselves. PROMS are mandatory this year as a part of our CQUIN contract. |
| What was our target? | To develop and implement a programme to capture outcome data which can be reported against nationally accredited benchmark data when available. |
| What did we achieve? | We are currently using several tools to measure patient health outcomes, and have agreed to implement two nationally accredited patient reported outcome measure tools across mental health and community services.<br><br>Outcome data is routinely collected at the start and end of treatment for all patients treated in complex care services who are on a Single Intervention Treatment or receiving phased treatment as part of the Complex PTSD Service or OCD Treatment Track. Outcomes are collected using the CORE 34 measure. This measure has high reliability and validity and is used across many different NHS services nationally. Recently it was the measure of choice in the National Audit of Psychological Therapies run by the Royal College of Psychiatrists.<br><br>Warwick-Edinburgh Mental Well-being Scale (sWEMWBS) was launched in Triage services in November 2013. Triage teams are receiving weekly performance updates to monitor compliance, and are currently meeting our internally agreed target of receiving feedback from 30% of patients. A health outcomes measure (EQ5D) was launched in Diabetes, Respiratory and Musculoskeletal services in November 2013. Data collection is underway to evaluate response rates in these services. |
| What needs to improve? | Further roll-out of these measures to other services will be implemented in 2014-15. Analysis and interpretation of outcome data will need to be benchmarked against similar services through the payment by results steering group. |
| How will we continue to monitor and report? | Triage teams are receiving weekly performance updates to monitor compliance. |

## Patient Identified Care Goals

| | |
|---|---|
| Why did we choose to focus on this? | Mental health service users have been an integral part of the development of our quality account. While benchmarkable outcome data is a national priority for all health services, our service users have expressed that every individual will have a unique and personal experience which can only be measured on an individual level. A standard was set following a stakeholder workshop to develop a measure which will identify if the plan of care agreed with service users contains individual and personal goals toward recovery. |
| What was our target? | To continue to develop and consistently deliver recovery based care with a target of 90% of all patients being supported to achieve individual recovery goals. |

| | |
|---|---|
| What did we achieve? | An audit based on 4572 patient records over the financial year indicated that 94% of patients had patient identified goals together with personal involvement in care planning.<br>  <br> |
| What needs to improve? | We will continue to monitor this aspect of care and continue to involve and encourage patients to take ownership and empower them to take responsibility and participate in their recovery. |
| How will we continue to monitor and report? | Monitoring will be maintained through the ward and community quality assurance process to ensure that this remains an important issue and scores remain high. |

## Emergency Readmissions

| | |
|---|---|
| Why did we choose to focus on this? | This standard is measured to address potentially avoidable readmissions into hospital. The Trust may be helped to prevent potentially avoidable readmissions by seeing comparative figures and learning lessons from incidents of readmission. |
| What was our target? | The Trust aims to maintain a standard of less than 5% of emergency readmissions to inpatient services within 28 days of discharge. |
| What did we achieve? | During quarters 1-3 in 2013-2014 there were 25 emergency readmissions out of 1167 planned admissions (2.1%). |
| What needs to improve? | Continue to monitor in 2014-15 |
| How will we monitor and report? | Performance is monitored through monthly service line performance meetings and at Board Committee level. |

# QUALITY STATEMENTS

During 2013 - 2014 Barnet Enfield and Haringey Mental Health NHS Trust provided eight NHS services in six service lines. BEH has reviewed all the data available to them on the quality of care in all eight of these NHS services. The income generated by the NHS services reviewed in 2013- 2014 represents 100% of the total income generated from the provision of NHS services by BEH for 2013-14.

## National Audits

During 2013 - 2014 Barnet Enfield and Haringey Mental Health NHS Trust participated in 4 of 5 national clinical audits applicable to the services provided by the Trust (80%).

| Topic | Trust Participation | | National Participation | |
|---|---|---|---|---|
| | Teams | Submissions | Teams | Submissions |
| Topic 13a: Prescribing for ADHD | 0 | 0 | 374 | 5523 |
| Topic 7d: Monitoring of patients prescribed Lithium | 80 | 27 | 6306 | 883 |
| Topic 4b: Prescribing Anti-Dementia Drugs | 2 | 60 | 420 | 9005 |

| Audit | Number of Participating Services | Therapist Questionnaire | | Case Note Audits | | Service User Questionnaires | |
|---|---|---|---|---|---|---|---|
| | | Submissions | Minimum number of submissions | Submissions | Minimum number of submissions | Submissions | Minimum number of submissions |
| National Audit of Psychological Therapies for Anxiety and Depression | 2 | 118 | n/a | 4999 | 6 (guideline) | 86 | n/a |

| Audit | Trust Participation | Organisational Questionnaire Completed | Audit of Practice | | Service User Questionnaires | | Carer Questionnaires | |
|---|---|---|---|---|---|---|---|---|
| | | | Submissions | Minimum number of submissions | Submissions | Minimum number of submissions | Submissions | Minimum number of submissions |
| National Audit of Schizophrenia | Participating – report not yet published | Complete | 100 | 100 | 47 | 50 | 18 | 25 |

## Local Audits

The reports of 75 local clinical audits were reviewed by BEH in 2013– 2014. For full reports of local audits visit our Trust website.

## CQC

Barnet Enfield and Haringey Mental Health NHS Trust is required to register with the Care Quality Commission and its current registration status is currently registered. BEH has no conditions to its registration. BEH is subject to periodic reviews by the Care Quality

Commission. BEH has not participated in any special reviews or investigations by the CQC during the reporting period. The Care Quality Commission has taken enforcement action against BEH during 2013-14.

Over recent months, our inpatient mental health services have been under enormous pressure. This has meant that, on occasion, we have had to use seclusion rooms on our mental health wards when a bed was not available and an urgent admission was required. This is not good clinical practice and this issue has recently been identified as a serious concern by the Care Quality Commission (CQC). Trust was issued with an enforcement notice in relation to regulation 9 outcome 4, in respect of the use of seclusion for non-seclusion purposes. The Trust immediately ceased this practice and has been compliant with this regulation since 10th December 2013 and has remained compliant up to 31st March 2014. Following a further visit from the CQC on 11 April 2014, the CQC has confirmed the Trust's compliance with regulation 9 outcome 4 and has rescinded the enforcement notice.

## Research

TBC

## CQUIN

A proportion of Barnet Enfield and Haringey Mental Health NHS Trust income in 2013 - 2014 was conditional on achieving quality improvement and innovation goals agreed between BEH and NHS North Central London through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2013 - 2014 and for the following 12 month period are available on our website.

## Hospital Episode Statistics

Barnet Enfield and Haringey Mental Health NHS Trust submitted records during 2013 - 2014 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was: 98.9% for admitted patient care; and 99.8% for outpatient care. The percentage of records in the published data which included the patient's valid General Medical Practice Code was 99.5% for admitted patient care; and 99.9% for outpatient care.

## Information Toolkit

Barnet Enfield and Haringey Mental Health NHS Trust score for 2013 - 2014 for Information Quality and Records Management, assessed using the Information Governance Toolkit was Level 2.

## Payment by Results

Barnet Enfield and Haringey Mental Health NHS Trust was subject to the Payment by Results clinical coding audit during the reporting period as part of the Information Governance Toolkit annual submission and the error rate reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was: Primary Diagnosis 6.56%.

To access the Barnet Enfield and Haringey Mental Health NHS Trust Clinical Strategy 2013-18 and Quality Strategy for 2013-16 go to: http://www.beh-mht.nhs.uk/?shortcutid=444372

## NORTH LONDON HOSPICE

The Committee scrutinised the North London Hospice Quality Account 2012/13 and wishes to place on record the following comments:

- The Committee noted the high quality of care provided by the Hospice and welcomed the patient focus.
- The Committee supported the use of volunteers and the training that the Hospice provided for them.
- The Committee noted that a large proportion of the Hospices' income was derived from fundraising activity and commended this.
- The Committee welcomed the participation of the Hospice on the End of Life Care Board and Frail Elderly Group
- The Committee supported the introduction of a target of a 75 – 80% bed occupancy rate for 2013/14.
- The Committee welcomed the decrease in the number of closed bed days from 156 in 2011/12 to 85 in 2012/13.
- The Committee welcomed the Hospice beginning to work within a local five hospice consortium to benchmark performance.
- With reference to Information Governance Assessment, the Committee noted that the Hospice had achieved an overall score of 60% and had been graded 'not satisfactory'. Hospice staff reported that this had been due to issues regarding connecting IT systems to the NHS Intranet which had very high security requirements. Members were advised that was an action plan in place to ensure that the required score of 66% was achieved for 2013/14. The Committee noted the response and supported the actions taken to improve performance.
- The Committee noted that staff had been considering recommendations made in the Francis Report and how the Hospice would respond to these.
- The Committee highlighted the increase in pressure sores (an increase from one in 2011/12 to four in 2012/13) and noted that these were attributable to an increased number of patient days in the hospice and the medical conditions suffered by the patients which made regular movements painful.

## ROYAL FREE LONDON NHS FOUNDATION TRUST

The Committee scrutinised the Royal Free London NHS Foundation Trust Quality Account 2012/13 and wishes to place on record the following comments:

- The Committee welcomed that all targets, with the exception of C.difficile infection cases, had been met for 2012/13. The Committee noted that the Infection Control Team had been undertaking detailed analysis of cases and steps were being taken to address this increase.
- The Committee welcomed the move towards patient rather than clinician defined performance metrics.

- The Committee noted that the hospital had been found to be non-compliant with one outcome relating to medicine management following a CQC inspection in October 2012 and that an action plan was being implemented to address this area of improvement.
- The Committee noted work being undertaken by the Trust to ensure there was sufficient capacity for emergency operations.

**CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST**

The Committee scrutinised the Central London Community Healthcare NHS Trust Quality Account 2012/13 and wishes to place on record the following comments:

- The Committee welcomed the continuing involvement of the Quality Stakeholder Group.
- The Committee commended the award winning work of the Central London Community Healthcare NHS Trust staff.
- The Committee supported work of the Trust to introduce technology to improve clinical record keeping and increase the amount of staff to patient time.

However, the Committee wished to express concern in relation to the following:-

- The Committee commented that the Patient Survey Results indicated a lower performance for Barnet than in other boroughs and sought assurance that Barnet residents were not receiving a lower standard of service.
- The ideal of having interdisciplinary meetings for individual patients' treatment is splendid. However, there is no mention in the Quality Account of how this will happen.

**BARNET AND CHASE FARM HOSPITALS NHS TRUST**

The Committee scrutinised the Barnet and Chase Farm Hospital NHS Trust Quality Account 2012/13 and wishes to place on record the following comments:-

- The Committee welcomed the positive developments set out in the Quality Accounts and were encouraged by the Trust's improved performance on Priority Three: Pressure Ulcers.
- The Committee were pleased to note the improvements that had been made in respect of Priority Five: Liverpool Care Pathway and the emphasis on dignity, respect and compassion.
- The Committee noted the Trust's intention to improve record keeping.
- The Committee congratulated the Trust in relation to their work on Priority One: Dementia Services.

However, the Committee wished to express concern in relation to the following:-

- The Committee questioned why the Trust had not contributed to this year's National Diabetes Audit and expressed concern that the data held on the Trust's existing system was not adequate or specific to the audit. The Committee were reassured to hear that the software required to contribute to this audit had been purchased and that the Trust intended to contribute to next year's audit.
- The Committee noted the number of large scale projects on-going at the Trust (including the response to the Francis Report, the business case for the acquisition of the Trust by the Royal Free London NHS Foundation Trust and delivering the objectives set out in the Quality Accounts) and expressed concern at the ability of the Trust to manage and prioritise these projects. The Committee noted that the Trust were aware of the risks in balancing a number of projects and received assurance that they would monitor Key Performance Indicators closely.
- The Committee expressed concern at the Clinical Coding Error Rate and questioned what action would be taken to improve these figures.
- The Committee raised concern over the performance for MRSA instances in 2012/13 and noted that the target of four cases had been breached, with seven MRSA cases occurring within the period. The committee noted that root cause analysis of the cases had shown that the cases had not been a result of cross-contamination.
- The Committee raised concerns that five "never" events had taken place during 2012/13, and sought assurance that appropriate action would be taken.
- The Committee expressed great concern that the target to see patients at Accident and Emergency within four hours had been breached in five months out of 12 during 2012/2013, especially in light of the changes due to be implemented in November 2013 as part of the Barnet, Enfield and Haringey Clinical Strategy.

**BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST**

The Committee scrutinised the Barnet, Enfield and Haringey NHS Trust Quality Account 2012/13 and wishes to place on record the following comments:

- The Committee welcomed that emergency readmissions to the Barnet, Enfield and Haringey Mental Health Trust were lower than the national average.

However, the Committee wished to express concern in relation to the following:-

- The Committee noted that, following the attendance of a Committee Member at the Barnet Clinical Commissioning Group Board meeting, there was awareness that the patient "crisis line" was not fully operational. The Committee expressed concern that the telephone line had not been working to the expected standard and highlighted the need for improvement.
- The Committee expressed concern that Members had received reports that the "GP Line" had not been answered when called.
- The Committee identified that comments submitted by the North Central London Sector JHOSC in relation to the 2011/12 Quality Accounts (which requested that more information on the absolute number of patients and the different types of treatment given be included within the Trust's Quality Account to give those reading the report a clearer impression of the work of the Trust) had not been addressed. The Committee requested that this information be added to the final version of this year's Quality Accounts.

**BARNET, ENFIELD AND HARINGEY MENTAL HEALTH TRUST**

*Note: The submission below is a joint submission to BEH MHT made by the London Boroughs of Barnet, Enfield, and Haringey following consideration of the Quality Account at a special meeting between the three Boroughs held on 28 May 2013.*

Clara Wessinger and Maria Green from Barnet, Enfield and Haringey Mental Health Trust introduced its draft Quality Account 2012/13.

The Committee scrutinised the Quality Account, and wishes to place on record the following comments:

- The Committee welcomed that the statistics for the rate of Emergency Readmissions within 28 days of discharge was below the national average.
- The Committee welcome the addition of the achievements of staff within the Quality Account.
- The Committee were pleased to note that there had been no enforcement action from the Care Quality Commission.
- The Committee welcomed the objectivity of the comments made within the Quality Account about the lack of Communication with GPs, but were concerned that the target had not been met in 2012/13. The Committee request that the BEH MHT consider this as an official priority for 2013/14.

However, the Committee also wishes to place on record the following comments:

- The Committee expressed concern that, under the category of GP Communications, the Care Plan Review Update sent to GPs (within two weeks) was 54%, below the internal trust target of 95%.

- The Committee were disappointed to note that one of the priorities for 2012/13, “Safety – Improve Communications with GPs” had only been partially met.
- The Committee expressed concern over the poor GP involvement in Mental Health issues, and requested to be advised of GP attendance statistics to organised training academies.
- The Committee noted that concerns had been raised regarding the reported functionality of the patient “crisis line” and the “GP line”. The Committee were advised that reports on both of these telephone lines were currently being prepared, and would be provided to the Committee.

**The Committee also made the following requests:**

- The Committee noted that the Trust is currently conducting a piece of work on The Francis Report, and requests that a link to that document is placed in the final paragraph of the Chief Executive Statement in the final version of the Quality Account.
- That the Committee are advised whether or not Magnolia Ward, at St. Michael’s Hospital in Enfield, is included within the statistics for Emergency Readmissions within 28 days of discharge.
- The Committee have also requested that the Trust provide Barnet, Enfield and Haringey with an update on the following topics:

    1) Primary Care Academies
    2) GP Link Workers
    3) GP Line
    4) Crisis Line
    5) Training Updates (The Committee requested that when this information is provided, where possible, it is broken down to Borough level for clarity)

- The Committee noted the importance of reporting Patient Safety Incidents and requested that an explanatory note is added to the Quality Account to outline what follow-up action is taken on' the reports of Patient Safety Incidents once they have been received.
- Barnet, Enfield and Haringey request that the Trust provide an update on their progress against the comments made herein at a meeting to be held in six months’ time. In particular, this is to include an update on the Care Plan.

**RESOLVED that:-**

1. **That the above mentioned comments by the Committee be noted by the North London Hospice and individual Trusts and incorporated into the final versions of their Quality Accounts for 2012/13.**

2. **The Royal Free Hospital NHS Foundation Trust be requested to provide the Committee with details of changes to the National Patient Survey and the impact on measuring performance against key quality objectives.**

3. **NHS partners be requested to present a six month update to the Committee on actions taken to respond to the comments by the Committee when considering the Quality Accounts.**

4. **Barnet and Chase Farm Hospitals NHS Trust be requested to provide details to the Committee on actions taken to address performance issues in relation to the Clinical Coding Error Rate.**

**Appendix 7** – Minute Extract – Health Overview and Scrutiny Committee 12 December 2013

## 1. NHS QUALITY ACCOUNTS - MID YEAR UPDATE

The Committee considered updates received from NHS health service providers on progress made in addressing the comments / recommendations made by when the 2012/13 Quality Accounts were reviewed on 9 May 2013.

### NORTH LONDON HOSPICE

The Committee welcomed Pam McClinton, the Nursing Director at the North London Hospice. She made the following comments in addition to the update report set out in the committee report:

The Hospice had now achieved full compliance with Level 2 of the 2013/14 Information Governance Toolkit.

Whilst staffing ratios were currently good, recruitment could be an issue and the Hospice had been investigating ways to address this.

The Hospice Board had been undergoing a development programme facilitated by Help the Hospices. A new governance structure had been implemented which had delivered a more joined up approach. In addition, the Board of Trustees would be considering the implications of the Government's response to the Francis Report in early 2014.

The Committee noted that the table on pressure sore numbers should read 4 in 2012/13 and not 2 as per the published table.

Members were informed that Douglas Bennett would be stepping down as Chief Executive of the Hospice and would be replaced by Pam McClinton.

### ROYAL FREE LONDON NHS FOUNDATION TRUST

The Committee welcomed Dr Steve Powis, Medical Director at the Royal Free London NHS Foundation Trust. He made the following comments in addition to the update report set out in the committee report:

Dr Powis reported that meeting the C. difficile target had been challenging and it was expected that the Trust would not meet the target in 2013/14. The Committee were advised that detailed root and branch reviews had been undertaken to investigate C. difficile cases. He added that a recent study by Oxford University had shown that reductions in the same of C. difficile cases could be attributed to reductions in the use of antibiotics rather than hospital cross-infection control measures.

Responding to a question, Dr Powis reported that patient-reported outcome or experience metrics were not related to satisfaction, but rather health improvements and pain management. He added that the system was currently being tested.

## CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST

The Committee noted that Central London Community Healthcare (CLCH) had been unable to send a representative to the meeting

Members commented that whilst PREMs (Patient Reported Experience Measures) responses from Barnet residents had increased to 20% of the total responses for CLCH, this was still represented poor performance from a borough with a population of 350,000.

## BARNET AND CHASE FARM HOSPITALS NHS TRUST

The Committee welcomed Fiona Smith (Chief Operating Officer at Barnet and Chase Farm Hospitals NHS Trust) and Terina Riches (Director of Nursing at Barnet and Chase Farm Hospitals NHS Trust). They made the following comments in addition to the update report set out in the committee report:

In relation to MRSA, the Trust undertook a root and branch reviews to ascertain the reasons for these failures in care.

The Committee were informed that there had been one 'Never Event' where potassium had been given to a patient and it was reported that this had been referred to the serious incident panel.

A Member questioned whether the root cause analysis for specific incidents was shared across the NHS. Terina Riches reported that this did not happen routinely and at present, learning was shared with the Commissioning Support Unit.

## BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST

The Committee welcomed Clara Wessinger (Head of Clinical Audit and Effectiveness at Barnet, Enfield and Haringey Mental Health Trust).

At the invitation of the Chairman, Councillor Helena Hart (Cabinet Member for Public Health), addressed the Committee. She expressed serious concerns regarding the findings of recent Care Quality Commission (CQC) inspections of Barnet, Enfield and Haringey Mental Health Trust services. Members were informed that she had written to the Barnet Clinical Commissioning Group Chairman and that John Morton had written to the Trust regarding these issues. She reported that the recent CQC inspections were a follow-up from inspections undertaken in May 2013 which identified issues. Whilst there had been improvements at The Oaks at Chase Farm Hospital, there had been no improvements in a number of other wards. Of the six basic quality and safety standards, four had been breached. She highlighted that there had been failures on medicines and oxygen management, patients had been forced to wear continence pads and that mealtime arrangements required improvements.

The Committee noted that the Cabinet Member for Public Health would be taking an urgent item to the next meeting of the Health and Well-Being Board on 23 January 2014. The Chairman suggested that a special meeting of the North Central London Sector Joint Health Overview and Scrutiny Committee be convened to consider the CQC inspection reports as soon as possible.

John Morton (Chief Officer at Barnet Clinical Commissioning Group) advised the Committee that Enfield Clinical Commissioning Group (CCG) were the lead commissioners for Barnet, Enfield and Haringey Mental Health Trust across the three boroughs. Members were informed that Mr Morton had been meeting regularly with Barnet, Enfield and Haringey Mental Health Trust. The Committee were informed that the Mental Health Trust had a new medical director who had significant experience in the field.

In response to these concerns, Clara Wessinger reported that she was not able to respond to issues on the Quality and Safety Action Plan. She made the following comments in relation to the update report on NHS Quality Accounts set out in the committee report:

In relation to communications, process mapping work had been undertaken across services to identify gaps and as a result new protocols had been put in place.

A Member advised the Committee that that at a recent CCG meeting, GPs had commented that they had felt unsupported by the Mental Health Trust in relation to the GP Advice Line. It was highlighted that the number of calls to the GP Advice Line had been deteriorating. Clara Wessinger advised the Committee that there was no mechanism in place to capture feedback on the service. She added that the decline might be attributable to the recent Primary Care Academies which had introduced other systems to support GPs.

**RESOLVED that:-**

1. **The Committee note the updates on the NHS Quality Accounts 2012/13 as set out in the reports and above.**

2. **Barnet and Chase Farm Hospitals NHS Trust be requested to circulate the outcome of the Diabetes Audit to the Committee.**

3. **Barnet and Chase Farm Hospitals NHS Trust be requested to provide a written response to the Committee on the arrangements for sharing learning from "Never Events" across the NHS.**

4. **The Chairman of the North Central London Joint Health Overview and Scrutiny Committee be requested to set up a special meeting (of Barnet, Enfield and Haringey Members only) to consider the recent Care Quality Commissioning reports on Barnet, Enfield and Haringey Mental Health Trust, with representatives from Clinical Commissioning Groups, local Healthwatches and Cabinet Members for Health being invited to attend.**

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AGENDA ITEM 8

| | |
|---|---|
| Meeting | Health Overview & Scrutiny Committee |
| Date | 12 May 2014 |
| **Subject** | **Health Overview and Scrutiny Committee Forward Work Programme** |
| Report of | Overview and Scrutiny Office |
| Summary | This report provides Members with the Health Overview and Scrutiny Committee Forward Work Programme. |

| | |
|---|---|
| Officer Contributors | Anita Vukomanovic - Overview and Scrutiny Officer |
| Status (public or exempt) | Public |
| Wards affected | All |
| Enclosures | Appendix A – Health OSC Forward Work Programme |
| Reason for urgency / exemption from call-in | Not applicable |
| Key decision | N/A |

Contact for further information: Anita Vukomanovic – Overview and Scrutiny Officer, anita.vukomanovic@barnet.gov.uk – 0208 359 7034

## 1. RECOMMENDATION

**1.1 That the Committee consider the Health Overview and Scrutiny Committee Forward Work Programme attached at Appendix A.**

## 2. RELEVANT PREVIOUS DECISIONS

2.1 None.

## 3. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

3.1 The Overview and Scrutiny Committees must ensure that the work of Scrutiny is reflective of the Council's priorities.

3.2 The three priority outcomes set out in the 2013 – 2016 Corporate Plan are: –

- Promote responsible growth, development and success across the borough;
- Support families and individuals that need it – promoting independence, learning and well-being; and
- Improve the satisfaction of residents and businesses with the London Borough of Barnet as a place to live, work and study.

3.3 The work of the Barnet Health Overview and Scrutiny Committee supports the delivery of the following outcomes identified in the Corporate Plan:

- To sustain a strong partnership with the local NHS, so that families and individuals can maintain and improve their physical and mental health; and
- To promote a healthy, active, independent and informed over 55 population in the borough to encourage and support our residents to age well.

## 4. RISK MANAGEMENT ISSUES

4.1 None in the context of this report.

## 5. EQUALITIES AND DIVERSITY ISSUES

5.1 In addition to the Terms of Reference of the Committee, and in so far as relating to matters within its remit, the role of the Committee is to perform the Overview and Scrutiny role in relation to:

- The Council's leadership role in relation to diversity and inclusiveness; and
- The fulfilment of the Council's duties as employer including recruitment and retention, personnel, pensions and payroll services, staff development, equalities and health and safety.

5.2 The Council is required to give due regard to its public sector equality duties as set out in the Equality Act 2010 and, as public bodies, health partners are also subject to equalities legislation; consideration of equalities issues should therefore form part of their reports.

## 6. USE OF RESOURCES IMPLICATIONS (Finance, Procurement, Performance & Value for Money, Staffing, IT, Property, Sustainability)

6.1 None in the context of the report.

## 7. LEGAL ISSUES

7.1 None in the context of the report.

## 8. CONSTITUTIONAL POWERS

8.1 Council Constitution, Overview and Scrutiny Procedure Rules – sets out the terms of reference of the Health Overview and Scrutiny Committee which includes:

i) To perform the overview and scrutiny role in relation to health issues which impact upon the residents of the London Borough of Barnet and the functions services and activities of the National Health Service (NHS) and NHS bodies located within the London Borough of Barnet and in other areas.

ii) To make reports and recommendations to the Executive, Health and Well-Being Board and/or other relevant authorities on health issues which affect or may affect the borough and its residents.

iii) To receive, consider and respond to reports and consultations from the NHS Commissioning Board, Barnet Clinical Commissioning Group, Barnet Health and Well-Being Board and/or other health bodies.

## 9. BACKGROUND INFORMATION

9.1 Under the current overview and scrutiny arrangements, the Health Overview & Scrutiny Committee are required to ensure that the work of Scrutiny is reflective of Council priorities, as evidenced by the Corporate Plan and the programme being followed by the Executive. The Committee are requested to consider and agree the items contained within the work programme.

## 10. LIST OF BACKGROUND PAPERS

10.1 None.

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# London Borough of Barnet

# Health Overview and Scrutiny Committee

# May 2013 – May 2014

Contact: Andrew Charlwood Tel: 020 8359 2014 email: andrew.charlwood@barnet.gov.uk

| Subject | Decision requested | Cabinet Member | Author |
|---|---|---|---|
| **12 March 2014** | | | |
| GP Services at Finchley Memorial Hospital | NHS England have been requested to make a written submission to the Committee on:<br>i) the decision to relocate Dr Thwe's practice to Finchley Memorial Hospital;<br>ii) progress made in relocating GP practices into the vacant space at Finchley Memorial Hospital; and<br>iii) the impact of dispersing the patient lists of two practices in the West Finchley area | N/A | NHS England |
| Site Issues at Finchley Memorial Hospital | NHS Property Services and Community Health Partnerships have been requested to make a written submission to the Committee on site issues at Finchley Memorial Hospital | N/A | NHS Property Services and Community Health Partnerships |
| Barnet Healthwatch Enter and View Reports | To consider enter and view reports from Barnet Healthwatch | N/A | Barnet Healthwatch |
| Annual Report of the Director for Public Health | To consider the 2013 Annual Report of the Director of Public Health: Barnet and Harrow on the Move | Cabinet Member for Public Health | Director of Public Health |
| Public Health Commissioning Intentions | To consider the commissioning intentions for Public Health in Barnet for 2014/15 | Cabinet Member for Public Health | Director of Public Health |
| NHS Health Checks Scrutiny Review | To receive the final report of the joint Barnet / Harrow NHS Health Checks Scrutiny Review | N/A | Scrutiny Office |

| Subject | Decision requested | Cabinet Member | Author |
|---|---|---|---|
| **12 May 2014 (NHS Quality Accounts)** | | | |
| Barnet and Chase Farm Hospitals NHS Trust Quality Accounts | To receive and comment upon the Quality Accounts from Barnet and Chase Farm Hospitals NHS Trust for 2013/14 | N/A | NHS |
| Barnet, Enfield and Haringey Mental Health NHS Trust Quality Accounts | To receive and comment upon the Quality Accounts from Barnet, Enfield and Haringey Mental Health NHS Trust for 2013/14 | N/A | NHS |
| Central London Community Healthcare NHS Trust Quality Accounts | To receive and comment upon the Quality Accounts from Central London Community Healthcare NHS Trust for 2013/14 | N/A | NHS |
| North London Hospice Quality Accounts | To receive and comment upon the Quality Accounts from North London Hospice for 2013/14 | N/A | North London Hospice |
| Royal Free Hospital NHS Foundation Trust Quality Accounts | To receive and comment upon the Quality Accounts from Royal Free Hospital NHS Foundation Trust for 2013/14 | N/A | NHS |
| Foundation Trust Status Updates | To receive updates on the attainment of Foundation Trust status from NHS partners at:<br>• Barnet and Chase Farm Hospitals NHS Trust<br>• Barnet, Enfield and Haringey Mental Health Trust<br>• Central London Community Healthcare NHS Trust | N/A | NHS Trusts |

| Subject | Decision requested | Cabinet Member | Author |
|---|---|---|---|
| **Unallocated Items** | | | |
| NHS Trusts Performance | To receive a report on the performance of NHS Trusts providing services to Barnet residents against the NHS Outcomes Framework | N/A | Scrutiny Office / NHS Trusts |
| Health and Wellbeing Strategy | TBC | Cabinet Member for Public Health | Director for Public Health |